Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 4 January 2018

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: 4 January 2018

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
Acting Director of Finance and Performance	-	Jason McIntyre

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 *(apologies)*

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	Professional Governance Services Ltd, has been commissioned by Age UK to undertake governance reviews. One of the charities selected for a review is Age UK, East Grinstead.	Nil	Nil	Nil
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	Director, Sharpthorne Services Ltd; Director CIEH Ltd	Nil	Nil	• Trustee for The Chartered Institute of Environmental Health and member of its risk and audit committee • Governor at Staffordshire University	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
Jason McIntyre Acting Director of Finance	Nil	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
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Sharon Jones Director of Operations	Nil	Nil	Nil	Nil	Spouse currently has three-month contract with Sophos (Sophos Safeguard used by Trust as one of its software programmes).	Nil	Nil
Geraldine Opreshko Director of HR & OD	Nil	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
Jason McIntyre Acting Director of Finance	NA	NA	NA	NA	NA	NA	NA
Ed Pickles	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.
Medical Director							
Jo Thomas Director of Nursing	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 Foundation Trust

Business meeting of the Board of Directors
Thursday 4 January 2018
10:00 – 13:00
The Board Room, Blond McIndoe Building, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
05-18	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
06-18	**Patient Story** *Jo Thomas, Director of Nursing*	*Assurance*	-
07-18	**Draft minutes of the meeting session held in public on 2 November 2017** *Beryl Hobson, Chair*	*Approval*	1
08-18	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	11
09-18	**Chief executive's report** *Steve Jenkin, Chief Executive*	*Assurance*	12
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
10-18	**Board Assurance Framework** *Sharon Jones, Director of Operations and Jason McIntyre, Acting Director of Finance*	*Assurance*	17
11-18	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	*Assurance*	19
12-18	**Operational performance** *Sharon Jones, Director of Operation*	*Assurance*	23
13-18	**Financial performance** *Jason McIntyre, Acting Director of Finance*	*Assurance*	33
Key strategic objective 1: outstanding patient experience			
14-18	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	*Assurance*	51
15-18	**Corporate risk register (CRR)** *Jo Thomas, Director of Nursing*	*Review*	52

16-18	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	-
17-18	**Quality and safety report** *Jo Thomas, Director of Nursing*	*Assurance*	72
18-18	**CQC children and young person's inpatients and day case survey 2016** *Jo Thomas, Director of Nursing*	*Assurance*	113
Key strategic objective 2: world-class clinical services			
19-18	**Board Assurance Framework** *Ed Pickles, Medical Director*	*Assurance*	131
20-18	**Medical director's report** *Ed Pickles, Medical Director*	*Assurance*	132
Key strategic objective 5: organisational excellence			
21-18	**Board assurance framework** *Geraldine Opreshko, Director of Workforce & OD*	*Assurance*	136
22-18	**Workforce monthly report** *Geraldine Opreshko, Director of Workforce & OD*	*Assurance*	137
Board governance			
23-18	**Board development** *Clare Pirie, Director of Communications and Corporate Affairs*	*Assurance*	149
24-18	**Board of Directors annual evaluation** *Clare Pirie, Director of Communications and Corporate Affairs*	*Assurance*	157
25-18	**Annual review of Board committee Terms of Reference** *Clare Pirie, Director of Communications and Corporate Affairs*	*Approval*	161
26-18	**Nomination & remuneration committee** *Beryl Hobson, Committee and Trust Chair*	*Assurance*	180
27-18	**Audit committee** *Kevin Gould, Committee chair*	*Assurance*	181
Any other business (by application to the Chair)			
28-18	*Beryl Hobson, Chair*	*Discussion*	-
Observations and feedback			

29-18	**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.Saunders1@nhs.net 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: 1 March 2018 at 10:00	**F&P:** 22 January 2018 **N&R:** 01 February 2018 **Q&G:** 15 February 2018 **Charity:** 08 March 2018 **Audit**: 21 March 2018	**Public**: 15 Jan 2018 at 16:00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 02 November 2017, 10.00 – 13.00, Boardroom, Blond McIndoe Research Centre, QVH RH19 3DZ**	
Present:	Beryl Hobson, (BH)	Trust Chair (voting)
	Ginny Colwell (GC)	Non-Executive Director (voting)
	Kevin Gould (KG)	Non-Executive Director (voting)
	Steve Jenkin (SJ)	Chief Executive (voting)
	Sharon Jones (SLJ)	Director of Operations
	Gary Needle (GN)	Non-Executive Director (voting)
	Geraldine Opreshko (GO)	Director of Workforce and organisational development
	Ed Pickles (EP)	Medical Director (voting)
	Clare Pirie (CP)	Director of Communications and Corporate Affairs
	Jo Thomas (JMT)	Director of Nursing (voting)
	Jason McIntyre (JMc)	Acting Director of Finance (voting)
	John Thornton (JT)	Non-Executive Director (voting)
In attendance:	John Belsey (JEB)	Lead Governor
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
	Elin Richardson (ER)	Associate Director of business development
Public gallery	3 members of the public, (including 2 governors)	

Welcome	
161-17	**Welcome, apologies and declarations of interest** The Chair opened the meeting. She welcomed JMc who was attending his first meeting as Acting Director of Finance and went on to welcome the three members of the public, including two governors and a representative of the Care Quality Commission, (Kathryn Stoneman). SLJ asked the Board to note the update to her Declaration of Interest relating to her spouse's current 3-month contract with Sophos (Sophos Safeguard used by Trust as one of its software programmes). There were no further new declarations of interest.
Standing items	
162-17	**Patient Story** BH reminded the Board of the underlying principle of the 'patient story' session which was to ensure that the patient remained at the centre of what we do as an organisation; she went on to welcome a patient and his spouse to the meeting who had agreed to join the session today. The patient and his spouse described their recent experience at QVH, and whilst commending the high standard of care received, were critical of the way in which communication around the cancellation of his original operation had been handled. They went on to provide additional detail on the impact this had on not only the patient but also his family. The Director of Nursing assured the patient that the Trust had learned from this episode and described some of the recent improvements to the patient pathway made since this incident, which had included the opening of a new dedicated trauma centre. Other members of the Board sought assurance regarding process and agreed it was very helpful to receive this type of feedback. BH thanked the patient and his spouse for attending today to apprise the Board of issues, both good and

	bad. There were no further comments and they both left the meeting.
163-17	**Draft minutes of the meeting session held in public on 7 September 2017 for approval** The Board **APPROVED** the minutes of the meeting held on 7 September as a correct record subject to the following amendments: • 140-17: One Serious Incident was reported in August • 155-17: 'HEKSS Deanery' to be changed to HEKSS project', and 'performance management' to be amended to 'change' • ER to be added to the list of those in attendance at the meeting.
164-17	**Matters arising and actions pending** The board received and **APPROVED** the current record of matters arising and actions pending.
165-17	**CEO report** SJ presented his report highlighting the following: • The Memorandum of Understanding with Brighton & Sussex University Hospitals NHS Trust had recently been approved, (the QVH Board had approved the MOU at their July meeting). A meeting between organisations to progress was scheduled for 15 November; • Deputy Medical Director, Dr Rachael Liebmann, had been awarded the Royal College of Pathologists Medal for Distinguished Service. This is the highest accolade the College has for a Fellow and is not awarded every year. In addition, Rachael has been elected Vice-President of the College and starts her three-year role this month; • With reference to the BAF, it was noted that 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; • Bob Alexander Executive Director of Resources/Deputy Chief Executive with NHS Improvement has been announced as the new Executive Chair of the local Sussex & East Surrey Sustainability & Transformation Partnership (STP). He is meeting with all 24 lead accountable officers and chairs, and visited QVH on 24 October. BH had assured Bob Alexander of the Trust's commitment to the STP; he in turn was keen to break down artificial barriers and to progress transformation; • The Care Quality Commission (CQC) had published its annual assessment of the quality of health and social care in England, *'State of Care'*. This report had highlighted "unprecedented pressure" on the system and the impact that this was having on performance. SJ noted that this report reflected where the STP was locally, citing focus on treatment of illness rather than prevention, and slow responses to innovation. The Trust was keen to embrace integration with GPs; to this effect, from 16 November a GP from one of the local surgeries would be based in MIU to provide urgent 'on the day' care. It was hoped that this practice would extend across the remainder of local surgeries by the end of February. The Board considered in detail the CEO's review of the *State of Care* report, noting that Sir David Behan, CEO of the CQC had highlighted a deterioration in service quality over the last twelve months. The current model of care had been designed in 1948 when focus of care was on treatment not prevention. There was an urgent need to change but the only way to address this was through collaboration and partnership. , There were no further comments and the Board **NOTED** the contents of the CEO's update.
166-17	**Freedom to Speak Up (FTSU) Guardian** The Chair welcomed Andi Heaton, the Trust's FTSU guardian, to the meeting. She had been invited to present on the FTSU guardian role and its purpose. This was an inaugural review, and would become a standing item with updates provided to the Board at regular intervals throughout the year.

	The Board was reminded that in line with all Trusts in England, QVH appointed a Freedom to Speak Up Guardian in May 2017. This role provides confidential advice and support to staff in order to protect patient safety, and empower staff to act. At QVH this appointment was by staff vote, and the time currently allocated to the role is half a day per week. AH described the ways in which the role (overseen by the national guardian) had been implemented at QVH and provided some insight into the first four months' activity. She gave a snapshot of the national picture but noted that it was difficult to benchmark QVH against other trusts as the number of staff differs widely as does the length of time in post and time availability. However, the national demographic of those raising concerns was reflected at QVH. 18 cases had been raised in total at QVH since June. Two had related to potential patient safety issues, but others related to staffing/employment, service provision and patient experience, and unacceptable behaviour by QVH staff. No staff had raised a concern anonymously, but four had asked for their identity to be protected due to concerns about how they would be treated if identified. fear of reprisals. AH's initial insight from early conversations included: • That there was a strong desire to encourage 'speaking up' and embracing transparency in the NHS, although there were issues around 'trust' in the Trust; • Leadership from the chief executive and support from other members of the Board had been very valuable; However, AH had also experienced some mistrust from middle managers who resented having to give up time to meet with her; some had also been unwilling to accept that there were any issues within their respective departments. Feedback on the service obtained via a survey had overall been very positive, although the Board noted with concern that a small number of f respondents had stated they had suffered ramifications as a result of speaking up. The Board asked AH to highlight the ways in which it could provide ongoing support for the role and to facilitate speaking up as 'business as usual' at QVH. AH set out an overview of plans and ideas for the next stage which included: • Greater promotion of the service; • Budget allocation for the role (currently, there was no budget and no backfill provided for AH's substantive post); • Increase the time allocated to the role, which could enable a more proactive rather than reactive service; • Identification of a suitable location in which to hold confidential meetings, funded from the corporate budget; • Recruitment of a deputy guardian. (GO noted a similar election process should be followed, but that candidates from non-clinical areas could be invited to stand); • Recruitment of Speak Up champions; • Training managers in the benefits of speaking up, with implementation of a mandatory 360° appraisal process for B8 staff; • Reintroduction of 'Schwarz' rounds (used successfully by the Trust up until a couple of years ago); • Ways in which to demonstrate that the process has had a positive outcome - maybe using an anonymous 'you said, we did' model; • Provision of credit card size business cards (to replace the current leaflets) which would be less conspicuous for users pick up.

	The Board discussed at length the implications of this update, in particular: • Ways in which to tackle the middle-management issue, and that Leading the Way leadership training and other work was designed to address culture at the Trust; • Clarification regarding the process, how issues were tracked and the assurance required before a matter was closed; • This role was important to the Trust's culture and should be embedded, together with the 'Tell Jo', Datix and Whistleblowing options for raising concerns. However, the Board had yet to identify the best way in which to collate this intelligence and review it as a whole in order to develop a 'Culture of Improvement'. The Chair agreed that this important matter should be addressed and would ensure this was would be considered at the next board seminar (likely to be as part of the Well Led discussions). There no further questions and the Chair thanked AH for her comprehensive update, the contents of which were **NOTED** by the Board.
Key strategic objective 1: outstanding patient experience	
167-17	**Board Assurance Framework: KSO1** JMT reported that the risk rating had been increased to 15 in response to the increase in negative Friends and Family comments regarding waiting times. Additional work was being undertaken by the Patient Experience Group to ascertain the issues and identify appropriate actions. There were no further questions and the Board **NOTED** the contents of the report.
168-17	**Corporate Risk Register (CRR)** The CRR had recently been reviewed by the Quality and governance committee, The Head of Risk had now met with all senior managers and the Board was asked to note the CRR information and progress from the previous report. Key changes included seven new corporate risks added, thirteen re-scored to below 12 (therefore becoming local risks) and fourteen corporate risks closed. The Board sought and received additional clarification in respect of the following: • 1079: DCT stood for dental care trainees; • 1082: Relating to the General Data Protection Regulation (GDPR). Although the Information & governance group reported into Q&GC, it was agreed that the F&PC would monitor progress. JMc confirmed that Internal Audit were scheduled to review the Trust's GDPR preparedness in Q4 and an action plan was already in place; • 1074: Had been a new risk but during the risk review process had already been downgraded; • 1054: Training compliance levels of Safeguarding Children L3 were improving as per the trajectory previously reported; The Board noted the improvements to the CRR and asked that the Head of Risk, (Karen Carter-Woods) be commended. There were no further comments and the Board **NOTED** the latest update.
169-17	**Quality and governance assurance report** GC presented the Quality and governance assurance report. She asked the Board to note in particular that following on from the decision taken previously for the Committee to meet with specialty teams, the Plastics speciality would be further broken down in order to gain additional assurance in sub-specialty areas. These meetings would be scheduled into the annual work programme.

	The Board approved the latest version of the Terms of Reference which had been revised to show that an additional meeting would be held in July, (rather than September), which would facilitate timely review of annual reports from those clinical groups who report to the Committee. There were no further questions and the Board **APPROVED** the latest terms of reference and **NOTED** the contents of the assurance update.
170-17	**Quality and safety report** JMT presented the Quality and safety report, asking the Board to note the following: • An update on recent work in defining establishment figures. The total establishment for nursing, theatre practitioners and health care assistants stood at 352.74WTE with the current total number of vacancies at 73.16 WTE. The trust is recruiting substantively to 44.26 WTE of these, (14% of the workforce). JMT explained that the remaining 28.9 WTE was flexible uplift and would not form part of the substantive workforce. She went on to commend this piece of work which would facilitate better management of the nursing budget; • Issues in decontamination (the Wassenberg machine in theatres remained out of service), but this was being carefully managed. JMT went on to report the details of a Never Event which had occurred the previous week during an eye procedure. Surgery had then proceeded correctly, but initial investigations indicated the error was as a result of misinterpretation of the WHO check list. Parts of the resultant action plan had already been incorporated into practice, with key staff fully engaged in the process. EP suggested additional time and resource was needed to ensure WHO checklist processes were embedded culturally, noting that in the short term this could have an adverse effect on activity levels. EP highlighted the similarities between this never event and the recent serious incident where the structure of a lengthy policy document meant important parts had not been immediately apparent. JMT described work relating to policies which had been undertaken, with reminders to specific groups of staff on key policies and procedures as well as how to access all policies. However, an overhaul of all policies to underscore areas relating specifically to critical patient safety would require resource. The Board queried whether the use of agency staff in theatres could increase risks, but JMT was assured that this incident was not directly attributable to agency staff. The WHO checklist was widely used and a competent practitioner would be familiar with this. The bigger risk was around culture, with SJ reiterating the importance of learning after such events. The Chair recognised that this issue would be monitored through the Quality and governance committee but asked that the Board also receive updates on progress. JT noted changes in formatting of the Complaints report. This had been revised to ensure patient confidentiality was maintained, however the detailed report was still contained within the Q&GC reports which all board members received. There were no further questions and the Board **NOTED** the contents of the update.
171-17	**Six-monthly nursing workforce review** The Board received its bi-annual review of nurse staffing levels at QVH. JEB sought assurance that the Trust could not become unsafe and was apprised of the robust procedures in place to ensure staffing levels remained safe at all times. These included regular meetings with the site practitioners, Director of Nursing

	and Deputy Director of Nursing, methods of escalating concerns and a real time rostering system. JMT was equally assured at weekends and was not aware of any failures to escalate at these times. There were no further questions and the Board **NOTED** the contents of the latest report.
172-17	**Emergency planning assurance** JMT presented the Emergency planning assurance report. This detailed the results of the external assessment by the CCG and NHSE of the Trust's preparedness against NHS EPRR core standards and provided assurance of the effectiveness of emergency planning and business continuity at QVH. It was noted that of the 66 core standards, QVH was compliant in 59 with seven standards rated as amber. This was an improvement on last year's results, although the Trust's compliance rating remains as Partial. JMT assured the Board that although there was work to be done, none of the areas rated as amber would impede our ability to respond to an incident or emergency. It was noted that as a small trust QVH does not have a dedicated emergency planning role, and that further consideration was needed on how to resource this work. There were no further questions and the Board **NOTED** the partial compliance rating and the contents of the report its appendices.
Key strategic objective 2: world class clinical services	
173-17	**Board assurance framework** EP reported that there had been no changes to the BAF risk rating since the last meeting. There were no further questions and the Board **NOTED** the contents of the report.
174-17	**Medical director's report** The Medical Director update was taken as read. The Board went onto raise the following queries: • Routine data on transfers out, returns to theatre and unexpected readmissions to hospital within 30 days of discharge had shown that there were 8 patients transferred out unexpectedly from QVH in August. However, EP assured the Board that this figure was within the normal range; • This was the first report since our new policy 'Responding to and Learning from Deaths' had been published. Although the Trust only had a small number of deaths on site, for each death, QVH will contact the family, carers, and GP to ask if they have any concerns regarding care provided. Any concerns raised will prompt a Structured Judgement Review and ensure full duty of candour process is adhered to. There were no further questions and the Board **NOTED** the contents of the update.
175-17	**Paediatric inpatient burns services update** EP presented a report to the Board regarding the Trust's current paediatric inpatient service, its risks and current and planned mitigation. EP described the background leading to the current position. In 2013, following a revision of National Burns Care standards a number of significant gaps against the specification had been identified. Although services at the Trust were deemed to be safe, (with agreed derogation against certain standards) the significant infrastructure changes required were not practical for QVH alone, and in 2014 NHS England had asked QVH to consider an alternative service model, working with partners to ensure future compliance.

	In March 2016, a Strategic Outline Case (SOC) for the development of Paediatric Burns and Lower Limb Trauma care was developed between QVH and Brighton and Sussex University Hospitals (BSUH). The original plan was for services to be fully implemented by February 2017. However, the funding gap was estimated to be c£876,000; when a request for assistance from NHS England was declined, progress ceased and the momentum was lost. EP then went on to describe the options considered by QVH and the London and South East Burns Network in the intervening years, but the current clinical partnerships between QVH and BSUH showed that a shared, dual site service option remained the most clinically relevant solution. To this end a Memorandum of Understanding (MoU) had now been signed by both boards proposing clinical partnerships. It was recognised that paediatric burns care was the most urgent. It was also noted that the MOU aligned to STP collaboration across acute specialties. EP set out the risks and mitigations in place to support current service provision, and assured the Board that the Trust continued to operate a safe, effective service. In order to progress the MOU, the following was required: • A paediatric burns work stream, (managed by a jointly appointed project manager) should be developed as a matter of urgency; • QVH currently employed five of the six consultant posts needed for a sustainable on call rota for plastics at the BSUH major trauma centre. It was hoped there would be financial support for the additional post; • There was a requirement for a transfer of nursing skills in burns care; this remained a challenge in view of the current recruitment issues, but it was hoped this was achievable through increased collaboration in the STP and MoU. JMT stated that she was currently liaising with her counterpart at the Royal Alexandra Children's Hospital (RCAH) and had been assured by the level of enthusiasm for this proposal; The Board went on to consider the impact of this report, noting the following: • Satisfaction that the MoU had now been agreed by both boards. SJ remarked that the CEO of Western and BSUH was keen to progress, and he was optimistic of a positive outcome; • That if the clinically appropriate number of consultants was agreed to be six, then the Board should support this additional post; • The adult burns service was also included in the overall MoU. . There were no further comments and the Chair thanked EP for his comprehensive update which was **NOTED** by the Board.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
176-17	**Board assurance framework** The Board **NOTED** the content of the BAF reports for KSO3 and KSO4.
177-17	**Financial and operational performance assurance report** JT provided an update of the recent meeting which had taken place. There were no questions or comments and the Board **NOTED** the contents of the assurance report.
178-17	**Operational performance** The report was taken as read, and SLJ stated that she would provide a summary of service improvement at the next meeting. In the meantime, she asked the Board to note that: • A series of clinics and theatres 'Super Saturdays' would be operating on ten Saturdays from November through to February to ensure the timely treatment of patients. In some cases both the appointment

	and procedure could take place on the same day. • An update on the backlog at Medway and the efforts to improve capacity through implementing transformational change. SJ reported that NHSI had brokered a meeting between Medway and QVH, and the agenda would include discussion on the most appropriate allocation of breaches. It was noted that whilst there was money available for improvements, a different approach was now required, which would focus on service improvement. There were no further questions and the Board **NOTED** the contents of the update.
179-17	**Financial performance** JMc presented the latest financial update. The Trust reported a £1,097k surplus at Month 6 and had met its NHSI control total. However, the Trust had benefitted from a non-recurrent VAT gain of £377k. Had this not been available, then we would not have received the Q2 Sustainable Transformation Funding (STF) of £188k. This would have resulted in an underlying surplus of only £532k, and the Trust would have missed its NHSI control total by £565k. The underlying issues had been swiftly identified in the first six months of the year, and underperformance of income had been partially offset by underspend in pay and non-pay. However, JMC warned that the Qs 3 and 4 were likely to be the most challenging that the organisation had faced. Our usual strategy to increase activity was less likely to be successful than in previous years and a radical change in approach was now required. The position was being closely monitored through the Finance and performance committee. GC sought clarification regarding the agency ceiling analysis which showed a variance above the Trust's agency cap. JMc explained the recruitment and retention strategy included a focus on bank rather than agency staff, and corporate agency contracts had been moved across to the Trust bank. Whilst we would continue to breach the cap for the remainder of the year, this had not impacted on our ability to achieve the STF, and we should reach our control total without financial penalty. JT highlighted the issue of income this year; costs were now being closely controlled so falls in income would have a significant impact on surplus. It was important to maintain pressure to improve income in the second half of the year. There were no further questions and the Board **NOTED** the contents of the update.
Key strategic objectives 5: organisational excellence	
180-17	**Board assurance framework** There were no questions or comments on the KSO5 BAF update and the Board **NOTED** the contents of the report.
181-17	**Workforce monthly report** As requested at the previous Board meeting, GO's report focused predominantly on updates relating to the recruitment and retention programme. Highlights included: • Following on from item 179-17, GO remarked that bank utilisation remained much higher than the previous financial year, with demand highest in specialist nursing clinical areas such as Theatres and Critical Care due to national staff shortages. However, agency usage within corporate and operational management areas was also increasing in order to cover vacancies on medium term placements. • Early indications showed that the recently introduced TRAC recruitment system was proving successful. The timescale from going out to recruit, to new employee actual start date had reduced from 99 days last year to 38 this year. More detailed analysis, including the associated costs savings, would be

	presented to the Board at a future date. • Mandatory and statutory training (MAST) rates were around 90% which was a significant achievement given the vacancy rates, particularly within theatres; • The appraisal rate was in reality still ahead. However reports showed a slight decline which had been as a result of due to the reporting deadlines; • The 2nd Quarter Staff Friends and Family Test (SFFT) test showed a marked improvement in staff recommending QVH as a place to work. Reminders were going out shortly regarding the deadline for return of staff surveys. • An external agency had now been appointed to support QVH on a recruitment campaign involving social media. The campaign will launch in early January after a staff engagement exercise and will focus initially on theatre and critical care staff; • An experienced nurse has been appointed as the Nurse Workforce Lead. This role will specifically support nurse retention aspects of the plan, including bank promotion, rostering practices, induction, policies and career pathways • The staff relocation policy had been re-written to now also include B6 clinical staff; • The Deputy Director of Nursing and Deputy Director of Human Resources were reviewing current bank staff bandings to address any anomalies and ensure consistency; • GO is the executive sponsor of the STP temporary staffing project which is supporting collaborative working across Trusts including reviewing consistent payments, reduction in agency spend options for collaborative banks with a view to reducing costs and improve efficiency. • On behalf on the East Surrey and Sussex STP, GO had prepared a Workforce Statement of Intent covering such areas as leadership and talent, apprentice levy, and wellbeing. This had been agreed by the Local Workforce Action Board (LWAB) and demonstrated additional evidence in respect of collaboration. There were no further questions and the Board received and **NOTED** the contents of the latest report.
Board governance	
182-17	**Annual report on use of Trust seal** The Trust **NOTED** the contents of the annual report on the use of the Trust seal (as required under S10 of its standing orders). There were no further questions or comments.
183-17	**Annual review on co-operation with third parties** As required under the FT Code of Governance, the Board considered a report on the effectiveness of the Trust's co-operation with relevant third parties. The Board noted that due to current Strategic Transformation Partnerships (STPs) and collaborative working, the regulation pertaining to this report was less relevant now than when FTs were first established. The Board acknowledged that co-operation and collaboration was crucial to the organisation's sustainability and noted key developments over the last twelve months. KG asked that the Chair be commended in particular for her work chairing the local STP oversight meeting. The Chair thanked CP for her update and the Board **NOTED** assurance of this report regarding the continued effectiveness of the Trust's co-operation with relevant third parties.
184-17	**Audit committee** The Board **NOTED** the contents of the Audit committee assurance report and sought additional clarification

	in respect of the current status of the internal audit contract. KG confirmed that the committee had agreed to extend this for 12 months from 31 March 2018. This had been subject to the outcome of discussions between the chair, the Acting Director of Finance and Mazars regarding the audit plan and audit committee reporting. Anecdotal evidence suggested there had been an improvement in performance, and despite some management reservations, data also showed that Mazars were performing well. JMc suggested gaining a collective view regarding the number of days required in the contract, which would better inform future tenders. KG expressed concern that whilst internal audit reports highlighted issues of concern, there was little contained around assurance.
185-17	**QVH Charity** The Board **NOTED** the contents of the latest Charity assurance report. GN advised that since submitting his report, a new Head of Fundraising and Volunteers had been appointed and would join the Trust at the end of November.
Any other business	
186-17	JMT tabled the new laminated 'Safeguarding' cards which had recently been introduced around the Trust.
Observations and feedback	
187-17	**Questions from members of the public** There were none and the Chair closed the public session of the Board at 12:50.

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
	Nov 2017		Workforce Race Equality Standard (WRES)	KSO5: Organisational excellence	As permitted under Trust Standing Orders, the WRES was approved electronically by the Board following recommendation for approval by the Finance and performance committee in November	GO	Jan-17	QVH is required to analyse and publish its Workforce Race Equality Scheme report for 2017 (using 16/17 data) and an associated action plan on the Trust's external website, which must first be approved by Trust Board. As permitted under S5.15 of the Trust's standing orders, Board approval was received by 20 November 2017 and will be recorded in January board minutes	**Complete**
	Sept 2017	143-17	Patient experience annual report	KSO1: outstanding patient experience	'Learning from complaints, concerns and feedback' section to include *'this is what you said, this is what we did to make a difference'* section.	JMT	Sep-18		**Complete**
	Sept 2017	155-17	Engagement and retention options	KSO5: Organisational excellence	Actions within E&R action plan to be prioritised according to what will make most difference, with an update provided within the next Workforce report	GO	Nov-17		**Complete**

Chief Executive's Report					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04 January 2018**		**Agenda reference:**	**09-18**	
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:	20.12.2017	Decision:	Review BAF	

CHIEF EXECUTIVE'S REPORT
JANUARY 2018

TRUST ISSUES

Director of Finance and Performance

Michelle Miles has been appointed as our Director of Finance and Performance following interviews at the end of last year. Michelle will start on Monday, 4 February; she joins us from her current role of Deputy Director of Finance at Croydon Health Services NHS Trust.

NHS Patient Survey

The 2016 Children and young people's inpatient and day case survey was published on 28 November 2017 by the Care Quality Commission (CQC). The survey received feedback from 34,078 patients who received care in 132 NHS acute trusts during November and December 2016. A total of 11,166 young patients aged 8-15 told CQC directly about their experiences through questionnaires designed especially for them as well as receiving feedback from parents and carers. QVH was the only Trust categorised in the higher band as it was identified as 'much better than expected' for both age groups (0-7 years and 8-15 years). Across the board we have maintained or done better in all categories during a challenging 12 months which is a tremendous achievement and well deserved by the team.

Trusts achieving 'much better than expected' results

One trust, Queen Victoria Hospital NHS Foundation Trust, was classed as 'much better than expected' for experiences of both 0-7 and 8-15 year-olds. A further five trusts were categorised in the highest band for one age group.

	Aged 0-7				Aged 8-15				Overall CQC rating	Core service rating
	Band	Most Negative (0/10)	Middle	Most Positive (10/10)	Band	Most Negative (0/10)	Middle*	Most Positive (10/10)		Site 1
Trust average		**7**	**20**	**74**		**6**	**18**	**75**		
Moorfields Eye Hospital NHS Foundation Trust	S	4	17	79	MB	3	9	88	G	G
Northern Devon Healthcare NHS Trust	MB	2	11	87	S	3	16	81	RI	G
Queen Victoria Hospital NHS Foundation Trust	MB	3	9	88	MB	2	11	87	G	G
Royal Brompton and Harefield NHS Foundation Trust	B	3	14	83	MB	4	12	85	RI	G
Salisbury NHS Foundation Trust	B	4	15	81	MB	3	13	84	RI	RI
St Helens and Knowsley Teaching Hospitals NHS Trust	S	6	19	75	MB	3	11	86	G	G

Key:					
Trust performance	Much worse (MW)	Worse (W)	About the same (S)	Better (B)	Much better (MB)
CQC rating	Inadequate (I)	Requires improvement (RI)	Good (G)	Outstanding (O)	No rating (NR)

Team Brief

Following the staff briefings held in the summer, the new bi-monthly Team Brief was launched on 14 November 2017. Team Brief is designed to ensure all staff receive information about our hospital in a timely and consistent way, as well as give everyone the opportunity to raise questions, provide news and offer ideas. It will also help to ensure all staff are engaged in team meetings, recognising that key information is best received in the context of what it means for each work area.

Minor Injuries Unit (MIU)

The NHS England Five Year Forward View published in October 2014 and the General Practice Forward View published in April 2016 set out the clear view that "the NHS will take decisive steps to break down barriers in how care is provided". To this end Horsham and Mid Sussex Clinical Commissioning Group have agreed to provide funding for additional capacity in Primary Care over winter and beyond.

In East Grinstead the four GP practices have been working with QVH to provide the best possible local care and access to patients under the umbrella of the Healthy East Grinstead Partnership. The practices have agreed to work collectively to deliver a town wide urgent on the day service providing additional appointments at a hub located in the MIU at QVH. The first session involving Crawley Down Health Centre took place on 23 November 2017 and GPs have been available in MIU for a number of sessions each week since. These appointments are within usual GP hours and will only be bookable on the day through their respective GP practice.

National Guardian's Office - Visit
Lorraine Turnell, National Engagement Manager from the National Guardian's Office together with Gavin Rogers, Communications and Engagement Manager visited QVH on 21 November meeting with Andi Heaton, our Freedom to Speak Up Guardian and the CEO. Their feedback was very positive and they saw for themselves that front line staff saw the importance of this role and valued the skills which Andi brings to it alongside to her substantive post as a senior psychological therapist.

Business Planning 2018/19
The process commenced earlier this year so as to engage more widely through our newly formed Hospital Management Team (HMT). Clinical leads together with business managers and executive colleagues have spent two half day sessions in November and December considering service development plans, cost improvement programmes (cost reductions) and our capital development programme. This work will continue in January at the next HMT.

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

KSO 4 Financial Sustainability risk rating has increased to 20 due primarily to income performance below plan which is partially offset by expenditure underspends. The Trust is still forecasting to achieve plan by the end of the financial year, however there are risks to full year delivery in relation to capacity.

SECTOR ISSUES
Clinical Commissioning Groups - Sussex
Two clinical commissioning groups in Sussex have been given legal directions after their forecast deficits increased significantly after seven months of the financial year. Crawley CCG and Horsham and Mid Sussex CCG had originally agreed full year deficits of £4.1m and £13m respectively with NHS England.

A statement from the CCGs said: "The CCGs have reported at month seven a forecast deficit of £7m for Crawley and £27m for Horsham and Mid Sussex reflecting the crystallisation of risks previously reported. The CCGs continue to work with NHS England to mitigate these deficits as far as possible."

Both CCGs were rated inadequate in NHS England's annual assessment for 2016/17 and agreed to appoint a turnaround director, and to carry out a review of capability and capacity. The legal directions require them to produce a financial recovery plan.

In November, the CCGs, together with High Weald Lewes Havens and Brighton and Hove CCGs, announced they would form the Central Sussex Commissioning Alliance in January and share an accountable officer – Adam Doyle from Brighton and Hove CCG.

Geraldine Hoban, the current accountable officer for Crawley and Horsham and Mid Sussex CCGs, will be the managing director for the north part of this alliance and QVH will work to maintain a strong approach to partnership working locally as well as across the wider STP.

Sussex and East Surrey clinically effective commissioning programme
CCGs across Sussex and E Surrey are working together to remove unwarranted variation in the tests, treatments and procedures for which patients can be referred. The aim is to make services fairer for patients as well as to manage demand and capacity. QVH clinicians and/or business managers have been involved in the workshops related to our services in MSK (hands, lower limb trauma), general and cosmetic surgery (plastics) and eyes and ENT. It should be noted that CCGs may cease to commission some procedures with limited evidence of clinical effectiveness. The first tranche of policies addressed are those where there is very little variation between CCGs. Later in 2018 the programme will address procedures where the level of variation, and therefore potentially of challenge, is greater.

Sussex & East Surrey Sustainability & Transformation Partnership (STP)
The last report noted Bob Alexander's appointment as STP lead. He will become full-time from February and will meet with the chief executives from the acute trusts on 5 February.

Brighton & Sussex Hospital NHS Trust (BSUH)
The Board of BSUH approved the Memorandum of Understanding between our two trusts at their Board meeting on 26 October 2017. The ambition is to secure sustainable specialist and tertiary healthcare services for the populations currently served by BSUH and QVH. The aim is to do this in a way that contributes to designing services that:

- Place patients at the centre of care
- Are productive and efficient
- Improve clinical outcomes
- Are clinically effective and sustainable
- Improve patient's experience of care
- Support the development of a sustainable workforce

Through the delivery of the above, the ambition will directly contribute to the delivery of the local STP. The programme of work delivering the priorities identified above will be managed jointly by both organisations.

NATIONAL ISSUES
Budget settlement 2018/19
The autumn budget was delivered by the Chancellor on 22 November 2017. For this current year an extra £355m was announced for winter pressures. It delivered for the NHS an extra £1.6bn of NHS revenue and £354m of public capital for 2018/19. Whilst the extra revenue the budget allocated is welcomed by NHS England, age-weighted NHS revenue growth per person (which factors in the growing and ageing population) will be 0.9% in 2018/19 and -0.4% in 2019/20.

At NHS England's Board meeting on 30 November, it published a paper setting out the five principles they will adhere to in their discussions with government and other arms-length bodies over the next four months about priorities:

1. Deal with current levels of unfunded care (deficits) that need funding going in to next year. NHSE estimates CCGs are funding around £500m more patient care this year than is currently budgeted for.
2. Setting realistic activity plans for growth in urgent and emergency care.
3. Protecting planned investment in mental health, cancer and primary care.
4. Realistic expectations regarding the remaining available funds. Really focussed on workforce who are already 'going the extra mile.'
5. Ensure that where the Government sets pay rises above the current budgeted 1% cap; and that these are separately funded.

NHS Improvement (NHSI) Q2 publication of Providers Finance and Performance
Published on 16 November 2017, the figures cover the six month period ending 30 September 2017.

The key headlines:

- Hospitals in England have succeeded in treating more patients within key operating standards, and sustained efficiency levels, despite an extremely challenging operating environment that has placed considerable pressure on NHS staff.
- 90.2% of emergency patients were seen within four hours.
- While huge strides have been made in improving the NHS provider sector's financial position, so far this year NHS trusts and foundation trusts are collectively predicting a full-year deficit of around £623 million; that is £127 million worse than planned.
- This does not include additional pressures and potential spending needed to meet them over the coming winter months.
- 152 (64%) of 238 providers are reporting a deficit, compared to 142 (60%) that reported a deficit in Q2 2016/17. Overall 111 providers are forecasting a year-end deficit.
- Q3 figures will be published on 19 February 2018.

NHS Improvement
Ian Dalton started on 4 December 2017 as the new Chief Executive of NHS Improvement taking over from Jim Mackey who after two years in the role has returned to Northumbria Healthcare NHS Foundation Trust. Ian was more recently CEO of Imperial College Healthcare NHS Trust for a few months after three years as President of global government and health for BT Global Services. Prior to this he held very senior roles within NHS England including Deputy CEO.

Health Education England
Health Education England published its draft national workforce strategy – *Facing the Facts: Shaping the Future* on 13 December. A consultation is now open on the draft document, with a final report to be published in July to coincide with the NHS 70 anniversary. Measures to 'future-proof' the NHS workforce include:

- targeted retention schemes to encourage staff to continue working in healthcare;
- improvements to medical training and support for junior doctors;
- a far-reaching technology review across England;
- making the NHS a more inclusive and 'family-friendly' employer.

The strategy acknowledges rising demand and pressure on NHS staff, noting 42,000 vacancies across nursing, midwifery and allied health professions. The strategy suggests without further action to reduce demand the NHS will need to grow by 190,000 posts by 2027.

Steve Jenkin
Chief Executive

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed – 12/12/2017

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;
- Demand, capacity, process & system issues within the appts team
- 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;
- Fortnightly improvement meeting re appointments in place, currently chaired by Dir of Ops;
- As above re 18RTT recovery plan also in place and chaired by Dir of Ops;
- 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) is understood 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
- Shared pathways for cancer cases with late referrals from other trusts
- Demand and capacity modelling with benchmarking requires continual development for each speciality
- Late referrals for 18RTT from neighbouring trusts, two of which are in special measures and others with severe pressures
- 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

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Finance & Performance
Date last reviewed: 14th December 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 5(L)= 20 , major risk
Residual Risk Rating 4(C) x 4 (L) = 16, major risk

Rationale for current score (at Month 08)

- Surplus £959k/£1544k surplus plan (-1.19%)
- CIP forecast delivery - (c£0.2m gap)
- Finance & Use of resources – 1
  - Capital Service cover - 1
  - Liquidity -1
  - I&E Margin –1
  - I&E Margin Var from plan – 3
  - Agency Cap – 2
- 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 – Clinical effective commissioning
- Annual NHS contract
- 5YFV & Sustainability and transformation footprint plans
- Proposed 2 year tariff arrangements
- Pay awards – removal of 1% pay cap
- 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
- Audit Committee and reports
- Internal Audit Plan including main financial systems and budgetary control.

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Carter Report Review and implementation
- Costing Transformation Programme – business case developed, approved and procurement underway – Implementation Q4 2017/18
- Enhanced pay and establishment controls including performance against the agency cap

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04 January 2018**		**Agenda reference:**	**11-18**	
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 25 September and 23 October				
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:	18/12/17	Decision:	For information	
Next steps:	N/A				

Report to: Board of Directors
Meeting date: 4 January 2018
Reference no: 11-18
Report from: John Thornton, committee chair
Report date: 22 December 2017

Finance and performance assurance report

1. Operational performance

The trust still isn't meeting its aggregate 18 week RTT target and more theatre time will be required if we are to recover the position. There is physical capacity in the theatres and medical staff are largely available. But the constraint is the high level of nursing and 'operating department practitioner' vacancies. Until this improves the effectiveness of the recovery plan will be limited.

Committee was provided with a monthly forecast of 18 week performance which shows achievement of 87% by March next year and 90% by the end of the summer. Committee accepted this as a reasonable recovery and will track performance against this trajectory. It was noted that the target trajectory didn't include any set back caused by inclusion of the Medway figures. But it also didn't include any upside from the use of capacity at Queen Mary's.

Committee discussed the monthly breaches of the 62-day cancer target. Given the impact on patients it was agreed that we will continue to focus on performance in this area. But given that the main drivers of the breaches are hard to control it will be difficult to improve this position significantly. Committee was assured that failure to meet this target wasn't leading to significant patient issues or complaints.

2. Workforce performance

Despite the focus on recruitment and some successes the turnover of staff remains high and the level of vacancies is significant especially in key nursing posts. At the present time the committee can't given assurance to the board that the current plans will lead to a meaningful improvement in the near term. This will continue to have a negative impact on key areas of the hospital's performance.

The position is made worse by an increase in the level of sickness absence. this is steadily increasing and is higher than this time last year. There is a concern that this reflects not only genuine sickness but an underlying dissatisfaction with the increasing pressures on full time staff.

As a result our use of agency staff reached its highest ever level in November and use of bank staff increased month on month. We are now breaching our agency cap and this is reducing our overall score for use of resources. It was agreed that keeping the agency figure below the cap should be a key objective for the year end if possible.

Our performance on completion of appraisals and MAST training has been effectively flat for some time with monthly variations. It was recognised that this was affected by staff

pressures. But Committee asked for a trajectory to be provided to show the expected level of achievement against these targets for the next twelve months - effectively a forecast against which we can judge progress towards our target level of performance.

3. Financial performance

Financial performance in November generated a small deficit against a planned surplus for the month. Income was below plan and both pay and non pay costs were over budget for the first time this year. This is a concerning position.

We have still generated a surplus for the year to date but this includes a one off gain of £377k and we are almost £600k behind plan. The current forecast shows that we won't hit our control total at the end of December and therefore won't receive our S&T funding. This deteriorating position is reflected in an increase in the BAF risk score to 20 from 16.

One positive feature is that the planned cumulative surplus for November of £1500k is effectively the same as our full year target. The monthly performance in the plan for the next four months doesn't lead to any net improvement in our overall surplus. This gives us the opportunity to improve our monthly performances and hit the annual plan.

The finance report is still projecting an on plan performance by March. But the committee wasn't assured that the recovery plans currently in place were adequate to achieve this. The committee was particularly concerned that the plans were mainly reliant on income improvement rather than meaningful cost controls/reductions. Given the external constraints discussed earlier this was felt to be optimistic.

It was agreed that the Executive would provide a more detailed forecast of monthly performance between now and the year end. Together with a clear indication of how budget would be achieved. It was proposed and agreed that this would be discussed at a private board meeting in January.

4. F&P Effectiveness Review

The feedback from the review had been discussed briefly at the previous F&P. This had suggested that our overall effectiveness was satisfactory but that we could be more forward looking and not focus so much on the current position. A report had now been provided to the committee with a number of recommendations which were agreed.

The terms of reference were reviewed as a part of this exercise and approved with a few minor changes. A formal work plan was also discussed and approved with some additions.

5. Service Improvement and Productivity Groups Update

A update was provided on the initial findings from the review of activity in theatres, outpatients and wards. It is too detailed to summarise here but I would encourage all board members to read it.. The paper was considered to be very useful assessment of the overall position. It was greed that the identified areas for improvement or further enquiry now needed to be taken forward within specific work streams led by the appropriate business lead.

It was agreed that committee would be provided with a progress update in March 2018.

5. Hospital Pharmacy and Medicines Optimisation Programme.

Following a presentation to committee earlier in the year the Chief Pharmacist Judy Busby provided a further update on the current position. This included a structured project plan with priorities and time lines for the next two years.

The committee thanked Judy for the progress that had been made and it was agreed that she would provide a further update on progress against the plan in six months time.

John Thornton
Chair

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	4 January 2018	Agenda reference:	12-18		
Report title:	Operational Performance				
Sponsor:	Sharon Jones, Director of Operations				
Author:	Paula Smith, Deputy Director of Operations				
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:	Approval ~~Y/N~~	Information ~~Y/N~~	Discussion ~~Y/N~~	Assurance ~~Y/N~~	Review ~~Y/N~~
Link to key strategic objectives (KSOs):	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:	Finance and performance committee				
	Date:	18/12/2017	Decision:	Noted	
Next steps:	None				

Report to:	Board of Directors
Meeting date:	4th January 2018
Reference number:	12-18
Report from:	Sharon Jones, Director of Operations
Author:	Paula Smith, Deputy Director of Operations
Appendices:	Appendix 1: *Trajectory Performance for 18RTT and 62CWT* Appendix 2: *Cancer Breaches*
Report date:	11th December 2017

Operational Performance: Targets, Delivery and Key Performance Indicators

1. Diagnostic Waits

- There were two diagnostic breaches in Radiology in November related to off-site cardiac CT delays and one diagnostic breach in Sleep Studies. The trust therefore delivered 99.66% 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

- It is too early in the month to give an estimated view of the December position. The main areas of underperformance continue to be Plastics and Max Fax and this position will not change for the next year.

- As previously stated, much of the 18RTT issue lies in the admitted element of the open pathway. Therefore more theatre time is required to be able to recover the position. There is the physical capacity in theatres to provide this and to undertake more work both at the weekends and by undertaking longer days/three session days. The medical staffing availability is sufficient to provide these and there have been offers to undertake this. However the limiting factor that is preventing us from using this capacity is the high level of nursing and Operating Department Practitioner (ODP) vacancies. Until this is addressed it is likely that the recovery plan will be limited in the level of percentage improvement it can gain. This will also impact upon the ability of the trust to reduce 52 week waiters. This is on the risk register;

- The key elements of any 18RTT recovery plan remain as described in the previous reports with the following updates:-

  - To continue to undertake additional validation of some of the longer waiters, additional theatre and clinic sessions and the consideration of further outsourcing for some of the Max Fax activity. The trust will also need to assess how to manage the demand for further validation once the Medway PTL is visible (and to a lesser extent DVH & EHST PTL's) as well as how we can move to validating the under 18RTT waiters;

  - The outsourcing of the routine hands work to the McIndoe has commenced with 15 patients already being treated and 25 more being scheduled in;

  - 'See and Treat' clinics for skin patients continue to be successfully run with three clinics booked for December; These clinics continue to be popular with patients as they either have their entire pathway undertaken or leave with a 'TCI' and this is a good patient experience and the consultants and junior doctors have been positive about this as a service model. It is also contributing positively to the financial position;

- The new trial payment system described in last month's paper of a sessional rate of £150 for a 4-hour period for a trained nurse and £100 for a 4-hour period for a HCA has proved successful. At the time of writing, most Saturday's are booked from the beginning will monitored in January & an evaluation undertaken;

- All of the above encompasses 52 week waiters;

- There is a fortnightly 18RTT recovery & appointments service improvement meeting to oversee the above and this is chaired by the Director of Operations. There are longstanding issues with a lack of standard systems, processes and investment within the appointments team. A service improvement lead has commenced on a 12week placement to review and lead on action planning in relation to appointments and management of referrals;

- A summary of achievement against the STP trajectories for 18RTT, 52 weeks and 62 CWT are included in **Appendix 1.** These will be reviewed once recruitment and retention has improved in theatres and when a full assessment has been undertaken of the feasibility of using Queen Mary's at Sidcup and The McIndoe for additional max fax capacity.

- The Trust was required to submit the trajectories for both 18weeks and the elimination of 52week breaches to NHSI recently and at the time of writing no feedback has been received from NHSI on these trajectories;

3. Elective Day Cases

- The plan for day cases for 2017/18 is a weekly average of 239 patients;

- In November the weekly activity was 214; 218; 174; 184; and 237 respectively giving a weekly average for November of 205 patients treated compared to 209 in October. 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 November this was 17; 14; 8; 12; and 10 respectively giving a weekly average of 12; compared to 11 in October;

4. Elective/In Patient Activity

- The plan for elective patients treated per week for 2017/18 is 47 per week;

- In November the numbers of patients treated was 49; 37; 42; 45; and 33 respectively giving a weekly average of 41 compared to 40 in October;

- Non-surgical elective activity has a plan of 31 per week and for October this was 27; 35; 25; 32; and 32 respectively giving a weekly average of 30 compared to 36 in October;

- In November Peanut (Paediatric) ward had staffing available for 23 nights out of 30 if required for either elective or trauma patients;

- In total 15 patients were in over 9 of the staffed nights;

- 14 nights had no children in the hospital so staffing was not required;

- On 7 nights the ward was closed as no staff available – meaning 1 child was transferred to Royal Alex and 1 child was held until the next morning to come for admission;

- On 5 occasions the ward was closed at 19.30 hours;

5. Medway Backlog

- The work highlighted in previous report continues;

- There are still data quality issues from Medway and so it is difficult to take a view of the current performance with any accuracy. The operations team are working closely with the information team to try and resolve these issues or at least get to an acceptable level of data quality that is 'good enough'. Currently an interim validator extra to establishment is being used to undertake the additional validation work. Historically there has been no resource for this work (as there wasn't a Medway PTL) and so a bid for additional validator has been submitted as part of the business planning process. However, as previously highlighted, it is very likely that the Medway data, once fully visible will result in further deterioration in the 18RTT position. There has recently been a meeting with Medway and NHSI to see if they can give us further capacity at Medway, and also whether we can undertake any productivity improvements in how we utilize capacity. However, the data shared, again has quality issues and so this is being reviewed but the indications are that we are using the available capacity appropriately.

6. Cancelled Operations

- There were 18 non-urgent operations cancelled on the day in November (compared to 17 in October; 5 in September; 13 in August; 25 in July; 9 in June; 14 in May; 26 in April and 35 in March);

- There were 8 plastics patients cancelled – 4 due to lack of beds on the day; 1 due to lack of time with other cases taking longer than expected; 2 due to trauma cases; and 1 due to an equipment issue on the day;

- There were 8 Max Fax cases cancelled – 5 due to the power failure on one day; 2 due to lack of time with other cases taking longer than expected; and 1 due to no critical care bed being available;

- There were 2 corneo patients cancelled – 1 due to lack of time with other cases taking longer than expected and 1 due to no beds available on the day;

- One of the Max Fax patients above was an urgent case and was cancelled due to no critical care bed being available on the day- their surgery was re-scheduled within 11 days;

7. Monitor Cancer Standards

- Below is the Trusts performance for October 2017. The breach report is attached as **Appendix 2.**

Month	Target	Standard	Total	Breaches	Performance
October	2WW GP referral to first seen (urg. susp. cancer)	93%	252	26	89.7%
October	31 day Decision to first treatment	96%	76	2	97.4%
October	31 day Decision to subsq treatment (surgery)	94%	53	2	96.2%
October	62 day GP referral to first treatment	85%	25.5	6	76.5%

8. Actions within Cancer

- These continue as highlighted in previous reports. Improvements in the 62 day cancer wait are dependent upon referral times from other trusts, for example, on average we get breast referrals on day 60 making it impossible to give surgery by day 62;

- NHSI undertook a critical friend visit to the Trust on 8th December to review both skin and breast pathways to see if they can offer any advice or guidance to the trust on how to manage our pathways. At this visit they met with clinicians and all administration staff form health records to the 2WW hub. They plan to visit again to attend a PTL meeting and then to work with us on some formal capacity and demand work in skin initially. The latter will

require a considerable investment in time from both the operational and business intelligence team. A report will be produced by NHSI in January.

9. Business Unit Specific Operational and Performance Issues

- Business unit specific updates are given below;

10. Max Fax/Oral Surgery Business Unit

- 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%. As part of this the business unit is exploring ways to increase activity including use of Queen Mary's at Sidcup for day cases. This site is more accessible for West Kent patients than traveling to QVH;

- Additional Saturday theatre lists have been scheduled until the end of December 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;

11. Plastics Business Unit

- Activity and hence income are have both been below plan in relation to day case work in breast and hands. Whilst a key driver of this has been the absences mentioned above, the service is not being complacent and is further reviewing how lists are booked and utilised to ensure all lists are used to a maximum;

- Average timings for theatre procedures are shared with Consultants with a view to amending current timings utilised to book lists in theatres;

- The new trauma clinic opened on the 4th September with an increased template for clinic attendances and dedicated treatment slots for procedures. The coding of these procedures will be monitored and reviewed to ensure we are fully capturing all the work undertaken and gaining the correct amount of income;

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; 8 in July 2 in August 5 in September 3 in October and 4 in November;

- 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;

- To date this year (8 months) 3010 trauma patients have been operated on which by year end would mean a prediction of 4515 will be operated on – a 9.7%% increase from 2016/17 to this year – compared to the predicted 13% increase in August; 11.5% increase in September and 10.9% increase in October;

13. Ophthalmology Business unit

- The business unit has delivered activity above plan in month and year to date. However income has been variable to date and the business unit is investigating this. Income has increased in Month 7 but has dropped again in month 8. It is expected to improve once the activity has been fully coded. Additional complex activity has been scheduled to improve the activity and income;

- The business unit have been approached by the commissioners regarding Glaucoma activity with additional 900 patients being referred to Queen Victoria Hospital. The business manager and finance are working through the impact and reviewing space to accommodate this opportunity.

14. Sleep Services

- The business unit continue to deliver activity above plan this year month on month and forecasting to be well above plan;

- 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 the success of this new site which has seen increasing volumes of activity. The business unit have identified and agreed space at Arundel. The sleep centre will deliver clinics weekly at this site once they are fully established and have given notice to Bognor

15. Clinical Support Services

- 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 has started and an urgent on the day solution for primary care capacity, linked to our MIU started successfully in November 2017. This is delivering 6 sessions a week of GP capacity at present rising to 10 sessions a week in due course.

- Issues with Rheumatology provision in East Sussex has led to a significant increase in Rheumatology referrals from this area and a rise in waiting times. QVH is liaising with Sussex MSK Partnership East to discuss and working towards increasing capacity and has approval to recruit a GP with special interest to work alongside our consultant Rheumatologist.

16. MIU

- The Trust MIU performance for the weeks in November was 100%; 100%; 99% and 100% and 100%respectively giving a weekly average of 99.8%;

- Activity through the MIU was 205; 208; 189; 187; and 177 in November – giving a weekly average of 193 patients compared to 203 patients in October;

17. Recommendation

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

Appendix 1 – Original Trajectory & as in Contract 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%	86.81%	84.41%	83.50%					

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%	84.1%	66.7%	64.4%	76.5%					

The trajectory submitted for 52weeks

Month	Trajectory
November 2017	26
December 2017	22
January 2018	16
February 2018	11
March 2018	8
April 2018	0

The revised trajectory submitted for 18weeks RTT

Month	Trajectory
November 2017	84.0%
December 2017	84.5%
January 2018	85.0%
February 2018	86.0%
March 2018	87.0%
April 2018	87.0%
May 2018	88.0%
June 2018	88.5%
July 2018	89.0%
August 2018	90.0%
September 2018	90.0%
October 2018	90.0%

Appendix 2 – Cancer Breaches

62 Day Referral to Treatment

Reporting Month	Tumour Type	First seen Trust	Treating Trust	Wait Days	Breach reason	Accountability
Oct-17	Breast	Maidstone District General Hospital	Queen Victoria Hospital NHS Foundation Trust	91	Referral received on day 40 – need to co-ordinate visiting surgeon for mastectomy	0.5
	Head & Neck	Queen Victoria Hospital NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust	71	Referral received from Medway day 39	1
	Head & Neck	Queen Victoria Hospital NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust	75	Complex diagnostics	1
	Head & Neck	Queen Victoria Hospital NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust	111	Surgery date given prior to breach but non compliance regarding medication prior to admission and capacity issues	1
	Skin	Sussex Community Dermatology Service	Queen Victoria Hospital NHS Foundation Trust	128	Referred on day 40 and then complex pathway due to ongoing health needs	0.5
	Skin	Sussex Community Dermatology Service	Queen Victoria Hospital NHS Foundation Trust	129	Referral received day 84 then complex diagnostics and pathway	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust	105	Referral received day 13 but patient requested treatment at local Trust – capacity issues	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust	79	Referral received day 55	0.5
	Skin	Medway NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust	75	Referral received day 32.	0.5

31 Day to First Treatment

Reporting Month	Tumour Type	Wait Days	Breach Reason
Oct-17	Breast	43	Capacity
	Skin	42	Capacity

31 day to Subsequent Treatment (surgery)

Reporting Month	Tumour Type	Wait Days	Breach Reason
Oct-17	Skin	32	Capacity
	Skin	38	Capacity and patient complex history

2 Week Waits

Reporting Month	Tumour Type	Wait Days	Breach Reason
Oct-17	Head & Neck	28	Patient choice
	Head & Neck	22	Clinic capacity
	Head & Neck	27	Patient choice
	Head & Neck	67	Admin delay
	Head & Neck	21	Clinic capacity
	Head & Neck	21	Clinic capacity
	Head & Neck	27	Clinic capacity
	Head & Neck	15	Clinic capacity
	Head & Neck	16	Patient choice
	Head & Neck	22	Clinic capacity
	Head & Neck	17	Clinic capacity
	Head & Neck	17	Clinic capacity
	Head & Neck	16	Clinic capacity
	Head & Neck	21	Patient choice
	Head & Neck	22	Clinic capacity
	Head & Neck	32	Clinic capacity
	Head & Neck	22	Clinic capacity
	Head & Neck	19	Clinic capacity
	Head & Neck	18	Clinic capacity

Reporting Month	Tumour Type	Wait Days	Breach Reason
	Head & Neck	17	Patient choice
	Head & Neck	15	Patient choice
	Head & Neck	27	Patient choice
	Head & Neck	19	Clinic capacity
	Head & Neck	22	Clinic capacity
	Skin	17	Patient choice
	Skin	21	Patient choice

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**04/01/2018**		**Agenda reference:**	**13-18**	
Report title:	**Finance Report M8 November 2017**				
Sponsor:	Jason McIntyre, Acting Director of Finance and performance				
Author:	Alan Macalister, Interim Deputy Director of Finance				
Appendices:	Finance Report M8 November 2017				
Executive summary					
Purpose:	The Trust delivered a deficit of £47k in month; £313k below plan. The YTD surplus has decreased to £959k; £585k behind plan. The Trust is forecasting to achieve plan by the end of the year. However there are risks to full year delivery.				
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:	See BAF update				
Corporate risk register:	See latest CRR				
Regulation:	The Finance Use of Resources rating is 2.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and performance Committee 18th December 2017				
	Date:	18/12/2017	Decision:	N/A	
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
November 2017

Executive Director: Jason McIntyre

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Queen Victoria Hospital
NHS Foundation Trust

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15. Appendix 2: Agency ceiling & Analysis
16. Appendix 3: Activity trend
17. Appendix 4: Forecast

Summary Position – YTD M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 – Financial Performance

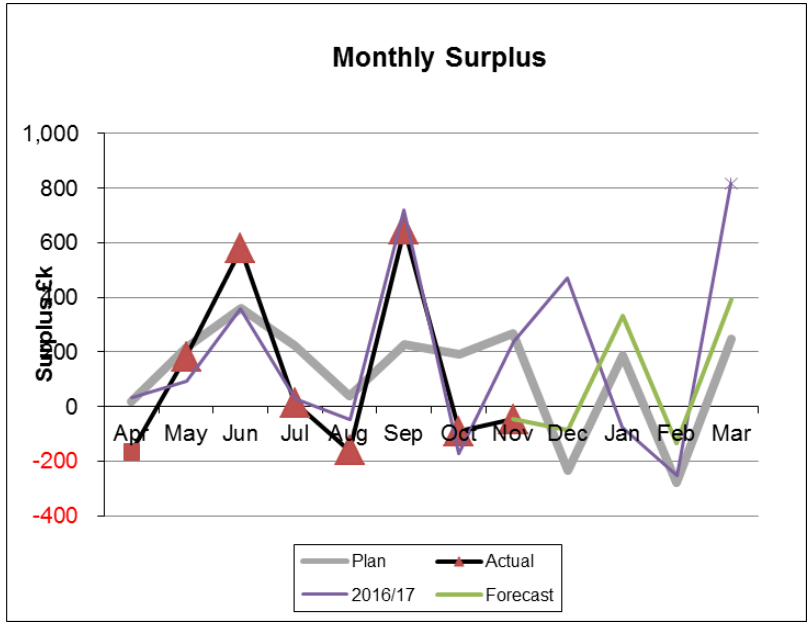
Financial Performance	2017-18	November 2017			Year to Date 2017-18		
Income and Expenditure	Annual Plan £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	66,056	5,496	5,729	(233)	42,932	44,266	(1,333)
Other Income	3,706	338	266	72	2,786	2,744	41
Total Income	**69,762**	**5,834**	**5,995**	**(161)**	**45,718**	**47,010**	**(1,292)**
Pay	(44,537)	(3,829)	(3,711)	(118)	(29,284)	(29,692)	408
Non Pay	(19,271)	(1,704)	(1,643)	(60)	(12,663)	(12,782)	118
Financing	(4,489)	(348)	(374)	27	(2,812)	(2,993)	180
Total Expenditure	**(68,297)**	**(5,880)**	**(5,729)**	**(151)**	**(44,759)**	**(45,466)**	**707**
Surplus / (Deficit)	**1,465**	**(47)**	**266**	**(313)**	**959**	**1,544**	**(585)**
Surplus (Deficit) %	2.10%	-0.80%	4.44%	-5.24%	**2.10%**	3.28%	**-1.19%**
Adjust for Donated Depn.	(288)	(19)	(24)	(5)	(154)	(192)	(38)
NHSI Contol Total	**1,753**	**(27)**	**290**	**(317)**	**1,113**	**1,736**	**(623)**

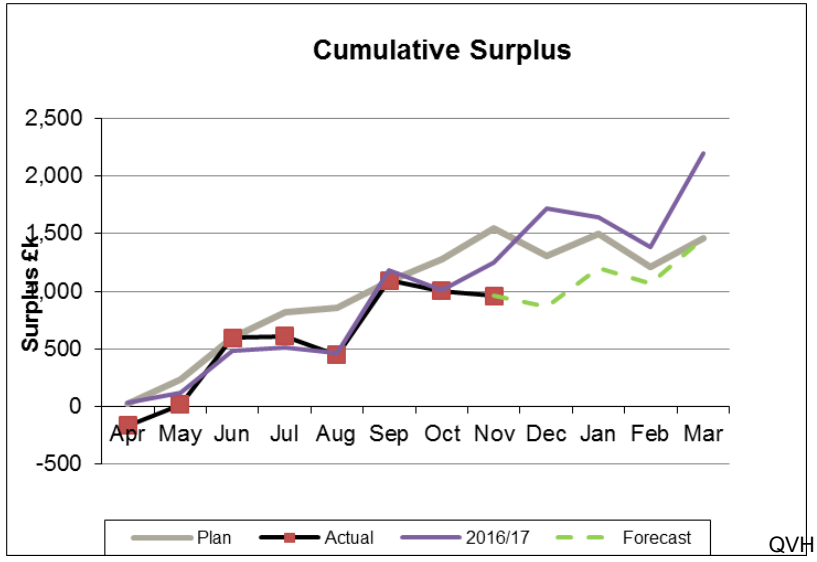
Summary - Plan Performance

- The Trust delivered a deficit of £47k in month; £313k below plan. The YTD surplus has decreased to £959k; £585k behind plan. The reported surplus includes non recurrent benefit of £377k.
- The main driver of the YTD position is under-recovery of income of £1,292k which is partially offset by expenditure underspends.
- Income has underperformed in month by £161k. The key drivers are:-
  - Clinical income was below plan by £233k in month 8. The main areas of underperformance remain in Hand Surgery planned care (£121k), Burns non elective activity (£85k) and Breast Surgery planned inpatient activity (£45k).
  - Sustainability and Transformation funding of £94k in month (£188k ytd) has not been assumed as the control total has not been met for the month.
  - CQUIN risk of £17k (£134k YTD)and a provision for activity challenges £8k (£60k YTD) have been factored into the in month position .
  - Other income was significantly over recovered in month due to the realisation of FRAME income to offset against the backdated costs of the consultant leading the project.
- Pay expenditure is overspent by £118k decreasing the YTD underspend to £408k. There was a one off payment for the backdating of pay to the research consultant for the FRAME project which contributed £50k to the overspend, this was offset by the income. The other areas contributing to the overspend were Agency usage (£177k) this has increased due to usage of SHO agency within Plastics (£25k), subsequently the NHSI Agency Target will be breached. There has also been significant recruitment within Anaesthetics (£47k), which has been partially offset by vacancies within AHPs / Healthcare scientists and Nursing.
- Non pay is overspent by £60k in month. The key driver to this is a £64k overspend on clinical supplies driven by the higher than usual levels of activity delivered in month. The YTD position is underspent by £118k and the key drivers include overspends on clinical supplies (£295k) , Stationery (£62k) and Catering (£42k) being offset by prior year VAT benefit of £377k and Rent and Rates underspend of £121k.
- Financing is underspent in month by £27k (£180k YTD) due to depreciation.
- The Finance Use of Resources rating is 2.
- The Trust is forecasting to achieve plan by the end of the year. However there are risks to full year delivery; particularly in relation to capacity.

Surplus Trend Position – M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust





Summary

- There is a £47k deficit in month against a planned surplus of £266k. The YTD surplus is £959k which is £585k 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 : M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Activity Performance			Month 08 (November)			Month 08 (November)			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	909	938	832	(106)	69	61	(8)	7,344	7,678	334	542	567	25
Elective (Daycase)	Spells	1,038	1,129	1,039	(90)	1,257	1,191	(66)	8,739	8,295	(444)	9,672	9,215	(457)
Elective	Spells	324	349	349	0	821	820	(1)	2,723	2,643	(80)	6,392	6,134	(258)
Non Elective	Spells	447	464	417	(47)	1,189	1,009	(180)	3,637	3,771	134	9,312	9,098	(214)
XS bed days	Days	75	120	62	(58)	33	17	(16)	938	403	(535)	260	114	(146)
Critical Care	Days	52	62	72	10	80	90	10	485	602	117	626	626	(0)
Outpatients - First Attendance	Attendances	3,761	3,961	4,205	244	556	574	18	30,987	30,040	(947)	4,348	4,118	(230)
Outpatients - Follow up	Attendances	10,415	10,790	10,707	(83)	777	804	28	84,379	83,996	(383)	6,074	6,212	138
Outpatient - procedures	Attendances	2,147	2,418	2,183	(235)	326	288	(38)	18,942	19,569	627	2,551	2,618	67
Other	Other	3,370	2,685	3,842	1,157	477	455	(23)	21,033	30,110	9,077	3,713	3,704	(9)
Work in progress and coding adjustment						143	187	44				776	526	(251)
						5,729	**5,496**	**(233)**				**44,266**	**42,932**	**(1,334)**

Activity Financial Performance	Month 07 (October)			Year to date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Perioperative	80	90	10	626	626	0
Clinical Support	540	768	227	4,193	4,953	759
Eyes	611	564	(47)	4,591	4,296	(294)
Oral	1,163	1,159	(4)	9,111	9,149	38
Plastics	2,844	2,321	(522)	22,249	20,161	(2,088)
Sleep	347	407	60	2,720	3,221	501
Other incuding WIP/coding	223	277	54	1,403	1,152	(251)
Grand Total	5,729	5,496	(233)	44,266	42,932	(1,334)

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 106 fewer and £8k below plan. YTD activity is 334 attendances and £25k above plan. There has been a decrease in activity in month due to Trauma Clinic activity being coded to Outpatients.
- **Daycase** activity in month is 90 spells and £66k below plan with underperformance see n across all specialties except for Burns and Skin. The significant overperformance within Skin is related to the continuation of the Super Saturday working. YTD activity is 444 spells and £457k under plan with Hand Surgery contributing £429k and £344k to the under delivery. This has been partially offset by the exceptional performance within Skin which has generated an additional £457k above their planned income target year to date.
- **Elective** activity in the month has achieved plan and under delivered income by £1k - caused by underperformance within Oral Surgery (£26k), being offset by Eyes (£28k). YTD activity is 80 spells and £258k under plan largely within Plastics (Hand Surgery) (£192k) and Breast Surgery (£161k). These have been partially offset by overperformance within Skin (£153k.

- **Non-elective activity** has under performed by 47 spells and £180k in month (Burns £85k) . The YTD position reports an overperformance of 134 spells and £214k underperformance with overperformance in Oral being offset by an underperformance in Burns. There is an overperformance on Oral due to BSUH transfer activity - which is being offset by underperformance within Plastics (Burns/ Hands). The miscoding issue with Trauma Clinic activity being incorrectly coded to MIU remains within the activity data however has been manually adjusted for in the accounts to reflect the true business unit positions, £750k of activity has been reattributed to Plastics & Oral.
- **Critical care** days have overperformed by 10 days in month and £10k. The YTD position is an achievement of plan however there is the WIP accrual for critical care long stayers who have yet to be discharged to be applied, which will further improve the position.
- **Outpatient** attendances (FA/FUs) are £161k above plan in month and £92k below plan YTD. The in month overperformance is related to the change in how MIU patients have been coded. Outpatient procedures are £38k under plan in month and £67k over YTD this is caused by a timing issue in coding.
- The YTD under performance is largely driven by planned activity (Elective & Daycase) within the Plastics (Breast & Hands) and Eyes service lines which is being offset by overperformance within Clinical Support and Sleep . The two key concerns are the underperformance within plastics partly due to medical sickness and the deteriorating position within Eyes.

Actions

- Plastics business unit to continue to refine recovery plans to address underperformance and Eyes to formulate a recovery plan to deliver an increased run rate to recover their position. These will be tested and assessed via performance review meetings.

Financial Position by Business Unit – M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for November 2017			Total Year To Date		
performance against financial plan	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual	Actual	Budget	Variance	Actual	Budget	Variance
Operations															
1.1 Plastics	(151)	(1,330)	31	36	(46)	67	2	44	(23,983)	(1,867)	(2,031)	(164)	(15,023)	(16,206)	(1,183)
1.2 Oral	195	98	14	24	47	90	15	(61)	(6,192)	(823)	(551)	271	(4,377)	(4,226)	151
1.3 Eyes	(47)	(324)	13	(11)	10	55	(2)	35	(3,732)	(320)	(345)	(25)	(2,223)	(2,468)	(245)
1.4 Sleep	56	541	(0)	(0)	(26)	(161)	(28)	(128)	(1,887)	(169)	(168)	2	(1,539)	(1,287)	252
1.5 Clinical Support	(269)	10	(83)	(162)	23	370	(41)	(72)	2,149	471	100	(371)	1,237	1,384	147
1.6 Perioperative	22	(1)	2	18	(58)	(56)	(103)	(509)	11,454	1,088	952	(136)	8,177	7,629	(548)
1.7 Operational Nursing	1	4	15	52	24	159	11	(23)	3,662	254	305	51	2,249	2,441	192
Operations Total	**(193)**	**(1,001)**	**(8)**	**(43)**	**(26)**	**524**	**(145)**	**(715)**	**(18,529)**	**(1,365)**	**(1,738)**	**(373)**	**(11,498)**	**(12,733)**	**(1,235)**
Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure	(0)	(0)	(0)	(0)	(8)	(55)	(1)	(28)	990	92	83	(9)	743	660	(83)
2.5 Director Of Nursing	-	-	18	(100)	(56)	(87)	19	192	2,819	255	237	(19)	1,879	1,884	5
Nursing & Clinical Infrastructure	**(0)**	**(0)**	**18**	**(100)**	**(64)**	**(142)**	**18**	**164**	**3,809**	**347**	**319**	**(28)**	**2,622**	**2,544**	**(78)**
Corporate Departments															
3.1 Non Clinical Infrastructure	(13)	(105)	31	136	(21)	(28)	4	(9)	4,123	342	343	1	2,753	2,747	(6)
3.2 Commerce & Finance	-	1	1	5	(42)	(15)	(17)	48	2,631	277	218	(59)	1,720	1,759	39
3.4 Finance Other	(26)	(228)	(4)	9	42	111	145	875	3,876	214	370	156	1,630	2,398	768
4.1 Human Resources	-	-	31	23	2	14	(31)	(88)	892	73	74	1	645	595	(51)
5.4 Corporate	-	-	4	12	(8)	(56)	(7)	23	1,734	158	147	(11)	1,168	1,147	(21)
Corporate Total	**(40)**	**(332)**	**62**	**185**	**(28)**	**26**	**94**	**849**	**13,255**	**1,065**	**1,153**	**88**	**7,917**	**8,645**	**728**
QVH Total	**(233)**	**(1,333)**	**72**	**41**	**(118)**	**408**	**(34)**	**299**	**(1,465)**	**47**	**(266)**	**(313)**	**(959)**	**(1,544)**	**(585)**

Non Pay expenditure: In month there has been an overspend for clinical supplies relating to higher levels of activity than usual (82k). There have also been overspends relating to one off professional fees (£25k) as well as the receipt of the invoice for the STP wide work from NHS Commercial Solutions for which the income was released (£18k). The YTD position is driven by clinical supplies reflected in the position which has been offset by the underspend on premises costs.

Summary

Activity Income: The two areas of key concern are Plastics (£151k adverse in mth £1,330k adverse YTD) and Eyes (£47k adverse in mth £324k adverse YTD) (more detail on activity performance slide). This has been offset by overperformance in month and YTD within sleep (demand), clinical support (radiology demand) . There was an in month underperformance for STF £94k (£188k ytd) as this will not be recognised until the quarter three control total is delivered . The remainder of the in month overperformance relates to Oral and in particular NEL Maxillofacial Surgery.

Other income: Plastics other income is over delivered in month due to performance against the West Kent Dermatology SLA. Histopathology is underdelivered by £67k in month and ytd due to the transfer of budget for the West Kent Dermatology income. This has been invoiced within the activity income. Radiography under delivered by £8k in month and £61k ytd due to the loss of CEA awards (£30k) and reduced Activity from High Wealds, Lewes and Haven CCGs. Under recovery of research income (£89k) is the main contributor to the Director of Nursing adverse variance ytd. The over delivery of other income within Non Clinical Infrastructure is largely due to the Patient Transport Service income (£100k) this offsets some of the costs incurred within non pay.

Pay: The key drivers of the pay overspend are:-

- Medical and Dental Expenditure (£132k in month) due to a backdated payment to a Research Consultant for £50k, £30k relates to arrears payments and new starters within the Plastics medical staffing. There was also an additional £30k expenditure within the Anaesthetic consultant body expenditure this month which is expected to continue in line with the approval of the Anaesthetic business case .
- HCAs (£20k in mth £325k YTD) partially mitigated the overspend on medical staffing.This underspend is reducing with the recruitment to the posts in the theatres business case.
- Nursing (£70k in month and £418k YTD) this is mainly due to the vacancies being carried within Theatres, Canadian Wing, ITU and Paediatrics. These are proving difficult areas to recruit into.
- AHPs/Healthcare scientists (£49k underspent in month £467k YTD). This is within clinical support services due to vacant posts within radiography, therapies and histopathology.
- Admin is £7k below plan in month against £409k YTD underspend. The YTD underspends are mainly attributable to vacancies within corporate areas.
- This has been partially offset by agency costs of £177k in month and £1,207k YTD.

CIPP – M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 – CIPP Performance YTD

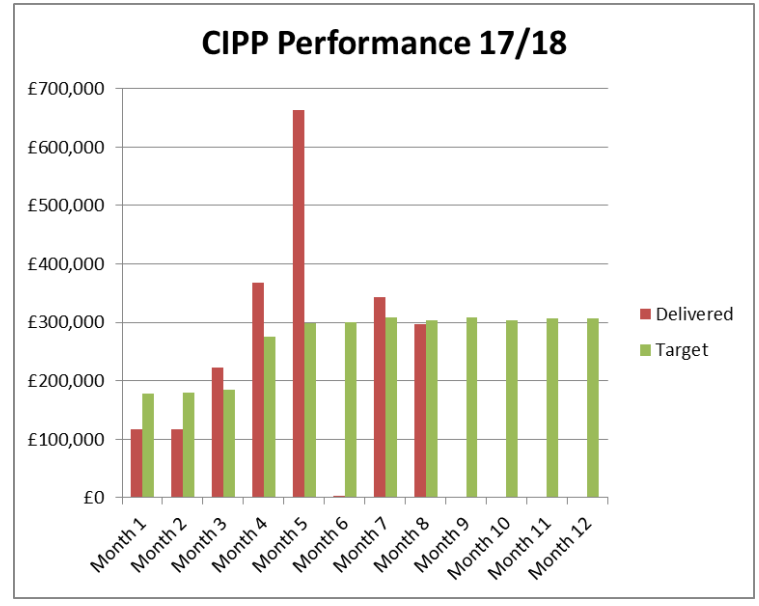
Business Unit	Month 8 Plan	Month 8 Actual	Month 8 Variance	YTD CIPP Plans	YTD Delivery	Performance Against Target
Clinical Infrastructure	3	1	(2)	22	5	(17)
Clinical Support Services	36	74	38	261	464	203
Corporate	50	7	(43)	379	307	(72)
Eyes	23	31	8	191	87	(104)
Non Clinical Infrastructure	12	12	-	93	93	0
Oral	49	12	(37)	340	354	14
Plastics	75	110	34	524	398	(126)
Sleep	7	29	23	46	280	234
Theatres	3	-	(3)	17	14	(3)
Operational Nursing	38	21	(17)	141	127	(14)
Director of Nursing	4	-	(4)	34	3	(31)
Grand Total	**301**	**297**	**(4)**	**2,049**	**2,132**	**83**

Table 2 – CIPP Forecast

Business Unit	CIPP target	Forecast Delivery	Performance Against Target
Clinical Infrastructure	286	3	(283)
Clinical Support Services	409	662	253
Corporate	580	352	(228)
Eyes	194	182	(12)
Non Clinical Infrastructure	140	140	-
Oral	537	603	66
Plastics	826	546	(280)
Sleep	71	296	225
Theatres	29	20	(9)
Operational Nursing	129	234	105
Director of Nursing	51	6	(45)
Grand Total	**3,252**	**3,045**	**(207)**

Summary

- The Trust have delivered savings of £2,132 YTD against a planned savings target of £2,049k. The YTD delivery represents 104% of planned savings.
- The key drivers of the YTD overperformance are the additional contribution generated by the increased activity delivered within Radiology (£163k) and Sleep (£226k) which are offsetting against the reduced delivery of schemes within Plastic Surgery due to the underdelivery on the MSK Hub, Delayed Breast Reconstruction and SNLB income generation CIPPs (£277k).
- The Trust are continuing to explore additional schemes to mitigate against under performance against existing schemes and in preparation for next years CIPP program.
- The Trust is forecasting delivery of £3.05m against a target of £3.25m, a shortfall of £207k. 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 has been undertaken looking into the utilisation and booking of theatre lists. This has been shared with Business Units for action.**
- **Current CIPP will be reviewed to determine if further savings can be generated/ underperformance mitigated.**
- **A review of issues causing the non delivery of the schemes in Plastics is underway and further schemes are being worked up and brought forward to bridge the current gap on the forecast position.**

	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	£117,380	£116,535	£223,214	£367,686	£662,907	£3,638	£343,591	£297,474	£0	£0	£0	£0
Target	£178,000	£179,000	£184,000	£275,000	£298,000	£300,000	£309,000	£304,000	£309,000	£304,000	£307,000	£306,000

Balance Sheet – M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet as at the end of November 2017	2016/17 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	44,279	43,847	43,765
Other Receivables	-	-	-
Sub Total Non-Current Assets	44,279	43,847	43,765
Current Assets			
Inventories	429	435	435
Trade and Other Receivables	7,068	9,233	8,756
Cash and Cash Equivalents	7,784	7,489	7,845
Current Liabilities	(7,413)	(8,288)	(8,038)
Sub Total Net Current Assets	7,868	8,869	8,998
Total Assets less Current Liabilities	52,147	52,716	52,763
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**	**45,821**	**45,867**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	22,614	23,574	23,621
Revaluation Reserve	10,011	10,010	10,010
Total Tax Payers' Equity	**44,862**	**45,821**	**45,867**

Summary

- Net current assets have remained stable with a net decrease of £0.1m this month.
- Trade and other receivables have increased by £0.5m due to activity performance income accruals
- Cash has decreased by £0.4m
- Current liabilities have increased by £0.2m reflecting an increase in capital accruals

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 – M08 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Month 8 - November 2017	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	172	179	7	172	7
Backlog maintenance - Health & Safety	226	87	94	7	226	-
Backlog maintenance - Cladding & Fenestration	179	29	75	46	64	115
Backlog maintenance - Energy Management	124	18	52	34	124	-
Backlog maintenance - Internal Accommodation	194	34	81	47	194	-
Trauma Clinic	113	100	113	13	101	12
Other projects	680	326	677	351	448	232
Estates projects	**1,695**	**766**	**1,270**	**504**	**1,329**	366
Medical Equipment	**576**	**378**	**475**	**97**	**699**	**(123)**
Information Management & Technology (IM&T)						
EDM	130	167	100	(67)	210	(80)
Ordercomms (IM&T Strategy)	310	25	-	(25)	310	-
Health & Social Care Network (IM&T Strategy)	150	26	19	(7)	26	124
Other projects	289	100	246	146	306	(17)
Information Management & Technology (IM&T)	**879**	**318**	**365**	**47**	**852**	27
Commitments	**-**	**-**	**-**	-	**250**	(250)
Contingency	**250**	**-**	**-**	**-**	**270**	(20)
Contingency	**250**				**520**	(270)
Total	**3,400**	**1,462**	**2,110**	**648**	**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 IM&T programme is largely based on the IM&T Strategy. The EDM project is continuing although deployment in OMFS has taken longer than planned as a number of issues during implementation. The Evolve product is fully live in Sleep and OMFS services and currently being deployed in Eyes ;the implementation within Plastics later than planned. The capital element of the project cost is above plan but the increase is offset in-year by savings on the deferred Health & Social Care Network.
- Capital YTD expenditure is £1,462k, £648k behind indicative plan. It is expected that spend will be largely in line with plan by year end.

Issues

- Achievement of the annual plan is largely dependent on projects being delivered as per project plans.

Risks

- Material delays in project delivery could put the achievement of the plan at risk.

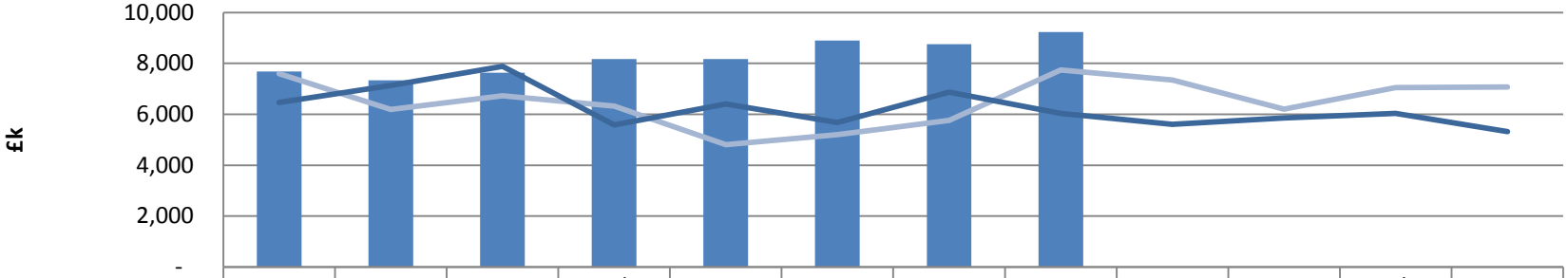
Action

- Progress will be actively monitored by the Capital Planning Group and reported to the Finance & Performance Committee.
- Further analysis to be undertaken to understand revised project timeline and financial implications for the delays within EDM.

Debtors – M08 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	8,172	8,901	8,756	9,233				
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	7,068
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

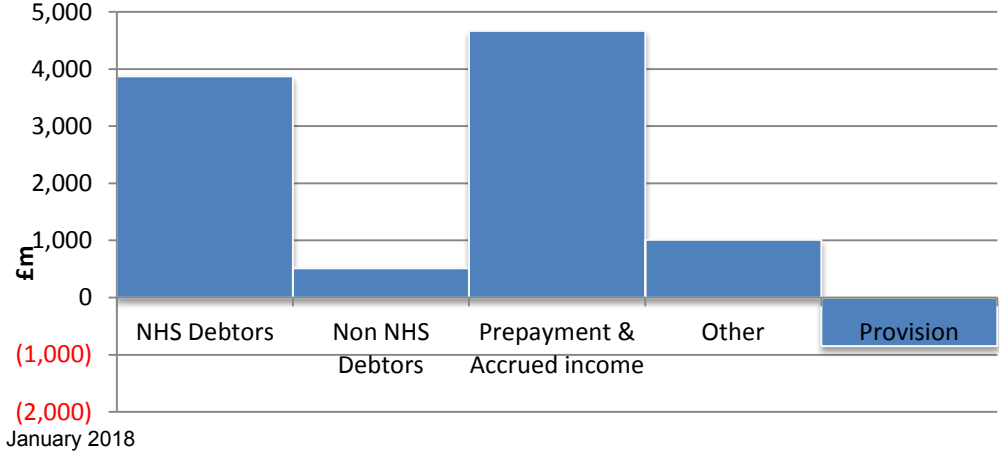
Summary

- The debtor balance increased by £0.5m (5%) from month 7. This is due to a decrease in NHS debt of £0.2m offset by an increase in pre-payments of £0.7m.
- The month 8 debtor balance of £9.2m is 41.5% above the average monthly balance in 2016-17. This is due to an increase in the invoices raised relating to over-performance.
- At month 8 there is £2.1m of accrued income for activity over-performance and NCAs which is an increase of £0.2m compared to the previous month.

Next Steps

- Financial services continue to work with the business development team to ensure billing is accurate, timely and resolutions to queries are being actively pursued.

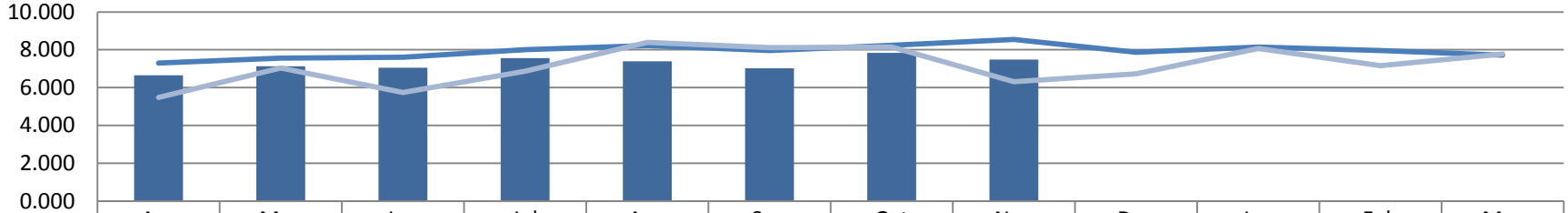
Debtors 2017/18



Cash – M08 2017/18

Queen Victoria Hospital NHS
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	7.387	7.029	7.846	7.490				
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	Aug	Sep	Oct	Nov
Opening Balance	**7.784**	**6.657**	**7.124**	**7.048**	**7.561**	**7.387**	**7.029**	**7.846**
Receipts from invoiced income	4.620	5.989	5.579	4.692	5.624	5.060	5.681	5.440
Receipts from non-invoiced income	0.142	0.158	0.134	1.152	0.636	0.271	0.175	0.164
Total Receipts	**4.763**	**6.147**	**5.714**	**5.844**	**6.260**	**5.331**	**5.857**	**5.604**
Payments to NHS Bodies	(0.488)	(0.513)	(0.312)	(0.340)	(1.030)	(0.422)	(0.338)	(0.641)
Payments to non-NHS bodies	(2.049)	(1.715)	(1.463)	(1.492)	(1.884)	(1.097)	(1.146)	(1.751)
Net payroll payment	(1.909)	(1.968)	(1.980)	(1.966)	(2.011)	(2.008)	(2.007)	(2.048)
PAYE, NI & Levy payment	(0.886)	(0.924)	(0.970)	(0.961)	(0.950)	(0.975)	(0.969)	(0.945)
Pensions Payment	(0.557)	(0.560)	(0.572)	(0.573)	(0.558)	(0.571)	(0.580)	(0.575)
PDC Dividends Paid	0.000	0.000	0.000	0.000	0.000	(0.616)	0.000	0.000
Commercial Loan Repayment	0.000	0.000	(0.492)	0.000	0.000	0.000	0.000	0.000
Total Payments	**(5.890)**	**(5.680)**	**(5.790)**	**(5.332)**	**(6.434)**	**(5.689)**	**(5.040)**	**(5.960)**
Actual Closing Balance	**6.657**	**7.124**	**7.048**	**7.561**	**7.387**	**7.029**	**7.846**	**7.490**
17/18 NHSI Plan	**7.294**	**7.563**	**7.604**	**8.012**	**8.216**	**7.960**	**8.243**	**8.554**

Summary

- The in month cash position is favourable on the basis of current liquidity and debt service ratios.
- The cash balance at the end of Month 8 has an adverse variance of £1.1m against the plan submitted to NHSI. This is due to the payment of high value invoices in Month 8 and lower than anticipated receipts from invoiced income.
- Cash balances are forecast to remain favourable for the Trust's finance score liquidity measure.

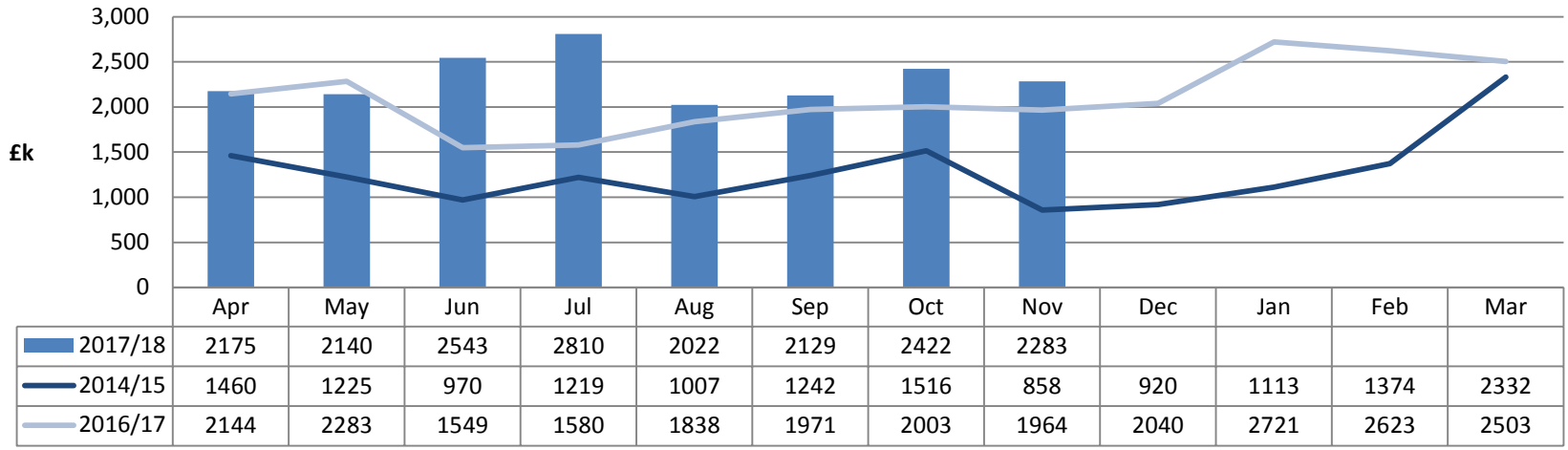
Next Steps

- 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 – M08 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	2022	2129	2422	2283				
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 8 is £2.3m compared to an average of £2.1m during 2016-17.
- There is an decrease of £0.1m in month due to the payment of high value invoices and a large number of invoices which were previously on hold due to authorising-staff absence
- The Trust's BPPC percentage has increased in month by 10% and the average days to payment decreased to 32 days.
- Savings from prompt payment discounts taken in month amounted to £2k, in line with plan.

Better Payment Practice Code (17/18) November	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	1,908	1,824	13,249	13,843
Total **Non NHS** trade invoices paid within target	14,932	17,627	1,649	1,548	11,431	11,602
Percentage of Non-NHS trade invoices paid within target	**81%**	**78%**	**86%**	**85%**	**86%**	**84%**
Total **NHS** trade invoices paid	801	4,496	91	406	581	2,601
Total **NHS** trade invoices paid within target	504	2,879	62	211	375	1,402
Percentage of NHS trade invoices paid within target	**63%**	**64%**	**68%**	**52%**	**65%**	**54%**

Next Steps

- Financial services are continuing to review areas where invoice authorisation is delayed in order to target and support training needs.

Appendices

Appendix 1b: Finance Score (Single Oversight Framework)

Table 1

Single Oversight Framework					
Finance Score: November 2017					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus (Adj YTD	3,779	2.87	1	20%	0.20
Capital Servicing Obligation YTD	1,316				
Liquidity					
Working Capital	8,353	48.6	1	20%	0.20
Operating Costs (per day)	172				
Financial Efficiency:					
I&E Margin (%)					
Adj. Surplus (deficit) YTD	1,113	2.43%	1	20%	0.20
Income year to date	45,718				
I&E Margin Variance From Plan					
Adj. Actual surplus margin	2.43%	-1.26%	3	20%	0.60
Adj. Plan surplus margin	3.69%				
Agency Cap					
Agency Spend	1,206	2.55%	2	20%	0.40
Agency Cap	1,176				
Finance Score: November 2017			2		

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 2, the second highest available. The Trust scored a 1 for 3 of the 5 metrics, a 3 for the margin variance from plan and a 2 for agency spend. The NHSI scoring mechanism scored aggregated the Trust score as a 2.
- Table 2 details a definition of each of the metrics and the scoring mechanism.

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	147	147	147	147	147	147	148	147	147	147	147	150	1,768	1,177
Agency Actuals	171	58	129	171	176	189	137	177						1,207
Variance	(24)	89	18	(24)	(29)	(42)	11	(30)						(30)

Table 2 - Agency Expenditure by staff category

Staff Group	Current Month Actuals £'000	YTD Actulas £'000
AGENCY NURSING	61	701
ALLIED HEALTH PROFESSIONALS AGENCY	0	39
CAREER STAFF GRADE AGENCY	15	91
CONSULTANTS AGENCY	-	10
HEALTHCARE SCIENTISTS AGENCY	-	-
MEDICAL TRAINEE GRADE AGENCY	25	64
OTHER AGENCY	76	303
Total	177	1,207

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 £1.768m for the year. The cap is monitored on a monthly basis via the monthly financial monitoring returns. The YTD agency expenditure of £1.207m is £30k more than the QVH NHSI ceiling.
- The Trust has to average £139k agency expenditure each month for the remainder of the year.
- Performance on the agency ceiling is one of the 5 metrics included within the Use of Resources measure in the single oversight framework.
- The year to date Agency expenditure on Clinical Operations is £1.007m and Corporate £200k. Table 2 - within the Nursing category - Theatres accounts for £375k of the total £701k.

Appendix 3: Activity 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	M05	M06	M07	M08	Trend
Minor injuries	799	921	859	989	917	961	912	865	817	837	702	910	918	993	993	1,095	1,005	880	895	832	
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	1,039	1,037	1,131	1,039	
Elective	345	302	325	318	311	343	352	326	310	325	291	322	275	329	329	343	338	340	340	349	
Non Elective	379	445	433	497	440	473	446	440	416	381	355	447	453	502	502	541	482	413	447	417	
XS bed days	237	130	111	19	66	64	66	39	71	59	109	146	41	39	39	30	45	75	40	62	
Critical Care	58	76	47	59	89	45	66	37	43	52	58	34	28	30	30	76	52	53	55	72	
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	3,928	3,760	3,943	4,205	
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	10,668	10,549	10,942	10,707	
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	1,916	1,820	2,442	2,183	
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	2,643	3,583	3,512	3,842	
Work in progress and coding adjustment																					

Appendix 4: Forecast

Income and Expenditure	Best £'000	Expected £'000	Worst £'000
17/18 Plan	1,464	1,464	1,464
Normalised M8 Forecast (includes earned STF)	698	698	698
Other expenditure	(568)	(418)	(462)
Recovery Plans			
- Plastics	550	275	-
- Eyes	220	70	-
- Oral	248	248	-
Surplus/Deficit (excluding STF)	1,149	873	236
STF (Contingent upon plan delivery)	613	613	-
Actual Surplus / (Deficit)	**1,762**	**1,486**	**472**
Variance to Plan	**298**	**22**	**(992)**

Income and Expenditure	Annual Plan £k	M1-8 Actual £k	M9	M10	M11	M12	Total
Patient Activity Income	66,056	42,932	5,456	5,674	5,474	5,905	65,440
Other Income	3,706	2,786	327	327	327	327	4,093
Total Income	**69,762**	**45,718**	**5,783**	**6,001**	**5,801**	**6,232**	**69,534**
Pay	(44,537)	(29,284)	(3,722)	(3,722)	(3,722)	(3,722)	(44,170)
Non Pay	(19,271)	(12,663)	(1,681)	(1,681)	(1,681)	(1,681)	(19,388)
Financing	(4,489)	(2,812)	(369)	(394)	(419)	(494)	(4,489)
Total Expenditure	**(68,297)**	**(44,759)**	**(5,772)**	**(5,797)**	**(5,822)**	**(5,897)**	**(68,047)**
Surplus / (Deficit)	**1,465**	**959**	**11**	**204**	**(21)**	**335**	**1,486**

The STF funding is assumed in M9 and M12

Summary

The baseline forecast has been updated based on YTD M8 actual performance adjusted for non recurrent items and cost pressures. Interventions have been risk adjusted and applied to the baseline to determine the expected forecast. The mostly likely scenario (detailed above), forecasts that the annual plan is achieved . A worse case scenario has been modelled - surplus of £0.472m , (interventions not delivering & impact on STF funding). The best case scenario is a surplus of £1.762m due to the recovery plan being fully delivered.

The forecast assumes the following :-

- No further deterioration of clinical income performance on M1-8 run rate
- CQUIN delivery risk and challenges are consistent with M1-8
- CIPP delivery in line with forecast
- STF funding delivery of £0.942m (assumes full delivery in expected and best case scenarios – YTD normalised position includes £329k actuals)

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed: 14 December 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 3(C) x 5(L) = 15, moderate risk
Residual Risk Rating 3(C) x 3 (L) = 9 , 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 early warning triggers
Theatres consultation
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
Theatres consultation

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

COMPETITION
Patient choice -services closer to home
5YFV, integration of health and social care, STP – impact on market share, growth and commissioning intentions.
National staff shortages and difficulties in attracting and retaining at QVH.

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

RESILIENCE
Many services single staff/small teams.
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, update on estates strategy at board seminar 02/02/17
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
Sub group for theatre workforce/recruitment, proposals approved at HMT June 2017
Interim paediatric staffing model in place to address vacancies in paeds
Trust recruitment and retention strategy mobilised, Joined NHSI nursing retention initiative

Gaps in controls / assurance
Development of full estates strategy and development control plan, incorporating patient expectations
Robust clinical outcomes to be developed to ensure as effective baseline of clinical care
Lack of structured feedback from PLACE audits
Vacancies in critical care , paediatrics and theatres
Long term strategy required for paediatric service updated paeds paper to be presented at November Board
Increase in negative FFT comments re waiting times, further work required to fully understand and identify appropriate actions
Lack of learning across the trust from never events

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/01/2018**		**Agenda reference:**	**15-18**	
Report title:	**Corporate Risk Register**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Karen Carter-Woods – Head of Risk and Patient Safety				
Appendices:	None				
Executive summary					
Purpose:	For assurance that risks are being identified, reviewed and updated in a timely manner				
Recommendation:	The Committee is requested to note the Corporate Risk Register information and the progress from the previous report. The key changes are three new corporate risks added, two re-scored & remained on CRR and there were no corporate risks closed.				
Purpose:		Information		Assurance	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:					
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in place to manage risk effectively.				
Legal:	As above				
Resources:					
Assurance route					
Previously considered by:	The Corporate Risk Register is considered monthly by the Executive Management Team and bi monthly at quality and governance committee.				
	Date:	20/12/17 EMT 21/12/17 Q&GC	Decision:	Update to risk 1084 required CRR noted	

Corporate Risk Register Report
October and November 2017 Data

Key issues

1. **Three new risks were added** to the Corporate Risk Register between 01/10/2017 and 30/11/2017

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1084	Data quality issue from Patient Tracking list (PTL)	Identified/reported by BU Manager Plastics
3x5=15	1087	Not able to demonstrate full compliance with Mental Capacity Act in adult patient records	Unable to demonstrate we are safeguarding our most vulnerable patients (i.e. those without capacity to consent to treatment or surgery)
3x4=12	1089	QVH not currently providing level 3 adult safeguarding training as part of its training programme, this means there is a gap	Some staff groups need to have level 3 adult safeguarding competencies we need a level 3 face to face session to support staff in the development of these

2. Corporate risks reviewed and re-scored: 2

Risk ID	Risk Description	Previous Risk Score	Updated Risk Score	Rationale for Rescore	Committee where change(s) agreed/ proposed
1049	Unable to recruit qualified paediatric staff leading to challenges maintaining a 24 hour service	3x5= 15	3x4=12	New matron now in post	9/10: reviewed with Exec Lead (DoN) & HoR
1075	Risk to BSUH outsourced CT service when XDS is operational across S&S PACS Consortium: inability to report cross-site	4x5=20	3x5=15	Initial score too high	Discussed with Risk Owner

3. **No Corporate Risks were closed during October and November 2017**

4. The Corporate Risk Register is reviewed monthly at Executive Management Team meetings (EMT), quarterly at Hospital Management Team meetings (HMT) and presented at each Quality & Governance Committee meetings for assurance. It is also scheduled 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 is 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 NHSI.

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 Trust's 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. The Board is asked to **note** the contents of the report.

Corporate Risk Register to end of November 2017
Greyed out = new risk

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1089	24/11/2017	QVH not currently providing level 3 adult safeguarding training as part of its training programme, this means there is a gap	Some staff groups need to have level 3 adult safeguarding competencies we need a level 3 face to face session to support staff in the development of these	Level 2 adult safeguarding session in place Support from adult safeguarding named nurse Adult safeguarding link staff in place level 3 session to be provided during first quarter of 2018 for specified QVH staff	Jo Thomas	Pauline Lambert	Patient Safety	12		
1087	03/11/2017	Not able to demonstrate full compliance with Mental Capacity Act in adult patient records	Unable to demonstrate we are safeguarding our most vulnerable patients (i.e. those without capacity to consent to treatment or surgery)	MCA health records audit has been completed and action plan in place MCA paperwork has been updated and made available to staff via QNET. Awareness has been raised at meetings Safeguarding section on new EDM system in which to save safeguarding and MCA forms	Jo Thomas	Pauline Lambert	Patient Safety	15		6/12/17: Multi-professional meeting held to discuss issues
1084	03/10/2017	Data quality issue from Patient Tracking lIst (PTL)	Data being produced from the PTL is not accurate to work from due to failings in the system meaning booking of clinics and lists is difficult and understanding where the true backlogs are is difficult	regular validation and reviews of lists	Paula Smith	Rob Lock	Information Management and Technology	15	Specific detail requested, meeting has taken place between informatics and operations team.	

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1083	22/09/2017	Deterioration in 18RTT performance	The trust's 18RTT position has deteriorated and although is not an outlier when compared to other trusts, this will mean that patients will wait longer, regulators will be giving QVH more attention and our reputation could suffer	-All areas are developing recovery trajectories with those failing working to achieve or improve their position and those already achieving looking to further improve their position, -18RTT recovery meeting in place - held fortnightly and chaired by the Director of Ops, -progress also monitored at the monthly performance review meetings chaired by the CE. -Additional sessions being put on where possible, eg Super Saturdays with 60 skin patients attending 'see & do' clinics: two limiting factors for additional proceedures and theatre time are the high level of vacancies in theatres and the increase in dental referrals from Kent, we are the only provider. -The Max Fax business & service manager are putting together a business case for 2 additional consultants	Sharon Jones	Paula Smith	Compliance (Targets / Assessments / Standards)	20		
1082	20/09/2017	Potential lack of compliance with requirements of General Data Protection Regulation	Specific compliance areas required under new data protection legislation. Insufficient resources currently in place to ensure successful implementation of required actions.	Action plan to attain compliance Regular review at Information Governance Group Working group to be implemented	Jason Mcintyre	Dominic Bailey	Information Governance	12		**27/11/2017: Action group underway.** Update papers are regularly presented to IGG, EMT and Q&GC with progress updates against Action Plan. IG lead qualified as GDPR Practitioner 3/10/17: reviewed at IGG - Working group to be implemented

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1081	19/09/2017	Longstanding demand & capacity mismatch in the appointments team, exacerbated by poor systems & processes within the team	Growth in referrals over the past two years not matched by increase in appt team staffing; Systems & processes in the team are not standardised nor supported by adequately trained staff; Exacerbated by vacancies in the team plus sickness in the plastics clinical teams so a shortage of appts available	Fortnightly Improvement Meeting Chaired by Dir of Ops with key people attending; Service Manager advised to get additional staff for a period of up to 12 weeks and agency if needed, and to train these staff on focused areas; Some key work areas to be transferred to plastics for the interim period and to be reviewed fortnightly; Service Manager to focus on systems and process improvement alongside electronic referral system - the latter will also help with improving workflows in the medium to long term;	Sharon Jones	Paula Smith	Compliance (Targets / Assessments / Standards)	20		
1079	06/09/2017	Inappropriate prescribing by Eastbourne DCTs due to lack of QVH induction	Eastbourne based DCTs are covering 1 in 10 rota at QVH with inadequate medicines training: All medicines have the potential to cause harm, risk is higher if inappropriately prescribed or not prescribed.	1. All trainees have been sent prescribing assessment packs 2. All have been made aware they cannot prescribe until assessment completed and passed.	Dr Edward Pickles	Judy Busby	Patient Safety	12		

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1077	22/08/2017	Recruitment and retention in theatres, critical care and paediatrics	* Theatres vacancy rate is increasing * Pre-assessment vacancy rate is increasing * Critical Care vacancy rate is high but improving * Paediatric vacancies are high with difficulty booking paediatric trained agency staff * Age demographic of QVH nursing workforce: 20% of staff are at retirement age * Impact on waiting lists as staff are covering gaps in normal week & therefore not available to cover additional activity at weekends	1. HR Team review difficult to fill vacancies with operational managers 2. Targeted recruitment continues: Business Case progressing via EMT to utilise recruitment & retention via social media 3. Specialist Agency used to supply cover: approval over cap to sustain safe provision of service / capacity 4. Trust is signed up to the NHSI nursing retention initiative 5. Trust incorporated best practice examples from other providers into QVH initiatives 6. RAG rating on the numbers of agency/substantive staff discussed on daily basis. 7. Management of activity in the event that staffing falls below safe levels.	Jo Thomas	Nicola Reeves	Patient Safety	12		**12/12/17:** **-Increased Bank rates implemented** **-'recommend a friend' staff incentive scheme** **-staff development (Dec QVH 'Workforce Matters' newsletter)** **October 2017 reduction in nursing vacancies, New paed ward matron commenced and reviewing interim paediatric staffing arrangements**. Deputy ward matron now in post in crtical care. 12 HCA post accepted in theatres start dates are staggered across October and November August 2017: * Nursing Retention Group launched * DoN to meet with all nursing leavers for next three months to hear first hand what the issues are & to identify and implement plans to address these issues

Corporate Risk Register to end of November 2017
Greyed out = new risk

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1075	16/08/2017	Risk to BSUH outsourced CT service when XDS is operational across S&S PACS Consortium: inability to report cross-site	Image Sharing (XDS) is planned to go-live Jan/Feb 2018. When XDS is live the Image Exchange Portal (IEP) cannot be used to exchange images across these trusts. Currently all outsourced CT images scanned at BSUH are transferred to QVH using IEP for formal reporting by QVH radiologists on the radiology information system (CRIS) and available for viewing on QVH PACS by the referring doctor.	-Philips alongside QVH & BSUH PACS are investigating a solution post XSD go-live -VPN solution is being discussed -Transfer images via IEP and delete from BSUH PACS -QVH developing a CT business case to deliver own CT service	Sharon Jones	Sheila Black	Patient Safety	15		XDS has been delayed by Philips PACS provider Date for go-live is Jan/Feb 2018
1059	22/06/2017	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	PEG service review	**28/9/17: following PEG service review, PEG insertion service suspended for six months.** **- CT Business Case in development** **- MOU with BSUH awaiting BSUH Board approval** 3/8/17: Response to PFD Notice tabled at Quality Surveillance Group with ongoing surveillance at CCG & CQC. Response to Prevention of Future Deaths notice required by August 2nd
1052	12/05/2017	Limited spaces in busy Corneo and OPD environments could be problematic for children	Paediatric safeguarding - 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 Update in January 2017 Monitored at quarterly Patient Experience Group	Jo Thomas	Pauline Lambert	Patient Safety	12		**October: works agreed and planned for Q4 2017/18** 21/8/17: Plan drafted & consultation completed Glaucoma moving to Rycroft USS moving back to radiology 17/7/17: HoN, Outpatient managers and Patient Experience manager asked to identify suitable waiting areas for children

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1049	28/04/2017	Unable to recruit qualified paediatric staff leading to challenges maintaining 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. -Impacts negatively on retention -Variable opening hours can result in clinicians being unaware of timeframes required to complete surgical cases to allow adequate recovery time	* 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 * temporary Band 7 providing ward leadership until new ward matron takes up post	Jo Thomas	Nicola Reeves	Patient Safety	12		**12/12/17:** **-Increased Bank rates implemented** **-'recommend a friend' staff incentive scheme** **-Paper to EMT 18/12 re: Paediatric Services** 23/10/2017: B5 Nurses interviewed 16/10/2017 - unsuitable for post - not appointed - risk remains 9/10: reviewed with Exec Lead (DoN) & HoR, score reduced to 12 21/8/17: Paper presented at HMT detailing the agreed option for staffing the ward for next 6 months - new matron commencing September 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1040	13/02/2017	Age of X-ray equipment in radiology	All X-Ray equipment is reaching end of life. No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics. Plain Film-Radiology has 3 CR x-ray rooms and therefore patients capacity can be flexed should 1 room breakdown. Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of extended downtime. Ultrasound- 3 US units are over the Royal College of Radiologists (RCR)5 year's recommended life cycle for clinical use. Plan is to replace 1 US machine in 2017-2018. Should machines fail, then clinical service will be compromised. Cone Beam CT installed in 2008- RCR recommends that all CT machines are on a replacement programme every 7	Sharon Jones	Sheila Black	Patient Safety	12		**06/09/2017- business planning for 2017-2018 agreed for the CBCT and 1 US machine imaging equipment to be replaced.** 14/03/2017: Replacement items to be included in Business Plan for 2018/19

Corporate Risk Register to end of November 2017
Greyed out = new risk

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1035	09/01/2017	Inability to recruit adequate numbers of skilled critical care nurses across a range of Bands	* Failure to recruit adequate numbers of skilled critical care nurses across a range of Bands * 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 has increased the vacancy rate	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. 2. A register is kept of all agency nurses working in CCU:they all have ITU Course or extensive experience 3. Concerns are raised and escalated to the relevant agencies where necessary and any new agency staff are fully vetted and confirmed as fully competent to required standards 4. Recruitment drive continues & review of skill mix throughout the day and appropriate changes made 5. Review of patient pathway undertaken following move of step-down patients to CCU: for review October 2017	Jo Thomas	Nicola Reeves	Patient Safety	12	Actions update	**9/10/17: further improvement in recruitment - x2 Band 6** 21/8/17:Two HCA's have joined the team & all staff working on the unit who do not have a formal ICU qualification undertake specific 'competencies' to develop the required skill set: this is a National document 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1015	08/11/2016	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	Attempting to recruit agency doctors	**06/09/2017: r/v at Ops meeting: BU Manager to discuss with Medical Director** 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1004	14/10/2016	Information Technology Server Software Operating System	Windows 2003 Server operating system is no longer supported by Microsoft as of July 2015. 17 out 140 servers are currently using unsupported operating system.	1. Internet access has been restricted or limited access is provided external support or so that application can function correctly. 2. Up-to-date antivirus software has been installed with continuous updates. 3. No access to the servers for users, only access to the application. 4. The network is protected by firewalls 5. Full nightly backups of the entire operating system where the server is virtualised. 6. Project plan has been produced to upgrade the servers.	Jason Mcintyre	Nasir Rafiq	Information Management and Technology	12	Supplier has confirmed that 4 servers cannot be upgraded - additional controls isolated system have been implemented. For remaining servers upgrade paths have been agreed with supplier which are due to be completed by the 31/03/17. A detailed plan to upgrade servers with dates of migration from software supplier 31/12/2016 All unsupported operating systems to have the latest updates installed - 31/12/2016 Controls to be put in place to restrict the software suppliers from carrying out upgrades until fully testing and compatibility assurance is provided 31/12/2016	**5/9/17: r/v by Exec Lead: This risk reflects servers for ARC only** -In total 6 servers are currently unsupported -4 servers have actions to resolve and these are stated separately in risk 1031 -The action in relation is that we will migrate to a supported server by the end of October; delay has been with the supplier, engagement and technical issues. Once implemented this risk can be closed. (1) 23/12/2016 - action plan has been developed showing the status and date the migrations will be completed or not in some cases. (2) 23/12/2016 - where there is no migration route, Microsoft windows security updates and security controls will be installed in Jan 2017

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
1003	14/10/2016	Information Technology Network Outage	Risk that a power outage within the Trust will result in the IT network taking up to 60 minutes to fully restore network connectivity after the power is restored. The impact could be loss of connectivity to all IT services and systems on-site and access to and from off-site.	1. The Data Centres are protected with uninterrupted power supplies (UPS). 2. Each Data Centre is feed from a separate electricity feed and a separate generator. 3. Some key areas are protected using UPS's e.g Theatres.	Jason Mcintyre	Nasir Rafiq	Information Management and Technology	12	Communicate to departments to update their Business Continuity Plans in light of risk. 31/12/2016 Use existing UPS's to protect the network in keys areas. 31/01/2017 Additional electrical upgrade required to allow existing 4 UPS to be installed. Arranged to be completed and UPS installed 15/04/2017 New UPS to be installed in prioritised critical areas 30/04/2017 30/03/2017: Additional electrical upgrade required to allow existing 4 UPS to be installed. New UPS to be installed in prioritised critical areas Arranged to be completed and UPS installed 15/04/2017 Investigate costs of UPS protection to cover the entire network - 31/12/2016 Investigate and implement reboot process of the network devices so that key areas are	**12/12/17: UPS onsite & work progressing** Updated 03/10/2017 Alternative UPSs are still being sourced. 5/9/17: r/v by Exec Lead: The order for the electrical contractor was raised in August 2017 The electrical contractor tested the solution and expressed re approach Currently in the process of agreeing/sourcing an alternative - update expected by end of September - Once implemented this risk can be closed Update: 03/08/17: A full review of the locations has been undertaken by the electrical contractor, the order for the UPS will be placed in Aug 2017 for the work to be completed by Sept 2017.

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	-Potential increase in the risk to patient safety -on-call paediatrition is 1 hour away in Brighton -Potential loss of income if burns derogation lost -no dedicated paediatric anaesthetic lists	*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 *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 all children having general anaesthesia under 3 years of age. *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	To be reviewed in July following Clinical Cabinet discussions Paper to be presented at Clinical Cabinet in June 2016 Paediatric review group met in August, paper to private board in September 2016.	**November 2017: Paper presented to Board** 9/10/17: reviewed with Exec Lead - Paediatric Position Paper re: paediatric inpatient burns to be presented at Board Nov 2017 21/8/17: Paper re: Paeds staffing agreed at EMT and presented at HMT. Issue re: no dedicated Paeds anaesthetic lists raised at HMT & Paeds Gov meeting - Plan: to be resolved at Theatre Utilisation Group July 2017: Review of all safety / clinical governance issues at monthly Paeds governance meeting; including all incidents & children transferred out for care. This links with 1049

Corporate Risk Register to end of November 2017
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ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
949	08/04/2016	Threat to scheduling and reporting of patient waits and performance (RTT18) through system enhancement	Improved stability and detail of data from off-site locations will improve visibility of underperformance against national standards e.g. waiting time RTT18 but this will impact adversely upon reported performance. The lack of good data, along with access to their patient administration systems and so inability to include these patients on the QVH patient tracking list, is a long standing issue which is now being addressed. Medway is the main risk area as apart from a three month period in the summer of 2015, they have not been able to report their 18 RTT position since November 2014 and this has impacted upon QVH. When Medway was reporting, it was one of the worst performers in England.	1.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	Paula Smith	Compliance (Targets / Assessments / Standards)	15	22/06/2016 Risk reviewed with IHoR and IM Progress been made with East Kent to provide a data warehouse 3.A recovery plan will be commenced as soon as there is enough data and a trajectory agreed, this will be revised once there is more accurate data via the warehouse functionality To gain access to offsite PAS systems	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
898	04/11/2015	Ageing specialist Histopathology laboratory equipment	The increasing age of the very specialist laboratory equipment.	Items will be included in the capital business planning as required and will also be put on rolling program over the next 3 years. Where available, specialist maintenance contracts in place to ensure rapid response to repair essential equipment. However, this is not possible for some machines as they are too old and parts are no longer manufactured.	Sharon Jones	Fiona Lawson	Estates Infrastructure & Environment	12	Ensure equipment to be replaced is part of business planning and capital bids for 2016-17	19/5/17: 'staining machine' request to be submitted to June Capital Planning meeting.

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
884	22/10/2015	Potential for Unauthorised Data Breaches	Lack of technical and physical security measures around handling of personal information.	EXTERNAL CONFIDENTIAL PATIENT INFORMATION BREACHES 1. Mail checked for visible personal details 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 controls	Jason Mcintyre	Sheila Black	Information Governance	12	Contractor to be selected 25/07/2016 HoR & IG Lead reviewed risk - IG Lead to obtain update from radiology Purchase encryption hardware for Radiology IT disposal Policy to be ratified at July 2016 IGG Implement Data Leakage Prevention Software on Trust e-mail exchange	**27/11/2017: All staff now have nhs.net accounts. IG Lead and HoR to meet and rationalise remainder of risk.** 5/9/17: R/V by Exec Lead Unsecured e-mail accounts – issue will be resolved through full roll-out of NHS mail solution for all users. This is currently underway and will be completed by the end of October 2017. Update required re: PACS encryption - e-mail sent to IG Lead and Radiology Manager 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
877	21/10/2015	Financial sustainability	1) Failure to achieve key financial targets would adversely impact the NHSI "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	Jason Mcintyre	Jason Mcintyre	Finance	20	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent ro risk owner requesting an update, sent 22nd June 2016 1) Development and implementation of delivery plan to address forecast underformance. Review of performance against delivery plan through PR framework with appropriate escalation policies. 2) Development of multi-year CIP/ transformational programme which complies with best practice guidelines. 3)Development and embedding of integrated business planning framework and pro	**3/10/17: reviewed at senior team meeting = no change** 06/12/2016: Reviewed by Senior Management Team. DoF to review further to ensure score accurately reflects current status.

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
844	13/10/2015	Medical cover out of hours	Ability of on site medical staff to function safely within the hospital at night team and ensure all patients have access to adequate medical expertise appropriate to both the needs of adults or children within a suitable timeframe; lack of understanding of the need for greater medical cover at all levels out of hours. Failure to comply with intensive care unit cover guidance; ability to assure support for junior medical and nursing staff out of hours, complying with the requirement of the 7 day services NHS standards.	Currently QVH has a skilled multidisciplinary team available 24/7. There is always a senior doctor on site (ST Anaes) however they can be pulled in more than one direction, in particular when they have responsibility for a case in theatres. Consultant advice is always immediately attendance is half an hour away. Communication with surgical leads has allowed a better time based understanding of the risks to care out of hours in particular the ability to a certain extent to control the level of activity and exposure to risk by adjusting and controlling the cases in theatres. Out of hours operating is managed according to absolute need on the background of the needs of other patients in the organisation. First assessment of the anaesthetic cover provided by consultant staff and how that links to handover ensuring patients can be clearly assessed and managed. Locum cover promised is now in place. This mitigates against the risk posed by	Dr Edward Pickles	Dr Tim Vorster	Patient Safety	12	3rd June 2016 Risk Reviewed with IHoR and MD: Actions now completed andtherefore removed and new controls added. Review again in one month Proposals for achieving cover OOH prepared and to be put to exec team as cost pressure Business case has been approved and now in discussion with peers re costing infrastructure	**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.
792	31/03/2015	Unable to recruit adequate dental staff for off site clinics and theatres	• Unable to treat patients within RTT 18 • More Doctors are needed to deliver services in a timely manner Feb 16 - unable to recruit dental middle grades; score increased to 12 from 10.	• Cancelling Clinics when unable to staff Some cases diverted to QVH and consultant lists	Dr Edward Pickles	Ruth Barton-Anderson	Patient Safety	12	03/06/2016 - Risk discussed with IHoR and MD no new controls added and current rating (12) remains unchanged. this is to be discussed with Execs June 2016 Rolling recruitment advertisement Consultants approached to undertake additional activity to clear the back log Reviewing Clinic templates and operating sessions to provide additional capacity	**12/12/17: additional staff recruited in September 2017 & reducing the waiting time for first appointment and treatment, however these are still outside of 18 weeks** 28/9/17: reviewed with MD - Risk Owner e-mailed for update 19/9/17: Risk owner e-mailed for update 15/8/17: reviewed with MD - Risk Owner e-mailed for update 24/7/17: reviewed with MD - Risk Owner e-mailed for update

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Actions	Progress / Updates
789	12/03/2015	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: developed & submitted to HEE & LaSE 8. Deanery visit planned Nov 2017	Dr Edward Pickles	Chetan Patel	Compliance (Targets / Assessments / Standards)	15	Recruitment drive commenced Permanent Education Centre has had outline Board approval and funding TBA Reduced activity in some areas 03/06/2016 Risk Reviewed with IHoR and MD: continued recruitment drive in place with focus upon plastics new contolrs added but scores remain unchanged as still a risk to the Trust review in one month	**01/11/2017: Risk reviewed at October 2017 Workforce Meeting - risk not responsibility of HR (Changed to Medical (Doctors))** 24/7/17: reviewed with MD - from Sept 2017 there will be a full complement of Plastics trainees (from Deanery) - vacancies in Maxfacs (registrar level)October 2017 - GMC survey 2017: disappointing 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

Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Trust Board				
Meeting date:	**04/01/18**	**Agenda reference:**	**17-18**		
Report title:	Quality and Safety Report, January 2018 Board (period covers October and November 2017)				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	1. Safe staffing/ workforce report 2. Patient Experience report				
Executive summary					
Purpose:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Recommendation:	The Board is asked to **note** the contents of the report which reflects 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: **N**	KSO4: **N**	KSO5: **N**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	KSO1: Outstanding patient experience and KSO2:World-class clinical services				
Corporate risk register:	The CRR was reviewed prior to writing this report.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above				
Resources:	No changes				
Assurance route					
Previously considered by:	This paper has been reviewed and discussed at Q&GC and EMT prior to Board.				
	Date:	20/12/17	Decision:	Noted at EMT	
Previously considered by:					
	Date:	21/12/17	Decision:	Discussed and noted at Q&GC	

Executive Summary - Quality and Safety Report, January 2018

Domain	Highlights
Safe	The trust had the first 'new format' quarterly quality assurance visit 30 November. This consisted of a meeting with the Director of Nursing and two CQC inspectors then two focus groups with surgical and anaesthetic consultants and medical director and band 6 nursing staff. The visit did not highlight any new concerns, there was a comprehensive assessment submitted to the trust prior to the visit which was discussed in detail with a focus on the serious incidents and never events.
Effective	QVH has completed the national Seven Day Services audit (re-audit) and audited against local guidance to ensure consistency with locally set speciality indicators.
Caring	There were 5 new complaints in October and November these have been graded as minor.
Responsive	MIU performance continues to perform better than national indicator. In October 99% and in November 100% of patients were assessed and treated within 4 hours.
Well led	QVH currently undertaking its NHS Improvement Well - Led review which will help to identify areas of leadership and governance attend further remedial or development work to be taken forward.
Nursing Workforce	The Trust is participating in the NHSI retention support programme and has developed plans to improve nursing retention over the next 12 months 2017 with the aim of improving retention in participating trust in the next 12 months. The trust received feedback from NHSI in December on the submissions which was positive and we are currently reviewing the recommendations made and incorporating these into existing workforce action plans. The trust is actively recruiting for 35.62 wte nurses and theatre practitioners which equates to 15.26 % vacancy rate and15.26 wte health care assistants which equates to 15.32% vacancy rate (October ESR data). Sickness has increased in both these groups since the last Board report. Key areas of focus for recruitment and retention are theatres, critical care and paediatrics, though there has been some improvement in critical care and paediatric recruitment.

Safe - Current Compliance

Domain	Current Compliance	Next Steps
Infection control	Zero MRSA bacteraemia cases and zero Clostridium difficile infections (CDI) attributed to QVH in Q2 2017. Wassenberg machine in theatres remains out of service. A new Reverse Osmosis machine has been purchased and will be installed in December 2017. The machine will not be able to be commissioned for use until water testing is complete and a decontamination lead has been established. Alternative arrangements for decontamination continue. Increase in Hospital acquired MRSA cases. Nine patients identified with hospital acquired MRSA positive result in Q2. Root Cause Analysis (RCA's) have been completed for each case. The MSSA positive blood culture documented in the previous Board report has been declared a contaminant from skin. RCA completed and learning needs identified which are predominantly around poor documentation.	Work continues with ward staff to reduce MRSA colonisation risk. Enhanced surveillance remains on burns ward, this is not an outbreak as different strains are identified. Some cases have been solely colonisation but there have been 5 cases of MRSA cultured from wounds. Actions include additional support and teaching from infection control team and deep cleaning of the environment.

Medication errors	**October:** Twenty patient safety medication related incidents were reported – all no or low harm. **November:** Sixteen patient safety medication related incidents were reported, all with no or low harm. Intervention by Pharmacy staff prevented harm from occurring.	This is a significant increase against previous months, incorporating a majority of prescribing errors, including prescribing 'omissions'- notably of routine medications that patients have been prescribed prior to admission for surgery: all resulting in no harm, but does not impact on patient experience. The Pharmacy Medicines Governance and Medication Safety officer investigates 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. In areas of highest incidents, a member of the pharmacy team attends specialty governance meetings to discuss and advise along with teaching sessions for doctors upon induction and when an increase in errors is identified.
Serious Incidents/ Never Event	**October:** One Never Event occurred – a wrong side block on a Corneo patient. The error was immediately corrected and the patient received their surgery. **November:** No Serious Incidents or Never events were reported in November 2017	A review of the previous five years Never Events has been undertaken and presented to the December Quality and Governance Committee. This shows a small increase in the number of Never Events. Variable adherence to & compliance with the WHO checklist has been identified as an issue and, following immediate raising of awareness, ongoing work around improving of processes is underway.

Pressure ulcers	There were no grade 2 or above hospital acquired pressure ulcers reported during October or November 2017.	Theatres will be trialling consumables to reduce the prevalence pressure sores resulting from the insertion of nasopharyngeal airways. A tissue viability nurse has been recruited and is working with the Head of Nursing – Non Elective to review findings of the quiz undertaken during the national 'stop the pressure' day on 16th November 2017 to assess staff knowledge and confidence.
Falls	**October:** There was one inpatient fall reported during October 2017. **November:** There were eight inpatient falls during September 2017. These both occurred within the this time.	A clinical assessment flowchart for patients at risk of falls has been implemented and is held in all adult inpatient bedside folders. The risk assessment booklet has also been updated to ensure patients have both lying and standing blood pressure on admission. A leaf symbol is also displayed above the patient's bed when they are at risk of falls and on the patient white board. Screensavers have also been formulated to support this initiative and roll out the new process.

Safe - Performance Indicators

Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2015/16 total / average	Target	Quarter 3 2016/17	Quarter 4			Quarter 1 2017/18			Quarter 2			Quarter 3 2017/18		12 month total/ rolling average
			Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	1	0	0	0	0	0	0	0	0	0	0	0	1
MRSA screening - elective	98%	>95%	97%	98%	97%	97%	98%	98%	97%	99%	99%	99%	97%	98%	98%
MRSA screening - trauma	97%	>95%	93%	96%	94%	99%	95%	96%	96%	94%	97%	95%	96%	96%	96%
Incidents															
Never Events	0	0	0	0	0	0	1	0	0	0	1	0	1	0	3
Serious Incidents	3	0	0	0	1	0	0	1	0	0	0	1	0	0	3
OOH inductions:															
All patients: Number of patients operated on out of hours 22:00 - 08:00		5	4	5	2	1	2	6	5	8	2	5	3	4	38
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00		0	0	0	0	0	0	0	0	0	0	0	0	2	2
Paediatric transfers out (<18 years)			0	1	2	1	3	0	1	0	2	0	0	2	12
Medication errors															
Total number of incidents involving drug / prescribing errors	191		4	11	16	11	8	10	8	4	8	9	20	17	126
No & Low harm incidents involving drug / prescribing errors	191		4	11	16	11	8	10	8	4	8	9	20	17	126
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		0.6	0.7	0.7	1.1	2	2.7	0.5	1.7	0.5	2.2	2.4	1.2	1.4
Harm free care rate (QVH)	97%	>95%	98%	96%	97%	97%	100%	100%	100%	98%	97%	100%	100%	97%	98%
Harm free care rate (NATIONAL benchmark) - one month delay	94%	>95%	94.3%	94.1%	94.0%	94.1%	94.0%	94.2%	94.1%	94.2%	94.1%	94.3%	94.3%		
Pressure Ulcers															
Hospital acquired - category 2	11	15	1	0	1	0	0	2	2	1	0	3	0	0	10
Hospital acquired - category 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital acquired - category 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VTE initial assessment	98%	>95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	94%	>95%	98%	96%	100%	97%	100%	100%	100%	100%	100%	100%	100%	97%	98.86%
Patient Falls resulting in no or low harm (inpatients)	40		2	6	10	2	3	7	6	4	0	2	1	8	51
Patient Falls resulting in moderate or severe harm or death	0		0	0	1	0	1	1	0	0	0	0	0	0	3
Flu vaccine uptake		75%	51.5%	51.5%	51.5%	Figures reported from Oct - Feb							40.6%	51.5%	51.5%

Effective - Current Compliance

Domain	Current Compliance	Next Steps
Seven Day Services	Guidance on consultant review of non-elective inpatients at QVH within 1 hour, 14 hours and 24 hours has been added to the Trauma Policy and Operational Guidance which was approved at the Trust's Clinical Governance Group in October 2017. The Trust has now completed the September 2017 audit cycle which focussed on clinical standard 2: Time to Consultant Review for clinical standard 2 only.	As part of the audit, the Trust audited its local guidance to ensure it is currently meeting its locally set speciality indicators. Results will be fed back to our lead Clinical Commissioning Group.
Mortality	**October:** There were no QVH mortalities and one patient died elsewhere. **November:** There were no QVH mortalities and no patients died elsewhere.	The quarterly QVH Foundation Trust: Learning from Deaths Dashboard (produced by NHS England) is tabled at the Clinical Group in conjunction with the Trust's Clinical Indicators Report. This dashboard complements the wider guidance provided in the National Framework on Learning From Deaths and separate methodology guidance on the Structured Judgement Review (SJR) as developed by the Royal College of Physicians (RCP).
Transfers out	There were three emergency or unexpected transfers out in October 2017. None of these were paediatric patients. There were seven emergency or unexpected transfers out in November 2017. Two were paediatric patients - Both were clinically appropriate.	Transfers out continue to be discussed at the Joint Hospital Governance Meeting to ensure Trust oversight.

Antimicrobial Stewardship	Quarters one and two data on antibiotic consumption has been submitted for the 'Reducing the impact of serious infections' CQUIN. Q1 data published by PHE shows that our total consumption was up by 1%, piperacillin/tazobactam down by 30% and carbapenem up by 33% on 2016/17.A snap shot audit on Canadian Wing was carried out over one week and individual prescribers who did not comply with antimicrobial prescription requirements were written to individually to highlight their poor practice. WHO Antibiotic Awareness Week was marked with an email to all prescribers highlighting poor prescribing practice at the Trust and a poster was displayed for patients in the pharmacy waiting area.	A Microbiologist, the antimicrobial pharmacist and the Medical Director will be presenting on Antimicrobial Stewardship at the next Joint Hospital Governance Meeting In January 2018. A draft version for an antimicrobial prescribing prescription for inclusion onto the adult prescription chart, has been compiled and will be taken to MMOGG for approval in January. A re-audit of prescribing will be undertaken in December 2017.
Clinical audit	An audit has been undertaken on the Care of Dying Policy against NICE NG31: Care of dying adults in the last days of life and QS114 Care of dying adults in the last days of life, and Royal College of Physicians End of Life Care standards. Results found a holistic assessment of the patient's needs were undertaken. The Trust is currently completing the organisational questionnaire for the NCEPOD Study: Peri-operative management of surgical patients with diabetes.	The Trust's An Organisation-Wide Document for Undertaking and Learning from Clinical Audit has been updated at aligned to the Clinical Audit Strategy. It was approved for use by the Clinical Governance Group in December 2017.

CQC

The CQC attended site for a planned visit in October 2017 as part of their new inspection regime assurance process. They reviewed performance indicators related to each of the five domains: safe, effective, caring, responsive and well led.

They held two focus groups and specified which staff they wanted to speak to: the first was with Consultant anaesthetists, consultant surgeon and medical director and the second with band 6 nursing staff. The purpose of these focus groups is to hear what staff are most proud about what they would change and test out information they have received. The feedback from the CQC before they left was that they appreciated staff making time for them to meet and that staff spoke to them freely.

They also met with the Director of Nursing and Quality the meeting focused on the learning from recent Never Events and how the Trust is managing its workforce issues in nursing, theatre practitioners and medical staff.

At this meeting, the CQC informed the Trust that there had been a concern raised directly with them by a member of the public about patients being x-rayed prior to being reviewed by a QVH doctor and staff did not feel able to challenge this. An investigation has been undertaken led by the Medical Director and a report has been returned to the CQC. The Trust found no evidence to support this concern. The CQC fully accepted the report and the case has been closed.

Effective - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 3 2016/17	Quarter 4			Quarter 1 2017/18			Quarter 2			Quarter 3		12 month total/ rolling average
			Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	
Mortality															
QVH Mortalities	6	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Mortality elsewhere within 30 days of discharge	15	0	1	1	2	2	1	4	2	0	1	0	1	0	14
Readmissions															
Emergency Readmissions Within 30 Days	1.87%	2.24%	1.98%	2.07%	2.02%	2.83%	2.64%	3.07%	4.72%	4.02%	4.19%	2.40%	2.72%	2.64%	3.33%
Emergency Readmissions Within 7 Days	1%	1.21%	1.12%	1.31%	1.05%	1.60%	1.03%	1.18%	1.90%	2.30%	1.77%	1.10%	1.26%	1.78%	1.55%
Paediatric safeguarding															
Paediatric safeguarding cases*			15	24	10	16	15	18	21	23	24	20	18	17	221
Allegations against staff			0	0	0	0	0	0	0	0	0	0	0	0	0
Safeguarding adults															
Adult Safeguarding cases*			5	4	2	10	4	5	8	5	5	7	3	6	64
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			1	1	0	0	0	0	1	0	0	0	0	0	3
Prevent Referrals			0	0	0	0	0	0	0	0	0	0	0	0	0
Infection control audit															
Hand hygiene audit %			100%	100%	100%	99%	99%	100%	100%	99%	99%	98%	100%	97%	99%
Bare below the elbows %			99%	99%	99%	99%	99%	100%	100%	100%	99%	100%	98%	99%	99%
Trust Cleaning %			90%	89%	89%	90%	86%	88%	89%	88%	91%	90%	**		89%

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

** New reporting methodology being finalised

Caring - Current Compliance

Domain	Current Compliance	Next Steps
Patient experience	We are undertaking a review of outpatient services and the concerns that patients have raised specifically about waiting times.	We need to ascertain the reasons for this and have put together a small working group to capture some specific data on waiting times from patients. The group will meet in December 2017 and will report progress to the Patient Experience Group.
Complaints	October and November – five complaints were received. Two relate to communication, one relates to admission arrangements, two relate to clinical care/treatment. All complaints have been graded as minor.	Training on the complaints handling procedure will continue to be rolled out for all front line staff. In addition, we will continue to strive for further improvement in relation to meeting our internal target of responding to formal complaints within 30 working days. The Trust continues 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 October 98% of inpatients (response rate of 40.5%) who completed FFT survey would recommend QVH. In November this was 99% (with a significant decline in the response rate of 29% (national target is 40%)) who completed the FFT survey would recommend QVH.Outpatients: The FFT score for out-patients in October was 94%. A total of 2233 outpatients out of a possible 13767 completed the questionnaire either by paper, SMS or integrated voice message (response rate of 16%). In November this was 95% (response rate again of 16%(national target is 20%). A total of 2288/ 14415 completed the survey.	The response rate for inpatients in November is disappointed and this will be discussed at Nursing and Quality Advisory Group to discuss ideas and initiative to improve the situation.

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

Caring - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 3 2016/17	Quarter 4			Quarter 1 2017/18			Quarter 2			Quarter 3 2017/18		12 month total/ rolling average
			Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	
Complaints															
Complaints per 1000 spells *	2.7		1.2	5.4	2.8	2.1	2.0	2.2	2.2	3.9	1.6	3.9	0.6	2.3	2.5
Claims per 1000 spells *	1.1		0.0	1.4	0.0	1.1	2.0	1.1	1.6	0.0	0.0	0.6	1.2	0.0	0.8
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	97%	98%	98%	99%	99%	99%	98%	98%	98%	98%	98%	99%	98%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
FFT score MIU: likely and very likely to recommend QVH	94%	>90%	95%	97%	97%	94%	98%	98%	96%	95%	92%	96%	97%	97%	96%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		3%	2%	1%	2%	0%	1%	3%	3%	4%	1%	0%	1%	2%
FFT score OPD: likely and very likely to recommend QVH	95%	>90%	94%	94%	94%	95%	95%	95%	95%	94%	93%	94%	94%	95%	94%
FFT score OPD: unlikely and very unlikely to recommend QVH	2%		2%	2%	2%	2%	2%	2%	2%	2%	3%	2%	2%	2%	2%
FFT score DSU: likely and very likely to recommend QVH	97%	>90%	97%	96%	96%	97%	97%	97%	96%	96%	98%	98%	97%	97%	97%
FFT score DSU: unlikely and very unlikely to recommend QVH	1%		0%	0%	1%	0%	1%	2%	0%	1%	0%	0%	0%	2%	1%
FFT score Sleep disorder centre: likely and very likely to recommend QVH	97%	>90%	91%	96%	99%	100%	98%	94%	93%	100%	100%	98%	99%	94%	97%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	1%		0%	0%	0%	0%	1%	1%	2%	0%	0%	0%	0%	0%	0%
Privacy and dignity															
Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	99%	>90%	100%	100%	100%	100%	99%	100%	99%	100%	100%	100%	100%	100%	100%

* 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
Incident Reporting	**October:** 158 incidents were reported, 69 of which were Patient Safety incidents; eight – Level of Harm Unknown, 53 - No Harm/Near Miss incidents, 7 were Minor Harm and one moderate harm. **November:** 191 incidents were reported, 81 of which were Patient Safety incidents; 11 of these were Level of Harm Unknown, 60 No Harm/Near Miss incidents, 9 were Minor Harm incidents and one was Moderate Harm involving a delayed appointment following two week wait referral.	investigated thoroughly and learning identified along with actions to prevent recurrence. We have added a new field to Datix which allows for accurate documentation when the level of harm is unknown for example awaiting diagnostics result or needle stick injury. The Patient Safety Team work with investigators, supporting with incident investigations as well as attending specialty Governance meetings to discuss specific incidents and share learning from Trust wide incidents.

Well led - Current Compliance

Domain	Current Compliance	Next Steps
QVH Well Led Review	The Trust is currently undertaking its three year Well - Led review as mandated by NHS 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. 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	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. This review could also help us to look at our key challenges including the risks and mitigations around being a small trust.
Local Strategy	Specialties across the Trust have been working on local visions and strategies as part of their well led preparations.	Individual visions ans strategies wil be displayed within each clincal area.

Nursing Workforce - **Current Compliance**

Domain	Compliance	Actions
Ross Tilley	During October and November 13/122 occasions where staffing numbers did not meet planned levels, all escalated, no safety incidents linked to these dates. Reasons: staffing levels adjusted to bed occupancy, vacancy and short notice sickness. In addition, on occasions, staff were moved to support other areas. 3 shifts where there was no additional help able to support, one trained and two HCA shifts.	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	During October and November 14/122 occasions staffing numbers did not meet planned level, all escalated no safety incidents linked to these dates. Reasons for not meeting planned staffing levels due to staffing adjusted to bed occupancy, vacancy and short notice sickness. Four shifts where no additional help available all HCA shifts.	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.
Burns	During October and November 9/122 occasions staffing numbers did not meet planned levels, all escalated, no safety incidents linked to these dates. Reasons for not meeting planned staffing, vacancy and failure of agency nurse to attend 1 booked shift. One shift where no additional help available.	Practice educator has returned from sabbatical and is reviewing the burns ward education and development plans.

Peanut	During October and November there were 16/122 occasions staffing numbers shift did not meet planned level, no safety incidents linked to these dates. Interim opening hours of 07.00 to 00.00 with on call cover after 00.00 continue. Staff are not rostered to work full night when there is no elective activity. Burns ward will take paediatric referrals if Peanut closed. Reasons for not meeting planned staffing include no requirement to be open due to lack of patients, vacancy and short notice sickness.	In October the ward had staff for 25 of the 31 nights. There was a total of 36 in patients on 17 nights. The impact of the ward being closed from 1930 or 0000 for 6 nights was: one child was transferred to another hospital. In November the ward had staff for 23 of the 30 nights. There was a total of 15 inpatients on nine nights. The impact of the ward being closed from 1930 or 0000 was: one child transferred to another trust and one child held at referring site, with medical advice overnight. 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 was an impact on patient experience for the two children transferred out . Line booking of one agency nurse continues. A six month review paper on the staffing and opening times of Peanut ward was discussed at EMT in December.
Critical Care (ITU)	During October and November 4/122 occasions, staffing numbers did not meet planned levels, escalated and no safety incidents linked to these dates. Reasons for not meeting planned staffing levels due to staffing adjusted to bed occupancy, vacancy and failure of agency nurse to attend a booked shift. One shift where there was no additional nursing support available and the anaesthetic registrar was based in critical care to provide safe cover.	Recruitment continues to critical care, a new deputy ward matron has commenced and an experienced band 6 nurse has also been recruited. The area still requires support from site practitioners and senior nurses to provide safe care, which is achieved by staff being very flexible with changing shifts at short notice. The initial positive impact on morale with the change to critical care pathway has been maintained.

Site Practitioner Team	During October and November 31/122 occasions, staffing numbers did not meet planned levels of two staff on duty. Reasons for not meeting planned staffing are vacancy related, secondment within the trust and phased return.	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. Twilight shifts have been used to provide additional cover at the busiest times. Pilot of new ways of working has been completed ways of reducing the volume of phone calls and to the team have been identified and implemented for example: a different pathway for discharged patients with queries now in place which avoids contacting site team is now in place.

Data extracted from the workforce score card in appendix 1

Qualified Nursing Workforce - Performance Indicators

QUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17 & 2017-18			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Establishment WTE				267.61	267.61	267.61	267.61	267.61	257.21	257.21	257.21	257.21	253.30	253.30	253.28	**253.28**	◄►
Nursing Headroom				*0.00*	*0.00*	*0.00*	*0.00*	*0.00*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	◄►
Adjusted Establishment (removed Headroom)				267.61	267.61	267.61	267.61	267.61	238.99	238.99	238.99	238.99	235.08	235.08	235.06	**235.06**	◄►
Staff In Post WTE				206.67	204.02	201.21	200.89	199.87	200.37	199.66	200.21	201.53	201.35	199.35	199.44	**198.44**	▼
Vacancies WTE				60.94	63.59	66.40	66.72	67.74	38.62	39.33	38.78	37.46	33.73	35.73	35.62	**36.62**	▲
Vacancies %	>12%	8%<>12%	<8%	22.77%	23.76%	24.81%	24.93%	25.31%	16.16%	16.46%	16.23%	15.67%	14.35%	15.20%	15.15%	**15.58%**	▲
STARTERS WTE (Excluding rotational doctors)				3.00	0.46	0.00	1.49	0.00	2.61	2.00	1.64	0.76	1.10	1.00	2.24	**2.00**	▼
LEAVERS WTE (Excluding rotational doctors)				5.37	3.00	4.60	2.40	2.00	1.96	2.85	2.00	0.80	1.00	4.26	3.28	**3.00**	▼
Starters & Leavers balance				-2.37	-2.54	-4.60	-0.91	-2.00	0.65	-0.85	-0.36	-0.04	0.10	-3.26	-1.04	**-1.00**	
Agency WTE				12.41	11.77	11.47	13.27	13.31	8.88	9.55	12.58	18.05	21.41	21.78	19.69	**23.58**	▲
Bank WTE				8.48	6.88	9.22	10.54	12.54	10.44	12.97	13.30	10.78	11.48	8.90	10.99	**11.86**	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	21.83%	22.75%	21.40%	21.44%	20.95%	19.87%	20.32%	19.95%	19.57%	18.58%	18.70%	16.76%	**15.67%**	▼
Monthly Turnover				2.55%	1.89%	2.27%	1.19%	0.74%	0.98%	1.42%	0.99%	0.40%	0.50%	2.14%	1.64%	**1.51%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	4.17%	3.81%	3.25%	3.50%	2.67%	1.79%	2.56%	1.90%	2.22%	3.97%	4.79%	4.56%	4.00%	November Indicative Figure

Unqualified Nursing Workforce - Performance Indicators

Unqualified Nursing

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Workforce KPIs (RAG Rating) 2017-18		Nov-17	Compared to Previous Month
Establishment WTE		90.01	90.01	90.01	90.01	90.01	99.54	99.54	99.54	99.54	107.92	107.92	107.92		*Note 1	107.92	◄►
Nursing Headroom		0.00	0.00	0.00	0.00	0.00	8.33	8.33	8.33	8.33	8.33	8.33	8.33			8.33	◄►
Adjusted Establishment (removed Headroom)		90.01	90.01	90.01	90.01	90.01	91.21	91.21	91.21	91.21	99.59	99.59	99.59			99.59	◄►
Staff In Post WTE		76.21	73.17	75.44	76.09	76.55	76.17	77.13	82.13	81.19	81.81	78.25	84.33			85.64	▲
Vacancies WTE		13.80	16.84	14.57	13.92	13.46	15.04	14.08	9.08	10.02	17.78	21.34	15.26			13.95	▼
Vacancies %	>12% / 8%<>12% / <8%	15.33%	18.71%	16.19%	15.46%	14.95%	16.49%	15.44%	9.96%	10.99%	17.85%	21.43%	15.32%	>12% / 8%<>12% / <8%		14.01%	▼
STARTERS WTE (Excluding rotational doctors)		0.00	0.60	1.65	1.64	2.00	1.00	2.85	2.80	0.80	1.00	3.00	7.61	TARGETS: XXX		1.00	▼
LEAVERS WTE (Excluding rotational doctors)		2.00	1.00	0.46	0.00	1.00	0.38	1.00	2.20	2.73	0.00	5.00	2.19			0.46	▼
Starters & Leavers balance		-2.00	-0.40	1.19	1.64	1.00	0.62	1.85	0.60	-1.93	1.00	-2.00	5.42			0.54	▼
Agency WTE		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00	◄►
Bank WTE *Note 2		1.99	2.62	2.75	10.54	4.33	3.72	2.81	4.79	4.59	4.92	4.12	4.40			5.35	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12% / 10%<>12% / <10%	16.92%	23.34%	21.75%	20.97%	19.75%	16.86%	18.46%	19.85%	22.10%	20.83%	23.19%	25.18%	>=12% / 10%<>12% / <10%		23.03%	▼
Monthly Turnover		2.62%	2.73%	0.60%	0.00%	1.31%	0.50%	2.60%	2.66%	3.42%	0.00%	5.93%	2.69%			0.56%	▼
Sickness Absence %	>=4% / 4%<>3% / <3%	3.04%	4.73%	3.21%	2.24%	1.97%	2.26%	1.49%	0.91%	1.39%	1.77%	3.93%	6.78%	>=4% / 4%<>3% / <3%		4.50%	November Indicative Figure

BURNS WARD 12 MONTH ROLLING		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	DoN Rating					
Staff Utilisation	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	6.7	6.7	6.7	9.65	7.15	8.84	8.84	9.92	7.91	2.88	1.91		10%					Vacancy rate calculated on minimum staffing requirement as opposed to budget w.e.f Oct 2017
Est =	(hrs)	1088	1088	1088	1568	1161	1436	1436	1612	1285	468	310							
Temp staffing exc RMN	Bank	145	248	366	276	394	372	337	513	426	447	249		10%					
	Agency	11.5	293	110	0	34.5	178	92	23	69	121	46							
Sickness	%	2.0%	3.4%	1.9%	1.8%	1.3%	1.1%	3.8%	2.3%	3.80%	3.1%	2.9%		2%					Sickness being monitored by HoN
Shift meets est %	RN	97%	99%	98%	98%	99%	94%	98%	99%	98%	99%	93%		95%					
Day	HCA	100%	97%	100%	94%	97%	95%	98%	98%	100%	100%	95%		95%					
Shift meets est %	RN	95%	104%	97%	93%	98%	102%	100%	97%	95%	94%	90%		95%					
Night	HCA	300%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Training / Appraisal	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	69%	67%	69%	81%	86%	81.3%	83.3%	93.3%	93.1%	87%	92.3%		95%					Email and dicussion taken place with ward Matron. Situation must be addressed to
Statutory & Mand.	%	94%	94%	91%	93%	91%	86.8%	86.8%	88%	92.2%	90%	82.4%		95%					
Drug Assessments	%	100%	100%	100%	100%	100%	93%	93%	89%	89%	100%	100%		95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	72240	56203	134000	40384	34632	38138	31005	2798	1539	26714	55353		>0					
Safe Care	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	0	0	0	0	0	0	0	1	0	0		0					
Falls	With harm	0	0	0	0	1	0	0	0	0	0	0		0					
Medication Errors	All	1	0	0	0	0	1	1	1	2	2	2		0					
C. Diff		0	0	0	0	0	0	0	0	0	0	0		0					
MRSA		0	0	0	0	0	0	0	0	0	0	0		0					
Incidents Reported (Datix)	Patient Safety	3	8	2	3	4	3	2	4	3	6	6							
VTE reassessment	%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	100%	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	100%	100%	0%	100%	100%	100%	100%	100%	N/A	100%	100%	100%						
Patient numbers		46	39	56	37	60	61	56	44	41	57	52		N/A					
Patient FFT Score	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					

CRITICAL CARE 12 MONTH ROLLING		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	DoN Rating					
Staff Utilisation	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	7.89	7.89	7.89	7.89	14.39	9.02	9.02	13.28	11.28	5.65	5.01		10%					Vacancy rate calculated on minimum staffing requirement as opposed to budget w.e.f Oct 2017
Est =	(hrs)	1282	1282	1282	1282	2338	1465	1465	2158	1833	918	814							
Temp staffing exc RMN	Bank	16.5	0	150	227.5	101.5	169	189	179	182.5	175	223		10%					
	Agency	195.5	368	226	448.5	252.5	265	586	825.5	839.5	444	827.5							
Sickness	%	4.3%	3.1%	3.8%	1.0%	1.5%	0.9%	0.7%	0.0%	2.2%	2.3%	2.5%		2%					
Shift meets est %	RN	99%	95%	95%	99%	100%	97%	97%	95%	99%	92%	96%		95%					
Day	HCA	100%	100%	115%	100%	100%	90%	100%	88%	94%	100%	97%		95%					
Shift meets est %	RN	94%	97%	78%	94%	91%	92%	95%	88%	83%	69%	94%		95%					
Night	HCA	100%	150%	100%	100%	100%	100%	100%	100%	100%	125%	65%		95%					
Training / Appraisal	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	57%	58%	83%	88%	88%	100%	89.5%	100%	100%	94%	90.5%		95%					Email and dicussion taken place with ward Matron. Situation must be addressed to
Statutory & Mand.	%	80%	82%	77%	79%	80%	89.3%	88.3%	92%	92.8%	89%	88.0%		95%					
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	81%	88%		95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	4502	17418	33000	13367	34161	58686	894	-20940	9594	943	11190		>0					
Safe Care	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	1	0	0	0	2	0	0	1	0	0		0					
Falls	With harm	0	0	0	0	0	0	0	0	0	0	0		0					
Medication Errors	All	0	3	0	0	1	0	0	0	0	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	6	12	3	10	6	9	20	11	5	4	6							
VTE reassessment	%	100%	66.7%	100%	N/A	100%	0%	100%	100%	100%	N/A	100%	100%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	N/A	100%	50%	100%	100%	100%	100%	100%	100%	95%					1 patient not reviewed
	7 day r/v	N/A	100%	N/A	N/A	100%	N/A	100%	100%	100%	N/A	75%	N/A						
Patient numbers		–	–	–	–	–	–	–	–	–	–	–	–	N/A					
Patient FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	95%					

CANADIAN WING 12 MONTH ROLLING		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	DoN Rating					QVH
Staff Utilisation							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	11.85	6.45	7.12	7.12	4.79	6.29	8.99	11.13	11.82	5.62	6.55		10%					Vacancy rate calculated on minimum staffing requirement as opposed to budget w.e.f Oct 2017
Est =	(hrs)	1925	1048	1157	1157	778	1022	1460	1808	1921	913	1064							
Temp staffing exc RMN	Bank	317	368	509.5	243.5	316.5	555	407	424.5	360.5	541.5	732		10%					Increased use of bank and agency due to current vacancy. Now budget accurate can clearly map staff required to be recruited.
	Agency	162	188	314.5	54	174.5	115	173	333.5	464.5	331	799							
Sickness	%	2.1%	3.3%	3.2%	2.2%	3.2%	3.5%	2.6%	2.9%	0.5%	4.9%	3.6%		2%					
Margaret Duncombe							*Safe Staffing*							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	98%	99%	98%	99%	100%	97%	99%	97%	100%	98%	98%		95%					
Day	HCA	98%	94%	95%	102%	100%	90%	97%	94%	100%	105%	102%		95%					
Shift meets est %	RN	100%	93%	98%	95%	100%	97%	94%	91%	96%	93%	98%		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	81%	59%	89%	93%	100%	100%	73%	84%	90%	68%	77%		95%					
Ross Tilley							*Safe Staffing*							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Shift meets est %	RN	99%	96%	95%	99%	100%	100%	100%	98%	99%	102%	99%		95%					
Day	HCA	95%	102%	92%	100%	98%	100%	98%	94%	100%	100%	93%		95%					
Shift meets est %	RN	95%	87%	98%	89%	94%	83%	99%	91%	104%	93%	95%		95%					lower staffing levels at night reflect bed occupancy
Night	HCA	71%	84%	89%	90%	96%	95%	85%	84%	81%	67%	79%		95%					
Training / Appraisal							No / %							Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	91%	98%	98%	100%	100%	98%	94%	95.9%	91%	93.5%	93.5%		95%					
Statutory & Mand.	%	85%	87%	89%	88%	88%	91%	94.5%	94.6%	95%	95%	94.8%		95%					
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Staff FFT Score	%	–	–	–	–	–	–	–	–	–	–	–	–	–					
Budget	(YTD)	42346	85078	103000	11267	20589	28289	33744	47435	47435	47794	63502		>0					Budget now reflected therefore underspend in budget.

CANADIAN WING 12 MONTH ROLLING		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	DoN Rating					QVH
Safe Care		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Margaret Duncombe																			
Pressure Ulcers	G2+	0	0	0	0	0	0	1	0	0	0	0		0					
Falls	With harm	0	1	1	1	0	0	0	2	0	0	0		0					
Medication Errors	All	5	5	3	4	0	1	0	5	4	8	6		0					Review by ward pharmacist and ward matron new training package developed
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	12	7	11	8	8	6	16	7	10	12							
VTE reassessment	%	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%	88.9%	91.7%	95%					
Nutrition assessment (MUST)	Initial	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%					
	7 day r/v	100%	100%	100%	100%	33.3%	100%	100%	100%	100%	100%	0%	66.7%						
Patient numbers		116	114	166	171	170	169	160	145	144	139	146		N/A					
Patient FFT Score	%	97%	97%	100%	98%	100%	96%	99%	99%	96%	100%	100%		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	1	0	0	0	0	0		0					
Medication Errors	All	2	7	0	2	6	2	1	1	2	4	5		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	11	9	4	3	11	6	8	6	5	8	16							
VTE reassessment	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	71.4%	88.2%	95%					
Nutrition assessment (MUST)	Initial	100%	93.8%	100%	100%	100%	100%	100%	100%	100%	100%	92.9%	100%	95%					
	7 day r/v	N/A	100%	N/A	N/A	100%	100%	100%	100%	75%	100%	50%	80%						
Patient numbers		157	137	189	168	206	212	234	227	199	209	219		N/A					
Patient FFT Score	%	99%	99%	97%	100%	97%	99%	97%	96%	97%	97%	98%		95%					

PEANUT WARD 12 MONTH ROLLING		JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	DoN Rating					QVH
Staff Utilisation	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	WTE	4.5	4.5	4.5	6	6.49	6.5	6.5	4.89	3.89	2.45	2.45		10%					Vacancy rate calculated on minimum staffing requirement as opposed to budget w.e.f Oct 2017
Est =	(hrs)	731	731	731	975	1054	1056	1056	795	632	398	398							
Temp staffing exc RMN	Bank	322	260	365	234.5	265	381	373	253	324.5	369	437.5		10%					
	Agency	80	34.5	34.5	50	46	46	210	213	236	197	17.5							
Sickness	%	8.0%	6.4%	3.1%	3.2%	2.6%	3.1%	3.7%	4.8%	8.7%	12.0%	5.6%		2%					Increase in sickness is being monitored by HoN includes 2 long term sick
Shift meets est %	RN	100%	99%	96%	98%	101%	90%	99%	98%	99%	101%	93%		95%					
Day	HCA	94%	97%	106%	100%	100%	97%	103%	94%	97%	91%	100%		95%					
Shift meets est %	RN	89%	70%	56%	51%	49%	51%	59%	44%	49%	67%	45%		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 / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals	%	75%	64%	64%	77%	80%	84%	83.3%	83.3%	82.6%	79%	75.0%		95%					Email and dicussion taken place with ward Matron. Situation must be addressed to
Statutory & Mand.	%	82%	84%	85%	84%	88%	90.2%	91.3%	89.5%	85.7%	86%	84.3%		95%					as above
Drug Assessments	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		95%					
Staff FFT Score	%	_	_	_	_	_	_	_	_	_	_	_	_	_					
Budget	(YTD)	21223	21307	29000	2222	4611	5910	11060	1469	6253	1682	23045		>0					
Safe Care	No / %													Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	G2+	0	0	0	0	0	0	0	0	0	0	0		0					
Falls	With harm	0	0	0	0	0	0	0	0	0	0	0		0					
Medication Errors	All	0	0	1	1	0	0	1	0	0	1	0		0					
C. Diff		0	0	0	0	0	0	0	0	0	0	0		0					
MRSA		0	0	0	0	0	0	0	0	0	0	0		0					
Incidents Reported (Datix)	Patient Safety	1	3	4	1	2	5	5	1	3	1	3							
VTE reassessment	%	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
Nutrition assessment (MUST)	Initial	_	_	_	_	_	_	_	_	_	_	_	_	95%					N/A
	7 day r/v	_	_	_	_	_	_	_	_	_	_	_	_						
Patient numbers		149	139	191	191	209	205	222	205	196	191	193		N/A					
Patient FFT Score	%	98%	96%	97%	100%	100%	100%	99%	100%	100%	97%	98%		95%					

1 October 2017 – 30 November 2017

Performance Indicators	Nov 2017	Oct 2017	Sept 2017	Aug 2017	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
Overall number of active complaints	**8**	8	13	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of new formal complaints received in the month	4	1	7	3	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	0	1	0	0	1	0	0	0	0	2	0	0	0	0	0	0
Number of complaints re-opened	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0	0
Number of complaints closed	4	3	4	3	3	2	5	1	2	4	0	6	2	3	1	2	5
'NEW DATA' Number of complaints closed within 30 days	**2**		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of complaints upheld	2	2	1	0	2	1	0	1	0	2	0	5	1	2	1	1	1
Number of complaints upheld in part	1	1	1	2	0	1	2	0	1	0	0	0	1	0	0	1	3
Number of complaints unsupported	1	0	2	1	1	0	3	0	1	2	0	1	0	1	0	0	1
Overall number of active claims	70	71	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of new claims	0	2	1	0	4	2	2	3	2	0	2	0	1	1	0	0	4
Number of closed claims	1	3	2	1	0	0	0	1	0	0	2	1	1	0	0	2	0

Complaints Activity

This section of the report aims to provide a review of the complaints activity over the past two months.

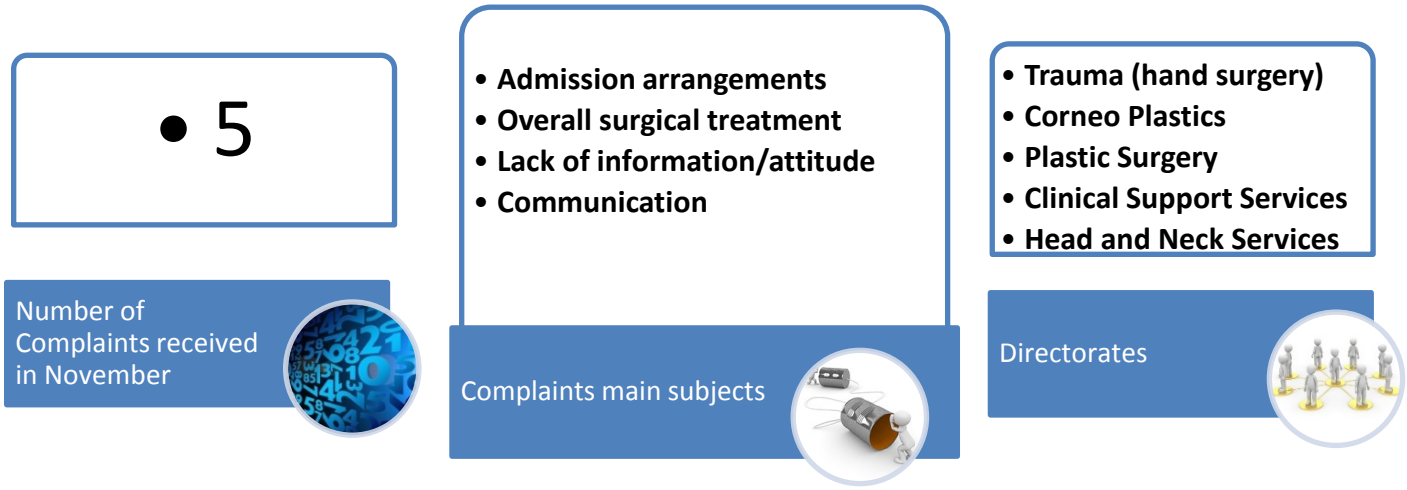
If a complainant is unhappy with the response received from the Trust, they have the right to contact the Parliamentary and Health Service Ombudsman (PHSO) to request an investigation. All PHSO requests and decisions are outlined in this section of the report.

Across the Trust we take all complaints very seriously and wherever possible we use them to learn from and to make changes and improvements to our services. We ensure that all staff at induction are given training about handling and dealing with complaints.

Open Complaints

In October and November 2017 we received five 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.



Summary of Complaints open

October

Plastic Surgery

1. **Inpatient – Medical – Treatment medical/staff communication:** Concerns raised about aspects of treatment following hand trauma injury and surgery. Felt that information given and treatment plan inconsistent. **Investigating lead – Consultant/Clinical Lead**

   Initial risk grading: Minor

   Likelihood of recurrence as: Possible

   Comment/Action – Case still under investigation.

November

Corneo Plastics

2. **Outpatient – Corneo – Medical – Admission arrangements:** Delays in surgery being performed as patient was given a further outpatient appointment. Also delays in corrective lens being ordered.

   Risk grading: Minor

   Likelihood of recurrence as: Possible

   Current status: Closed (see closed complaint 4)

Plastic Surgery

3. **Day surgery – Plastics – Medical/Nursing – Overall surgical treatment:** Patient experienced pain procedure. There was also a lack of communication with the patient during the procedure and lack of information given about aftercare.

   Risk grading: Minor

   Likelihood of recurrence as: Possible

   Current status: statements obtained – response being drafted

Clinical Support Services (visiting consultant)

4. **Outpatients – Medical – Clinical information/attitude:** Concerns raised about content of clinic letter following consultation and also overall manner of clinician.

   Risk grading: Minor

   Likelihood of recurrence as: Possible

   Current status: still under investigation

Head and Neck Services

5. **Outpatients – Medical – Clinical information/communication:** Patient unhappy with clinical outcome following surgery. The patient also considers that they were given insufficient information prior to surgery.

   Risk grading: Minor

   Likelihood of recurrence as: Possible

   Current status: still under investigation

Summary of Complaints closed

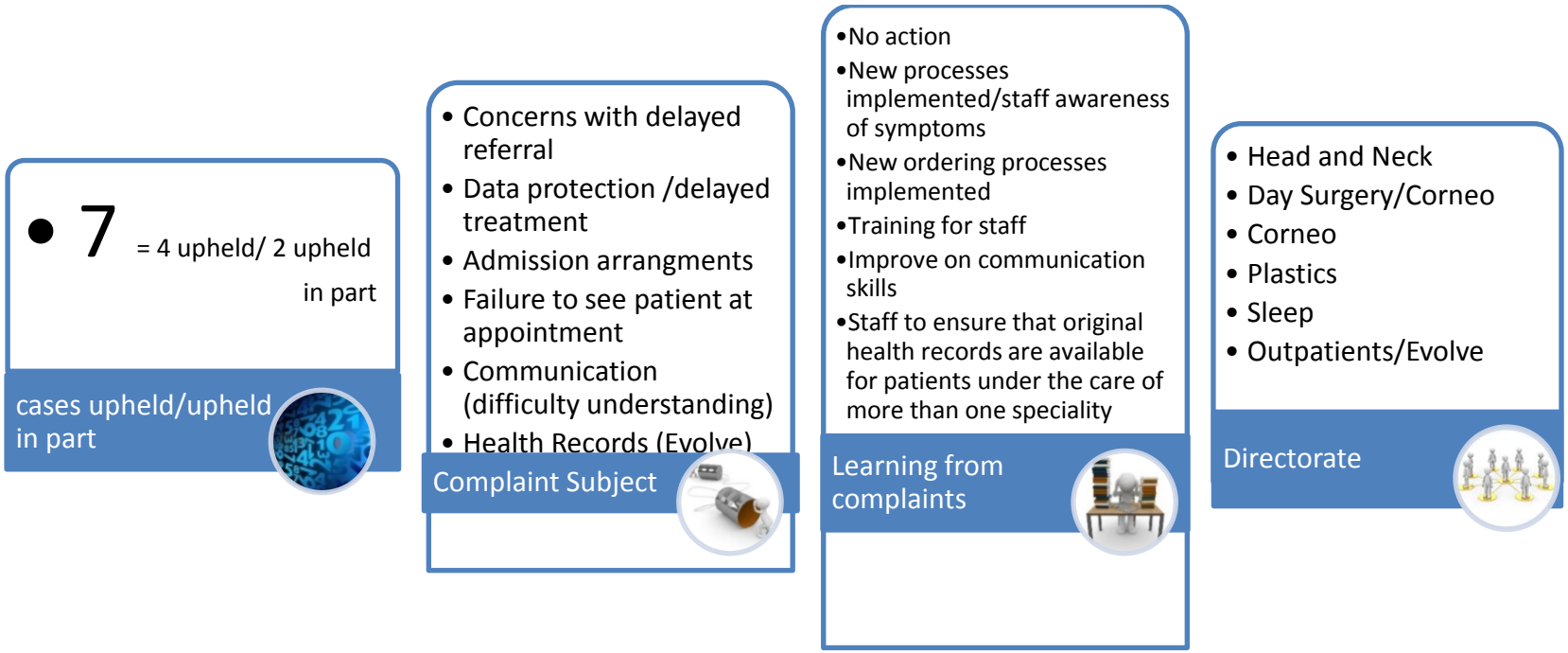
Overall seven complaints were closed during this period. Four cases were upheld, two were partially upheld and one case was unsupported.

For information the following is the definition of how closed cases are :

Upheld: If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint is recorded as upheld.

Not upheld: Where there is no evidence to support any aspects of a complaint made, the complaint is recorded as not upheld.

Partially upheld: Where a complaint is made about several issues, if one or more of these, (but not all), are upheld then the complaint is recorded as partially upheld.



October

Sleep

1. **Outpatient – Medical – Communication:** The patient was disappointed with the consultation and found the member of staff difficult to understand. **Investigating lead – Nurse Manager**

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

   Comment/Action – Member of staff will ensure that they work on their communications skills. **– Outcome: complaint upheld in part - responded to but not closed within 30 working days.**

Outpatients/Evolve

2. **Outpatients – Administration/Reception – Communication:** There were delays in clinic and issues relating to the Evolve system. **Investigating lead – Business Unit Manager**

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

   Comment/Action – There were issues with the rostering of the junior doctors which resulted in the consultant seeing all patients on his own. There was a problem with Evolve, the original health records having to be retrieved back from the scanning centre which took 2 hours. **Outcome: complaint upheld - responded to and closed within 30 working days.**

Plastics/Appointments

3. **Appointments – Secretarial – Length of wait for appointment/communication:** Delays in referral being received and then appointment being allocated and failures by administration team to return the patients calls. **Investigating lead – Business Unit Manager/Team Leaders**

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

   Comment/Action – This case was upheld as there were delays in the referral being processed and staff did not return the patients call. There is a review of the appointments shortly being undertaken (there has been staffing and sickness issues

within this area) to ensure that patients are allocated appointments in a timely manner. Staff must return patients calls to update the patient even if there has been no progress. Also a reminder has gone out in 'Connect' to staff reminding them that they must ensure that voicemail messages are up-to-date and details of who else to contact if a member of staff is on leave.
Outcome: complaint upheld - responded to but not closed within 30 working days.

November

Head and Neck

4. **Outpatient – Medical – Referral:** Concerns raised by family of patient due to radio/chemotherapy treatment. Felt that there were delays in treatment being provided. **Investigating lead – Consultant/Clinical Lead**

   Risk grading: Minor

   Likelihood of recurrence as: Possible

   Comment/Action – Family of patient have been given a full explanation of patient's diagnosis and treatment pathway. Several multi-disciplinary meetings held and patient had palliative treatment. The patients referral and treatment met all of the cancer pathway targets.

   Outcome: complaint unsupported- responded to but not closed within 30 working days (delays due to waiting for information from another hospital where palliative treatment was being provided).

Day Surgery/Corneo

5. **Day surgery/Corneo – Nursing – communication with patient:** Following eye surgery, information leaflet handed to patient was incorrect. Copy of Electronic Discharge Notification (EDN) was given to another patient with a similar name Patient then had post op concern and had to wait 5 days to be seen.

   Risk grading: Minor

Likelihood of recurrence as: Possible

Comment/Action – There was a data protection breach. New processes regarding EDN's have been implemented within Day Surgery (this particular issue was reported and investigating as an incident (Datix ID18169). There was a delay in the patient being seen (although this has not had an adverse effect on the patient's outcome). As a result patients with such symptoms should be seen the next day – this information has been conveyed to all staff in the corneo unit.

Outcome: complaint upheld- responded to but not closed within 30 working days.

Corneo (see open complaint 2)

6. **Outpatient – Corneo – Medical – Admission arrangements:** Delays in surgery being performed as patient was given a further outpatient appointment.

   Risk grading: Minor

   Likelihood of recurrence as: Possible

   Comment/Action: It has been ascertained that the patient was given an unnecessary appointment and there were delays in the lens being ordered. This was due to clinician not putting the order through to the administrative team. There are now new ordering processes in place.

   Outcome: complaint upheld- responded to and closed within 30 working days.

Plastics

7. **Outpatients – Nursing:** Patient attended for appointment and waited over 40 minutes. Was then told by nurse that they didn't realise that the patient was waiting and that the member of the nursing staff that the patient was due to see had left for the day.

   Comment/Action –. There was no indication on the check in system that the patient had arrived. However the member of staff that the patient was scheduled to see did go to the waiting rooms and call the patient on several occasions with no response.

Although we have the electronic check in kiosks, these are directly linked to the receptionist's computer screens and who are able to electronically monitor and see when patients arrive and check in. Additional training with reception staff is to be undertaken to ensure that staff can appreciate the patients' perspective; identity if there are issues e.g. check-ins process not being completed and how to appropriately resolve any issues.

Outcome: complaint upheld in part- responded to and closed within 30 working days.

Summary of Complaints re-opened

The proportion of complaints which are re-opened is a useful indicator of how satisfied complainants are with the response they received from the Trust to the concerns that they raised. It should be noted that whilst response times are one quality indicator in complaints management, another important aspect is the quality of the response.

Please note that there no complaints re-opened during this period.

Parliamentary and Health Service Ombudsman (PHSO)

Please note that there have been no complaints reported to the PHSO this month.

If a complainant is unhappy with the response received from the Trust, they have the right to contact the PHSO to request an investigation into their complaint.

The PHSO is the final point in the NHS complaints process and offers an independent view on whether the NHS has reasonably responded to a complaint. The PHSO has increased the number of investigations it undertaken and consequently the Trust has seen a slight increase in the number of complaints investigated by the PHSO.

Parliamentary and Health Service Ombudsman (PHSO) - outcome

There has been one case referred to the PHSO in June 2017.

This is a complaint that was made in July 2015. The concerns raised were in relation to a cancer diagnosis. Following an investigation by the PHSO there final decision was that the complaint would not be upheld. This decision and report of their findings has been shared with the complainant and the Trust.

Claims

Please note that there are 70 active claims all at varying levels of the litigation process.

There were two claims opened in October.

Incident date	Claim opened date	Type	Speciality	Service	Description (allegations within solicitors letter)	Complaint made	Reported as Incident
N/K	01/10/17	Clinical Negligence	Sleep	Medical	Delay in diagnosing neurological issues. GP also indicated as Defendant. .	No	No
N/K	31/10/17	Clinical Negligence	Plastics	Medical	No details given.	No	No

Three claims were closed in October.

Incident date	Claim opened date	Type	Speciality	Service	Description (allegations within solicitors letter)	Complaint made	Reported as Incident	Outcome
25/11/2011	15/09/2015	Clinical Negligence	Maxfac	Medical	Intra-operative issues following jaw surgery.	No	No	Claim dormant for 3 years.
04/02/2014	13/06/2014	Clinical Negligence	Corneo	Medical	Intra-operative issues during eye procedure.	No	Yes	Claim dormant for 3 years
20/12/2010	29/12/2015	Clinical Negligence	Plastics	Medical	Issues regarding orthopaedic treatment (other hospital) and plastic surgery treatment in relation to leg surgery.	No	No	Claim withdrawn.

There were no claims opened in November 2017 and one claim closed.

Incident date	Claim opened date	Type	Speciality	Service	Description (allegations within solicitors letter)	Complaint made	Reported as Incident	Outcome
02/11/2012	14/03/2013	Clinical Negligence	Burns	Medical	Limited information. Treatment of burns.	No	No	Claim dormant for more than 3 years.

Patient Experience – NHS Choices/Care Opinion

This month the NHS Choices/Care Opinion websites received one comment. The Patient Experience Manager has responded to this comment.

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

Published by Care Opinion 06/10/17

'I was admitted to the hospital on Thursday 28th September for a cataract removal. Although I was only there a short time,, the staff from start to finish were knowledgeable, caring, and understanding. Although I was not nervous, they made me feel at home.Especially one of the nurses who held my hand when I appeared to get agitated whilst on the operating table. The surgeon, who performed the op was excellent. Professional and patient. My retired Ophthalmic nurse wife said they did a superb job. She is now monitoring my movements 24 hrs for a month. Again, thank you so much for the wonderful care.'

Published by Care Opinion – 15/10/17

'Please accept my very sincere thanks for the excellent treatment I received yesterday whilst attending the minor injuries clinic. By excellent I mean thorough, caring, professional and friendly, together with comprehensive follow up advice. I am particularly grateful to the Nurse and the surgeon who inserted the required stitches.'

Published by Care Opinion - 16/10/17

'Last October i was referred from my dentist to Medway Maritime Hospital, as i couldn't have sedation at my dentist to have 5 teeth out. Back in June i got a date for out patients where i see consultant, had xrays done, had my pre op assessment and was told i can't have it done on Sunderland day surgery ward, because its 5 teeth and my health conditions.

The pre op nurse said I am not suitable for Sunderland any more, so they referred me to Queen Victoria hospital East Grinstead. Then i was told i would have to choose between having my knee op or my teeth op. I got a letter to ring Queen Victoria hospital, which i did and was given a cancellation date, then the next day i got a letter about my knee op, so choose to have my knee op.

My first date for surgery was cancelled, while waiting to go to theatre, another date offered, got cancellation date, had my knee op, then last week i got another letter for Queen Victoria Hospital, so i rang them, they gave me a solid date for my teeth op in February, unless a cancellation comes up.

My teeth are painful, i cant believe the wait I've got to wait, this is making me very anxious, i just want it over and done with

I am not moaning about the hospitals involved, just disappointed that it couldn't be done on Sunderland day surgery, but i know when i had my wisdom teeth out 25 years ago at the dentist i bleed heavy, and i hope it doesn't happen when i have 5 teeth out, as its a long journey home.'

Published by NHS Choices 14/11/17

My experiences at QVH for inpatient surgery under GA

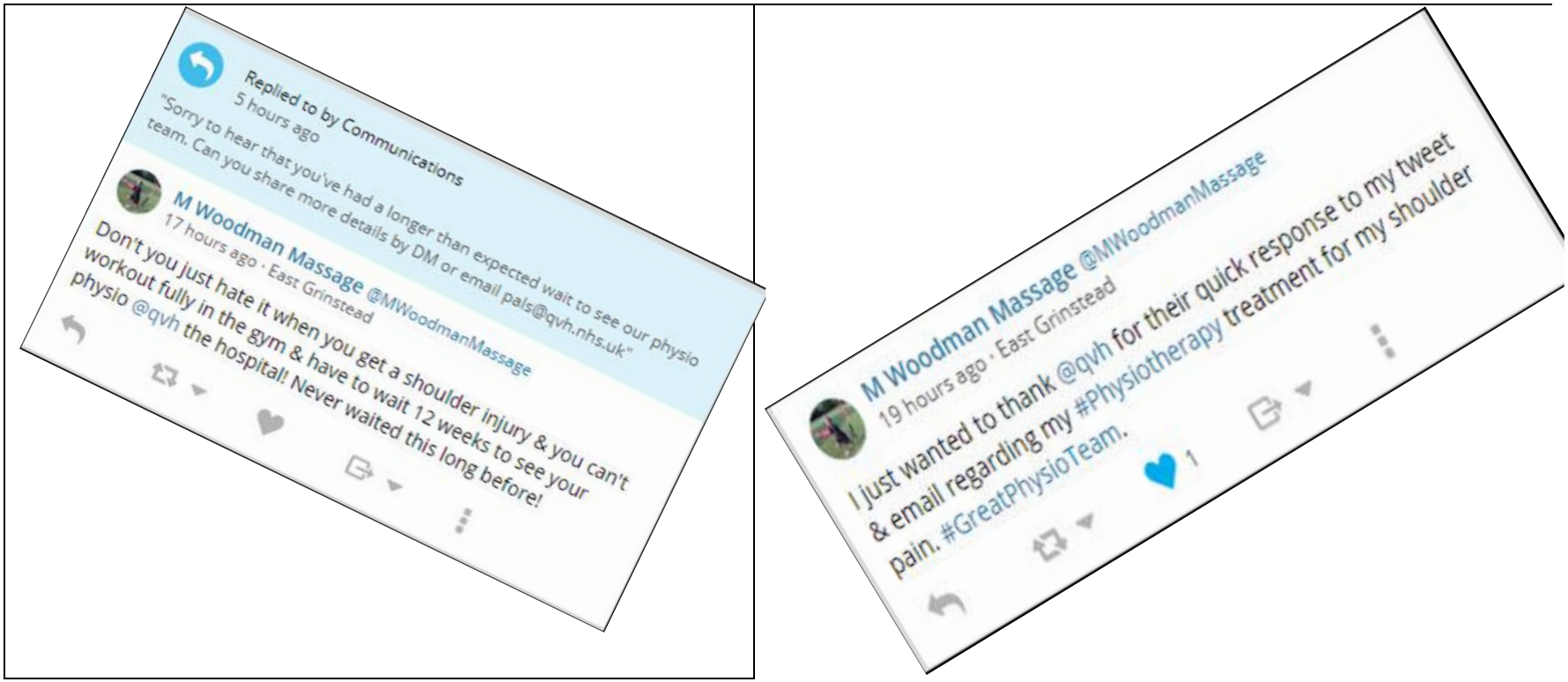
I guess like most people entering hospital, fear of the unknown is not uncommon. However, from the time I entered into reception at the Operating Theatres right through to being discharged, I was always made to feel at ease by the staff. The nurses, anaesthetist,

surgeon and support staff were very reassuring and took the time to explain things. Hospitals are not somewhere that I would choose or like to be, but in the case of the QVH I might make an exception.

Thank you for all your kindness, understanding, patience and professionalism

Social Media

The following are posting that have been put on social media:



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

Please note that the FFT data for November 2017 was not available at the time of writing this report.

	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			**Target >40%**		
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
Aug		98%	0%	38.5%	239	621
Sept		96%	0%	49%	284	580
Oct		**98%**	**0%**	40.5%	**241**	**596**
Nov		**99%**	**0%**	**29%**	**175**	**610**
	Outpatients			**Target >20%**		
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
Aug		93%	3%	15.5%	2044	13305
Sept		94%	2%	16.5%	2079	12635
Oct		**94%**	**2%**	**16%**	**2233**	**13767**
Nov		**95%**	**2%**	**16%**	**2288**	**14415**
	MIU			**Target >20%**		
April		98%	0%	24%	220	919
May		98%	1%	20%	202	994
June		96%	3%	22%	233	1060
July		95%	3%	22%	239	1097
Aug		92%	4%	25%	249	1006
Sept		96%	1%	24%	209	880

Oct		**97%**	**0%**	**26%**	**229**	**896**
Nov		**97%**	**1%**	**25%**	**208**	**833**
NEW	**Trauma clinic**			**Target >20%**		
Sept		82%	6%	22%	78	353
Oct		**96%**	**0%**	**23%**	**79**	**348**
Nov		**90%**	**4%**	**23%**	**82%**	**350**
	Day Surgery			**Target >20%**		
April		97%	1%	40%	295	740
May		97%	2%	37%	285	778
June		96%	0%	48%	308	649
July		96%	1%	54%	323	597
Aug		98%	0%	42%	374	887
Sept		98%	0%	31%	268	865
Oct		**97%**	**0%**	**35.5%**	**334**	**941**
Nov		**97%**	**2%**	**40%**	**352**	**900**

Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**04/01/2018**		**Agenda reference:**	**18-18**	
Report title:	CQC children and young person's inpatients and day case survey 2016				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Jo Thomas, Director of Nursing				
Appendices:	None				
Executive summary					
Purpose:	To provide the full report on the 2016 children's and young person's inpatient and day case survey for discussion and assurance about the quality of patient and parent experience at QVH. The survey published at the end of November analysed feedback from 34, 708 patients who received care in 132 NHS trusts. A total of 11,166 young patients aged 8-15 gave information about their experiences in a specially designed survey. Parents and carers for children 0-15 also shared their experiences. The trust achieved top scores in both age groups, 7 and under and 8-15. In 25 of the 63 questions asked QVH was the highest scoring trust nationally. A detailed review of the report is underway and actions will be agreed and monitored at the paediatric governance group.				
Recommendation:	Following discussion the committee is asked to note the report				
Purpose	Approval N	Information **Y**	Discussion N	Assurance **Y**	Review N
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	BAF reviewed , this report primarily links to KSO1				
Corporate risk register:	This report provides additional assurance and controls for items on CRR relating to paediatric patient experience and staff engagement.				
Regulation:	CQC requirement for all paediatric providers to participate in the survey				
Legal:	N/A				
Resources:	Cost of commissioning survey, all other requirements were managed from existing budget and resources				
Assurance route					
Previously considered by:	Q&GC				
	Date:	21/01/17	Decision:	Noted and commendation of the level of achievement by QVH staff	

Patient survey report 2016

2016 Children and young people's inpatient and day case survey

Queen Victoria Hospital NHS Foundation Trust

NHS patient survey programme
2016 Children and young people's inpatient and day case survey

The Care Quality Commission

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

2016 Children and young people's inpatient and day case survey

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

The 2016 survey of children and young people involved 132 acute and specialist NHS trusts across England. We received 34,708 completed questionnaires, a response rate of 26%. Patients were eligible to participate in the survey if they were admitted to hospital as an inpatient or day case and aged between 15 days and 15 years old when discharged between the 1 November and 31 December 2016[1]. Full sampling criteria can be found in the survey instruction manual (see further information section).

The 2016 survey of children and young people used three different questionnaires, each one appropriate for a different age group:

- The 0-7 questionnaire; sent to patients aged between 15 days and 7 years old at the time of discharge.
- The 8-11 questionnaire; sent to patients aged between 8 and 11 years old at the time of discharge.
- The 12-15 questionnaire; sent to patients aged between 12 and 15 years old at the time of discharge.

Copies of the questionnaires are available here: http://www.nhssurveys.org/surveys/1009

Questionnaires sent to those aged 8-11 and 12-15 had a short section for the child or young person to complete, followed by a separate section for their parent or carer to complete. Where a child was aged 0-7, the questionnaire was completed entirely by their parent or carer.

Fieldwork for the survey (the period during which questionnaires were sent out and returned) took place between February 2017 and June 2017.

The children and young people’s inpatient and day case survey is part of a wider programme of NHS patient surveys, which covers a range of topics including adult inpatients, emergency departments, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS Improvement will use the results to guide its work to improve the quality of care provided by NHS Trusts and Foundation Trusts.

[1]Five trusts sampled back to 1 October 2016 in order to achieve the minimum sample size.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part.

It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

Results presented in this report are grouped depending on i) whether parent and carers or children and young people were asked the question and ii) whether the question was common across multiple questionnaires or unique to one. As a result, there are five different benchmark groups:

- Children aged 8-11; questions which were asked of children in the 8-11 questionnaire only.
- Young people aged 12-15; questions which were asked of young people in the 12-15 questionnaire only.
- Children and young people aged 8-15; questions which were asked of both children and young people and were common across the 8-11 and 12-15 questionnaires.
- Parents and carers of children aged 0-7; questions which were asked of parents or carers in the 0-7 questionnaire only.
- Parents and carers of children and young people aged 0-15; questions which were asked of parents or carers and were common across the 0-7, 8-11 and 12-15 questionnaires.

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

As multiple versions of the questionnaire were used, a mapping tool has been developed which provides information on:

- Full question text
- Question number within each questionnaire version
- Benchmark group which answered the question
- Whether the question was scored or not,

The mapping tool is available at: http://www.nhssurveys.org/surveys/1009

Standardisation

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

To account for this, we ‘standardise’ the data. Results have been standardised by age group (survey version), route of admission (emergency or elective) and length of stay (0 or 1+ overnight stays) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-admission type-length of stay profile reflects the national age-admission type-length of stay distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

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

It is not appropriate to score all questions in the questionnaire as not all of the questions assess trust performance. For example, they may be a descriptive question which asks respondents if their

child’s attendance was an emergency or planned. Alternatively they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be “During their stay in hospital, did your child have any operations or procedures?”

For full details of the scoring please see the ‘Survey Technical Document’ (see further information section).

Graphs

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

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

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same'.

These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

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

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

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

Tables

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

Results for 2016 are not comparable with previous surveys owing to differences in the methodology used. Children and young people were sampled at a different time of year which may impact on any change in results.

Further information

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

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/953

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

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

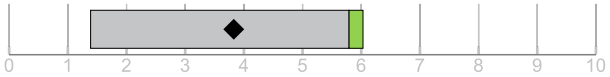
This survey used, under licence, questionnaires originally developed and owned by Picker Institute Europe.

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

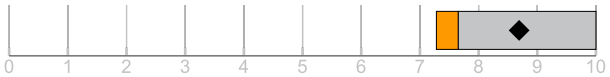
Going to hospital (answered if the patient's visit was planned or they were on a waiting list)

Parents/carers of 0 to 7 year olds were asked:

Did the hospital give you a choice of admission dates?



Did the hospital change your child's admission date at all?

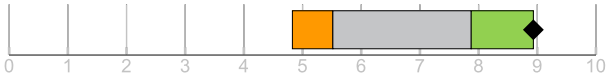
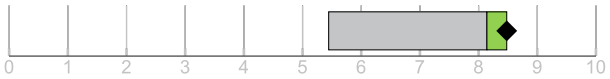
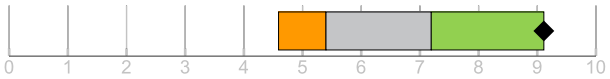
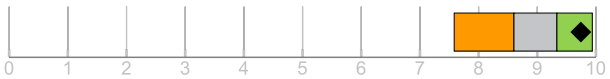


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

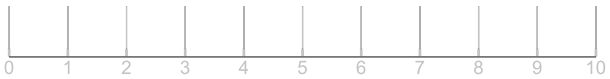
2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

The hospital ward

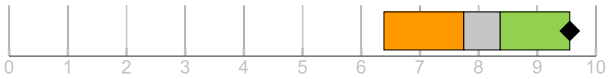
Children/young people aged 8 to 15 were asked:

Were there enough things for you to do in the hospital?		Better
Did you like the hospital food?		Better
Was it quiet enough for you to sleep when needed in the hospital?		Better
Were you given enough privacy when you were receiving care and treatment?		Better

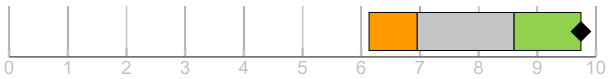
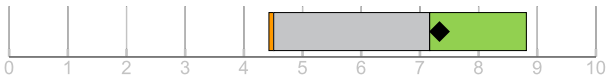
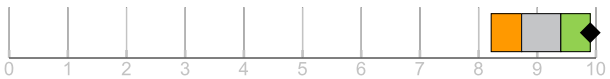
Children aged 8 to 11 were asked:

Did hospital staff play with you or do any activities with you while you were in hospital?		

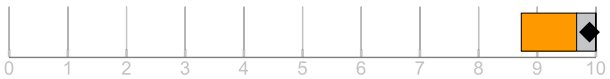
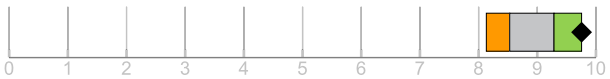
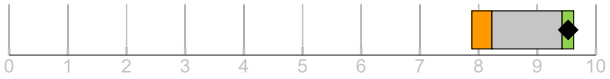
Young people aged 12 to 15 were asked:

Was the ward suitable for someone of your age?		Better

Parents/carers of 0 to 7 year olds were asked:

Did staff play with your child at all while they were in hospital?		Better
Were there enough things for your child to do in the hospital?		Better
Did your child like the hospital food provided?		Better
Was your child given enough privacy when receiving care and treatment?		Better

Parents/carers of 0 to 15 year olds were asked:

For most of their stay in hospital what type of ward did your child stay on?		
Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?		Better
How clean do you think the hospital room or ward was that your child was in?		Better

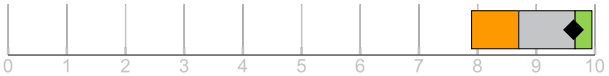
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

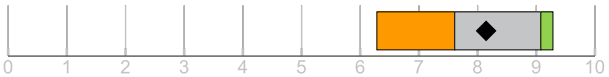
Hospital staff

Children/young people aged 8 to 15 were asked:

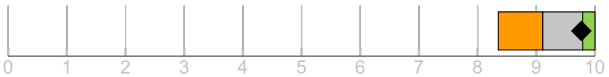
Did hospital staff talk with you about how they were going to care for you?



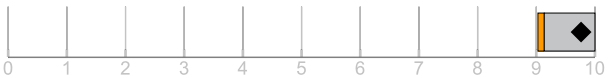
When the hospital staff spoke with you, did you understand what they said?



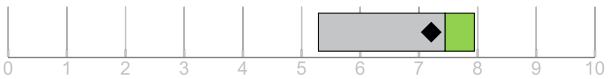
Did you feel able to ask staff questions?



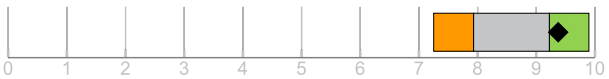
Did the hospital staff answer your questions?



Were you involved in decisions about your care and treatment?



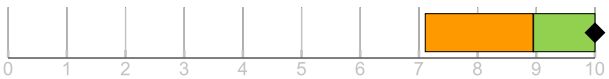
If you had any worries, did a member of staff talk with you about them?



Better

Young people aged 12 to 15 were asked:

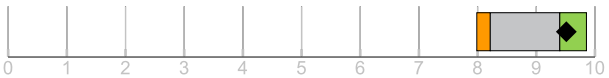
If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?



Better

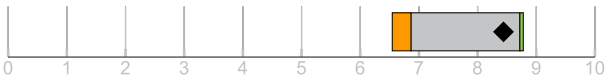
Parents/carers of 0 to 7 year olds were asked:

Did new members of staff treating your child introduce themselves?

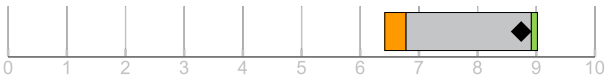


Better

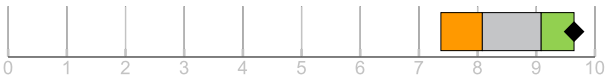
Did members of staff treating your child communicate with them in a way that your child could understand?



Did different staff give you conflicting information?



Do you feel that the people looking after your child listened to you?



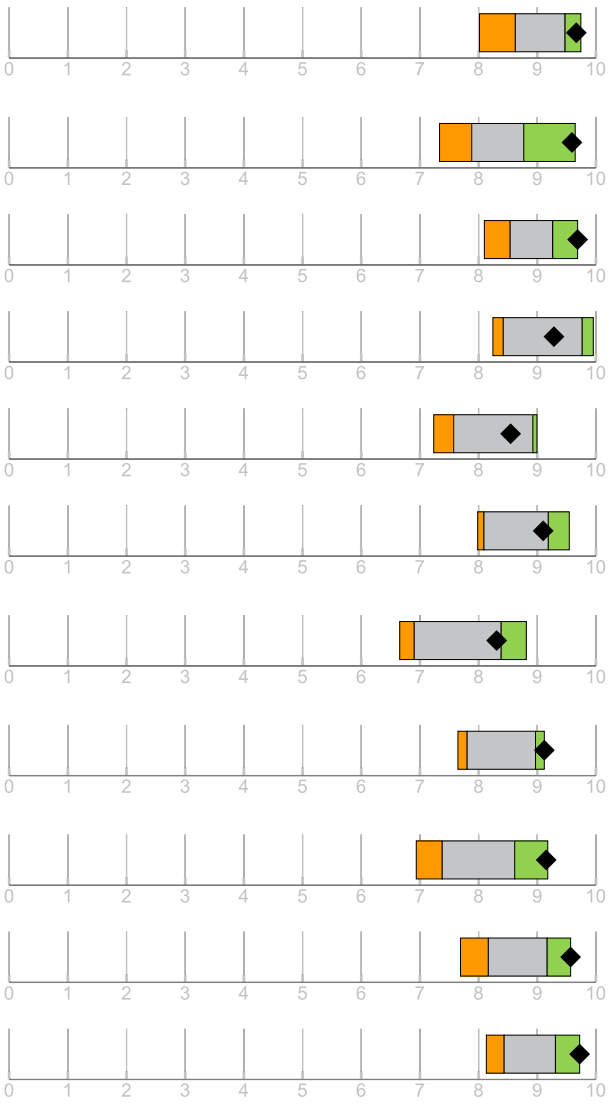
Better

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

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

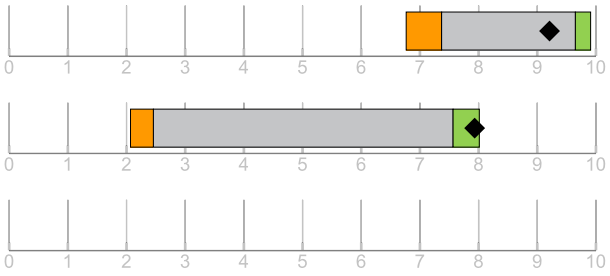
Hospital staff

Parents/carers of 0 to 15 year olds were asked:



Facilities for Parents & Carers

Parents/carers of 0 to 15 year olds were asked:



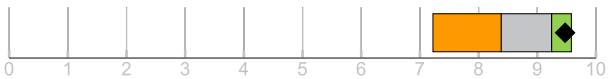
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

Pain management

Children/young people aged 8 to 15 were asked:

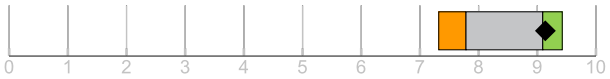
If you felt pain while you were at the hospital, do you think staff did everything they could to help you?



Better

Parents/carers of 0 to 15 year olds were asked:

If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?



Better

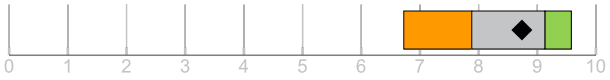
Operations and Procedures

Children/young people aged 8 to 15 were asked:

Before the operations or procedures, did hospital staff explain to you what would be done?

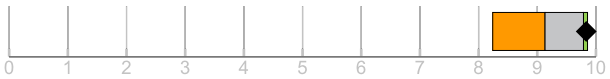
Better

Afterwards, did staff explain to you how the operations or procedures had gone?



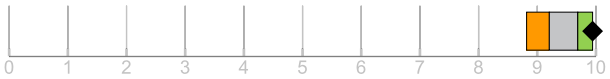
Parents/carers of 0 to 15 year olds were asked:

Before your child had any operations or procedures did a member of staff explain to you what would be done?



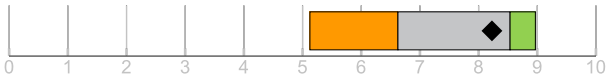
Better

Before the operations or procedures, did a member of staff answer your questions in a way you could understand?



Better

During any operations or procedures, did staff play with your child or do anything to distract them?

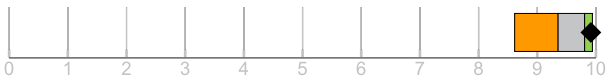


Afterwards, did staff explain to you how the operations or procedures had gone?

Medicines (answered if the patient was prescribed new medicines)

Parents/carers of 0 to 15 year olds were asked:

Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?



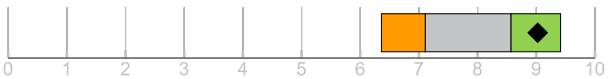
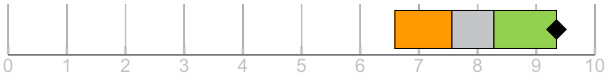
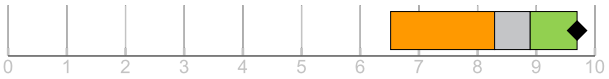
Better

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

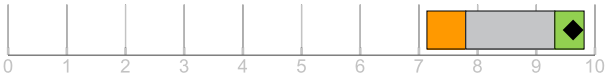
2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

Leaving Hospital

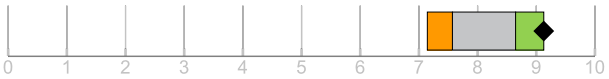
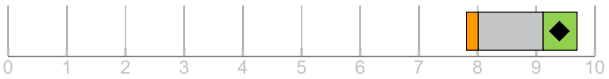
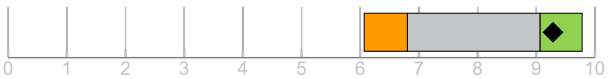
Children/young people aged 8 to 15 were asked:

Did a member of staff tell you who to talk to if you were worried about anything when you got home?		Better
When you left hospital, did you know what was going to happen next with your care?		Better
Did a member of staff give you advice on how to look after yourself after you went home?		Better

Parents/carers of 0 to 7 year olds were asked:

Did a member of staff tell you who to talk to if you were worried about your child when you got home?		Better

Parents/carers of 0 to 15 year olds were asked:

When you left hospital, did you know what was going to happen next with your child's care?		Better
Did a staff member give you advice about caring for your child after you went home?		Better
Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?		Better

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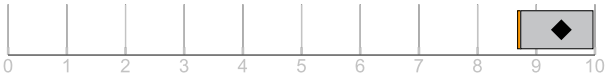
Worst performing trusts		

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

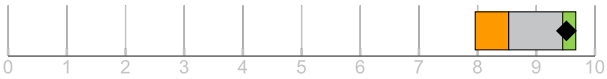
Overall

Children/young people aged 8 to 15 were asked:

Do you feel that the people looking after you were friendly?



Overall, how well do you think you were looked after in hospital?



Better

Parents/carers of 0 to 7 year olds were asked:

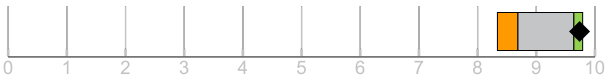
Do you feel that the people looking after your child were friendly?

Better

Do you feel that your child was well looked after by the hospital staff?

Better

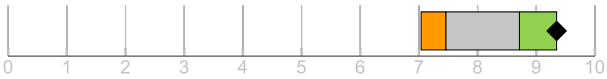
Were you treated with dignity and respect by the people looking after your child?



Better

Parents/carers of 0 to 15 year olds were asked:

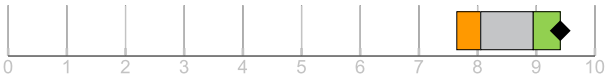
Do you feel that you (the parent/carer) were well looked after by hospital staff?



Better

Very poor experience Very good experience Better

Overall, I felt my child had a...



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

2016 Children and young people's inpatient and day case survey

Queen Victoria Hospital NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Going to hospital (answered if the patient's visit was planned or they were on a waiting list)				
Parents/carers of 0 to 7 year olds were asked:				
Did the hospital give you a choice of admission dates?	3.8	1.6	6.0	38
Did the hospital change your child's admission date at all?	8.7	7.3	9.7	41
The hospital ward				
Children/young people aged 8 to 15 were asked:				
Were there enough things for you to do in the hospital?	8.9	4.8	8.9	114
Did you like the hospital food?	8.5	5.5	8.5	72
Was it quiet enough for you to sleep when needed in the hospital?	9.1	4.6	9.1	62
Were you given enough privacy when you were receiving care and treatment?	9.7	7.6	9.9	116
Children aged 8 to 11 were asked:				
Did hospital staff play with you or do any activities with you while you were in hospital?	-	2.5	6.6	
Young people aged 12 to 15 were asked:				
Was the ward suitable for someone of your age?	9.6	6.4	9.6	85
Parents/carers of 0 to 7 year olds were asked:				
Did staff play with your child at all while they were in hospital?	9.2	4.3	9.7	46
Were there enough things for your child to do in the hospital?	9.7	6.1	9.7	73
Did your child like the hospital food provided?	7.3	4.4	8.8	48
Was your child given enough privacy when receiving care and treatment?	9.9	8.2	9.9	75
Parents/carers of 0 to 15 year olds were asked:				
For most of their stay in hospital what type of ward did your child stay on?	9.9	8.7	10.0	187
Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	9.8	8.1	9.8	149
How clean do you think the hospital room or ward was that your child was in?	9.5	7.9	9.6	189

2016 Children and young people's inpatient and day case survey

Queen Victoria Hospital NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Hospital staff				
Children/young people aged 8 to 15 were asked:				
Did hospital staff talk with you about how they were going to care for you?	9.6	7.9	9.9	115
When the hospital staff spoke with you, did you understand what they said?	8.1	6.3	9.3	115
Did you feel able to ask staff questions?	9.8	8.4	10.0	102
Did the hospital staff answer your questions?	9.8	9.0	9.9	99
Were you involved in decisions about your care and treatment?	7.2	5.4	7.9	105
If you had any worries, did a member of staff talk with you about them?	9.4	7.3	9.9	91
Young people aged 12 to 15 were asked:				
If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	10.0	7.1	10.0	41
Parents/carers of 0 to 7 year olds were asked:				
Did new members of staff treating your child introduce themselves?	9.5	8.0	9.9	76
Did members of staff treating your child communicate with them in a way that your child could understand?	8.4	6.5	8.8	75
Did different staff give you conflicting information?	8.7	6.4	9.0	76
Do you feel that the people looking after your child listened to you?	9.6	7.4	9.6	76
Parents/carers of 0 to 15 year olds were asked:				
Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	9.7	8.0	9.7	191
Did hospital staff keep you informed about what was happening whilst your child was in hospital?	9.6	7.3	9.6	190
Were you able to ask staff any questions you had about your child's care?	9.7	8.1	9.7	190
Did a member of staff agree a plan for your child's care with you?	9.3	8.2	10.0	181
Did staff involve you in decisions about your child's care and treatment?	8.5	7.2	9.0	188
Were you given enough information to be involved in decisions about your child's care and treatment?	9.1	8.0	9.5	191
Were the different members of staff caring for and treating your child aware of their medical history?	8.3	6.7	8.8	158
Did you feel that staff looking after your child knew how to care for their individual or special needs?	9.1	7.6	9.1	147
Were members of staff available when your child needed attention?	9.2	6.9	9.2	182
Did the members of staff caring for your child work well together?	9.6	7.7	9.6	188
Did you have confidence and trust in the members of staff treating your child?	9.7	8.1	9.7	191

2016 Children and young people's inpatient and day case survey

Queen Victoria Hospital NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Facilities for Parents & Carers				
Parents/carers of 0 to 15 year olds were asked:				
Did you have access to hot drinks facilities in the hospital?	9.2	6.8	9.9	182
Were you able to prepare food in the hospital if you wanted to?	7.9	2.1	8.0	53
How would you rate the facilities for parents or carers staying overnight?	-	4.5	8.6	
Pain management				
Children/young people aged 8 to 15 were asked:				
If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	9.5	7.2	9.6	87
Parents/carers of 0 to 15 year olds were asked:				
If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	9.1	7.3	9.4	149
Operations and Procedures				
Children/young people aged 8 to 15 were asked:				
Before the operations or procedures, did hospital staff explain to you what would be done?	9.8	8.7	10.0	109
Afterwards, did staff explain to you how the operations or procedures had gone?	8.7	6.7	9.6	109
Parents/carers of 0 to 15 year olds were asked:				
Before your child had any operations or procedures did a member of staff explain to you what would be done?	9.8	8.2	9.9	175
Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	9.9	8.8	9.9	171
During any operations or procedures, did staff play with your child or do anything to distract them?	8.2	5.1	9.0	111
Afterwards, did staff explain to you how the operations or procedures had gone?	9.0	7.3	9.6	175
Medicines (answered if the patient was prescribed new medicines)				
Parents/carers of 0 to 15 year olds were asked:				
Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?	9.9	8.6	9.9	61

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

	Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)
Leaving Hospital				
Children/young people aged 8 to 15 were asked:				
Did a member of staff tell you who to talk to if you were worried about anything when you got home?	9.0	6.4	9.4	102
When you left hospital, did you know what was going to happen next with your care?	9.3	6.6	9.3	116
Did a member of staff give you advice on how to look after yourself after you went home?	9.7	6.5	9.7	115
Parents/carers of 0 to 7 year olds were asked:				
Did a member of staff tell you who to talk to if you were worried about your child when you got home?	9.6	7.1	9.8	72
Parents/carers of 0 to 15 year olds were asked:				
When you left hospital, did you know what was going to happen next with your child's care?	9.1	7.1	9.1	180
Did a staff member give you advice about caring for your child after you went home?	9.4	7.8	9.7	187
Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	9.3	6.1	9.8	140
Overall				
Children/young people aged 8 to 15 were asked:				
Do you feel that the people looking after you were friendly?	9.4	8.7	9.9	116
Overall, how well do you think you were looked after in hospital?	9.5	8.0	9.7	116
Parents/carers of 0 to 7 year olds were asked:				
Do you feel that the people looking after your child were friendly?	9.7	8.1	9.7	76
Do you feel that your child was well looked after by the hospital staff?	9.8	7.9	9.8	76
Were you treated with dignity and respect by the people looking after your child?	9.7	8.3	9.8	75
Parents/carers of 0 to 15 year olds were asked:				
Do you feel that you (the parent/carer) were well looked after by hospital staff?	9.3	7.0	9.3	190
Overall, I felt my child had a...	9.4	7.6	9.4	188

2016 Children and young people's inpatient and day case survey
Queen Victoria Hospital NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	192	34708
Response Rate (percentage)	36	26

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	55	55
Female	45	45
Ethnic group (percentage)	(%)	(%)
White	85	77
Multiple ethnic group	4	5
Asian or Asian British	3	8
Black or Black British	3	3
Arab or other ethnic group	0	1
Not known	6	6

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Board of Directors
Date last reviewed: 14th December 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, conflict between education vrs service delivery, and GMC NTS survey results
Internal and spoke governance resources.
External and internal research funding and organisation.
Job planning.
Coroner's Report to Prevent Future Deaths.
Induction and training processes for dual site junior doctors and dentists.

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
Limited data from spokes/lack of service specifications
Scope delivering and monitoring seven day services (OOH)
Plan for sustainable ITU on QVH site
Recruitment challenges
Achieving sustainable research investment
Balance service delivery with medical training cost
Job planning
Compliance with new Junior Doctor contract terms and conditions
January 2018 actions in response to Coroner's PFD report

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04 January 2018**		**Agenda reference:**	**20-18**	
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: [one only]	Approval	Information **Y**	Discussion	Assurance **Y**	Review
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]	KSO1: *Outstanding patient experience*	KSO2: **Y** *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	BAF KSO2				
Corporate risk register:	NA				
Regulation:	NA				
Legal:	NA				
Resources:	None				
Assurance route					
Previously considered by:	NA				
Next steps:	NA				

Report to: Board of Directors
Meeting date: 04 January 2018
Reference number: 20-18
Report from: Ed Pickles, Medical Director
Author: Ed Pickles, Medical Director
Appendices: N/A
Report date: 27th December 2017

Medical Director's Report January 2018

1. Clinical Governance and Responding to and Learning from Deaths

In line with our policy, 'Responding to and Learning from Deaths', we publish numbers of all on-site deaths and all deaths occurring within 30 days of treatment at the QVH. All on-site deaths will undergo 'Structured Judgement Review' (SJR) of case notes, in accordance with methodology described by the Royal College of Physicians. All case notes of off-site deaths undergo a preliminary review, with any concerns leading to a full SJR. For all deaths, the relatives or carers and the General Practitioner are contacted to enquire if they have any concerns regarding the quality of care delivered by the QVH. Any concerns will be investigated via the SI and Datix systems. Two clinicians have been identified who will lead on SJR, and training will be delivered to them in January.

a) Mortalities (2017)

	Aug	Sept	Oct	Nov
QVH mortalities	0	0	0	0
Mortalities elsewhere within 30 days of discharge	1	0	1	0

No concerns were raised from the mortality in August 2017 from the consultant, the case note review, GP or family.

The death in October 2017 followed uncomplicated day case surgery under local anaesthetic. Preliminary case note review revealed concern around one element of documentation. This has been raised via the Datix system and is currently being investigated.

Since April 2017 there has been one mortality on the QVH site and nine deaths elsewhere within 30 days of discharge.

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 three patients transferred out unexpectedly from the QVH in October, and seven in September. The September transfers included a patient with a significant inhalational burn injury who was retrieved by the ECMO (extra-corporeal membrane oxygenation) team from St.Thomas' Critical Care. ECMO was commenced at QVH prior to transfer.

c) Never events and serious incidents

A further 'never event' occurred in October 2017 (local anaesthetic eye block inserted on incorrect side). The investigation for this will be completed and submitted to the January Clinical Governance meeting.

We have now recorded three never events for 2017, with an average of two per annum for the last six years.

The events are linked to inadequacy of the WHO Safer Surgery Checklist and its use. The checklist and marking policies are under review and will be produced as stand-alone documents. A new senior staff member in theatres is being recruited who will lead on WHO checklist use and theatre safety culture, supported by medical staff trained in multidisciplinary team simulation.

d) Clinical Audit

In November, we completed the latest data submission for the Seven Day Services initiative. This audit period focused on 'Standard 2 – Time to Consultant review'. It is expected that all emergency admissions will be reviewed by a consultant within 14 hours of admission.

The results have yet to undergo national validation, but QVH results for 14 hour review are at 72%. This has increased from 45% 12 months ago, and 51% in March 2017. The greatest improvement was in the standard of documentation.

The 14 hour standard was developed for emergency admissions admitted through an Emergency Department, and are not as easily applicable to a specialty hospital where 'emergency' patients are generally systemically well with isolated peripheral injuries, eg hand lacerations. The audit cohort was also audited against internally developed standards for timely consultant review. We were compliant in 92% of cases using these unique criteria. These standards, having been agreed with the CGG and consultant body, will now be discussed with NHSE and the local commissioners.

2. Sustainability and Transformation Plan and Regional Services

The 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.

The revised 'case for change' is under development. A new sub-group of acute provider Medical Directors has been formed to strengthen the acute configuration elements of that case for change. The STP will be sighted on the QVH/BSUH MoU partnership progression.

3. Education

The action plan in response to the GMC National Training Survey has been monitored by a meeting of the QVH Local Academic Board, with the Associate Dean of HEE LaSE in attendance. Funding has been agreed for 2 additional 'SHO' posts in plastic surgery from February 2018, which will allow for additional training opportunities. The 'SHO' rotation has been revised and additional teaching time made available. We are actively promoting exception reporting of any breaches of the new junior doctor contract, both for rota and educational opportunity breaches. We have received only one report.

We have not yet received notice of the Deanery visit discussed as an action following the Coroner's PFD report and GMC NTS 2017.

The trust has had a project proposal for a 'Darzi fellowship' shortlisted (paediatric burns service development). Fellow applications remain open. If the QVH project were chosen by an appointed fellow, the post would commence in August 2018.

4. Medical & Dental Staffing

We have recently appointed three new plastic surgery consultants to the trust. Mr Ruben Kannan to the facial palsy service; Miss Jennifer O'Neill, with an interest in skin surgery; and Mr Paul Drake, with an interest in trauma, burns and skin surgery.

In December, subject to references etc, we also appointed three new substantive consultant anaesthetists, including an experienced intensive care doctor, who will strengthen the intensive care medical provision significantly.

There are currently 101 doctors for whom the QVH is the Designated Body. (LETB trainees have a prescribed connection to their Deanery). All doctors are registered with a licence to practice. There are no current GMC processes.
The current rate of appraisals completed within 12 months is 88% for consultants (increased from 82% last report) and 88% for medical staff overall. Thanks to the Medical Workforce team, the production of appraisal data packs for consultants has just commenced to aid their information gathering for appraisal, including an individual annual review of complaints, incidents and mandatory training.

The trust auditors have recently audited the QVH Appraisal and Revalidation arrangements. The report is awaited.

We have now received training on the Allocate 'e-job planning' software, which will be also delivered to consultants in January. The new job planning policy has been agreed by the Local Negotiating Committee. It is planned for all permanent staff to have undergone a job plan review by the end of March 2018.

There is no update on progress with the new '2018' Consultant Contract. The new contract is likely to include significant changes to the Clinical Excellence Award (CEA) scheme, however, the EMT have agreed to hold a CEA round for Consultants before April 2018, as per the current 2003 contract.

5. IM&T

Mr Jeremy Collyer and Dr Chris Barham continue to share the Chief Clinical Information Officer role, reporting to the Medical Director, and working with the CIO, James Cooper, and Jason McIntyre, SIRO.

Capital funding for year 2 of the IM&T strategy has been agreed. Initiatives and priorities for 2018/19 include the development of a 'Clinical Portal' to access all other clinical IT systems with single sign on, and 'Order Communications' to enable paperless access to pathology and radiology ordering and results. The roll out of Evolve continues, with ophthalmology and plastic surgery to be included by April 2018.

All medical staff have been reminded of their GMC responsibilities with regard to the use of social media, which is becoming ever more relevant as applications such as 'WhatsApp' are increasingly used for communications between healthcare professionals.

Dr Edward Pickles
Medical Director
27th December 2017

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Committee: Trust Board
Date: 14 December 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 and part of NHSI Retention Support Programme
-Increased compliance requirement to 95% for MAST and Appraisal from Jan 2017
-Performance review meetings to identify and address identified staffing shortfalls and workforce challenges
--Investment made in key workforce e-solutions, implementation has begun, TRAC delivered on time, E-job plan super user training taken place
-Engagement and Retention paper presented to Board Sept 2017 implementation progressing at pace including new newsletter

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 workforce 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
- Reconciliation required between ledger and ESR to enable full establishment control

Report cover-page					
References					
Meeting title:	Board Meeting				
Meeting date:	04 January 2018		**Agenda reference:**	22-18	
Report title:	**Workforce Report – December 2017 (November data)**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	Jill Dale, ESR and Workforce Intelligence Manager/David Hurrell, Deputy Director Workforce				
Appendices:	A: Workforce Report				
Executive summary					
Purpose:	The Workforce and OD report for December 2017 (November data) provides the Board of Directors with a breakdown of key workforce indicators and information linked to performance and an update on Engagement and Retention Activities.				
Recommendation:	The Board are asked to note the report.				
Purpose:		Information	Discussion	Assurance	
Link to key strategic objectives (KSOs):	**KSO1**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care				
Corporate risk register:	Recruitment and retention being addressed along with sickness absence and bank and agency usage.				
Regulation:	N/A				
Legal:	N/A				
Resources:	Managed by HR/OD with support from Finance and Operations				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	18/12/17	Decision:	Noted	

Queen Victoria Hospital NHS
NHS Foundation Trust

Human Resources & Organisational Development

Workforce Report – December 2017

Reporting Period: November 2017

1.1 Contextual Narrative

Please note the recommendations from the Safe Nursing paper were implemented October 2017 so that establishment and vacancy levels are more accurately reflected.

1.2 Current Month Picture

KPI	Narrative
Vacancies Section 2	'Staff in Post' numbers shows a small decrease in month of 3.78wte. Recruitment into corporate vacancies continues a positive trend. Perioperative Services have gained a healthcare assistant but lost two registered practitioners in month, though one is a retire-and-return due back early 2018. A registered nurse has left Canadian Wing, but two registered nurses have started in ITU and in Burns. Of 11.93wte recruits in the pipeline, 2wte are qualified nursing/practitioner staff being recruited to from outside of the Trust. 20wte registered practitioner vacancies were also out to advert in month. There are more staff in post than the same time last year.
Turnover Section 3	Data from the last couple of months suggests that the month-on-month increase in the rolling 12 month Trust Turnover has now plateaued, and remains relatively stable at 18.41%. Turnover in nursing areas remains high, with the reduction in turnover in month stemming from no leavers within Corporate Services in month.
Temporary Staffing Section 4	Bank utilisation has increased to 47.11wte. Agency usage has also increased to 30.96wte, the highest since electronic records began. Temporary staffing usage overall has grown Trust-wide, increasing from 68.51wte to 78.07wte. Usage remains highest in Perioperative services (increasing from 24.66wte to 27.96wte), with Operational Nursing as the second highest user (increasing from 7.82wte to 11.4wte) followed by Corporate (increasing from 9.03wte to 9.85wte). From December revised bank rates have been launched to attract more substantive staff to cover bank shifts and all additional whole shifts must be done via the bank and not through overtime. A campaign to attract more bank only staff has also gone live.
Sickness Section 5	The Trust overall sickness absence figure increased to 3.59% in October 2017 driven by an increase in short-term sickness absence from 1.17% to 1.72%. This is higher than this time last year, but is consistent with the previous 3 years. A breakdown of reasons for absence split into short term and longer term (over 28 calendar days) is included from January to October 2017.
Appraisals Section 6	Appraisal rates have increased marginally in month, from 81.24% to 81.38%. Rates remain relatively unchanged in most areas, with the notable exceptions of Clinical Support Services increasing from 79.87% to 90.13% (driven by Prosthetics) and Corporate Services reducing from 84.94% to 77.65% (driven by Finance, Estates & Facilities). The following departments (12+ headcount) have achieved 100% compliance rates: Canadian Wing, Main Outpatients, Pharmacy, Prosthetics, Workforce & OD.
MAST Section 6	The Trust MAST compliance rates have decreased marginally to 88.81%. A decrease is consistent across most business units, with the exception of Clinical Support Services (increasing by 1.1%) and Corporate Services (increasing by 0.51%) At individual competence level, compliance rates have continued to decline for Information Governance (77.25% to 72.45%). Small reductions have also been seen in Equality, Diversity & Human Rights (-3.81%), Resuscitation (-3%) and Emergency Planning (-2.7%). Improvements in compliance rates are most notable in Infection Control (2.55%).

1.3 KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17			Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Workforce KPIs (RAG Rating) 2017-18				Nov-17	Compared to Previous Month
Establishment WTE *Note 1*				962.72	962.72	962.72	962.72	962.72	969.76	969.76	969.76	969.76	980.46	980.46	955.65					**955.65**	◄►
Staff In Post WTE				838.92	833.01	828.91	824.59	822.81	825.71	834.28	837.51	831.88	840.54	843.26	859.91					**856.13**	▼
Vacancies WTE				123.80	129.71	133.81	138.13	139.91	144.05	135.48	132.25	137.88	139.92	137.20	95.74					**99.52**	▲
Vacancies %	>12%	8%<>12%	<8%	12.86%	13.47%	13.90%	14.35%	14.53%	14.85%	13.97%	13.64%	14.22%	14.27%	13.99%	10.02%	>12%	8%<>12%	<8%		10.41%	▲
Agency WTE				30.84	25.22	26.04	25.48	26.36	16.02	15.15	17.38	25.64	28.60	28.53	28.12					**30.96**	▲
Bank WTE *Note 2*				37.40	31.22	35.72	37.76	47.79	40.37	44.05	48.60	47.60	47.05	42.01	40.40					**47.11**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	16.92%	17.58%	16.72%	16.55%	17.06%	17.02%	17.09%	17.92%	18.98%	18.58%	18.92%	18.22%	>=12%	10%<>12%	<10%		18.41%	▲
Monthly Turnover				1.53%	1.32%	1.43%	1.04%	1.60%	1.34%	1.08%	2.11%	2.24%	1.02%	1.74%	1.00%					**1.56%**	▲
Stability %	<70%	70%<>85%	>=85%	98.5%	98.5%	98.7%	99.2%	98.8%	98.7%	99.1%	98.4%	98.5%	97.64%	98.77%	98.58%	<70%	70%<>85%	>=85%		**98.61%**	▲
Sickness Absence %	>=4%	4%<>3%	<3%	2.69%	2.90%	3.20%	3.01%	2.43%	2.06%	2.75%	2.04%	2.06%	2.61%	3.15%	3.59%	>=4%	4%<>3%	<3%		***3.56%***	***Nov trend figure***
% staff appraisal compliant (Permanent & Fixed Term staff)	<70%	70%<>85%	>=85%	75.7%	80.1%	78.7%	82.3%	92.6%	83.3%	84.8%	83.5%	84.1%	86.27%	83.86%	81.24%	<80%	80%<>95%	>=95%	**NEW RAG 2017-18**	**81.38%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 3*	<70%	70%<>80%	>=80%	85.8%	86.8%	87.0%	88.9%	89.3%	87.2%	81.6%	88.5%	89.2%	89.57%	89.94%	89.60%	<80%	80%<>95%	>=95%	**NEW RAG 2017-18**	**88.81%**	▼

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%**	2016-17 Quarter 2: Of 42 responses: 92.9% : 4.8%	2016-17 Quarter 4: Of 236 responses: 95.3% : 2.1%	2017-18 Quarter 1: Of 273 responses: 95.2% : 2.6%	2017-18 Quarter 2: Of 212 responses: 92% : 2.4%	National Staff Survey 2017 : *indicative response rate: 55%*		Qtr 2 & Qtr 2 ▼Responses ▼ Likely ▼ Unlikely
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%**	2016-17 Quarter 2: Of 42 responses: 57.1% : 32.0%	2016-17 Quarter 4: Of 236 responses: 64.0% : 18.7%	2017-18 Quarter 1: Of 273 responses: 57.5% : 24.2%	2017-18 Quarter 2: Of 212 responses: 66% : 19.8%			Qtr 2 & Qtr 2 ▼Responses ▲ Likely ▼ Unlikely

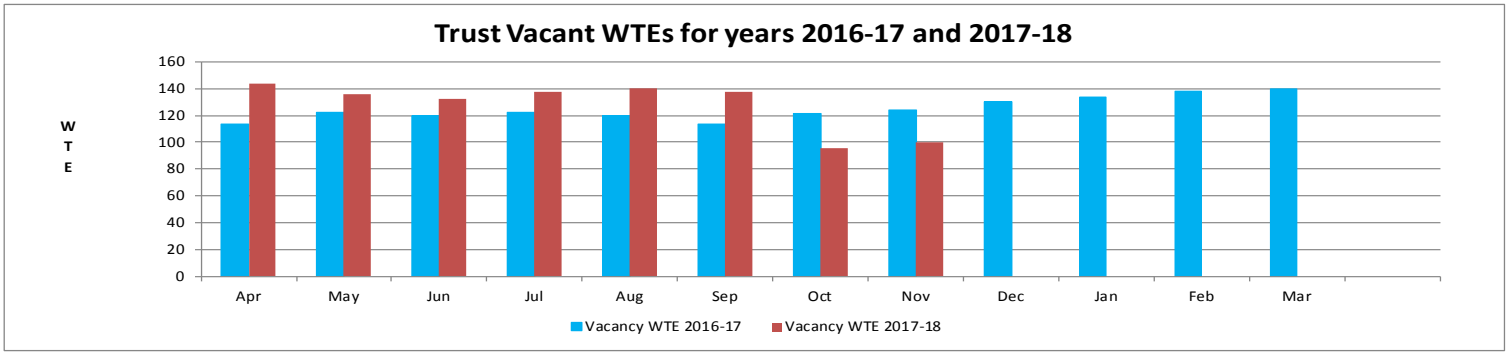
*Note 1 - 2017/18 Establishment not available in May data reporting period, establishment updated for April, May and June in this report. Establishment updated in August 2017 with nursing update in October 2017
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment 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 Safeguarding Adults Level 2.

2. Vacancies and Recruitment

VACANCY PERCENTAGES	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate	9.90%	8.17%	5.83%	▼
Eyes	8.14%	8.40%	11.06%	▲
Sleep	-8.46%	-8.46%	-5.52%	▼
Plastics	7.70%	1.67%	-0.21%	▼
Oral	10.06%	9.63%	9.86%	▲
Periop	25.65%	18.77%	19.91%	▲
Clinical Support	9.02%	6.64%	6.94%	▲
Clinical Infrastructure	15.20%	8.32%	13.76%	▲
Director of Nursing	14.86%	14.36%	19.65%	▲
Operational Nursing	18.36%	12.14%	13.18%	▲
QVH Trust Total	13.99%	10.02%	10.41%	▲

NON-MEDICAL RECRUITMENT(WTE)	Posts advertised this month	Recruits in Pipeline
Corporate	2.00	2.00
Eyes	1.60	
Sleep	1.53	2.69
Plastics	1.80	1.00
Oral	1.00	
Periop	17.00	1.00
Clinical Support	4.90	2.00
Clinical Infrastructure	4.00	
Director of Nursing	1.00	
Operational Nursing	3.84	3.24
QVH Trust Total	*38.67*	11.93
of which Qual Nurses / Theatre Practs (external)	20.00	*2.00*
of which HCA's & Student/Asst Practs (external)	2.34	*1.84*

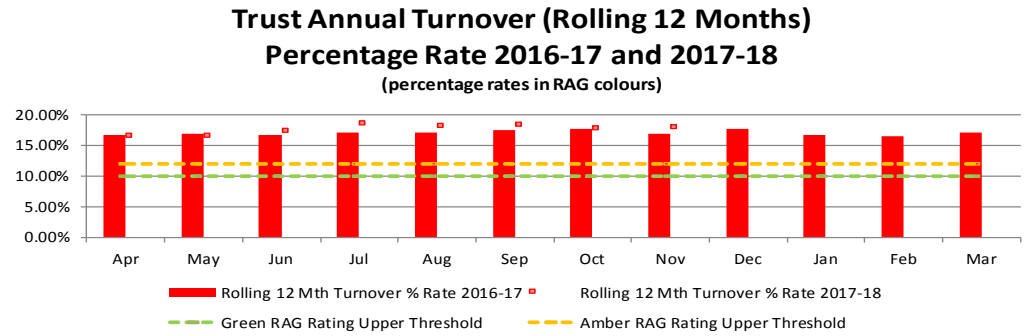
MEDICAL RECRUITMENT (WTE)	Posts advertised this month	Recruits in Pipeline
Clinical Support	0.00	1.00
of which are Deanery Trainees, Trust Registrars or Fellows		*1.00*
of which are SAS doctors		
of which are Consultants (including locums)		
Plastics	4.00	7.00
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*4.00*
of which are SAS doctors		
of which are Consultants (including locums)	*3.00*	*3.00*
Eyes	2.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*2.00*	*2.00*
of which are SAS doctors		
of which are Consultants (including locums)		
Sleep	0.00	0.00
Oral	0.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows		*2.00*
of which are SAS doctors		
of which are Consultants (including locums)		
Periop	4.00	7.00
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*7.00*
of which are SAS doctors		
of which are Consultants (including locums)	*3.00*	
QVH Trust Total	10.00	19.00
of which are Deanery Trainees, Trust Registrars or Fellows	*4.00*	*16.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*6.00*	*3.00*

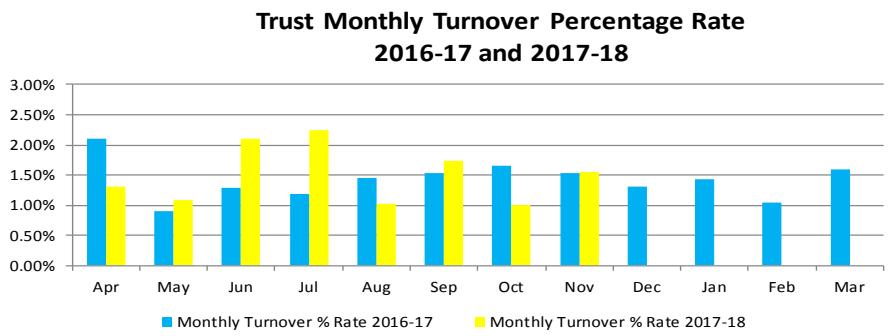


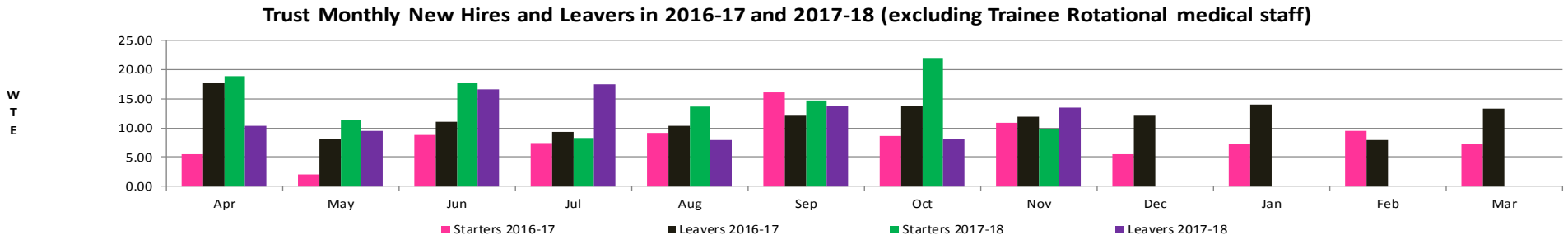
3. Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate %	16.17%	14.30%	14.13%	▼
Eyes %	18.41%	22.67%	25.02%	▲
Sleep %	13.13%	13.07%	16.08%	▲
Plastics %	29.14%	26.43%	27.95%	▲
Oral %	14.14%	13.22%	11.69%	▼
Peri Op %	16.90%	15.97%	17.76%	▲
Clinical Support %	15.29%	15.51%	15.18%	▼
Clinical Infrastructure %	29.44%	30.81%	34.01%	▲
Director of Nursing %	6.45%	6.49%	9.83%	▲
Operational Nursing %	30.59%	29.15%	23.37%	▼
QVH Trust Total %	18.92%	18.22%	18.41%	▲

MONTHLY TURNOVER excl. Trainee Doctors	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate %	0.65%	0.00%	0.62%	▲
Eyes %	0.00%	4.20%	2.34%	▼
Sleep %	0.00%	0.00%	3.01%	▲
Plastics %	5.22%	0.00%	1.29%	▲
Oral %	0.90%	0.00%	0.60%	▲
Peri Op %	2.79%	1.66%	2.81%	▲
Clinical Support %	0.08%	0.80%	0.91%	▲
Clinical Infrastructure %	3.24%	1.78%	3.15%	▲
Director of Nursing %	0.00%	0.00%	3.72%	▲
Operational Nursing %	3.41%	2.14%	0.61%	▼
QVH Trust Total %	1.74%	1.00%	1.56%	▲







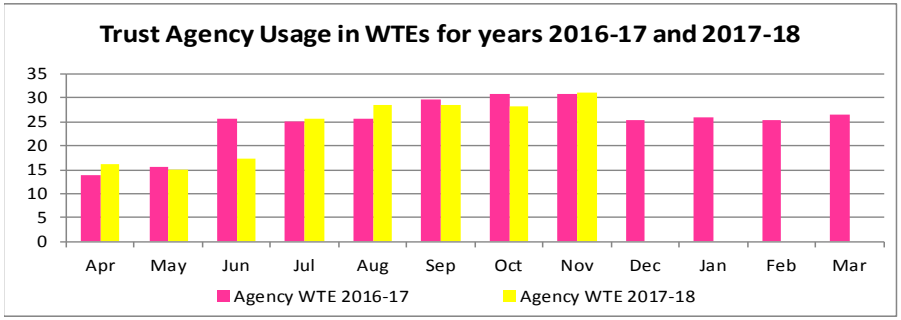
4. Temporary Workforce

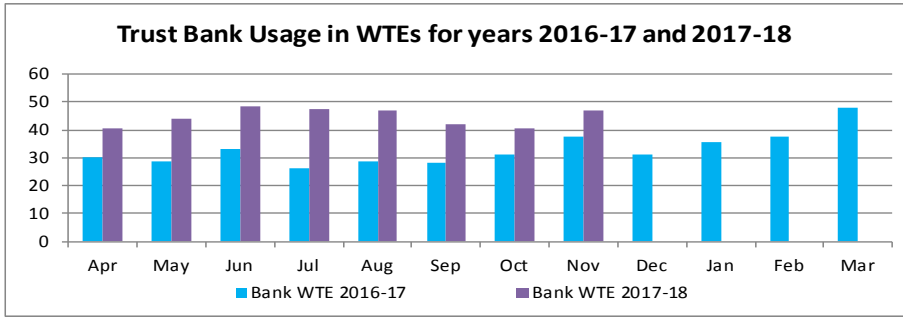
Agency				
BUSINESS UNIT (WTE)	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate	2.90	4.05	4.05	◄►
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.00	◄►
Plastics	0.65	1.30	0.71	▼
Oral	1.56	1.43	0.92	▼
Periop	17.01	15.60	18.29	▲
Clinical Support	2.06	2.39	1.98	▼
Clinical Infrastructure	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	4.35	3.34	5.01	▲
QVH Trust Total	28.53	28.11	30.96	▲

Bank				
BUSINESS UNIT (WTE)	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate	6.38	4.98	5.80	▲
Eyes	1.19	1.75	2.42	▲
Sleep	2.55	2.19	2.88	▲
Plastics	3.73	3.58	3.20	▼
Oral	2.55	1.60	2.51	▲
Periop	7.23	9.06	9.67	▲
Clinical Support	7.88	6.35	7.02	▲
Clinical Infrastructure	6.00	5.42	6.00	▲
Director of Nursing	0.89	0.99	1.22	▲
Operational Nursing	3.62	4.48	6.39	▲
QVH Trust Total	42.02	40.40	47.11	▲

Agency				
STAFF GROUP (WTE)	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Qualified Nursing	21.78	19.69	23.58	▲
HCAs	0.00	0.00	0.00	◄►
Medical and Dental	0.23	0.55	0.43	▼
Other AHP's & ST&T	2.06	2.39	1.98	▼
Non-Clinical	4.46	5.48	4.97	▼
QVH Trust Total	28.53	28.11	30.96	▲

Bank				
STAFF GROUP (WTE)	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Qualified Nursing	8.90	10.99	11.86	▲
HCAs	4.12	4.40	5.35	▲
Medical and Dental	0.00	0.00	0.00	◄►
Other AHP's & ST&T	3.94	3.26	3.23	▼
Non-Clinical	25.06	21.75	26.68	▲
QVH Trust Total	42.02	40.40	47.11	▲



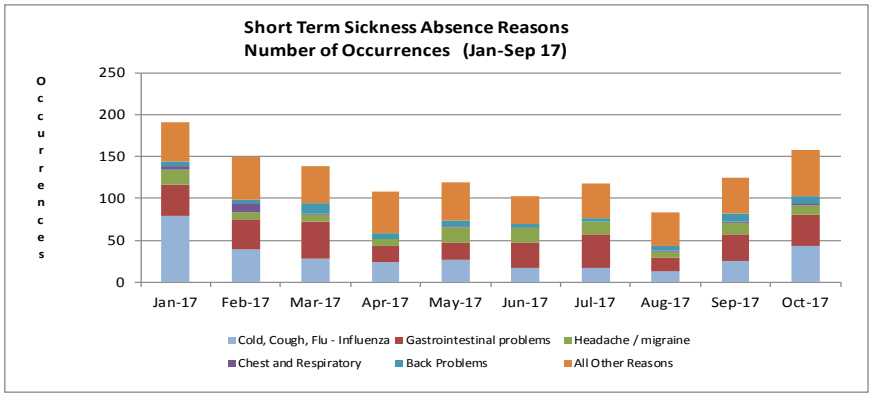


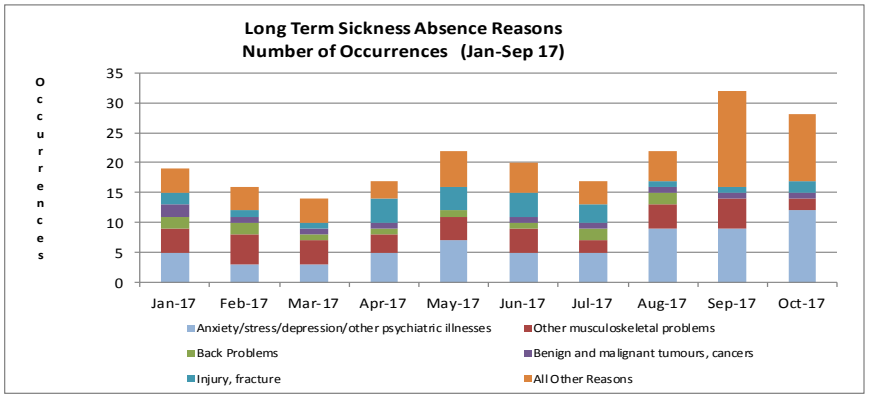
5. Sickness Absence

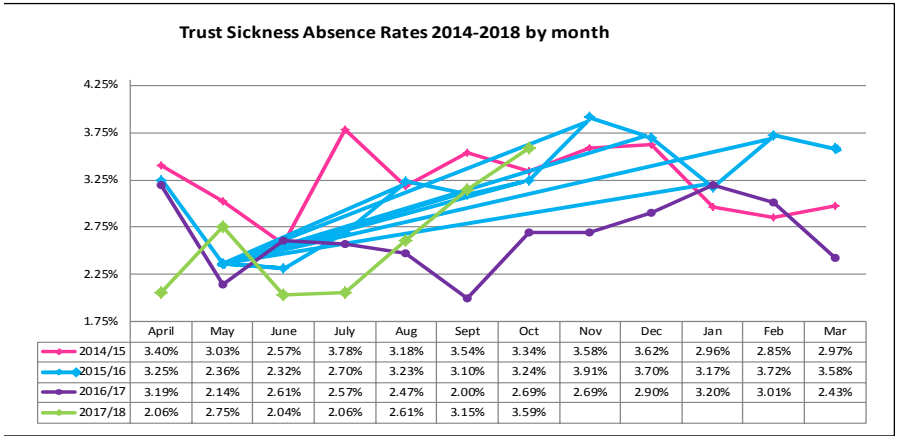
SHORT TERM SICKNESS	Aug-17	Sep-17	Oct-17	Compared to Previous Month
Corporate	1.97%	0.75%	1.74%	▲
Clinical Support	0.16%	0.86%	1.68%	▲
Plastics	1.09%	0.69%	1.36%	▲
Eyes	0.07%	1.64%	1.88%	▲
Sleep	0.38%	0.88%	0.31%	▼
Oral	2.53%	1.45%	1.34%	▼
Periop	1.38%	1.85%	2.17%	▲
Clinical Infrastructure	1.07%	2.51%	1.60%	▼
Director of Nursing	0.38%	0.49%	0.62%	▲
Operational Nursing	1.53%	0.81%	2.47%	▲
QVH Trust Total	1.02%	1.17%	1.72%	▲

LONG TERM SICKNESS	Aug-17	Sep-17	Oct-17	Compared to Previous Month
Corporate	0.72%	0.70%	0.00%	◄►
Clinical Support	0.59%	0.51%	0.74%	▲
Plastics	0.64%	0.99%	0.00%	▼
Eyes	0.00%	0.42%	2.99%	▲
Sleep	0.00%	1.81%	4.17%	▲
Oral	3.82%	4.54%	3.44%	▼
Periop	1.92%	3.07%	1.97%	▼
Clinical Infrastructure	1.98%	3.84%	7.57%	▲
Director of Nursing	1.64%	2.47%	4.02%	▲
Operational Nursing	1.89%	3.12%	3.55%	▲
QVH Trust Total	1.59%	1.98%	1.87%	▼

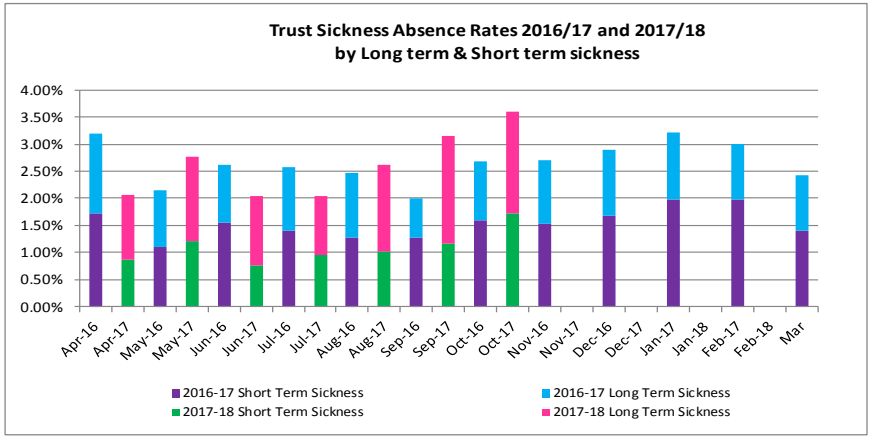
ALL SICKNESS (with RAG)	Aug-17	Sep-17	Oct-17	Compared to Previous Month
QVH Trust Total	2.61%	3.15%	3.59%	▲







	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	3.40%	3.03%	2.57%	3.78%	3.18%	3.54%	3.34%	3.58%	3.62%	2.96%	2.85%	2.97%
2015/16	3.25%	2.36%	2.32%	2.70%	3.23%	3.10%	3.24%	3.91%	3.70%	3.17%	3.72%	3.58%
2016/17	3.19%	2.14%	2.61%	2.57%	2.47%	2.00%	2.69%	2.69%	2.90%	3.20%	3.01%	2.43%
2017/18	2.06%	2.75%	2.04%	2.06%	2.61%	3.15%	3.59%					



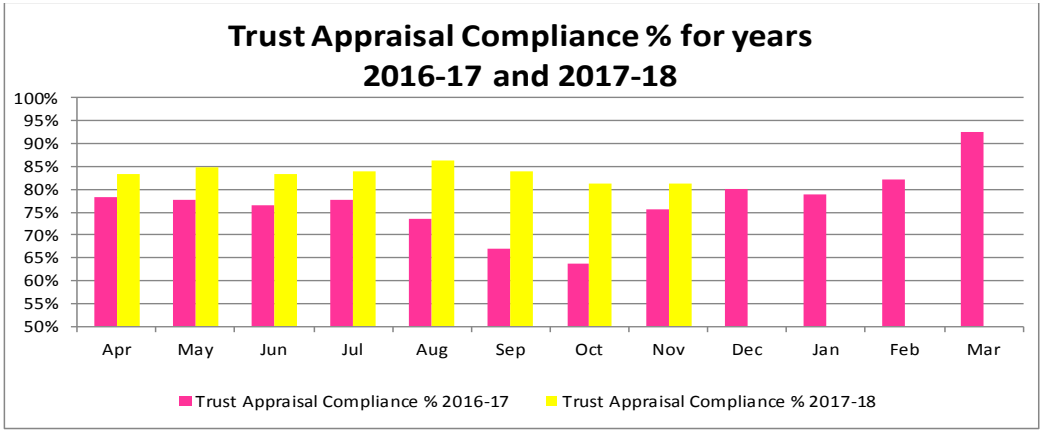
6. Training, Education and Development

New Targets/RAG ratings for 2017/18:

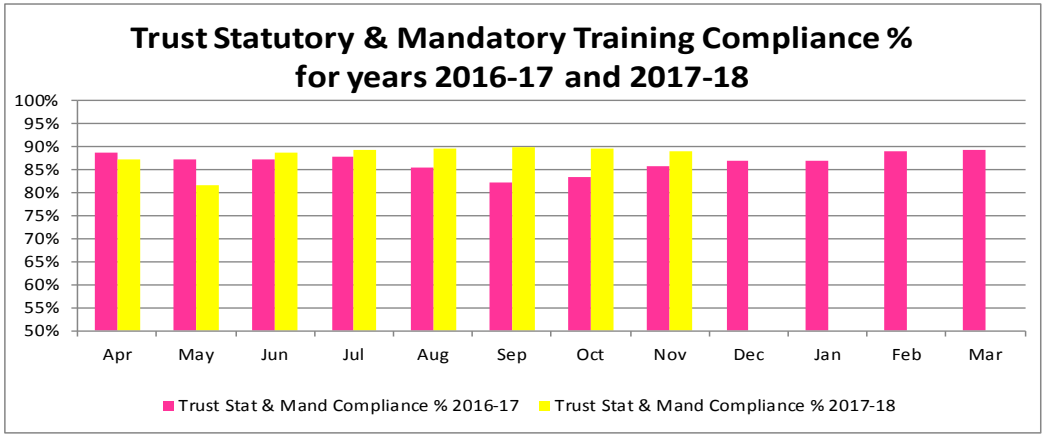
% staff - appraisal compliant	<80%	80%<>95%	>=95%
% staff - Statutory & Mandatory Training compliant	<80%	80%<>95%	>=95%

Performance:

APPRAISALS	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate	83.33%	84.94%	77.65%	▼
Clinical Support	87.16%	79.87%	90.13%	▲
Plastics	83.81%	84.11%	78.45%	▼
Eyes	79.63%	81.13%	82.69%	▲
Sleep	90.63%	90.63%	93.55%	▲
Oral	88.30%	84.21%	85.57%	▲
Periop	78.38%	71.89%	74.74%	▲
Clinical Infrastructure	74.36%	72.50%	63.16%	▼
Director of Nursing	80.56%	77.14%	69.70%	▼
Operational Nursing	91.40%	91.30%	93.55%	▲
QVH Trust Total	83.86%	81.24%	81.38%	▲



MANDATORY AND STATUTORY TRAINING	Sep-17	Oct-17	Nov-17	Compared to Previous Month
Corporate	91.64%	91.92%	92.43%	▲
Clinical Support	93.56%	92.71%	93.81%	▲
Plastics	83.81%	81.42%	80.52%	▼
Eyes	91.45%	93.55%	91.38%	▼
Sleep	91.84%	94.13%	93.12%	▼
Oral	90.44%	89.17%	88.89%	▼
Periop	88.08%	87.84%	86.60%	▼
Clinical Infrastructure	88.67%	91.13%	88.14%	▼
Director of Nursing	91.74%	91.54%	88.81%	▼
Operational Nursing	91.41%	90.30%	88.53%	▼
QVH Trust Total	89.94%	89.60%	88.81%	▼



7. Medical and Dental Workforce

Medical Workforce

- **Job Planning:** a training session for the job planning software was provided to the Project Team and some Business Managers, with plans underway to review all Consultant job plans by April 2018. A further set of training sessions for clinical colleagues is planned for January 2018.
- **Recruitment:** 3 successful Consultant appointments were made to the Plastics team. Next month sees a further 3 Advisory Appointments Committees for Consultant Anaesthetists.
- **Revalidation and Appraisal:** Appraisal rates for medical and dental staff has slightly decreased to 88.33% from 88.65%:

Business Unit	Headcount required	Headcount achieved	Compliance %
Clinical Support	7	7	**100.00%**
Eyes	12	12	**100.00%**
Oral	31	28	**90.32%**
Peri-Op Services	25	21	**84.00%**
Plastics	41	34	**82.93%**
Sleep	4	4	**100.00%**
Grand Total	**120**	**106**	**88.33%**

- **Medical and Dental Locum Bank and Agency Locums**: usage remains low, with only 0.43wte being utilised on agency in month

Medical Education

November 2017

- Action plans for core surgery and higher plastic surgery following the GMC survey results have been submitted to HEE KSS and discussed at the Local Academic Board meeting (with HEE KSS Patch Dean in attendance). Further changes are being implemented and a report is due to HEE KSS in January 2018.
- Initial planning is underway to put processes in place to deal with the proposed centralisation of Deanery trainees' study leave budgets.
- An additional bid to HEE KSS for SAS doctor CPD funding was successful.

Upcoming developments

- A head and neck anatomy course to prepare for the MRCS Part A will be held at QVH on 21 December.
- The next junior doctors forum will be in January 2018
- There will be an evening lecture meeting on Weds 17 January – Mr Keith Altman, OMFS consultant, will be speaking.

Statutory and mandatory training compliance

- Permanent/fixed term medical and dental employees are currently showing 83.6% compliant, which is around the same as the previous month.
- Medical and dental bank workers are showing 75.3% compliant, which is the same as the previous month.

Organisational Development and Wellbeing

Update on Engagement and Retention:

- A new newsletter, Workforce Matters' has been launched with a particular focus on nursing/clinical staff to inform and update on progress with all the planned activities so far in the engagement and retention plan.
- Pegasus has facilitated focus groups and is launching the closed Facebook page as a precursor to the launch of the recruitment campaign in January
- The CEO and Director of Workforce have met with the first new starters after 3 months in the organisation
- Refer a Friend scheme has launched
- We have a careers fair at the University of Brighton in December and are in the process of arranging an open day with South Bank University
- Through business planning the permanent post of Trust Educator has been reinstated
- The revised re-location policy has been ratified
- The Trust is working collaboratively across the STP on the Band 4 Nurse Associate role. We will be supporting 3 existing HCA's through competitive process on to the programme which we hope will be approved by the NMC in April 2018
- New Bank rates have been agreed and will begin to roll out for a trial period. This includes a return to weekly pay for bank only nurses in the new year
- The chief executive and chair hosted two events in December to celebrate 10 and 15 years of continuous NHS service

Update on Leading the Way:

- Staff are being given another opportunity via Leading the Way and the welcome event is planned for 30th January 2018
- A new provider will be delivering the qualification part of the programme and staff have a chance to gain a CMI accredited qualification in management & leadership
- Focus Groups will be held in January for those people on the Passport and Qualification Route to gauge some initial feedback from the pilot programmes
- We have offered an opportunity for managers/leaders to participate in Action Learning Sets starting March 2018
- For those on the passport route, we have delivered 27 workshops to date and more are planned for 2018

Other initiatives:

- Staff are being offered Functional Skills training in Maths from January 2018
- Staff have the opportunity to gain a qualification in Buddy/Mentor Training, applications are being sought at present
- TRAC Usage : **1st Aug 2017 – 8th Dec 2017 SNAPSHOT (**General Recruitment, Substantive ONLY)

  In Process :
  - 569 applications – in process / processed
  - Average Time To Hire = 56 days from 99 days

  End to End Completion (authorisation to in-post):
  - 246 (215 external / 31 internal) applications resulted in 26 appointments (8 external / 18 internal)
    - Appointees: 74% NHS Jobs; 5% QVH Site; 5% Search Engines; 16% Other (various)
  - 85% hired within 11 weeks (external candidates) / 95% hired within 9 weeks (internal candidates)
  - 86% employment checks completed within 17 working days

		Non-medical							
Employer name	OU1 Name	Applied	Shortlisted	Interview attended	Appointed	Applied %	Shortlisted %	Interview attended %	Appointed %
Queen Victoria Hospital NHS Foundation Trust	Clinical Support	34	15	8	2	13.82	44.12	53.33	25
	Corporate	96	41	28	9	39.02	42.71	68.29	32.14
	Eyes	28	14	6	1	11.38	50	42.86	16.67
	Nursing & Cl	59	41	27	12	23.98	69.49	65.85	44.44
	Oral	12	3	0	0	4.88	25	0	0
	Perioperative Services	13	12	3	1	5.28	92.31	25	33.33
	Plastics	3	2	2	1	1.22	66.67	100	50
	Sleep	1	0	0	0	0.41	0	0	0
Total		246	128	74	26	100.00	52.03	57.81	35.14

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/01/18**		**Agenda reference:**	**23-18**	
Report title:	**Board development programme**				
Sponsor:	Clare Pirie, Director of Communications and Corporate Affairs				
Authors:	Clare Pirie, Director of Communications and Corporate Affairs, and Hilary Saunders, Deputy Company Secretary				
Appendices:	NA				
Executive summary					
Purpose:	The purpose of this paper is to enable the Board of Directors to ensure it has the skills, experience and approach needed to ensure Queen Victoria Hospital NHS Foundation Trust remains an innovative and high performing organisation.				
Recommendation:	The Board is asked to **NOTE** the contents of the report and support proposals for further development opportunities.				
Purpose:	**Approval**	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	In line with Foundation Trust Code of Governance				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				

Report to:	Board of Directors
Meeting date:	04 January 2018
Agenda item reference no:	23-18
Report from::	Clare Pirie, Director of communications and corporate affairs
Authors:	Clare Pirie, Director of communications and corporate affairs and Hilary Saunders, Deputy Company Secretary
Date of report:	27 December 2017

BOARD DEVELOPMENT

Introduction

The purpose of this paper is to review our approach to ensuring the Board of Directors at QVH has the skills, experience and approach needed to ensure Queen Victoria Hospital NHS Foundation Trust remains an innovative and high performing organisation. The Board consider this on an annual basis.

What are we aiming to achieve?

Shaping organisational culture

As an effective board we need to shape a culture for the organisation which reflects QVH's values and is ambitious, self-directed, responsive, and encourages innovation. We have a commitment to openness and transparency and to put patients and communities at the centre of everything we do.

Board members are also expected to exemplify the seven Nolan Principles of public life: selflessness, integrity, objectivity, accountability, openness, honesty, leadership.

A strong team

A number of new directors have joined the Board during the current year and we need to make sure we continue to work together as a unitary Board, with members able to give and receive challenge and support in a constructive manner.

The most effective Boards are those that drive organisational performance especially at times of great stress and change. Sound leadership creates an organisational culture of continuous improvement, motivated staff, and enhancing its long term sustainability.

Identifying development needs

In line with national guidance, we have commissioned an external organisation to conduct a leadership and governance review for the Trust. This will provide insight into the effectiveness of our Board and may identify additional areas for development. The findings of this review will be considered at the Board seminar in February 2018 with a final action plan considered at the public Board meeting in March 2018.

The timetable of internal review of effectiveness of Board and sub-committees agreed by the Board in September 2017 will ensure the performance of the Board is reviewed biannually, with action taken where potential improvements are identified.

The Trust has a well-developed appraisal process which is used to identify individual development needs. The Chief Executive will agree with executive directors a personal development plan (PDP) as part of their individual appraisal. The Chair conducts annual non-executive director appraisals and is

herself appraised by the chair of the Council of Governors Appointments committee; the Chair and NEDs also have individual development needs documented and reviewed through this process.

During the year new executive and non-executive directors have been appointed with any need for additional development needs identified as part of the appointment and reviewed during the individual's first months in post.

Resourcing Board development
As a small trust the funds available for Board development work are limited. The Trust Board budget includes c£1,000pa for training, supporting a small number of paid for opportunities, and c£2,500 for facilitated whole Board development.

As in all areas of the Trust, personal development is achieved through networks, shadowing, opportunities provided at no cost by national bodies such as NHS Providers, Federation of Specialist Hospitals, Healthcare Financial Management Association, NHS Improvement as well as more specialist professional bodies. Board members at QVH have a strong presence in national and regional professional bodies, both contributing and benefiting from these relationships and opportunities.

Board seminars held every other month are also used as development opportunities. The details of these are described below.

Board members work hard to balance the time commitment needed for their role at QVH with identifying time to step outside of the Trust for personal development. The culture at QVH encourages and supports personal development while recognising that for executive directors, creating the time needed is often a challenge.

What have we delivered in the way of Board development?

Individual development
All individual members of the Board, both executive and non-executive, have participated in development opportunities during 2017/18. *Appendix A* sets out the events attended by NEDs and the paid for opportunities taken up by executive directors. This should not be considered a comprehensive list as executive directors spend a considerable proportion of their time on meetings outside of the Trust, but each executive director has identified what they consider their key personal development opportunities over the year.

New directors have attended the two day corporate induction which now has a stronger focus on our values and the nature of the work carried out at QVH, with statutory and mandatory training followed up outside of this. The Deputy Company Secretary also provides a tailored local induction programme for new NEDs.

The Nomination and Remuneration Committee discussed the value of 360 degree appraisal to ensure wider understanding of how Board members are perceived both within and outside the organisation. The Director of HR and Organisational Development is building this into our approach for 2018/19.

Board seminars and clinician presentations
Throughout the year there have been a series of Board seminars providing opportunities to gain an understanding of the services provided by the Trust as well as to review the strategic direction. In 2017/18 seminars have included sessions planned to improve Board member's overall knowledge

base and technical skills. These included sessions on the strategic outline case for the burns service, the estates strategy, the IM&T strategy, Board level responsibilities around equality and diversity; the role of the corporate trustee. The Board seminar programme is set out in Appendix B. Future seminars are likely to continue to provide a balance of strategic level in depth discussion and opportunities to extend the knowledge and understanding of Board members. The options currently under discussion for external input into future seminars are set out in Appendix C.

The AGM included presentations by the clinical lead for prosthetics and the clinical lead for head and neck cancer. These were much appreciated by both the public audience and Board members. In March 2017 Board members will be attending an event to celebrate the digitisation of Guinea Pig records which includes a presentation by the lead clinician for burns.

The education department delivers an annual programme of evening clinical lectures which are attended by many Board members. In 2017/18 these have covered plastic surgery, facial palsy, military medicine and critical care, with facial feminisation surgery scheduled for mid-January.

Board members also regularly attend the monthly joint hospital governance committee which has a clinical focus including, for example, the findings of clinical audit.

Statutory and mandatory training
All Board members remain up to date with core training in areas like information governance and fire safety.

What Board development do we need in 2018?

The Board is asked to consider the approach we have taken to date, and the priorities for Board development in the coming year. Some of the options for full Board development activities are set out in appendix C; the costs of these need to be negotiated but as a ball park figure we may expect to pay c. £1000 for a senior partner to prepare and deliver a two hour session.

It is proposed that the facilitated Board development session planned for June 2018 include work on individual preferences with whole Board with feedback and discussion to understand each other's behaviours and perspectives.

Appendix A

	EVENT
Beryl Hobson	• NHSI Leadership and governance in delivery of STPs • NHSI Chair and CEO meetings
Ginny Colwell	• NHS Providers NED network • HFMA Chair, Non-Executive Director & Lay Member Forum
Gary Needle	• NHS Providers NED induction programme
Kevin Gould	• NHS Providers NED induction programme • HFMA Audit Conference
John Thornton	• NHS Providers NED network
Steve Jenkin	• Mentor: Dr Peter Steer, CEO, Great Ormond Street Hospital • Conferences o Kings Fund annual conference o NHS Providers – quarterly Chairs/CEOs plus two evening events • STP workshops • Various half days such as Get It Right First Time (GIRFT) • Acute Services • PLACE based systems • Mental Health Steering Group • NHSI Event for CEOs • Federation of Specialist Hospitals: Quarterly meetings although only personally attended one plus meeting with NHSE
Jo Thomas	• NHSI recruitment and retention masterclass and 2 subsequent days on nursing retention initiative • Caldecott training 1 day • Serious incident training 2 days • 2 days NHS provider days for nursing and medical directors • 3 days at regional directors of nursing • 2 days (march 2017) at national Chief Nursing Officers conference • I day major incident planning/response within STP
Ed Pickles	• NHSE meetings on revalidation; responsible officer; responding to concerns • Training on Root Cause Analysis report and investigation • NHSE medical director induction training • STP meetings & away days • Clinical Research Network: regional research meetings Place secured at 2018 Kings Fund Medical Directors course (12 days)
Sharon Jones	• NHS Providers Chief Operating Officers Network

	• Referral to Treatment Best Practice – NHSI in conjunction with Barking, Havering and Redbridge University Hospitals NHS Trust; • NHSI Theatre Productivity with Deloitte & 4 eyes • Demand and Capacity Summit - NHS England & NHS Improvement • NHS South Region Cancer collaborative event
Jason McIntyre	• 8-9 Dec 2016 HFMA Conference London • 21 Sep 2017 National Provider Finance Directors' Congress London • 13-14 Oct HFMA Conference, Ashford • 30 Nov Living Within Our Means, Bracknell
Geraldine Opreshko	• Kings Fund, Leadership Summit – 1 day • NHS Employers – Strategic Workforce Conference – 2 days • HEE – Talent Management Masterclasses – total 4 days over several months • Twice a year attend NHS Provider HR Directors workshops • Every two Months HEKSS/NHS Employers supported HR Directors meetings which are a mix of information updates and development • NHSI – Retention Masterclasses x 2
Clare Pirie	• June 2017 – Executive director induction – NHS Providers • Sept – fundraising mutual interest group • NHS Providers networks for communications, charity and company secretaries throughout the year. • Regular attendance at STP communications and engagement meetings

Appendix B

Board seminar work programme between October 2016 and December 2017

Month	Seminar topics
October 2016	**Board development day (externally facilitated)** Objectives included: • Strategic stock-take and forecast midway through the financial year; • Reflection on the effectiveness of the Board over the preceding 12 months; • An opportunity to think about effectiveness collectively and informally; • Opportunity to think ahead to 2017 prior to commissioning of independent "well-led" review.
December 2016	• Local providers and STP update • Safeguarding update • QVH Charity strategy • Information governance update

February 2017	• Review of QVH strategy in current context
	• Update on strategies and approach to:
	  • Estates
	  • Research
	  • Junior doctors
	  • IM&T
	• Post implementation review of EDM in Sleep Disorder Unit

April 2017	• Review of issues raised at February seminar, plus STP update • Urgent care and future of MIU • Burns and lower limb trauma • Growing QVH market share at all service sites • Next steps
June 2017	• Learning from a coroner's inquest • Discussion of implications for QVH clinical practice and strategy • Discussion of assurance and processes
October 2017	• Board responsibilities in relation to Equality delivery system (EDS2) – delivered by Capsticks • The role of the corporate trustee – delivered by BDB • CQC inspection preparation
December 2017	Away day (led by Helen Mason Hill): The focus was on agreeing strategic direction for the next 5 years, (including follow up actions), and how this is to be communicated to those outside the Board.

Appendix C

Options for Board Development Programme 2018

Topic	Provider	Comments
Risk Management	BDO	**Adam Spires, Director** (very strong recommendation from Co Sec network) 2 hour facilitated session thinking about risk appetite which often sparks some debate.
	KPMG	**Neil Hewitson, Partner** Trust's current EA. Acting Director of Finance has recommended an external provider would provide more independent thinking
Corporate manslaughter	Eversheds	**Paul Verrico, partner** (recommendation through the CoSec network)
	Capsticks	**David Firth, Partner** Proposal for presentation to cover the following, but will be happy to adapt it for our specific requirements: • the consequences of health and safety failings including those resulting in fatalities; • dealing with HSE in the course of their enforcement activity; • corporate manslaughter – summary of the offence, and case update; • other sources of criminal liability, and the distinction between corporate vs individual liability; • Health and Safety at Work Act 1974; Wilful Neglect; CQC fundamental standards; Gross Negligence Manslaughter; • effect of the Sentencing Guidelines in force since 1 February 2016; and • other consequences of prosecution/conviction.
Bribery Act 2010	local counter fraud current internal auditors, Mazars	Enable Board members to seek assurance on the process to ensure that all contractors, have a compliant bribery policy. Audit Committee leads on this responsibility.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/01/18**		**Agenda reference:**	**24-18**	
Report title:	**Board effectiveness review**				
Sponsor:	Clare Pirie, Director of Communications and Corporate Affairs				
Author:	Hilary Saunders, Deputy Company Secretary				
Appendices:	NA				
Executive summary					
Purpose:	The purpose of this report is to comply with the FT Code of Governance, which requires the Board of Directors to undertake a formal annual evaluation of its own performance and that of its committees and individual directors.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Purpose:	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	FT Code of Governance				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				

Report to:	Board of Directors
Meeting date:	04 January 2018
Agenda item reference no:	24-18
Sponsor:	Clare Pirie, Director of Communications and Corporate Affairs
Author:	Hilary Saunders, Deputy Company Secretary
Date of report:	27 December 2017

Board of Directors Annual Evaluation

Introduction

The purpose of this paper is to comply with the FT Code of Governance, which requires the Board of Directors to undertake a formal annual evaluation of its own performance and that of its committees and individual directors. The Code also requires that details of this evaluation are included in the Annual Report and Accounts. The Board's last effectiveness review was in January 2017.

In addition to the regulatory requirements, establishing a culture of board evaluation allows the board a chance to benchmark itself against its own objectives, assess its rate of progress, set action plans and identify development gaps. It also allows an assessment of the board's skill mix for succession planning and it provides for a measurement of overall effectiveness.

Due to changes in board membership and revised guidance from NHSI with an increased emphasis on leadership, culture, system working and quality improvement, the Board underook a governance and capability self-assessment in September 2017. Results are being used to inform the current external Well Led review. Provisional findings will be presented to the Board at its seminar next month, with a formal report scheduled for the March Board meeting.

Executive Summary

This report is an internal evaluation which covers the following areas:

- The collective performance of the board;
- The performance of the board's committees, and
- The individual performance of the directors.

It should also be read in conjunction with items 23-18 (Board development), 25-18 (Annual review of terms of reference), and 27-18 (Audit committee assurance update, which includes a report on the recent effectiveness review).

1. Collective performance of the Board

a. The Board has continued to ensure that the organisation has a robust and effective risk management system. Each section of the Board agenda is prefaced by the relevant part of the BAF, with the front sheet being incorporated as part of the CEO report. Detailed explanations of changes to risk scores are provided within the relevant section of the Board report. On a quarterly basis, the Audit committee has continued to undertake a thorough examination of an individual KSO, seeking assurance in respect of gaps and controls. The corporate risk register is reviewed by both the Board and the Audit committee at each of its respective meetings.

b. The Board ensures it continues to meet its responsibility to engage with stakeholders through various means. In the past year, these have included:

- Regular scrutiny of Friends and Family Test and patient experience results.
- A QVH patient has attended the public session of most Board meetings over the last year to describe their experience of care at the Trust, which is designed to keep the Board focused on keeping the patient 'at the heart of everything we do'.
- The Lead Governor role continues to enable strong and direct engagement between governors and the Board, especially NEDs.
- In November 2017, the Board received its annual update on the the trust's relationships with third parties. The Board recognises that co-operation and collaboration is key to the sustainability of the organisation and over the last year has continued to develop its relationships in the wider community.

c. In July 2017, the Board revised and approved its Standing Financial Instructions, Standing Orders and Schedule of Matters Reserved for the Board.

d. In September 2017, following consultation with the Council of Governors, the Board appointed John Thornton as senior independent director, following the departure of Lester Porter.

e. Two new non-executive directors joined the Board this year, following successful in-house recruitment drives led by the Council of Governors' Appointments Committee, with the support of the Trust. Gary Needle joined the Trust on 01 July 2017 and chairs the QVH Charity. Kevin Gould joined on 01 September and is now Chair of the Audit committee.

f. Two new executive directors were also appointed in 2017; Geraldine Opreshko, Director of Workforce and Organisational Development, and Clare Pirie, Director of Communications and Corporate Affairs.

g. In October 2017, the Board appointed Michelle Miles as Director of Finance and performance following the departure of Clare Stafford. Michelle is due to join the Trust in February 2018.

h. The facilitated Board development day December 2017 focussed on strategy development.

2. **Performance of the Board's committees**

a. In September, the Board approved a framework for the regular review of effectiveness and adequacy of its committees, including terms of reference and work plans. This programme is aligned to the work of the 'Well led' review and will support the Board's annual evaluation of its own performance in the future. Changes were implemented with immediate effect.

b. In September 2017, the Audit committee undertook a full self-assessment of its effectiveness. Responses were collated and results processed and reported to the December Audit Committee. The Audit Committee effectiveness report is part of the separate assurance report to the Board this month and forms part of the Board's overall corporate effectiveness review.

c. The Terms of reference for the Board's committees are scheduled for review this month (under item 25-18).

3. **Individual performance of directors**

a. Performance appraisal of the Trust Chair and non-executive directors was led by the Chair of the Council of Governors Appointments Committee, with the support of the Trust. Feedback was sought from governors and non-executive and executive directors. Performance was assessed against values, strategic input, holding executives to account, chairing of meetings and internal and external relationships. The challenges of the STP and the appointment of a new Chief Executive and Medical Director were noted. Overall feedback was very positive.

b. A programme of appraisals for the executive directors was undertaken at the same time, led by the Chief Executive and a report submitted to the Nomination and Remuneration Committee in May 2017. It was noted that this had been largely a successful year for QVH in terms of patient experience, quality and finances although there has been some significant change and challenges, including the staff survey and workforce issues in areas of national shortage.

Recommendation

The board of directors is asked to:

- **NOTE** the contents of this annual review, also taking into account information provided under with items 23-18 (Board development), 25-18 (Annual review of terms of reference), and 27-18 (Audit committee assurance update).
- **NOTE** that a comprehensive report following the current 'WellLed' review will be presented in March 2018.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/01/18**		**Agenda reference:**	**25-18**	
Report title:	**Annual approval of Board committee Terms of Reference**				
Sponsor:	Clare Pirie, Director of Communications and Corporate Affairs				
Author:	Hilary Saunders, Deputy Company Secretary				
Appendices:	Statutory Committee ToRs • Audit • Nomination and remuneration Board committee ToRs • Finance and performance • Quality and governance				
Executive summary					
Purpose:	As part of the annual Board evaluation, the Board is asked to review and approve its committees' terms of reference. Key changes for the respective ToRs are highlighted and/or tracked. (The Board is asked to note that a revised version of the Q&GC ToRs was approved at its November meeting, but these are included here for consistency).				
Recommendation:	The Board is asked to review and **approve** the latest ToRs				
Purpose:	**Approval**				
Link to key strategic objectives (KSOs):	**KSO1:** *Outstanding patient experience*	**KSO2:** *World-class clinical services*	**KSO3:** *Operational excellence*	**KSO4:** *Financial sustainability*	**KSO5:** *Organisational excellence*
Implications					
Board assurance framework:	NA				
Corporate risk register:	NA				
Regulation:	FT Code of governance				
Legal:	NA				
Resources:	None				
Assurance route					
Audit previously considered by	Audit committee				
	Date:	13/12/17	Decision:	Recommended for approval	
F&PC ToRs previously considered by:	Finance and performance committee				
	Date:	18/12/17	Decision:	Recommended for approval	
Q&GC ToRs previously considered by:	Quality and governance committee				
	Date:	19/10/17	Decision:	Approved by BOD in November 2017	
N&RC ToRs previously considered by:	Nomination and remuneration committee				
	Date:	02/11/17	Decision:	Recommended for approval	
Next steps:	Once approved the respective terms of reference will be implemented and reviewed annually (or more frequently if necessary). The next scheduled review will take place in January 2019.				

Terms of reference

Name of governance body

Audit Committee

Constitution

The Audit Committee ("the committee") is a statutory, non-executive committee of the Board of Directors.

Accountability

The Committee is accountable to the Board of Directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The Committee is authorised by the Board of Directors to:

- investigate any activity within its terms of reference.
- commission appropriate independent reviews and studies.
- seek relevant information from within the Trust and from any employee (all departments and employees are required to co-operate with requests from the committee).
- obtain relevant legal or other independent advice and to invite professionals with relevant experience and expertise to attend meetings of the committee.

Purpose

The purpose of the Committee is the scrutiny of the organisation and maintenance of an effective system of governance, risk management and internal control. This should include financial, clinical, operational and compliance controls and risk management systems. The Committee is also responsible for maintaining an appropriate relationship with the Trust's internal and external auditors.

Duties and responsibilities

On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's:

1. **Integrated governance, risk management and internal control**
   The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

   In particular, the Committee will review the adequacy and effectiveness of:
   - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.
   - The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
   - The draft quality accounts, including the rigour of the process for producing the

quality accounts, in particular whether the information included in the report is accurate and whether the report is representative of both the services provided by the Trust, and of the issues of concern to its stakeholders.
- The Board of Director sub-committees, including terms of reference, workplans and span of reporting on an annual basis.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key governance bodies of the Trust (for example, the Quality and Governance Committee) so that it understands processes and linkages.

2. Financial reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board of Directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submissions to the Board of Directors focusing particularly on:
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

The Committee should review the Trust's standing financial instructions, standing orders and the scheme of delegation on an annual basis and make recommendations for change to the Board of Directors.

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Chief Executive (as accounting officer) and Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation.
- Reviewing all external audit reports, including the Trust's annual quality report (before its submission to the board of directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Whistle blowing
The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns raised were investigated proportionately and independently.

Counter fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

Other assurance functions
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and the NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the Committee will review the work of other Committees within the organisation whose work can provide relevant assurance to the Committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

In reviewing the work of a clinical governance committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Meetings

Meetings of the Committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust's codes of conduct.

The Committee will meet quarterly.

At least once a year, the Committee should meet privately with representatives of the external and internal auditors.

The Chair of the Committee may cancel, postpone or convene additional meetings as necessary for the Committee to fulfil its purpose and discharge its duties.

The Board of Directors, Chief Executive (as accounting officer), representative of the external auditor and head of internal audit may request additional meetings if they consider it necessary.

Chairmanship

The Committee shall be chaired by a non-executive director, appointed by the Trust Chair following discussion with the Board of Directors.

If the Chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the Committee shall be chaired by one of the other non-executive director members of the Committee.

The representative of the external auditor, head of internal audit, and counter fraud specialist have the right of direct access to the Chair of the Committee to discuss any matter relevant to the purpose, duties and responsibilities of the Committee or to raise concerns.

Secretariat

The Deputy Company Secretary shall be the secretary to the Audit Committee and shall provide administrative support and advice to the chair and membership. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the Chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and

issues to be carried forward
- Maintaining the Committee's work programme.

Membership

Members with voting rights

The Committee will comprise at least three non-executive directors who shall each have full voting rights. The Chair of the Trust shall neither chair nor be a member of the Committee but can attend meetings by invitation of the Committee Chair.

Ex-officio attendees without voting rights

- Chief Executive (as Accounting Officer) who shall discuss with the Committee at least annually the process for assurance that supports the annual governance statement. The Chief Executive should also be in attendance when the Committee considers the draft annual governance statement along with the annual report and accounts.
- Representatives of the Trust's internal auditors.
- Representatives of the Trust's external auditors.
- The Trust's counter fraud specialist who shall attend at least two meetings of the Committee in each financial year.
- Representative of the QVH Council of Governors

The Chair, members of the Committee and the Governor representative shall commit to work together according to the principles established by the Trust's policy for engagement between the Board of Directors and Council of Governors.

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the Committee in full or in part but shall neither be a member nor have voting rights:

- Executive Director of Finance.
- Executive Director of Nursing.
- The secretary to the Committee (for the purposed described above).
- Designated deputies (as described below).
- Any other member of the Board of Directors, senior member of Trust staff or advisor considered appropriate by the chair of the Committee, particularly when the Committee will consider areas of risk or operation that are their responsibility.

Quorum

For any meeting of the Committee to proceed, two non-executive director members of the Committee must be present.

Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chair and Committee secretary at least one clear day* prior to each meeting.

Attendees may, be exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on behalf of the Committee member.

Papers

Meeting papers to be distributed to members and individuals invited to attend at least five clear days prior to the meeting.

Reporting

Minutes of the Committee's meetings shall be recorded formally and ratified by the Committee at its next meeting.

The Committee chair shall prepare a report of each Committee meeting for submission to the Board of Directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the Board of Directors including where executive action is continually failing to address significant weaknesses.

Issues of concern and/or urgency will be reported to the Board of Directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the Trust chair. Instances of this nature will be reported to the Board of Directors at its next formal business meeting.

The Committee will also report to the Board of Directors at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

In addition, the Committee shall make an annual report to the council of governors in relation to the performance of the external auditor to enable the council of governors to consider whether or not to re-appoint them.

Review

These terms of reference shall be reviewed by the Committee annually or more frequently if necessary. The review process should include the company secretarial team. The Board of Directors shall be required to ratify all changes.

The next scheduled review of these terms of reference will take place in December 2016 in parallel with the next annual review of the effectiveness of the Board of Directors.

* Definitions

- In accordance with the Trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Terms of reference

Name of governance body

Nomination and Remuneration ('Nom and Rem' or 'N&R') Committee

Constitution

The nomination and remuneration committee (the committee) is constituted as a statutory non-executive committee of the trust's board of directors.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The committee is authorised by the board of directors to:

- Appoint or remove the chief executive, subject to the approval of the council of governors, and set the remuneration and allowances and other terms and conditions of office of the chief executive.
- Appoint or remove the other executive directors and set the remuneration and allowances and other terms and conditions of office of the executive directors, in collaboration with the chief executive.
- Consider any activity within its terms of reference.
- Seek relevant information from within the trust. (All departments and employees are required to co-operate with any request made by the committee).
- Instruct independent consultants in respect of executive director remuneration.
- Request the services and attendance of any other individuals and authorities with relevant experience and expertise if it considers this necessary to exercise its functions.

Purpose

The purpose of the committee is to:

- Determine the structure, size and composition (including the skills, knowledge, experience and diversity) of the board of directors, making use of the output of the board evaluation process as appropriate, and to make recommendations to the board and to the appointments committee of the council of governors, as applicable, with regard to any changes.
- Work with the chief executive to identify and appoint candidates to fill all executive director and other positions that report to the chief executive.
- Work with the chief executive to decide and keep under review the terms and conditions of office of executive directors and other positions that report to the chief executive, including:
    - Salary, including any performance-related pay or bonus;
    - Provisions for other benefits, including pensions and cars;
    - Allowances;
    - Payable expenses;

- Compensation payments.

- Set the overall policy for the remuneration packages and contractual terms of the executive management team.

Responsibilities and duties

Responsibilities

On behalf of the board of directors, the committee has the following responsibilities:

- To identify and appoint candidates to fill posts within its remit as and when they arise.
- In doing so, to adhere to relevant laws, regulations, trust policies and the principles and provisions regarding the levels and components of executive directors' remuneration as defined by section D of the Monitor *Code of Governance* [to be included as an annex to the terms of reference].
- To be sensitive to other pay and employment conditions in the trust.
- To keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.
- To give full consideration to and make plans for succession planning for the chief executive and other executive directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future.
- To sponsor the trust's leadership development and talent management programmes to support succession plans and meet specific recruitment and retention needs.
- To work with the appointments committee of the council of governors to ensure that processes for the nomination and remuneration and performance appraisal of the trust chairperson and non-executive directors and chief executive and executive directors are aligned.

Duties (nominations)

- When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment.
- Use open advertising or the services of external advisers to facilitate candidate searches.
- Consider candidates from a wide range of backgrounds on merit against objective criteria.
- Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.
- Ensure that proposed appointees meet the "fit and proper person test", and confirm their awareness of the circumstances which would prevent them from holding office.
- Consider any matter relating to the continuation in office of any executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract.

Duties (remuneration)

- Establish and keep under review a ~~remuneration policy~~ the national NHSI VSM pay strategy and associated QVH VSM pay principles in respect of executive board directors and other positions that report to the chief executive.
- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at

a level which is affordable for the trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors and other positions that report to the chief executive, while ensuring that increases are not made where trust or individual performance do not justify them.
- Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.
- The committee will work with the chief executive to determine the remuneration of the other executive directors.

Meetings

Meetings of the committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the trust's codes of conduct.

The committee will usually meet ~~quarterly~~three times a year.

The chair of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.

The board of directors, chief executive and director of workforce and organisational development may request additional meetings if they consider it necessary.

Chairmanship

The committee shall be chaired by the chair of the trust.

If the chair is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by the senior independent director of the trust.

Secretariat

The Director of corporate affairs and communications, working closely with the Director of Workforce organisational development, shall be the secretary to the committee and shall provide administrative support and advice to the chairperson and membership. The duties of the secretary shall include but not be limited to:
- Preparation of the draft agenda for agreement with the chair
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Maintaining the committee's work programme.

Membership

Members with voting rights

The committee shall comprise all non-executive directors of the trust who shall each have full voting rights.

Ex-officio attendees without voting rights
- Chief Executive
- Director of Workforce and Organisational Development

In attendance without voting rights

- The secretary to the committee (for the purposes described above)
- Any other member of the board of directors, senior member of trust staff or external advisor considered appropriate by the chair of the committee.

Quorum

For any meeting of the committee to proceed, two non-executive members of the committee must be present.

Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chair and committee secretary at least one clear day* prior to each meeting.

Attendees, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

Papers

Meeting papers shall be distributed to members and attendees at least five clear days prior to the meeting.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

The committee chair shall prepare a report of each committee meeting for submission to the board of directors at its next formal business meeting.

Review

These terms of reference shall be reviewed by the committee annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to approve all changes.

The next scheduled review of these terms of reference by the Board will take place in January 2019, in parallel with the next annual review of the effectiveness of the board of directors.

*** Definitions**

- In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Terms of reference
Name of governance body
Finance and Performance Committee (F&PC)
Constitution
The finance and performance committee ("the committee") is a standing committee of the board of directors. Finance and performance committee meetings should be formal and the Terms of Reference, membership and delegated powers should be approved by the Trust Board.
Accountability
The finance and performance committee is accountable to the board of directors, which holds it to account for its performance and effectiveness.
Authority
The committee is authorised by the board of directors to seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.
Purpose
The purpose of the committee is to assure the board of directors of: • Delivery of financial, operational and workforce performance plans and targets; and • Delivery of the trust's strategic initiatives. To provide this assurance the committee will maintain a detailed overview of: • The trust's assets and resources in relation to the achievement of its financial plans and key strategic objective four: financial sustainability; • The trust's operational performance in relation to the achievement of its activity plans and key strategic objective three: operational excellence; and • The trust's workforce profile in relation to the achievement of key performance indicators and key strategic objective five: organisational excellence. • Business planning assumptions, submissions and acceptance/delivery of targets To fulfil its purpose, the committee will also: • Identify the key issues and risks requiring discussion or decision by the board of directors; • Advise on appropriate mitigating actions; and • Make recommendations to the board as the amendment or modification of the trust's strategic initiatives in the light of changing circumstances or issues arising from implementation
Duties and responsibilities
Responsibilities On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of the trust's: • Monthly financial and operational performance • Estates strategy and maintenance programme • Information management and technology strategy, performance and development.

The committee will make recommendations to the board in relation to:

- Capital and other investment programmes
- Cost improvement plans
- Business development opportunities and business cases.

Duties

Financial and operational performance

- Review and challenge construction of operational and financial plans for the planning period as defined by the regulators.
- Review, interpret and challenge in-year financial and operational performance
- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment
- Oversee the development and delivery of any corrective actions plans and advise the board of directors accordingly
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the board of directors.
- Refer issues of quality or specific aspects of the quality and risk committee's remit, to the quality and risk committee and maintain communication between the two committees to provide joint assurance to the board of directors.

Estates and facilities strategy and maintenance programmes

- Review the delivery of the trust's estates and facilities strategy and planned maintenance programmes as agreed by the board of directors.
- Consider initiatives and review proposals for land and property development and transactions prior to submission to the board of directors for approval.

Information management and technology strategy, performance and development

- Review the delivery of the trust's IM&T strategy and planned development programmes as agreed by the board of directors.

Capital and other investment programmes& decisions

- Oversee the development, management and delivery of the trust's annual capital programme and other agreed investment programmes.

- Evaluate, scrutinise and approve the financial validity of individual significant investment decisions (that require Board approval), including the review of Outline and Full Business Cases. Business cases that require Board approval will be referred to the committee following initial review by the Executive Management Committee and/or Capital Planning Group.

Cost improvement plans

- To oversee the delivery of the trust's cost improvement plans and the development of associated efficiency and productivity programmes.

Business development opportunities and business cases

- Evaluate emerging opportunities on behalf of the board of directors.
- Consider the merit of developed business cases for new service developments and service disinvestments prior to submission to the board of directors for approval.

Chairmanship

The finance and performance committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

A second non-executive director shall be the deputy chairperson of the F&PC and shall chair meetings in the event that the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting.

Secretariat

The Executive Assistant to the Director of Finance and Performance shall be the secretary to the F&PC and shall provide administrative support and advice to the chairperson and membership. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the F&PC's work programme.

Membership

Members with voting rights

The following posts are entitled to membership of the Finance and performance committee and shall have full voting rights:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Chief Executive
- Director of Finance and Performance
- Director of Operations
- Director of HR and OD

Ex-officio members with voting rights

- The Director of Nursing
- Any other member of the board of directors or senior manager considered appropriate by the chair of the committee.

Unless defined within these terms of reference ex-officio members of the F&PC have all of the rights and privileges of membership, including the right to vote.

In attendance with no voting rights

- The following bodies shall be invited to nominate an ex-officio member of the F&PC to represent their interests:
    - Council of Governors
- The following post is invited to attend meetings of the F&PC but shall not be a member or have voting rights:
    - The Executive Assistant to the Director of Finance and Performance as secretariat

Quorum

For any meeting of the committee to proceed, two non-executive directors and one executive director of the trust must be present.

Attendance
Members are expected to attend all meetings or to send apologies at least 24 hours prior to each meeting.
Frequency of meetings
The committee will meet once in each calendar month, on the fourth Monday of the month. The chair of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.
Papers
Papers to be distributed to members and those in attendance at least three days in advance of the meeting.
Reporting
Minutes/a report of the meeting shall be prepared by the chairperson and secretary after every meeting and submitted to the Board of Directors at its next formal business meeting. Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.
Review
These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team for best practice advice and consistency. The next scheduled review of these terms of reference will take place in December 2018.

Terms of Reference

Name of governance body

Quality and Governance (Q&G) Committee

Constitution

The quality and governance committee ("the committee") is a standing and permanent sub-committee of the board of directors, established in accordance with the trust's standing orders, standing financial instructions and constitution.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The board of directors has delegated authority to the committee to take the following actions on its behalf:

- Approve specific policies and procedures relevant to the committee's purpose, responsibilities and duties
- Engage with the trust's auditors in cooperation with the audit committee
- Seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Purpose

The purpose of the committee is to assure the board of directors of:

- The quality and safety of clinical care delivered by the trust at either its hub site in East Grinstead or any other 'spoke' sites
- The management and mitigation of clinical risk
- The governance of the trust's clinical systems and processes.

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

- Health and safety
- Clinical and information governance
- Management of medicines and clinical devices
- Safeguarding
- Patient experience
- Infection control
- Research and development governance
- All associated policies and procedures.

To fulfil its purpose, the committee will also:

- Identify the key issues and risks requiring discussion or decision by the board of directors and advise on appropriate mitigating actions
- Make recommendations to the board about the amendment or modification of the trust's strategic initiatives in the light of changing circumstances or issues arising from implementation
- Work closely with the audit and finance and performance committees as necessary.

Responsibilities and duties

Responsibilities

On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of:

- the trust's performance against the three domains of quality; safety, effectiveness and patient experience.

- review all serious incident and never event root cause analysis investigations, ideally, prior to external submission to ensure assurance about the governance of the process and the appropriateness of actions and improvements identified. However, if timescales do not allow this the investigation report can be sent externally if it has been signed off by the Clinical Governance Group and reviewed by the chair of the Quality and Governance Committee.
- compliance with essential professional standards, established good practice and mandatory guidance including but not restricted to:

Duties

- Support the compilation of the trust's annual quality accounts recommend to the board of directors its submission to the Care Quality Commission
- Recommend quality priorities to the board of directors for adoption by the trust
- Ensure that the audit programme adequately addresses issues of relevance and any significant gaps in assurance
- To receive a quarterly report on healthcare acquired infections and resultant actions
- To receive and review bi-monthly integrated reports encompassing complaints, litigation, incidents and other patient experience activity
- To ensure that workforce issues, where they impact or have a direct relationship with quality of care are discussed and monitored
- Review bi-monthly quality components of the corporate risk register and assurance framework and make recommendations on areas requiring audit attention, to assist in ensuring that the trust's audit plans are properly focused on relevant aspects of the risk profile and on any significant gaps in the assurance
- Ensure that management processes are in place which provides assurance that the trust has taken appropriate action in response to relevant independent reports, government guidance, statutory instruments and ad hoc reports from enquiries and independent reviews
- Ensure there are clear lines of accountability for the overall quality and safety of clinical care and risk management
- Hold business units and directorates (clinical infrastructure/non clinical infrastructure) to account on all matters relating to quality, risk and governance.

Meetings

Meetings of the committee shall be formal, minuted and compliant with these terms of reference and the trust's relevant codes of conduct.

The committee will meet once every two months in the calendar month before the board. During the month where there is no formal committee meeting members of the committee will attend the local governance and departmental meeting of the key business units and clinical infrastructure to assess the clinical governance processes in place and to gain a deeper understanding of quality in the local services and departments. Members will provide formal feedback to each Q&GC on their observations of these meetings.

The Committee will have an additional meeting in July to receive the annual reports from the clinical groups which report to the Committee.

The chairperson of the committee may cancel, postpone or convene additional meetings as necessary

Chairmanship

The committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

If the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by one of the other non-executive director members of the committee.

Secretariat

The executive assistant to the director of nursing shall be the secretary to the committee and shall provide administrative support and advice to the chairperson and members. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the committee's work programme.

Membership

Members with voting rights

The following posts are entitled to permanent membership of the committee with full voting rights:

- x2 non-executive directors
- Chief Executive
- Director of Nursing
- Medical Director
- Deputy Director of Nursing
- Director of Finance
- Director of Operations
- Director of HR and Organisational Development.

Designated deputies (as described below) are entitled to temporary membership of the committee with full voting rights.

Ex-officio members

The following bodies shall be invited to nominate an ex-officio member of the committee to represent their interests:

Without voting rights

- Council of Governors of Queen Victoria Hospital NHS Foundation Trust: The chairperson, members of the committee and the governor representative shall commit to work together according to the principles established by the trust's policy for engagement between the board of directors and council of governors.
- The trust's internal auditor
- Clinical Commissioning Group (CCG) – principle commissioner of the trust's services

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the committee in full or in part but shall not be a member or have voting rights:

- The secretary to the committee (for the purposes described above)
- Business managers
- Allied health professional lead
- Infection control lead
- Head of quality and compliance
- Head of risk
- Patient experience lead
- Pharmacy lead
- Director of Communications & Corporate Affairs
- Audit and outcomes lead

Quorum

For any meeting of the committee to proceed, the following combination of members must be present:

- one non-executive director
- either the director of nursing or deputy director of nursing
- one other director with voting rights four members without voting rights.

Attendance

Members are expected to attend all meetings or to send apologies to the chair and committee secretary at least one clear day* prior to each meeting.

Applicable members may, by exception and with the consent of the chair, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on the behalf of the committee member.

Papers

Meeting papers shall be distributed to committee members and individuals invited to attend committee meetings at least five clear days* prior to the meeting.

In the event of a significant adverse variance in any of the key indicators of clinical performance or patient safety, the responsible executive director will make an immediate report to the committee chairperson copied to the trust chair and chief executive, for urgent discussion at the next meeting of the committee and escalation to the trust board.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

Minutes of committee meetings to be sent to all non-executive directors and the Chair to provide an assurance report to the board of directors at its next formal business meeting.

Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.

Final and approved minutes of committee meetings shall be shared with the clinical cabinet and a quarterly update from the committee chairperson shall be provided to the audit committee.

The committee chairperson and governor representative to the committee shall report verbally at quarterly meetings of the council of governors.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to approve all changes.

The next scheduled review of these terms of reference will take place in December 2018

* Definitions

- In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Report to:	Board of Directors
Meeting date:	04 January 2018
Reference number:	26-18
Report from:	Beryl Hobson, Chair
Author:	Beryl Hobson, Chair
Appendices:	N/A
Report date:	20 December 2017

Nomination and Remuneration committee

The committee met in November and discussed the following:

1. The committee's terms of reference – there were some minor amendments (eg changes to job titles) and frequency of meetings (from 4 times pa to 3 times) – subject to this the Terms of Reference were recommended for approval.

2. The committee accepted a proposed work plan for its work

3. Senior Managers Pay Strategy – the committee agreed that in the view of recent guidance from NHSI we should consider the national strategy in setting senior manager pay. This would replace any principles previously agreed by the committee regarding VSM pay and would take account of the outcome of annual appraisals conducted by the CEO (or Chair in the case of the CEO pay)
    - The level of the national pay award for the workforce on Agenda for Change
    - Any extenuating circumstances/market conditions highlighted by the CEO
    - Updated benchmarking information and guidance

4. The committee confirmed the appointment and salary of Michelle Miles as Finance Director

5. The committee confirmed the appointment and salary of Geraldine Opreshko as Director of Workforce.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**4 January 2018**		**Agenda reference:**	**27-18**	
Report title:	**Audit Committee**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	NA				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the Audit Committee meeting on 13 December 2017				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Purpose:	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				

Report to: Board of Directors
Meeting date: 4 January 2018
Reference number: 20-18
Report from: Kevin Gould, Chair
Author: Kevin Gould, Chair
Appendices: A: Self assessment assurance report
Report date: 21 December 2017

Audit Committee assurance report

Meeting held on 13 December 2017

1. The committee received the results of the Audit committee effectiveness survey, the details of which are covered in appendix A of this report. Based on the actions agreed, the committee is to recommend to the board that no changes to the Terms of Reference are required.

2. The committee received assurance from the Acting Director of Finance and Performance on the processes in place to identify, measure and manage risks in relation to KSO4 (Financial Sustainability). The Chair of the Finance & Performance committee added his perspective in relation to the assurance that committee received in relation to KSO4.

3. The BAF for KSO4 was reviewed as a result, and some potential minor modifications, including a review of the Risk Ratings, were discussed. It was noted that the Trust's ability to achieve its control total for this year and in for future years remains a risk over which full assurance cannot be provided.

4. The Corporate Risk Register was reviewed, in particular in relation to KSO4.

5. KPMG presented their plan for the 2017/18 audit, which was approved by the committee. They also provided a technical update.

6. Mazars advised that two internal audit reports have been issued since the last meeting. Both are rated "Satisfactory" and no Priority 1 recommendations were raised. Internal Audit's KPIs have all been met for the current year. The 2017/18 plan is 59% complete (at 30 November).

7. The committee received a report on the progress of counter fraud activity.

8. The committee received an enhanced report of outstanding Internal Audit and Counter Fraud recommendations, which gives better information about the outstanding issues. . Continued progress in closing issues by the Trust and Mazars was noted.

9. The committee reviewed a report on breaches of Conflict of Interest, and was assured that action taken in respect of the only potential breach was appropriate.

There were no other items requiring the attention of the Board.

Appendix A

Audit committee self-assessment 2017

Results

- There were 8 responses – 3 non-execs, 3 execs and 2 auditors
- I have not appended all the responses in the interests of brevity, but they are available on request
- Average scores are not always meaningful as some responses gave a yes/no response.
- On review by Kevin Gould, Jason McIntyre, and Hilary Saunders, a number of themes were identified based on both scores and comments. It should be noted that these themes are still coming from a minority of respondents (ie are not universal concerns) but we felt could be usually addressed to further enhance the role of the committee.

Themes

- Role of committee
    - Risk, BAF and risk register
    - Regulatory requirements
    - Clinical audit
- Understanding of risk appetite, focus on risk trends and split of time between focusing on risk identification/assessment effectiveness of the risk management framework itself
- Unusually high attendance and length of meetings
- Usefulness of private meetings with auditors
- Completeness of assurance coverage
- Internal audit reports to the committee

Recommendations & Discussion Points

- The committee currently receives a report on one KSO at each meeting from the executive owner. It is proposed that this discussion be expanded to include:
    - Assurance received by other committees (Finance & Performance (F&P) and Quality & Governance (Q&G)) – this would replace the current more general report from these committees
    - Internal (and, if relevant, external) audit assurance relating to that KSO
    - Relevant items from the Corporate Risk Register – this would replace the current more general review of the risk register (which is already reviewed at board and Q&G)
    - Any relevant reports from other assurance providers

  The committee will then consider whether the BAF for the KSO is current, relevant and complete, whether there are any significant gaps in assurance. This will provide more complete assurance around integrated governance, risk management (both the identification/assessment effectiveness of the risk management framework) and internal control to the board.

- The committee should discuss challenges in understanding of risk appetite and focus on risk trends, and determine what addition actions are needed.

- Clinical audit is in the remit of the Audit Committee but is not currently on the workplan. There is a clear expectation that it is considered by the Audit Committee (NHS Audit Committee Handbook). Q&G's terms of reference currently required it to "Ensure that the audit programme

adequately addresses issues of relevance and any significant gaps in assurance". Relevant audit reports are received by Q&G. This clearly aligns to Q&G's core purpose and care should be taken to avoid duplication. It is therefore proposed that clinical audit is considered by the audit committee as part of its review of assurance over KSO2 (World Class Clinical Services). This will include:

  - Reviewing the annual clinical audit plan and the planning process.
  - A summary of reports and actions taken as a result.
  - The completeness of coverage of clinical risks.

- The Committee's terms of reference appropriately defines attendance requirements, but this has grown in practice. Going forward it is recommended that the attendance requirements for each item are set out when the agenda is planned.

- It is recommended that private meetings with auditors are rotated so the internal and external audit meeting committee members at alternate meetings. It should be stressed that this does not affect the committee's willingness to discuss and matters which need to be brought to its attention during or outside formal meetings.

- The format of internal audit reports to the committee have been discussed between the chair and Mazars. Proposed changes will be discussed during the Internal Audit update. Some changes have been made immediately and are reflected at this meeting; others require implementation of the new audit report format (which more clearly articulated the assurance gained as well as issues).

Other matters - Whistleblowing

- A question was raised at the September meeting about the committee's role relating to whistleblowing, and this potentially relates to the theme around the committee's role.

- The terms of reference clearly articulates the committee's role in reviewing the effectiveness of whistleblowing arrangements. In doing so, the committee not only needs to understand the arrangements in place, but be assured that they are operating effectively with appropriate action and follow-up, and that any themes are addressed. This is likely to require review of specific cases. This may overlap with Q&G activity, as, although whistleblowing is not included in its terms of reference, matters raised by whistleblowing will clearly impact areas covered by Q&G.

- The audit committee should, at least annually, review whistleblowing processes, including the follow-up of cases, to confirm effectiveness. It has also been suggested that there should be a process to assess the effectiveness of, and themes arising from, whistleblowing, counter-fraud, speak-up guardian reports, and any other relevant sources taken together.