Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 3 May 2018

Session in public at 09.00

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

Queen Victoria Hospital
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 3 May 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 (apologies)
Deputy Medical Director	-	Rachael Liebmann
Director of Nursing	-	Jo Thomas
Director of Finance and Performance	-	Michelle Miles

In full attendance (non-voting):

Interim Director of service improvement	-	Mark Henry
Director of Workforce & OD	-	Geraldine Opreshko
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary	-	Hilary Saunders
Lead Governor	-	John Belsey

Annual declarations by directors 2018/19

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 Deputy 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 Director of Longmeadow Views Management Company	Part owner of Professional Governance Services Ltd		Nil	PGS clients include health charities, including a Royal College and a health based livery company. PGS has also recently undertaken work for a charity in East Grinstead	Not as far as I am aware	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 and Deputy Chair for The Chartered Institute of Environmental Health • Independent member of the Board of Governors at Staffordshire University	Nil	Nil	Nil

Gary Needle Non-Executive Director	1. Director, Gary Needle Ltd, (management consultancy) 2. Director, T& G Property Ltd (residential property development)	Chair of Board of Trustees at East Grinstead Sports Club Ltd (registered sport and lifestyle activities charity)	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
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Rachael Liebmann Deputy Medical Director	Nil	Nil	Nil	Trustee, Royal College of Pathologists	Castle Point and Rochford CCG secondary care clinician and TMC Medical Advisor		Spouse: • COO UNICEF UK • Trustee Royal College of Paediatrics & Child Health • Chair of Board of Trustees 1st Place Children and Parents' Centre Ltd, Southward • Board member University of Sussex
Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Ed Pickles Medical Director	Nil	Nil	Nil	Nil	I am a member of EGAS (East Grinstead Anaesthetic Services). A partnership of QVH anaesthetic consultants who, in addition to their NHS work, also provide some private perioperative and anaesthetic care to patients in several local independent hospitals. These patients may be privately insured, self-funded or as part of an NHS contract in the independent sector	Nil	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Mark Henry Interim Director of service improvement	Nil	Managing Director JMatch Ltd, Healthcare Improvement Consultancy/practitioner	Managing Director JMatch Ltd	Nil	Nil	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 Councillor, Mid Sussex District Council	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
Rachael Liebmann Deputy Medical Director	NA	NA	NA	NA	NA	NA	NA

Michelle Miles Director of Finance	NA	NA	NA	NA	NA	NA	NA
Ed Pickles Medical Director	NA	NA	NA	NA	NA	NA	NA
Jo Thomas Director of Nursing	NA	NA	NA	NA	NA	NA	NA
Other members of the board (non-voting)							
Mark Henry Interim Director of service improvement	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

Business meeting of the Board of Directors
Thursday 3 May 2018
09:00 – 13:00
The Archie McIndoe board room, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
59-18	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
60-18	**Draft minutes of the meeting session held in public on 1 March 2018** *Beryl Hobson, Chair*	*Approval*	1
61-18	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	9
62-18	**Chief executive's report (including BAF overview)** *Steve Jenkin, Chief Executive*	*Assurance*	11
63-18	**Freedom to speak up update** *Andi Heaton, FTSU guardian*	*Information*	16
Key strategic objective 1: outstanding patient experience			
64-18	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	*Assurance*	21
65-18	**Corporate risk register (CRR)** *Jo Thomas, Director of Nursing*	*Review*	22
66-18	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	43
67-18	**Quality and safety report** *Jo Thomas, Director of Nursing*	*Assurance*	50
68-18	**Bi-annual nursing workforce review** *Jo Thomas, Director of Nursing*	*Assurance*	84
69-18	**National inpatient survey results** *Jo Thomas, Director of Nursing*	*Information*	98

Key strategic objective 2: world-class clinical services			
70-18	**Board Assurance Framework** *Rachael Liebmann, Deputy Medical Director*	*Assurance*	110
71-18	**Medical director's report** *Rachael Liebmann, Deputy Medical Director*	*Assurance*	111
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
72-18	**Board Assurance Framework** *Mark Henry, interim Director of service improvement, and* *Michelle Miles, Director of Finance*	*Assurance*	115
73-18	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	*Assurance*	117
74-18	**Operational performance** *Mark Henry, interim Director of service improvement*	*Assurance*	120
75-18	**Financial performance** *Michelle Miles, Director of Finance*	*Assurance*	150
76-18	**Ratification of 2018/19 business planning process** *Michelle Miles, Director of Finance*	*Approval*	163
Key strategic objective 5: organisational excellence			
77-18	**Board assurance framework** *Geraldine Opreshko, Director of Workforce & OD*	*Assurance*	191
78-18	**Workforce monthly report** *Geraldine Opreshko, Director of Workforce & OD*	*Assurance*	192
Board governance			
79-18	**Leadership and governance developmental review** *Clare Pirie, Director of communications and corporate affairs*	*Assurance*	206
80-18	**QVH Self-certification 2018** *Clare Pirie, Director of communications and corporate affairs*	*Approval*	239
81-18	**Audit committee** *Kevin Gould, Chair*	*Assurance*	243
82-18	**Board of Director annual declarations** *Clare Pirie, Director of communications and corporate affairs*	*Assurance*	-
Any other business (by application to the Chair)			
83-18	*Beryl Hobson, Chair*	*Discussion*	-

Observations and feedback			
	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: **Public**: 05 July 2018 at 10:00	**Sub-Committees** **N&R:** 17 May 2018 **Audit**: 21 May 2018 (AR&A/C approval) **F&P:** 29 May 2018 **Charity:** 14 June 2018 **Audit:** 20 June 2018 **Q&G:** 21 June 2018	**Council of Governors** **Public**: 30 July 2018 at 16:00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 1 March 2018, 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
	Michelle Miles (MM)	Director of Finance and performance (voting)
	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)
	John Thornton (JT)	Non-Executive Director (voting)
In attendance:	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
	John Belsey (JEB)	Lead Governor
	Andi Heaton (AH)	FTSU Guardian [items 34-39]
Public gallery:	Two, including one public governor and one member of staff	

Welcome

34-18 **Welcome, apologies and declarations of interest**

The Chair opened the meeting and welcomed MM to her first meeting as Director of Finance.

Under Declarations of Interest, SLJ asked the Board to note that her spouse was currently employed by Astra Zeneca on a temporary contract.

There were no apologies.

JEB asked the Board to note that at its meeting on 15 January, the Council of Governors had appointed BH for a second three-year term as chair, with effect from 01 April 2018.

Standing items

35-18 **Patient story**

JMT explained that on this occasion it had not been possible to identify a patient for this session. However, as part of overall patient experience feedback, she felt it appropriate to draw to the Board's attention the diligence of those QVH staff who had gone the extra mile to ensure safety and continuity of care for patients during the recent inclement weather. BH asked that the Board's thanks be conveyed to the many staff involved.

36-18 **Draft minutes of the meeting session held in public on 4 January 2018**

The minutes of the meeting held on 4 January were **APPROVED** as a correct record.

37-18 **Matters arising and actions pending**

The Board received and approved the current record of matters arising and actions pending.

38-18 **Chief executive's report (including BAF overview)**

SJ presented his regular update focusing on Trust issues and also the wider sector and national issues. Those areas of the report to which he drew particular attention included:

- A welcome to MM to QVH as Director of Finance and performance. SJ also thanked Jason McIntyre who had taken on the Acting Director of Finance role for a number of months prior to Michelle's start date;
- SLJ had decided to take early retirement after 35 years in the NHS and would leave QVH next month. SJ noted that SLJ had overseen steady growth in activity during her three years at QVH and expressed his gratitude for her leadership during this time. Interviews for her replacement were already scheduled; in the meantime, Mark Henry had joined us as Interim Director of Service Improvement;

	• The excellent work undertaken by the Communications team achieving positive regional and national media coverage;
	• Dr Emma Worrell, principal MaxFacs prosthetist had been awarded the Rising Star Award at the National Institute for Health Research Clinical Research Network Kent, Surrey and Sussex Awards;
	• As required by the regulator, QVH had undertaken an external 'well led' review of its governance. The Board had received the initial findings of the review process in February; the final report would be available later this month;
	• SJ expressed his gratitude to the League of Friends which had agreed to fund the purchase of a CT (Computerised Tomography) scanner. This would enable swift diagnosis and improve patient experience. Commissioners had expressed their support and it was hoped that this should be in place by the summer;
	• With regard to the BAF overview, SJ drew particular attention to the following:
	  • The KSO 4 Financial Sustainability current risk rating which in January had been increased to 20. Whilst the Trust was now currently forecasting to achieve plan by the end of the financial year, there were still risks, not least of which was the impact of the current inclement weather;
	  • Workforce challenges remained a concern, and the KSO5 BAF risk rating had been adjusted accordingly;
	• Proposals are being considered for all accountable officers to form part of the executive team for the Sussex and East Surrey sustainability and transformation partnership (STP), and meet monthly. Concern remained with regard to the current STP financial deficit;
	• Key headlines from the NHS Improvement Q3 publication of providers finance and performance included:
	  • That a significant number of patients had attended A&E in December, compared to 2016;
	  • The provider sector was forecasting a deficit of £931 million by the end of 2017/18, (£435 million worse than originally predicted);
	  • NHSI workforce data showed the scale of the workforce challenge facing providers. Whilst QVH continued to explore creative solutions, these vacancies would continue to impact on provider performance.
	
	The Board sought and received clarification in respect of the following:
	• Due to the timings of the Finance and performance committee this week, the revised BAF risk rating was not reflected in this board report;
	• Data indicated that QVH was an outlier regarding the current vacancy levels. However, JMT noted that most vacancies were shown as a total percentage, and could give a misleading picture if comparing QVH to larger acute trusts. JMT agreed to check the feasibility of providing a more accurate representation (with the proviso that other trusts would be willing to share a breakdown of their vacancies) **[Action: JMT]**
	• The Board expressed concern with regard to the current financial deficit within the Sussex and East Surrey STP and cautioned against short-term solutions approach, urging QVH instead to advocate a more strategic approach. BH agreed to circulate new STP governance proposals once they were available **[Action: BH]**
	
	There were no further comments and the Board **NOTED** the contents of the update.

39-18	**Freedom to speak up (FTSU) update** AH had provided a written update on FTSU Guardian role activity since her last briefing in November 2017, and providing an overview of plans and ideas for the next stage. She opened by thanking the Board for approving the increase in hours for this role (from half to one full day per week) and asked members if they had any questions regarding the latest update. These were as follows: • A request for future reporting to include comparative data in order to identify any trends; • Confirmation that the increase in hours for the FTSU role now enabled AH to respond to concerns within 24 hours; • Assurance of a high rate of staff awareness of this role, which had been communicated through all internal communication channels. SJ noted that the representative of the national guardian's office had been impressed by AH's high visibility within the Trust, during a recent visit; • The Board queried whether any there had been any tangible changes resulting from the 10 'speak ups' recorded within the report. AH explained that her role was not to investigate but to bring concerns to the attention of those who could. However, feedback obtained through anonymous surveys indicated that whilst staff had previously not felt heard, they were now much more familiar with the idea of speaking up.

	• Since her last update to the Board, AH reported that there had been no resistance from those managers she approached to discuss potential issues; There were no further queries and the Chair thanked AH for her update, the contents of which were **NOTED** by the Board.
Key strategic objective 1: outstanding patient experience	
40-18	**Board Assurance Framework (BAF)** JMT presented the latest BAF for KSO1. This reiterated concerns with vacancies within theatres and critical care, but these now also included Canadian Wing. Data was triangulated to ensure maintenance of a good patient experience, but JMT noted that it was now much harder to recruit and retain staff to C-Wing than previously. Given the current situation, the Board sought confirmation that the residual risk rating of 9 remained appropriate. JMT gave assurance that the BAF was reviewed on a monthly basis by the Executive Management Team, and that the current rating was still deemed to be correct. The Board went on to discuss the status of the long term strategy for the Trust's paediatric burns inpatient service. Members of the executive provided the following updates: • A meeting to progress the Memorandum of Understanding with Brighton had been postponed but plans were in place to arrange a series of monthly meetings. • It was anticipated that a Darzi Fellow would join QVH in April; this appointment help us progress the strategy, (together with the support of a programme manager); • the Trust could clearly demonstrate that it had made every effort to progress and maintain channels of communication but progress has been limited; • Increasing focus on the compliance of Brighton's major trauma centre would likely accelerate progress, with EP noting that a shift in emphasis was already apparent. In the meantime, the Board was reminded that paediatric inpatient burns services at QVH continued to be commissioned and were still deemed to be safe (with agreed derogation against certain defined standards). There were no concerns regarding paediatric transfers, and mitigation was in place for identified risks. EP agreed to provide regular updates on progress through his Medical Director report with effect from May. **[Action: EP]** There were no further questions and the Board **NOTED** the content of the KSO1 BAF.
41-18	**Corporate risk register (CRR)** JMT presented the latest CRR, asking the Board to note key changes from the previous report which included: • The addition of five new corporate risks, (although noting that the risk relating to the Apprenticeship Levy Impact would now be removed); • Four risks had been reviewed and re-scored, and • One risk had been closed. The Board sought and received assurance in respect of the following: • MM and EP were working together to address the issue relating to ID 1096 (inappropriate storage facilities for special gases); • Additional clarification would be provided with regard to the residual risk rating. (KG would clarify with the Head of Risk Management at the next Audit committee meeting). • With regard to ID 1095 (inability to provide full pharmacy services due to vacancies), JMT explained that due to the departure of a senior pharmacist the Head of Pharmacy had raised this as an issue, but that mitigations were in place and recruitment underway to fill current vacancies. She went on to assure the Board that in the context of a national focus on medical prescribing errors, QVH was able to demonstrate good reporting on and learning from errors, through the quality and safety report. There were no further questions and the Board **NOTED** the contents of the latest CRR.

42-18	**Quality and governance assurance report** GC presented her assurance report, highlighting the progress of a number of internal investigations. The RCA for the Never Event, (relating to wrong side block) had been submitted to the CCG, and was awaiting sign off. The Board sought assurance in respect of the latest Infection control quarterly report, where recent audits, following introduction of new standards for cleanliness, had resulted in low scores. JMT explained that the expectations of the recently appointed Head of Facilities were more ambitious those held previously and it was anticipated that improvements in scores would be seen in the next report. There were no further questions and the Board **NOTED** the contents of the assurance report.
43-18	**Quality and safety report** JMT presented the latest Quality and Safety report which covered the safe staffing, workforce and patient experience reports. She continued by asking the Board to agreed the following three Quality Report (QR) priorities for 2018/19: 1. Patient Safety: measurement of compliance with the WHO surgical safety checklist 2. Clinical Effectiveness: increased theatre productivity 3. Patient experience: improved clinician communication and customer care expectations The Board sought clarification as to how the Clinical Effectiveness and Patient Experience priorities would be measured. JMT concurred that these were ambitious projects with a broad scope, and noted that there had already been much discussion on how best to measure progress. Work was currently underway on developing baseline metrics with a trajectory of quarterly improvement, which would ensure that intended benefits could be realised and evidenced. JMT assured the Board that progress against achievement of the QR priorities would be monitored by the Quality and Governance Committee on a quarterly basis, ensuring oversight and scrutiny around delivery. After due consideration, the Board **AGREED** the three Quality Report priorities for 2018/19, with the proviso that appropriate metrics would be developed to accurately assess progress. JMT went on to request the Board consider a proposal for changes in future Patient Experience reporting. This would comprise a refined version of the full report showing headline metrics, the details of which would continue to be reported to the Quality and governance committee. The new format would also include *'you said, we did….'* examples which would evidence learning. JMT assured the Board that it would still have sight of the full report via the Q&GC reporting mechanism, however, it was hoped that the new streamlined version would better protect patient confidentiality. The Board agreed to trial the new format from May 2018, and re-evaluate in September 2018. **[Action: JMT]** There were no further questions and the Board **NOTED** the contents of the update.
Key strategic objective 2: world-class clinical services	
44-18	**Board Assurance Framework** EP presented the latest BAF for KSO2. Whilst no changes had been made to either current or residual risk ratings, he asked the Board to note the addition of: • Culture of safe and collaborative practice (*rationale for current score*), and • Detailed partnership agreement with acute hospital (*gaps in controls and assurances*). There were no further questions and the Board **NOTED** the contents of the latest KSO2 update
45-18	**Medical Director's report** EP presented the latest Medical Director report to the Board. Highlights included: • Exception reporting by junior doctors of disrupted educational opportunities appeared better utilised since the rotation of junior doctors in February; • The excellent performance of the Clinical Research department in recruiting patients to national portfolio studies in 2017/18 had been recognised. The Trust's funding allocation from the Kent, Surrey, Sussex Clinical Research Network would be increased by around 15% in recognition of this. The Board proposed that members of the Clinical Research department should be invited to attend a future Board seminar

	[Action: EP]. • As reported previously, three new substantive consultant appointments had been made in anaesthetics. Whilst one appointment was already in post, EP cautioned that anaesthetic consultant staffing would be challenging until the remaining two appointments joined the Trust in the Spring; • Ken Sim, Consultant Anaesthetist, would be retiring in April. EP noted that in his 22 year consultant career Ken had held various leadership roles at QVH and he would be missed for his wealth of experience, wisdom and wit. The Board thanked him for his considerable contribution to the Trust. • Mark Pickford would shortly step down as Clinical Director for Plastic Surgery, and EP acknowledged his leadership over the last four years. Martin Jones had been appointed as his successor, with EP noting that Martin was a well respected colleague, whose skills would be particularly welcome as we continued to improve training for our junior doctors. The Board sought and received assurance with regard to the Clinical Director recruitment process, with SJ underlining the requirement for candidates to demonstrate a clear understanding of the breadth of the role. • SJ also reminded the Board that EP was due to start the King's Fund Senior Clinical Leaders Programme this month, and noted the programme's aims resonated strongly with our current internal and regional challenges. SJ reminded the Board that this was also a clear demonstration of the Trust's determination to invest in clinical staff. There were no further questions and the Board **NOTED** the contents of the Medical Director's report.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
46-18	**Board Assurance Framework** SLJ reported that the current risk rating remained at 20, with the residual risk rating at 15. Additional controls and assurance to mitigate risk included: • The approval of additional validator funding; • The business manager for spoke sites and access was now in post and would focus support on Appointments, Outpatients and access services. In addition, new Performance and Access & cancer data managers had now been recruited (as the Board was aware, both posts had been vacant for some time); • QVH had arranged for some patients to be treated by Horder Healthcare in order to ensure timely treatment, further work on this was planned. The BAF had been discussed in detail at the Finance and performance committee (F&PC) meeting earlier in the week. The Board also noted that the forthcoming change in Operations Director could impact on the current position. MM advised that she had not made any changes to the KSO4 BAF on this occasion. The residual risk rating had been discussed at F&PC in detail, but MM confirmed she intended to maintain a watching brief at present. In the meantime, she advised that next steps would focus on structure and systems, with a view to introducing enhanced cost control in the new financial year. There were no further questions and the Board **NOTED** the contents of KSO3 and KSO4 BAF updates. .
47-18	**Financial and operational performance assurance report** Given the tight reporting deadlines this month, it had not been possible for JT to include written assurance within the Board papers. He had, however, prepared a report the contents of which would be circulated with the draft Board minutes. In the meantime, he asked the Board to note the following: • Operational performance: The 18W RTT target had further deteriorated and was unlikely to improve quickly, particularly as theatre nurse vacancies are increasing month on month. A long discussion had taken place at F&PC at which assurance was sought that causes were understood and actions being taken. Actions included recruitment of theatre staff; outsourcing of work to Horder Healthcare, and recognition of the need to be more selective in respect of the type of work we accepted in future. The Trust had also been offered support from NHSI to review its processes. Given the concerns expressed by CCGs regarding performance, the Committee had also agreed to share action plans with them. In the meantime, the Committee would be provided with updated trajectories for the expected improvement in the position.

	• Workforce: The Committee had agreed that the main workforce issue remained turnover of staff in key roles, (particularly theatres) coupled with difficulties in recruiting, which impacted all aspects of performance. GO had been asked to provide progress updates against the recruitment and retention plan, to give assurance as to when the Trust could hope to return to more acceptable levels of staff. • Finance: Financial performance in January was below plan. It was still hoped that the Trust could meet its control total but the impacts of the current bad weather was not known at this stage. Concern had been raised regarding an overspend in clinical supplies (£524k), despite clinical income being significantly below plan. Expenditure would be tightly monitored and a stock audit undertaken at year end. • Business planning: The Committee had considered the timetable for the planning process and the progress to date. Last year QVH had agreed a two year plan which had helped formulate this year's control total. Although this seemed relatively modest, it would require a Cost Improvement and Productivity Programme (CIPP) of 5% which would be very challenging. At present the intention was for the Trust to accept the 2018/19 control total target. BH commended the 2018/19 business planning paper. There were no further comments or questions and the Board **NOTED** the contents of the F&PC assurance update.
48-18	**Operational performance** The main elements of the operational performance report had already been discussed throughout today's meeting, however the Board sought additional clarification of the following: • The governance in place for patients whose treatment had been outsourced by the Trust to Horder Healthcare. SLJ confirmed that whilst the activity belonged to QVH, Horder would be accountable for any patient experience concerns. The executive team were confident of the strong working relationships between QVH and Horder staff, and felt that any potential issues would be managed appropriately; • The concerns with the increasing number of theatre nursing vacancies was stressed and the impact on the 18wk RTT target; SLJ went on to describe how addressing the problems within MaxFacs would have a positive impact on remaining services; • Implementation of new Standard Operating Procedures should address difficulties experienced within Appointments. However, SLJ cautioned that this was a transformational programme and would require engagement by all staff affected by the changes. A draft set would be ready by 31 March and these would then be piloted for 4-6 weeks with final amendments made following the pilot period. • Concern was raised that in order to achieve the 18 RTT Open Pathway Target, Plastics performance might see improvements to the detriment of MaxFacs. SLJ conceded that both services required theatre time, but explained that they also both required nursing and anaesthetic support. The Board debated the likelihood of introducing a third session (evening working). In terms of managing costs it would be more beneficial to extend the working day rather than opt for 7-day services; however, it was acknowledged that regardless of enthusiasm, it was not feasible to build this into the current round of job planning and the current level of theatre nursing vacancies also means this is not currently possible. • SJ noted that NHSI did not anticipate any 52-week breaches beyond 31 March. With this in mind, he requested revised trajectories be prepared for the next Finance and performance committee meeting and asked that these should set out worst case/good case/best case scenarios. **[Action: SLJ]** There were no further comments and the Board **NOTED** the contents of operational performance update.

49-18	**Financial performance**
	MM provided an overview of the financial performance of the Trust, key points of which included:
	• Summary position: The Trust delivered a deficit of £72k in month, which was £258k below plan. The year to date (YTD) surplus had now decreased to £1,261k, (£235k behind plan). MM explained that removing the Sustainability Transformation Funding (STF) would give a clearer picture (£68k variance to plan). She went on to report:
	  • Pay expenditure was overspent by £83k; this had decreased the YTD underspend by £602k.
	  • As reported under item 47-18, clinical supplies had overspent by £524k;
	  • Financing was underspent by £238k (due to depreciation);
	  • The Finance use of resources rating remained at 2;
	• CIPP: Next year's focus would be on cost reduction, rather than dependency on income (as in previous years), and the Trust was continuing to explore additional opportunities in preparation for next year's Cost Improvement and Productivity Programme (CIPP);
	• Capital: The full year forecast was £3.15m which was below plan due to unused contingency. MM assured the Board that efforts were being made to ensure an earlier lead in time to next year's capital

	programme; • Creditors: There had been a slight increase due to a number of the invoices on the ledger awaiting authorisation. • Debtors: There had been a 3% increase in the Debtors balance. MM agreed to report back to F&PC how much of this was historic **[Action: MM]** • Cash: MM stated that she was less concerned about the creditor/debtor position give current liquidity and debt service rations, and noted that cash balances were forecast to remain above or in line with plan for the remainder of this financial year. MM concluded by reiterating that the Trust was forecasting to achieve plan by the end of the year. However, this was subject to the following: • Successful resolution of the recently highlighted issue relating to Post Graduate Medical Education income; • No further deterioration of clinical income performance; • Successful delivery of: • CQUINs in line with year to date performance; • CIPP delivery in line with forecast • Sustainability and Transformation Funding • Planned interventions The Board went on to discuss several aspects of the report, seeking additional clarification in respect of the following: • Given the substantial underperformance by the Plastics business unit this year, assurance was sought that the incoming clinical director would be given appropriate support. MM confirmed she was comparing data from the first half of the year against the second half to identify how income had been impacted by sickness absence within plastics. She would report her findings back to the Board in due course **[Action: MM]** • Given that in principle the Trust planned to accept its 2018/19 control total, how certain was it of its demand and capacity levels? MM reminded the Board that the deadline for the final submission was 30 April. Whilst there was still much work to do, data on activity, workforce and finance would be triangulated to ascertain the feasibility of achieving the control total in time for the deadline. Again, Board members were reminded of their invitation to join in with discussions at forthcoming F&PC meetings; • Given that next year's CIPP target of 5% was very ambitious, on which areas would the Trust focus to achieve this? MM advised that these currently included procurement; contract review, establishment figures and back office function. • The differentiation between 'agency cap' and 'agency ceiling', which had separate impacts. It was also agreed that the Trust should focus on agency savings for corporate rather than frontline staff. There were no further comments and the Board **NOTED** the contents of financial update.
50-18	**Delegation of authority** In order to meet the requirements of the 2018/19 business planning timetable, the Board considered a proposal for the Finance and performance committee to have delegated authority to approve the Trust's submission of its annual plan to the regulator. After due consideration, the Board **APPROVED** the proposal, noting that, as in previous years, all members of the Board would be invited to attend the F&PC meeting on Monday 23rd April to participate in discussions if required.
Key strategic objective 5: organisational excellence	
51-18	**Board Assurance Framework** GO asked the Board to note that although this was not shown correctly on the current BAF, the KSO5 current risk rating had increased from 16 to 20 as a result of the likelihood of having insufficient substantive staff in theatres to support productivity and meet the Trust's RTT targets. (GO also asked the Board to note that the date on the current BAF should be February 2018 and not December 2017) There were no further comments and the Board **NOTED** the contents of KSO5 BAF update.
52-18	**Workforce monthly report** GO presented the latest workforce update, asking the Board to note in particular the following:

	• Whilst data indicated that sickness had decreased, with a reduction in both long and short term sickness, GO felt these figures appeared low, given anecdotal reports of sickness in December. Workforce teams were checking to ensure all sickness and absence episodes had been correctly recorded; • Bank usage had increased. GO suggested this could be as a result of the new pay incentives which had come into effect recently, but also noted that changes in recording these shifts on 'Healthroster' could also explain the increase. GO went on to describe a consultation which was being led by Health Education England (HEE), entitled 'Facing the Facts, Shaping the Future'. This was a draft health and social care workforce strategy for England outlining why the NHS required a strategy and suggesting actions which might increase capacity and capability. (An overview was attached as an appendix). There were no further comments and the Board **NOTED** the contents of latest Workforce update.
Board governance	
53-18	**Nomination and remuneration committee** The Board **NOTED** the contents of the Chair's report on the recent Nomination and remuneration meeting.
Any other business	
54-18	As referenced in the Chief Executive's earlier update, SLJ had recently announced she would be retiring in April after 35 year's service in the NHS. The Chair noted that this would be SLJ's last public board meeting and thanked her for everything she had achieved for QVH in her three years as operations director, whilst wishing her all the best in her retirement.

Chair …… Date …….

Matters arising and actions pending from previous meetings of the Board of Directors									
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**CATEGORY**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
1	March 2018	38-18	Chief Executive's report	Standing items	JMT to aim to gain a more accurate representation of vacancy position at other local providers, dependent on trusts being willing to share vacancy data.	JMT	May		**Pending**
2	March 2018	38-18	Chief Executive's report	Standing items	New proposed STP governance arrangements to be circulated once available.	BH	July	Will be included in July board report	**Pending**
3	March 2018	40-18	KSO1 BAF	KSO1	Regular updates on paediatric service strategy to be provided through Medical Director report with effect from May	EP	May	Contained within May board report	**Complete**
4	March 2018	43-18	Quality and safety report	KSO1	New revised streamlined patient experience report to be trialled from May 2018, with board evaluation scheduled for September 2018	JMT	Sept		**Pending**
5	March 2018	45-18	Medical Director's report	KSO2	Members of Clinical Research department to be invited to present at future Board seminar	EP	TBA		**Pending**
6	March 2018	48-18	Operational performance	KSO3	Revised trajectories to be prepared for F&PC, setting out worst case/good case/best case scenarios	~~SLI~~ MH	ASAP		**Pending**
7	March 2018	49-18	Finance	KSO4	F&PC to receive details regarding historic level of debtor balance.	MM	ASAP	Finance report will report monthly the aged debt (and creditors) in 2018/19	**Complete**
8	March 2018	49-18	Finance	KSO4	Results of data comparisons to ascertain impact of sickness absence within Plastics in 2017/18 to be reported back to Board.	MM	May	Yes £140k has been increased into the contract value for this FY for the reduction in months 1-6 due to sickness	**Complete**
9	January 2018	15-18	Corporate risk register	KSO1	CRR to be updated to show correctly that implementation of GDPR is monitored by F&PC	MM	~~March~~ May	CRR has been be updated to reflect changes	**Complete**

10	January 2018	16-18	Q&GC assurance	KSO1	Governance process for FTSU reporting to be clarified	~~GC~~ KG/JMT	~~March~~ May	**01 03 18** Trust policy currently being updated to remove reference to Q&GC for Whistleblowing referrals. This policy will then go to Audit committee for approval. Concerns are raised through many other routes (in addition to FTSU and Whistleblowing) and to ensure complete overview, including identification of themes, all concerns will continue to be reported to the Audit Committee. Audit committee is responsible for assuring processes are adequate, and overseeing on behalf of Board. However any serious events will continue to be additionally reported directly to the BoD (private session).	**Pending**
11	January 2018	16-18	Q&GC assurance	KSO1	Governance process for CQC quarterly reporting to be agreed	GC/JMT	March	**01 03 18** Quarterly assurance to continue to go to Q&GC. Wil also go to EMT in advance of Q&GC and any concerns will be escalated. GC to report to BoD by exception.	**Complete**
12	January 2018	23-18	Board governance	Board development	Proposals for further development opportunities to be considered following results of well-led review	CP	May		**Pending**

Board Assurance Framework – Risks to achievement of KSOs

KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
Patients lose confidence in the quality of our services and the environment in which we provide them due to increasing patient safety incidents, a decline in care standards and a failure to maintain a modern care environment	Patients, clinicians & commissioners lose confidence in our services due to a decline in clinical outcomes, a reduction in research output and fall in teaching standards.	Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.	Regulators lose confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments.	We seek to maintain a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

Current Risk Levels

The entire BAF was reviewed at executive management team meeting in March 2018. KSO 1 and 2 were reviewed at the April Quality and Governance Committee and KSO 3, 4 and 5 were reviewed at the April Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets. Risk management training was undertaken by the board on Thursday 12 April which included time to discuss and reflect on the risk appetite of the board.

	Q1 2017/8	Q 2 2017/8	Q 3 2017/8	Q 4 2016/7	Residual risk
KSO 1	12	12	15	15	9
KSO 2	12	12	12	12	8
KSO 3	20	20	20	20	15
KSO 4	16	20	20	20	16
KSO 5	12	16	20	20	16

Chief Executive's Report					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03 May 2018**		**Agenda reference:**	62-18	
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:	16.04.2018	Decision:	Review BAF	

CHIEF EXECUTIVE'S REPORT
MAY 2018

TRUST ISSUES
Year end
The Trust is reporting a year-end control total surplus of £1.7m. In year, the Trust has earned £0.9m of STF income meaning the underlying control total surplus is £0.8m. The reported position in line with the planned forecast shared with the Finance and Performance Committee during March. In addition, the Trust has earned £1.2m incentive bonus from NHS Improvement General Fund. The finance use of resources rating is a '1'. The financial position remains subject to audit and the final reconciliation of 2017/18 activity and income with commissioners.

Director of Operations
Following interviews in March, I am pleased to announce the appointment of Abigail Jago as our new Director of Operations. Abigail will join QVH on 8 May, leaving her current role at Bart's Health NHS Trust. In the interim Mark Henry is raking responsibility for the operations directorate.

QVH System Assurance Meeting
The Single Oversight Framework (SOF) requires NHSI to meet with all trusts on a regular basis, and we have met quarterly for the past year. The first NHS England and NHS Improvement System Assurance Meeting involving QVH is scheduled to take place on the hospital site on 30 April. The meeting aims to build on and improve the existing approach to look at wider system matters. Representatives therefore from both NHSE and NHSI will be joined by local Clinical Commissioning Group colleagues.

NHS Improvement support
To assist the trust in reviewing its systems and processes aimed at improving our operational performance I invited the Intensive Support Team from NHSI to support that work. Three experienced managers from NHSI started their review earlier this month and will be concluding their work at the end of May.

Research
We have now finished collating our research recruitment figures for 2017-18, and I'm pleased to be able to report that QVH recruited 538 participants into a total of 31 active studies. Of these 538 participants, 441 were National Portfolio recruits. This represents a 47% increase in total activity over the previous year. This is a fantastic achievement, and a real testament to the hard work of the research team involved – Sarah Dawe, Gail Pottinger, Simon Booth, Debbie Weller, and Emma Foulds. 2018-19 looks like being an even more successful year, with several major new studies already in the pipeline.

Board Assurance Framework (BAF)
Attached is the BAF front sheet, the following points are worth noting:
KSO 4 Financial Sustainability risk rating was increased to 20 in January 2018 due primarily to income performance below plan which was partially offset by expenditure underspends. The Trust was still forecasting to achieve plan by the end of the financial year, and subject to audit we have reached our control total.

Media

Dr Mark Porter, GP and presenter of BBC Radio 4 show 'Inside Health' visited us recently to record interviews for a piece on corneal donation and transplant. The show featured the work of our eye bank, the sight saving surgery our experts carry out, and the perspective of one of our patients who has received two corneal grafts.

There is a national shortage of people donating their corneas after they pass away. We hope that the show will encourage many of the 1 million listeners to have the important conversation with their families about whether they would be a donor after they die. The piece was first aired on Tuesday 27 March and is also available on the radio station's website.

Alongside Dr Mark Porter is Damian Lake (top) and Nigel Jordan.

QVH recently held an event to celebrate the preservation and digitisation of all the Guinea Pig Club patient files. The records from these badly burned Second World War pilots, along with the thousands of other QVH patient files from the time, are a unique record of a period of great innovation in plastic surgery and the treatment of burns.

QVH consultant Baljit Dheansa (above right) gave a talk, intriguingly titled *Kiwis, guinea pigs, pineapples and hope,* and brought us up to date with twenty first century burns treatment. (Pineapples, we learned, contain an enzyme that helps strips away damaged tissue and allow healing to begin.) The audience was visibly gripped by the clinical detail and moved by the impact that has on the lives of our patients.

SECTOR ISSUES

Sussex & East Surrey Sustainability & Transformation Partnership (STP)

The new STP lead Bob Alexander has been visiting all the organisations within the footprint and has proposed some changes to the existing governance arrangements. These proposals will be brought back to individual Boards in due course.

NATIONAL ISSUES

Care Quality Commission

The Secretary of State has asked the Care Quality Commission (CQC) to carry out a themed review of 'Never Events in NHS trusts'. This topic is important to everyone providing or using services as a never event has the potential to have a real impact on the health and wellbeing of people. CQC will visit some Trusts as part of their planned inspection programme up to July and visit up to five additional Trusts outside the inspection process where we think they will give us additional valuable information. QVH was invited as one of the five additional trusts to allow CQC to look at good practice examples around the implementation and improvements in implementation of national safety requirements and we received a planned visit on 25 April. CQC will explore challenges Trusts have faced or overcome in the implementation of national safety requirements and will publish their findings later in the year.

Steve Jenkin
Chief Executive

Report cover-page					
References					
Meeting title:	**The Board of Directors**				
Meeting date:	03/05/18		**Agenda reference:**	63-18	
Report title:	**Freedom to Speak up Guardian update**				
Sponsor:	Andi Heaton, Freedom to speak up guardian				
Author:	Andi Heaton, Freedom to speak up guardian				
Appendices:	None				
Executive summary					
Purpose:	The purpose of this report is to provide the Board with an update on the FSUG role and activity to date.				
Recommendation	The Board is asked to **note** the report and **approve** the request for a designated area for the FSUG to meet in confidence with staff .				
Purpose:	**Approval**	**Information**			
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:	N/A				
Corporate risk register:	N/A				
Regulation:	N/A				
Legal:	N/A				
Resources:	N/A				
Assurance route					
Previously considered by:	NA				
	Date	dd/mm/yy	Decision:		
Next steps:					

Report to:	Board of Directors
Meeting date:	Thursday, 03 May 2018
Reference number:	63-18
Report from:	Andi Heaton, Freedom to Speak up Guardian
Author:	Andi Heaton, Freedom to Speak up Guardian
Appendices:	None
Report date:	24 April 2018

Background

1. A staff vote was held in February 2017 and Andi was appointed into role of Freedom to speak up guardian (FSUG) in May 2017. The role has been well received by all and well supported by the Trust board.

2. The FSUG has been in post for a year and the number of speak ups have been surprising. Each speak up requires an acknowledgment within 24-48 hours and arranging a place to meet face to face. The FSUG in conjunction with the Chief Executive is required to assess its urgency and who to pass the concern onto for investigation. Once the outcome has been received back from the investigator, contact is then made with the individual who has raised the concern. They are also followed up to ensure that they are not suffering any detriment for speaking up.

Activity since last board update

3. Regular meetings continue to take place with the Chief Executive once a month to provide an update on activity.

4. Meetings have taken place with other board members to provide an input into current ongoing investigations.

5. The contact card is in process of distribution across all staff areas in the hospital.

6. Team meetings have been attended following concerns raised by one staff group regarding management behaviour.

7. Andi continues to attend regional and national FSUG conferences. The Rt Hon Jeremy Hunt, Secretary of State for Health and Social Care spoke at the national conference in London and fully endorses the FSUG scheme, as did Simon Stevens, CEO NHS England.

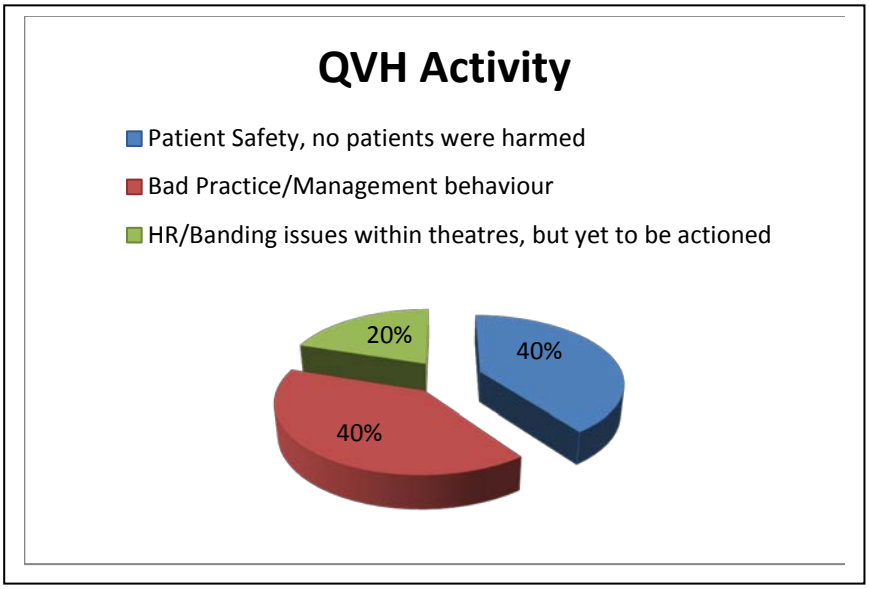
8. In April 2018 Andi will be attending a workshop in Crawley ‘Speak-up, Listen-up: Making it safer to be heard Workshop’ run by the NHS Leadership Academy.

9. The group reflective space was due to commence in March, however, this has been delayed until July 2018.

QVH activity

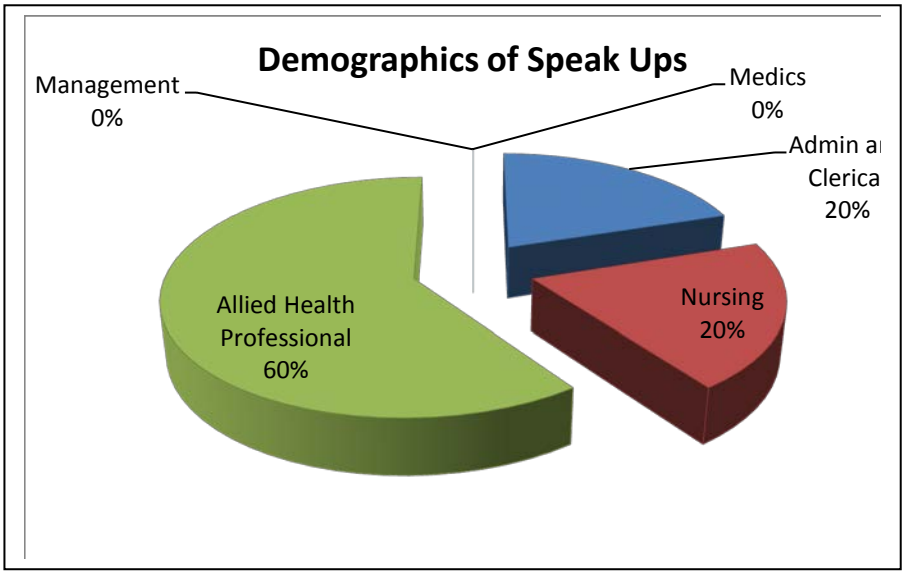
10. There have been a total of five speak ups since February 2018.

Patient Safety, no patients were harmed	**2**
Bad Practice/Management behaviour	**2**
HR/Banding issues within theatres, but yet to be actioned	**1**



Demographics of speak ups

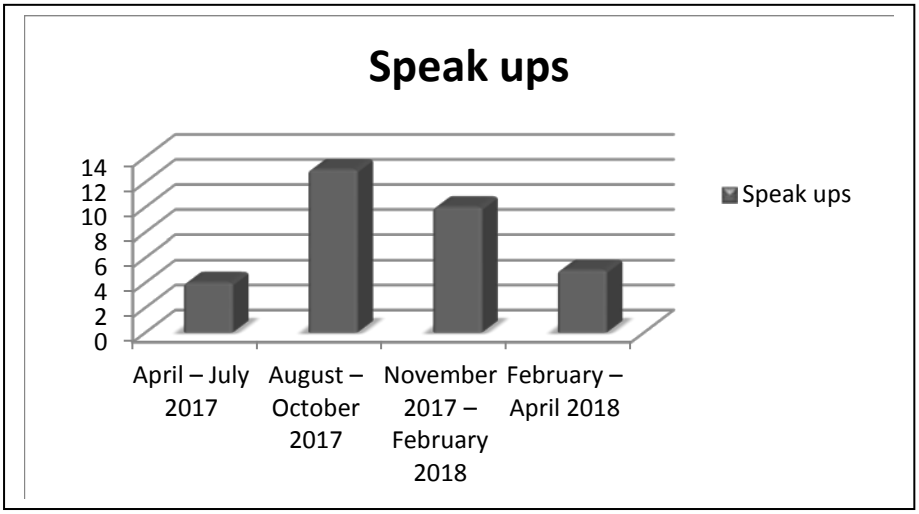
Admin and Clerical	**1**
Nursing	**1**
Allied Health Professional	**3**
Management	**0**
Medics	**0**



11. Feedback is continuing to be sought via Survey Monkey and is overwhelmingly positive. One speak up has been redeployed whilst an investigation is underway at their behest and is receiving ongoing support from HR and the FSUG.

12. Between April 2017 and April 2018 there have been a total of 32 speak ups.

Month	Speak ups
April 2017 – July 2017	**4**
August 2017 – October 2017	**13**
November 2017 – February 2018	**10**
February 2018 – April 2018	**5**



13. Majority of these speak ups have been received via the dedicated speak up email address.

Email to Qvh.speakup@nhs.net	**11**
Email to Andi.heaton@nhs.net	**5**
Phone call / text to Guardian Mobile	**6**
Corridor contact 'Are you Andi?'	**10**

Themes across the year

Patient experience no safety issues	**4**
Patient experience with potential safety issues	**8**
Staffing levels	**5**
HR issues	**3**
Bullying / unacceptable behaviour from management	**10**
Other issues	**2**

Conclusion

14. A recent meeting was held with the FSUG, Chief Executive and the Director of Workforce and OD to review the years speak ups and look at optimum ways of disseminating speak up data without compromising anonymity of individuals raising concerns and maintaining the integrity of the service.

15. When the staff survey has been fully disseminated there are plans for the FSUG and the Director of Workforce and OD to look at areas of high staff dissatisfaction/turnover and focus the FSUG activity proactively in the relevant department.

16. Once this has been formalised, there are plans to triangulate data with the '*Tell Jo'* service and the Head of Risk.

Recommendations

17. To date, there have been no requests from members of staff to be seen offsite. However, a frequent comment is that the meeting space does not feel secure. On this basis the Board is asked to **APPROVE** provision of a designated space to meet with staff.

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

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed: 10 April 2018

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 work, agreed at E&F Steering Group
Clinical quality standards and outcomes monitored by the Quality & Governance Committee , CGG and the JHGM ,monthly safer nursing care metrics, FFT and annual CQC audits
External assurance and assessment undertaken by regulatory bodies/stakeholders
Quality Account/CQUINS, PMO approach to CQUIN management
Benchmarking of services against NICE guidance, and priority audits undertaken
Compliance in Practice audits quarterly to check we are meeting CQC fundamental standards
Quality and safety strategy in place
Sub group for theatre workforce/recruitment, proposals approved at HMT June 2017, new theatres safety lead in post from Feb 2017
New paediatric staffing model in place has completed after successful pilot
Trust recruitment and retention strategy mobilised, Joined NHSI nursing retention initiative
SOC for inpatient paed burns being taken forward by Darzi Fellow who starts in post April 2018
MOU with RSUH

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 theatres, critical care and C-Wing
Increase in negative FFT comments re appointments/waiting times
Lack of shared learning across the trust from never events
Training QVH staff to have a faculty for simulation to support safety and learning culture initial focus will be in theatres

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	03/05/2018		**Agenda reference:**	65-18	
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 and one corporate risk closed during February and March 2018.				
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:	Internal links exist from the Corporate Risk Register to the BAF				
Corporate risk register:	This document				
Regulation:	All NHS trusts are required to have a corporate risk register and systems in place to identify & manage risk effectively.				
Legal:	As above				
Resources:	None				
Assurance route					
Previously considered by:	Executive management team				
	Date:	16/04/18	Decision:	Noted	
Previously considered by:	Quality and governance committee				
	Date:	19/04/18	Decision:	CRR 1101 HROD to speak to business unit managers re actions outstanding.	

Corporate Risk Register Report
February and March 2018 Data

Key updates:

1. **Three new risks were added** to the Corporate Risk Register between 01/2/2018 and 31/3/2018

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1101	Potential loss of sonography staff if recruitment and retention premia are not applied as had been previously agreed by trust'	Clinical Support services BU Meeting
3x4=12	1097	Concern that there may be missing cancer patients on the cancer PTL	Issue raised by NHSI further to STEIS submission from MFT
3x4=12	1102	BSUH Out-sourced CT service: BSUH have informally given notice to QVH for the delivery of out-sourced CT scanning.	Diagnostic imaging Department Manager & Operations Exec Lead

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
1093	Site Practitioner Staffing	5x3=15	4x3=12	Increased controls in place & recruited to 1wte post	R/V with Exec lead & HoR
1087	Not able to demonstrate full compliance with Mental Capacity Act in adult patient records	3x5=15	3x3=9	Effective controls in place currently	R/V by Exec Lead & handler

3. **One Corporate Risk was closed during February and March 2018**

Risk ID	Risk Description	Risk Score	Rationale for Rescore	Committee where change(s) agreed/ proposed
1090	Apprenticeship Levy Impact	3x4=12	This is a National issue over which Trusts have no influence & is unachievable	R/V by Exec lead

4. The Corporate Risk Register is reviewed monthly at Executive Management Team meetings (EMT), quarterly at Hospital Management Team meetings (HMT) and presented at 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.

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
1102	14/03/2018	BSUH Out-sourced CT service	BSUH has delivered CT scans on behalf of QVH since 2007. BSUH are currently installing a replacement CT scanner and they are struggling to deliver their workload within the access target time frames. BSUS have informally given notice to QVH for the delivery of out-sourced CT scanning.	-BSUH have a replacement mobile scanner on site to deliver their work -The SLA contract has 3 months notice period, this will give QVH time to find capacity in other private providers while procurement is progressing for the purchase of a CT scanner at QVH -BSUH will be asked to retain in-patient/on-call and Brighton based QVH patients until CT is installed at QVH	Sharon Jones	Sheila Black	Patient Safety	12	4		15/3/18 No Change
1101	01/03/2018	Potential loss of sonography staff if recruitment and retention premia are not applied as had been previously agreed by trust'	-Recognised national shortage of Sonographers. -Community, out-patient & MSK Ultrasound services at risk. -DM01 waiting list breaches. -AQP contract for US. Limited agency availability in the Southeast region and costs of agency staff significantly higher than Band 7 sonographers with 10% R&R allowance. In January 2016 the Director of Human Recourses approved a 10% recruitment & Retention (R&R)allowance for the QVH Ultrasound staff. This cost was agreed to be funded from the Radiology Cost-centre. The Ultrasound workforce was also informed of this R&R approval by QVH HR. In business planning for 2017-2018 £10,000 was approved for implementing this payment. The US workforce were made aware there was money approved for this	US workforce are aware R&R is being discussed at QVH, they are expecting to see this payment begin shortly. If approval is not agreed at QVH, then the whole US service is at risk. The radiologist workforce cannot manage this work ~750 referrals per month are seen by our current staff. Agency workforce is limited in the region. Outsourcing is not an option as local providers do not have capacity to absorb QVH activity for US.	Sharon Jones	Sheila Black	Patient Safety	12	4		**April 2018: awaiting update**

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
1097	07/02/2018	Concern that there may be missing cancer patients on the cancer PTL	Concern has been raised by NHSI at their 'critical friend' visit that there may be patients missing from the cancer PTL. Two incomplete patient details were given which did not give enough detail to track so further detail is being sought from Medway. The interim service review manager in appts raised a similar issue but further detail is required. All breast cancer patients also need to clearly visible on the PTL	Further details being sought from all parties to identify these patients. Cancer PTL in place but it hasn't been able to identify the patients from the information given to date. Head of risk informed and involved. New substantive cancer data manager in post after this post being vacant for a year plus and although covered by interims this was not ideal as there were three over this period which led to a fragmented service. New Performance & Access Manager joins the trust in March 18 and she has a robust cancer background and so will be asked to undertake a review. NHSI asked if they can also provide IMAS/IST support	Sharon Jones	Philip Kennedy	Patient Safety	12	4		**9/4/18: Update - Info flex system had not been maintained QVH side; fully updated for 46 identified patients.** 15/3/18 Being investigated independently and part of the Access & Appts action plan. Advised that all breast patients need to be on PTL, new Performance & Access Manager will oversee
1096	19/01/2018	Inappropriate storage facilities for special gases	Non compliance with national guidance on storage of special gases	1. Storage is locked and alarmed. 2. Restricted staff allowed access	Michelle Miles	Steve Davies	Compliance (Targets / Assessments / Standards)	12	6		Exec lead changed to Michelle Miles: confirmation of risk grading requested again 25/1/18:Exec lead & handler e-mailed for confirmation of risk grading
1095	19/01/2018	Inability to provide full pharmacy services due to vacancies	Delays to indirect clinical services (eg. updating policies / guidelines / audit / training Pharmacy vacancy rate is increasing. Lack of trained bank staff to cover	1. Recruitment for newly funded post in process (only one applicant) 2. Recruitment for part-time assistant underway - interviewed. 3. Recruitment for band 8a pharmacist underway. 4. Some part-time staff willing to work more hours. 5. Locum pharmacist agreed 6. Direct clinical work is the priority	Sharon Jones	Judy Busby	Patient Safety	12	4	1. Start recruitment for remaining vacancies	

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
1094	15/12/2017	Canadian Wing Staffing	Current vacancy 7.79 wte in total registered and unregistered workforce Unable to cover shifts with qualified nurses leading to constant micro management of off duty rotas. Unable to recruit staff to fill existing vacancy Unable to book sufficient agency staff to cover the shortfall On occasions there are insufficient staff to maintain safety and trauma or elective activity is cancelled or delayed to manage the shortfall	1. Use of agency and bank as available and movement of QVH staff to cover shortfall 2. Review of rota to identify new ways of working to address the shortfall in the short term & on-going rota scrutiny 3. Line-booked agency if available 4. Redeploying staff from other areas of the hospital to cover 5. Cancelling or holding trauma and electives	Jo Thomas	Nicola Reeves	Patient Safety	15	12	Discussion with Director of Nursing wc 18th December Proactive management of bed booking Line booking agency staff Planning further in advance to get increased choice of agency.	**9/4/18: Update - interest from campaign, small number of applications received** 12/2/18: Update - Social media recruitment campaign underway Pegasus) January 2018 update: - enhanced bank rates to include C-Wing - new ward matron in post
1093	18/12/2017	Site Practitioner Staffing	Current vacancy 2.0 out of 10 WTE of total registered workforce Unable to cover shifts with suitably qualified nurses leading to constant micro management of off duty rotas and leaving the organisation vulnerable due to lack of senior support. Unable to recruit staff to fill existing vacancy as two staff on temporary secondment. Unable to book agency staff to cover the shortfall due to the speciality of the role On occasions there are insufficient staff to maintain safety and trauma or elective activity	1. Use of existing staff to do bank. 2. Review of rota to identify new ways of working to address the shortfall in the short term & on-going rota scrutiny 3. night shifts prioritised over day shifts (x2 on duty) 4. Outreach bleep held by Critical Care 5. Site Practitioner phone with DDoN / HoN	Jo Thomas	Nicola Reeves	Patient Safety	12	9	Proactive management rota Substantive recruitment once the secondments completed Unable to support any further flexible working or secondment requests at this time.	**9/4/18: Update - 1 staff member commenced, other to start end of April** 12/2/18: 1wte post recruited to (= x2 part-time staff) To start in role March / April 2018

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
1083	22/09/2017	Deterioration in 18RTT performance	The trust's 18RTT position has deteriorated and is not meeting the target of 92%. This will mean that patients will wait longer, regulators are QVH more attention and our reputation will 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 procedures 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 Bid put in as part of business planning process for additional	Sharon Jones	Paula Smith	Compliance (Targets / Assessments / Standards)	20	15	Outsourcing Routine Hand Surgey Design and implenent different models of service provision	**9/4/18: Update -** **Theatre nursing vacancies continue to increase** **Anaesthetic appointments in post x3, 4th to start in May** Additional validators in post Cancer data manager and Performance and Access Manager appointed & in post. IST working with Trust to review capacity and demand 6/2/18: Additional outsourcing for max fax at the McIndoe being progressed & exploring insourcing with QVH theatres team NHSI 'Critical Friend' visit made (as with all trusts) and recommended improvements as to how the PTL meeting is run with 'SMART' objectives, joint working with the BI team as to the data pull from the PTL, and action logs
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	Michelle Miles	Dominic Bailey	Information Governance	12			**15/03/2018: Internal audit of GDPR completed. The GDPR action group continues to make progress on compliance. Additional administrative support secured.** 12/2/18: reviewed monthly at IGG 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	Residual Rating	Actions	Progress & Update SUMMARY
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 Health Records and Appointment 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	12	Recruitment of Interim Appts Service Improvment Manager Review, Recommendations & Action Plan	**9/4/18: Update - acting service manager working with appointments team to improve understanding & ensure the booking process meets the Access Policy** 15/3/18 Access and Appts action plan in place. Business Manager leading development of standard operation proceedures as part of this 16/2/18 Acting service manager to resolve going forward and to bring forward patients, plus training to be given. Business units to ensure that clinics are offered to the appts team in good time. Will also be part of the service improvement action plan 6/2/18 Draft review written and key recommendations will be made to EMT by the end of Feb. The detail is in an action
1079	06/09/2017	Inappropriate prescribing by Eastbourne DCTs due to inexperience	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. 3. A more structured induction training plan will be in place for the intake next year. 4. MMOGG support for pharmacists not allowing prescribing rights if they have concerns 5. Further assessments now prepared for those not passing the assessment first time	Dr Edward Pickles	Judy Busby	Patient Safety	12	8	1. Formal inductition QVH training to be set up for Eastbourne DCTs	22/1/18: new induction programme planned All except one have had basic training and passed their assessment 19/1/18 'Target' risk rating changed to 8

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
1077	22/08/2017	Recruitment and retention in theatres	* Theatres vacancy rate is increasing * Pre-assessment vacancy rate is increasing * 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	6		12/2/18: recruitment to pre-op assessment plus social media recruitment drive January 2018 update:all HCA's now in post 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, 12 wte HCA post accepted in theatres start dates are staggered across October and November August 2017: * Nursing Retention Group launched

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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	12	10	PEG service review	February 2018: confirmed all commissioners in agreement to proceed 22/1/18: reviewed with Exec Lead - MOU approved, CT business case approved & funding secured. PEG service remains suspended, review due in March 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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	Sharon Jones	Sheila Black	Patient Safety	12	2		13.12.2017- Cone Bean CT scanner in procurement phase 1 Ultrasound machine in procurement phase Business planning 2018-2019 has plan for rolling capital replacement of radiology equipment 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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	9	Actions update	February 2018: social media recruitment drive launched January 2018 update: - Increased Bank rates implemented -'recommend a friend' staff incentive scheme Dec vacancy rate = 6.01wte 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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	9	Attempting to recruit agency doctors	12/2/18: EMT agreement to recruit agency locum prior to substantive recruitment January 2018 update: Business Planning 2018/19 = additional plastics SHO x 2 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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.	Michelle Miles	Nasir Rafiq	Information Management and Technology	12	8	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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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.	Michelle Miles	Nasir Rafiq	Information Management and Technology	12	4	Communicate to departments to update their Business Continuity Plans in light of risk. 31/12/2016 Use existing UPS's to protect the network in keys areas. 31/01/2017 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	Update 07/02/2018: UPS are scheduled to be installed in Feb/April 2018. 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

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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.	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	To be reviewed in July following Clinical Cabinet discussions Paper to be presented at Clinical Cabinet in June 2016 Paediatric review group met in August, paper to private board in September 2016.	12/2/18: improving recruitment position, 1wte paeds S/N post offered for Sept start;position paper to go to March HMT November 2017: Position Paper presented to Board - final paper (Paeds staffing) to go to Feb 2018 HMT 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 &

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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 & 52 week breaches 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	6	22/06/2016 Risk reviewed with IHoR and IM Progress been made with East Kent to provide a data warehouse 3.A recovery plan will be commenced as soon as there is enough data and a trajectory agreed, this will be revised once there is more accurate data via the warehouse functionality To gain access to offsite PAS systems	**15/3/18** **New Performance & Access manager in post but vacancies in the BI team. NHSI working with the trust and this will be picked up as part of their work** 2/8/17: r/v at Ops meeting = no change 21/12/2016 Risk reviewed at Business Unit Managers meeting - No change 08/08/2016 Risk reviewed with IM Lead additional action added - No further changes at this stage
898	04/11/2015	Ageing specialist Histopathology laboratory equipment	The increasing age of the very specialist laboratory equipment.	-Hand coverslip all slides if the coverslipper breaks -Leica to loan a cryostat to cover the period of time between breakage and purchasing a replacement 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	6	Ensure equipment to be replaced is part of business planning and capital bids for 2016-17	Update 9/1/18: Capital funding application submitted

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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	Michelle Miles	Dominic Bailey	Information Governance	12	8	Contractor to be selected 25/07/2016 HoR & IG Lead reviewed risk - IG Lead to obtain update from radiology Purchase encryption hardware for Radiology IT disposal Policy to be ratified at July 2016 IGG Implement Data Leakage Prevention Software on Trust e-mail exchange	**15/03/2018: Two key risk that have different actions to manage therefore recommendation is to close risk and 2 new risks created by IG lead.** 27/11/2017: All staff now have nhs.net accounts. IG Lead and HoR to meet and rationalise remainder of risk. 10.10.2017- requested to review by KCW S. Black - Looking at this risk from a radiology point of view it would seem that only the unencrypted CDs arising from PACS being sent in the post is related to radiology. Apart from Subject Access requests Radiology sends all PACS images via the secure Image Exchange Portal. Private patients requesting copies of their images are handed the CD of their images

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Progress & Update SUMMARY
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	Michelle Miles	Jason Mcintyre	Finance	20	15	22/06/2016 Risk reviewed by IHoR need an update regarding current controls and any additional actions. Email sent ro risk owner requesting an update, sent 22nd June 2016 1) Development and implementation of delivery plan to address forecast underformance. Review of performance against delivery plan through PR framework with appropriate escalation policies. 2) Development of multi-year CIP/ transformational programme which complies with best practice guidelines. 3)Development and embedding of integrated business planning framework and pro	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	Residual Rating	Actions	Progress & Update SUMMARY
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	Dr Edward Pickles	Dr Tim Vorster	Patient Safety	12	6	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	9/1/18: NCEPOD/Emergency theatre hours have been amended to be in line with the extended hours now done by the Anaesthetic Consultants Job planning to be completed end of March 2018 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
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	6	03/06/2016 - Risk discussed with IHoR and MD no new controls added and current rating (12) remains unchanged. this is to be discussed with Execs June 2016 Rolling recruitment advertisement Consultants approached to undertake additional activity to clear the back log Reviewing Clinic templates and operating sessions to provide additional capacity	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	Residual Rating	Actions	Progress & Update SUMMARY
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	12	Recruitment drive commenced Permanent Education Centre has had outline Board approval and funding TBA Reduced activity in some areas 03/06/2016 Risk Reviewed with IHoR and MD: continued recruitment drive in place with focus upon plastics new contolrs added but scores remain unchanged as still a risk to the Trust review in one month	22/1/18: Plastics currently fully recruited, OMFS vacancies until April 2018. GMC survey results disappointing; Deanery visit awaited 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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/05/18**		**Agenda reference:**	**66-18**	
Report title:	**Quality and governance assurance report**				
Sponsor:	Ginny Colwell, NED and committee chair				
Author:	Ginny Colwell, NED and committee chair				
Appendices:	Quality and governance terms of reference (amended)				
Executive summary					
Purpose:	To provide assurance to the Board in relation to matters discussed at the Quality and governance committee 19 April 2018				
Recommendation:	The Board is asked to **NOTE** the contents of this report The Board is asked to **APPROVE** the amendment to the committee terms of reference.				
Purpose:	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: **Y** *Outstanding patient experience*	KSO2: **Y** *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	KSO1: Outstanding patient experience and KSO2:World-class clinical services				
Corporate risk register:	The CRR was reviewed at Q&GC				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:	dd/mm/yy	Decision:		
Previously considered by:					
	Date:	dd/mm/yy	Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	3 May 2018
Reference number:	66-18
Report from:	Ginny Colwell, committee chair and NED
Author:	Ginny Colwell, committee chair and NED
Appendices:	Q&GC terms of reference (amended) for approval
Report date:	25 April 2018

Quality and Governance Committee (Q&GC) Assurance Report
Meeting held on 19 April 2018
Areas of particular note for assurance

1. The committee was informed that a formal audit will take place prior to the decision about the future of the insertion of PEGs at QVH. This will entail a risk analysis, and further work on patient pathways.

2. Following the results of a questionnaire sent out to members some changes to the committee will take place to strengthen its function. The action plan coming out of the Well Led review is also likely to inform further changes.

3. The Committee's terms of reference were updated to reflect the change in the Authority that any concerns directly relating to 'Whistleblowing' will be discussed at the private section of the Board, to protect confidentiality in the first instance or escalated to the Accountable Officer. They are attached as an appendix to this report and the board is asked to **NOTE** and **APPROVE** the small amendment.

4. National Inpatient Survey 2017 was received in full. The action plan will be monitored by the Patient Experience Group. The report assured that when the survey took place patient experience was being maintained, however the Committee noted that staffing pressures have continued since then. Food has been identified as an area for further work.

5. CQC Provider Engagement Meeting Record: March 18 was received. Service area covered in detail, children and young people. No particular areas of concern were raised.

6. Hilary Durrant, theatre manager attended to give an update on theatres. The committee felt the new team were making good progress in improving the consistency of the use of the WHO checklist. Recruitment remains an issue.

7. The first draft of the Quality report was received and the overall form approved.

8. The 6-monthly workforce review was discussed. Recruitment remains a key risk within the Trust.

9. Policies ratified
    - Smoke Free
    - Freedom of Information
    - Data Protection
    - Access to personal data

10. Other reports received and are either covered by the executive report or had no significant assurance issues;
    - Risk exception report
    - Board assurance KSOs 1&2
    - Infection Control Q4 update
    - Patient experience
    - Reports from the;
    - Clinical governance group
    - Patient Experience Group
    - Information Governance Group
    - Research and Development Governance Group

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.
- *Any concerns directly relating to 'Whistleblowing' will be discussed at the private section of the Board, to protect confidentiality in the first instance or escalated to the Accountable Officer.*

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 for best practice advice and consistency.

The next scheduled review of these terms of reference will be undertaken by the Committee in December 2018 in anticipation of approval by the Board of Directors at its meeting in January 2019.

* 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 cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/05/18**		**Agenda reference:**	67-18	
Report title:	Quality and Safety Report, May 2018				
Sponsor:	Jo Thomas, Director of Nursing and Quality				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	Ward and outpatient nursing metrics				
Executive summary					
Purpose:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led. The Board is asked to note the revised nursing metrics which now cover all clinical inpatient wards and outpatient departments and the new concise complaints and patient experience sections.				
Recommendation:	The Board is asked to **NOTE** the contents of the report in respect of the quality and safety of care provided at 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:	Quality and Governance Committee				
	Date:	19/04/18	Decision:	Paper discussed no material changes prior to Board.	
Previously considered by:					
	Date:		Decision:		
Next steps:					

Executive Summary - Quality and Safety Report, May 2018

Domain	Highlights
Safe	Six monthly nursing safe staffing report forms part of the May 2018 Board papers assurance about the provision of safe care within the Trust. This report shows that the Trust meets national and network safe staffing levels and requirements, albeit this is achieved with the use of bank and agency staff. It also describes the national recruitment and retention issues that the nursing profession is currently experiencing and the steps QVH is taking to address.
Effective	The Trust's annual Quality Report 2017/18 is in development and three new priorities have been agreed for 2018/19.
Caring	There were five new complaints in February and four new complaints in March. The main themes of these were cancellation and treatment, all are under investigation. Friends and Family scores have been sustained or improved in most areas the only exception being trauma clinic which saw a minor decrease, which is being reviewed. 45 % of inpatients in February took part in the survey and 98% of these would recommend the services at QVH.
Responsive	MIU performance continues to be better than national indicator. In February and March 2018 100% of patients were assessed and treated within 4 hours.
Well led	The trust has received the external well led review. Once this report has been shared throughout the Trust the quality and safety teams will review, reflect and incorporate relevant recommendations into respective reports.
Nursing Workforce	The Trust is actively recruiting for 44 wte qualified nurses and theatre practitioners. The qualified vacancy rate is 18.72 % vacancy rate (February ESR data) which is a deterioration from last reported position of 17.54%. A social media recruitment campaign launched in February with a focus on theatre recruitment which has successfully raised the profile of QVH some applications are being processes following this campaign but the target areas - theatres and critical care did not receive any formal applications. Sickness remains above the target but has decreased in March. There is sustained agency and bank usage. Enhanced scrutiny of nursing deployment continues and there are local frameworks in place for ensuring safe skill mix on a daily basis . Close monitoring for any signs of early warning triggers, review of all patient safety incident correlated against actual staffing levels continues. Key areas of focus for recruitment and retention are Theatres, Critical Care and C-Wing.

Safe - Current Compliance

Domain	Current Compliance	Next Steps
Nursing recruitment initiatives	The Trust is exploring opportunities and implementing new initiatives to attract new nurses, including: - International recruitment for a range of staff with ward or Critical Care experience with potentially expanding this to include theatre staff. - Fast tracking of newly qualified staff and financial support to cover the cost of their first year registration. - New starter premium for registered nurses and theatre practitioners - Utilising a 'refer a friend scheme' to tap into existing networks.	QVH is having some success with return to practice nursing staff who are keen to work with us during their university programme on placement and afterwards in substantive posts. QVH is developing band 4 assistant practitioner roles in a number of clinical areas and collaborating with other providers to ensure readiness for the associate nurse roles once the Nursing and Midwifery Council agree on the process for registration of such a qualification.
Infection control	Zero MRSA bacteraemia cases and zero Clostridium difficile infections (CDI) attributed to QVH in February and March 2015. In March 2018, there was one MSSA bacteraemia in a patient admitted to the inpatient ward and one Pseudomonas bacteraemia in a patient admitted to Burns. Both cases discussed with the consultant microbiologist and all appropriate actions taken.	Enhanced surveillance and teaching to be undertaken with staff. Results of RCA learning disseminated amongst relevant staff and including in education sessions.

Medication errors	**February 2018:** nine patient safety medication related incidents were reported – all resulting in no or low harm. **March 2018:** 13 patient safety medication related incidents were reported - all resulting in no or low harm. In both months, identification of prescribing errors by pharmacy staff prevented harm from occurring.	Work is underway to ensure patients on admitted via main theatres have their necessary medications prescribed to reduce prescribing omissions. The Head of Pharmacy and the Medication Safety officer continue to work closely with clinical leads undertaking in-depth analysis of errors and attending specialty governance meetings to ensure that the learning from incidents is identified and shared.
Serious Incidents/ Never Event	No Serious Incidents or Never events were reported in February 2018 and March 2018. The Trust's last Never Event occurred 155 days ago.	Theatres Patient Safety lead appointed and in role, leading on the work around Five Safer Steps to Surgery, alongside assisting with the introduction of multi-professional simulation training for staff. The Trust's CGG have undertaken a follow up visit to Theatres in March 2018 and were assured about the new measures introduced. No concerns were raised on the day and the Trust awaits the formal report.
Pressure ulcers	There were no grade 2 or above hospital acquired pressure ulcers reported in February or March 2018.	The Trust's new Tissue Viability Nurse is scheduled to start July 2018 and will take forward actions identified from the pressure ulcer audit.
Falls	**February 2018:** There were eight inpatient fall reported during February 2018. All graded as no or very minor harm**.** **March 2018:** There were two inpatient falls during March 2018. Both were graded as no harm.	

Safe - Performance Indicators

Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2015/16 total / average	Target	Quarter 1 2017/18			Quarter 2			Quarter 3			Quarter 4			12 month total/ rolling average
			Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Infection Control															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	98%	>95%	98%	98%	97%	99%	99%	99%	97%	98%	96%	97%	97%	98%	98%
MRSA screening - trauma	97%	>95%	95%	96%	96%	94%	97%	95%	96%	96%	96%	97%	96%	98%	96%
Incidents															
Never Events	0	0	1	0	0	0	1	0	1	0	0	0	0	0	3
Serious Incidents	3	0	0	1	0	0	0	1	0	0	0	0	0	0	2
OOH inductions:															
All patients: Number of patients operated on out of hours 22:00 - 08:00		5	2	6	5	8	2	5	3	4	3	4	2	5	49
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00		0	0	0	0	0	0	0	0	2	0	0	0	0	2
Paediatric transfers out (<18 years)			3	0	1	0	2	0	0	2	0	0	0	0	8
Medication errors															
Total number of incidents involving drug / prescribing errors	191		8	10	8	4	8	9	20	16	16	10	9	13	131
No & Low harm incidents involving drug / prescribing errors	191		8	10	8	4	8	9	20	16	16	10	9	13	131
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		2	2.7	0.5	1.7	0.5	2.2	2.4	1.2	0.6	1.1	3	1.2	1.6
Harm free care rate (QVH)	97%	>95%	100%	100%	100%	98%	97%	100%	100%	97%	100%	100%	97%	96%	99%
Harm free care rate (NATIONAL benchmark) - one month delay	94%	>95%	94.0%	94.2%	94.1%	94.2%	94.1%	94.3%	94.3%	94.2%	94.4%	94.2%	94.2%		
Pressure Ulcers															
Hospital acquired - category 2	11	15	0	2	2	1	0	3	0	0	1	0	0	0	9
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%	94.7%	95.1%	97.3%	96.4%	98.6%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	94%	>95%	100%	100%	100%	100%	100%	100%	100%	97%	87%	98%	92%	96%	97.22%
Patient Falls resulting in no or low harm (inpatients)	40		4	7	6	4	4	1	2	8	4	7	8	2	57
Patient Falls resulting in moderate or severe harm or death (inpatients)	0		0	1	0	0	0	0	0	0	0	0	0	0	1

Effective - Current Compliance

Domain	Current Compliance	Next Steps
Mortality	**February 2018:** There were two QVH mortalities and one patient died elsewhere. **March 2018:** There was one QVH mortality and one patient died elsewhere.	The medical director reviews all deaths which have occurred and there is a process of escalation and investigation as part of the risk management framework where required.
Transfers out	There were nine emergency or unexpected transfers out in February 2018. None of these were paediatric patients. Three emergency or unexpected transfers occurred in March 2018. None were paediatric patients.	
Antimicrobial Stewardship	Submission of the data for the antimicrobial CQUIN is up to date. The national supply problem of antimicrobials remains ongoing and continues to be managed. An updated eye inpatient prescription and administration chart was been introduced at the beginning of April. It has incorporated a section for drops administered every hour thus removing the need for a separate hourly prescription chart. Intensive antimicrobial drops are required in severe infection, the new chart should improve compliance and reduce prescribing risks with less charts in use.	A proposal to increase the hours of the Antimicrobial Pharmacist is in place to help with Stewardship in the absence of Consultant Microbiologist cover. A Kent, Surrey and Sussex Antimicrobial Pharmacist network group is being set up with the aim of supporting the pharmacists in their role, as well as share learning and good practice.

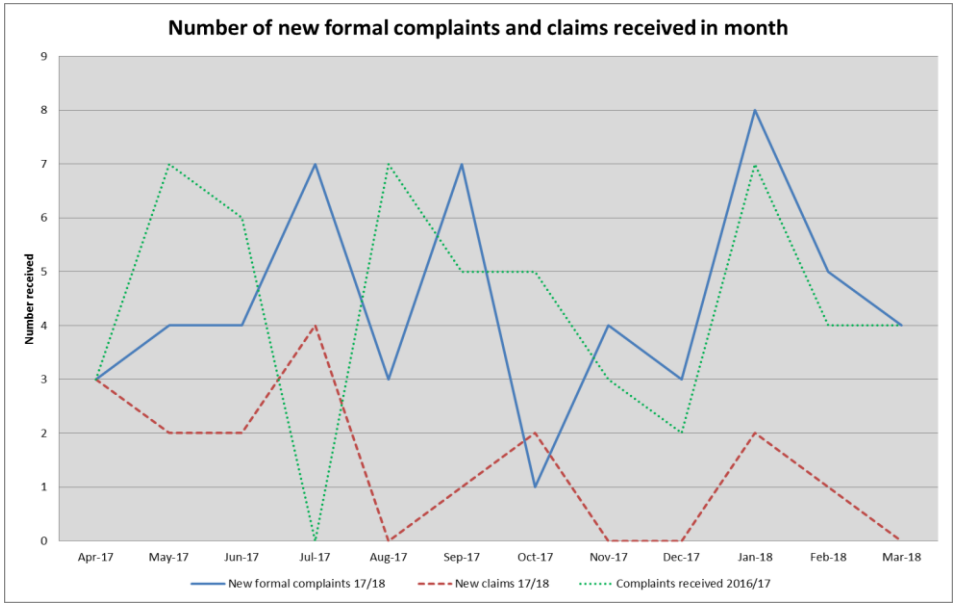
Quality Report 2017/18	The following three Quality Priorities have been agreed: **1. Patient experience:** measurement of compliance with the WHO Surgical Safety checklist. **2. Clinical effectiveness:** Increased theatre productivity (continuation of 2017/18 priority over a two year period - previously the 2017/18 patient safety priority)). **3. Patient experience:** Improved clinician communication and customer care expectations.	Metrics for each quality priority are currently being developed in preparation for the start of the new 2018/19 financial year. Quarterly priority achievements will be monitored by the Quality and Governance Committee.

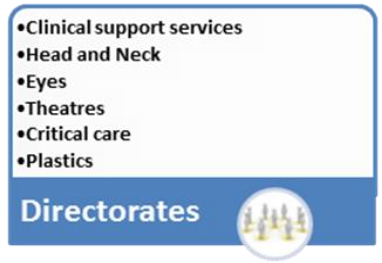
Effective - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 1 2017/18			Quarter 2			Quarter 3			Quarter 4			12 month total/ rolling average
			Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Mortality															
QVH Mortalities	6	0	0	1	0	0	0	0	0	0	0	0	2	1	4
Mortality elsewhere within 30 days of discharge	15	0	1	4	2	0	1	0	1	0	1	3	1	1	15
Readmissions															
Emergency Readmissions Within 30 Days	1.87%	2.24%	2.64%	3.00%	4.53%	3.89%	3.14%	2.40%	2.78%	3.18%	1.57%	2.82%	2.67%	1.44%	2.88%
Emergency Readmissions Within 7 Days	1%	1.21%	1.03%	1.17%	1.90%	2.23%	1.77%	1.10%	1.26%	1.88%	1.07%	1.41%	1.63%	1.29%	1.49%
Paediatric safeguarding															
Paediatric safeguarding cases*			15	18	21	23	24	20	18	17	17	24	15	15	227
Allegations against staff			0	0	0	0	0	0	0	0	0	0	0	0	0
Safeguarding adults															
Adult Safeguarding cases*			4	5	8	5	5	7	3	6	3	2	10	5	63
Allegations against staff			0	0	0	0	0	0	0	0	0	0	0	0	0
Female genital mutilation (FGM) Risk Assessments undertaken			0	0	0	0	0	0	0	0	0	0	0	0	0
DoLS Applications			0	0	1	0	0	0	0	0	1	0	0	0	2
Prevent Referrals			0	0	0	0	0	0	0	0	0	0	0	0	0
Infection control audit															
Hand hygiene audit %			99%	100%	100%	99%	99%	98%	100%	97%	98%	98%	98%	99%	99%
Bare below the elbows %			99%	100%	100%	100%	99%	100%	98%	99%	97%	100%	94%	99%	99%
Trust Cleaning %			86%	88%	89%	88%	91%	90%	**						88%

*Concerns are reported via internally processes, and then referred on to the appropriate external agency
** New reporting methodology being finalised

Caring - Current Compliance - Complaints and Claims





You said, we did:

The following examples highlight how we have used this information to implement learning and improvement based on patient feedback:

Patient information:

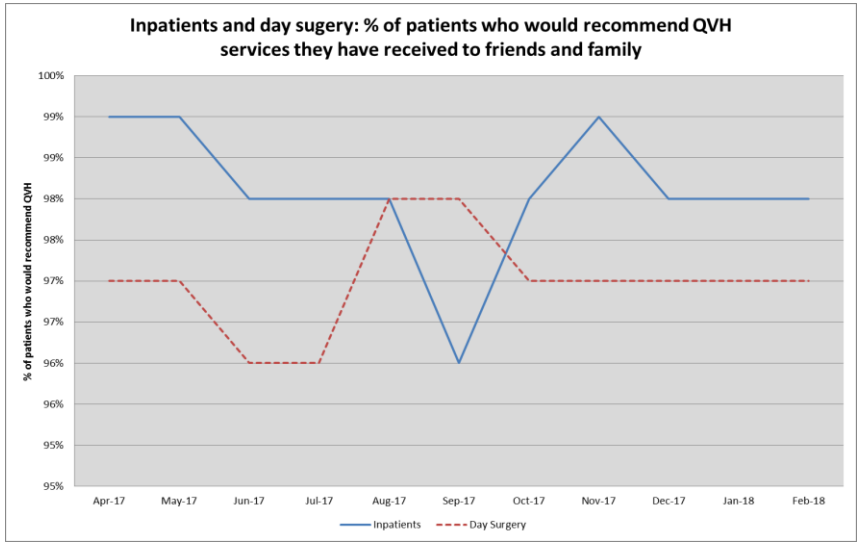
A patient told us that they needed more guidance on why nail varnish should be removed prior to any surgery. We are looking add to our literature patient information about why it is necessary to remove all cosmetics e.g. false eyelashes and nails prior to surgery.

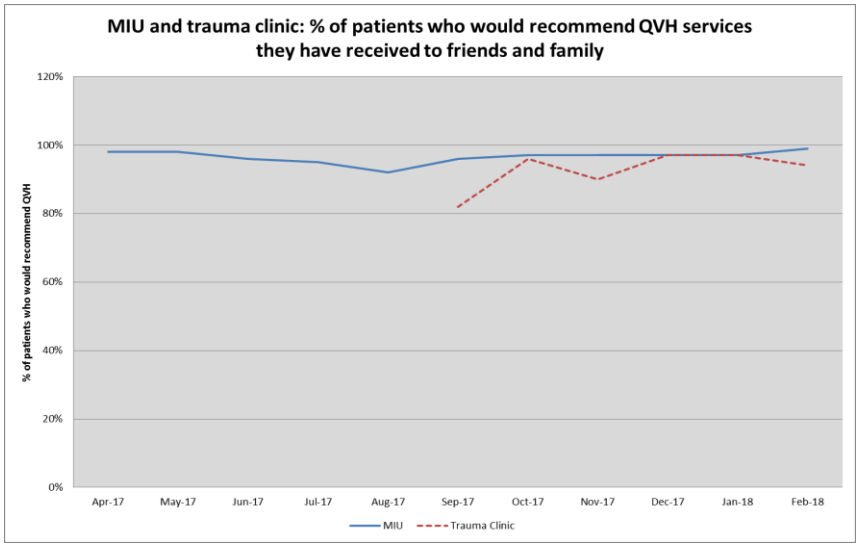
Patient experience:

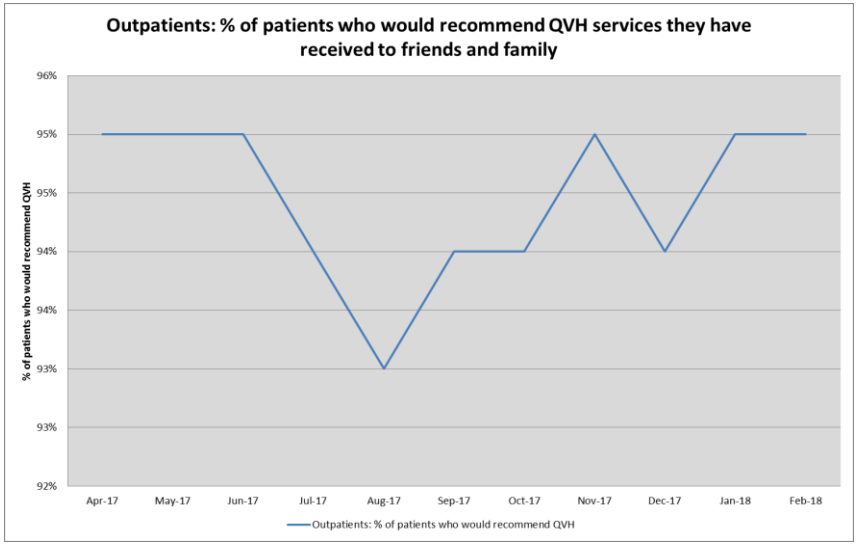
A patient told us of their experience with a delay in being discharged from the ward. We aim to discharge patients as promptly as possible however we have delays from the doctors when writing up discharge forms and prescriptions. The ward Matron is working with the staff to encourage the doctors to work in a more proactive way.

The waiting times in clinic. We are currently undertaken a review of the waiting times and the reasons for these.

Caring - Current Compliance - FFT







Caring - Performance Indicators

Metric	2015/16 total / average	Target	Quarter 1 2017/18			Quarter 2			Quarter 3			Quarter 4			12 month total/ rolling average
			Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Complaints															
Complaints per 1000 spells *	2.7		2.0	2.2	2.2	3.9	1.6	3.9	0.6	2.3	1.8	4.5	3.0	2.5	2.5
Claims per 1000 spells *	1.1		2.0	1.1	1.6	0.0	0.0	0.6	1.2	0.0	0.0	1.1	0.6	0.0	0.7
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	99%	99%	98%	98%	98%	98%	98%	99%	98%	98%	98%	99%	98%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0.0	0%
FFT score MIU: likely and very likely to recommend QVH	94%	>90%	98%	98%	96%	95%	92%	96%	97%	97%	97%	97%	99%	96%	97%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		0%	1%	3%	3%	4%	1%	0%	1%	3%	1%	0%	3%	2%
FFT score OPD: likely and very likely to recommend QVH	95%	>90%	95%	95%	95%	94%	93%	94%	94%	95%	94%	95%	95%	94%	94%
FFT score OPD: unlikely and very unlikely to recommend QVH	2%		2%	2%	2%	2%	3%	2%	2%	2%	3%	2%	2%	3%	2%
FFT score DSU: likely and very likely to recommend QVH	97%	>90%	97%	97%	96%	96%	98%	98%	97%	97%	97%	97%	97%	96%	97%
FFT score DSU: unlikely and very unlikely to recommend QVH	1%		1%	2%	0%	1%	0%	0%	0%	2%	1%	1%	0%	2%	1%
FFT score Sleep disorder centre: likely and very likely to recommend QVH	97%	>90%	98%	94%	93%	100%	100%	98%	99%	94%	94%	96%	94%	100%	97%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	1%		1%	1%	2%	0%	0%	0%	0%	0%	2%	0.0%	3.0%	0.0%	1%
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%	99%	100%	99%	100%	100%	100%	100%	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	**February 2018:** 178 incidents were reported, 70 of which were Patient Safety incidents: 52 = no harm/near miss incidents, eight were minor harm and nine were level of 'harm unknown' at the point of reporting. There was one Moderate Harm incident and no Major or Catastrophic incidents were reported. **March 2018:** 157 incidents were reported, 66 of which were Patient Safety incidents: 51 No Harm/Near Miss incidents, three were Minor Harm incidents and there were 12 where level of harm was 'unknown' at the point of reporting. There were no moderate, major or catastrophic harm incidents reported.	The Patient Safety Team are increasing the staffing establishment and recruiting into the new Patient Safety and Governance Facilitator post. This will enhance the ability to work with investigators, and support the introduction of Investigation Training within the Trust for senior staff. Work continues with the Datix reporting system to ensure that staff have the appropriate categories to select. This will enable enhanced data capture to ensure meaningful reporting and learning from the investigations.

Nursing Workforce - Current Compliance

Domain	Compliance	Actions
Ross Tilley	During February and March there were 9/118 occasions where staffing numbers did not meet planned levels (25/124 in December and January). All escalated to site practitioner as per trust protocol additional support provided which included HCA redeployed to the ward and site practitioner supporting.	Staffing according to bed occupancy and acuity with additional staff deployed on high acuity days and resources redeployed from other areas where template was below planned and additional staff required. All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information. No falls , pressure ulcers or nursing medication errors occurred on these shifts. Additional falls work led by Head of Nursing with C-Wing staff to reduce falls in bathrooms has commenced.
Margaret Duncombe	During February and March there were 15/118 occasions where staffing numbers did not meet planned levels (18/124 in December and January). All escalated to the site practitioner as per trust protocol additional support from CCU and ward manager to ensure safe care provision.	Staffing according to bed occupancy and acuity with additional staff deployed on high acuity days and resources redeployed from other areas where template was below planned and additional staff required. All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information. No falls, pressure ulcers or nursing medication errors occurred on these shifts.
Burns	During February and March there were 7/118 occasions where staffing numbers did not meet planned levels (10/124 in December and January). All escalated to site practitioner as per trust protocol.	Staffing according to bed occupancy and acuity resources redeployed from other areas where template was below planned and additional staff required. All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information. No falls , pressure ulcers or nursing medication errors occurred on these shifts.

Peanut	During February and March there were 10/118 (21/124 in December and January) occasions where planned numbers did not meet actual. The majority of these are night shifts as we have actively made the decision to prioritise staffing the day shifts when the majority of children require care. There were 14 nights in February and March when the ward was closed at 1930 due to this decision. One child was referred on to another burns units during this time. During February and March there were 20 inpatient cared for over 12 nights, on 33 nights staffing was available but no inpatients facility required.Burns ward continues to take paediatric referrals or give phone advice if Peanut closed.	A paper was received at EMT in December detailing plans to make these interim arrangements permanent which was agreed. No incidents or harms align to these dates but the trust acknowledges the impact on patient experience for the three children referred on to other burns unit. Recruitment continues, one staff nurse post accepted since the last report.
Critical Care (ITU)	During February and March there were 7/118 occasions where staffing numbers did not meet planned levels (18/124 in December and January).All were escalated to site practitioner as per trust protocol staff redeployed from burns and Cwing and site practitioner support provided. Reasons for not meeting planned staffing levels were staffing adjusted to bed occupancy and agency fill rates less than requested. All escalated to the site practitioner as per trust protocol. Lower patient numbers relating to seasonal variance meant that several shifts were below planned levels.	All dates where escalation re staffing required have been triangulated with Datix safety incidents, ward FFT scores and complaints information. No falls , pressure ulcers or nursing medication errors occurred on these shifts. There continues to be daily review of the number of critical care beds open which reflects available staff and acuity of the patients and temporary staffing cover.
Site Practitioner Team	During February and March there were 45/118 occasions where actual did not meet planned levels of two staff on duty (36/124 in December and January). Reasons for not meeting planned staffing are related to vacancy and higher levels of short term sickness and staff being released for training.	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. New site practitioner commenced in post of the 26th March 2018 and further staff member commencing 9 April 2018.

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	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Establishment WTE		267.61	257.21	257.21	257.21	257.21	253.30	253.30	253.28	253.28	253.28	253.28	253.28	253.28	◄►
Nursing Headroom		*6.66*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	◄►
Adjusted Establishment (removed Headroom)		267.61	238.99	238.99	238.99	238.99	235.08	235.08	235.06	235.06	235.06	235.06	235.06	235.06	◄►
Staff In Post WTE		199.87	200.37	199.66	200.21	201.53	201.35	199.35	199.44	198.44	193.82	189.62	190.34	193.66	▲
Vacancies WTE		67.74	38.62	39.33	38.78	37.46	33.73	35.73	35.62	36.62	41.24	45.44	44.72	44.01	▼
Vacancies %	>12% / 8%<>12% / <8%	25.31%	16.16%	16.46%	16.23%	15.67%	14.35%	15.20%	15.15%	15.58%	17.54%	19.33%	19.02%	18.72%	▼
STARTERS WTE (Excluding rotational doctors)		0.00	2.61	2.00	1.64	0.76	1.10	1.00	2.24	2.00	0.00	0.72	0.00	4.00	▲
LEAVERS WTE (Excluding rotational doctors)		2.00	1.96	2.85	2.00	0.80	1.00	4.26	3.28	3.00	6.31	2.26	2.61	3.40	▲
Starters & Leavers balance		-2.00	0.65	-0.85	-0.36	-0.04	0.10	-3.26	-1.04	-1.00	-6.31	-1.54	-2.61	0.60	
Agency WTE		13.31	8.88	9.55	12.58	18.05	21.41	21.78	19.69	23.58	20.02	24.14	24.91	29.07	▲
Bank WTE		12.54	10.44	12.97	13.30	10.78	11.48	8.90	10.99	11.86	11.08	19.13	19.03	21.12	▲
Trust rolling Annual Turnover %	>=12% / 10%<>12% / <10%	20.95%	19.87%	20.32%	19.95%	19.57%	18.58%	18.70%	16.76%	15.67%	16.95%	16.11%	15.95%	16.97%	▲
Monthly Turnover		0.74%	0.98%	1.42%	0.99%	0.40%	0.50%	2.14%	1.64%	1.51%	3.25%	1.22%	1.36%	1.75%	▲
Sickness Absence %	>=4% / 4%<>3% / <3%	2.67%	1.79%	2.56%	1.90%	2.22%	3.97%	4.79%	4.56%	4.17%	####	####	4.01%	*3.50%*	March Indicative Figure

Unqualified Nursing Workforce - Performance Indicators

Unqualified Nursing

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17			Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Workforce KPIs (RAG Rating) 2017-18				Mar-18	Compared to Previous Month
Establishment WTE				90.01	99.54	99.54	99.54	99.54	107.92	107.92	107.92	107.92	107.92	107.92	107.92				*Note 1*	107.92	◄►
Nursing Headroom				0.00	8.33	8.33	8.33	8.33	8.33	8.33	8.33	8.33	8.33	8.33	8.33					8.33	◄►
Adjusted Establishment (removed Headroom)				90.01	91.21	91.21	91.21	91.21	99.59	99.59	99.59	99.59	99.59	99.59	99.59					99.59	◄►
Staff In Post WTE				76.55	76.17	77.13	82.13	81.19	81.81	78.25	84.33	85.64	81.64	83.83	80.83					76.73	▼
Vacancies WTE				13.46	15.04	14.08	9.08	10.02	17.78	21.34	15.26	13.95	17.95	15.76	18.76					22.86	▲
Vacancies %	>12%	8%<>12%	<8%	14.95%	16.49%	15.44%	9.96%	10.99%	17.85%	21.43%	15.32%	14.01%	18.02%	15.82%	18.84%	>12%	8%<>12%	<8%		22.95%	▲
STARTERS WTE (Excluding rotational doctors)				2.00	1.00	2.85	2.80	0.80	1.00	3.00	7.61	1.00	1.00	2.80	1.00	TARGETS: XXX				0.00	▼
LEAVERS WTE (Excluding rotational doctors)				1.00	0.38	1.00	2.20	2.73	0.00	5.00	2.19	0.46	1.00	2.00	3.61					1.61	▼
Starters & Leavers balance				1.00	0.62	1.85	0.60	-1.93	1.00	-2.00	5.42	0.54	0.00	0.80	-2.61					-1.61	▼
Agency WTE				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.31	1.34	1.51					3.06	▲
Bank WTE *Note 2*				4.33	3.72	2.81	4.79	4.59	4.92	4.12	4.40	5.35	4.87	5.58	5.78					6.90	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>12%	10%<>12%	<10%	19.75%	16.86%	18.46%	19.85%	22.10%	20.83%	23.19%	25.18%	23.03%	21.26%	24.61%	29.45%	>=12%	10%<>12%	<10%		30.16%	▲
Monthly Turnover				1.31%	0.50%	2.60%	2.66%	3.42%	0.00%	5.93%	2.69%	0.56%	1.18%	2.38%	5.02%					2.05%	▼
Sickness Absence %	>=4%	4%<>3%	<3%	1.97%	2.26%	1.49%	0.91%	1.39%	1.77%	3.93%	6.78%	5.70%	3.16%	6.59%	5.77%	>=4%	4%<>3%	<3%		*5.36%*	*March Indicative Figure*

NURSING METRICS - 12 MONTH ROLLING

BURNS WARD

Contact Gavin Ferrigan on ext. 4556 for any formatting queries

No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18 Apr	May	June	Quarter 2 2017/18 July	Aug	Sept	Quarter 3 2017/18 Oct	Nov	Dec	Quarter 4 2017/18 Jan	Feb	Mar	Quarter 1 Apr	Year to Date Actual	Trend	Comments
SAFE																				
1	**Incidents**	Total reported - All incidents	139	_	18	19	6	5	8	13	13	14	9	7	19	8		121		
2		Total reported - Patient safety	45	_	3	4	3	1	3	4	6	5	3	3	8	2		42		
3		Internal investigation (Amber or Red)	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events	1	0	0	1	0	0	0	0	0	0	0	0	0	0		1		
5	**Falls**	Falls - All	12	0	0	3	0	0	0	0	1	0	1	1	5	1		12		
6		Falls - With harm	1	0	0	1	0	0	0	0	0	0	0	0	0	0		1		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	1	0	0	0	0	0	0		1		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	0	0	1	0	0	0	0	0	0		1		
9	**MRSA Screening**	Elective patients	99.5%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%		99%		
10		Trauma patients	99.3%	95%	100%	100%	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%		99%		
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene	94%	95%	100%	100%	100%	96%		93%		73%		100%	90%			93%		
14		Bare below the elbows	100%	95%	100%	100%	100%	100%		100%		100%		100%	100%			100%		
15	**Drug Assessments**	% staff compliant	97%	100%	100%	100%	93%	93%	89%	89%	100%	100%	100%	100%	100%			96%		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors	9	0	0	0	1	1	1	2	2	2	0	0	0	0		9		
20	**Safety Thermometer**	Harm Free Care %	98.3%	95%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	86%	97%		
21		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	99%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	99%		
23		24 hour follow up (S. Therm)	95.5%	95%	100%	100%	100%	100%	100%	n/a	100%	100%	100%	67%	83%	100%	100%	95%		
24		Monthly screening % (Informatics)		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN	96.7%	95%	98%	99%	94%	98%	99%	98%	99%	93%	97%	91%	96%	98%		97%		
31		HCA	96.6%	95%	94%	97%	95%	98%	98%	100%	100%	95%	84%	98%	100%	100%		97%		
32	**Shift meets requirement** Night %	RN	95.7%	95%	93%	98%	102%	100%	97%	95%	94%	90%	98%	82%	97%	102%		96%		
33		HCA	106.3%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	175%	100%		107%		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
35		7 day review (Safety Thermometer)	100%	95%	100%	100%	100%	100%	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%		
36	**Compliance in Practice** (CiP)	Inspection score		80%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)	652	_	37	60	61	56	44	41	57	52	64	62	62	56		615		
38		% return rate	45%	40%	60%	67%	73%	20%	36%	100%	37%	31%	38%	16%	42%	21%		44%		Compliance discussed with Ward Matron to disseminate this to all staff, including EBAC to increase return rate
39		% recommendation (v likely/likely)	98.3%	90%	100%	100%	100%	100%	100%	92%	100%	100%	100%	96%	100%	92%		98%		
40		% unlikely/extremely unlikely	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%		

RESPONSIVE																				
41	**Complaints**	No. recorded	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
WELL-LED																				
42	**Vacancy**	WTE	6.43	10%	9.65	7.15	8.84	8.84	9.92	7.91	2.88	1.91	2.51	6.12	5.43	6.03		6.1		
43	Establishment=	(hrs)	1044.88	10%	1568	1161	1436	1436	1612	1285	468	310	407	994.5	882	979		997.32		
44	**Temporary Staffing**	Agency Use	99.1	10%	0	34.5	178	92	23	69	121	46	11.5	69	161	384		108.09		
45	excluding RMN	Bank Use	360.1	10%	276	394	372	337	513	426	447	249	200	279	444	384.5		367.77		
46	**Sickness**	%	3.1%	2%	1.8%	1.3%	1.1%	3.8%	2.3%	3.8%	3.1%	2.9%	4.3%	6.6%	1.7%	4.6%		3.2%		All sickness managed via policy currenty
47	**Budget Position**	YTD Position		>0	40384	34632	38138	31005	-2798	-1539	26714	55353	70673	85983	166689			504850		
48	**Statutory & Mandatory**	Mandatory training	89.6%	95%	93%	91%	87%	87%	88%	92%	90%	82%	93%	93%	91%	89%		89%		Discussed with Ward Matron ways to improve compliance of both appraisal and CMTD
49		Appraisal	87.1%	95%	81%	86%	81%	83%	93%	93%	87%	92%	84%	84%	90%	90%		88%		
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING
CORNEOPLASTIC OPD

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18 Apr	May	June	Quarter 2 2017/18 July	Aug	Sept	Quarter 3 2017/18 Oct	Nov	Dec	Quarter 4 2017/18 Jan	Feb	Mar	Quarter 1 Apr	Year to Date Actual	Trend	Comments
SAFE																				
1	**Incidents**	Total reported - All incidents		_	7	12	11	6	3	4	4	6	6	11	5	11		79		
2		Total reported - Patient safety		_	0	5	2	1	3	0	1	4	3	4	2	4		29		
3		Internal investigation (Amber or Red)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
6		Falls - With harm		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	**MRSA Screening**	Elective patients		95%														#DIV/0!		
10		Trauma patients		95%														#DIV/0!		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%		100%		
14		Bare below the elbows		95%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%		100%		
15	**Drug Assessments**	% staff compliant		100%														#DIV/0!		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	0	6	2	0	1	0	1	1	3	1	1	2		18		This relates to doctors prescribing
20	**Safety Thermometer**	Harm Free Care %		95%	n/a													#DIV/0!		
21		New Harm Free %		95%	n/a													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	n/a													#DIV/0!		
23		24 hour follow up (S. Therm)		95%	n/a													#DIV/0!		
24		Monthly screening % (Informatics)		95%	n/a													#DIV/0!		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%														#DIV/0!		
31		HCA		95%														#DIV/0!		
32	**Shift meets requirement** Night %	RN		95%														#DIV/0!		
33		HCA		95%														#DIV/0!		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%														#DIV/0!		
35		7 day review (Safety Thermometer)		95%														#DIV/0!		
36	**Compliance in Practice** (CiP)	Inspection score		80%	Reported 1/4ly			Reported 1/4ly			80.1%			Reported 1/4ly			ported 1/	80%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_												1819		1819		
38		% return rate		20%	22%	21%	22%	22%	27%	22%	22%	24%	26%	23%	22%	20%		23%		Unit staff to raise awareness to patients to increase response rate. Matron to disseminate to team
39		% recommendation (v likely/likely)		90%	95%	94%	96%	95%	95%	95%	94%	96%	93%	94%	95%	94%		95%		
40		% unlikely/extremely unlikely		0%	2%	1%	1%	1%	1%	2%	1%	1%	2%	2%	0%	2%		1%		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	0	1	0	1	0	0	0	1	0	0	0	1		4		Response provided - late clinic cancellations
WELL-LED																				
42	**Vacancy**	WTE		10%											1.91	1.91		1.9		
43	Establishment=	(hrs)		10%											310.4	310.4		310.4		
44	**Temporary Staffing**	Agency Use		10%											0	0		0		
45	excluding RMN	Bank Use		10%											407.4	206.5		306.95		
46	**Sickness**	%		2%											0.8%	0.9%		0.9%		
47	**Budget Position**	YTD Position		>0											92109			92109		
48	**Statutory & Mandatory**	Mandatory training		95%											97%	97%		97%		
49		Appraisal		95%											95%	95%		95%		
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			20			ported 1/	20		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			20			ported 1/	20		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			100%			ported 1/	100%		

NURSING METRICS - 12 MONTH ROLLING
CRITICAL CARE UNIT

Contact Gavin Ferrigan on ext. 4556 for any formatting queries

No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18 Apr	May	June	Quarter 2 2017/18 July	Aug	Sept	Quarter 3 2017/18 Oct	Nov	Dec	Quarter 4 2017/18 Jan	Feb	Mar	Quarter 1 Apr	Year to Date Actual	Trend	Comments
SAFE																				
1	**Incidents**	Total reported - All incidents		_	11	5	11	24	18	8	6	12	14	16	13	9		136		
2		Total reported - Patient safety		_	9	5	9	18	11	6	4	6	8	11	8	5		91		
3		Internal investigation (Amber or Red)		0	1	0	2	0	0	1	0	0	0	0	0	0		3		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	0	0	0	2	0	0	0	0	0	0	0	0		2		
6		Falls - With harm		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	2	0	0	1	0	0	1	0	0	0		4		
8	**Inoculation Injury**	Reported incidents		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	**MRSA Screening**	Elective patients		95%	100%	100%	100%	n/a	n/a	n/a		100%	n/a	100%	100%	n/a		100%		
10		Trauma patients		95%	100%	100%	100%	100%	100%	100%		100%	100%	0%	80%	100%		88%		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	n/a	n/a	n/a	n/a	97%	81%	87%	100%	100%	90%	78%	90%		90%		Hand hygiene results inadequate compliance - Ward Matron to monitor this and challenge appropriately
14		Bare below the elbows		95%	n/a	n/a	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	90%		99%		
15	**Drug Assessments**	% staff compliant		100%	100%	100%	100%	100%	100%	100%	81%	88%	88%	94%	100%	100%		96%		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	1	1	0	0	0	0	0	0	1	1	0	0		3		
20	**Safety Thermometer**	Harm Free Care %		95%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	67%	50%	100%	93%		
21		New Harm Free %		95%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	n/a	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	96%		
23		24 hour follow up (S. Therm)		95%	n/a	100%	0%	100%	100%	100%	n/a	100%	100%	100%	100%	0%	33%	76%		
24		Monthly screening % (Informatics)		95%	100%	100%	100%	100%	100%	100%	n/a	100%	100%	100%	100%			100%		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%	99%	100%	97%	97%	95%	99%	92%	96%	92%	100%	98%	96%		97%		
31		HCA		95%	100%	100%	90%	100%	88%	94%	100%	97%	93%	92%	95%	104%		96%		
32	**Shift meets requirement** Night %	RN		95%	94%	91%	92%	95%	88%	83%	69%	94%	81%	94%	90%	91%		88%		
33		HCA		95%	100%	100%	100%	100%	100%	100%	125%	65%	53%	71%	86%	80%		89%		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%	n/a	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	50%	67%	89%		Discussed with Ward Matron, relates to 1 patient, to ensure each and every patient in unit up to 7 days is
35		7 day review (Safety Thermometer)		95%	n/a	100%	n/a	100%	100%	100%	n/a	75%	n/a	50%	n/a	100%	100%	91%		
36	**Compliance in Practice** (CiP)	Inspection score		80%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_	n/a													0		
38		% return rate		40%	n/a													#DIV/0!		
39		% recommendation (v likely/likely)		90%	n/a													#DIV/0!		
40		% unlikely/extremely unlikely		0%	n/a													#DIV/0!		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	0	0	0	0	0	0	0	0	0	0	1	1		2		
WELL-LED																				
42	**Vacancy**	WTE		10%	7.89	14.39	9.02	9.02	13.28	11.28	5.65	5.01	6.01	9.16	9.16	11.97		9.5		
43	Establishment=	(hrs)		10%	1282	2338	1465	1465	2158	1833	918	814	976	1488	1488	1945		1535.3		
44	**Temporary Staffing**	Agency Use		10%	448.5	252.5	265	586	825.5	839.5	444	827.5	482	689	641	846		608.91		
45	excluding RMN	Bank Use		10%	227.5	101.5	169	189	179	182.5	175	223	149	316	410	353.5		222.5		
46	**Sickness**	%		2%	1.0%	1.5%	0.9%	0.7%	0.0%	2.2%	2.3%	2.5%	4.1%	1.7%	3.0%	3.2%		2.0%		Long term sickness x 2 FT staff, being managed appropriately within policy, alongside the short term
47	**Budget Position**	YTD Position		>0	13367	-34161	-58686	-894	-20940	9594	-943	11190	25981	93023	93265			117429		
48	**Statutory & Mandatory**	Mandatory training		95%	79%	80%	89%	88%	92%	93%	89%	88%	90%	90%	90%	87%		89%		Ward Matron aware of complinace rate, due to vacancies this has been difficult to release staff, to identify a way of
49		Appraisal		95%	88%	88%	100%	90%	100%	100%	94%	91%	91%	91%	86%	72%		91%		
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING
MAIN OUTPATIENTS

Contact Gavin Ferrigan on ext. 4556 for any formatting queries

No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18			Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1	Year to Date Actual	Trend	Comments
					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																				
1	**Incidents**	Total reported - All incidents		_	13	7	9	12	7	8	8	8	10	12	24	16		121		
2		Total reported - Patient safety		_	3	1	1	2	4	2	0	5	1	2	4	3		25		
3		Internal investigation (Amber or Red)		0	0	1	0	0	0	0	0	0	0	0	0	0		1		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	0	0	0	0	0	0	0	0	0	0	1	0		1		
6		Falls - With harm		0	0	0	0	0	0	0	0	0	0	0	1	0		1		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents		0	0	0	0	0	0	0	0	0	2	1	0	0		3		
9	**MRSA Screening**	Elective patients		95%														#DIV/0!		
10		Trauma patients		95%														#DIV/0!		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%	100%	97%	97%	94.7%	93%	56%	70%	56%	70%	86%		83%		
14		Bare below the elbows		95%	100%	100%	100%	100%	100%	100%	77%	89%	90%	100%	100%	100%		96%		
15	**Drug Assessments**	% staff compliant		100%														#DIV/0!		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	0	0	0	0	0	0	0	0	0	0	0	1		1		
20	**Safety Thermometer**	Harm Free Care %		95%	n/a													#DIV/0!		
21		New Harm Free %		95%	n/a													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	n/a													#DIV/0!		
23		24 hour follow up (S. Therm)		95%	n/a													#DIV/0!		
24		Monthly screening % (Informatics)		95%	n/a													#DIV/0!		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%														#DIV/0!		
31		HCA		95%														#DIV/0!		
32	**Shift meets requirement** Night %	RN		95%														#DIV/0!		
33		HCA		95%														#DIV/0!		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%														#DIV/0!		
35		7 day review (Safety Thermometer)		95%														#DIV/0!		
36	**Compliance in Practice** (CiP)	Inspection score		80%	92.9%			Reported 1/4ly			82.1%			89.1%			ported 1/	88%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_												11984		11984		
38		% return rate		20%	16%	15%	15%	17%	16%	17%	16%	16%	17%	18%	17%	18%		16%		Matron working closely with staff to increase compliance and reponse rate
39		% recommendation (v likely/likely)		90%	95%	95%	95%	94%	93%	94%	94%	95%	94%	95%	95%	94%		94%		
40		% unlikely/extremely unlikely		0%	2%	2%	2%	2%	3%	2%	2%	2%	3%	2%	2%	3%		2%		

RESPONSIVE																					
41	**Complaints**	No. recorded		0	0	0	0	0	1	1	0	0	0	1	1	0		4		
WELL-LED																					
42	**Vacancy**	WTE		10%												1.26		1.3		
43	Establishment=	(hrs)		10%												204.75		204.75		
44	**Temporary Staffing**	Agency Use		10%												0		0		
45	excluding RMN	Bank Use		10%												304.5		304.5		
46	**Sickness**	%		2%												5.3%		5.3%		Long term sickness as well as short term, all being managed within the policy appropriately
47	**Budget Position**	YTD Position		>0														0		
48	**Statutory & Mandatory**	Mandatory training		95%												90%		90%		Matron working with team to ensure complinace is increased, appraisla due to be completed in April 2018
49		Appraisal		95%												85%		85%		
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING
MARGARET DUNCOMBE

Contact Gavin Ferrigan on ext. 4556 for any formatting queries

No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18			Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1	Year to Date Actual	Trend	Comments
					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																				
1	**Incidents**	Total reported - All incidents		_	17	12	11	11	20	15	14	18	18	17	15	12		163		
2		Total reported - Patient safety		_	11	8	9	6	16	7	10	11	9	12	12	7		107		
3		Internal investigation (Amber or Red)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	2	1	2	0	2	0	0	1	2	2	1	1		12		
6		Falls - With harm		0	1	0	0	0	2	0	0	0	0	0	1	0		3		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	1	0	0	0	0	0	0	0	0		1		
8	**Inoculation Injury**	Reported incidents		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	**MRSA Screening**	Elective patients		95%	98%	100%	100%	100%	98%	98%	93%	94%	91%	100%	100%	97%		97%		
10		Trauma patients		95%	94%	100%	93%	94%	97%	94%	98%	93%	92%	93%	97%	100%		96%		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
14		Bare below the elbows		95%	83%	100%	100%	100%	100%	100%	100%	100%	93%	100%	60%	100%		96%		
15	**Drug Assessments**	% staff compliant		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%		100%		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	4	0	1	0	5	4	8	6	1	2	2	1		30		
20	**Safety Thermometer**	Harm Free Care %		95%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%	99%		
21		New Harm Free %		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%	99%		
23		24 hour follow up (S. Therm)		95%	100%	100%	100%	100%	90%	100%	100%	89%	92%	54%	67%	80%	73%	87%		
24		Monthly screening % (Informatics)		95%	99%	100%	99%	97%	100%	99%	100%	96%	96%	99%	98%			98%		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%	99%	100%	97%	99%	97%	100%	98%	98%	95%	98%	97%	90%		97%		
31		HCA		95%	102%	100%	90%	97%	94%	100%	105%	102%	100%	104%	93%	107%		99%		
32	**Shift meets requirement** Night %	RN		95%	95%	100%	97%	94%	91%	96%	93%	98%	88%	95%	97%	94%		95%		
33		HCA		95%	93%	100%	100%	73%	84%	90%	68%	77%	88%	91%	88%	85%		86%		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
35		7 day review (Safety Thermometer)		95%	100%	33%	100%	100%	100%	100%	100%	0%	67%	50%	100%	0%	100%	71%		
36	**Compliance in Practice** (CiP)	Inspection score		80%	80.1%			Reported 1/4ly			87.4%			86.8%			ported 1/	85%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_	171	170	169	160	145	144	139	146	122	129	133	109		1566		
38		% return rate		40%	67%	74%	47%	47%	68%	54%	49%	31%	77%	78%	63%	76%		60%		
39		% recommendation (v likely/likely)		90%	98%	100%	96%	99%	99%	96%	100%	100%	95%	99%	96%	99%		98%		
40		% unlikely/extremely unlikely		0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%		0%		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	0	0	0	0	0	0	0	0	0	0	1	0		1		
WELL-LED																				
42	**Vacancy**	WTE		10%	7.12	4.79	6.29	8.99	11.13	11.82	5.62	6.55	7.41	9.79	8.92	10.02		8.3		
43	Establishment=	(hrs)		10%	1157	778	1022	1460	1808	1921	913	1064	1204	1590	1450	1628		1348.9		
44	**Temporary Staffing**	Agency Use		10%	54	174.5	115	173	333.5	464.5	331	799	968	1045	874	1229		591.5		
45	excluding RMN	Bank Use		10%	243.5	316.5	555	407	424.5	360.5	541.5	732	302	557	553	827.5		506.95		
46	**Sickness**	%		2%	2.2%	3.2%	3.5%	2.6%	2.9%	0.5%	4.9%	3.6%	3.9%	5.4%	6.3%	5.6%		3.9%		Matron working with HR and Occupational Health to support staff
47	**Budget Position**	YTD Position		>0	-11267	-20589	-28289	-33744	47435	47794	63502	72524	61585	36168				246386		
48	**Statutory & Mandatory**	Mandatory training		95%	88%	88%	91%	94.5%	94.6%	95%	95%	94.8%	91%	93%	95%			93%		
49		Appraisal		95%	100%	100%	98%	94%	96%	91%	94%	94%	100%	98%	82%			95%		Discussed with Matron who is working to imrpove this again
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING

ROSS TILLEY

Contact Gavin Ferrigan on ext. 4556 for any formatting queries

No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18 Apr	May	June	Quarter 2 2017/18 July	Aug	Sept	Quarter 3 2017/18 Oct	Nov	Dec	Quarter 4 2017/18 Jan	Feb	Mar	Quarter 1 Apr	Year to Date Actual	Trend	Comments
SAFE																				
1	**Incidents**	Total reported - All incidents		_	7	14	18	22	8	10	16	24	21	26	16	12		187		
2		Total reported - Patient safety		_	3	11	6	8	5	5	8	14	14	20	8	9		108		
3		Internal investigation (Amber or Red)		0	0	0	0	0	0	0	0	0	0	1	0	0		1		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	2	2	2	1	0	0	0	5	1	4	2	0		17		
6		Falls - With harm		0	0	0	1	0	0	0	0	0	0	0	0	0		1		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents		0	0	0	1	0	0	0	0	1	0	0	0	0		2		
9	**MRSA Screening**	Elective patients		95%	97%	98%	98%	96%	99%	100%	98%	100%	100%	98%	94%	95%		98%		
10		Trauma patients		95%	97%	100%	96%	93%	96%	96%	96%	98%	100%	99%	96%	99%		97%		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%		100%		
14		Bare below the elbows		95%	84%	100%	100%	100%	100%	100%	100%	100%	87%		100%	100%		99%		
15	**Drug Assessments**	% staff compliant		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%		100%		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	2	5	3	1	1	2	4	5	6	3	3	5		38		
20	**Safety Thermometer**	Harm Free Care %		95%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	99%		
21		New Harm Free %		95%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	99%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	100%	100%	100%	100%	100%	100%	100%	100%	94%	89%	100%	100%	100%	99%		
23		24 hour follow up (S. Therm)		95%	100%	100%	100%	100%	100%	100%	100%	71%	88%	83%	60%	50%	93%	87%		
24		Monthly screening % (Informatics)		95%	99%	100%	99%	93%	99%	99%	99%	98%	96%	99%	99%			98%		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%	99%	100%	100%	100%	98%	99%	102%	99%	91%	95%	97%	93%		98%		
31		HCA		95%	100%	98%	100%	98%	94%	100%	100%	93%	96%	91%	102%	96%		97%		
32	**Shift meets requirement** Night %	RN		95%	89%	94%	83%	99%	91%	104%	93%	95%	89%	89%	95%	96%		93%		
33		HCA		95%	90%	96%	95%	85%	84%	81%	67%	79%	73%	86%	96%	100%		86%		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	94%	100%	100%	99%		
35		7 day review (Safety Thermometer)		95%	n/a	100%	100%	100%	100%	75%	100%	50%	80%	100%	100%	25%	100%	86%		
36	**Compliance in Practice** (CiP)	Inspection score		80%	Reported 1/4ly			Reported 1/4ly			90.6%			86.6%			ported 1/	89%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_	168	206	212	234	227	199	209	219	181	215	174	174		2250		
38		% return rate		40%	39%	50%	32%	41%	35%	54%	56%	24%	79%	55%	43%	58%		48%		
39		% recommendation (v likely/likely)		90%	100%	97%	99%	97%	96%	97%	97%	98%	99%	97%	99%	99%		98%		
40		% unlikely/extremely unlikely		0%	0%	1%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%		0%		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	0	0	0	0	0	0	1	0	0	0	0	1		2		
WELL-LED																				
42	**Vacancy**	WTE		10%	7.12	4.79	6.29	8.99	11.13	11.82	5.62	6.55	7.41	9.79	8.92	10.02		8.3		
43	Establishment=	(hrs)		10%	1157	778	1022	1460	1808	1921	913	1064	1204	1590	1450	1628		1348.9		
44	**Temporary Staffing**	Agency Use		10%	54	174.5	115	173	333.5	464.5	331	799	968	1045	874	1229		591.5		
45	excluding RMN	Bank Use		10%	243.5	316.5	555	407	424.5	360.5	541.5	732	302	557	553	827.5		506.95		
46	**Sickness**	%		2%	2.2%	3.2%	3.5%	2.6%	2.9%	0.5%	4.9%	3.6%	3.9%	5.4%	6.3%	5.6%		3.9%		Matron working with HR and Occupational Health to support staff
47	**Budget Position**	YTD Position		>0	-11267	-20589	-28289	-33744	47435	47794	63502	72524	61585	36168				246386		
48	**Statutory & Mandatory**	Mandatory training		95%	88%	88%	91%	94.5%	94.6%	95%	95%	94.8%	91%	93%	95%			93%		
49		Appraisal		95%	100%	100%	98%	94%	96%	91%	94%	94%	100%	98%	82%			95%		Discussed with Matron who is working to imrpove this again
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING
MAX FAC OUTPATIENTS

Contact Gavin Ferrigan on ext. 4556 for any formatting queries

No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18			Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1	Year to Date Actual	Trend	Comments
					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																				
1	**Incidents**	Total reported - All incidents		_	0	0	3	1	0	4	3	4	3	2	5	5		30		
2		Total reported - Patient safety		_	0	0	0	1	0	1	2	1	2	0	0	1		8		
3		Internal investigation (Amber or Red)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
6		Falls - With harm		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents		0	0	0	1	0	0	0	0	0	0	1	0	0		2		
9	**MRSA Screening**	Elective patients		95%														#DIV/0!		
10		Trauma patients		95%														#DIV/0!		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
14		Bare below the elbows		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
15	**Drug Assessments**	% staff compliant		100%														#DIV/0!		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	0	0	0	0	0	0	1	0	1	0	0	0		2		
20	**Safety Thermometer**	Harm Free Care %		95%	n/a													#DIV/0!		
21		New Harm Free %		95%	n/a													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	n/a													#DIV/0!		
23		24 hour follow up (S. Therm)		95%	n/a													#DIV/0!		
24		Monthly screening % (Informatics)		95%	n/a													#DIV/0!		
25	**BMI Monthly**	Total no. of ward patients		_	n/a													0		
26		No. patients screened & documented		_	n/a													0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%														#DIV/0!		
31		HCA		95%														#DIV/0!		
32	**Shift meets requirement** Night %	RN		95%														#DIV/0!		
33		HCA		95%														#DIV/0!		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%														#DIV/0!		
35		7 day review (Safety Thermometer)		95%														#DIV/0!		
36	**Compliance in Practice** (CiP)	Inspection score		80%	80.5%			Reported 1/4ly			Reported 1/4ly			83.3%			ported 1/	82%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_												1436		1436		
38		% return rate		20%	18%	18%	18%	18%	19%	18%	18%	17%	18%	19%	17%	17%		18%		Discussed with team, aware to encourage patients to complete to improve this data and understand where
39		% recommendation (v likely/likely)		90%	92%	94%	95%	94%	88%	91%	91%	92%	91%	95%	94%	91%		92%		
40		% unlikely/extremely unlikely		0%	3%	2%	3%	2%	4%	5%	4%	2%	4%	2%	2%	4%		3%		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	2	0	2	1	1	1	0	1	0	3	2	0		11		
WELL-LED																				
42	**Vacancy**	WTE		10%											0.79	2.39		1.6		
43	Establishment=	(hrs)		10%											128.37	388		258.19		
44	**Temporary Staffing**	Agency Use		10%											0	0		0		
45	excluding RMN	Bank Use		10%											274.37	24		149.19		
46	**Sickness**	%		2%											5.5%	0.5%		3.0%		
47	**Budget Position**	YTD Position		>0											8270			8270		
48	**Statutory & Mandatory**	Mandatory training		95%											93%	90%		91%		Ward Matron aware compliance is required to improve with immediate effect, working closely with the team to
49		Appraisal		95%											85%	85%		85%		
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING

PEANUT WARD

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18 Apr	May	June	Quarter 2 2017/18 July	Aug	Sept	Quarter 3 2017/18 Oct	Nov	Dec	Quarter 4 2017/18 Jan	Feb	Mar	Quarter 1 Apr	Year to Date Actual	Trend	Comments
SAFE																				
1	**Incidents**	Total reported - All incidents		_	5	3	7	9	6	11	11	14	9	10	13	2		95		
2		Total reported - Patient safety		_	2	2	4	3	1	3	1	3	2	3	2	0		24		
3		Internal investigation (Amber or Red)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
6		Falls - With harm		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	**MRSA Screening**	Elective patients		95%	n/a													#DIV/0!		
10		Trauma patients		95%	n/a													#DIV/0!		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%		100%			94%			100%				99%		
14		Bare below the elbows		95%	100%	100%		100%			91%			100%				98%		
15	**Drug Assessments**	% staff compliant		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%		99%		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	1	0	1	1	0	0	1	0	1	0	0	0		4		
20	**Safety Thermometer**	Harm Free Care %		95%	100%	n/a	n/a	100%	100%	n/a	100%	n/a	n/a	100%	n/a	n/a	100%	100%		
21		New Harm Free %		95%	100%	n/a	n/a	100%	100%	n/a	100%	n/a	n/a	100%	n/a	n/a	100%	100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	n/a													#DIV/0!		
23		24 hour follow up (S. Therm)		95%	n/a													#DIV/0!		
24		Monthly screening % (Informatics)		95%	n/a													#DIV/0!		
25	**BMI Monthly**	Total no. of ward patients		_														0		
26		No. patients screened & documented		_														0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%	98%	101%	90%	99%	98%	99%	101%	93%	87%	100%	99%	96%		97%		
31		HCA		95%	100%	100%	97%	103%	94%	97%	91%	100%	100%	91%	103%	100%		98%		
32	**Shift meets requirement** Night %	RN		95%	51%	49%	51%	59%	44%	49%	67%	45%	55%	92%	88%	93%		63%		
33		HCA		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%	n/a													#DIV/0!		
35		7 day review (Safety Thermometer)		95%	n/a													#DIV/0!		
36	**Compliance in Practice** (CiP)	Inspection score		80%	84.0%			Reported 1/4ly			88.7%			88.1%			ported 1/	87%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_	200	209	205	222	205	196	191	195	181	173	192	171		2140		
38		% return rate		40%	11%	29%	12%	33%	36%	30%	18%	31%	33%	31%	34%	40%		30%		
39		% recommendation (v likely/likely)		90%	100%	100%	100%	99%	100%	100%	97%	98%	97%	100%	100%	100%		99%		
40		% unlikely/extremely unlikely		0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	0%	0%		0%		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
WELL-LED																				
42	**Vacancy**	WTE		10%	6	6.49	6.5	6.5	4.89	3.89	2.45	2.45	0.93	0	0	0		3.1		
43	Establishment=	(hrs)		10%	975	1054	1056	1056	795	632	398	398	151	0	0	0		503.64		
44	**Temporary Staffing**	Agency Use		10%	50	46	46	210	213	236	197	17.5	57	22.5	10	1		96		
45	excluding RMN	Bank Use		10%	234.5	265	381	373	253	324.5	369	437.5	168	229	217	34		277.36		
46	**Sickness**	%		2%	3.2%	2.6%	3.1%	3.7%	4.8%	8.7%	12.0%	5.6%	7.9%	4.5%	6.8%	3.6%		5.8%		Matron working with HR and Occupational Health to support staff
47	**Budget Position**	YTD Position		>0	2222	4611	5910	11060	-1469	-6253	1682	23045	811	-13480	-14325			11592		
48	**Statutory & Mandatory**	Mandatory training		95%	84%	88%	90%	91%	90%	86%	86%	84%	83%	83%	88%			87%		Discussed with Matron who is working to imrpove this.
49		Appraisal		95%	77%	80%	84%	83%	83%	83%	79%	75%	75%	75%	77%			79%		Discussed with Matron who is working to imrpove this.
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING

SLEEP DC

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1 2017/18 Apr	May	June	Quarter 2 2017/18 July	Aug	Sept	Quarter 3 2017/18 Oct	Nov	Dec	Quarter 4 2017/18 Jan	Feb	Mar	Quarter 1 Apr	Year to Date Actual	Trend	Comments
SAFE																				
1	**Incidents**	Total reported - All incidents		_	2	0	2	3	4	3	2	2	0	2	3	3		24		
2		Total reported - Patient safety		_	2	0	1	0	1	1	1	1	0	0	0	2		7		
3		Internal investigation (Amber or Red)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
6		Falls - With harm		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	**Pressure Damage**	G2 or above (hospital acquired)		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	**MRSA Screening**	Elective patients		95%														#DIV/0!		
10		Trauma patients		95%														#DIV/0!		
11		Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases		0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene		95%	100%	100%	100%		100%	100%	100%	100%	100%	100%				100%		
14		Bare below the elbows		95%	100%	100%	100%		100%	100%	90%	100%	100%	100%				99%		
15	**Drug Assessments**	% staff compliant		100%														#DIV/0!		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
19	**Medication Errors**	Reported errors		0	0	0	0	0	0	0	1	0	0	0	0	1		2		
20	**Safety Thermometer**	Harm Free Care %		95%	n/a													#DIV/0!		
21		New Harm Free %		95%	n/a													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%	n/a													#DIV/0!		
23		24 hour follow up (S. Therm)		95%	n/a													#DIV/0!		
24		Monthly screening % (Informatics)		95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
25	**BMI Monthly**	Total no. of ward patients		_														0		
26		No. patients screened & documented		_														0		
27		Patients with documented BMI %		95%														#DIV/0!		
28	**WHO Checklist**	Qualitative %		95%														#DIV/0!		
29		Quantitative %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		
30	**Shift meets requirement** Day %	RN		95%														#DIV/0!		
31		HCA		95%														#DIV/0!		
32	**Shift meets requirement** Night %	RN		95%														#DIV/0!		
33		HCA		95%														#DIV/0!		
EFFECTIVE																				
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)		95%	n/a													#DIV/0!		
35		7 day review (Safety Thermometer)		95%	n/a													#DIV/0!		
36	**Compliance in Practice** (CiP)	Inspection score		80%	87.4%			Reported 1/4ly			84.4%			89.0%			ported 1/	87%		
CARING																				
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_												903		903		
38		% return rate		20%	31%	21%	25%	26%	20%	20%	24%	21%	23%	21%	21%	21%		22%		
39		% recommendation (v likely/likely)		90%	96%	96%	93%	93%	95%	98%	99%	96%	95%	96%	94%	93%		95%		
40		% unlikely/extremely unlikely		0%	0%	2%	2%	4%	1%	1%	0%	2%	1%	0%	3%	4%		2%		

RESPONSIVE																				
41	**Complaints**	No. recorded		0	0	0	0	1	0	1	0	0	0	1	0	0		3		
WELL-LED																				
42	**Vacancy**	WTE		10%														#DIV/0!		
43	Establishment=	(hrs)		10%														#DIV/0!		
44	**Temporary Staffing**	Agency Use		10%														#DIV/0!		
45	excluding RMN	Bank Use		10%														#DIV/0!		
46	**Sickness**	%		2%														#DIV/0!		
47	**Budget Position**	YTD Position		>0														0		
48	**Statutory & Mandatory**	Mandatory training		95%														#DIV/0!		
49		Appraisal		95%														#DIV/0!		
50	**Uniform Audit**	Total no. of staff audited		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
51		No. of staff compliant		_	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	0		
52		Compliance with uniform policy %		95%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			ported 1/	#DIV/0!		

Queen Victoria Hospital
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/05/2018**		**Agenda reference:**	68-18	
Report title:	Bi-annual nursing workforce review				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Nicky Reeves, Deputy Director of Nursing				
Appendices:	1. NQB expectations 2. Safe staffing metric example 3. Recommendations to aid decision making				
Executive summary					
Purpose:	The bi-annual workforce review is prepared for the board in accordance with National Quality Board workforce guidance. The report reviews the staff levels in the organisation against national guidance and focuses on key actions being taken to address the recruitment and retention challenges for nursing , operating department assistants and health care assistants				
Recommendation:	The Board to **note** the sustained challenges in the nursing workforce and the **assurance** in the report of how the Trust is providing safe staffing levels to care for our patients.				
Purpose	Approval	Information	Discussion	Assurance **Y**	Review
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**	KSO3: **Y**	KSO4: **Y**	KSO5: **Y**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	Links to all 5 KSOs				
Corporate risk register:	Workforce risk is included on corporate risk register.				
Regulation:	Compliance with regulated activities in Health & Social Care Act 2008.				
Legal:	As above				
Resources:	As contained within the report				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	April 2018	Decision:	Committee noted assurance that safe staffing was being achieved when compared with national guidance, safety metrics and professional judgement.	
Previously considered by:					
	Date:	dd/mm/yy	Decision:		
Next steps:					

Bi-annual nursing workforce review
01 October 2017 – 31 March 2018

1. Purpose

This report provides the Board with the six monthly review of nurse staffing levels at Queen Victoria Hospital and fulfils the requirements of the National Quality Board (NQB) expectations (appendix 1) in providing assurance on staffing levels and quality of care.

The paper provides assurance that the National Quality Board "safe sustainable and productive staffing paper, An improvement resource for adult inpatient wards in acute hospitals (Edition 1, January 2018) has been reviewed as part of this report and referenced as appropriate.

The report reviews the staffing in theatre, inpatient and outpatient areas of the organisation and the range of initiatives being taken to improve the situation regarding recruitment and retention of registered and unregistered staff within the clinical areas.

2. Background

The benefits of having appropriate staffing levels are well evidenced and include safer care, greater staff satisfaction and align with the Trust's key strategic objectives;

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

As previously identified, following the Francis Public Inquiry Report and the Government's response to the inquiry recommendations "Hard Truths", there has been significant national focus on nurse staffing levels, and ensuring these are fit for purpose.

The data in this report is based on information available covering the 6 months from 01 October 2017 to 31 March 2018 inclusive. This data is based on a number of sources including ledger, HR, Safe Staffing and local templating and establishment information.

The appendices contain an example of the staffing review metrics which demonstrate the numbers of times the staffing levels fell below the planned levels for that day. This data is reviewed on a daily basis, in real time, by the nursing and quality team. (Appendix 2)

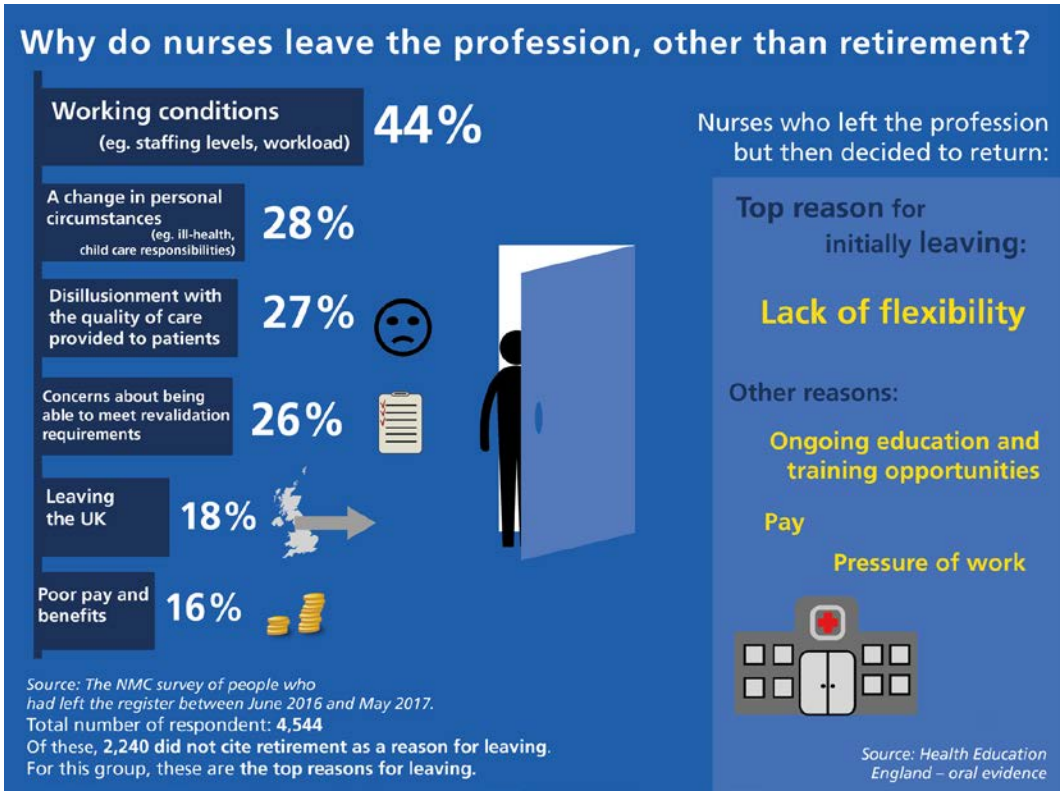
3. Recruitment and Retention Initiatives and Challenges

As part of this paper the House of Commons Health Committee report, the nursing workforce – Second report of session 2017 – 19 has been reviewed. The paragraph below summarises the national challenge which is mirrored here at QVH.

"Major changes have recently been made to routes in to nursing. However, too little attention has been given to retaining the existing workforce, and more nurses are now leaving the professional register than are joining it. There are many causes for the shortfall in the nursing workforce, including workload pressures, poor access to continuing professional

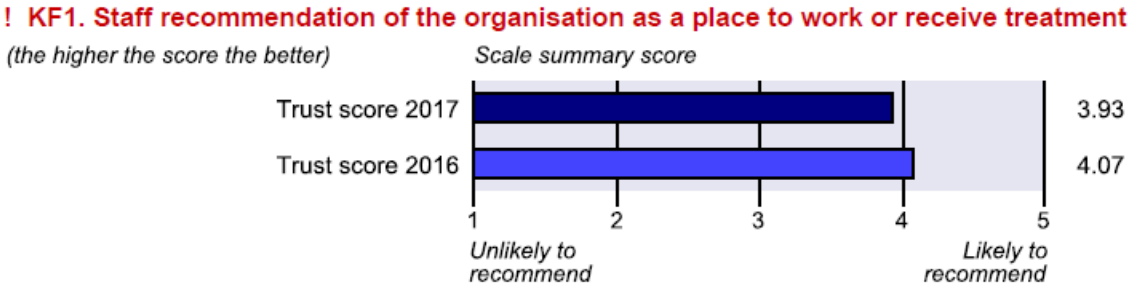
development, a sense of not feeling valued, ongoing pay restraint, the impact of Brexit and the introduction of language testing."

Below is a summary of a survey looking at the responses of 4,500 nurses



As previously reported the trust is part of the NHSI nursing retention initiative and ideas and learning from this have been transposed into QVH workforce strategy. QVH is concentrating on ensuring all Trust staff feel valued and supported, a range of improved bank rates of pay has been introduced to incentivise staff to cover more shifts flexibly. There are many funded opportunities for staff to attend study days and courses including conferences, formal educational opportunities, for example degree and diploma level study and apprenticeships.

The 2017 National NHS staff survey identifies deterioration in the numbers of staff recommending QVH as a place to work.



Themes identified through the "stay interviews" and "exit interviews" have been reviewed by the Deputy Director of HR and the Deputy Director of Nursing. Where there are issues identified, action is taken to address these. Examples of challenges have been stated as lack of flexibility in rota patterns, lack of leadership at unit level and communication issues. This action is intended to address the deterioration in this score.

QVH is actively seeking opportunities to promote the Trust at schools, colleges, universities and other careers events. In addition links are being forged with South Bank University to look at new opportunities for additional student nurses to come to QVH for placement however a recent UCAS (University and Colleges Admission Service) survey has identified a significant decrease in the numbers of trainee nurses applying.

“The number of applicants to study nursing in England decreased by 14 percent, from 36,720 in 2017 to 31,750 this year. This is the second year in a row the number of nursing applicants has dropped in England. Following the removal of the student bursary, numbers fell from 47,390 applicants in England in 2016.

The greatest percentage drop in nursing applications was in applicants over the age of 25, which has been a trend since 2016.

The number of women between aged 25-29 applying to do nursing in England fell by 57 per cent between 2016 and 2018 and for women aged 30-34 the number of applicants fell by 49 per cent during the same period. For 18 year old applicants, there was a 13 per cent drop between 2016 and 2018.

The number of male nurse applicants aged 25-29 also fell during this time period, dropping by 67 percent. For men aged 30-34 the number applicants fell to 270 in 2018 from 660 in 2016. For 18 year old male applicants, there was a 3 percent rise between 2016 and 2018.”

The Trust is exploring opportunities with international recruitment and is currently interviewing a range of staff with ward or Critical Care experience. QVH is also exploring tailored recruitment internationally for theatre staff.

A number of schemes are being implemented to attract staff including paying newly qualified staff at Band 4 until their registration is completed, fast tracking them through the incremental points during their first year on completion of a preceptorship programme and financial support to cover the cost of the first years registration.

QVH is offering “new starter premiums” to registered nurses and theatre practitioners in addition to relocation expense if eligible; the new recruit gets £500 after successful completion of the probationary period and then £1000 at 1 year.

There is a “refer a friend scheme” whereby existing staff are rewarded with a payment in the event that an applicant they introduced to the organisation is successfully recruited.

QVH is having some success with return to practice nursing staff who are keen to work with us during their university programme on placement and afterwards in substantive posts.

QVH is developing band 4 assistant practitioner roles in a number of clinical areas and collaborating with other providers to ensure readiness for the associate nurse roles once the Nursing and Midwifery Council agree on the process for registration of such a qualification.

The senior nursing team are ensuring recruitment and retention focuses on the speciality skill set of the teams and the vital role the specialisms play in the “QVH brand”. Two teams at QVH with a robust sense of speciality, Corneo plastics and Burns have favourable recruitment and retention metrics and are also sort after placements for student nurses carrying out elective placements and choosing to come to QVH for this experience. Learning from these areas and applying this to the other areas within the organisation may help to address the challenges with retention and recruitment.

Below is the last 12 months leaver and starter data for information.

QUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17 & 2017-18	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Compared to Previous Month
STARTERS WTE (Excluding rotational doctors)		0.00	2.61	2.00	1.64	0.76	1.10	1.00	2.24	2.00	0.00	0.72	0.00	4.00	▲
LEAVERS WTE (Excluding rotational doctors)		2.00	1.96	2.85	2.00	0.80	1.00	4.26	3.28	3.00	6.31	2.26	2.61	3.40	▲
Starters & Leavers balance		-2.00	0.65	-0.85	-0.36	-0.04	0.10	-3.26	-1.04	-1.00	-6.31	-1.54	-2.61	0.60	

UNQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Workforce KPIs (RAG Rating) 2017-18	Mar-18	Compared to Previous Month
STARTERS WTE (Excluding rotational doctors)		2.00	1.00	2.85	2.80	0.80	1.00	3.00	7.61	1.00	1.00	2.80	1.00	TARGETS: XXX	0.00	▼
LEAVERS WTE (Excluding rotational doctors)		1.00	0.38	1.00	2.20	2.73	0.00	5.00	2.19	0.46	1.00	2.00	3.61		1.61	▼
Starters & Leavers balance		1.00	0.62	1.85	0.60	-1.93	1.00	-2.00	5.42	0.54	0.00	0.80	-2.61		-1.61	▼

Sourced via ESR data

Vacancy rate has not impacted negatively on patient satisfaction scores (2017 Picker Survey, Complaints, Friends and Family Test). With patient satisfaction being sustained as some of the best in England from the national surveys and FFT scores. Patient experience is a key measure of quality and deterioration in this can be an early warning indicator that there are quality issues.

The risks associated with prolonged vacancies have been added to departmental risk registers, CRR and the BAF risk rating for key strategic objectives – KSO 5 Organisational Excellence has been increased to reflect the increased risk regarding workforce.

4. Establishment benchmarking sources

NICE guidance advises not more than 8 patients per registered nurse during the day time and one registered nurse to 10 patients at night as a national benchmark for a “general ward” and this has been used as the standard for review in Canadian Wing. In addition, the staffing establishments have also be measured using the Safe Care Patient Activity and Dependency models.

As before, RCN guidance advises a ratio of RN: HCA at 65:35 for a general ward. Canadian Wing has a ratio of 72:28. The skill mix is set above the RCN guidance due to the number of multi-specialty patients, the patient turnover, complexity and the range of skills required to provide high quality care.

National benchmarking data for Burns Units is difficult to identify however, staffing levels at QVH compare favourably to other burns units within the London and South East Burns Network.

The Royal College of Nursing (RCN) guidance on paediatric nursing staffing advises that regardless of patient numbers, there should be a minimum of 2 registered children’s nurses on duty at any time. The specific staffing solution for Peanut ward is described in more detail below.

Critical Care guidance provided by the Intensive Care Society requires that level 3 patients must be cared for on a ratio of one registered nurse per patient plus supervisory registered nurse support. Level 2 and 1 patients require a reduced ratio of registered staff, one nurse to two or three patients for example. Since Critical Care incorporated the Step Down Patient cohort, the overall critical mass of staff has increased which allows greater flexibility.

Theatre establishment are benchmarked against both the Association for Perioperative Practice (AfPP) guidance and the Royal College of Anaesthetist guidance relating to anaesthetic practitioners. These recommendations are used to create the overall theatre establishment.

In 2018 Picker Inpatient Survey, 81% of respondents identified that “in their opinion there were enough nurses on duty to care for you in hospital”, this is significantly better than the average score of 60 % for other organisations although it does demonstrate a 1% decrease on last year.

5. Establishment review findings

The Deputy Director of Nursing (DDN) undertook the six month reviews with the Heads of Nursing (HoN) and Ward Matrons for each ward area; in addition, the Theatre Manager and DDN reviewed the theatre staffing establishment. These reviews have been presented to the Director of Nursing and Quality (DNQ) for further review and quality assurance.

Nurse staffing across the whole site is reviewed in real time by the ward matrons and heads of nursing, and out of hours by the Site Practitioner. The DDN or DNQ monitor planned staffing levels against actual on a daily basis (example in appendix 2)

Ward and Outpatient areas as at 31st March 2018 (excl Ward clerk and admin posts)

Below is a summary of the staffing establishments including registered and non-registered workforce but excluding non-clinical, admin and clerical posts

Department	17/18 WTE Registered and Unregistered Establishment in ledger (incl 22% Uplift)	Minimum staff required (Substantive WTE)	Planned leave uplift (+12%) (Substantive WTE)	Total Recruitable (Substantive WTE)	Number of WTE in post 1st October 2017	Number of WTE in post 31st March 2018	Number of vacant posts 31st March 2018	% Vacant posts 31st March 2018	Staff in post change from Oct 17 to Mar18
Burns Ward	28.36	23.25	2.79	26.04	23.81	21.01	5.03	19.3%	↓
Canadian Wing	48.62	39.85	4.78	44.63	38.94	36.10	8.53	19.1%	↓
Corneo OPD	20.79	17.04	2.04	19.09	16.71	17.21	1.88	9.8%	↑
Critical Care	30.42	24.93	2.99	27.93	20.53	19.21	8.72	31.2%	↓
Max Fax OPD	23.28	19.08	2.29	21.37	21.41	19.61	1.76	8.2%	↓
Peanut ward*	18.64	15.28	1.83	17.11	14.59	17.43	0.00	0.0%	↑
Peri Op **	142.24	116.59	13.99	130.58	129.53	103.20	27.38	21.0%	↓
Plastics OPD	15.53	12.73	1.53	14.26	14.05	13.24	1.02	7.1%	↓
Totals	**327.88**	**268.75**	**32.25**	**301.00**	**279.57**	**247.01**	**54.31**	**18.0%**	↓

*Peanut have 1 post held for student nurse commencing in September 2018
**Peri op vacancies are Band 5 posts in pre-assessment, recovery, admissions, discharge and theatres.

Peri Op including Pre assessment

Theatre staffing has been benchmarked and assurance provided that each theatre is established with the correct number of staff compared with the AfPP guidance.

Theatres are actively recruiting to 27.38 WTE, mainly band 5 registered staff. There remains a national shortage of trained theatre nurses/practitioners which is more acute in the South region.

Theatres continue to line book a minimum of 10 agency theatre nurses per day to provide safe staffing in theatres. The “regular” agency staff receive local induction and orientation to the department. Staffing is risk assessed on a daily basis reviewing the impact of agency staff on the skill mix within theatre. Theatres operate at a higher level of risk due to the use of temporary staffing whilst trying to improve theatre productivity

It should be noted that the ongoing challenges with recruitment are impacting on operational delivery with a number of operating list cancelled on a weekly basis to maintain safety and ensure satisfactory skill mix is maintained within the department. Below is a chart indicating the numbers of list cancelled for the first quarter of the year.

January	6
February	15
March	27
Total	**48**

Canadian Wing

Canadian Wing has a bed compliment of 43 beds including 4 enhanced recovery beds and 4 corneo plastics beds which are staffed at a higher level due to the co morbidity and speciality nature of the patients; these are included within the overall staffing calculations. Following review in conjunction with the HoN and Ward Matron, Canadian Wing as a total runs on a registered staffing ratio of 1:6 during the day and 1:7 at night including the enhanced recovery area. In addition, there are Health Care Assistants working across both wards offering care and support to the patients under the supervision of a registered nurse. There are 8.53 WTE vacancies being actively recruited to.

Burns Ward

The benchmarking data for Burns Ward is consistent with our surrounding burns units. The staffing establishment for the 6 beds is 3 registered staff giving a ratio of 1:2 on a day shift at night there are 2 registered staff for 6 beds giving a ratio of 1:3. The Burns budget includes a number of additional staff who support the management of patients in the community, education, administration and audit. These additional posts are a requirement of the National Burns Care Standards. There are 5.03 WTE vacancies being actively recruited to.

Critical Care

Critical care has establishments set which are consistent and compliant with the specific guidance laid down by the Intensive Care Society. QVH Critical Care is established to deliver level 3 care to two to three patients (depending on the severity of the case) and level 2 and 1 care to varying numbers of patients. The maximum number of patients being cared for at Levels 3-1 is five. The skill mix and patient acuity are reviewed on an hour by hour basis to ensure the correct staffing levels are maintained. There remains a national shortage of qualified critical care nurses. In addition to recruitment initiatives, regular agency staff are utilised to ensure consistency and safety is maintained. The team is very flexible in changing shifts to accommodate peaks and troughs in critical care requirements. There are currently 8.72 WTE vacancies being actively recruited to. It should be noted in addition to the existing vacancy that Critical Care have 1.8 WTE registered staff on maternity leave which is impacting on temporary and agency staff usage.

Paediatrics

The paediatric ward establishment has been set using RCN guidance for staffing paediatric units.

After a successful trial the ward now runs an on call service at night and will only open in the event that a patient requires overnight care, otherwise staff go off duty at 00.00. This model of care has been approved by the executive and the hospital management team.

Corneo OPD

Corneo has excellent retention of staff and has developed a range of specialist roles to meet the needs of their patient group. Corneo are actively recruiting 1.8 WTE.

Max Fax OPD

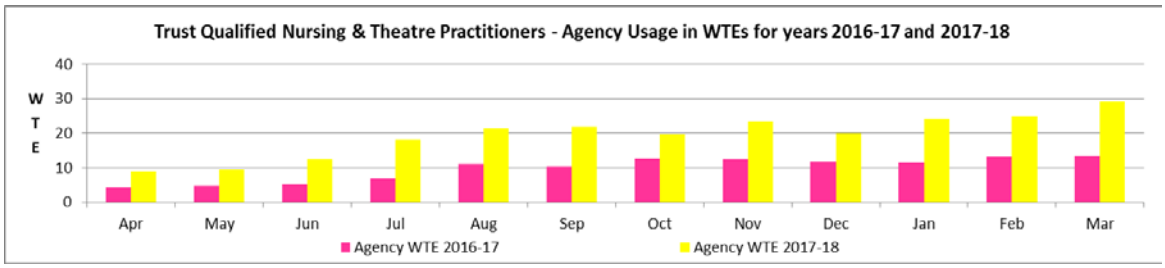
Max Fax has improved its recruitment and retention over the last 6 months and is recruiting to 1.76 WTE.

Plastics OPD

Plastics Outpatients has improved its recruitment and is recruiting to 1.0 WTE.

6. Temporary Staff usage

The graphs below demonstrate an increase in agency usage and therefore cost. Nursing vacancies make it necessary to use temporary staffing which is above the NHSI set agency cap to provide safe cover in some specialist areas for example in Theatres and Critical care (significant national shortages in all these staff groups).



Sourced via ESR

As stated earlier in the paper, temporary staff receive a local induction to their area.

There are 4 points throughout the day where staffing and safety are reviewed, at 08.00, 10.00, 15.30 and 20.00 via the site handover and bed meetings chaired by the Site Practitioner team with Multidisciplinary input.

Both the DDN and DoN monitor staffing levels via e roster and the safe staffing metrics as shown in appendix 2.

Monthly triangulation of actual staffing against planned is carried out and measured against incidents raised via datix.

7. Retirements

Please see table attached with qualified Nurses/theatres practitioners who could retire in the next 2 years. Included is anyone aged 53 and over for any NMC registered staff and anyone 58 and over for any HCPC registered staff.

Pay Scale	2 years
Review Body Band 5	31
Review Body Band 6	27
Review Body Band 7	16
Review Body Band 8 - Range A	1
Review Body Band 8 - Range B	1
Grand Total	**76**

8. Sickness and Maternity Leave

Each individual area is required to cover the vacancy left by a member of staff on maternity leave which creates a cost pressure of approximately 20% of the staff member pay costs, this varies depending on the length of service and the amount of occupational maternity pay an individual is entitled to.

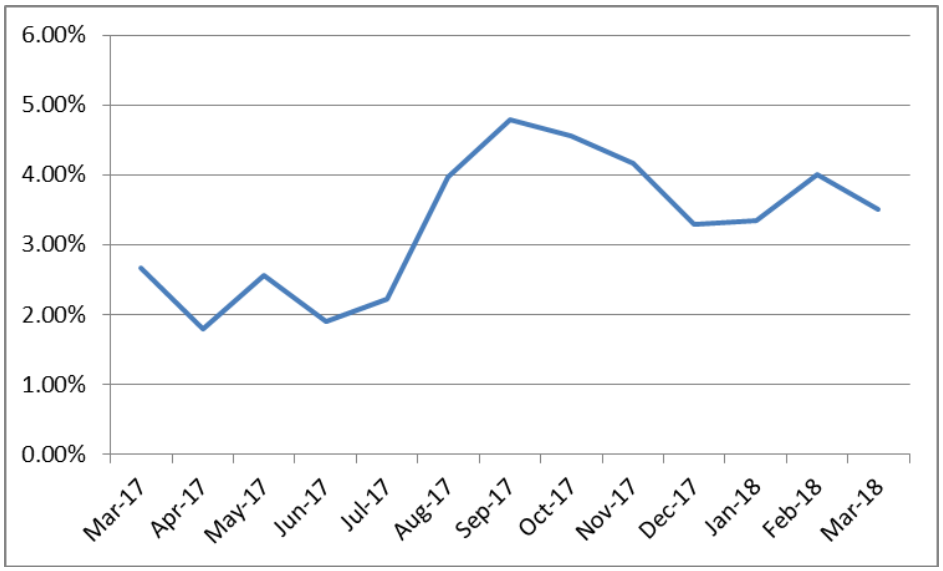
6.64 WTE registered nurses are currently as at 31st March 2018 on maternity leave across the nursing areas reviewed as part of this paper, a small increase from the October review

1.8 Critical Care
3.0 Theatre
1.23 C wing
0.61 Burns
6.64 Total

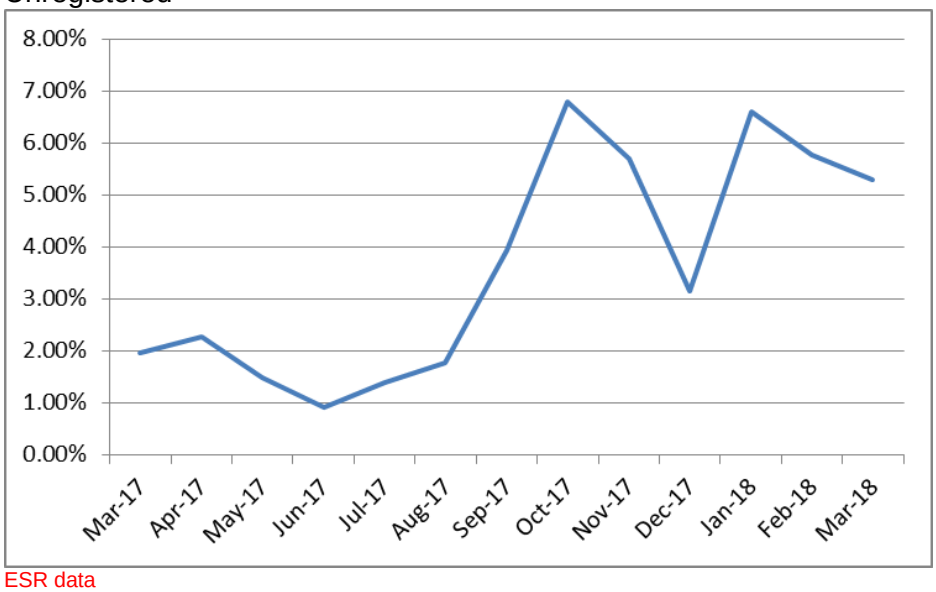
Sickness

Sickness continues to be managed within individual areas in conjunction with the Human Resources team. The charts below demonstrate the sickness rates in the registered and unregistered nursing workforce, including theatres.

Registered



Unregistered



ESR data

9. Assurance

The report details the actions being taken to address the recruitment challenges experienced within QVH at present whilst also demonstrating the national picture. In addition, the report

demonstrates QVH compliance with a variety of guidelines for safe staffing levels and recommended benchmarks.

Staffing levels continue to be reviewed regularly using evidence based tool (smarter nursing care tool) and there is a clear governance process for monitoring and escalation.

No moderate or above patient safety incidents as a result of inadequate staffing have been identified from this triangulation.

Patient experience has not been measurably affected by the levels of temporary of staff, as evidenced in the monthly FFT scores, complaints and the CQC national inpatient survey 2017 which shows patients continue to rate the experience at the trust very highly, with 57 of the 62 questions asked scoring significantly better than other trusts, an improvement on last year. As stated above however, the staff survey (2017) does demonstrate deterioration in the scores relating to staff recommending QVH as a place to work

During this process the DDN has benchmarked against the NQB recommendations (appendix 3) and is assured that QVH is meeting these recommendations.

10. Recommendations

The Board is asked to:

- note the 6 monthly establishment review
- note that we meet the benchmarks recommend by RCN, ICS, NICE and AfPP
- note the staffing levels and skill mix are effectively reviewed
- note that safe, high quality care is being delivered due to staff pride in their work and flexibility.
- note the key area of concern remains the high vacancy rate particularly within theatres and critical care
- note the actions being taken to address the recruitment and retention challenges

Nicky Reeves
Deputy Director of Nursing
April 2018

References

House of Commons Health Committee The nursing workforce Second report of session 2017-19

Picker Survey 2017

Safe Sustainable and productive staffing. An improvement resource for adult inpatient wards in acute hospitals. National Quality Board Edition 1, January 2018.

2017 National NHS Staff Survey – Results from QVH NHS Foundation Trust

Appendix 1 : NQB expectations

Recommendation	Current Position
Boards take full responsibility for the quality of care to patients and as a key determinant of quality take full and collective responsibility for nursing care and care staffing capacity and capability	The Board has a process in place for setting and monitoring nursing levels. The Board receives six monthly nursing workforce reports and an update on staffing levels and quality at every public board.
Processes are in place to enable staffing establishments to be met on a shift to shift basis	Nursing acuity and capacity is reviewed three times per day in the ward areas. This information is presented at the twice daily bed meeting where senior clinical and operational staff manages the patient flow for electives and trauma. Nursing and care staff can be reallocated at the start or during a shift Local escalation process is embedded. Heads of Nursing are visible in the clinical areas. Daily oversight of planned versus actual staffing levels by Director or deputy Director of Nursing.
Evidence based tools are used to inform nursing and care staffing capability and capacity	All ward areas use safer nursing care tool- acuity and dependency tool. Application of specialty specific national guidance to support establishments and professional judgement
Clinical and managerial leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns	Datix reporting system is established and used. 'Tell Jo' – confidential email to DoN. Trust policies eg Whistleblowing. Compliance in practice ward visits and clinical Fridays undertaken by DoN.
Multi-professional approach is taken when setting nursing and care staffing establishments	This is the third six monthly workforce review undertaken by the DoN in conjunction with the executive management team (EMT). Changes to establishments have been made only after consultation with EMT and trust staff.
Nurses and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	There is 22% uplift within the ward establishments to cover sickness, mandatory and statutory training and leave. Ward matrons are accountable for their budgets and have monthly meeting with the HoN and finance. All ward matrons have supervisory time to undertake management duties.
At each public board an update on workforce information, staffing capacity and capability is discussed six monthly with a nursing establishment review	The DoN provides updates on workforce in the quality report at every public board and there is a 6 monthly review of nursing workforce
Information is clearly displayed about nurses and care staff on duty in each ward on each shift.	All ward areas have status boards in public areas stating expected number and actual number of nurses and care staff on duty. When there are variations on this, the ward matron will review and escalate via agreed processes to ensure safe staffing maintained. The DoN will review this escalation and triangulate with safer care metrics and complaints data to ensure staffing levels allow provision of quality care
Providers take an active role in securing staff in line with workforce requirements	Recruitment days for general and theatre staff have taken place in the last 12 months. Staff are supported to undertake specialist modules for development and enhanced care. Director of HR

Recommendation	Current Position
	reviewing recruitment processes. Part of the theatre productivity work has a workforce subgroup. Different recruitments campaigns have been instigated in the last 4 months. This has results in increased interest in post however the trust is experiencing difficulty in recruiting to some posts mainly in Theatres and ITU (significant national shortages in these areas).
Commissioners actively seek assurance that the right people with the right skills are in the right place at the right time with the providers with who they contract.	DoN meets monthly with the CCG Chief Nurse. Staffing levels discussed at these meeting. The commissioners are aware of the nurse staffing levels and the actions the trust is taking to optimise recruitment and retention.

Appendix 2: Safe staffing metric sample

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

SAFE STAFFING DASHBOARD

CRITICAL CARE

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

MARCH 2018

M	T	W	Th	F	S	Su
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

MARCH 2018

M	T	W	Th	F	S	Su
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

When amber or red rationale to be provided below

Date (Day)	Planned staff RN	Planned staff HCA	Actual staff RN	Actual staff HCA	Rationale if amber or red
1	3	1	3	1	
2	4	0	4	0	1x RN deployed to Cwing to help out
3	4	0	3	0	2 pts
4	3	1	3	1	
5	4	0	4	0	
6	4	1	4	1	
7	3	1	3	1	
8	3	1	3	1	
9	4	1	4	1	
10	3	0	3	0	
11	3	0	2	0	1 Tr on call if needed.
12	3	0	3	0	
13	3	1	3	1	2 L1 patients
14	3	1	3	2	2 hcas orientation
15	3	1	3	1	
16	3	1	3	1	
17	3	1	3	1	
18	4	0	4	0	vent trained nurse borrowed from site team am
19	3	1	3	1	
20	4	1	4	1	
21	3	1	3	1	
22	4	0	4	0	
23	4	0	4	0	
24	4	1	4	1	
25	4	1	4	1	
26	4	1	3	1	
27	4	2	4	2	1 x RMN
28	3	2	2	2	
29	4	2	4	2	
30	4	1	4	1	
31	3	0	3	0	
ITU DAY	108	24	104	25	
HOURS	1242	276	1196	288	
% Achieved			96%	104%	

Date (Night)	Planned staff RN	Planned staff HCA	Actual staff RN	Actual staff HCA	Rationale if amber or red
1	3	0	2	0	x1 nurse sent to wing
2	4	1	3	1	covering outreach bleep
3	4	0	3	0	1x on call, CCU covering outreach bleep
4	2	0	2	0	2 x L1b pts
5	3	0	3	0	
6	4	0	3	0	CCU 4th Tr to Burns ward
7	3	0	3	0	RGN taken to work on MD due to staff shortages, closed unit t
8	2	0	2	0	Staffing safe but closed to admission due to lack of staff/skil
9	2	1	2	1	
10	2	0	2	0	
11	3	0	2	0	1 x Tr worked on MD
12	3	0	2	0	x1 nurse sent to wing
13	3	0	2	0	x2 patients CCU 3rd Tr to burns ward
14	3	0	3	0	
15	4	0	3	0	x3 patients (site pract worked in CCU)
16	4	0	3	0	x3 patients
17	4	0	4	0	
18	3	0	3	0	
19	3	0	3	0	
20	4	0	4	0	
21	3	1	3	1	x 3 patients, 1 x RMN
22	4	1	4	1	(site pract worked in CCU)
23	4	1	4	1	RMNx1
24	4	1	4	1	
25	4	1	4	1	
26	4	1	4	0	site support
27	4	1	4	0	1 RMN
28	4	0	4	0	
29	4	0	4	0	
30	4	0	4	0	
31	3	1	3	1	
ITU NT	105	10	96	8	
HOURS	1208	115	1104	92	
% Achieved			91%	80%	

Appendix 3: Recommendations to aid decision making

The resource includes recommendations to aid decision-making as outlined below.

In determining nurse staffing requirements for adult inpatient settings:	
1.	A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.
2.	A strategic staffing review must be undertaken annually or sooner if changes to services are planned.
3.	Staffing decisions should be taken in the context of the wider registered multi-professional team.
4.	Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process.
5.	Action plans to address local recruitment and retention priorities should be in place and subject to regular review.
6.	Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff.
7.	A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.
8.	Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified.
9.	All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff.
10.	All organisations should investigate staffing-related incidents and their outcomes on patients and staff, and ensure action and feedback.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/05/18**		**Agenda reference:**	69-18	
Report title:	**National Inpatient Survey 2017**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Picker Institute				
Appendices:					
Executive summary					
Purpose:	To provide assurance about the quality of patient experience at QVH, comparing trust performance with previous year and national benchmarks. The key messages being in comparison with other Trusts (surveyed by Picker) there are 62 comparable questions; QVH is significantly better on 57 questions significantly worse on 1 question and about the same on 4 questions. Comparing this year's result with previous years there are 56 comparable questions and QVH is significantly better on 2 questions, significantly worse on 2 questions and no significant difference on 52 questions.				
Recommendation:	The Quality & Governance Committee is requested to **note** the results of the National Inpatient Survey 2017, executive summary. The full report was presented at Q&GC April 2018; the committee recognised the excellent results. This forms part of our assurance that patient experience is being sustained and improved which is all notable given the challenges in our workforce.				
Purpose				Assurance **Y**	
Link to key strategic objectives (KSOs):	KSO1: **Y**	KSO2: **Y**	KSO3: **Y**	KSO4: **Y**	KSO5: **Y**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	This report links primarily to KSO1 which has been reviewed and amended following publication of the full report				
Corporate risk register:	There are several corporate risk which relate directly to patient experience this has been reviewed following publication of this report				
Regulation:	Part of regulatory requirement to undertake annual CQC inpatient survey				
Legal:	N/A				
Resources:	No additional resources required to produce the report				
Assurance route					
Previously considered by:	Q&GC				
	Date:	19/04/18	Decision:	Noted	
Previously considered by:					
	Date:	dd/mm/yy	Decision:		
Next steps:	Action plan has been completed and will be overseen and monitored by the patient experience manager at the patient experience group with feedback to Q&GC.				

Inpatient Survey 2017

Queen Victoria Hospital NHS Foundation Trust

Executive Summary

January 2018

www.picker.org

Introduction

This document summarises the findings from the Inpatient Survey 2017, mandated by the Care Quality Commission (CQC) and carried out by Picker, on behalf of Queen Victoria Hospital NHS Foundation Trust. The CQC report is due for publication in Summer 2018.

A total of 1242 patients from your Trust were sent a questionnaire. 410 patients returned a completed questionnaire, giving a response rate of 33.0%. The average response rate for the 81 'Picker' trusts was 38.3%.

How are your results reported?

Picker presents your survey results in the form of **problem scores**.

This is a unique feature of Picker reporting and operates as a summary measure to monitor the Trust's results over time and compare your scores to those of all 'Picker' trusts.

How are problem scores calculated?

- The problem score shows the percentage of patients for each question whose response indicated that **an aspect of their care could have been improved.**
- The problem score is calculated by combining responses which indicate a problem.
- To make the problem score as accurate as possible, all non-respondents for each question are removed from the calculation.

How should problem scores be used?

- **Lower scores reflect better performance.**
- Where there are high problem scores, or high in comparison with other trusts, this area should be highlighted as a potential area for further investigation.

As the name suggests, problem scores indicate where there may be an area of poorer experience.

More information on how problem scores are calculated can be found on p10 in the *Final Report*.

Top line results

Dartboard charts provide an easy visual summary of survey results.

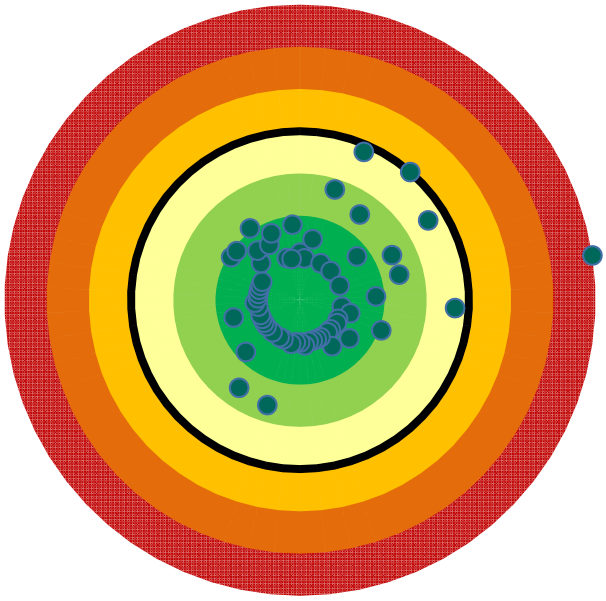
- Each dot indicates a score on a question
- The black line shows the base line, 0% difference from either other Picker trusts or historically

This score is considerably better than average/last year

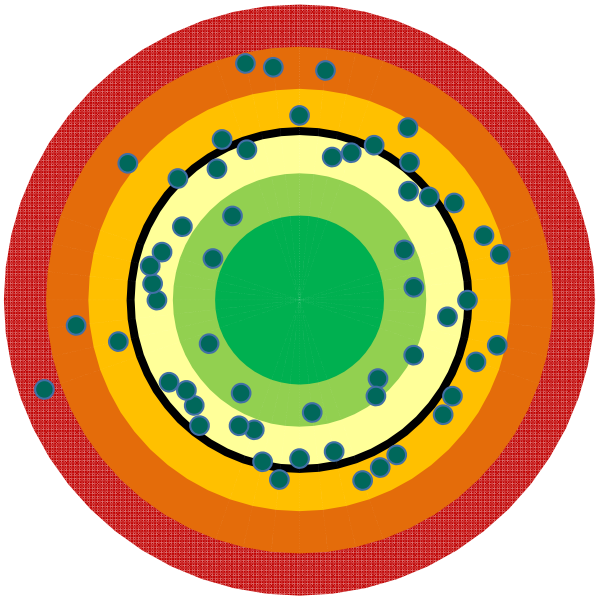
This score is considerably worse than average/last year

	More than 8% worse than the 'Picker average'/ historically
	Between 4-8% worse than the 'Picker average'/ historically
	Between 0-4% worse than the 'Picker average'/ historically
	Between 0-4% better than the 'Picker average'/ historically
	Between 4-8% better than the 'Picker average'/ historically
	More than 8% better than the 'Picker average'/ historically

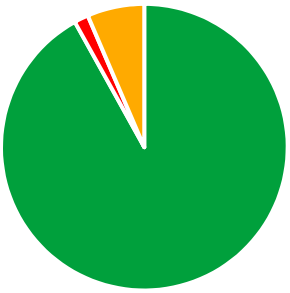
Differences from the 'Picker average' all questions



Historical changes for all questions



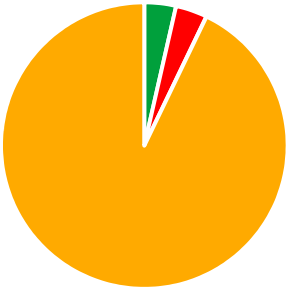
Significant differences



In comparison to other Picker trusts:

Of the 62 problem scored questions, your Trust is:

- Significantly BETTER on 57 question(s)
- Significantly WORSE on 1 question(s)
- The scores show no significant difference on 4 question(s)



Historically:

Of the 56 questions that were used in both the 2016 and 2017 surveys, your Trust is:

- Significantly BETTER on 2 question(s)
- Significantly WORSE on 2 question(s)
- The scores show no significant difference on 52 question(s)

For further information on how your results are reported, please see *Understanding this report* within the *Final Report.*

Understanding your Trust's results

Survey results highlight areas of success and where improvement may be needed to provide better care for patients. When deciding upon the improvements you would like to make there are a number of ways of looking at the results to decide which issues to focus on first.

Comparing results with others

- This section shows the Trust's problem score for each question and a comparison against the average score for all 'Picker' trusts.
- The 'Picker average' is designed to help the Trust focus on areas where its performance is poor compared to others and to identify areas where improvement can be targeted.

Full details can be found in the *Problem score summary* in the *Final Report*.

The tables below will only have data in when at least one question is **significantly better or worse than the average**.

Your results were significantly better than the 'Picker Average' for the following questions:

Lower scores are better

	Trust	Average
3. A&E Department: not enough/too much information about treatment or condition	10 %	21 %
4. A&E Department: not given enough privacy when being examined or treated	8 %	21 %
6. Planned admission: should have been admitted sooner	15 %	25 %
7. Planned admission: admission date changed by hospital	15 %	20 %
9. Admission: had to wait long time to get to bed on ward	10 %	34 %
11. Hospital: shared sleeping area with opposite sex	2 %	8 %
14. Hospital: bothered by noise at night from other patients	16 %	38 %
15. Hospital: bothered by noise at night from staff	10 %	19 %
16. Hospital: room or ward not very or not at all clean	1 %	3 %
17+. Hospital: did not always get enough help from staff to wash or keep clean	23 %	29 %
18+. Hospital: not always able to take own medication when needed to	13 %	34 %
19+. Hospital: food was fair or poor	32 %	39 %
23+. Doctors: did not always get clear answers to questions	15 %	30 %
24. Doctors: did not always have confidence and trust	6 %	17 %
25. Doctors: talked in front of patients as if they were not there	14 %	22 %
26+. Nurses: did not always get clear answers to questions	17 %	29 %
27. Nurses: did not always have confidence and trust	8 %	20 %
28. Nurses: talked in front of patients as if they weren't there	7 %	17 %
29. Nurses: sometimes, rarely or never enough on duty	19 %	40 %
30. Nurses: did not always know which nurse was in charge of care	24 %	49 %
31+. Other clinical staff: did not always have confidence and trust	11 %	22 %
32. Care: staff did not always work well together	9 %	21 %
33. Care: staff contradicted each other	18 %	30 %
34. Care: wanted to be more involved in decisions	23 %	43 %
35. Care: did not always have confidence in the decisions made	14 %	27 %
36. Care: not enough or too much information given on condition or treatment	7 %	19 %
37+. Care: could not always find staff member to discuss concerns with	37 %	61 %
38+. Care: not always enough emotional support from hospital staff	27 %	43 %
39. Care: not always enough privacy when discussing condition or treatment	11 %	23 %
40. Care: not always enough privacy when being examined or treated	3 %	9 %
42. Care: staff did not do everything to help control pain	13 %	29 %
43+. Care: staff did not help within reasonable time when needed attention	19 %	37 %
45+. Procedure: questions beforehand not fully answered	12 %	18 %
46. Procedure: not told how to expect to feel after operation or procedure	24 %	36 %
47. Procedure: did not explain how it had gone in an understandable way	21 %	30 %
48+. Discharge: did not feel involved in decisions about discharge from hospital	25 %	45 %
49. Discharge: not given notice about when discharge would be	21 %	43 %
50. Discharge: was delayed	18 %	40 %
52. Discharge: delayed by 1 hour or more	75 %	88 %
54+. Discharge: did not always get enough support from health or social care professionals	36 %	45 %
55+. Discharge: did not definitely know what would happen next with care after leaving hospital	25 %	47 %

56. Discharge: not given any written/printed information about what they should or should not do after leaving hospital	24 %	36 %
57+. Discharge: not fully told purpose of medications	7 %	25 %
58+. Discharge: not fully told side-effects of medications	37 %	61 %
59+. Discharge: not told how to take medication in an understandable way	8 %	24 %
60+. Discharge: not given completely clear written/printed information about medicines	11 %	27 %
61+. Discharge: not fully told of danger signals to look for	28 %	56 %
62+. Discharge: family or home situation not considered	29 %	37 %
63+. Discharge: family not given enough information to help care	41 %	49 %
64. Discharge: not told who to contact if worried	9 %	20 %
65+. Discharge: staff did not discuss need for additional equipment or home adaptation	9 %	19 %
66+. Discharge: staff did not discuss need for further health or social care services	10 %	18 %
67. Overall: not always treated with respect or dignity	6 %	16 %
68. Overall: rated as less than 7/10	5 %	14 %
69. Overall: not asked to give views on quality of care	57 %	69 %
70. Overall: did not receive any information explaining how to complain	43 %	57 %
71+. Overall: not always well looked after by non-clinical hospital staff	6 %	15 %

Your results were significantly worse than the 'Picker average' for the following questions:

Lower scores are better

	Trust	Average
20. Hospital: not always offered a choice of food	32 %	20 %

Comparing results over time

- The Inpatient Survey is currently **repeated every year**.
- By looking at changes in results over time it is possible to focus on those areas where performance might be slipping.
- Examining areas where performance has improved will help you to measure the effects of any service improvements that have been put in place.

Comparisons between the data from 2016 and that of this year is available in the *Historical Comparisons* section of the *Final Report*.

The tables below will only have data in when at least one question has shown a **significant change from 2016**.

The Trust has improved significantly on the following questions:

Lower scores are better

	2016	2017
27. Nurses: did not always have confidence and trust	12 %	8 %
32. Care: staff did not always work well together	13 %	9 %

The Trust has worsened significantly on the following questions:

Lower scores are better

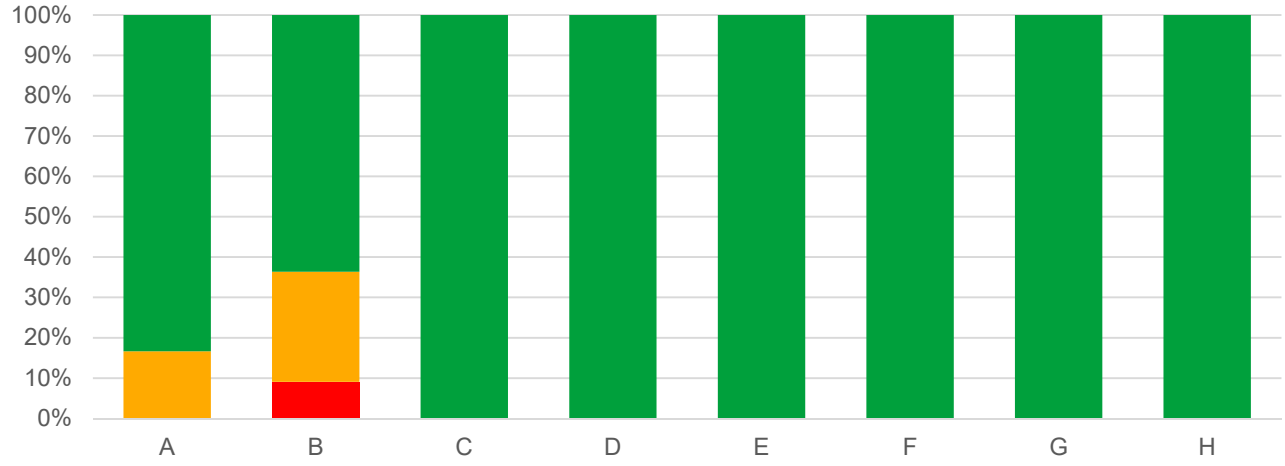
	2016	2017
54+. Discharge: did not always get enough support from health or social care professionals	26 %	36 %
69. Overall: not asked to give views on quality of care	50 %	57 %

Comparing survey sections

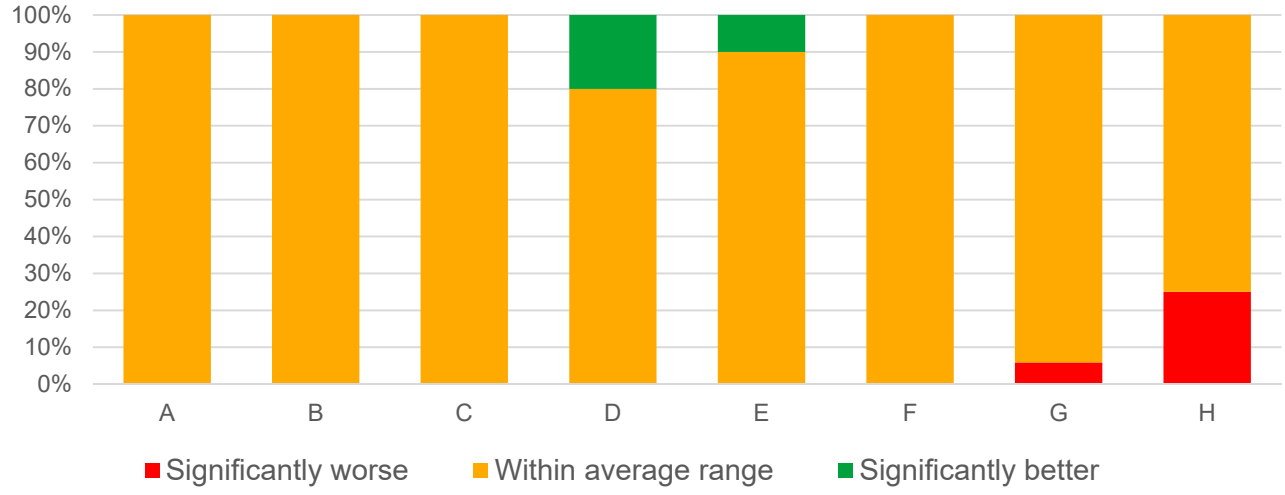
The ten sections of the Inpatient questionnaire are designed to mirror the service user journey. Below, the significant differences in your Trust's performance compared to the Picker average and to your own performance in 2016, are shown by section. The Picker average is made up of all results from all the trusts Picker worked with on this survey. At a glance, you can see which parts of the patient journey are performing best and which parts may require improvement.

A. ADMISSION
B. THE HOSPITAL & WARD
C. DOCTORS
D. NURSES
E. YOUR CARE AND TREATMENT
F. OPERATIONS & PROCEDURES
G. LEAVING HOSPITAL
H. OVERALL

Comparison with the Picker average



Comparison with the Trust's own performance from the previous survey



Next steps

These are just some of your Trust's headline results. In the *Final Report,* you will also find:

- **Ranked problem scores** – demonstrates where the Trust is performing well and where there may be room for improvement
- **Historical comparisons** – provides an overview of patient experience over the last six years
- **External benchmarks** – details Trust performance relative to other Picker trusts
- **Internal benchmarks** – establishes which sites have areas of best practice and where support may be needed

Other Picker tools are available to help identify Trust priorities:

- **Picker Improvement Maps™** – explain which issues are of higher importance to patients
- **Dartboard charts** – visual summary of performance compared to the Picker average and historically
- **Free text comments** – what are your patients saying about their experiences
- **Site and specialty reports** – detailed analysis of site and specialty performance at the trust

Also available:

- **On-site presentation** or **action planning meeting** – chaired by an experienced Picker presenter
- **Free text reports** – detailed analysis of common themes and requests
- **Experience review** – in-depth holistic review of all recent patient and staff experience surveys

For more information about any of the above, understanding your results or any other aspect of the Inpatient survey, please contact the Patient Feedback Team (patientfeedbackteam@pickereurope.ac.uk or 01865 208137).

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KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Board of Directors
Date last reviewed: 10 April 2018

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.
Culture of safe and collaborative practice

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
Outstanding actions in response to Coroner's PFD report
Detailed partnership agreement with acute hospital

Report cover-page					
References					
Meeting title:	QVH Business Meeting of the Board of Directors (public)				
Meeting date:	03 May 2018		**Agenda reference:**	71-18	
Report title:	Medical Directors Report				
Report from:	Dr Rachael Liebmann, Deputy medical director				
Author:	Dr Ed 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]				Assurance	
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:	3 May 2018
Reference number:	71-18
Report from:	Ed Pickles, Medical Director
Author:	Ed Pickles, Medical Director
Appendices:	N/A
Report date:	25 April 2018

Medical Director's Report May 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.

a) Mortalities (2017 / 2018)

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
QVH mortalities	0	0	0	0	0	0	2	1
Mortalities elsewhere within 30 days of discharge	1	0	1	0	1	3	1	1

Structured Judgement Reviews of the case notes from the 3 on-site deaths from February and March is underway, including training of 2 case note reviewers. Karen Carter-Woods, Head of Risk and Patient Safety has now been trained as a trainer for case note review. No significant concerns regarding clinical care have been raised thus far. A paper to the June Quality and Governance Committee will summarise the SJR and preliminary case note reviews for mortalities elsewhere for the year 2017 / 2018.

Since April 2017 there have been four mortalities on the QVH site (3 burns patients and one head and neck cancer patient) and fifteen deaths elsewhere within 30 days of discharge. These numbers are broadly similar to previous years.

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 twelve patients transferred out unexpectedly from the QVH in February and March. None were paediatric patients. Rates of transfer out remain stable.

c) Never events and serious incidents

No Serious Incidents or never events were reported in February or March 2018. The Deputy Theatre Manager post, with responsibilities for clinical quality and safety improvement in theatre, is coordinating the re-launch of the '5 steps to Safer Surgery', assisted by Dr Niamh Gavin, Consultant Anaesthetist and Simulation Lead and other senior clinical staff. Qualitative and quantitative audit methodology has been improved and will be reported through the Clinical Governance Group.

The trust has been invited by the CQC to contribute to a national thematic review of never events.

d) Clinical Research

In April, the trust appointed Mr Jag Dhanda as a Consultant Head and Neck Surgeon. Included within his job plan are 3PAs / week for clinical research, generously funded by the QVH Charity for an initial period of 2 years. The progress against research objectives described in the job plan will be monitored via the Research and Development Strategy Group and also reported to the QVH Charity Committee.

2. Sustainability and Transformation Partnership 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. Major themes include the further development of the case for change, clinically effective commissioning, and the Getting it Right First Time Programme (GIRFT).

Meetings have commenced between WSHT, BSUH and QVH maxillofacial regarding network solutions to the provision of elective and trauma maxillofacial surgery at BSUH, including meeting the demands of the Major Trauma Centre.

Ms Emer Keating, the newly appointed Darzi leadership fellow commences on 11th May 2018. Ms Keating is currently a senior physiotherapist at WSHT, with excellent leadership and managerial experience. She will begin to develop clinical pathways for paediatric burns dual site delivery of services, backed by the memorandum of understanding between WSHT/ BSUH and QVH.

3. Theatre productivity

A new meeting group has been formed for the improvement of theatre productivity, chaired by the Clinical Director for Strategy, Dr Ian Francis. A dashboard of metrics is under final development, and the group membership will vary depending on current projects, but the intention is to maintain high clinical leadership and engagement.

4. Education

There were no Junior Doctor exception reports in the period October – December 2017, but this has risen to five for the next 3 month period. All of these exception reports relate to missed educational opportunities due to service demands, and followed a further period of encouraging junior doctors to report. In addition to exception reporting, feedback from junior doctors is collated via Local Academic Board meetings (3 annually), Local Faculty Group meetings (3 annually for each training specialty), interim and exit questionnaires and the Junior Doctors' forum, chaired by the Guardian of Safe Working. The 2018 GMC National Training Survey is currently open for responses.

Major themes from feedback include dissatisfaction with rota and shift patterns in plastics and OMFS, provision of food out of hours, rest areas, departmental induction in plastic surgery and access to local teaching. Positive feedback is received for educational facilities, particularly the library, availability of study leave, handover and support from colleagues.

Actions underway include rota changes, with the reintroduction of a firm structure, mentoring of junior trainees by senior trainees, plans for meal provision out of hours, changes to the teaching programme and the way of timetabling it, and renewed plans for the departmental induction, particularly in plastic surgery.

It is likely that a Deanery visit to measure the quality of teaching in plastic surgery will occur within the next six months.

5. Medical & Dental Staffing

There are currently 102 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.

In March 2018, Miss Alex Molina was appointed to the post of Consultant Plastic Surgeon. Miss Molina is currently a locum consultant in the Royal Marsden Hospital, but has been a trainee at the QVH for many years, and demonstrates huge commitment to the trust. She will be specialising in breast reconstruction and providing care at the QVH and spoke sites in Kent.

After many years of being the Clinical Lead for Burns, Mr Baljit Dheansa is stepping down from April 2018, and handing over to Miss Nora Nugent. Miss Jennifer O'Neill has been appointed Clinical Tutor for Plastic Surgery. Dr Niamh Gavin is stepping down from her role as Clinical Lead for Paediatrics, to concentrate on her simulation lead role. Lt Col Mark Wyldbore is taking over. I am grateful to all for the leadership and commitment they have all demonstrated.

Consultant job planning onto electronic systems is behind schedule, but nearing completion.

6. IM&T

Current work continues of the scoping and procurement of an e-observations system, secure messaging system and a replacement for the computerised anaesthetic record keeping system.

Dr Edward Pickles
Medical Director
25 April 2018

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed – 15/3//18

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) = 20, major risk

Rationale for current score

- Vacancy levels in theatre nursing increasing month on month from 18.77% in Oct to 22.2% in Jan;
- Demand, capacity, process & system issues within the appts team;
- Demand and Capacity issues in MaxFax alongside lack of PTL and visibility of waiting list at Medway (will impact upon 18RTT & 52 week breaches) when visible) 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 across cancer, 18RTT & 52 week breaches;
- 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- including Cancer;
- Revised Access and Appts action plan in place. New weekly PTL Meeting format developed
- Additional Validator funding approved & interims in post;
- New role of business manager for spokes and access in post to give focus to the appts , outpatients and access services alongside successful recruitment to the performance & access manager & cancer data manager – both posts have been vacant for a significant period;
- Outsourcing in place and more being sourced but more required;
- Monthly business unit performance review meetings & dashboard in place with a focus on exceptions, actions and forward planning;
- Data warehouse project in place and beginning to give off site PTL visibility with associated validation being undertaken so the scale of the issue & impacts (particularly at Medway) can be seen and managed accordingly

Gaps in controls / Assurance

- Not all spoke sites on QVH PAS so access to timely information can be limited plus some spoke sites have reporting issues – when visible will impact negatively upon 18RTT & 52 week breaches
- 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
- High vacancy rate in theatre nursing/OPD worsening and so limits ability to out on extra lists in a sustainable manner

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Trust board
Date last reviewed: 23rd April 2018

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 12)

- Surplus £1638k/£1,465k surplus plan
- CIP forecast delivery - (£80k gap)
- Finance & Use of resources – 1
    - Capital Service cover - 1
    - Liquidity -1
    - I&E Margin –1
    - I&E Margin Var from plan – 1
    - 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
- Impact of winter pressure on spoke sites – cancellation of theatre sessions
- 2018/19 CIPP Gap
- 2018/19 Contracting alignment agreement

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 a 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
- Budget Setting and Business Planning Processes (including capital programme)

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Carter Report Review and implementation
- Costing Transformation Programme -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:	**03/05/18**		**Agenda reference:**	**73-18**	
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 26 March and 23 April				
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:	23/04/18	Decision:	For information	
Next steps:	N/A				

Report to: Board of Directors
Meeting date: 3 May 2018
Reference no: 73-18
Report from: John Thornton, committee chair
Report date: 24 April 2018

Finance and performance committee assurance report

1. 2018/19 Annual Plan

All members of the Board were invited to join F&PC for this section of the meeting.

The Executive directors presented the current version of the proposed annual plan. The plan delivers a surplus excluding STF income of £400k which is in line with the figure included in the two-year budget agreed last year. The presentation explained how the plan had been developed from last year's anticipated outturn to the adjusted baseline and the actions required on revenue and costs to deliver the proposed plan for this year.

The committee then discussed in detail the key risks to the plan and the proposed actions required for delivery.

It was acknowledged that the CIPP target of £3m (5% of relevant expenditure) is a challenge and that as yet there aren't enough identified and agreed targets to deliver this figure. But it is in line with our two year plan and similar to 2017/18.

The other key issue is the need to finalise suitable targets with our commissioners.

The view of the committee was that the plan presented material challenges for the Trust. But it was agreed that the action plans developed and presented by the executive were serious, sensible and showed an appetite for change in approach.

The committee concluded that its preferred route was to maintain our commitment set out in the two year plan to deliver a small surplus for 2018/19 and to challenge ourselves to deliver on the necessary changes.

The committee agreed that the current plan could be submitted on 30 April as required and that it should be presented to the Board meeting on 3 May for final approval.

2. Operational performance

Our performance against key national operational targets, especially around waiting times, continues to be well below plan. Some areas are stabilising but others especially MaxFacs continue to deteriorate.

The executive team provided an update on the contribution and involvement of the NHSI support team and the action plans that are being put in place to develop the processes and procedures which will allow us to better understand our operational challenges and to build towards a more sustainable level of performance.

The committee was disappointed that more progress had not been made with the comprehensive Appointments, Access and Outpatients Plan that had been in place for some months. The conclusion was that while our current position is unacceptable there is significant room for improvement in processes and procedures that creates the opportunity to deliver improved performance.

3. Workforce performance

Although staff in post numbers increased we also saw an increase in staff turnover for the fifth consecutive month. Unfortunately much of this is in key clinical areas. As a result total temporary staffing increased a further 12% to over 100 WTEs for the first time.

Current plans for improving recruitment in key areas aren't yet working. More attention is being placed on possible overseas recruits especially the Middle East, but this will take several months.

The executive weren't able to give any assurance that this will improve in the short term and serious consideration is being given to how we use the resource available more efficiently rather than spreading it too thinly across too many theatres.

A separate paper was presented providing an evaluation of the Leading the Way management development programme during its first year. Evidence from the staff opinion survey and elsewhere suggests that staff are noticing a change and improvement in management behaviour across a number of areas.

A number of areas for improvement have also been identified and these are being implemented in the second phase of the programme.

The committee thanked GO for a clear and helpful paper and strongly endorsed the continuation of the programme for a further year.

4. Financial performance

Patient activity income was well below plan for the month and unlike earlier in the year pay was also over budget for the month. This isn't a healthy position to be in.

Fortunately due to a number of largely one off adjustments both Other Income and Non Pay costs were better than budget and the net result was that we over achieved against our monthly surplus target and were able to meet our cumulative annual surplus target.

This means that we not only will receive out budgeted STF funding for the quarter but we are also likely to receive an additional 'bonus'. This will put additional cash on our balance sheet. This won't directly make delivery of our current year budget surplus any easier but it will allow additional capital expenditure if suitable projects can be identified and delivered.

The significant efforts of the Finance team in managing the year-end position, especially the major review of stock, were recognised.

John Thornton
Chair

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	03/05/18		**Agenda reference:**	74-18	
Report title:	**Operational Performance**				
Sponsor:	Mark Henry – Interim director of service improvement				
Authors:	Operations Team				
Appendices:	1. Appointments, Access and Outpatient Action Plan 2. Trajectory Performance for 128RTT and 62CWT 3. 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**~~	KSO2: ~~**Y/N**~~	KSO3: ~~**Y/N**~~	KSO4: ~~**Y/N**~~	KSO5: ~~**Y/N**~~
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	**Controls / Assurance** • Regular access meetings with forward plans activity/booking, (including cancer) • Revised Access and Appts action plan in place • Additional Validator funding approved and interims in post • New role of business manager for spokes and access in post to give focus to the appts, outpatients and access services alongside successful recruitment to the performance & access manager & cancer data manager, (both posts have been vacant for a significant period) • Outsourcing in place, and more being sourced,(but more required) • Monthly business unit performance review meetings and dashboard in place with a focus on exceptions, actions and forward planning • Data warehouse project in place and beginning to give off-site PTL visibility with associated validation being undertaken so the scale of the issue & impacts (particularly at Medway) can be seen and managed accordingly.				
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 – when visible will impact negatively upon 18RTT & 52 week breaches • 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 • High vacancy rate in theatre nursing/OPD worsening and so limits ability to out on extra lists in a sustainable manner.				
Regulation:	CQC (operational performance) covers all 5 domains, 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:	23/04/18	Decision:	**Noted**
Previously considered by:				
	Date:	dd/mm/yy	Decision:	
Next steps:	None			

Report to:	Board of Directors
Meeting date:	3 May 2018
Reference no:	74-18
Report from:	Mark Henry, interim Director of service improvement
Report authors:	Operational management team
Report date:	16 April 2018

Operational Performance: Targets, Delivery and Key Performance Indicators

1. Diagnostic Waits

1.1. There were 8 diagnostic breaches in Radiology in March related primarily to off-site CT delays and 1 breach in Sleep Studies related to staffing capacity. The Trust therefore achieved 99.2% 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

2.1 The submission for March 2018 will be made on 19 April (after the submission date for these papers). The latest validation suggests that the reported position will be 77.15%. The main area of underperformance is Max Fax and this is a key RTT18 risk to the trust followed by plastics;

2.2 A Task and Finish Group focusing on Max Fax services and NHSI will be fully working with the Trust on both 18RTT and Cancer performance. Max Fax performance is consistently decreasing month on month and so this additional capacity and leadership is welcomed;

2.3 The trajectory is being reviewed and a model being built with colleagues in Business Intelligence. Due to vacancies in the business intelligence team this is not complete at the time of writing, plus the impact of the days lost due to poor weather, the increasing vacancies in theatres need to be reviewed and factored in along with the improvement initiatives that will be forthcoming from the interim Director of Service Improvement services and NHSI. The model will have three elements best case, worst case and most likely scenarios. It will tie in with the activity plan that is being submitted to commissioners and the working assumptions based on previous pathway closures. A draft model will be sense checked with the Operational teams by end of April;

2.4 The main reason for the underperformance is an under estimation of list cancellations due to workforce issues & the impact of the snow so late in the year. The vacancies in peri-op have increased from 18.77% in October to 22.2% in January. This trend appears to have continued in March. The vacancy rates are increasing by, on average, 0.85% per month over the last 5 months. Although there is a regular cohort of agency nurses being used, they often don't confirm availability until relatively late. Line booking is being revisited. Therefore lists continue to be cancelled due to this issue, e.g. 8 lists the week of 5 March. However this masks that individual specialities may lose more lists than this as lists are reallocated to ensure that cancer patients, those with a complex work up and post up care needs (such as a critical care bed) and patients already cancelled once before are not re-cancelled. The impact of this can be seen in the eyes business units 18RTT performance as this has been slowly decreasing since December;

2.5 The severe weather event at the end of February continued into March causing cancellations by both patients due snow causing them to be unable to attend the hospitals and Doctors being able to attend off site commitments. As in February this impacted both activity & income;

2.6 There was also a short term lack of anaesthetics which had a negative impact. This meant that general anaesthetic lists were converted to local anaesthetic lists due to lack of anaesthetists (8 lists week of 5 March). All of this impacts upon scheduling, long waiters and 18RTT performance. It also means that the additional lists scheduled at weekends etc. do not give a performance gain and only partially mitigate the lost lists;

2.7 Summary of speciality achievement in March:-
This is our unvalidated March position, due for submission tomorrow.

	Over 18	**Under 18**	**Total**	**Percentage**
Corneo	136	1342	1478	90.79
Max Fax	1413	2633	4046	65.07
ENT		1	1	100.00
Plastics	546	2280	2826	80.68
Cardiology	14	81	95	85.26
Other - sleep	24	865	889	97.29
Total	**2133**	**7202**	**9335**	**77.15**

- A summary of achievement against the STP trajectories for 18RTT, 52 weeks and 62 CWT are included in **Appendix 2.**

- The current performance for 52 week breaches is as follows:-
  - Plastics have 4 with a TCI in April, 3 had a first appointment in April, 1 has a first appointment in May;
  - Max Fax have 5 with a TCI in April, 12 awaiting a TCI, 2 follow-up appointments in May, 1 TCI in May;
  - Therefore 12 with no TCI

- The actions undertaken for 52 weeks breaches are as follows:-
  - Requested additional theatre lists on Saturdays but currently not able to staff (even with agency) and so remains unlikely;
  - Looking to further outsource but provider cannot accommodate prior to 31 March;
  - Working to slot patients in where possible onto existing lists but dependent on case mix, length of procedure and surgeon etc. and at present is only making good cancellations due to snow and staffing issues – lists cancelled last week and this week due to theatre and CCU vacancies;

- A monthly clinical harm meeting is in place and is chaired by the Medical Director.

2.8 Elective Day Cases

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

- In March the weekly activity was 160; 193; 192 and 153 respectively giving a weekly average for March of 140 patients treated compared to 206 in February and 207 in January. The reason for the difference in numbers patients treated per week is as in previous papers;

- Non-surgical day cases have a planned weekly average of 11 and for March this was 12; 18; 23; and 19 respectively giving a weekly average of 18; compared to 21 in February; 13 in January and 9 in December.

2.9 Elective/In Patient Activity

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

- In March the numbers of patients treated was 58; 52; 52 and 31 giving a weekly average of 48 compared to 50 in February; 44 in January; and 38 in December.

- Non-surgical elective activity has a plan of 31 per week and for March this was 33; 25; 33 and 28 respectively giving a weekly average of 30 compared to 33 in February; 21.5 in January and 24 in December.

3 Medway Backlog

3.1 The new data warehouse is in place and so now tracking and validation needs to be undertaken. As per previous reports, the validation resource for this work has been temporarily redirected to focus on the overall 18RTT position, however with the additional posts this will be reviewed so this work can be undertaken. The vacant post of Performance and Access Manager has been successfully recruited to and so this will add to the ability to undertake this work. When this work is undertaken, the Trust's 18RTT and the long-waiters performance will worsen - this is on the risk register. Therefore this is why it is important that onsite performance improves and the appointment of an interim Director of Service Improvement to focus on Max Fax services provides the additional capacity to lead on this. On site Max Fax performance is consistently decreasing month on month;

- However, this will mean that the long standing issue of the Trust not being able to capture or have visibility of the patients at some of the spoke sites (and in particular Medway) will be resolved.

4 Cancelled Operations

4.1 There were 31 non-urgent operations cancelled on the day in February (compared to 11 in January and 14 in December);

There were 18 plastics patients cancelled – 4 due to lack of time on the day due to other cases taking longer than expected; 1 due to a bed not being available in Burns; 3 due to no nursing staff on the day; 1 due to an electrical issue on the day affecting power; 1 due to a trauma case taking priority; and 8 due to no nurses during the snow;

There were 2 hand trauma patients cancelled on the day due to more urgent cases;

There were 4 Max Fax patients cancelled – 1 due to lack of time and 3 due to no nurses in the snow;

There was 1 ENT patient cancelled on the day due to staffing issues;

There were 6 corneo patients cancelled – 2 due to lack of time; 3 due to medical staffing issues and 1 due to anaesthetist sickness;

3 of the patients cancelled on the day were urgent – the operations were all rescheduled within 25 days;

This pattern looks to have continued in March.

5 Monitor Cancer Standards

5.1 Below is the Trusts performance for February 2018. The breach report is attached as appendix

Month	Target	Total	Breaches	Performance	Standard
Feb-18	2WW GP referral to first seen (urg. susp. cancer)	225	10	95.6%	93%
Feb-18	62 day GP referral to first treatment	14	2.5	82.1%	85%
Feb-18	31 day Decision to first treatment	41	2	95.1%	96%
Feb-18	31 day Decision to subsq treatment (surgery)	39	5	87.2%	94%

5.2 2 Week Waits Broken Down by Tumour Site

Month – Quarter 4	Speciality	Total	Breaches	Performance	Standard
Feb-18	Head and Neck	145	9	93.8%	93%
Feb-18	Skin	78	1	98.7%	93%
Feb-18	Children's	1	0	100%	93%
Feb-18	Sarcoma	1	0	100%	93%

5.3 Actions within Cancer

We have started shadow reporting for the 38 day target (this relates to draft breach allocation guidance for the 62 day GP referral to first treatment target) and if this had been implemented our position for January would have changed by the following: -

- Lost 1 breach (2 patients)
- Gained 0.5 breach (1 patient)
- Treatments: 13.5
- Breaches: 2
- Performance: 85.2%

5.4 Although our performance would have improved it's clear we need to be very vigilant with our shared pathways to ensure we treat within 24 days. The definitions are included in **Appendix 3.**

5.5 The main issues in 31day achievement relate to the number of patients being referred for Sentinel Lymph Node Surgery and the capacity to treat within the time due to late referrals to the trust;

5.6 The post of cancer data manager has now been successfully recruited to after a significant vacancy gap which meant that prior to the successful recruitment, 5 people (mainly interims) had been in this post in a 30 month period;

5.7 NHSI fully started work at the Trust from 3 April and the Interim Director of Service Improvement will be taking this work forward.

6 Business Unit Specific Operational and Performance Issues

Business unit specific updates covering issues not already mentioned are given below;

6.1 Max Fax/Oral Surgery Business Unit

The key focus point for Max Fax/Oral Surgery Business Unit remains to improve the current RTT & long waiter performance against the open pathway target of 92% for QVH and spoke site services. Max Fax is the main driver for both issues on and off site;

Additional lists at McIndoe are being organised– with a start date for one list being planned for 16 April;

Additional Saturday theatre lists have been scheduled until the end of March 2018, however these are reliant on the availability of the workforce. Critical care nursing vacancies are also having an impact upon the ability to book and manage those cases that require a critical care bed;

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 is reduced from five to three;

Additional clinics are also being booked to support opd and this has been supported with an agreement in enhanced payments for dental nurses

6.2 Plastics Business Unit

The outsourcing of the routine hands work to the McIndoe continues and will be increased with the addition of routine breast patients – circa 15 per month & is due to commence in April;

6.3 Ophthalmology Business unit

The business unit lost lists this month due to lack of staffing in theatre and were unable to run their Saturday lists for the same reason. This impacts upon 18RTT and the trajectory;

The service continues to face a period of challenge relating to staffing and the number of clinical fellows in post until April 2018.

The number of senior registrars within the business unit is reduced from six to four. The service will be fully established again in June 2018. This has had a significant impact on opd with clinics being cancelled and rebooked. Locum doctors are not available to support this speciality at this grade. Clinical staff are supporting additional sessions when possible until the service is fully established.

The business unit need to increase OPD space to support activity as the present space does not have the capacity to treat the number of referrals and accommodate safely 5 consultants and 6 fellows. A business case is being prepared to support additional accommodation

6.4 Sleep Services

The business unit continue to deliver activity above plan this year and are delivering the 18RTT target;

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. Two additional posts are being recruited to at present and the business unit is supporting theatres

Space is an issue with the increasing number of patients being treated on site .This has been escalated to the Space Utilisation Group who are supporting this but there are co dependencies with other business units that need to be worked through. Lack of space has a significant impact on activity and ability to treat patients.

Referrals for the sleep centre are going up significantly by 60 additional referrals a month

The service has gained funding for a clinical fellow for sleep which will enable the treatment of additional patients & contribute towards workforce resilience;

A further business case is awaiting approval for a clinical fellow and for an additional kit in the sleep centre that would enable us to treat more patients weekly at night.

6.5 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 recruited a GP with special interest to work alongside our consultant Rheumatologist, who began work on 20th Feb 2018. The team expect to return to a sustainable waiting list size by August 2018.

6.7 MIU

There were no 4 hour breaches in March giving overall performance for March as 100%.

Activity through the MIU was 183; 226; 205 and195 in March – giving a weekly average of 202 patients compared to 189 in February; 193 in January and 200 patients in December;

7 Service Improvement

7.1 The main area of activity has been within the Access, Appointments and Outpatients areas. A comprehensive action plan has been developed and this is included as **Appendix One;**

7.2 Work is underway to remove the staggered arrival times in theatres. The Deputy Director of Nursing is leading on this with the support of two surgeons, one from Max Fax, one from Plastics. Discussions have been held with theatre staff to ensure they are engaged with the process. The process is now being mapped, with meetings with the medical secretaries being the next steps. It is the medical secretaries who coordinate and schedule theatre admissions. The letters sent to the patients will be reviewed as part of this process to ensure accurate information is provided for patients. It is currently planned that this will go live in May.

7.3 A new Theatre User Group will commence in April 2018 to create and oversee the Theatre Improvement Programme.

8 Recommendation

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

APPENDIX 1:

Appointments, Access & Outpatients Action Plan

Lead Director – Director of Operations
Lead Manager – Business Manager – Access & Spoke Sites

No	Recommendation	Actions to be undertaken	By whom	Timescale	Progress – Inc. date of updated	RAG Rating
1. Backlog Clearance						
a)	Trust to ensure waiting list is consistently validated, and to continue to date patients by clinical priority & chronologically.	Additional validation support to be put into place to cleanse PT with a focus on key off site spokes	~~DDOPS~~ PAM	~~29/10/17~~ 31/5/18	• Oct 17 - An additional validator was sourced & allocated however this resource has been transferred to support Max Fax with validation; • Nov 17 – Substantive additional validation resource included as part of business planning; • 29/1/18 – Bid put into CSU for additional validators; • 8/2/18 –two interim validators interviewed and appointable; • 8/2/18 – POAP submitted for EMT approval for three substantive validators • 17/4/18 JDs to be reviewed in light of NHSI work and advertised asap	
		To bring forward the long waiter focus to 30 weeks rather than 40 weeks	DDOPS	29/10/17	Complete – also 46 week return undertaken and returned to CCG each week	
b)	Each business unit to validate their elements of the PTL to be able to produce a recovery trajectory with timeframes for the clearance of backlog of patients in the open pathway		All BMs	~~26/2/18~~ 30/4/48	In progress – original trajectory being revisited in light of further capacity opportunities, increased validation resource and rejection of tier one & two dental referrals; 15/4/18 – NHSI fully engaged from early April, Interim Director of Service Improvement is leading a weekly task and finish group with a focus on Max Fax	

2.	Demand & Capacity					
a)	To introduce the IMAS/IST demand & capacity tool to identify review what is needed to achieve sustainable delivery of 18 RTT and to match the demand and capacity analysis once the backlog has been cleared, providing a more accurate indication of target waiting list size and capacity requirements, which should also include actual rather than historic capacity.	Once PAS upgrade is complete to ensure the IMAS Demand and capacity tool can be put into place	AD BI supported by BMs	30/4/18	• AD BI & Head of BI are in discussion with a company to see if they can scope out (for free) what a possible solution would look like as there is no current capacity within the BI team to undertake this work; • In conversation with IMAS/IST to see if they can help to resource this work; • IST will fully commence at the beginning of April to undertake this work	
c)	Outsourcing Max Fax dental work to McIndoe	Ascertain costings	BM MF/SM MF	9/2/18	Have met with McIndoe reps and awaiting confirmation if a 10% discount will be offered rather than the current sliding scale – Feedback to be given by 9/2/18; 10% discount achieved	
		Complete POAP	BM MF/SM MF	19/2/18	Dependent on above; Approval gained	
		Negotiate start date	BM MF/SM MF	2/2/18	Ideal start date 1/3/18 – however trajectory will be based on an April 1st start date; 15/3/18 – April 5th start date looking realistic	
		Patients identified to transfer	BM MF/SM MF	19/2/18	Completed	
		Process to transfer patients in place	BM MF/SM MF	19/2/18	Will mirror the plastics process	
		Monitoring process in place	BM MF/SM MF	19/2/18	Will mirror the plastics process	
d)	Max Fax insourcing by Medinet	Ascertain costings	BM MF/SM MF	29/1/18	In progress and awaiting finance view	
		Complete POAP or briefing paper if not feasible and why	BM MF/SM MF	2/2/18	Dependent on above	
		Negotiate start date	BM MF/SM MF	10/2/18	TBC	
		Identify patients	BM MF/SM MF	10/2/18	To be undertaken once case mix agreed	
		Monitoring process in place	BM MF/SM MF	10/2/18	Will mirror the plastics process	
e)	Max Fax to use facilities at QMS to ensure start date of April 1st 2018	POAP to be submitted at EMT	BM MF/SM MF	5/2/18	Meetings in place with DVH – awaiting feedback from them re costs & room availability; 15/3/15 – appears to have slipped – updated required from Service Manager	

f)	Outsourcing to McIndoe for hand patients	Review all patients sent for surgery dates against beach date	DDOPs	2/2/18	Completed	
g)	Max Fax to cease taking tier 1 dental referrals from April 1st	Letter to commissioners with notice	AD BI	26/1/18	Completed	
h)	Super Saturdays	Additional funding to be sought for Super Saturdays in main theatres (max fax & Plastics) & then lists booked	DDOPs	5/2/18	• Complete – extended until the end of Feb & subject to review will continue; • Approval given to continue	
		New model of payment (4 hour rate) to be piloted as above	DDOPs	31/10/17	As above	
i)	Max Fax to undertake an options appraisal re the Tuesday list given to CHD and whether to take this back or whether there are other options within ENT	Option appraisal to be written and to go to EMT	BM MF/SM MF	31/3/18	Low priority – to be undertaken after outsourcing options worked up	
j)	To continue to work to maximise the offsite opportunities to use engagement with Commissioners/Regulators to support this.	Discussions to take place with commissioners and actions to be agreed – Medway meeting & QMS meeting booked for 8/11/17 & then quarterly between Planned Care COO and DOPs	DOPs	8/11/17	In progress – however MMH cancelled the Jan meeting, next meeting in place for Feb – high risk of cancellation again as Planned Care COO about to go on secondment; 15/3/18 – Feb meeting cancelled due to snow – to be picked up by new Director of Operations	
		To plan the gain from theatre productivity improvement at Medway to be developed to include booking one extra case per list and maximising usage of minutes for Max Fax	BM MF/SM MF	23/11/17	In progress – however the issue appears to be start times and requires further investigation – BM AS to assess issue and opportunity with MMH colleagues and SM MF; 15/3/18 – update required from service manager	
	To develop a dashboard for the KPIs in this action plan that can be used as an operational tool and to hold to account at Performance Review	Dashboard to be developed	AD BI & BM AS	31/5/18	To review timeframe – have suggested to be in place for Q2	
3. Systems & Processes – 18RTT						
a)	PAM to review standard operating procedures with regard to DNA and cancellation management, and ensure staff are suitably trained as part of their induction.	Revised SOPs in place with training undertaken and yearly review & updates	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th 17/4/18 First review of RTT undertaken with NHSI team in early April	

b)	• PAM to review of the 18 RTT team's working SOPs, numbers validated on a daily/weekly basis and to ensure a proactive approach is taken to tracking patients ; • To ensure there is a cohesive and robust training strategy in place covering all staff groups including medical secretaries for cancer and RTT; • ERS will help to make bottle necks visible;	• All SOPs to be reviewed; • Yearly review process to be put in place; • All SOPs to be available electronically as well as hard copies; • To assess if double screens are required so that the 18RTT can track patients on one and deal with other queries, check SOPs etc. on others; • Robust escalation policies to be produced as part of this	PAM	31/5/18	To commence as a priority when joins the Trust on March 12th 17/4/18 –two Joint training sessions across staff groups with NHSI held in April with follow up to be arranged	
c)	A National review of access policies was undertaken last year using feedback from NHSI/E and the required changes made. A model access policy has been released by the NHS	• Ensure current policy meets national policy; • All staff trained on a yearly basis and when any changes are made; • Yearly audits to be put in place to ensure that staff are following the new policy; • Training and audits to be included in the performance review dashboard	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th NHSI reviewing Local Policy in April	
d)	Service Manager for Appts, Outpatients and Health Records role to reviewed to ensure there is the capacity to be able to focus on the spoke sites as well as QVH site	• Capacity review undertaken; • JD review undertaken	BM AS	30/4/18	This will be a possible cost pressure as to date the role has focused with the onsite aspects	
e)	Service Manager for Appts, Outpatients and Health Records to review & put in place a standard turnaround timescales for receipt of referrals to registration on PAS and other systems	• To review/ agree Trust standard turnaround time; • To put in place regular audits; • For this to be a KPI on the dashboard	SM OP APPTS HR	TBC	To commence when back in post; 15/3/18 – part of SOP process 17/4/18 – to tie in with review of role as part of on-going process	
		• Automated system to record information to be captured on Patient Centre re time of receipt and registration for each week to be used as a KPI for the dashboard	AD BI & BM A&S	31/5/18	To review timeframe – have suggested to be in place for Q2	

f)	Management should review the definition and reporting of 'Outpatient clinics starting late' indicator as per KMPG recommendation	The validation of the actual clinic start times would be to sample in real time a range of clinics, which will be incorporated into a monthly audit. This will be then reported to the outpatient productivity board for a monthly review against the target.	BM A&S	30/6/18	In workplan	
4.	Systems & Processes – CWT					
a)	Consideration should be given to accelerating the development of a cancer "hub" to provide focus on cancer management	Already agreed in principle – to be fully scoped out as to realistic although stretching timescales & any additional investment required; Then to agree implementation timetable	DDOPs	30/4/18 - scoping to be completed	Likely to require organisational restructuring of appts team and may require additional investment	
b)	To develop a standardised SOP for management of elective care to ensure consistency of approach across all specialties	To review & benchmark against best practice SOPs from other Trusts & develop 31/3/18;	BM A&S	31/3/18	15/3/18 – first draft of SOP will be ready by 31/3/18, will be piloted for 4/6 weeks and then refined and finalised 17//4/18 – included within NHSI review of Cancer management	
c)	The trust should develop and implement a detailed escalation protocol/policy for elective pathway management to support operational teams particularly around capacity constraints and agreed trigger points	Escalation policy exists – to reviewed & reviewed yearly onwards	DDOPs	~~9/2/18~~ 31/8/18	15/3/18 Needs to be reviewed by 31/3/18 and relaunched. Dep Dir of Nursing, Head of Theatres & Dep Dir of Ops meeting to review current processed	
d)	The trust should ensure there is robust analysis of all breach patients (>62 days cancer and >52weeks for RTT) to fully understand blockages in system	Revised RCA process in place; Breaches and reasons part of Operational F&P report; To discuss with NHSI re late referral RCA process	DDOPs	30/3/18	To discuss with NHSI re late referral RCA process 17/4/18 – forms part of NHSI workplan	
e)	To ensure there is an adequate clinical harm review process in place for all patients breaching 104 days (as well as all patients with extended waits)	In place and led by Medical Director – commencing Feb 12th	MD	12/2/18	In place and led by Medical Director – commencing Feb 12th	

f)	The trust should ensure there is a cohesive and robust training strategy in place covering all staff groups including medical secretaries for cancer and RTT	• All staff trained on induction and on a yearly basis and when any changes are made; • Yearly audits to be put in place to ensure that staff are following the new policy; • Training and audits to be included in the performance review dashboard	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th 17/4/18 – RTT training has been held across staff groups with cancer specific sessions to follow in May	
g)	The trust should ensure all clinical pathways are timed and reviewed	Seeking further clarification from NHSI as to whether this is internal from receipt or for the whole pathway	MD	TBC	Significant piece of work which will need support from cancer alliances - to be further discussed with NHSI	
h)	The trust should ensure current paper based processes are reviewed and assured. Where possible electronic systems should be utilised	Review of all paper process undertaken; To reduce these and only use for business continuity processes	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th	
i)	The trust should ensure attendance at cancer alliance meetings to ensure shared learning across system	• Trust has been regular attendees at Kent and Medway Cancer Alliance; • Trust was regular attendees at Surrey and Sussex Cancer alliance but stopped being invited; • Leads contacted;	DOPs	29/3/18	• Contacted Surrey and Sussex Cancer alliance in Dec re this; • The want to meet - meeting for March 29th (their choice of date – we can meet earlier) with Phil McNamara & Dr Fiona McKinna from Surrey & Sussex Cancer Alliance; • Focus of meeting - QVH 62 day cancer waiting times performance, future of cancer services and diagnostics • Meeting took place with SySx as planned. Follow up sessions to be arranged.	
j)	The trust should ensure detailed joint clinical pathways are agreed with referring organisations where clear expectations are agreed on transfer time and issues such as clinical investigations to be undertaken	• Trust to scope out capacity to undertake this across all referring organisations; • Focus on the high risk pathways initially breast, followed by head and neck	MD	TBC	Significant piece of work which will need support from cancer alliances - to be further discussed with NHSI	
a)	A standardised SOP for management of IPTs should be developed including expectations on minimum dataset (MDS) information	To review and develop SOP	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th 17/4/18 – Draft SOP to be reviewed with NHSI	

b)	The trust should ensure all clinical pathways shared with referring trusts are timed and reviewed	Significant piece of work which will need support from cancer alliances - to be further discussed with NHSI	MD	TBC	Significant piece of work which will need support from cancer alliances - to be further discussed with NHSI	
c)	The trust should ensure it commences shadow reporting against the 28 day target in preparation for changes scheduled for later this year	• 95% of patients should receive a definitive diagnosis or ruling out of cancer within 28 days of a referral; • New Cancer data manager to be appt; • Cancer Data Manager to be trained how to use, and get the best out of, the new functionality of the CWT system; • New data items relating to the Faster Diagnosis Standard will be 'required' from April 2018 to June 2018 inclusive; • To allow a three month period for data collection processes and practices to be established; • From July 2018, the collection of these data items will be mandated;	CDM supported by PAM	30/6/18	• CDM in post from Jan 18 and being inducted & trained; • PAM has a robust CDM background and so will be able to assist with this	
d)	Formal demand and capacity modelling should be undertaken for all tumour sites/specialties using a recognised methodology to fully understand capacity constraints	• To undertake the IMAS/IST demand and capacity tool; • This will need joint working & capacity released between Ops & BI	AD BI & DDOPs	TBC	• AD BI scoping feasibility with an external company; • 15/3/18 – NHSI will commence fully with Trust early April and this will be part of the work	
e)	The trust should assure itself that there is only one source of information for managing cancer pathways and no "additional" waiting lists are in use	• One data source to be used and this to be audited on a 3 monthly basis so there is no 'creep'	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th	
f)	All referrals must be registered on PAS and no local spreadsheets should be used to manage cancer pathways – all patients should be moved to active PTL	One data source to be used and this to be audited on a 3 monthly basis so there is no 'creep'	PAM	30/4/18	To commence as a priority when joins the Trust on March 12th	

g)	The trust needs to ensure sufficient succession planning is in place, particularly for pressured specialties/tumour sites	Assess numbers of further consultants required once demand and capacity tool is completed;	DDOPs	TBC	• Successful business cases have been made for additional consultants have already been recruited to key tumour sites in plastics and Max Fax; • Locum cover has been sourced when key staff absent due to sickness;	
		• Recruitment & Retention Strategy in place for nursing; • To revisit nursing workforce numbers once the above is completed	DWOD	In place	• Issue is the high level of theatre nursing vacancies in theatres (currently 21.52%) which limits additional lists being scheduled – either ad hoc or permanent	
h)	The trust should ensure that equipment to facilitate SMDT is available and effective	To review all equipment and identify which needs to be replaced and in what priority order;	BM CS	30/3/18	IT in discussion with relevant business manager	
		To identify funding stream	BM CS	30/4/18	Will depend on what is required as to whether this is capital or revenue	
i)	Trust should try to formalise arrangements for visiting consultants through job planning cycles to ensure more certainty for complex surgery on site	To be managed through job planning cycles	MD	31/3/18 & yearly reviews	15/3/18 – Business & Service Managers undertaking job planning reviews with clinical directors in Q4 of 17/18	
j)	Trust should engage actively with CCG to revisit demand management plans for dermatology services	Ongoing as part of contract discussions	AD BI	As per contract management cycle	Regular contract and performance management meetings in place	

k)	Trust need to ensure robust mitigation plan in place for planned PAS upgrade this year	Risk mitigations to be shared with NHSI	CIO	As per upgrade cycle	15/3/18 :- • The upgrade will not include any data migration or revalidation. The key changes will be mitigated with a plan for the minimal staff training with the incoming additional functionality. There is a robust plan in place for end user testing with engagement in clinical / operational areas already under way; • The PAS team have reviewed the release notes for all versions and there is nothing that identifies any change/impact to the way users will input data; • There will be standard mitigations in place in terms of the go live plan, roll back process with associated timings with roles and responsibilities identified; this will have a governance process as at a project level that will then report to the IM&T Group chaired by the Director of Finance; • CIO will also meet with IST when onsite to talk through the below and give assurance back to region as part of our support package.	
l)	Information and operational teams should integrate more closely to support effective cancer management	BI team member to attend the PTL meeting – both 18 RTT & CWT	AD BI	Immediate	Completed	
5 PTL						
a)	The trust should consider separating RTT and cancer PTL meetings until both are in more stable position.	To separate meetings	PAM	31/3/18	Meetings will be separated with effect from 18/4/18	
b)	The trust should ensure the meeting has clear TOR with structured agenda, mandatory attendees and should be held weekly.	• In place and based feedback and on the ones offered by IMAS at their last visit; • Will review again when new PAM commences based on her experience	PAM	30/3/18 (for additional review)	Completed TOR, Format and Procedure for PTL meetings have been reviewed and will be re-launched from 18/4/18, initially chaired by NHSI	

c)	The meeting should ensure attendees are held to account for actions agreed at the meeting and should adopt a clear action orientated approach. Actions from the meeting should be minuted.	To recruit to the vacant 0.6 wte admin support for the business managers	PAM	23/2/18 (advert placed)	To place advert by 23/2/18; To source bank member of staff in the interim and identify office space; 15/3/18 – update required 17/4/18 – Agreed to combine with existing PA establishment and awaiting approval to recruit	
d)	The trust should ensure that the information team participate in this group to support utilisation of an appropriate and accurate data set for effectively managing patient pathways (PTL)	To attend the meetings	AD BI	31/3/18	15/3/18 – BI colleagues attending meeting however there is a risk as to the consistency of this due to the size of team and vacancies TOR, Format and Procedure for PTL meetings have been reviewed and will be re-launched from 18/4/18, initially chaired by NHSI	
e)	The trust needs to develop a performance dashboard for managing elective care identifying and managing key KPIs across the entire PTL (not just +42 week patients)	To be completed to be in place by Q2	AD BI, HBI & PAM	1/6/18	15/3/18 – to be informed by the SOP development & IST work TOR, Format and Procedure for PTL meetings have been reviewed and will be re-launched from 18/4/18, initially chaired by NHSI	
f)	Trust should ensure that one source of data (PTL) is used for management of elective care and local spreadsheets should be excluded	To be in place ASAP	~~DDOP~~ PAM	31/3/18	In place TOR, Format and Procedure for PTL meetings have been reviewed and will be re-launched from 18/4/18, initially chaired by NHSI	
g)	The trust should engage some dedicated expert support to clean DQ issues and PTL and this might be supported by application of some agreed logic to stratify process	AD BI & HBI to assess how best to undertake this	AD BI & HBI	31/5/18	Initial view required	
h)	The trust need to ensure that the PTL is complete and that all patients cared for at "spoke" sites are visible on it	• Additional Validators to be sourced (interim and then substantive) to support data quality from all spoke sites; • Data quality/cleansing exercise to be undertaken; • Aim to commence reporting from Q1 2018 therefore April 18RTT data will include all spoke sites	DDOP & PAM	~~1/4/18~~ 1/6/18	15/3/18 – needs to be part of the work that IST are undertaking and also a key focus of the Max Fax task and finish group led by the Interim Director of Finance Format of PTL report has been reviewed and will be re-launched from 18/4/18,	

i)	Robust training programme should be developed for clinical and non-clinical staff to ensure issues such as outcoming of clinics are improved and DQ issues addressed	• The current service standards, & SOP's need to be rewritten/written & fit for purpose with staff trained; • Yearly review process to be put in place; • All SOPs to be available electronically as well as hard copies; • Robust escalation policies to be produced; • Yearly audits to be put in place to ensure that staff are following the new policy; • Training and audits to be included in the performance review dashboard	SM OP APPTS HR	31/3/18	Current SM is on sick leave, acting up arrangements in place but this will present a capacity issue; 15/3/18 – BM A&S has identified support to work on this. First draft will be ready by 31/3/18, piloted for 4-6 weeks, then finalised and launched.	
j)	Information staff should work alongside operational staff to ensure PTL can be used effectively to manage patients pathways and "cut" to reflect operational needs	To work jointly on this	HBI & PAM	~~31/3/18~~ 30/4/18	15/3/18 – will be joint and evolving work on this now that the PAM has joined us and as the IST work progresses 17/4/18 – First review of PTL report undertaken and new format to be shared from 18/4/18 with further development required	

6	Systems & Processes – Appointments					
a)	The current standard operating procedures are not fit for purpose.	• The current service standards, & SOP's need to be rewritten/written & fit for purpose with staff trained; • Yearly review process to be put in place; • All SOPs to be available electronically as well as hard copies; • Robust escalation policies to be produced; • Yearly audits to be put in place to ensure that staff are following the new policy; • Training and audits to be included in the performance review dashboard	SM OP APPTS HR	~~30/6/18~~ 31/3/18	Current SM is on sick leave, acting up arrangements in place but this will present a capacity issue; 15/3/18 – BM A&S has identified support to work on this. First draft will be ready by 31/3/18, piloted for 4-6 weeks, then finalised and launched. First draft SOPs for review by 20/4/18	
b)	Once the SOPs are embedded and business as usual - to establish how many appts should be processed per wte per day/week	• Daily workloads to be established and monitored	SM OP APPTS HR	30/6/18	Current SM is on sick leave, acting up arrangements in place but this will present a capacity issue; 15/3/18 – A recommendation to be made once the SOPs are embedded and working practices more consistent	
c)	To separate the outpatient reception cover from the appts	• To identify establishment required; • This is likely to be a cost pressure	SM OP APPTS HR	30/6/18	Current SM is on sick leave, acting up arrangements in place but this will present a capacity issue; 15/3/18 – A recommendation to be made once the SOPs are embedded and working practices more consistent – this will allow a view to be taken as to whether any capacity can be released to allocate staff members permanently to Outpatients or whether an investment is needed	
d)	Trust to ensure suitable mandatory training for staff within the central appointments team, admissions schedulers and medical secretaries arranging admissions, forming part	To ensure that systems are in place so that all staff are trained as part of induction and receive annual update which is recorded	SM OP APPTS HR	30/4/18	15/3/18 – Appraisals and all training requirements for staff to be updated by end of April and then localised training requirements as per the bullet points to be put in place for 18/19	

	of an annual performance appraisal process including: • Patient administration system referral registration and appointment booking functions (including processes relating to DNA's and cancellations), and discharging processes; • E - referrals • Access Policy &18 week rules • Cancer waiting times rules	SM for appointments to work with Performance & Access manager to ensure they are trained & competent; To include as part of the Business Unit – Access & Spoke sites dashboard	SM OP APPTS HR	31/5/18	Current SM is on sick leave, acting up arrangements in place but this will present a capacity issue; Acting up manager to undertake this action 17/4/18 –two Joint training sessions across staff groups with NHSI held in April with follow up to be arranged	
e)	Trust to ensure PAS is the primary system used to arrange admission dates, and the use of manual diaries and excel spread sheets is eliminated	Establish whether any secretaries are still using manual diaries, why this is, what needs to change and agree a date for when these will cease.	BMs	30/4/18	Requires Update	
7	Other Workforce Issues					
a)	~~To devolve the appointments team to each business unit so they can function as 'Points of Delivery';~~ ~~This will bring together the administrative support teams for our specialist services so that local GPs and patients can easily arrange their appointments and keep in contact with us. This is the model that has successfully worked in eyes and sleep and is being introduced in other trusts of Croydon;~~ Once the appts team has stabilised and the SOPS are in place – BM A&S to take a view as to whether the currently model should continue or it should be devolved to the BU as a points of delivery model with a single direct telephone number and a dedicated email address for each group of specialist services;	• ~~To develop - Point of Delivery teams with a single direct telephone number and a dedicated email address for each group of specialist services;~~ • ~~Initially this will be the appts team moving into the BU as in the eyes and sleep model with a view taken once that has embedded whether the tracking and validating team need to be part of the POD or as a separate function;~~ • ~~To phase this approach with the appts remaining as they are until the new SOPs etc. are embedded and then phase one will be for plastics to go live followed by max fax;~~ • ~~Will need project management support;~~ • To review and make recommendations in paper to EMT	BM A & S	30/6/18	15/3/18 – SOP development first aspect of this	

b)	There is no admin support for the PTL meeting	To recruit to the vacant 0.6 wte admin support for the business managers	PAM	23/2/18 (advert placed)	• To place advert by 23/2/18; • To source bank member of staff in the interim and identify office space; • 15/3/18 – require update • 17/4/18 – Agreed to combine with existing PA establishment and awaiting approval to recruit	
8 Other Enabling Workstreams						
a)	To deliver the e referral service in line with the timescales	See separate action plan	BM AS	As per separate plan	In progress & currently on track	
b)	Trust to review appointment letters, cancellations and DNA letters confirm implications of non-attendance and cancellations.	BAU activity and needs to be undertaken yearly	SM OP APPTS HR	30/6/18	Update to OPD productivity group	
c)	Trust to review outcome form completion by consultants / medical staff in clinic, and specifically the requirements for further follow up review.	BAU activity and needs to be undertaken yearly	SM OP APPTS HR	30/6/18	OPD productivity group	

Implementation RAG Rating key
Green – On target, no delays
Amber – Implementation progressing as planned
Red – Needs escalating to EMT due to issues causing delivery delays
Grey – Not due to commence yet
Blue – Action completed
Actions in bold & italic are a NHSI recommendation

BM AS	Business Manager Access & Spokes
DDOPs	Deputy Director of Operations
SM OP APPTS HR	Service Manager – OPD, Appts & Health Records
AD BI	Associate Director – Business Intelligence
HBI	Head of Business Intelligence
CIO	Chief Information Officer
BM CS	Business Manager Clinical Support
DWOD	Director of Workforce & Organisational Development
PAM	Performance & Access Manager
BM MF	Business Manager – Max Fax
SM MF	Service Manager – Max Fax

Appendix 2 – 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%	83.0%	80.5%	79.29%	79.3%	

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%	85.4%	64.9%	61.90%	69.2%	

The trajectory submitted for 52weeks

Month	Trajectory	Performance
November 2017	26	20
December 2017	22	18
January 2018	16	14
February 2018	11	
March 2018	8	
April 2018	0	

The revised trajectory submitted for 18weeks RTT

Month	Trajectory	Performance
November 2017	84.0%	83.0%
December 2017	84.5%	80.5%
January 2018	85.0%	79.29%
February 2018	86.0%	79.3%
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%	

Reporting Month	Tumour Type	Wait Days	Breach Reason 2WW
Quarter 4 – Feb-18	Head and Neck	75	Patient choice – given earlier dates.
	Head and Neck	24	Clinic cancellation – consultant on sick leave.
	Head and Neck	21	Admin delay –referral not passed on to the booking team.
	Head and Neck	20	Patient cancellation.
	Head and Neck	19	Patient declined offered appointments within the two week – travelling abroad.
	Head and Neck	18	Admin delay – incorrect patient information given to booking team.
	Head and Neck	17	Outpatient capacity inadequate.
	Head and Neck	15	Outpatient capacity inadequate.
	Head and Neck	15	Clinic cancellation – consultant on sick leave.
	Skin	18	Patient declined an offered appointment within the two week.

Reporting Month	Tumour Type	First seen Trust	Treating Trust	Wait Days	62 Day Referral to Treatment	Accountability
Quarter4 Feb-18	Head and Neck	Brighton General Hospital	Queen Victoria Hospital	63	Referred to QVH on day 56, treated within 24 days.	0.5
	Head and Neck	Queen Victoria Hospital	Maidstone District General Hospital	65	First appointment day 7 at Darent Valley. Delay to diagnostics at QVH. QVH referred to treating trust on day 56, patient was treated within 24 days.	0.5
	Head and Neck	East Surrey Hospital	Queen Victoria Hospital	97	Referred to QVH on day 59, not treated within 24 days. Delay to treatment (surgery) start date due to capacity.	0.5
	Skin	Eastbourne Hospital	Queen Victoria Hospital	68	Referred to QVH on day 61, treated within 24 days.	0.5
	Skin	East Surrey Hospital	Queen Victoria Hospital	133	Referred to QVH on day 67, not treated within 24 days. Admin delay in the patient receiving a first appointment at QVH – took 38 days from receiving the referral to outpatient appointment with Plastics.	0.5

Reporting Month	Tumour Type	Wait Days	31 Day to First Treatment Breach Reason
Feb-18	Head and Neck	35	Capacity – unable to book within target due to lack of capacity.
	Skin	32	Delay to clearance for surgery due to more information needed from referring Dr regarding medical problems.

Reporting Month	Tumour Type	Wait Days	31 day to Subsequent Treatment (surgery) Breach Reason
Feb-18	Breast	37	Co-ordination of two surgeons.
	Skin	60	Hospital cancellation - original surgery date cancelled due to an overbooked list.
	Skin	36	Treatment delayed due to medical reasons – inpatient with pneumonia.
	Skin	32	Patient choice – daughter unable to bring the patient in.
	Skin	32	Capacity – unable to book within target due to lack of capacity.

Appendix Three – QVH: ITR Shadow Report 62D 2017/18

Scenario	Referral timeframe	Total timeframe	Allocation
1	> 38 days	< 62 days	100% of success allocated to the treating provider
2	< 38 days	< 62 days	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	< 38 days	>62 days	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating trust treats within 24 days	100% of breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in >24 days	50% of breach allocated to the referring provider and 50% allocated to the treating provider

QVH Summary

Gained 11 breaches (referred to QVH within 38 days, QVH did not treat within 62 days) – equivalent of 22 patients
Lost 8.5 breaches (referred to QVH over 38 days, QVH treated within 24 days) – equivalent of 17 patients
16 remained the same (referred over 38 days, QVH did not treat within 24 days) – equivalent of 32 patients

Actions

I. Clear and concise tracking comments to identify if a patient has been referred into the trust on an existing 62D pathway – this is to include the date of the ITR so the 24 day target can be easily identified (ensuring this is discussed at PTL).
II. Weekly contact with our referring trusts to ensure an ITR has been sent and received within the trust. To agree date of ITR.
III. Develop a standardised SOP for the management of IPT's, including expectations on the minimum dataset.
IV. Agree processes to analyse and resolve regular underperformance where either treating trust or referring trust(s) are unable to meet the agreed handover date or waiting time target on a regular basis.

62D Performance – Quarter 1

Apr-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	2.5	1.5	40.0
Head and Neck	6.5	1.5	76.9
Skin	17	1	94.1
TOTAL	26	4	84.6

May-17	No. of Patients Treated	No. of Breaches	% Achieved

Shadow 62D Performance – Quarter 1

Apr-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	3.5	2.5	28.6
Head and Neck	6.5	1.5	76.9
Skin	18	2	88.9
TOTAL	28	6	78.6

May-17	No. of Patients Treated	No. of Breaches	% Achieved

Breast	1	0.5	50
Head and Neck	7.5	4.5	40
Skin	16.5	4	75.8
TOTAL	25	9	64.0

Breast	1	0.5	50.0
Head and Neck	7.5	4.5	40.0
Skin	17	4.5	73.5
TOTAL	25.5	9.5	62.7

Jun-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Head and Neck	4	3.5	12.5
Sarcoma	1	0	100.0
Skin	14	2	85.7
Urology	0.5	0	100.0
TOTAL	19.5	5.5	71.8

Jun-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Head and Neck	4	3.5	12.5
Sarcoma	1	0	100.0
Skin	15	3	80.0
Urology	0.5	0	100.0
TOTAL	20.5	6.5	68.3

QTR 1	70.5	18.5	73.8

QTR 1	74	22	70.3

Quarter 1 saw a decrease in performance due to gained breaches.

62D Performance – Quarter 2

Jul-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Head and Neck	5.5	2.5	54.5
Skin	16.5	1	93.9
TOTAL	22	3.5	84.1

Shadow 62D Performance – Quarter 2

Jul-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Head and Neck	5.5	2.5	54.5
Skin	16.5	1	93.9
TOTAL	22	3.5	84.1

Aug-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Haematology	0.5	0.5	0.0
Head and Neck	1.5	0	100.0
Sarcoma	0.5	0.5	0.0
Skin	17	5.5	67.6
TOTAL	19.5	6.5	66.7

Aug-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Haematology	0.5	0.5	0.0
Head and Neck	1.5	0	100.0
Sarcoma	0.5	0.5	0.0
Skin	18	6.5	63.9
TOTAL	20.5	7.5	63.4

Sep-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	1.5	1.5	0.0
Head and Neck	6.5	4	38.5
Sarcoma	0.5	0.5	0.0
Skin	21	4.5	78.6
TOTAL	29.5	10.5	64.4

Sep-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	1.5	1.5	0.0
Head and Neck	4.5	2	55.6
Sarcoma	0.5	0.5	0.0
Skin	22	5.5	75.0
TOTAL	28.5	9.5	66.7

QTR 2	71	20.5	71.1

QTR 2	71	20.5	71.1

Quarter 2 saw the performance remain the same as there was a balance of both lost and gained breaches.

62D Performance – Quarter 3

Shadow 62D Performance – Quarter 3

Oct-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	1	0.5	50.0
Head and Neck	6.5	3	53.8

Oct-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	1	0.5	50.0
Head and Neck	6.5	3	53.8

Skin	18	2.5	86.1
TOTAL	25.5	6	76.5

Skin	18.5	3	83.8
TOTAL	26	6.5	75.0

Nov-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	1.5	0	100.0
Head and Neck	9	1.5	83.3
Skin	13.5	2	85.2
TOTAL	24	3.5	85.4

Nov-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	1.5	0	100.0
Head and Neck	8.5	1	88.2
Skin	14.5	3	79.3
TOTAL	24.5	4	83.7

Dec-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Head and Neck	5	2.5	50.0
Other	0.5	0.5	0.0
Skin	13	3.5	73.1
TOTAL	18.5	6.5	64.9

Dec-17	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0	0	#DIV/0!
Head and Neck	4.5	2	55.6
Other	0.5	0.5	0.0
Skin	12.5	3	76.0
TOTAL	17.5	5.5	68.6

QTR 3	68	16	76.5

QTR 3	68	16	76.5

Quarter 3 saw the performance remain the same as there was a balance of both lost and gained breaches.

62D Performance – Quarter 4

Jan-18	No. of Patients Treated	No. of Breaches	% Achieved

Shadow 62D Performance – Quarter 4

Jan-18	No. of Patients Treated	No. of Breaches	% Achieved

Breast	0	0	#DIV/0!
Head and Neck	4.5	2	55.6
Skin	15	4	73.3
TOTAL	19.5	6	69.2

Breast	0	0	#DIV/0!
Head and Neck	4	1.5	62.5
Skin	14.5	3.5	75.9
TOTAL	18.5	5	73.0

Feb-18	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0.5	0	100.0
Head and Neck	2.5	1.5	40.0
Skin	11	1	90.9
TOTAL	14	2.5	82.1

Feb-18	No. of Patients Treated	No. of Breaches	% Achieved
Breast	0.5	0	100.0
Head and Neck	2.5	1.5	40.0
Skin	10.5	0.5	95.2
TOTAL	13.5	2	85.2

Mar-18	No. of Patients Treated	No. of Breaches	% Achieved
Breast			#DIV/0!
Head and Neck			#DIV/0!
Skin			#DIV/0!
TOTAL	0	0	#DIV/0!

Mar-18	No. of Patients Treated	No. of Breaches	% Achieved
Breast			
Head and Neck			
Skin			
TOTAL	0	0	

QTR 4	33.5	8.5	74.6

QTR 4	32	7	78.1

Currently for quarter 4 we have seen an improvement on performance due to lost breaches.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/05/18**		**Agenda reference:**	**75-18**	
Report title:	**Financial performance**				
Sponsor:	Michelle Miles, Director of Finance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	NA				
Executive summary					
Purpose:	The Trust delivered a surplus of £815k in month; £547k above plan. The year-end surplus has increased to £1,726k; £10k favourable to plan.				
Recommendation:	The Board is asked to **note** the contents of this report.				
Purpose:				Assurance **Y**	
Link to key strategic objectives (KSOs):			KSO3: **Y** *Operational excellence*	KSO4: **Y** *Financial sustainability*	KSO5: **Y** *Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	The Finance Use of Resources rating is 1.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	23/04/18	Decision:	Noted	
Previously considered by:	Executive management team				
	Date:	23/04/18	Decision:	Noted	
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Abridged Finance Report (Subject to audit review)
March 2018

Executive Director: Michelle Miles

Contents

3. Summary Position
4. Surplus Trend Position
5. Activity Performance by POD
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12. Appendix 1: Single Oversight Framework Finance and use of resources score - QVH Calculation

Summary Position – YTD M12 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 – Financial Performance

Financial Performance	2017-18	Mar-18			Year to Date 2017-18		
Income and Expenditure	Annual Plan £k	Budget £k	Actual £k	Variance (Favourable/ (Adverse))	Budget £k	Actual £k	Variance (Favourable/ (Adverse))
Patient Activity Income	66,056	5,707	5,381	(327)	66,056	64,017	(2,040)
Other Income	3,706	248	898	650	3,706	4,731	1,026
Total Income	**69,762**	**5,955**	**6,279**	**323**	**69,762**	**68,748**	**(1,014)**
Pay	(44,537)	(3,711)	(3,925)	(213)	(44,537)	(44,236)	302
Non Pay	(19,271)	(1,622)	(993)	628	(19,271)	(18,605)	666
Financing	(4,489)	(374)	(421)	(47)	(4,489)	(4,269)	220
Total Expenditure	**(68,297)**	**(5,707)**	**(5,340)**	**368**	**(68,297)**	**(67,110)**	**1,188**
Surplus / (Deficit)	**1,465**	**248**	**939**	**691**	**1,465**	**1,638**	**173**
Surplus (Deficit) %	2.10%	4.16%	14.96%	10.80%	**2.10%**	2.38%	**-0.28%**
Adjust for Donated Depn.	(251)	(21)	124	(145)	(251)	(87)	(164)
NHSI Contol Total	**1,716**	**269**	**815**	**547**	**1,716**	**1,726**	**10**

YTD Performance

- Income has under recovered by £1,014k, which is due to Patient Activity of £2,040k with Other income over recovery of £1,026k. The key drivers are:-
  - Clinical Income has seen a reduction in Day cases & Elective surgery through out the year, due to a combination of issues including sickness, staffing levels, poor weather and annual leave in Q4.
  - Other Income has seen an increase which is mainly due to an increase from services we provide to other providers, charitable & training income, with some of this being offset against expenditure.
- Pay is £302k under spent at year end which is mainly due to vacancies not being fully back filled with temporary shifts. Medical staffing group is the only area to have a over spend at year end, £632k including agency usage. Total agency YTD of £2,158k; £390k above agency ceiling.
- Non pay is £666k underspent, this is mainly due to non recurrent VAT savings in year, reserves and rent underspends.
- Financing is underspent £220k YTD which is due to depreciation offset by PDC.

Summary - Plan Performance

- The Trust delivered a surplus of £815k in month; £547k above plan. The Year end surplus has increased to £1,726k; £10k favourable to plan.
- The main driver of the YTD position is the under-recovery of income of £1,014k which was offset by expenditure underspends.

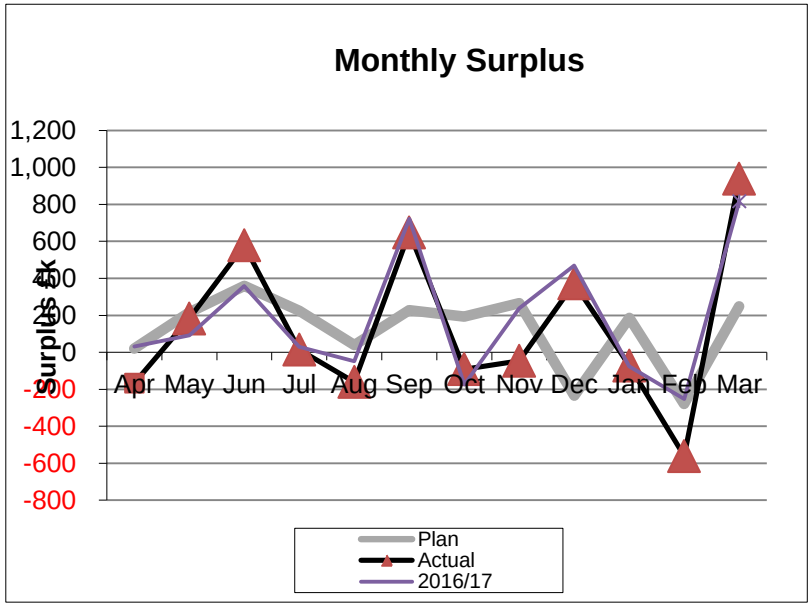
In Month Performance

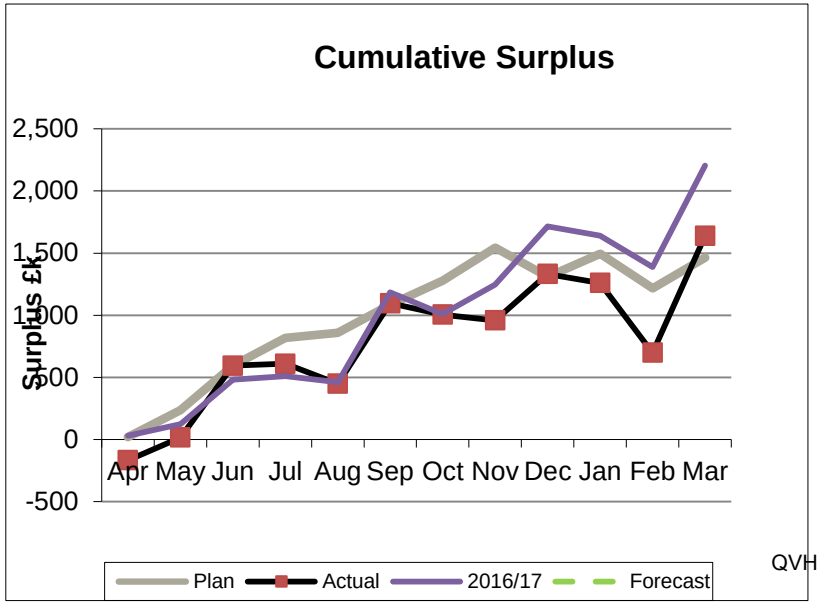
The in month position has seen a continued underperformance within clinical income and increasing pay overspend which has been fully offset by non pay stock adjustment in month.

- Income has over-performed in month by £323k, with Patient Activity Income continuing to under-perform. The key drivers are:-
  - Clinical income was below plan by £327k in month 12. Mainly due to annual leave and cancelations.
  - Sustainability and Transformation funding of £110k in month and £220k for months 10 and 11 has been assumed as the control total has been met for quarter 4.
  - Other income has over recovered in month by £650k due to PGME additional income of £36k, additional training income £102k, recharges to other providers £271k (Histopathology being the main area with the West Kent Dermatology work), income from Charitable funds of £148k, additional income from R&D £28k and a technical adjustment of £67k.
- Pay expenditure is overspent by £213k in month decreasing the YTD underspend to £302k. Agency usage continues to grow in month and is greater than last month by £38k largely within Nursing (Theatres), admin and additional junior doctors.
- Non pay is underspent by £628k in month which is mainly due to adjustment to stock of £745k in month with theatres being the main area.
- Financing is over spent in month by £47k which is due to increased PDC as result of revaluation.
- The Finance Use of Resources rating is 1. All metrics scored 1 (the highest possible rating) apart from agency which scored a 2 due to the breach of ceiling.

Surplus Trend Position – M12 2017/18

Queen Victoria Hospital
NHS Foundation Trust





Summary

- There is a £939k surplus in month against a planned surplus of £248k. The YTD surplus is £1,638k, which is above plan by £10k. .
- 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 : M12 2017/18

Queen Victoria Hospital NHS Foundation Trust

Table 1 - Performance by POD

Activity Performance			Month 12 (March)			Month 12 (March)			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	932	931	863	(68)	69	64	(5)	10,892	10,953	61	804	808	5
Elective (Daycase)	Spells	1,077	1,121	905	(216)	1,249	1,014	(235)	13,019	12,262	(757)	14,445	13,840	(605)
Elective	Spells	335	346	317	(29)	816	746	(70)	4,043	3,830	(213)	9,505	9,158	(347)
Non Elective	Spells	460	461	386	(75)	1,180	951	(229)	5,394	5,419	25	13,810	13,215	(595)
XS bed days	Days	76	119	98	(21)	33	27	(6)	1,392	642	(750)	385	180	(205)
Critical Care	Days	71	62	49	(13)	79	54	(26)	720	958	238	929	1,092	164
Outpatients - First Attendance	Attendances	3,845	3,933	3,644	(289)	552	501	(51)	45,978	44,114	(1,864)	6,452	6,043	(410)
Outpatients - Follow up	Attendances	10,682	10,715	10,132	(583)	771	768	(3)	125,218	122,320	(2,898)	9,013	9,134	121
Outpatient - procedures	Attendances	2,382	2,401	1,565	(836)	323	210	(113)	28,093	28,928	835	3,783	3,865	82
Other	Other	3,770	2,666	3,142	476	475	494	19	31,194	45,179	13,985	5,537	5,452	(84)
Work in progress and coding adjustment						159	552	0				1,394	1,229	(0)
						5,707	**5,381**	**(327)**				**66,056**	**64,017**	**(2,040)**

Table 2 - Performance by Service Line

Activity Financial Performance	Month 11 (February)			Year to date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Perioperative Care	79	54	(26)	929	1,093	164
Clinical Support	569	508	(60)	6,655	7,625	969
Eyes	620	524	(95)	7,064	6,456	(608)
Oral	1,123	954	(169)	13,142	13,192	50
Plastics	2,825	2,392	(433)	33,029	29,768	(3,261)
Sleep	332	390	57	3,888	4,597	709
Other incuding WIP/ coding	159	558	399	1,350	1,286	(64)
Grand Total	**5,707**	**5,381**	**(327)**	**66,056**	**64,017**	**(2,040)**

NB

* Other clinical income has been added to analysis (i.e. STF, RTA, Private patients) to reconcile to total Clinical Income.

** Total in month and YTD service line performance does not reconcile to activity income analysis by business unit as non SLAM activity income has not been disaggregated to business unit.

Summary

- The March in month position was adversely impacted by £327k, due to continuation of theatres capacity issues and high annual leave usage.
- **Minor injuries** attendances are 68 and £5k lower than plan. YTD activity is 61 attendances and £5k above plan.
- **Daycase** activity in month is 216 spells and £235k below plan with under-performance in Hands £100k, Corneo Plastics £52k, Max Facs £78k. YTD activity is 757 spells and £605k under plan with Hand Surgery £568k, Corneo Plastics £442k and Max Facs £307k below plan. This has been partially offset by above plan performance within Skin which has generated an additional £675k above their planned income target year to date.
- **Elective** activity in the month is 29 spells and £70k below plan with under performance in Max Facs £63k, Skin £22k and Hands £18k, with over performance from ENT £31K - YTD activity is 213 spells and £347k under plan largely within Hand Surgery £272k and Breast Surgery £280k offset by an over-performance in Burns £210k and ENT £378K.
- **Non-elective activity** has under performed by 75 spells and £229k in month. The YTD position reports an over-performance of 25 spells and £595k underperformance with over-performance 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 (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. £1,126k of activity has been reattributed to Plastics & Oral.
- **Critical care** days have under-performed by 13 days in month and £26k. The YTD position is an over achievement of plan of 238 bed days and £164k. 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. There was refurbishment work completed in month which reduced capacity.
- **Outpatient** attendances (FA/FUs) are 872 attendances and £54k lower than plan in month and £289k below plan YTD. Outpatient procedures are £113k under plan in month and £82k over YTD.
- **Overall** - 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 Sleep . The two key concerns are the underperformance within plastics partly due to medical sickness and the YTD position within Eyes which has been addressed by weekend working.

Actions

- Plastics and Maxillofacial are undertaking additional Saturday lists. However, there are ongoing operational risks regarding theatre staffing impacting upon day case and elective income .
- Eyes services to continue generating additional income by undertaking a second Femto laser list.

Balance Sheet – M12 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet as at the end of March 2018	2016/17 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	44,279	44,753	43,864
Other Receivables	-	-	-
Sub Total Non-Current Assets	44,279	44,753	43,864
Current Assets			
Inventories	429	1,178	431
Trade and Other Receivables	7,068	7,037	7,778
Cash and Cash Equivalents	7,784	8,914	8,817
Current Liabilities	(7,413)	(8,894)	(8,822)
Sub Total Net Current Assets	7,868	8,235	8,203
Total Assets less Current Liabilities	52,147	52,988	52,068
Non-Current Liabilities			
Provisions for Liabilities and Charges	(684)	(665)	(684)
Non-Current Liabilities >1 Year	(6,600)	(5,823)	(5,823)
Total Assets Employed	**44,862**	**46,500**	**45,561**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	22,614	24,253	23,314
Revaluation Reserve	10,011	10,010	10,010
Total Tax Payers' Equity	**44,862**	**46,500**	**45,561**

Summary

- Capital asset value has increased in month due to planned projects being completed in March.
- Net current assets have remained stable this month.
- Inventories have increased following an extension to the size and scope of the stock measurement for year end of £0.7m.
- Trade and other receivables have decreased by £0.7m, reflecting the drop in activity income and performance invoices due to be paid.
- Cash has increased by £0.1m due to increased receipts from debtors.
- Current liabilities have increased only marginally by £0.1m.

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 – MONTH 12 2017/18

Queen Victoria Hospital NHS
NHS Foundation Trust

Month 12 - March 2018	Annual Plan £000s	Full Year Actual £000s	Full Year Variance £000s
Estates projects			
Backlog maintenance - Roofs	179	164	15
Backlog maintenance - Health & Safety	226	308	(82)
Backlog maintenance - Cladding & Fenestration	179	48	131
Backlog maintenance - Energy Management	124	170	(46)
Backlog maintenance - Internal Accommodation	194	137	57
Trauma Clinic	113	102	11
Other projects	680	462	218
Estates projects	**1,695**	**1,391**	**304**
Medical Equipment	**576**	**661**	**(85)**
Information Management & Technology (IM&T)			
EDM	130	276	(146)
Ordercomms (IM&T Strategy)	310	282	28
Health & Social Care Network (IM&T Strategy)	150	79	71
Other projects	289	473	(184)
Information Management & Technology (IM&T)	**879**	**1,110**	**(231)**
Contingency	**250**	**-**	**-**
Total	**3,400**	**3,162**	**238**

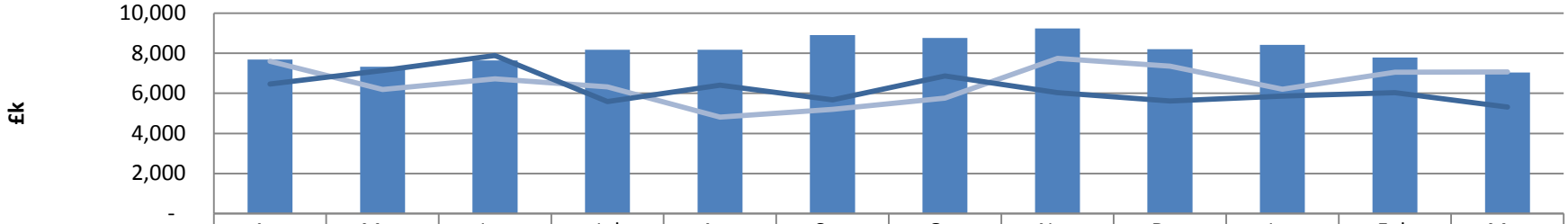
Summary

- 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 has reached the end of the 2nd year of a 5 year programme. There has been some slippage, notably in Cladding & Fenestration due to a decision to defer works on the Estates/Rehab buildings pending a review of their future.
- The IT programme is largely based on the IM&T Strategy. The EDM project is continuing although there have been delays in deployment. The Evolve product is fully live in Sleep and OFMS services and Eyes; the implementation within Plastics is later than expected and will continue in 2018/19. 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. Developments in network storage and switching have been brought forward since funds were available in the overall capital programme.
- Capital full year expenditure is £3,162k, £238k behind plan due to unused contingency and in line with forecast.

Debtors – M12 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	8,206	8,419	7,778	7,037
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

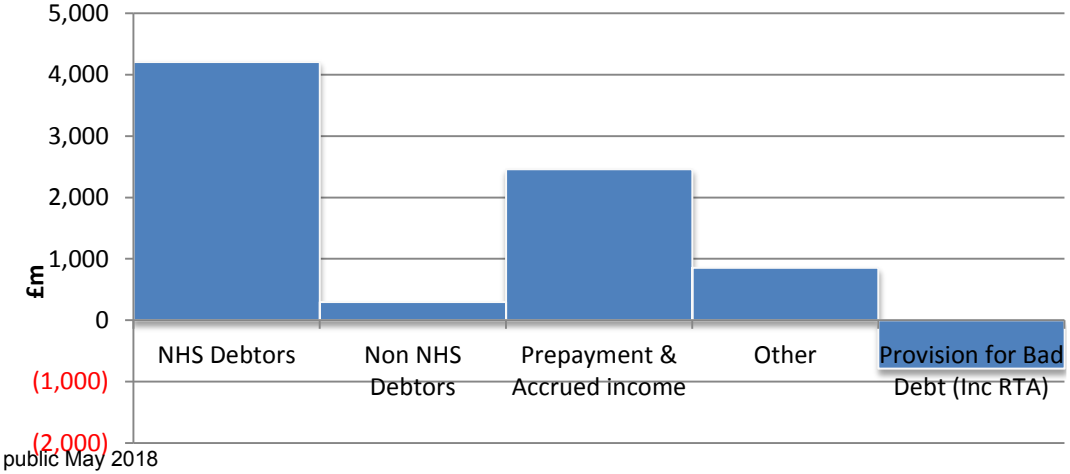
Summary

- The debtor balance decreased by £0.7m (10%) from month 11. This is due largely to recovery of aged debt relating to prior months over performance invoices in month.
- The month 12 debtor balance of £7.0m is 8.2% above the average monthly balance in 2016-17.
- At month 12 there is £1.2m of accrued income for activity over-performance and NCAs, which is a decrease of £0.3m 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.

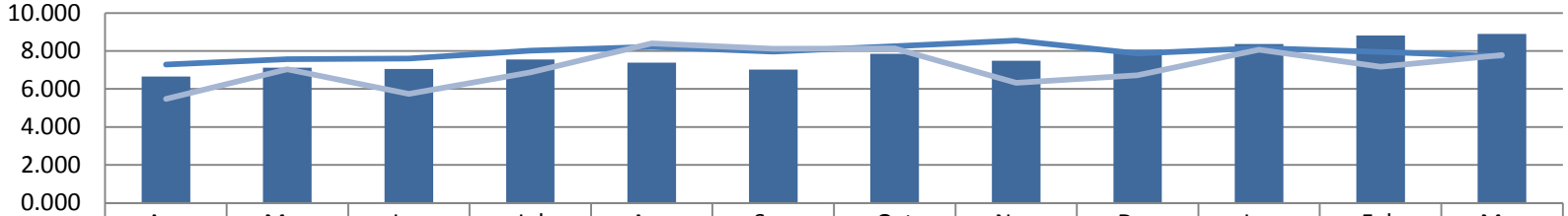
Debtors 2017/18



Cash – M12 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	8.060	8.367	8.817	8.895
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	Dec	Jan	Feb	Mar
Opening Balance	**7.784**	**6.657**	**7.124**	**7.048**	**7.561**	**7.387**	**7.029**	**7.846**	**7.490**	**8.060**	**8.367**	**8.817**
Receipts from invoiced income	4.620	5.989	5.579	4.692	5.624	5.060	5.681	5.440	6.110	5.482	5.918	6.174
Receipts from non-invoiced income	0.142	0.158	0.134	1.152	0.636	0.271	0.175	0.164	0.425	0.139	0.133	0.467
Total Receipts	**4.763**	**6.147**	**5.714**	**5.844**	**6.260**	**5.331**	**5.857**	**5.604**	**6.535**	**5.621**	**6.051**	**6.641**
Payments to NHS Bodies	(0.488)	(0.513)	(0.312)	(0.340)	(1.030)	(0.422)	(0.338)	(0.641)	(0.429)	(0.377)	(0.443)	(0.812)
Payments to non-NHS bodies	(2.049)	(1.715)	(1.463)	(1.492)	(1.884)	(1.097)	(1.146)	(1.751)	(1.435)	(1.378)	(1.550)	(1.512)
Net payroll payment	(1.909)	(1.968)	(1.980)	(1.966)	(2.011)	(2.008)	(2.007)	(2.048)	(2.016)	(2.013)	(2.056)	(2.068)
PAYE, NI & Levy payment	(0.886)	(0.924)	(0.970)	(0.961)	(0.950)	(0.975)	(0.969)	(0.945)	(1.003)	(0.966)	(0.978)	(0.987)
Pensions Payment	(0.557)	(0.560)	(0.572)	(0.573)	(0.558)	(0.571)	(0.580)	(0.575)	(0.595)	(0.580)	(0.574)	(0.586)
PDC Dividends Paid	0.000	0.000	(0.492)	0.000	0.000	(0.616)	0.000	0.000	(0.487)	0.000	0.000	(0.598)
Commercial Loan Repayment	0.000	0.000	0.000	0.000	0.000	0.000	0.000	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)**	**(5.965)**	**(5.314)**	**(5.601)**	**(6.564)**
Actual Closing Balance	**6.657**	**7.124**	**7.048**	**7.561**	**7.387**	**7.029**	**7.846**	**7.490**	**8.060**	**8.367**	**8.817**	**8.895**
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**
Monitor Plan 17/18	**7,294**	**7,563**	**7,604**	**8,012**	**8,216**	**7,960**	**8,243**	**8,554**	**7,862**	**8,143**	**7,959**	**7,718**

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 12 has a favourable variance of £1.2m against the plan submitted to NHSI. This is due to higher than anticipated receipts relating to aged debt and lower than expected capital payments.

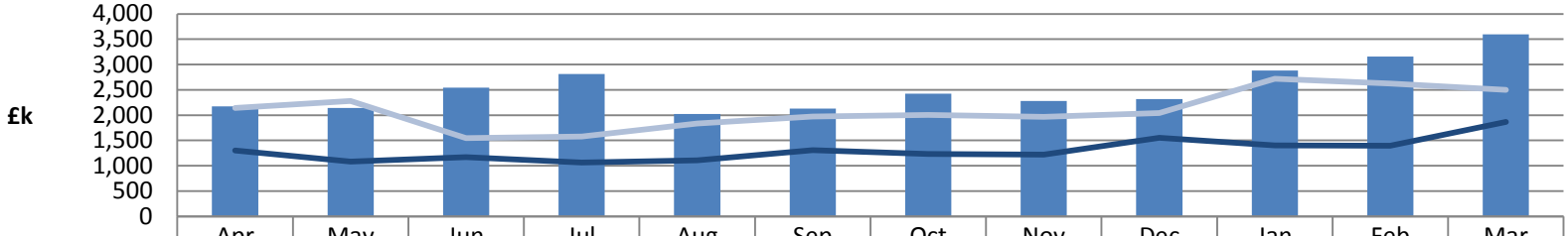
Next Steps

- 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 – M12 2017/18

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	2,175	2,140	2,543	2,810	2,022	2,129	2,422	2,283	2,318	2,882	3,157	3,598
2015/16	1,302	1,082	1,173	1,066	1,111	1,308	1,236	1,220	1,551	1,400	1,399	1,864
2016/17	2,144	2,283	1,549	1,580	1,838	1,971	2,003	1,964	2,040	2,721	2,623	2,503

Summary

- Trade creditors at Month 12 is £3.6m compared to an average of £2.1m during 2016-17.
- There is an increase of £0.3m in month, due to receipt of a number of high value invoices on the ledger. This balance will reduce as these invoices are authorised.
- The Trust's BPPC percentage has increased in month by 2% and the average days to payment increased to 27 days.
- Savings from prompt payment discounts taken in month amounted to £2k, in line with plan.

Better Payment Practice Code (17/18) March	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	1,671	2,695	20,090	21,583
Total **Non NHS** trade invoices paid within target	14,932	17,627	1,523	2,494	17,585	18,501
Percentage of Non-NHS trade invoices paid within target	**81%**	**78%**	**91%**	**93%**	**88%**	**86%**
Total **NHS** trade invoices paid	801	4,496	84	708	884	4,181
Total **NHS** trade invoices paid within target	504	2,879	27	173	521	2,020
Percentage of NHS trade invoices paid within target	**63%**	**64%**	**32%**	**24%**	**59%**	**48%**

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: March 2018					
	Metrics £k	Measure	Rating	Weight	Score
Continuity of Services:					
Capital Service Cover					
Operating surplus (Adj YTD)	5,779	2.59	1	20%	0.20
Capital Servicing Obligation YTD	2,229				
Liquidity					
Working Capital	7,057	41.0	1	20%	0.20
Operating Costs (per day)	172				
Financial Efficiency:					
Control Total Margin (%)					
Adj. Surplus (deficit) YTD	1,726	2.52%	1	20%	0.20
Adj. Income year to date	68,600				
Margin Variance From Plan					
Adj. Actual surplus margin	2.52%	0.04%	1	20%	0.20
Adj. Plan surplus margin	2.48%				
Agency Cap					
Agency Spend	2,158	22.06%	2	20%	0.40
Agency Cap	1,768				
Finance Score: March 2018			1		

Table 2

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

Summary

- The use of resources score is 1, the highest available. The Trust scored a 1 for 4 of the 5 metrics, a 2 for agency spend. The NHSI scoring mechanism scored aggregated the Trust score as a 1.
- Table 2 details a definition of each of the metrics and the scoring mechanism.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**03/05/18**		**Agenda reference:**	**76-18**	
Report title:	**Ratification of business planning process**				
Sponsor:	Michelle Miles, Director of Finance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices	None				
Executive summary					
Purpose:	The paper provides an update on the business planning process for 2018/19 and recommends the 2018/19 annual operating plan.				
Recommendation:	The Committee is asked to note the contents of this report and ratify the approval given in the board section of the Finance and Performance Committee on the 23rd of March 2018. The operating plan was submitted to NHSI on the 30th April 2018.				
Purpose:	**Approval**				
Link to key strategic objectives (KSOs):			KSO3: **Y**	KSO4: **Y**	KSO5: **Y**
			Operational excellence	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	NHS improvement (NHSI) issues guidance for business planning in February each financial year that NHS Foundation Trusts are mandated to comply with.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	23/04/18	Decision:	N/A	
Previously considered by:	Executive Management Team				
	Date:	23/04/18	Decision:	N/A	
Next steps:	N/A				

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Planning 2018/19 Update

Board – 03.05.2018

Lead – Director of Finance and Performance

- National Context - Timeframe
- Business planning approach
- Recurrent baseline and 2018/19 modelling
- Commissioning and CIPP updates
- Control total and risk outlook

National Context - timeline

- July 2016:
  - NHS Improvement and NHS England jointly published Strengthening Financial Performance and Accountability in 2016/17
  - Importantly, the document introduced a two year planning cycle
- December 2016:
  - National tariff for 2 years confirmed and finalised
  - Trust submitted final Board approved 2017-19 operating plans
  - 2-years contracts agreed and signed
- September 2017:
  - Commissioner intentions published for 2018/19
  - Draft national contract variation for 2018/19
  - National NHS Director's of Finance Meeting – NHSI indicated no further guidance but opportunity to refresh plans in Q4
- February 2018
  - NHSI/ NHSE to issued planning guidance for refresh of 2018/19
- March 2018
  - 8 March Draft 2018/19 plan (£'s, activity and workforce)
- April 2018
  - 30 April Final 2018/19 plan (£'s, activity and workforce)

National Context - Tariff assumptions / Business Rules

Queen Victoria Hospital NHS
NHS Foundation Trust

Tariff	Impact	Context
Net Price Adjustment	+0.1%	
Cost Inflation	+2.0%	Average – does not reflect individual organisational impact of national and/or local cost pressures
Efficiency Factor	-2.0%	Average – implied efficiency based on global tariff calculations. The actual requirement will be higher due to other factors.

Business Rules	Context
Two year tariff and planning cycles	Support stability, longer-term planning and delivery
1.0% CQUIN	Link to STP engagement
Marginal rate for emergency admissions	Retained at the 70% level agreed in 2016/17
Emergency re-admissions within 30 days	Admissions above a set threshold will not be paid
Market Forces Factor	No changes
Pay inflation	NHSI instruction to plan pay at 1% uplift. Plans have prepared assuming on this basis. The 2018/19 settlement funding arrangements as yet to be confirmed for the proposed 3% increase.

Updated Control Total (letter 6th February)

Queen Victoria Hospital NHS
NHS Foundation Trust

Description	2018/19 Guidance (Feb 2018) £m	2017/18 to 2018/19 Guidance (Sept 2016) £m	Var £m	Notes
2018/19 control total	1.874	1.874		
CNST impact	0.088			1
Risk reserve	-0.163			1
Additonal STF	0.383			2
CT flexibility	-0.231			3
Revised control total	1.951	1.874	-0.077	
less STF	-1.325	-0.942	0.383	
CT before STF	0.626	0.932	0.306	
less Depn	-0.226	-0.226	0	
Underlying surplus	**0.400**	**0.706**	**0.306**	

Notes

CNST funding over provided in Tairiff nationally - net impact QVH is reduction of control total of £0.075

1 (CNST impact £0.088m less Risk reserve £0.163m)

2 QVH share of additional £650m STF - £0.383m

3 Control total (CT) flexibility if QVH hits 2017/18 CT

4 Agency cap reduced from £1.758 to £1.628 - Reduction of £0.13m.

The impact for QVH is to reduce the control total before STF by £0.3m. This means that the Trust will have to deliver a surplus of £0.4m in order to achieve a STF payment of £1.325m for 2018/19.
The Trust has submitted the month 12 key data return which confirm control total has been met for 2017/18. This is a draft position subject to External audit.

Local Context – Approach to Business Planning (1)

Queen Victoria Hospital NHS
NHS Foundation Trust

Clinical Activity and Income

- Based on a 6 -month period 01/04/2017– 30 /09/2017 doubled and adjusted for seasonality, RTT; 18/19 tariff applied

Non Clinical Activity and Income

- Current budget adjusted for material outturn changes

Pay and Non Pay

- Based on current run-rate
- Adjusted to reflect material known changes and / or non recurrent items

Cost Improvement Programme

- c.5% of influencable expenditure budget = £3.049m
- Made up of the contribution from income generating schemes and cost reduction schemes

Cost Pressures

- Current 2 year plan assumes £1.6m

Local Context – Approach to Business Planning (2)

Queen Victoria Hospital NHS
NHS Foundation Trust

Approach to Capital

- Capital Planning Group, two year old, full representation, open & transparent, agreed criteria for prioritisation, recommendations and timely decision making.
- 2018/19 includes a multi-year programme
- Backlog maintenance – based on 2015 six facet survey
- IM&T – IM&T strategy approved June 2017
- Medical equipment based on review and prioritisation Business unit submissions
- The capital programme will be funded from internal sources only i.e. estimated depreciation, any slippage from the current financial year and cash from historic surpluses
- The Trust's proposed capital programme for 2018/19 is £3.1m plus £0.25 carry forward from 2017/18; All bids have been reviewed and prioritised at the Hospital Management Team.

Review process

- Iterations of the 2018/19 planning has been discussed at F&P committee each month since November 2017.
- Updates have been provided from November 2017 to present to EMT and HMT.

2018/19 Model - Recurrent Baseline

Description	2017/18 Budget	2017/18 Draft Outturn	2017/18 Normalisation	2018/19 Baseline Plan
	£k	£k	£k	£k
Patient Activity Income	64,726	63,075	966	64,041
Other Income	4,094	4,583	(476)	4,107
Total Income	**68,820**	**67,658**	**490**	**68,148**
Pay	(44,537)	(44,282)	(883)	(45,165)
Non pay	(19,271)	(18,559)	(575)	(19,134)
Financing	(4,489)	(4,269)	44	(4,225)
Total Expenditure	**(68,297)**	**(67,110)**	**(1,414)**	**(68,524)**
Surplus *	**523**	**548**	**(924)**	**(376)**

*** Excludes STF and donated asset depn and Income**

Key Message

The Trust has achieved plan in 2017/18 however Income is materially below plan circa £1.2m which has been offset by Expenditure underspends.

The 2017/18 normalised position creates a baseline challenge of £0.9m.

The Recurrent baseline forms the basis of 2018/19 model is based on the current run-rate which has been adjusted to reflect material known changes and / or non recurrent items.

The recurrent baseline is £0.9m less than forecast 2017/18 outturn reducing surplus from £0.55m surplus to a £0.4m deficit due to the following:

- Clinical Income the benefit of the FYE of part year service development began in 2017/18 £0.7m and non recurrent underperformance.
- Other Income – reduction in education and training income £0.1m/ EDM income / R&D income
- Pay – Recruitment to vacant posts – pay underspend in earlier quarters in 2017/18 but actual expenditure in line with plan in recent periods £1.1m.
- Non pay – non recurrent benefits not expected in 2018/19 i.e. VAT and FYE expenditure/ stock adjustments

2018/19 Plan

Description	2018/19 Baseline Plan	2018/19 Net Tariff Uplift & Inflation	2018/19 Cost Pressures	2018/19 Additional Commitments	Demographic	RTT	CIPP 2018/19		2018/19 Plan
							2018/19 Service Developments	2018/19 Cost Reductions	
	£k	£k	£k	£k	£k	£k	£k	£k	£k
Patient Activity Income	64,041	64	(155)		598	1,642	799		66,989
Other Income	4,107							10	4,117
Total Income	**68,148**	**64**	**(155)**	**0**	**598**	**1,642**	**799**	**10**	**71,106**
Pay	(45,165)	(710)	(335)	(202)			(347)	1,439	(45,320)
Non pay	(19,134)	(402)	(878)	30	(149)	(1,396)	(108)	1,255	(20,782)
Financing	(4,225)	(119)	(260)					0	(4,604)
Total Expenditure	**(68,524)**	**(1,231)**	**(1,473)**	**(172)**	**(149)**	**(1,396)**	**(455)**	**2,694**	**(70,706)**
Surplus *	**(376)**	**(1,167)**	**(1,628)**	**(172)**	**448**	**246**	**344**	**2,704**	**400**

*** Excludes STF and donated asset depn and Income**

The financial plan is based on recurrent baseline -uplifted for inflation, cost pressures and adjusted for CIPP.

- The recurrent baseline shows a deficit of £376k
- Net tariff uplift and inflation in line with NHSI national planning assumptions. The recent pay award notification has not been reflected in the model as advised by NHSI.
- Cost pressures of £1.6m have been reviewed and agreed by the EMT.
- Additional commitments recognised in the model of £172k.
- CIPP target of £3049k - (5% of influencable expenditure) is in line with current 2 year operating plan (submitted Dec 2016). Both service developments and cost reductions fall under the remit of CIPP's.
- Service developments consistent with proposals to commissioners – currently being updated and number may change and could impact make up of CIPPS.

2018/19 Gap

Queen Victoria Hospital NHS
NHS Foundation Trust

- The Trust draft 2018/19 operating plan submission assumed meeting control total
- Budget setting identified additional cost pressures of £0.9m due to commitments, normalisation models
- EMT reviewed and approved a number of mitigations to offset this gap – detailed in the table below.

Mitigations	£k
Consultant Anaesthetists	-240
Max Facs Admin	-26
Phlebotomy	-18
Stock adjustment	-300
CIO	-50
CQC	-30
Inflation	-200
Total	-864

Current Risk Analysis on control total

Queen Victoria Hospital NHS
NHS Foundation Trust

Description	£k
RTT - contribution	246
CQUIN - risk re delivery	100
Commissioning challenges	120
CIP gap	2000
Consultant Job planning	TBC
Other in year risks	TBC
Total	4466

Key Message

Other cost pressure may occur within the year, however other non recurrent benefits may also occur

- RTT risk is the contribution (income less cost of delivery) risk is due to current CCG plans do not include payment of the RTT, the risk is the net of the anticipated income less the anticipated costs at 85%, if costs exceed 85% this will be a greater pressure.
- CQUIN – operating plan assumes 100% delivery, therefore if 100% is not achieved the element unpaid is a risk to the plan c£100k
- Commissioners Challenges risk is based on figures from 2017/18
- CIPP gap is the latest CIPP view of identified c£0.6m plans and proposed targets in development – QIA outstanding

Mitigations to the current level of risk

Queen Victoria Hospital NHS
NHS Foundation Trust

Description	£k
Increase CIP target to 5%	626
Remove contingency	325
RTT contribution - Increase to 50%	575
Delayed appointment 6 months	
Practice Nurse	23
Trauma Co -ordinator	23
	1572

Key Message

- **Non recurrent or recurrent benefits may arise during the year in addition to this list**

- Increase CIP target, however at present the current CIP has not been identified
- Removal of contingency will not allow for any additional spend to be agreed in 18/19 and will not allow for any potential under performance of income which does not drive the equal spend reduction or allow for any unknown costs or any pump priming of future period projects / initiatives.
- Reduce the amount of spend required to undertake the RTT activity – i.e. this means that the backlog would have to be undertake at 25% of income which would mean the use of outsourcing options to be unaffordable (however based on the current plan anything providing less than a 15% contribution would increase the cost pressure)

CIP Plan for Operating Plan Submission

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Unit	Specialty	Title	Estimated Financial Delivery RAG rating	Status per monitoring return	Rev CIPP 2018/19 Gross Contribution / Cost Saving (£k)	% based on RAG rating	Estimated Financial Delivery based on RAG rating (£k)	WTE Reduction - high level Est
Pharmacy		Reduction of c5% phased from month 3 equally - required clinical engagement	Amber	Opportunity	(100)	50%	(50)	
Procurement		Pricing refresh and standardisation & Contract reviews for KPI's - Phased from month 3 equally	Amber	Opportunity	(300)	50%	(150)	
Less than £10k target		Various smaller schemes of less than £10k target - phased from month 3 equally	Green	Opportunity	(100)	80%	(80)	
Demand and capacity review		Review of outpatients to ensure efficiency and clinic templates standardised - phased from month 7 onwards	Red	Opportunity	(550)	10%	(55)	(12.00)
Theatres review		Undertake a review of the theatres utilisation to ensure national standard productivity - phased from month 4 onwards	Amber	Opportunity	(950)	50%	(475)	(30.00)
Total Targets					**(2,000)**		**(810)**	**(42.00)**
Total Current PID's					**(651)**		**(161)**	**(0.50)**
Service Developments					**(397)**		**(147)**	
Grand Total					**(3,048)**		**(1,118)**	**(42.50)**

- This is the latest version of the progress on CIP as at 19.04.18.
- The Trust has reviewed and enhanced current CIPP governance processes which has improved the quality of the underpinning saving schemes via rag rating process.
- The Trust implemented revised CIPP programmes which will have Executive leads
- Each of the programmes has been allocated targets. All programmes will ensure that each scheme is accurate and has been correctly phased with clearly articulated deliverables.
- Weekly monitoring processes have been implemented.

The Trust has a significant challenge to meet CIPP challenge in 2018/19. current Gap £1.9m

Commissioners Contract offer Analysis

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Unit	17/18 plan	M06 FOT - Price Actual	FYE of 17/18 developments (£)	Adjustment for One Off Issues (£)	Activity to be done to recover the RTT	18/19 service developments (£)	Demographic Growth (£)	18/19 Plan (£)
Clinical Infrastructure	46,685	54,452					490	54,942
Clinical Support	6,564,410	6,508,466	0	(47,316)	0	323,413	61,061	6,845,621
Eyes	7,063,642	6,377,289	545,963	(5,524)	0	0	62,260	6,979,988
Oral	13,141,512	13,330,133	13,059		1,202,929	200,640	132,721	14,879,480
Perioperative Care	928,671	958,407	0	0	0	0	8,625	967,034
Plastics	33,029,296	31,325,455	139,902	(18,390)	439,055	198,111	288,757	32,372,889
Sleep	3,887,785	4,671,981	95,289			77,177	43,600	4,888,047
Grand Total	**64,661,999**	**63,226,183**	**794,213**	**(71,230)**	**1,641,984**	**799,341**	**597,514**	**66,988,001**

Key Message
The Trust has a material challenge to deliver plan; especially given 2017/18 performance.

The table above explains the movements in contract offer in more detail.

- Outturn for 2017/18 was £63.1m for clinical income which is is £1.6m less than plan for the year. Therefore the current plan for 18/19 is £3.9m higher than 17/18 outturn.
- Normalisation adjustments increase plan by £0.7m.
- Service developments of £0.8m, RTT activity of £1.6m and demographic growth increase plan of £0.6m – increase plan for 2017/18 by £3m, net £1m.
- The above analysis includes RTT £1.6m and service development £0.8m, however this is yet to be agreed with commissioners. Commissioners have agreed in principle to FOT plus demographics, which is a net risk to the plan of £0.6m.

Commissioning and Contracting Update

Queen Victoria Hospital NHS
NHS Foundation Trust

CCG	Sum of M06 x2 (£)	FYE of 17/18 developments (£)	Adjustment for One Off Issues (£)	Activity to be done to recover the RTT position (£)	18/19 service developments (£)	Demographic Growth (£)	18/19 Plan (£)	CCG (Initial) Offer	Variance (outturn plus growth only)	Risk
NHS BRIGHTON AND HOVE CCG	1,212,810	£3,633	-£620	£8,488	£7,623	£11,087	£1,243,022	1,223,082	-3,829	-£19,940
NHS CRAWLEY CCG	1,951,045	£15,528	-£2,134	£13,597	£23,411	£18,013	£2,019,460	1,962,804	-19,648	-£56,656
NHS EAST SURREY CCG	2,900,426	£10,039	-£9,568	£23,114	£28,143	£26,569	£2,978,724	2,916,876	-10,591	-£61,848
NHS HIGH WEALD LEWES HAVENS CCG	3,863,095	£55,853	-£4,716	£39,786	£62,828	£36,152	£4,052,997	3,871,952	-78,430	-£181,044
NHS HORSHAM AND MID SUSSEX CCG	6,021,223	£46,404	-£28,104	£30,786	£61,837	£55,189	£6,187,336	6,018,277	-76,435	-£169,058
Main CCG Total	**15,948,598**	**131,458**	**-45,141**	**115,772**	**183,841**	**147,011**	**16,481,538**	**£15,992,992**	**-£188,933**	**-£488,546**
NHS England Dental	13,497,543	13,059	0	1,131,423	189,463	133,483	14,964,971	**14,344,198**	700,113	-£620,773
NHS England Specialised	6,997,817	477,231	0	7,317	851	67,349	7,550,565	7,482,000	-60,397	-£68,565
NHS England Total	**£20,495,360**	**£490,290**	**£0**	**£1,138,739**	**£190,315**	**£200,832**	**£22,515,536**	**£21,826,198**	**£639,716**	**-£689,338**
Grand Total*	**£36,443,958**	**£621,747**	**-£45,141**	**£1,254,511**	**£374,156**	**£347,843**	**£38,997,074**	**£37,819,190**	**£450,783**	**-£1,177,884**

The table above explains current position with the Trust's main commissioners*.

- CCG contract values in current position (draft operating plan) of £16.5m. CCGs have offered contract of £15.9m. The main driver are that CCGs are not agreeing to the Trust proposals for RTT and for services developments.
- Specialised commissioning contract values in current QVH position of £22.5m. Specialised commissioning have offered £21.8m a variance of £0.7m. This is driven by the NHS dental not agreeing to RTT.
- Current gross risk of £1.2m.

Key Message

Commissioners have material financial challenges in 2018/19. Contract negotiation will be difficult with limited flexibility to resolve gap.

Commissioning Update

W/C 16/04/2018

- CCG contracts
  - NHSE have advised CCGS not to sign contract that are outside their affordability envelope
  - Current expecting update from NHSE to progress

- Dental
  - Not recognised the RTT position. Currently sharing RTT trajectories and will meet to discuss result to assess if this changes their current position

- Spec Commissioning
  - Currently have a gap of £60k – likely to resolve and sign in next week (Monday 23.04.18)

2018/19 Capital

Queen Victoria Hospital NHS
NHS Foundation Trust

Decision	Description	Value (£)
Pre-approved	IM&T Strategy	1,274,000
	Maintenace Backlog	900,000
Partially agreed	Replacement - broken / obsolete	84,690
Prioritised	Development	305,526
	Replacement - broken / obsolete	24,350
	Rolling programme	16,000
Agreed	Development	6,000
	Replacement - broken / obsolete	63,006
	Rolling programme	84,000
Capital contingency T	Capital contingency Total	250,000
Balance		92,428
Grand Total		**3,100,000**

The Trust has an agreed capital plan for 2018/19 of £3.1m plus £0.25m of slipped schemes for 2017/18.

This includes £2.2m of pre -approved capital expenditure (IM&T strategy £1.3m and Estates backlog maintenance £0.9m). The Trust has set aside a reserve of £0.25m in order to meet urgent capital requirements that are identified in year.

The Trust has a remaining balance of £0.7m. The Trust has reviewed and prioritised Capital bids at Hospital Management Team (HMT) £0.24m were agreed and £0.35m prioritised.

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NB The Trust has included the donated asset CT scanner (£0.5m donated by the League of friends) in the operating plan but this is not part of the Trust internal capital programme planning above.

QVH Decision - Accept Control Total

Advantages

- No single oversight intervention
- Access to £1.3m STF funding
- Not subject to fines regime – (NB Trust would have liable to circa £3m of fines in 2017/18)
- Messaging re future sustainability of QVH
- STP – support the STP in addressing sector financial challenge

Disadvantages

- Risk re control total delivery
- Intervention later if fail to delver
- STP – not supporting the STP in addressing sector financial challenge – risk re STP engagement CQUIN

QVH Decision – Do not accept Control Total

Advantages

- Ability to set an achievable plan – subject to agreement with NHSI

Disadvantages

- Single oversight intervention
- No Access to £1.3m
- Subject to fines regime
- Messaging re future sustainability of QVH
- Management Capacity to respond to regulator

Risk Outlook

Queen Victoria Hospital NHS
NHS Foundation Trust

Risk	Detail	Mitigations
CiPP programme	2017/18 forecasting delivery of £3.1m 2018/19 – Draft CIPP target £3.1m - significant gap identified circa £1.7m	Business units continue to work up CIPP opportunities / Review of Cost pressure Implementation of PLICS to identify unprofitable areas
Capacity constraints	Key staffing issue in nursing within Theatres, critical care, paediatrics within Trust and across the wider Health economy.	Long term – recruitment and retention strategy/ Short term – incentives for overtimes, improvements in bank rates, weekly bank payment
Financial pressures for commissioners increase challenge burden	2018/19 contract not fully agreed. Effective Commissioning agenda Commissioners look for increased cost savings through increased challenges for example on data quality, low priority procedures and other contractual challenges; Increases the burden to the Trust;	Proactive data quality measures internally Regular documented communication with commissioners about activity levels Internal re-iteration of low priority procedure policies
Genuine reduction in demand where high fixed costs in place e.g. critical care	Potential for sustained reduction in complex work, particularly critical care, burns where high fixed costs and the need to keep capacity available (e.g. for major burns) result in unviable services	Flexible staffing models; Negotiation of fixed and variable income contracts;
STP	STP decision making impacting upon clinical pathways	Active engagement with STP and supporting work streams to influence decision making
RTT	Emerging issues relating to RTT. This will include potential additional costs, lost contribution and management capacity to deliver the CIP programme.	Action plan to address RTT. Identify additional resources.

Key Decisions

Queen Victoria Hospital NHS
NHS Foundation Trust

1. CIPP programme – note risks and actions to mitigate

2. Risks outlook – note current risk profile and mitigations

3. Agree operating plan for 2018/19 for submission

Appendix A – 2018/19 Plan

Queen Victoria Hospital NHS
NHS Foundation Trust

Description	2017/18 Budget	2017/18 Forecast Outturn	2017/18 Normalisation	2018/19 Baseline Plan	2018/19 Net Tariff Uplift & Inflation	2018/19 Cost Pressures	2018/19 Additional Commitments	Other	Demographic	RTT	CIPP 2018/19		2018/19 Plan
											2018/19 Service Developments	2018/19 Cost Reductions	
		£k	£k	£k	£k	£k	£k				£k	£k	£k
Patient Activity Income	64,726	63,075	966	64,041	64	(155)			598	1,642	799		66,989
Other Income	4,094	4,583	(476)	4,107								10	4,117
STF Income	942	942		942	383								1,325
Donated Asset Income		148	(148)	0				500					500
Total Income	**69,762**	**68,748**	**342**	**69,090**	**447**	**(155)**	**0**	**0**	**598**	**1,642**	**799**	**10**	**72,931**
Pay	(44,537)	(44,282)	(883)	(45,165)	(710)	(335)	(202)				(347)	1,439	(45,320)
Non pay	(19,271)	(18,559)	(575)	(19,134)	(402)	(878)	30		(149)	(1,396)	(108)	1,255	(20,782)
Financing	(4,489)	(4,269)	44	(4,225)	(119)	(260)						0	(4,604)
Total Expenditure	**(68,297)**	**(67,110)**	**(1,414)**	**(68,524)**	**(1,231)**	**(1,473)**	**(172)**	**0**	**(149)**	**(1,396)**	**(455)**	**2,694**	**(70,706)**
Surplus	**1,465**	**1,638**	**(1,072)**	**566**	**(784)**	**(1,628)**	**(172)**	**0**	**448**	**246**	**344**	**2,704**	**2,225**
Adjust for Donated Depn.		88	139	226				(500)					(274)
Surplus after Donated Asset Depn.		**1,726**											**1,951**
NHSI Contol Total		**1,716**											**1,951**
Control Total Variance		**10**											**(0)**

22

Operating plan including STF and donated assets income / depn to show performance to control total.

Appendix B – National deadline

Queen Victoria Hospital NHS
NHS Foundation Trust

Milestones	Date	Status
Draft 2018/19 Organisational Operating Plans submitted	8 March 2018	Complete – Accepted control total
Draft 2018/19 STP Contract and Plan Alignment template submitted	8 March 2018	Complete
National deadline for signing 2018/19 contract variations and contracts	23 March 2018	Not agreed – in progress
Final Board or Governing Body approved Organisation Operating Plans submitted	30 April 2018	Delegated authority to F&P 23/04/2018
2018/19 Winter Demand & Capacity Plans submitted	30 April 2018	
Final 2018/19 STP Contract and Plan Alignment template submitted	30 April 2018	
Final date for experts to notify outcome of determinations for 2018/19 update	8 June 2018	

Appendix C - Current CIP

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Unit	Specialty	Title	Estimated Financial Delivery RAG rating	Status per monitoring return	Rev CIPP 2018/19 Gross Contribution / Cost Saving (£k)	% based on RAG rating	Estimated Financial Delivery based on RAG rating (£k)
3.2 Commerce & Finance	IMT	Review of IT contracts (POAP)	Red	Opportunity	(25)	10%	(3)
3.2 Commerce & Finance	Finance	Procurement non pay review	Red	Opportunity	(50)	10%	(5)
3.2 Commerce & Finance	Finance	NEP contract reduction	Red	Plan in Progress	(2)	10%	(0)
3.2 Commerce & Finance	Business Development	Cessation of CHKS Market Intelligence Software due to lack of use Evidence to attach (Email)	Green	Plan in Progress	(18)	80%	(14)
3.2 Commerce & Finance	Finance	Loan interest savings	Green	Plan in Progress	(22)	80%	(17)
1.5 Clinical Support		With the introduction of Evolve there will be a cost saving of transporting notes to the off site clinics that does not require Nasendoscopes transported as well	Red	Opportunity	(17)	10%	(2)
1.5 Clinical Support		Year 2 3D scanner/printer savings	Blue	Plan in Progress	(13)	100%	(13)
1.5 Clinical Support		Savings against current CT spend (above the £5k identified in 2017/18) * Potential to be higher if CT procurement proceeds	Amber	Plan in Progress	(43)	50%	(22)
1.5 Clinical Support		MRI contract reprocurement (saving beyond those identified and delivered in 2017/18)	Amber	Plan in Progress	(20)	50%	(10)
1.5 Clinical Support		Maintenance contract review	Amber	Plan in Progress	(5)	50%	(3)
1.5 Clinical Support		Sterilisation of Photographic Equipment	Amber	Plan in Progress	(12)	50%	(6)
4.1 Human Resources	HR	Current planning number	Red	Opportunity	(54)	10%	(5)
1.2 Oral		Reduction in costs procurement	Blue	Plan in Progress	(10)	100%	(10)
1.7 Operational Nursing		Topical Negative Pressure Dressings. Removed £15k in 17/18. Still need to obtain clinical buy-in.	Red	Plan in Progress	(5)	10%	(1)
2.5 Director of Nursing	R&D	Reduction in pay costs (subject to confirmation with lead clinician)	Red	Opportunity	(15)	10%	(2)
2.5 Director of Nursing	R&D	To generate a contribution towards staffing costs	Red	Opportunity	(10)	10%	(1)
1.4 Sleep		Full year effect of CPAP testing machine savings (1718SL06). Savings to be split between Sleep and Clinical Audit.	Amber	Plan in Progress	(12)	50%	(6)
3.1 Non Clinical Infrastructure	Estates	LED lights	Red	Plan in Progress	(30)	10%	(3)
3.1 Non Clinical Infrastructure	Estates	New Boiler replacement scheme	Red	Opportunity	(9)	10%	(1)
3.1 Non Clinical Infrastructure	Estates	Catering income generation	Red	Opportunity	(10)	10%	(1)
1.6 Perioperative		Phaco packs	Amber	Plan in Progress	(12)	50%	(6)
1.4 Sleep		CPAP: reduction in pass through costs (requesting 50%). Resmed contract is a 5 year commitment.	Red	Plan in Progress	(86)	10%	(9)
2.1 Performance & Access		Sending our clinic correspondence via email to GPs and Referrers	Red	Opportunity	(10)	10%	(1)
1.6 Perioperative		Theatre procurement non pay review	Red	Plan in Progress	(150)	10%	(15)
1.6 Perioperative		Surgical Instrument management System (SIMS) contract for Storz video intubating scopes	Amber	Plan in Progress	(12)	50%	(6)
Total					**(651)**		**(161)**

Appendix D- CIPP Ideas

Queen Victoria Hospital NHS
NHS Foundation Trust

Currently on the tracker with no values

Clinical Audit	To work with clinical areas/ services across the Trust to review and procure medical device services contracts which are fit for purpose and cost effective.	Red
Clinical Audit	To work on a standardised Trust medical devices list (Trust standard of devices to be ordered), to reduce variation and eliminate cavalier spending.	Red
	Ders to treatment plan cut offsite x ray by 50%. When we receive DERS referrals they come with an x-ray - when the consultant is offsite they cannot access the system so they order another x-ray.	Red
Estates	Collaborative Waste Project (ASK for POAP)	Red
	"The Perfect Week"	Red
	Patients booking their own appointment via an app.	Red

Additional Ideas to fulfil the less than £10k target

Reviews of Spend High level	Current Spend	c5% Saving
Drugs	£1.7m	£85k
Small under £20k cost reduction ideas	tbc	£40k
Taxi review	£200k	£10k
Other transport costs	£70k	£3k
Travel review	£240k	£12k
Engineering and building maintenance	£190k	£9.5k
Postage	£200k	£10k
Stationary	£160k	£8k
Subscriptions	£100k	£5k
Professional fees	£360k	£18k
Total	£3.2m	£200k

Potential Transformation Schemes
- Admin review
- Theatres staffing review
- Demand and capacity reivew
- Theatre Utilisation
- Car parking increase
- Recruitment and Retention premium review
- Overtime review
- On Call review
- Digital dictation
- Recharges to other Trust
- Service re-design
- Contracts review

Appendix E- Service Developments

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Unit	Specialty	Title	Estimated Financial Delivery RAG rating	Rev CIPP 2018/19 Gross Income INC CQUIN (£k)	Rev CIPP 2018/19 Gross Expenditure (£k)	Rev CIPP 2018/19 Gross Contribution / Cost Saving (£k)	% based on RAG rating	Estimated Financial Delivery based on RAG rating (£k)
1.5 Clinical Support	AQPENT	Expansion of the Community ENT Service	Amber	96	50	46	50%	23
1.5 Clinical Support	Rheumatology	Expansion of the QVH Rheumatology service	Amber	61	19	42	50%	21
1.5 Clinical Support	Urology	Expansion of the Community Urology Service	Amber	29	57	29	50%	14
1.5 Clinical Support	Psychotherapy	Psychological therapy for increased insomnia demand	Amber	64	58	6	50%	3
1.5 Clinical Support	OT / SALT	Therapies & Speech & Language Therapy	Red	9	10	1	10%	0
1.5 Clinical Support	Physiotherapy	MSK Physiotherapy additional activity	Green	42	40	2	80%	1
1.5 Clinical Support	Radiology	Recovery radiology income from revised MTW contract	Red	23	0	23	10%	2
1.2 Oral	Maxfacs	Increase in medical workforce to support return of a consultant from a sabatical with supporting admin staff (D Coombes)	Red	200	120	80	10%	8
1.1 Plastics	Skin	Skin pathway / MDT Clinics / One-stop lymph node assessment clinic	Red	38	0	38	10%	4
1.1 Plastics	Skin	Facial Palsy BC (Dan Harvey)	Amber	161	78	83	50%	41
1.4 Sleep	Sleep Fellow	Clinical Fellow/Consultant + support	Amber	288	247	41	50%	21
1.4 Sleep	Add Remote Monitoring	Remote monitoring	Blue	56	23	33	100%	33
1.4 Sleep	PSG	PSG	Red	118	107	12	10%	1
1.4 Sleep	Coding	PSGs with CPAP: Convert 50 WD22Zs to DZ18Ds	Red	21	0	21	10%	2
Total				**1,206**	**808**	**397**		**147**

Appendix F - Cost Pressures

Queen Victoria Hospital NHS
NHS Foundation Trust

Cost Pressure Type	£k	
Contingency	325	
Capital charges	260	
EDM	120	
RMN Nursing Burns Nursing	155	
CNST	140	
CCIO role - Band 8d	101	*50% could be capatalised*
STP cost pressure	50	
Revenue costs IM&T strategy & Microsoft licences	143	
Clinical fellow in anaesthetics.	30	
Pharmacy International shortages of remifentanil & other drugs	95	
QNET license and maintenance costs	34	
17/18 agreed CIPP. FEMTO Maintenance Contract (Full year £40,800, Yr 1 £6,800 put into budget in 17/18)	34	
CQC cost increase Estimate	30	*No longer a cost pressure as new rules is a saving*
Estates department summary	102	
Freedom to Speak up Guardian, 1 day per week Band 7	9	
Total	**1,628**	

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Committee: Trust Board
Date: 16th April 2018

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 5 (L) = 20, major risk
Residual Risk Rating 4 (C) x 5 (L) = 20, 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
- Impact on adequate substantive staffing resource in theatres to support productivity/meet RTT

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
-Consultant contract negotiations resume in 2018
- Agenda for Change reform
-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, continuing in 2018 with encouraging on going high demand
-Engaged in NHS Employers workforce retention programme nationally and part of NHSI Retention Support Programme
--monthly challenge to Business Units at Performance review
--Investment made in key workforce e-solutions, TRAC delivered on time, E-job plan ongoing, HealthRoster implemented
-Engagement and Retention paper presented to Board Sept 2017 actions ongoing, launched social media campaign February, overseas recruitment now ongoing

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 and C Wing
-Theatre productivity group relaunched
-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:	03/05/18		**Agenda reference:**	78-18	
Report title:	**Workforce – April 2018 (March data)**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Authors:	• David Hurrell, Deputy Director Workforce/Felicity King, Workforce Services Manager • Annette Byers, Head of OD & Learning/Katharine Bond, Snr L&D Facilitator				
Appendices:	Leading the Way evaluation				
Executive summary					
Purpose:	The Workforce and OD report for April 2018 (March data) provides the Board of Directors with a breakdown of key workforce indicators and information linked to performance Leading the Way was launched 12 months ago. This report is intended to provide assurance in relation to its positive impact on individuals as well as demonstrate some areas of improvement in the 2017 staff survey.				
Recommendation:	The Board are asked to note the report.				
Purpose:				Assurance	
Link to key strategic objectives (KSOs):	KSO1				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:	23/04/18	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		

Queen Victoria Hospital NHS
NHS Foundation Trust

Human Resources & Organisational Development

Workforce Report – April 2018

Reporting Period: March 2018

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 have increased to return the Trust to the December 2017 position of 845wte. The biggest change in month is from Clinical Infrastructure, moving from 22.46% vacancy rate to 12.13% vacancy rate, with other small improvements also noted within Eyes and Clinical Support units. Vacancy rates within Perioperative Services stabilised in month, pausing an 18 month increasing trend to remain at just under 25%. 67.59wte posts were advertised in month, with 22.40wte currently being processed through clearances. 48.3wte of the total advertised relates to qualified nursing / theatre practitioners positions, with 3.8wte currently going through clearances.
Turnover Section 3	Turnover increased for the fifth consecutive month, from 19.3% to 19.57%. This was prompted by small increases in turnover within Clinical Infrastructure, Perioperative Services and Plastics, mitigated somewhat by a decrease in Corporate Services. Leavers from the Trust included 4.2wte qualified nurses / theatre practitioners across: Burns, Critical Care, Discharge Lounge, Maxillofacial Nursing and Theatres.
Temporary Staffing Section 4	Total temporary staffing usage across the Trust increased a further 11.7% from 96.44wte to 107.77wte. 50.2wte of this related to qualified nurse usage, an increase of 14.2% compared to last month, which correlates to a spike in taking annual leave outside of normal monthly Trust rostering targets (particularly within Operational Nursing). Bank utilisation increased from 58.16wte to 65.26wte (+12.2%), led predominantly by increases in qualified nursing and administration. Agency utilisation increased from 38.28wte to 42.51wte (+11.1%), caused predominantly by increases in qualified nursing and health care assistants. Recruitment for health care assistants has been absent in recent months, and Matrons have been reminded to instigate for areas where they hold vacancies.
Sickness Section 5	Confirmed February sickness information shows an increase from January of 3.59% to 3.73%, driven by an increase in long term absence despite a drop in short term absences. Days lost due to reasons of anxiety/stress/depression/other psychiatric illnesses rose from 155 days to 219 days lost, with absences from coughs, colds and flu dropping from 219 days to 193 days. Other (non-back related) musculoskeletal conditions accounted for 106 days lost. There remains a concern of service managers not reporting medical and dental absences which has led the Medical Staffing Manager instructing all records to be sent directly to her to ensure accuracy until the 'medic on duty' project is implemented, expected to commence in June 2018.
Appraisals Section 6	Appraisal compliance figures rose from 78.58% to 81.89%, prompted by an increase in all areas. The biggest increase was seen within Clinical Support Services, moving from 87.9% to a new high of 96%. The lowest appraisal rate remains Clinical Infrastructure, where the position improved from 55.6% to 61.1% compliance. The following business units remain red rated with a compliance under 80%: Eyes, Plastics, Perioperative and Clinical Infrastructure.
MAST Section 6	The Trust MAST compliance rates dropped marginally from 90.72% to 89.59%; Trust-wide rates have remained relatively constant since June 2017, fluctuating within 2% for this period. A cancellation report shows that 30% of staff either withdraw or do not attend. 6 directorates continue to report in excess of 90% compliance, with Clinical Support remaining within 1% of the Trust 95% target.

1.3 KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2017-18			Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Establishment WTE *Note 1*				962.72	969.76	969.76	969.76	969.76	980.46	980.46	955.65	955.65	955.65	955.65	955.65	**955.65**	◄►
Staff In Post WTE				822.81	825.71	834.28	837.51	831.88	840.54	843.26	859.91	856.13	845.60	841.32	838.58	**845.26**	▲
Vacancies WTE				139.91	144.05	135.48	132.25	137.88	139.92	137.20	95.74	99.52	110.05	114.33	117.07	**110.39**	▼
Vacancies %	>12%	8%<>12%	<8%	14.53%	14.85%	13.97%	13.64%	14.22%	14.27%	13.99%	10.02%	10.41%	11.52%	11.96%	12.25%	**11.55%**	▼
Agency WTE				26.36	16.02	15.15	17.38	25.64	28.60	28.53	28.12	30.96	26.95	33.76	38.28	**42.51**	▲
Bank WTE *Note 2*				47.79	40.37	44.05	48.60	47.60	47.05	42.01	40.40	47.11	40.40	58.13	58.16	**65.26**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	17.06%	17.02%	17.09%	17.92%	18.98%	18.58%	18.92%	18.22%	18.41%	18.67%	18.87%	19.30%	**19.57%**	▲
Monthly Turnover				1.60%	1.34%	1.08%	2.11%	2.24%	1.02%	1.74%	1.00%	1.56%	1.80%	1.75%	1.47%	**1.91%**	▲
Stability %	<70%	70%<>85%	>=85%	98.8%	98.7%	99.1%	98.4%	98.5%	97.64%	98.77%	98.58%	98.61%	98.90%	98.68%	97.17%	**98.78%**	▲
Sickness Absence %	>=4%	4%<>3%	<3%	2.43%	2.06%	2.75%	2.04%	2.06%	2.61%	3.15%	3.59%	3.46%	2.66%	3.59%	3.73%	***3.50%***	***Feb-18 = Trend figure***
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	92.6%	83.3%	84.8%	83.5%	84.1%	86.27%	83.86%	81.24%	81.38%	81.00%	81.22%	78.58%	**81.89%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 3*	<80%	80%<>95%	>=95%	89.3%	87.2%	81.6%	88.5%	89.2%	89.57%	89.94%	89.60%	88.81%	88.48%	89.97%	90.72%	**89.59%**	▼

Friends & Family Test - Treatment Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment	**Measure Extremely likely / likely % : Extremely unlikely / unlikely%**	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 : 55%	**2017-18 Quarter 4: Of 306 responses: 90% : 5.23%**	Qtr 2 & Qtr 2 ▼Responses ▼ Likely ▼ Unlikely
Friends & Family Test - Work Quarterly staff survey to indicate likelihood of recommending QVH to friends & family as a place of work	**Measure Extremely likely / likely % : Extremely unlikely / unlikely%**	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%		**2017-18 Quarter 4: Of 306 responses: 57.19% : 26.47%**	Qtr 2 & Qtr 2 ▼Responses ▲ Likely ▼ Unlikely

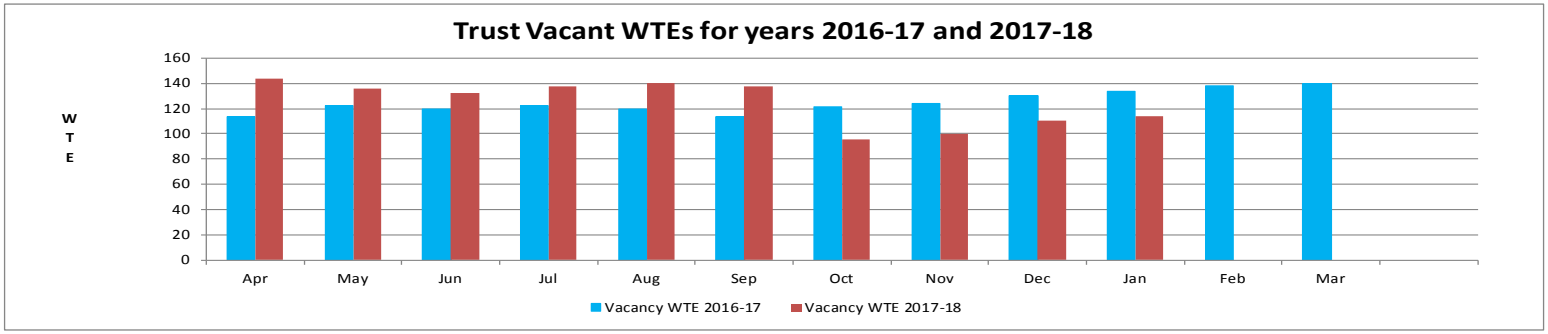
*Note 1 - 2017/18 Establishment not available in May data reporting period, establishment updated for April, May and June in this report. Establishment updated in August 2017 with nursing update in October 2017
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment 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	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Corporate	9.45%	9.58%	9.69%	▲
Eyes	9.52%	11.44%	8.75%	▼
Sleep	-9.84%	-14.29%	-18.12%	▼
Plastics	3.60%	0.65%	-0.89%	▼
Oral	9.23%	7.37%	8.85%	▲
Periop	22.20%	24.86%	24.84%	▼
Clinical Support	8.40%	8.71%	7.82%	▼
Clinical Infrastructure	19.74%	22.46%	12.13%	▼
Director of Nursing	19.95%	18.27%	18.27%	◄►
Operational Nursing	10.31%	11.02%	11.90%	▲
QVH Trust Total	11.96%	12.25%	11.55%	▼

NON-MEDICAL RECRUITMENT(WTE)	Posts advertised this month	Recruits in Pipeline
Corporate	7.20	2.00
Eyes	2.80	1.00
Sleep	1.59	1.00
Plastics	3.00	0.00
Oral	1.50	1.80
Periop	41.50	9.00
Clinical Support	3.00	5.60
Clinical Infrastructure	2.00	1.00
Director of Nursing	0.00	0.00
Operational Nursing	5.00	1.00
QVH Trust Total	*67.59*	22.40
of which Qual Nurses / Theatre Practs (external)	48.30	*3.80*
of which HCA's & Student/Asst Practs (external)	0.00	*4.00*

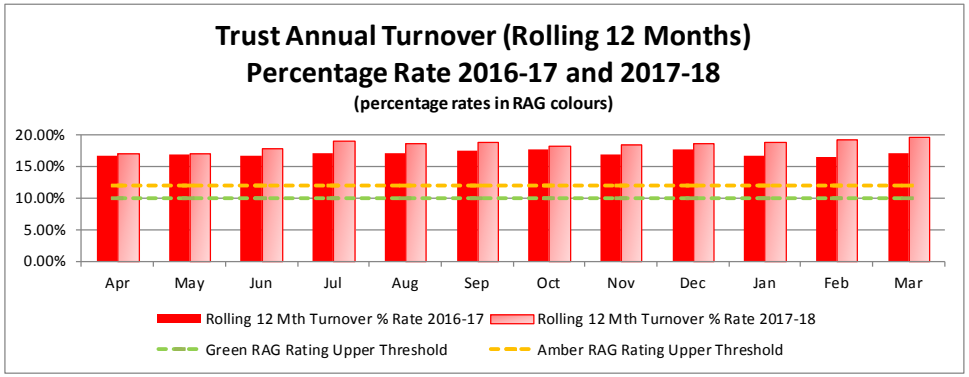
MEDICAL RECRUITMENT (WTE)	Posts advertised this month	Recruits in Pipeline
Clinical Support	0.00	1.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*1.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Plastics	2.00	5.00
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*5.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*1.00*	*0.00*
Eyes	0.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*2.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Sleep	0.00	0.00
Oral	3.00	1.00
of which are Deanery Trainees, Trust Registrars or Fellows	*2.00*	*1.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*1.00*	*0.00*
Periop	0.00	3.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*3.00*
QVH Trust Total	5.00	12.00
of which are Deanery Trainees, Trust Registrars or Fellows	*3.00*	*8.00*
of which are SAS doctors	*0.00*	*1.00*
of which are Consultants (including locums)	*2.00*	*3.00*

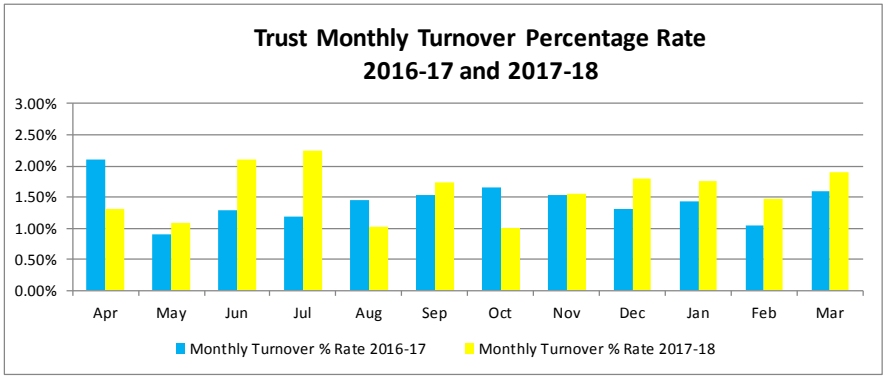


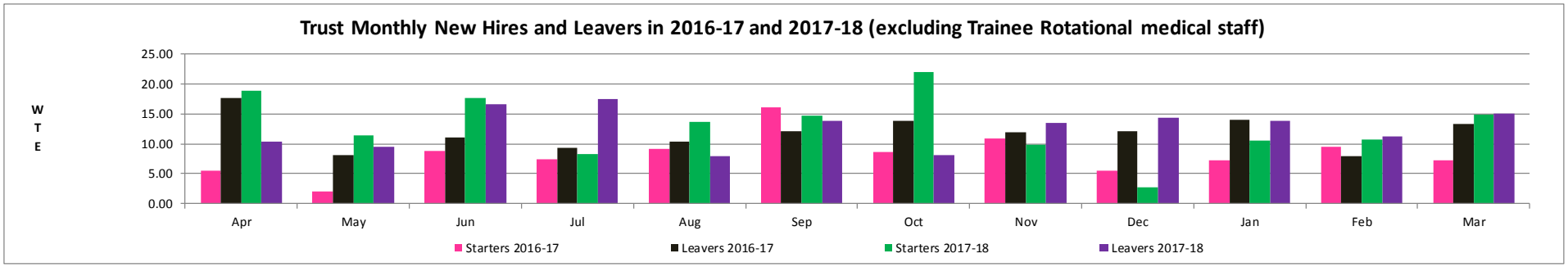
3. Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Corporate %	17.61%	18.31%	17.00%	▼
Eyes %	22.93%	22.98%	21.60%	▼
Sleep %	10.83%	10.62%	10.42%	▼
Plastics %	21.76%	18.85%	19.87%	▲
Oral %	14.03%	13.98%	13.86%	▼
Peri Op %	19.26%	21.24%	23.59%	▲
Clinical Support %	16.08%	16.59%	16.09%	▼
Clinical Infrastructure %	37.72%	44.50%	46.54%	▲
Director of Nursing %	8.41%	8.48%	8.54%	▲
Operational Nursing %	21.79%	20.57%	20.70%	▲
QVH Trust Total %	18.87%	19.30%	19.57%	▲

MONTHLY TURNOVER excl. Trainee Doctors	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Corporate %	2.54%	0.89%	2.12%	▲
Eyes %	2.13%	0.00%	2.11%	▲
Sleep %	3.13%	0.00%	0.00%	◄►
Plastics %	0.00%	0.00%	2.50%	▲
Oral %	1.22%	0.00%	2.29%	▲
Peri Op %	1.68%	3.16%	1.99%	▼
Clinical Support %	1.65%	2.13%	0.81%	▼
Clinical Infrastructure %	3.39%	7.01%	3.17%	▼
Director of Nursing %	1.87%	0.00%	0.00%	◄►
Operational Nursing %	1.29%	0.80%	2.83%	▲
QVH Trust Total %	1.75%	1.47%	1.91%	▲







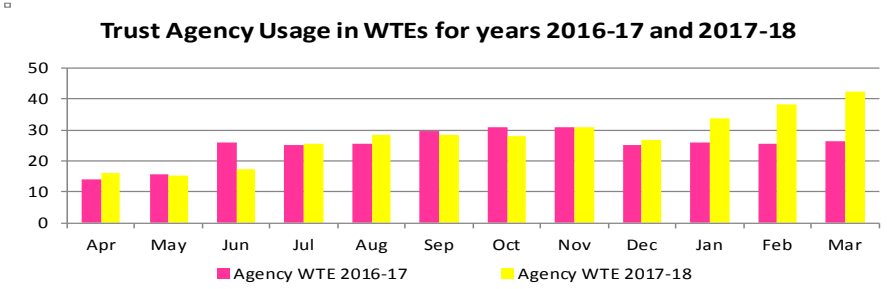
4. Temporary Workforce

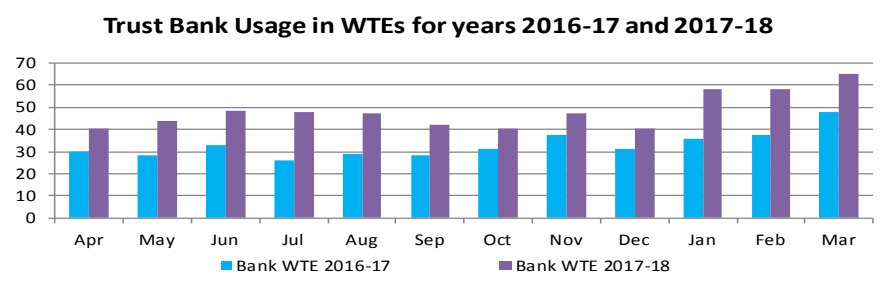
Agency				
BUSINESS UNIT (WTE)	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Corporate	5.11	6.08	5.39	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.36	0.29	0.00	▼
Plastics	1.36	3.11	2.07	▼
Oral	0.64	0.41	0.12	▼
Periop	17.19	18.48	20.66	▲
Clinical Support	1.23	2.51	2.90	▲
Clinical Infrastructure	0.00	0.74	1.80	▲
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	7.87	6.68	9.58	▲
QVH Trust Total	33.76	38.28	42.51	▲

Bank				
BUSINESS UNIT (WTE)	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Corporate	6.57	8.76	9.74	▲
Eyes	3.29	1.94	3.30	▲
Sleep	3.09	3.19	3.23	▲
Plastics	2.28	4.93	4.06	▼
Oral	2.57	2.49	2.98	▲
Periop	16.06	13.67	14.63	▲
Clinical Support	7.72	7.41	8.18	▲
Clinical Infrastructure	7.06	5.96	6.52	▲
Director of Nursing	2.14	1.84	2.63	▲
Operational Nursing	7.36	7.97	10.00	▲
QVH Trust Total	58.14	58.16	65.26	▲

Agency				
STAFF GROUP (WTE)	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Qualified Nursing	24.14	24.91	29.07	▲
HCAs	1.34	1.51	3.06	▲
Medical and Dental	0.93	1.84	0.18	▼
Other AHP's & ST&T	1.60	2.80	2.90	▲
Non-Clinical	5.75	7.22	7.30	▲
QVH Trust Total	33.76	38.28	42.51	▲

Bank				
STAFF GROUP (WTE)	Jan-18	Feb-18	Mar-18	Compared to Previous Month
Qualified Nursing	19.34	19.03	21.12	▲
HCAs	5.58	5.78	6.90	▲
Medical and Dental	0.00	0.00	0.00	◄►
Other AHP's & ST&T	3.80	4.31	4.86	▲
Non-Clinical	29.41	29.04	32.38	▲
QVH Trust Total	58.14	58.16	65.26	▲



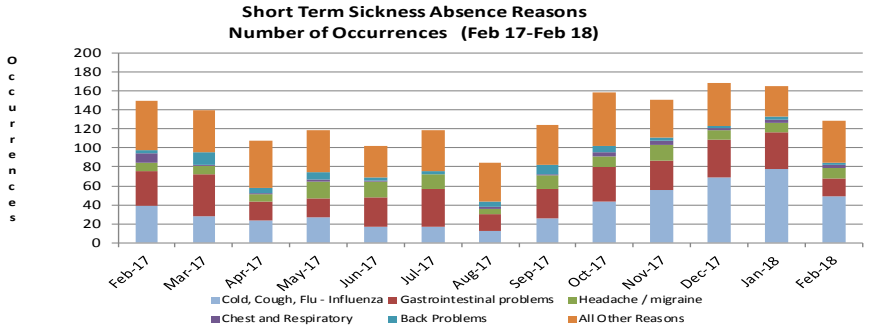


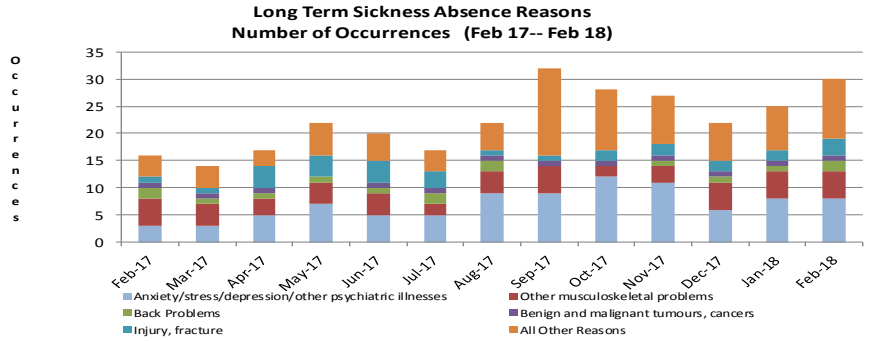
5. Sickness Absence

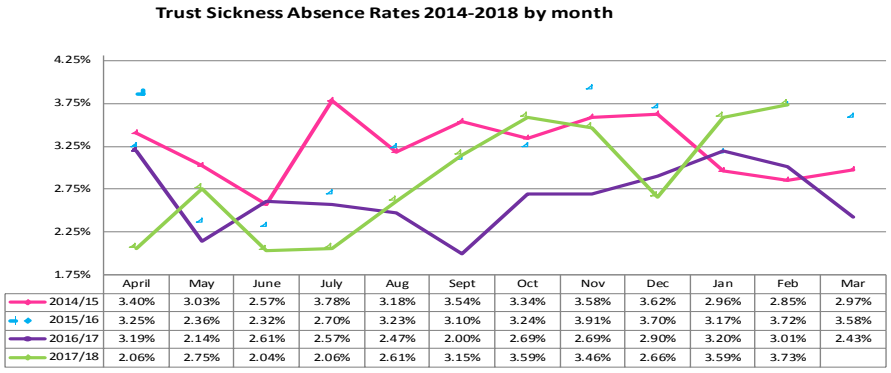
SHORT TERM SICKNESS	Dec-17	Jan-18	Feb-18	Compared to Previous Month
Corporate	1.28%	1.66%	0.70%	▼
Clinical Support	1.10%	2.31%	2.16%	▼
Plastics	1.70%	2.36%	0.88%	▼
Eyes	0.43%	0.20%	0.73%	▲
Sleep	1.78%	1.45%	0.60%	▼
Oral	1.06%	1.07%	1.19%	▲
Periop	1.25%	1.78%	1.59%	▼
Clinical Infrastructure	1.12%	2.21%	0.24%	▼
Director of Nursing	1.32%	3.44%	2.28%	▼
Operational Nursing	2.24%	2.05%	2.80%	▲
QVH Trust Total	1.33%	1.82%	1.38%	▼

LONG TERM SICKNESS	Dec-17	Jan-18	Feb-18	Compared to Previous Month
Corporate	0.28%	0.64%	0.57%	▼
Clinical Support	1.21%	2.18%	1.95%	▼
Plastics	0.00%	0.00%	1.70%	▲
Eyes	0.03%	0.31%	0.00%	▼
Sleep	4.29%	4.23%	7.54%	▲
Oral	0.78%	2.23%	3.48%	▲
Periop	1.40%	1.77%	2.00%	▲
Clinical Infrastructure	12.42%	9.55%	7.09%	▼
Director of Nursing	0.00%	0.00%	0.00%	◄►
Operational Nursing	1.92%	2.97%	5.86%	▲
QVH Trust Total	1.33%	1.77%	2.35%	▲

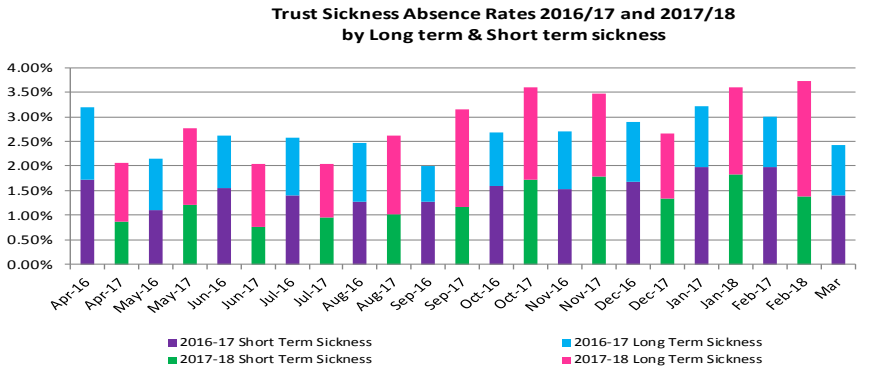
ALL SICKNESS (with RAG)	Dec-17	Jan-18	Feb-18	Compared to Previous Month
QVH Trust Total	2.66%	3.59%	3.73%	▲







	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%	3.46%	2.66%	3.59%	3.73%	



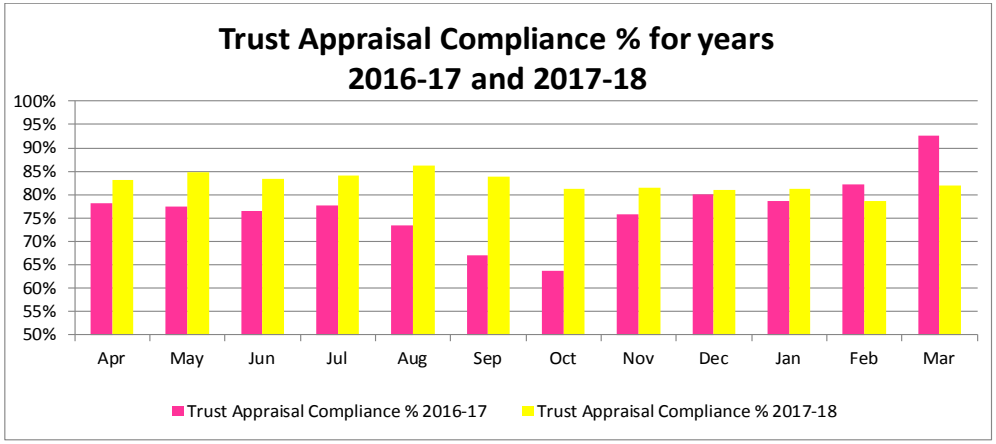
6. Training, Education and Development

New Targets/RAG ratings for 2017/18:

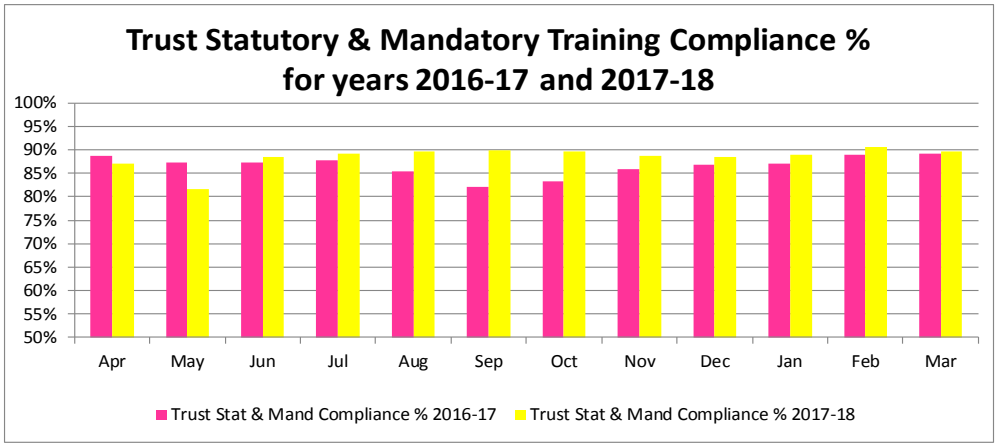
% staff - appraisal compliant	<80%	80%<>95%	>=95%
% staff - Statutory & Mandatory Training compliant	<80%	80%<>95%	>=95%

Performance:

APPRAISALS	Mar-17	Feb-18	Mar-18	Compared to Previous Month
Corporate	92.54%	82.14%	83.33%	▲
Clinical Support	92.54%	87.92%	96.00%	▲
Plastics	74.40%	70.91%	74.77%	▲
Eyes	90.26%	67.31%	71.15%	▲
Sleep	83.13%	84.38%	90.63%	▲
Oral	86.62%	84.38%	85.42%	▲
Periop	73.53%	71.68%	73.41%	▲
Clinical Infrastructure	90.91%	55.56%	61.11%	▲
Director of Nursing		88.24%	90.91%	▲
Operational Nursing		82.80%	84.95%	▲
QVH Trust Total	92.59%	78.58%	81.89%	▲



MANDATORY AND STATUTORY TRAINING	Mar-17	Feb-18	Mar-18	Compared to Previous Month
Corporate	90.19%	94.17%	93.49%	▼
Clinical Support	95.18%	94.62%	94.57%	▲
Plastics	79.56%	84.28%	82.96%	▼
Eyes	93.11%	91.27%	90.82%	▼
Sleep	93.68%	93.43%	91.22%	▼
Oral	91.64%	89.77%	85.87%	▼
Periop	87.47%	88.56%	87.70%	▼
Clinical Infrastructure	88.70%	88.36%	84.01%	▼
Director of Nursing		90.73%	91.57%	▲
Operational Nursing		92.28%	92.34%	▼
QVH Trust Total	89.29%	90.72%	89.59%	▼



7. Medical and Dental Workforce

Medical Workforce

- **Plastic Surgery:** Whilst the new Registrar Rota will be implemented in April, a shortage of two HEKSS trainees will impact on successful implementation and agency locums are being sourced to cover the vacancies.
- **Anaesthetics:** New Consultant Anaesthetists start this month and further consultant recruitment is expected in the summer.
- **Recruitment:** Recruitment continues to be a challenge due to a shortage of UK doctors and difficulties in overseas doctors obtaining visas to work.
- **Job Planning:** E Job Planning is underway and it is hoped all consultants will be job planned by end April 2018.
- **Clinical Excellence Awards:** – the 2017 round will be held in April.
- **Revalidation and Appraisal:** Appraisal rates for medical and dental staff has improved slightly, with the Trust's month-end reportable position at 82.35%.

Clinical Directorate	Headcount of medics	Number with in-date appraisal	Compliance rate
Clinical Support	8	7	87.50%
Eyes	10	9	90.00%
Oral	40	34	85.00%
Peri-Operative Services	23	19	82.61%
Plastics	51	41	80.39%
Sleep	4	2	50.00%
Grand Total	**136**	**112**	82.35%

Medical Education

Monthly update

- A new cycle of local faculty group meetings took place throughout January, February and March, reporting to the Local Academic Board in March.
- Two new educational events took place in March – on 1 March Lt Col Cubison ran a Non-Technical Skills for Surgeons session for all surgery trainees, and on 7 March Mr Khandwala ran a hand workshop afternoon; a multidisciplinary event targeted at all staff who work with hand patients at QVH. Both were very well received.
- The ever-popular Trauma and Burns course took place on 14 March, attended by delegates working in MIUs and A&Es around the region.

Upcoming developments

- A new cohort of junior doctors started on Wednesday 4 April and will attend Junior Doctors' induction on their first day.
- Interviews for a new Surgical Tutor in Plastic Surgery, to replace Miss Nugent who is stepping down, will take place on 17 April.

Statutory and mandatory training compliance

- Permanent/fixed term medical and dental employees are currently showing 82.4% compliant, which is a slight drop on the previous month.
- Medical and dental bank workers are showing as 65% compliant, which is similar to the previous month.

Leading the Way
Evaluation and Progress Report

1. Purpose

This paper provides an overview of a participant evaluation and a review of progress and impact of 'Leading the Way', the internal management and leadership programme for Queen Victoria Hospital.

2. Background

Leading the Way was designed to build management and leadership capacity across QVH. It was developed and designed in-house with the aim of offering a flexible approach to management training across the Trust across all staff groups clinical and non-clinical. It is comprised of a passport route and a qualification route and was launched on 21st January 2017 with 71 staff able to attend this face to face session.

We worked with an external provider, Qube Learning, to develop the qualification route accredited by the Institute of Leadership and Management (ILM) at Level 3 and Level 5. The qualification programme uses a blended learning approach, in which theory is underpinned by work based projects. It is funded using the Apprenticeship Levy.

The passport route was developed in-house and has similar themes to the qualification route but without a formal qualification attached so enables a more flexible 'pick and mix' approach to learning.

To date, we have supported one QVH passport programme, two Level 3 and two Level 5 ILM qualification programmes. 25 staff members are undertaking the qualification route programme. On the passport route we have delivered 31 in house training sessions to 328 attendees (see below).

We also ran a leadership seminar run by Professor Michael West attended by around 50 people in the Spring 2017.

Session	Number	Attended
Becoming an Effective Leader	2	22
Collaboration, Change and Challenge	2	19
Conducting an Investigation	2	9
Conversations that Count	3	27
Developing and Leading Teams	2	21
Firm Management or Bullying	4	25
Introduction to Leadership	2	19
Introduction to NHS finance	2	12
Leadership in the NHS	1	43
Leading the Way - Launch and Information Event	3	71
Managing Non-attendance at Work	2	15
Managing your budget and the Business Planning cycle	2	11
Procurement	1	3
Project Management	1	10
So you think you want to be a Manager	2	21
Total	**31**	**328**

3. Staff Survey 2017

With data extracted from the 2017 Staff Survey, we can compare the results from 2016 survey to core areas covered within Leading the Way:

Local changes and improvements since the 2016 Survey:

Key Finding	Area	QVH 2016	QVH 2017
5	Recognition and value of staff by managers and the organisation	*3.42	*3.51
6	% of staff reporting good communication between senior management and staff	28%	31%
7c	Immediate manager gives clear feedback on my work	54%	65%
7e	Immediate Manager supportive in a personal crisis	68%	74%
8c	Senior managers try to involve staff in important decisions	25%	31%
10	Support from immediate managers	*3.68	*3.80
26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	22%
19	Organisation and management interest in and action on health and wellbeing	60%	69%
11	Percentage of staff appraised in last 12 months	82%	87%

*0 – 5 Low to High

Based on key findings of the staff survey, whilst acknowledging we are on a journey, there is an improvement around management and leadership behaviours and practice at QVH in the latest staff survey.

With the development and continued investment in our leaders at QVH the expectation is that these results will continue to improve.

4. Programme Evaluation

Evaluation of Leading the Way participants experience is key to the future development of this programme and the skills of leaders at QVH.

At the outset of the programme all applicants undertook a skill scan (copy attached) to self-assess their leadership knowledge, skills and behaviours using a RAG assessment. They repeated this skill scan in February 2018. The table below shows the overall % for before and after self-assessment and the overall % changes over time.

All staff self-assessment of knowledge, skills and behaviours

RAG	% for all staff Before participating in the programme	% for all staff After participating in the programme	Overall % point change Jan 2017 – Feb 2018
Red	**8%**	**5%**	**Decrease 3%**
Amber	**45%**	**33%**	**Decrease 12%**
Green	**47%**	**62%**	**Increase 15%**

Throughout the programme we asked for participant feedback using session evaluations. 92% of all sessions have been rated as good or excellent.

A series of participant focus groups were a key part of the programme. These enabled us to obtain a deeper understanding of the programme and its impact on participants.

5. Key findings

Based on our evaluation of the programme our key findings are:.

What went well:

- The passport programme was an invaluable in-house programme that delivered high quality training.
- The development of practical skills. Staff who participated felt the programme supported their development as managers and leaders.
- Participants grew in confidence. This was particularly noted as a benefit by less experienced managers.
- Opportunities to develop networks with other leaders across the Trust.
- Development of leaders' self-awareness and ability to self-reflect.
- For the qualification route participants all cited that dedicated 1:1 time with a knowledgeable tutor provided a valuable learning experience.
- The range of topics selected was suitable to target the needs of managers across the Trust.
- The OD&L team provided valuable support and guidance for participants.

Could be even better if:

- Communication by the qualification provider (Qube Learning) needed to be clearer. Some participants felt that expectations could have been laid out in a clear and more coherent manner at the outset.
- A more structured and consistent approach to is needed for the qualification programme. Lack of a suitable tutor in the early months of the programme delayed learning and led to some confusion around learning outcomes.
- Overlap should to be removed on sessions delivered in the passport programme*.
- External providers who came from 3 different training companies sometimes overlapped each other to a significant extent.
- There had been greater engagement across the Trust to ensure that the right people attended the programme. Some staff groups didn't feel it was applicable to them despite leading teams for example Band 6 nurses.
- If line managers supported staff to implement their learning back in the workplace this would move it from theory to reality.
- IT resources need to be further developed to support programme delivery. Some resources for learning were on platforms not available using the Trusts IT systems.

*some participants attended both aspects of the programme

6. Recommendations and Next Steps

Passport route

The passport route was well received and demand for workshops remains high. To enable streamlining of delivery and to utilise limited resources we will continue to deliver a number of sessions using in-house trainers. For the 2018/19 passport programme we have been successful in a bid for external funding again so have commissioned NHS Elect to deliver a number of bespoke leadership and management sessions. We will also be able to access some of their public courses which will further broaden the scope of the Leading the Way programme.

Qualification Route

Based on feedback and experience of out qualification route training provider (Qube learning) we have procured a new provider (Hawk Training) for future qualification route cohorts.

The qualification programme is currently being designed with a new provider and is incorporating feedback from our evaluations to ensure that it better meets the needs of QVH and its staff.

General recommendations

- We will provide targeted engagement with senior managers and the EMT to improve uptake of the Leading the Way programme with those groups and individuals who have not yet engaged.

- We will continue to monitor and evaluate the Leading the Way Programme and act upon feedback. Measures will include Staff Survey, Friends and Family test, end of session evaluations and trainer observations.

- We plan to continue to identify future needs and develop approaches to meet demand eg MBTI, coaching and shadowing opportunities.

- We plan to develop action learning sets and other approaches to encourage managers to better utilise their new skills in the work place. This will also provide the opportunity for staff to deepen their networks across the Trust.

- We have identified through the programme key themes which have been discussed and will be delivered by NHS elect:
  - Change management
  - Resilience
  - Strategic management
  - Courageous conversations
  - Service Improvement and quality, etc.

- We will continue to engage with senior managers, collaborate across the STP and other organisations to identify challenges and develop the Leading the Way programme to meet changing needs.

- We are planning a leadership conference in the winter which will focus on system challenges

7. Conclusion

We believe that leading the way has had a positive impact on the knowledge, skills and behaviour of leaders and managers across the Trust and that this has more potential to have a positive influence on staff engagement.

We recognise that there is the desire and the willingness amongst managers and leaders to receive and act on training and development, however, it is essential that they have the necessary resources and the support of their line managers and EMT to facilitate this.

QVH has secured funding to allow the Leading the Way programme to run in the 2018/19 financial year. However to be effective in the long term the programme will need ongoing support.

Report cover-page					
References					
Meeting title	**Board of Directors**				
Meeting date	**03/05/18**		**Agenda reference**	**79-18**	
Report title	**Leadership and governance developmental review**				
Author	Clare Pirie, Director of communications and corporate affairs				
Appendices	A: Full report				
Executive summary					
Purpose	The purpose of this report is to provide assurance that the Trust's governance arrangements remain fit for purpose.				
Recommendation	The Board is asked to **NOTE** the findings of the external review and **CONSIDER** the action plan (below) which addresses the key recommendations in the report.				
Purpose				Assurance	
Link to KSOs	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework	Following recommendation, the Board Assurance Framework will be refined to aid clarity of understanding.				
Corporate risk register	Following recommendation, the Corporate risk register will be refined to aid clarity of understanding.				
Regulation	This report had been produced in accordance with the framework set out by NHS Improvement.				
Legal	None				
Resources	None				
Assurance route					
Previously considered by	The Board of Directors at its February seminar.				
	Date	01/02/18	**Decision**:	Noted	
Next steps	Whilst the report has not highlighted any material governance concerns, the Trust will continue to build on the findings of the review.				

Report to:	Board of Directors
Meeting date:	3 May 2018
Reference no:	79-18
Report from:	Clare Pirie, Director of communications and corporate affairs
Report date:	25 April 2018

Leadership and governance developmental review

Background
Foundation Trust boards are required to undertake an external review of governance every three years to ensure that governance arrangements remain fit for purpose. QVH has approached this as a positive opportunity to improve our governance effectiveness and leadership culture.

QVH appointed an external team to carry out a review and the initial outputs of this review process were worked through in detail by Board members at the Board seminar workshop in February 2018.

Review process
The review began with an initial self-assessment completed by members of the Board, and over the period from November 2017 to January 2018. The independent review team carried out:

- Desktop document review
- One to one interviews with Board and staff
- Focus groups with internal and external stakeholders including members of the Council of Governors
- Board and committee observations

The team conducting the review noted that all those they came in contact with engaged positively and wholeheartedly with the review.

In line with national guidance, the chair has written to NHS Improvement confirming the review has been completed and that there were no material issues of concern.

Findings
The well-led framework is structured around eight key lines of enquiry as below.

Is there the **leadership capacity and capability** to deliver high quality sustainable care?	Is there a clear **vision** and credible **strategy** to deliver high quality sustainable care to people who use services, and robust plans to deliver?	Is there a **culture of** high quality sustainable care?
Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well-led?**	Are there clear and effective processes for managing **risks,** issues and **performance?**
Is robust and appropriate **information** being analysed and challenged?	Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	Are there robust systems and processes for **learning,** continuous **improvement** and **innovation**?

In each of the eight key lines of enquiry QVH demonstrated areas of good practice as well as areas for improvement. The full report is shown as Appendix A.

Recommendation
The Board is asked to **NOTE** the findings of the external review and **CONSIDER** the action plan (below) which addresses the key recommendations in the report.

Leadership and governance developmental review
Action plan

Recommendation	Lead	Context	Actions	Updates
1. Finalise development of the medium-term **strategy** and associated underpinning strategies along with an options appraisal which delivers safe, sustainable care, compliant with current and known future requirements and aligns with the STP in the longer term.	Chief executive	The QVH strategy *QVH 2020: Delivering excellence* has been reviewed recently through the Hospital Management Team, and the strategy and underpinning strategies (IT, estates etc) have been regularly discussed by the Board at bi-monthly seminars. The leadership of the organisation are very aware of the impact of STPs on the strategic approach. QVH continues to work in collaboration with NHS partners. The Board is well informed about close working with BSUH and WSHFT.	Continue to work closely with the STP and through direct collaboration with NHS partners. Ensure staff remain informed about this and engaged in any process of strategy refresh.	

2. Development of an **OD strategy** to support the above activities and the existing Workforce and Engagement Plan and to help with staff retention and fostering a culture of self-learning and improvement.	Director of workforce and organisational development	The two main areas of focus of organisational development work over the last year have been • The *Leading the Way* programme for people who manage people, with positive results visible in staff survey, • Work undertaken as part of the engagement and retention plan.	Consider bringing the current work done in organisational development together in a strategy document.	
3. **NED challenge** to be strengthened via assurance-based reports which incorporate forward looking actions, timelines and improvement trajectories which facilitate holding to account.	Chair, with the support of Director of communications and corporate affairs	The reviewers commented that they observed good NED challenge, and that this needed to be supported through assurance rather than reassurance from execs.	Awaiting examples of best practice from external reviewers. NHSI Board development session on seeking assurance around operational performance scheduled 3 May 2018. Ensure all papers include a top level summary setting out key messages.	

4. Review the current focus on compliance with a view to developing a more devolved **framework of accountability** that creates and promotes an environment for learning and continuous improvement at individual and team levels whilst also clarifying and improving the organisation's ability to hold both individuals and teams to account.	Chief executive, with medical director and clinical directors	The Hospital Management Team has been established relatively recently and, alongside the performance review meetings, is addressing the accountability of clinical directorates. As a small trust there is already a relatively high level of devolved accountability.	Consider further work to reinforce the accountability of clinical directors for delivering on activity and budget plans.	
5. Development of a board **stakeholder engagement plan** which will better connect the board to the trust, to triangulate evidence and also raise its profile with external stakeholders.	Director of communications and corporate affairs	Board members have been actively engaging with staff in a wide variety of forums but this has not been captured or planned centrally. QVH has strong relationships with external stakeholders, again this has not been documented.	Create a forward plan including opportunities for NEDs to engage with teams; capture existing Board engagement; ensure all areas of the Trust are covered. Document lead responsibilities for external stakeholders.	

6. Consider a **triumvirate management model** which develops buy-in from medical staff for their corporate role and invest in management teams to operate effectively in their role.	Chief executive	This model has been discussed but limited resources mean it has not been practical for each clinical directorate to have a unique nursing lead and business manager.	The STP HR workstream, through work led by QVH director of HR, will provide access to developmental opportunities for clinical directors to support them in their leadership roles.	
7. Review the provision of **information** to the board to provide greater insight and forward look including refinement of the BAF and CRR to aid clarity of understanding of risk, controls and assurances and support risk-based discussion focused on risk management not just risks themselves.	Director of nursing and quality		Board seminar on 5 April addressed appetite for risk. Director of nursing leading follow up work.	
8. Deployment of a **continuous improvement methodology** to facilitate innovation and learning.	Chief executive	Organisational support sourced from NHS Elect includes opportunities for management training around this.	Continue discussions with WSHFT and BSUH around potential partnership working on this issue.	

9. Development of a realistic but aspirational **plan** which returns the trust to regulatory compliance across all operational and financial targets.	Director of operations		This forms part of operations workstreams which the Board are aware of through other plans.	
10. Review the role of **Governors** on committees to avoid possible conflicts of interest.	Director of communications and corporate affairs	QVH has a highly successful model for governor engagement, with motivated and supportive governors and a lead governor role on sub-committees that enables them to see NEDs at work and more fully discharge their responsibilities around holding NEDs to account.	Review the role description for lead governors to ensure risk of conflict of interest addressed. Review how the attendance of lead governors is noted in the minutes of sub-committees and Board to ensure role is clear.	

APPENDIX A

Well-led Review

Report for

Queen Victoria Hospital NHS FT

frontline

we help you do things better

Well-led Review – Report for Queen Victoria Hospital NHS FT

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Executive Summary

Queen Victoria Hospital (QVH) has a proud legacy resulting in many patients being able to live fulfilling lives through the work of its expert clinicians. QVH rose to prominence in challenging times, and it is now entering further challenging times that place the NHS Foundation Trust and the services provided at QVH at a cross-roads.

Well-led Review

This is the first formal Well-led Review since QVH became a Foundation Trust (FT). It is one of the smaller FTs, operating in a new context of system-wide sustainability and transformation partnerships (STPs). Our Well-led Review followed the framework set by NHS Improvement, and built on an initial self-assessment completed by the trust board. We then reviewed a wide range of documentation, spoke to and met with staff and external stakeholders, observed meetings and facilitated focus groups over the period from November 2017 to January 2018. All those we came in contact with engaged positively and wholeheartedly with the review.

Overall, the board self-assessment presented a more positive view of the eight key lines of enquiry (KLoE) than our fieldwork supported. This points to an over-arching need for the board to strengthen its connection with the rest of the organisation to improve triangulation of the assurance it receives.

RAG rating

For each KLoE, we found many areas of existing good practice in that particular area, and also evidence of opportunity for improvement. These details are presented extensively in Section 3 of our report, and result in a RAG rating for each KLoE as follows:

	KLoE	RAG
1.	Leadership capability and capacity	
2.	Vision and Strategy	
3.	Culture	
4.	Responsibilities, roles and systems of accountability	
5.	Processes for managing risk, issues and performance	
6.	Information	
7.	People, public, staff and external partners	
8.	Learning, improvement and innovations	

This RAG rating results in three clusters of KLoEs:

1. **Leadership, strategy and culture** emerge as the key areas of focus resulting from our review
2. These are followed by **accountability and risk/performance management and innovation**
3. Finally, **information and engagement** still require focus and improvement actions, but these are seen as a lower order priority in terms of greatest impact on delivering impactful improvements for the trust

Below are the definitions for the RAG ratings:

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver

Recommendations

Going forward from this Well-led Review, we have identified a set of 'Top 10' recommendations that the board can implement in order to give itself assurance that the Well-led key lines of enquiry can be met, building on the many areas of good practice, and addressing areas where practice can be improved.

'Top 10' recommendations:

1. Finalise development of the medium-term **strategy** and associated underpinning strategies along with an options appraisal which delivers safe, sustainable care, compliant with current and known future requirements and aligns with the STP in the longer term. These should include SMART objectives and timelines that realistically show how it will be delivered.
2. Development of an **OD strategy** to support the above activities and the existing Workforce and Engagement Plan and to help with staff retention and fostering a culture of self-learning and improvement.
3. **NED challenge** to be strengthened via assurance-based reports which incorporate forward looking actions, timelines and improvement trajectories which facilitate holding to account.
4. Review the current focus on compliance with a view to developing a more devolved **framework of accountability** that creates and promotes an environment for learning and continuous improvement at individual and team levels whilst also clarifying and improving the organisation's ability to hold both individuals and teams to account
5. Development of a board **stakeholder engagement plan** which will better connect the board to the trust, to triangulate evidence and also raise its profile with external stakeholders.
6. Consider a **triumvirate management model** which develops buy-in from medical staff for their corporate role and invest in management teams to operate effectively in their role.
7. Review the provision of **information** to the board to provide greater insight and forward look including refinement of the BAF and CRR to aid clarity of understanding of risk, controls and assurances and support risk-based discussion focused on risk management not just risks themselves.
8. Deployment of a **continuous improvement methodology** to facilitate innovation and learning.
9. Development of a realistic but aspirational **plan** which returns the trust to regulatory compliance across all operational and financial targets.
10. Review the role of **Governors** on committees to avoid possible conflicts of interest.

The board has been on a journey and continues to be on one. From our discussions and presentations, many of the elements we have highlighted from our Well-led Review are not unfamiliar to all or some on the board. As the board moves forward into a new context which it will help shape, there will be a need for it to be both pastoral for its staff and the community in which it is located, and reflective on the changes needed to continue its strive for excellence and innovation in the new STP environment.

1 Introduction and Background

1.1 Overview

This Well-led Review for Queen Victoria Hospital (QVH) NHS FT was carried out between November 2017 and January 2018. We followed the revised framework from NHS Improvement, shown below:

As background, the trust board carried out an initial self-assessment, presented to us in two stages, and we were asked to "specifically focus on those areas where we have assessed ourselves as requiring improvement."

The review was carried out at a time of significant change for QVH, both externally and internally:

- **External context** – the pre-eminence of the sustainability and transformation partnership (STP) to drive system working, and the emerging place of QVH in integrated care
- **Internal context** – the lessons learned from both the investigation and inquest into the death of a patient, and the Never Events that have occurred over recent months

The trust therefore wished to carry out a bespoke review, covering a limited range of key lines of enquiry (KLoE) relating to its self-assessment. We originally estimated that there would be four KLoEs which we would need to review in-depth, but in reality we carried out in-depth assessment of all eight.

1.2 Approach

Our approach to the Well-led review encompassed a range of methods to gather evidence for assessment of the KLoEs, including:

- **Document review** covering minutes, board reports, and a wide range of other documents (quality, clinical, CQC, culture, governance, etc)
- **1:1 meetings** with key staff
- **Focus groups** with staff groups, particularly medical and nursing
- **Observation** of board, committees and team meetings
- **Interviews** with external stakeholders

The **external stakeholders** with whom we spoke, and in some cases met, as agreed by QVH included:

- FacialPalsy UK
- Federation of Specialist Hospitals
- Healthwatch West Sussex
- London and South-East England Burns Network
- NHS England
- NHS Horsham and Mid Sussex CCG
- NHS Improvement
- Sussex and East Surrey STP

As a result of emerging findings, we carried out further drill-down assessment, both internally and externally. All staff and stakeholders engaged fully with the Well-led process. The appendix shows the individuals, groups and organisations we had contact with.

1.3 Moderation and reporting

Our team used a Dropbox document repository to gather and analyse findings, and we carried out a number of moderation meetings to cross-tabulate our findings and build the Well-led picture.

We then presented our initial findings in two stages:

- Meeting with the chair, chief executive and director of communications and corporate affairs on 29 January 2018
- Presentation to a board seminar on 1 February 2018

This report therefore draws on the feedback from these initial stages to test our findings. We now present our draft Well-led findings under the following headings:

- Board self-assessment
- Findings for key lines of enquiry
- RAG rating
- External perspective
- Action planning

The board's self-assessment is now presented in the following section.

2 Board Self-Assessment

The board's self-assessment was completed and supplied to us in two stages, with the first submission covering KLoEs 1-4 and the second tranche covering KLoEs 5-8.

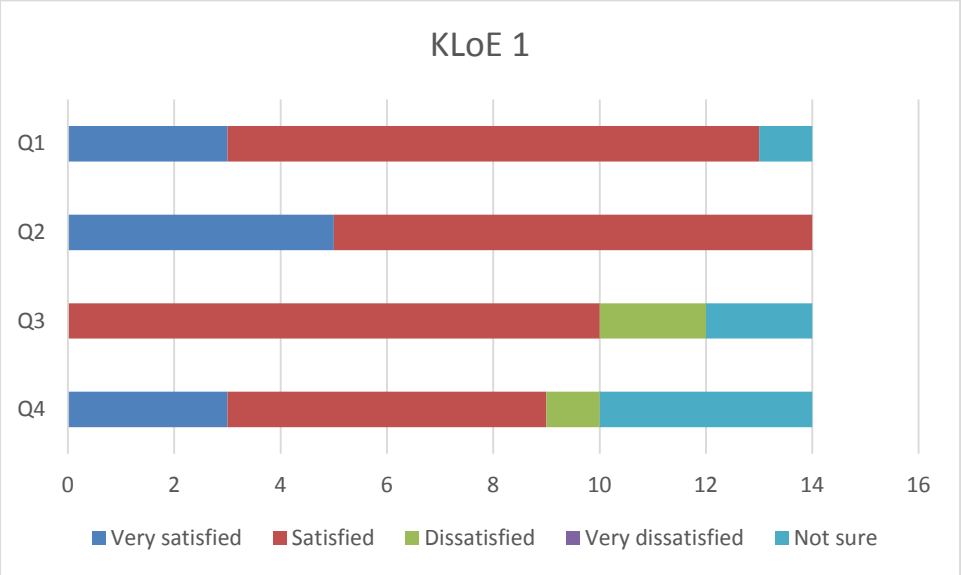
The self-assessment process was the issuance of an online questionnaire which followed the format of the KLoEs and sub prompts as contained within the revised Well-led guidance. There was space for respondents to populate free text at the end of each KLoE section. The trust administered the on-line survey and supplied the responses, including written responses, to us as part of our data request. We have set out in the table below our summary of the responses for each KLoE, and have also included graphical presentation of the responses to each KLoE and sub prompt question from the board's self-assessment.

2.1 Self-assessment summary

We have set out below our summarisation overview of our high-level analysis of the self-assessment. Overall, this points to a more positive view than our fieldwork suggests and this links into one of our recommendations regarding the need for the board to strengthen its connection with the rest of the organisation to improve triangulation of assurance.

KLoE	Observation
KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	Overall board members are satisfied/very satisfied with the capacity and capability of leadership. A number of the board are unsure as to whether the leadership is visible around the trust which possibly reflects the lack of triangulated feedback into the boardroom.
KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	Recognition that the trust needs to finalise and communicate its updated strategy and provide a clearer steer to the organisation. One board member commented "The 2020 vision needs updating to take account of recent changes in the internal and external operating environments".
KLOE 3 Is there a culture of high quality, sustainable care?	Generally high levels of satisfaction/very satisfied with the clarity of vision, values and culture within the trust. The question relating to collective responsibility is the area of least satisfaction for this KLoE.
KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	High levels of satisfaction/very satisfied with regard to clear accountabilities, roles and responsibilities within the trust. One respondent is less sure but there are two recent NED appointments.
KLOE 5. Are there clear and effective processes for managing risks, issues and performance?	Generally high levels of satisfaction/very satisfied other than a large number of board members are unsure re the role and function of clinical and internal audit in relation to quality governance. This was picked up in December 2017 during the Audit Committee's annual self-assessment and is being rectified.
KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?	57% of board members are either satisfied or very satisfied with the balance of focus (quality v sustainability) with therefore 43% either not sure or dissatisfied. These levels also reflect the views surrounding integrated reporting. In addition, there is some concern that information is not used to hold people to account and a large number of the board are unsure re the IT coverage in terms of the quality agenda.
KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	Generally high levels of satisfaction although a sizeable number of board members are unsure re the breadth and depth of engagement with all stakeholders including staff engagement.
KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?	A mixed bag of views across individual questions in this KLoE. In particular whether there are embedded improvement methodologies. There is a high level of satisfaction that the organisation learns from internal and external reviews which seems at odds with the never event experiences.

2.1.1 KLoE 1 responses – Leadership capacity and capability



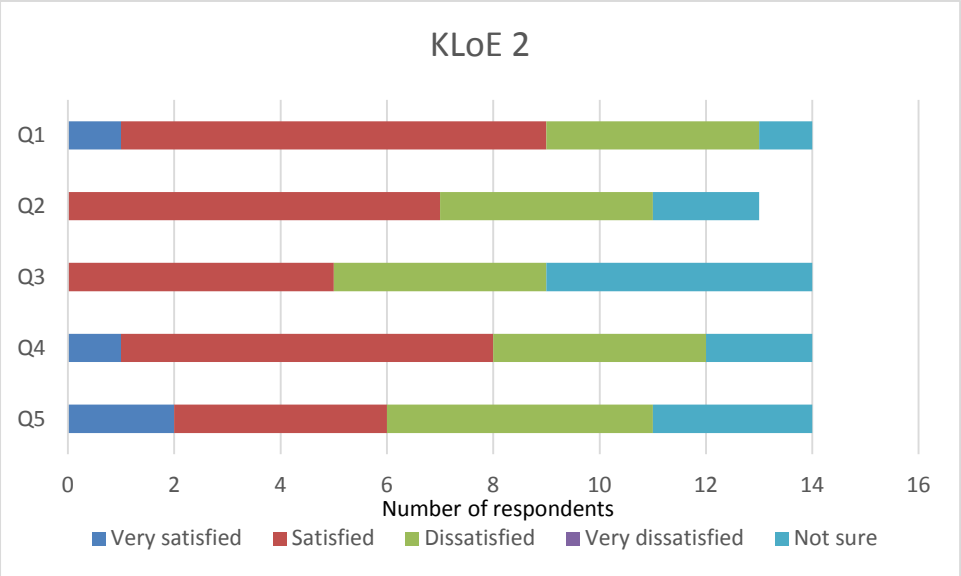
Q1 – Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Q2 – The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.

Q3 – Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.

Q4 – Leaders at every level are visible and approachable.

2.1.2 KLoE 2 responses – Vision and strategy



Q1 – There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.

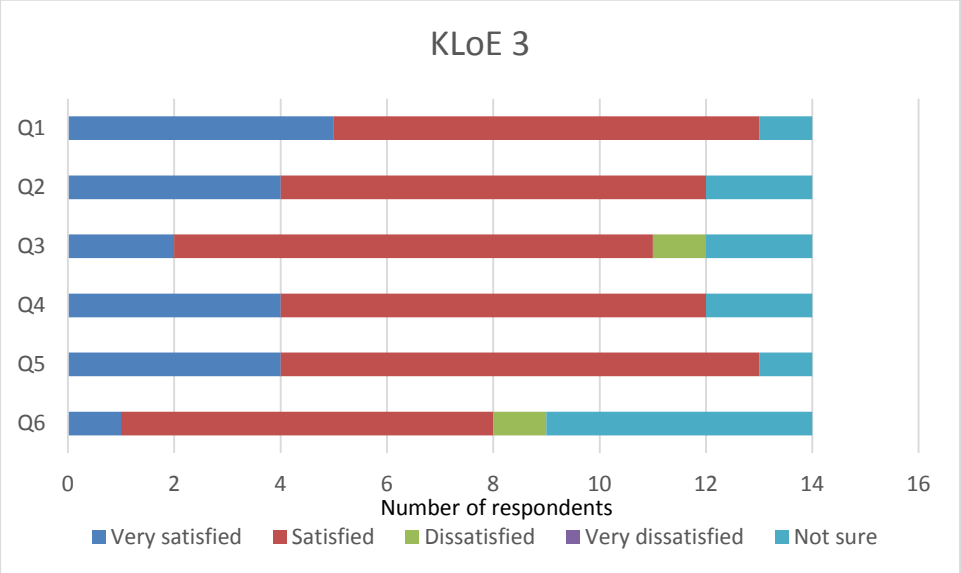
Q2 – The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

Q3 – Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

Q4 – The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

Q5 – Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

2.1.3 KLoE 3 responses – Culture



Q1 – Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.

Q2 – Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

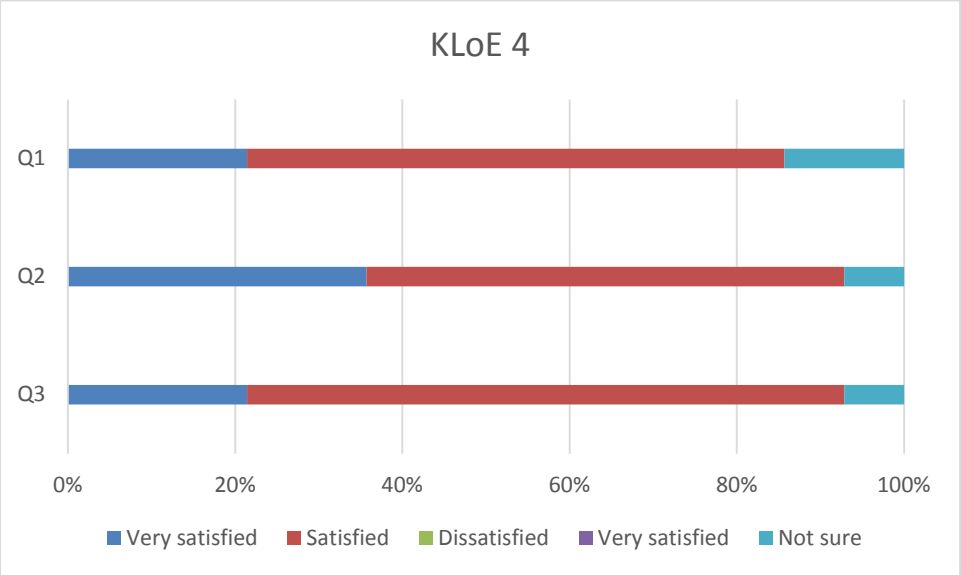
Q3 – There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

Q4 – Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.

Q5 – Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

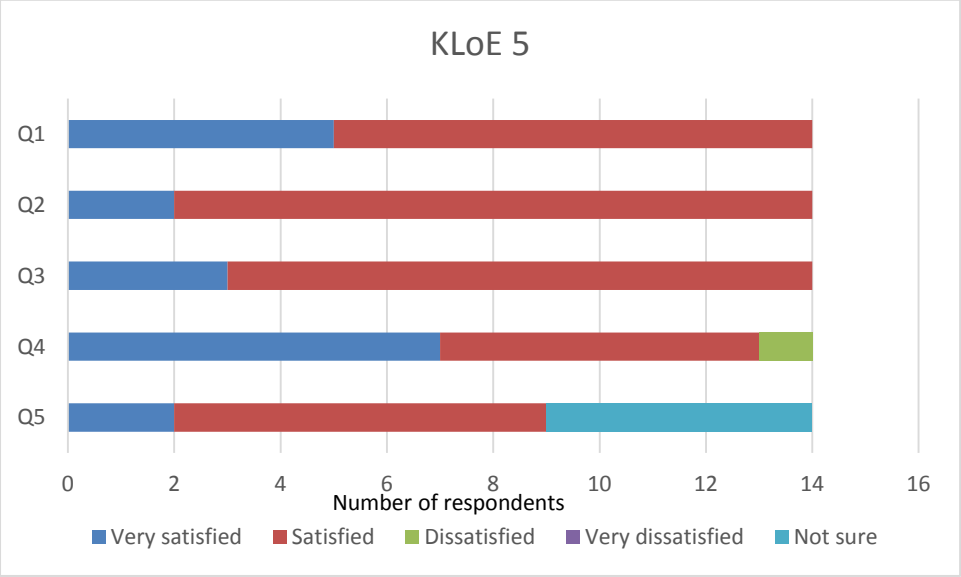
Q6 – There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

2.1.4 KLoE 4 responses – Responsibilities, roles and systems of accountability



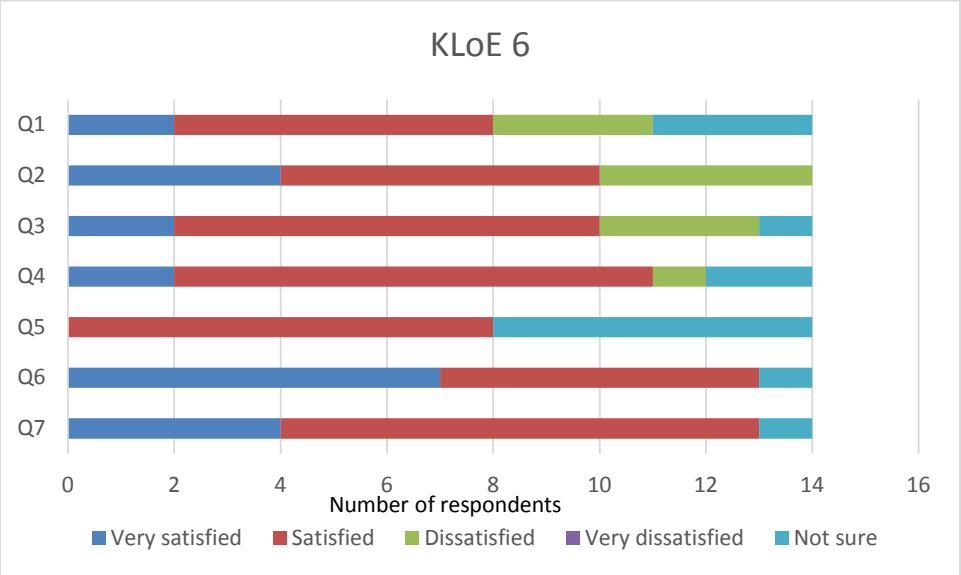
Q1 – Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.
Q2 – The board and other levels of governance in the organisation function effectively and interact with each other appropriately.
Q3 – Staff are clear on their roles and accountabilities.

2.1.5 KLoE 5 responses – Processes for managing risks, issues and performance



Q1 – There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.
Q2 – Financial pressures are managed so that they do not compromise the quality of care.
Q3 – Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.
Q4 – The organisation has the processes to manage current and future performance.
Q5 – Performance issues are escalated to the appropriate committees and the board through clear structures and processes.
Q6 – Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

2.1.6 KLoE 6 responses – Information



Q1 – Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.

Q2 – Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.

Q3 – Performance information is used to hold management and staff to account.

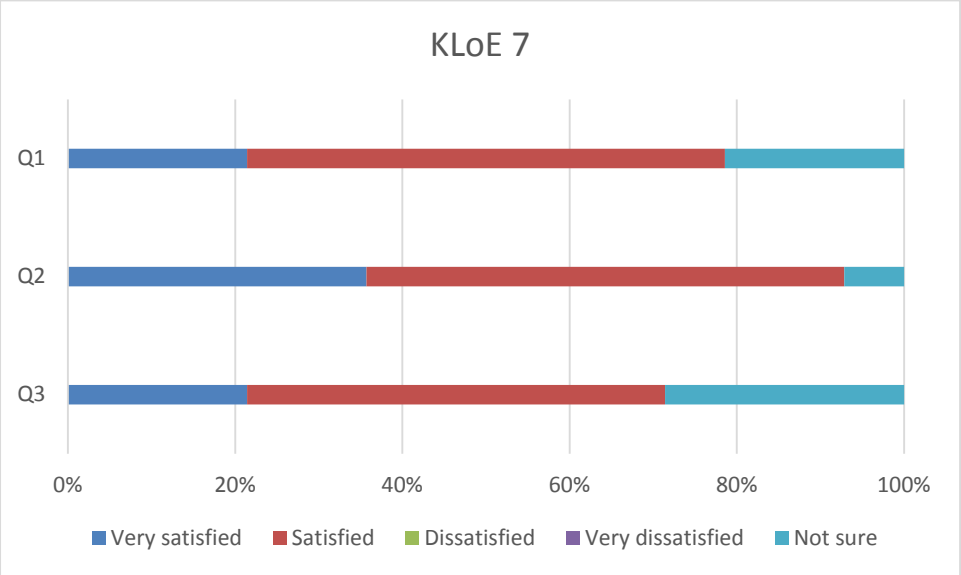
Q4 – The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Q5 – Information technology systems are used effectively to monitor and improve the quality of care.

Q6 – Data or notifications are consistently submitted to external organisations as required.

Q7 – There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

2.1.7 KLoE 7 responses – People, public, staff and external partners

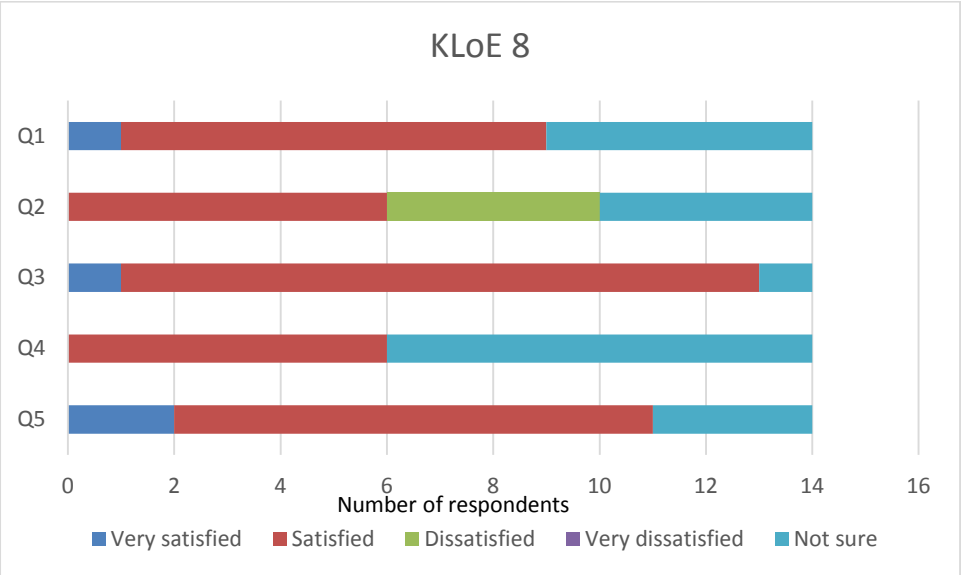


Q1 – A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

Q2 – The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

Q3 – The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

2.1.8 KLoE 8 responses – Learning, improvement and innovations



Q1 – There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

Q2 – There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

Q3 – The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

Q4 – Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

Q5 – There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

Against the background of this board self-assessment, which we received partly in November and then fully in January, we carried out our triangulation with the KLoEs through meetings, focus groups, discussions and observations. The following section now presents our findings.

3 Findings for Key Lines of Enquiry

Within this section we have set out our key findings against each KLoE, evidencing existing good practice in that particular area and also where, in our opinion, the trust needs to strengthen.

3.1 KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

3.1.1 Evidence of good practice

- The board conducts a bi-annual skills inventory to inform future training and recruitment.
- The board has an annual development programme that is focused on ensuring that the board is equipped and informed in terms of the current external environment and relevant update/refresh training on internal processes. Our board observation exercise observed the draft 2018 Board Development Programme being submitted to the board and containing relevant matters.
- The trust has relatively recently invested in a leadership development programme which is open to all leaders called *Leading the Way*. We were informed that the programme is in the process of being evaluated to inform evolution of the programme where necessary for future cohorts.
- Whilst there has been churn at board level which can often be seen as having a negative impact on the trust, the new NED appointments are seen as a strength which we would wholeheartedly agree with. The quality of the new NED appointments is testament to the trust's ability to attract and recruit high calibre non-executive directors.
- Quality of care is high profile in our observations and review of documentation. The recent series of Never Events has reinforced the need for additional and constant vigilance and assurance in this area. Board agendas are flexed to focus on areas of need.
- Values statement presented on website: "Our values are humanity, continuous improvement of care and pride, under-pinned by quality". Our engagement at the various staff forum events evidenced staff knowledge and understanding of the values.
- The trust is a specialist trust and is delivering leading edge, innovate surgery with excellent outcomes for patients in addition to mainstream 'normal' surgery and care. The challenge is to ensure consistent high quality and focus irrespective of whether individuals are delivering specialised or non-specialised care.

3.1.2 Areas to strengthen

- In overall terms, the trust is a small specialist trust which is the size of a directorate in many much larger trusts. Whilst in many ways this can be a positive, the trust incurs all of the organisational and regulatory burden of trusts much larger and therefore more able to establish and fund an appropriate hierarchical leadership structure. At QVH, the trust runs a relatively flat management structure and lean corporate infrastructure which inevitably impacts on leadership capacity. Furthermore, due to the small size of the trust it tends to attractive first-time executives who are setting out on their executive careers, which impacts on leadership capability to some extent.
- The trust self-assessment scores relatively lower on visible and approachable leadership, which recognises the need to improve board level visibility. This is supported by feedback from the staff focus groups, which indicated a perceived distance from board members. We do note that elements of the board are very visible and make the effort to engage with staff via staff briefings, Chair/CEO breakfast/afternoon tea sessions, attendance at induction events, etc; however, overall the board as a whole needs to be collectively more visible.

- We were informed that several clinical leaders have attended external training (King's Fund Senior Clinical Leaders course) to help induct them into the role. Internally, clinical leaders are invited onto the *Leading the Way* leadership development programme but, to date, have elected not to participate and attendance is not mandatory for the role.
- In terms of "compassionate, inclusive and effective leadership", there is a strong compassionate element that comes across among clinicians, but less buy-in to their corporate role. To assist in building the corporate role, the trust has recently introduced the Hospital Management Team (HMT) meeting whose membership includes executives, clinical leads and operational senior management to build corporate ownership and input into organisational wide matters. The HMT is embryonic in its maturity but has the potential to build greater clinical buy-in and help break down the disconnect between the operational teams and the corporate body and encourage senior clinicians to work more collectively alongside management to address issues jointly.
- The Quality Strategy was not strongly referenced in discussions or in staff focus groups, which provided a sense that this is not seen as a centrally important document that helps inform and drive investment and operational decision making. Upon review of the strategy, we note that here are 33 quality targets to work towards, which feels too many and too disparate for staff to truly focus on what priorities the trust considers mission critical.
- The future sustainability of the trust and absence of a long-term strategy also appears to be impacting on leadership, in that there is a perceived lack of clarity in relation to the direction of travel. Whilst there is an existing strategy which runs through to 2020, staff seem to be awaiting a refreshed or new strategy which clarifies matters for them. This, in part, appears to be linked to the relatively recent appointment of the CEO and staff linking each new strategy with the then new CEO appointment. We are cognisant of the impact that the wider STP strategy formulation is having on individual trusts when setting out a long-term vision and strategy. In the absence of a coherent STP strategy, discussions have been held at board level regarding the QVH's revised strategy, although to date these have not culminated in a refreshed strategy being developed. It would be beneficial for staff to have greater sight of and clarity over the timeline of a revised Trust strategy and the process to achieve this.
- Review of trust documentation and observed practice demonstrates a greater current focus on the operational quality challenge for the trust, and less focus on the strategic sustainability challenge which is perhaps understandable given the Never Events and Coroner's report. It is important that the trust redresses the balance and ensures that both operational and strategic matters receive due attention.

3.2 KLOE 2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

3.2.1 Evidence of good practice

- There is an existing strategy through to 2020 but it is well-acknowledged and recognised by the trust that this needs a refresh to take into account the changing external environment which the trust is currently discussing.
- Sussex & East Surrey Sustainability & Transformation Partnership (STP) is one of the more challenged and least developed STPs in the country, and therefore whilst the trust does need to refresh its strategy, it is limited to some degree regarding having a clear system strategy within which to develop the trust's strategy.
- The trust self-assessment scores recognise and reflect the absence of a current clear strategy that takes into account the changing context within which a new strategy will be developed.
- From our engagement with the trust board, it is clear that there is a keenness to contribute to the development of the STP plan and associated strategic decisions, along with a recognition that this will impact the future of QVH.

- The trust also recognises the increasing expectations and requirements linked to modern healthcare delivery, regarding what support infrastructure needs to be in place when undertaking some of the more complex care that currently takes place at the trust's main site. The trust has proactively sought to increase and formalise partnership working through a Memorandum of Understanding arrangement with partner trusts to sustain services at the QVH site.
- From our engagement with external stakeholders, they perceive the trust to be a willing partner to contribute to strategic discussions at STP and network levels.
- There was a sense of reality amongst staff that we engaged with regarding the changing environment and the need for the trust to change. What is currently lacking for staff is a clear understanding of how the trust is proactive in influencing this agenda and the timeline for clarity of the strategic direction.

3.2.2 Areas to strengthen

- The board needs to be clear on its position in relation to its strategic future and how it is influencing the direction of travel and ensuring the very best outcome for patients and staff. This then needs communicating better to staff and stakeholders.
- Despite the recognised challenges with the Sussex & East Surrey STP plan, the trust needs to set out a clear plan and timeline to develop its strategy. This needs to take into account the national direction of travel of service specifications and pathways, e.g. burns, STP, etc, and be clear on what is required by the trust to meet the requirements for safe and sustainable care.
- We know that the board utilised part of its December and February Board Development sessions to consider strategy as part of its ongoing strategy development. This is timely and reflects recognition by the board of the need to communicate a revised strategy which considers the changing external environment.
- In addition to the need to refresh the overall trust strategy, it is not surprising that there is also a need to develop refreshed underpinning strategies including OD, workforce, estate, finance, quality that give assurance that the trust's overall strategy can be delivered.
- In relation to operational plans as opposed to strategy, we note the absence of a plan that returns the trust to a compliant RTT access target trajectory in the short term. The trust should consider what further action it can take to speed up the date by which it will deliver against these targets.

3.3 KLOE 3. Is there a culture of high quality, sustainable care?

3.3.1 Evidence of good practice

- Positive self-assessment, albeit with a higher level of 'not sure' in relation to "culture of collective responsibility between teams and services".
- The latest available published staff survey shows above average levels of staff reporting errors, near misses and incidents (94% versus 92% nationally), which is also one of the trust's top 5 ranked scores.
- Perception of positive culture in some quarters, with the nurse focus group commenting "The culture in the room at the moment feels supportive".
- General stakeholder view of high quality, leading edge care being provided by QVH.
- The staff survey references an above average score for staff referring a friend or relative for treatment (91% versus 90% nationally).
- Strong sense of identity and loyalty amongst staff to the QVH brand, creating a family feel to the organisation.

3.3.2 *Areas to strengthen*

- Based on a number of engagements across focus groups, 1:1 interviews and observations, the relationship between medical staff and other staff appears hierarchical in nature and a cause for some concern, with a number of those engaged with commenting that this is an area where the trust values are being undermined. This was a strong and consistent theme of our review, and whilst the extremes of this may be constrained to a limited number of individuals, the impact and perception caused by this behaviour appears far reaching.
- The staff survey results for 2016 (latest published available) show a marked decline in most scores when compared to 2015 (62% – down from 76% previous year and well below national average of 72%). The timing of our review meant that the 2017 results were not available for public consumption. Dependent upon those results and whether there is a marked improvement which will add further clarity to the current mood within the trust, but based on our engagement, this is an area that needs management focus in order to improve staff welfare and retention.
- The trust is being proactive in recognising the need to invest in senior and middle management skills via *Leading the Way* management development programme. This needs supplementing with a recasting of the accountability framework within which the trust operates. In part, due to the size of the trust, there is a tendency to manage down into the organisation, which may impact on the perceived level of autonomy at operational management level, and for the trust to maximise the benefit from its investment in *Leading the Way* it needs to ensure that an appropriate level of devolved responsibility is applied within an agreed framework of accountability.

3.4 KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

3.4.1 *Evidence of good practice*

- The trust board self-assessment is positive about the governance infrastructure in place, including responsibilities, roles and systems of accountability.
- The small size of the trust and the relatively flat management structure supports clarity of roles for individuals.
- The trust incorporates annual reviews of its board and committees. Through our observations and document review, we noted the latest annual reviews of Audit Committee and Finance & Performance Committee in addition to trust board. There is clear evidence of improvement actions resulting from these annual reviews, and in particular we noted a number of positive actions that emanated from the recent review of the Audit Committee.
- Following a significant review a number of years ago, we have observed and noted a strong compliance driven governance approach within the trust.
- The structure of the agenda of the Council of Governors helps embed their understanding of their role, which was observed in practice.

3.4.2 *Areas to strengthen*

- As noted in KLoE 3 there is a tendency to drift towards a centralist approach to management and accountability, which creates some tension with operational management, who are keen to retain a level of autonomy and decision making.

- Regular performance management meetings take place each month and are well attended by trust executives. The agenda is structured around a balanced scorecard covering the expected domains. Review of documentation suggests that these generally perform well, although a review of the minutes evidences that these meetings could be more two-way with the business units taking the opportunity to raise concerns and hold the corporate elements to account regarding the level and quality of support received. This would assist in building a more devolved and accountable culture within the organisation, whilst at the same time strengthen the connection between the corporate entity and the operational elements.
- During our review we generally observed good NED challenge, but this was generally not followed through to conclusion, resulting in reduced effectiveness of holding to account. There were high levels of reassurance provided in meetings, with limited evidence of assurance given or being asked for. Holding to account would be strengthened by having greater specificity over actions, timelines and responsibilities, i.e. who?, what?, when? and expected impact, i.e. trajectory of improvement or date for compliance. This would allow those holding to account a clarity of detail which is often currently lacking and inhibiting a higher quality of accountability being discharged.
- Whilst we have noted the compliance driven culture as a positive approach within the trust, our observations and document review have indicated that this can, at times, constrain generative conversation where staff are focusing on the processes being applied rather than the messages and outcomes. This was evidenced well when observing the Nursing Quality Forum discuss incidents where the focus was on the correct reporting procedure and form filling rather than lessons learned from the incidents.
- We note the current practice of Governors sitting on, and actively contributing to, committees. We feel that such contribution can lead to a confusion of roles and possible conflict of interest in the Governors' role of holding NEDs to account for their performance.

3.5 KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

3.5.1 Evidence of good practice

- The trust self-assessment is largely positive in this area, with exception of clinical and internal audit processes where there is a disproportionate number of 'not sure' in relation to how these add value in terms of assuring the trust over risks and performance. We do note, however, that the issue of clinical audit was identified within the annual review of the Audit Committee in that there is recognised concerns regarding how the outputs from clinical audit feed into the appropriate committee. Going forward, Audit Committee is seeking to have a closer role in overseeing the development of the programme, programme delivery and outcomes from the clinical audit programme.
- Risk has a high profile on meeting agendas, which are structured along the lines of corporate objectives. This ensures that the respective BAF risks have a high profile and consequent discussion than in many other organisations that we have worked with.
- There is evidence of frequent updating of risks, with new ones coming onto the register and other risks being closed down.
- As mentioned earlier, the trust has a strong compliance driven culture, ensuing that processes are in place and that the organisation focuses on the presence of controls to give assurance.

- Balanced scorecard in place to support business unit performance meetings.
- Our observed practice evidenced effective escalation of concerns and risks to the board. This included the Finance & Performance Committee escalating its concern over the increasing risk over financial outturn and this being the subject of a board part 2 agenda the following month.

3.5.2 Areas to strengthen

- One area to focus on would be to move beyond the strong compliance driven culture to not only focus on the presence of controls, but also the effectiveness of them. This would move the trust beyond acceptance of the processes for assurance – a 'tick box' culture – to a 'so what' culture.
- Whilst we note clear evidence of risk management processes and paper trail, there is a lack of evidence of impact of discussion on risk. Risk discussion is often at too detailed a level for board/committee discussions, possibly due to the small size of the trust. This needs reframing to a more strategic level and will most likely lessen the level of detail currently being provided, but provide for clearer, more structured discussion.
- Observation and review of minutes indicates an adequate level of discussion on BAF and Risk Register related agenda items at Committees, but minimal discussion at Board on such matters. Discussions generally result in unclear outcomes re the management of risk or of risks driving decisions.
- The format of the BAF pages appear confused, as they mix controls and gaps with controls and assurances – little sense of what the risk is, what is being done about it, and what is still to be done.
- Feedback from NHSI on the inadequate processes underpinning the ability to meet RTT and cancer 62-day standards shows areas for improvement.
- From the trust self-assessment, document review and 1:1 meetings, it is clear that the trust needs to strengthen its integrated reporting. One such simple suggestion is to utilise existing but summarised balanced scorecards from performance meetings at board/committee meetings to help improve integrated reporting and show performance across the domains. This is additional to the current portfolio based reports.
- The trust financial position was escalated by the Finance and Performance Committee to a private board session. Having been identified as a key risk and worthy of escalation and focus as a single agenda item private board session, the response was inadequate in terms of content, quality and comprehensiveness and did not provide sufficient assurance to the board. There is a need for better quality board papers that adequately address the board's concerns, provide appropriate assurances and allow for informed discussion. Furthermore, should board or committee papers fall short of the above requirements there is a need for board members to challenge this and ensure that future papers are fit for purpose and allow the board to discharge their duties. Assigning a level of assurance to each agenda item following debate would help crystallise any such concerns.

3.6 KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

3.6.1 Evidence of good practice

- Data quality was not identified as a significant issue via either the trust self-assessment or through our interactions with trust staff as part of this review.
- There is a flexibility in the agenda that allows the board to focus on the areas of greatest need, e.g. getting an appropriate balance of conversation on quality and financial matters

- Review of board and committee agendas identifies that they receive and discuss information covering quality, operations and finance, with each committee's particular focus being relevant to its terms of reference.
- A balanced scorecard approach to performance information relating to quality, performance, finance and staffing is routinely used to hold business units to account.
- External stakeholders confirmed that the trust submits its external reporting requirements on time.
- The board and its committees appear sighted on material matters including the non-compliant RTT and cancer target trajectories.

3.6.2 Areas to strengthen

- External stakeholders raised concerns about the manual recording of information to monitor achievement of the cancer target. Manual systems are inherently susceptible to inaccuracy and manipulation, and therefore the automation of such processes should be seen as a priority by the trust.
- There was mixed feedback on the trust self-assessment with concern regarding the holistic nature of reporting that could inhibit a more generative discussion on quality and sustainability.
- Whilst the trust appears to have adequate data to manage its day-to-day functions, there is a clear appetite within various levels of the trust for better information rather than data reporting.
- The trust does not have a fully functioning Service Line Reporting function which is routinely used to aid decision making.
- Board and committee reporting would benefit from strengthening in the areas of trends, benchmarks, forecasts, trajectories and clear management actions which are capable of holding to account those tasked with implementation.

3.7 KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

3.7.1 Evidence of good practice

- The trust self-assessment indicates general satisfaction with engagement, albeit with less confidence surrounding the area of staff engagement, which fits with the evidence from the most recent staff survey. That said, there are numerous activities that Board members undertake to 'hear the voice' of staff including staff briefings, CEO attendance at team meetings, monthly Chair and CEO breakfast/afternoon tea meetings and attendance at staff induction meetings.
- External stakeholders generally spoke very highly of the relationships with QVH and how the trust actively engages with them.
- New management is seen to be engaging positively in system discussions.
- The trust board, its committees and senior clinical forums regularly receive incidents and complaints data.
- Review of board private sessions suggest that minimal amount of business is conducted in private session and when this happens it is appropriate to do so.
- Review of documentation and observations demonstrate that Governors are enabled to hold the non-executive directors individually and collectively to account for the performance of the board and to represent the interests of NHS foundation trust members and of the public.

3.7.2 Areas to strengthen

- The trust should consider the introduction of a formal engagement strategy and implementation plan encompassing all relevant stakeholders to ensure considered and proportionate coverage and engagement is maintained. The trust also needs to consider how it ensures that the outcome of engagement activities is formally fed into the board to help triangulate against other information received.

- Equally, the trust should consider introducing a more formalised process of environmental scanning to ensure that the board is well sighted on wider system changes, external expectations and the national direction of travel, and how such things will impact on QVH.
- In the 2016 staff survey (latest published available) the staff engagement score has reduced to 3.87 from 4.01 the previous year and is now below the national average for specialist trusts which is 3.98.
- The absence of a formal board engagement plan and evidence of the whole board not engaging with staff on a regular basis needs attention, since feedback from such activities is an integral part of the assurance processes.
- In addition to the good practice staff engagement activities referred to above, there is a need for the whole board (particularly NEDs) to be more visible outside of the boardroom in order to triangulate what is being said and written within board and committee meetings.

3.8 KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

3.8.1 Evidence of good practice

- *Leading the Way* management development programme is evidence of investment in staff development for a cohort of staff.
- As a specialist trust, there is evidence of clinical innovation in leading edge/world class delivery.
- A further example of investment in technology is that the trust has invested in mobile technology to reduce prescription errors.
- The trust actively engages in the burns network and specialist hospitals network to support its learning, continuous improvement and sustainability.
- General levels of staff appraisals are fairly high, albeit below the trust's own stretch target.

3.8.2 Areas to strengthen

- The trust self-assessment recognises the current capacity gap surrounding areas of continuous learning, improvement methodologies and team reflective practice. *Leading the Way* is a good example of investing in managerial staff and equipping them to fulfil their duties and responsibilities. However, there is the need to introduce standardised improvement methodologies for all staff within the trust.
- Equally, from our review and interaction with senior leaders, there is growing recognition that whilst the trust has responded to the never events – including sharing the outcome from the root cause analysis and learning at a joint hospital governance meeting and the appointment of a deputy theatres leader with a specific safety remit – there remains an overall need to ensure that a cultural shift is overseen and embedded to minimise the risk of such an event happening again.
- Our review has identified a lack of cross-organisational and learning opportunities with a preponderance for individuals to focus at business unit level which hampers cross-organisational learning opportunities. The trust should consider how it further encourages and supports such opportunities and embed these as normal practices within its governance processes.
- There is a need to foster more team-based problem-solving approaches.
- Whilst the trust has a recruitment and retention strategy to address workforce issues, it may be helpful to set out a training and development strategy or policy so that clinical staff can better understand the career development opportunities open to them and how they might access them. This appears particularly relevant for Band 5 nurses, and if more can be done to provide additional opportunities this might lead to improved retention of this staff group.
- The quality of non-mandatory training, learning and development is one of the trust's bottom 5 lowest ranked scores in the 2016 staff survey.

4 RAG Rating

Following the detailed feedback against each individual KLoE in Section 3, we set out below a summary of the RAG rating given to each KLoE. Whilst there is no requirement to 'score' the Well-led review, we believe that there is merit in doing so in line with the current regulatory approach. From our experience, trusts have welcomed the transparency that the old Well-Led Framework RAG rating provided, along with a translation into the current overall assessment criteria in use by the CQC.

4.1 Risk scoring criteria

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions
Amber-Green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-Red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver

The above constitutes an established and recognised form of scoring and is a methodology that boards themselves are generally familiar with, and allows a consistency and continuation of scoring which enables easy comparison with previous and/or future reviews to be made and, therefore, shows where progress is being made.

4.2 Summary RAG rating for each KLoE

	KLoE	RAG
1.	Leadership capability and capacity	
2.	Vision and Strategy	
3.	Culture	
4.	Responsibilities, roles and systems of accountability	
5.	Processes for managing risk, issues and performance	
6.	Information	
7.	People, public, staff and external partners	
8.	Learning, improvement and innovations	

The above essentially brackets the priority areas into three groups with **leadership, strategy and culture** as the key areas of focus resulting from our review. These are followed by **accountability and risk/performance management and innovation**. Finally, **information and engagement** still require focus and improvement actions, but these are seen as a lower order priority in terms of greatest impact on delivering impactful improvements for the trust.

5 Recommendations

We have set out below the ten most impactful recommendations which have resulted from our findings. These are not all of the possible actions that the trust could implement to respond to each of the areas for strengthening set out within each KloE in Section 3, and for which the trust should read through and develop a more detailed action plan. We have set out the 'Top 10' to ensure focus and priority is given to these in a 'less is more' approach which echoes a number of our findings within this review, whereby we feel that the trust can, on occasions, lose itself in the detail rather than focus on the key issues – hence, we do not wish to be guilty of what we are elucidating to the trust.

5.1 'Top 10'

1. Finalise development of the medium-term **strategy** and associated underpinning strategies along with an options appraisal which delivers safe, sustainable care, compliant with current and known future requirements and aligns with the STP in the longer term. These should include SMART objectives and timelines that realistically show how it will be delivered.
2. Development of an **OD strategy** to support the above activities and the existing Workforce and Engagement Plan' and to help with staff retention and fostering a culture of self-learning and improvement.
3. **NED challenge** to be strengthened via assurance-based reports which incorporate forward looking actions, timelines and improvement trajectories which facilitate holding to account.
4. Review the current focus on compliance with a view to developing a more devolved **framework of accountability** that creates and promotes an environment for learning and continuous improvement at individual and team levels whilst also clarifying and improving the organisation's ability to hold both individuals and teams to account.
5. Development of a board **stakeholder engagement plan** which will better connect the board to the trust, to triangulate evidence and also raise its profile with external stakeholders.
6. Consider a **triumvirate management model** which develops buy-in from medical staff for their corporate role and invest in management teams to operate effectively in their role.
7. Review the provision of **information** to the board to provide greater insight and forward look including refinement of the BAF and CRR to aid clarity of understanding of risk, controls and assurances and support risk-based discussion focused on risk management not just risks themselves.
8. Deployment of a **continuous improvement methodology** to facilitate innovation and learning.
9. Development of a realistic but aspirational **plan** which returns the trust to regulatory compliance across all operational and financial targets.
10. Review the role of **Governors** on committees to avoid possible conflicts of interest.

Appendix – Contacts Listing

QVH contacts

Consultation With…	How
Jo Thomas, Director of Nursing	1:1 Meeting
Hilary Saunders, Deputy Company Secretary	1:1 Meeting
Sharon Jones, Director of Operations	1:1 Meeting
Senior Nurse meeting	Observation
Senior Nurse meeting focus group	Focus Group
Andi Heaton, FTSU Guardian	1:1 Meeting
Nicolle Ferguson, Patient Experience Manager	1:1 Meeting
John Thornton, Senior Independent Director	1:1 Meeting
Ed Pickles, Medical Director	1:1 Meeting
Governor focus group	Focus Group
Gary Needle, Non-Executive Director	1:1 Meeting
John Belsey, Lead Governor	1:1 Meeting
Elin Richardson, Associate Director of Business Development	1:1 Meeting
Jason McIntyre, Acting Director of Finance	1:1 Meeting
Steve Jenkin, Chief Executive	Conference Call
Beryl Hobson, Chair	1:1 Meeting
Finance & Performance Committee	Observation
Quality & Governance Committee	Observation
Ginny Colwell, Non-Executive Director	1:1 Meeting
Board of Directors	Observation
Kevin Gould, Non-Executive director	1:1 Meeting
Clare Pirie, Director of Communications & Corporate Affairs	1:1 Meeting
Consultants Meeting	Observation
Joint Hospital Governance Committee	Observation
Consultant Focus Group	Focus Group
Clinical Governance Committee	Observation
Geraldine Opreshko, Director of Workforce & OD	1:1 Meeting
Damian Lake, Clinical Director and Consultant Ophthalmologist	Conference Call
Hospital Management Team	Focus Group
Staff focus group	Focus Group
EMT	Observation
Council of Governors	Observation
Performance Review Group (all specialties)	Observation

External contacts

Consultation With…	How
FacialPalsy UK – Karen Johnson, Deputy CEO	Conference call
Federation of Specialist Hospitals – Greg Stafford, Director	Conference call
Healthwatch West Sussex – Katrina Broadhill, Service Manager	Conference call
London & SE England Burns Network – Pete Saggers, Network Manager	Conference call
NHS England – Felicity Cox, Director of Commissioning Operations SE	Conference call
NHS Horsham & Mid Sussex CCG – Geraldine Hoban, Accountable Officer	Conference call
NHS Improvement – Paul Bennett, Director of Improvement & Delivery KSS Suzanne Cliffe, Head of Delivery & Improvement KSS	Meeting Meeting
Sussex and East Surrey STP – Bob Alexander, Executive Chair	Conference call

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	03/05/18		**Agenda reference:**	80-18	
Report title:	Self Certification 2018				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Author:	Clare Pirie, Director of communications and corporate affairs				
Appendices	NA				
Executive summary					
Purpose:	The Board is required to self certify that it is assured that it has complied with the NHS Provider Licence and NHS Acts, and has had regard to the NHS Constitution.				
Recommendation:	The Board is asked to **CONFIRM** that:: • It has complied with the NHS provider licence condition • It has has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • It has complied with required governance arrangements (Condition FT4(8)) • It has a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (Condition CoS7(3) over the next financial year but specific factors may cast may doubt on this				
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:	None				
Corporate risk register:	None				
Regulation:	NHS Provider Licence NHS Acts NHS Constitution.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
Next steps:	Publication of self-certification statement to QVH website • G6/CoS7 before 31 May 2018 • FT4 before 30 June 2018				

Report to:	Board of Directors
Meeting date:	3 May 2018
Reference number:	80-18
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
Appendices:	N/A
Report date:	25 April 2018

Self Certification 2018

1. Introduction

1.1. The Board is asked to sign off that it is assured that it has complied with the NHS Provider Licence and NHS Acts, and has had regard to the NHS Constitution.

1.2. NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

2. What is required

2.1. Providers need to self-certify the following after the financial year end:

- That it has complied with the NHS provider licence condition
- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

2.2. It is up to providers how they carry out this process. Any process should ensure that the provider's board understands clearly whether or not the provider can confirm compliance.

3. QVH self certification

3.1 The Board is asked to **confirm** that it supports a compliant self declaration on all items as follows:

3.1.1 Condition G6 requires NHS foundation trusts to have processes and systems that:

a) identify risks to compliance
b) take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

This is set out in section 3.7 of the annual report.

3.1.2 Condition FT4 requires that NHS foundation trusts certify compliance with required governance standards and objectives. This is set out in section 2.2 of the annual report.

3.2 Condition CoS7 only applies to NHS foundation trusts designated as providing commissioner requested services (CRS).

3.3 Commissioner requested services are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

3.4 QVH is commissioned by NHS England to provide the following specialised services which have commissioner requested service designation:

Trauma and Head

- D/06/S/a Specialised Burns Care
- D/10/S/a Specialised Orthopaedics (Adult)
- D/12/S/a Specialised Ophthalmology (Adult)
- D/12/S/b Specialised Ophthalmology (Paediatrics)

Women and Children

- E/02/S/a Paediatric Surgery: Surgery (and Surgical Pathology, Anaesthesia and Pain)

The template requires CRS-designated foundation trusts to select 'confirmed' for one of three declarations about the resources required to provide designated services:

a) the required resources will be available over the next financial year
b) the required resources will be available over the next financial year but specific factors may cast may doubt on this
c) the required resources will not be available over the next financial year.

Required resources include: management resources, financial resources and facilities, personnel, physical and other assets.

Only one declaration should be confirmed (and providers do not need to state the other two are not confirmed). Providers should explain the reasons for the chosen declaration in the free text box provided.

The Director of Finance has recommended that QVH should confirm option b, that is that the required resources will be available over the next financial year but specific factors may cast may doubt on this. The reason for this is that the QVH burns service does not meet the national specification and therefore is in derogation.

3.5 Providers must review whether their governors have received enough training and guidance to carry out their roles. There is no set requirement for this, it is left to the discretion of the trust how this is delivered. In July 2017, arrangements were made for newly appointed governors to join the Trust's two-day induction. In the same month, they were also invited to attend a half day induction programme specifically focusing on their role as governor. In September 2017, the Trust ran a workshop aimed at helping governors understand how they should carry out their main responsibilities of holding the non-executive directors individually and collectively to account for the performance of the Board of Directors, communicating with their member constituencies and the public and transmitting their views to the Board of Directors, and contributing to the development of the Trust's forward plans. At its meeting in January 2018, the Council of Governors carried out its annual review of effectiveness. This included consideration of the training opportunities offered by the Trust

in the previous twelve months. Council was assured that it was meeting its duties and that induction programme, the lead governor system, *Governors' Monthly Update* publication and the AGM/AMM all contribute to this. Compliance with this was confirmed by the Council of Governance at the meeting in April 2018.

4. Recommendation

The Board is asked to **CONFIRM** that:

4.1 It has complied with the NHS provider licence condition

4.2 It has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))

4.3 It has complied with required governance arrangements (Condition FT4(8))

4.4 It has a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (Condition CoS7(3) over the next financial year but specific factors may cast may doubt on this

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	03/05/18		**Agenda reference:**	81-18	
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 21 March 2018				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Purpose:				**Assurance**	
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:	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:	3 May 2018
Reference number:	81-18
Report from:	Kevin Gould, Committee chair
Author:	Kevin Gould, Committee chair
Appendices:	N/A
Report date:	22 April 2018

Audit Committee report
Meeting held on 21 March 2018

1. The committee considered and approved its work programme for 2018-2019, which increases the focus on the Board Assurance Framework for each KSO on a rotating basis, all to be covered annually.

2. The committee received the interim audit report from KPMG. It was noted that some recommendations from the previous year are outstanding and overdue; the committee asked that EMT consider a process to ensure that such recommendation are tracked going forward and progress is reported to the Audit Committee.

3. KPMG raised three recommendations as a result of their interim audit and a further five recommendations relating to their work to date on the quality report. None of these is considered high priority, seven are medium priority, and one is low.

4. The committee received the draft Head of Internal Audit Opinion which reports that “significant assurance can be given that there is a generally sound system of internal control”.

5. The Internal Audit Plan for 2018/19 was considered and approved. It was noted that the plan for later in the year would need to be reviewed and updated to take account of the committee’s comments and emerging themes.

6. Mazars advised that three internal audit reports have been issued since the last meeting. Two are rated “Satisfactory” and no Priority 1 recommendations were raised. The third – on Health & Wellbeing – was unrated but had two Priority 1 recommendations; the committee discussed the recommendations and management responses to this report and asked EMT to ensure the issues raised were included in the development of actions relating to the staff survey and well led review.

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

8. The committee received a report on breaches of Conflict of Interest; there were no breaches reported since the previous meeting. Ongoing improvement in transparency and awareness was noted.

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