Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 5 July 2018

Session in public at 10.00

The Archibald 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: 5 July 2018

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	John Thornton
Non-Executive Directors:	-	Ginny Colwell
	-	Kevin Gould
	-	Gary Needle
Chief Executive:	-	Steve Jenkin
Medical Director	-	Ed Pickles
Director of Nursing	-	Jo Thomas
Director of Finance and Performance	-	Michelle Miles

In full attendance (non-voting):

Director of Operations	-	Abigail Jago
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	I have known David Cowan (of Cowan Architects, East Grinstead) for 20 years	Nil	Nil
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)							
Abigail Jago Director of operations	Nil	Nil		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

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)							
Abigail Jago Director of operations	NA	NA	NA	NA	NA	NA	NA
Geraldine Opreshko Director of HR & OD	NA	NA	NA	NA	NA	NA	NA
Clare Pirie Director of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA
John Belsey Lead governor	NA	NA	NA	NA	NA	NA	NA

NHS
Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 5 July 2018
10:00 – 13:00
The Archibald McIndoe board room, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
97-18	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
98-18	**Patient story** *Jo Thomas, Director of nursing*	*Assurance*	-
99-18	**Draft minutes of the meeting session held in public on 3 May 2018** *Beryl Hobson, Chair*	*Approval*	1
100-18	**Matters arising and actions pending** *Beryl Hobson, Chair*	*Review*	10
101-18	**Chief executive's report (including BAF overview)** *Steve Jenkin, Chief executive*	*Assurance*	14
Key strategic objective 5: organisational excellence			
102-18	**Board assurance framework** *Geraldine Opreshko, Director of workforce & OD*	*Assurance*	20
103-18	**Workforce monthly report** *Geraldine Opreshko, Director of workforce & OD*	*Assurance*	21
104-18	**Staff survey 2017** *Geraldine Opreshko, Director of workforce & OD*	*Assurance*	32
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
105-18	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*Assurance*	44
106-18	**Financial and operational performance assurance report** *John Thornton, Non-Executive Director*	*Assurance*	46
107-18	**Operational performance** *Abigail Jago, Director of operations*	*Assurance*	49

108-18	**Financial performance** *Michelle Miles, Director of finance*	*Assurance*	70
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
109-18	**Board Assurance Framework** *Jo Thomas, Director of nursing* *Ed Pickles, Medical director*	*Assurance*	89
110-18	**Quality and governance assurance report** *Ginny Colwell, Non-executive director and committee chair*	*Assurance*	91
111-18	**Corporate risk register (CRR)** *Jo Thomas, Director of nursing*	*Review*	94
112-18	**Quality and safety report** *Jo Thomas, Director of nursing* *Ed Pickles, Medical director*	*Assurance*	106
Board governance			
113-18	**Audit committee** *Kevin Gould, Chair*	*Assurance*	142
114-18	**Annual review of corporate governance documentation** *Clare Pirie, Director of communications and corporate affairs, and* *Michelle Miles, Director of finance*	*Approval*	144
115-18	**Board-level governance: engagement with governors** *Clare Pirie, Director of communications and corporate affairs*	*Approval*	152
Any other business (by application to the Chair)			
116-18	*Beryl Hobson, Chair*	*Discussion*	-
Questions from members of the public			
117-18	*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.* *Beryl Hobson, Chair*	*Discussion*	-

Motion to exclude the press and members of the public			
118-18	*Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss confidential information concerning the trust's corporate governance* *Beryl Hobson, Chair*	*To note*	-
119-18	**Observations and feedback** *Led by Kevin Gould, non-executive director*	*Discussion*	-

Date of the next meetings		
Board of Directors: **Public**: 6 Sept 2018 at 10:00	**Sub-Committees** **F&P:** 23 July 2018 **Q&G:** 16 August 2018 **Charity:** 13 September 2018 **Audit**: 19 September 2018	**Council of Governors** **Public**: 30 July 2018 at 16:00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 3 May 2018, 09:00 – 13:00, Archibald McIndoe board room, QVH site**	
Present:	Beryl Hobson, (BH)	Trust chair (voting)
	Ginny Colwell (GC)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Mark Henry (MH)	Interim Director of service improvement (non-voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Rachel Liebmann (RL)	Deputy medical director (voting)
	Michelle Miles (MM)	Director of finance (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Geraldine Opreshko (GO)	Director of workforce and organisational development (non-voting)
	Clare Pirie (CP)	Director of communications and corporate affairs (non-voting)
	Jo Thomas (JMT)	Director of nursing (voting)
	John Thornton (JT)	Non-executive director (voting)
In attendance:	John Belsey (JEB)	Lead governor
	Hilary Saunders (HS)	Deputy company secretary
Apologies:	Ed Pickles (EP)	Medical director (voting)

Welcome

59-18	**Welcome, apologies and declarations of interest** The Chair opened the meeting and welcomed Mark Henry, interim director of service improvement and Rachael Liebmann, deputy medical director who was attending on behalf of EP. She went on to welcome four members of the public, including three public governors, noting that in the recent uncontested public governor election, Chris Halloway would be returning to the Council for a second term. The Chair advised it had been necessary to increase the time of today's public session to accommodate the longer than usual agenda, but assured the board that this would not become a regular occurrence. There was no patient story this month. There were no additional declarations of interest. Apologies were noted as above.

Standing items

60-18	**Draft minutes of the meeting session held in public on 1 March 2018** The minutes of the meeting held in public on 1 March were **APPROVED** as a correct record.
61-18	**Matters arising and actions pending** The Board received and approved the current record of matters arising and actions pending.
62-18	**Chief executive's report, including Board Assurance Framework (BAF) overview** SJ presented his regular report to the board. This included the BAF overview and an update on external issues which could impact on our ability to achieve the internal targets. In particular he asked the board to note: • The Trust had met its control total. It had also earned a £1.2m incentive bonus from the NHS Improvement General Fund. SJ commended the work of the Finance team and reported the positive feedback received from NHSI at the recent system assurance meeting; • A reminder that, later on today, the board would receive a presentation from Peter Kennedy (NHSI

	Intensive Support Team), following a review of the Trust's systems and processes, • The fantastic achievement of the research and development team; • The work of the Communications and corporate affairs team whose efforts continued to raise the profile of QVH. The board deliberated on the contents of the report, seeking clarification in respect of the following: • Sustainable Transformation Partnership governance arrangements, with confirmation that these would be presented to the board in July for approval **[Action: SJ]** • That there was only limited potential for developing synergies between the QVH research team and Imperial College at this stage. However, QVH was currently discussing with the Imperial War Museum the possibility of incorporating a selection of QVH 'guinea-pig' stories into its World War II display; • How the £1.2m incentive bonus would be invested. MM advised that this was restricted to capital items, and would support the Trust's current backlog maintenance programme. The board sought and received assurance that the Trust's capital programme would be appropriately managed to achieve plan in 2018/19; Members of the board who had not attended the recent System Assurance Meeting asked for a recap. SJ summarised the discussion, and it was noted that this could be a useful forum to develop work around burns and derogation. Following the update, the board asked that thanks be conveyed to the Finance, Research and development, and Corporate affairs teams. There were no further comments, and the board **NOTED** the contents of the Chief Executive's report.
63-18	**Freedom to speak up (FTSU)** SJ presented a paper written by the FTSU guardian, the purpose of which was to provide an update on the guardian role and associated activity since the last report in March. Of the themes recorded in the 12 months since the role had been established, it was noted by the board that 'bullying / unacceptable behaviour from management' had been raised the most times. This reflected the results of the 2017 staff survey and the board asked what actions were being taken to address this. Members were advised that because QVH was such a small trust it was difficult to provide additional detail without attributing incidents to specific areas. GO went on to assure the board that in cases where several 'speak ups' had been reported within a particular team, significant investigations were already underway. The board was also reminded that once the staff survey had been fully disseminated, the FTSU guardian and GO would be working together to review areas of high staff dissatisfaction and/or turnover in order to focus proactively on the relevant department. Additional guidance had recently been published by NHS Improvement to help boards identify areas for development and improve the effectiveness of leadership and governance arrangements in relation to Freedom to Speak Up. CP and GO would review the guidance and make recommendations to the board before its next meeting. **[Action: GO]** The board **NOTED** the contents of the report, whilst recognising that the request for a designated meeting space for use by the FTSU guardian was within the remit of the Chief executive. There were no further comments.

Key strategic objective 1: outstanding patient experience	
64-18	**Board assurance framework** JMT provided a brief update on the latest BAF for KSO1, asking the board to note that there was no change to the scores this month. The board sought clarification with regard to the status of the full estates strategy and development control plan. MM assured the board that she was reviewing this with SJ and it would be returned to the board for further discussion. **[Action: MM]**
65-18	**Corporate risk register** The JMT presented a report on the latest corporate risk register, asking the board to note that three new risks had been added, two re-scored and one closed since this was last reviewed at board. The board queried whether the score for risk 1077 (recruitment and retention in theatres) was appropriate given the severity of the current staffing situation and its impact on all five of the trust's key strategy objectives. It was agreed that the executive management team should review all risks relating to recruitment and retention to ensure consistent scoring and an appropriate reflection of the overall situation. **[Action: JMT]** The board was reminded that, following the recent board risk management workshop and in line with recommendations from the Well Led review, work was also underway to review definitions/draft a heat map for current and residual risk ratings. **[Action: JMT]** In addition, the executive team was undertaking a refresh of the BAF, to include reference to risk appetite. This would be returned to the board for approval **[Action: JMT]** There were no further questions and the board **NOTED** the contents of the latest update.
66-18	**Quality and governance committee assurance report** As chair of the Q&GC, GC presented an assurance report following the meeting held on 19 April. She drew particular attention to the Committee's amended terms of reference which had been updated to reflect the change in Authority: Any concerns directly relating to 'Whistleblowing' would in future be discussed at the private section of the Board, or escalated to the Accountable Officer. The board **NOTED** the change and **APPROVED** the amendment. GC advised that the committee felt good progress was being made by theatre teams in improving the consistency of the use of the WHO checklist. RL asked if she could be included in future circulation of Q&GC minutes. **[Action: JMT]** The board asked for additional clarification regarding the formal audit to review the future of PEG insertions at the Trust. It was confirmed that this would be an internal exercise undertaken by the clinical audit team; a final decision was still to be made. There were no further questions and the board **NOTED** the contents of the assurance report.
67-18	**Quality and safety report** JMT presented the quality and safety report. Its purpose was to provide assurance that the quality of care at the trust was safe, effective, responsive, caring and well led. The board was asked to note that this report included revised metrics covering all clinical inpatient wards and outpatient departments, in addition to a more concise summary of complaints and patient experience. JMT assured the board that patient experience was reviewed as a measure of safety and quality, and

	triangulation of data had not indicated any significant early warning signs despite challenges with staffing. The board considered the report, seeking additional clarification and assurance for the following: • The status of the recent Facebook recruitment campaign which had been launched to specifically target specialist nursing staff. A formal evaluation would be undertaken in due course and reported back through the Finance and performance committee **[Action: GO]** • The board noted that the report made reference to a ward matron who had been encouraging doctors to work in a more proactive way. The board queried whether this was a cultural issue and why the doctors needed to be encouraged. It was recognised that clinical directors should take overall responsibility for leadership. • The board asked how assurance could be gained within burns and critical care, given the infrequency of Compliance in Practice visits in this area over the last 12 months. JMT agreed to investigate why there may have been a decline and report back **[Action: JMT]** • The board raised concerns regarding the increasing vacancy rate for unqualified nursing staff, and questioned its impact. JMT advised that unusually the Trust was currently using agency staff for this cohort. CP advised that the recent Facebook recruitment campaign had attracted interest in this area through social media. GO confirmed work was underway to match enquiries with current vacancies. The Lead governor sought and received additional clarification regarding staffing on Peanut Ward which had been revised to prioritise staffing of day shifts. Whilst there had been no negative impact attributed to closure of the ward at night, the Trust was cognisant of patient experience for children referred to other burns units. The board went on to commend the format of the new report, in particular the way in which metrics relating to never events were now presented. It was agreed this maintained a focus whilst providing assurance of continuing improvement in culture. There were no further questions and the board **NOTED** the contents of the update.
68-18	**Bi-annual nursing workforce review** JMT presented the six-monthly workforce review. This compared staff levels at QVH against national guidance. It also focused on key actions being taken to address the recruitment and retention challenges for nursing, and operating department and health care assistants The board commended the report for its comprehensiveness. It was noted that there appeared to be more day cases than inpatients and the board sought assurance that staff were able to flex to the needs of the service. JMT confirmed that this was well managed, but relied heavily on the goodwill of staff. The board asked about the impact of the recent 'refer a friend' recruitment initiative. No payments had been made to date, but the situation was being monitored. The board questioned the metric relating to 'recommendation of the organisation as a place to work or receive treatment'. Whilst the overall score in the staff survey was consolidated, the board felt it would be more helpful to separate out the two to reflect the current disparity that a much lower percentage of staff would recommend QVH as a place to work than to receive treatment. There were no further questions and the board **NOTED** the contents of the report.

69-18	**National inpatient survey results** JMT presented the executive summary of the 2017 Picker Inpatient survey. The full report had previously been reviewed at the Quality and governance committee and circulated to all members of the board. Compared to other trusts surveyed by Picker, QVH was significantly better on 57 questions, significantly worse on one question and on a level with four questions. Although QVH had made considerable improvements against its own targets, Picker results showed that the Trust remained significantly worse on the choice of food being offered. MM advised that work was continuing to improve this. There had also been a significant increase in the percentage of patients stating there was insufficient support from health or social care professionals at the point of discharge. This was something over which the Trust had limited control, and was under review by commissioners. There were no further questions and the board **NOTED** the contents of the report.
Key strategic objective 2: world-class clinical services	
70-18	**Board assurance framework** RL presented the latest BAF for KSO2, noting that there had been no significant changes since the board's last update.
71-18	**Medical director's report** RL presented a report prepared by the Medical director. The board was asked to note in particular: • The newly appointed Darzi leadership fellow would join the Trust shortly, and focus on developing clinical pathways for delivery of paediatric burns dual site services. • Major themes from junior doctor feedback included dissatisfaction with rota and shift patterns in plastics, departmental induction in plastic surgery and access to local teaching; it was likely that the Deanery would visit to measure quality of teaching in plastic surgery. GO confirmed this was now scheduled for September. The board requested that a report on the outcome of the visit be scheduled for the January 2019 board meeting **[Action: EP]** RL queried the relatively low number of job plans signed off to date and asked for this to be followed up by the Workforce team. **[Action: EP]** GO advised this was an issue which had been debated at length by the executive management team (EMT). Prior to full and final sign off, EMT now required evidence that job plans were aligned to productivity. SJ had reinforced the May deadline at recent performance review meetings. The board sought clarification as to how the work of the Theatre productivity group would be aligned to job planning. SJ advised that Ian Francis, Director of clinical strategy had been appointed to chair the group. Job planning would be included as part of the overall programme of activity. The Directors of nursing and operations would also play an integral role in improving productivity. GO explained how supporting professional activities (SPAs) used previously in job planning had lacked transparency, and that annual leave had not been planned around clinical activity. The e-job planning system now in place would address this. The Chair queried the use of the word 'Firms' in the medical director's report and asked that EP provide an alternative description for this. **[Action: EP]**

	There were no further questions and the board **NOTED** the contents of the update.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
72-18	**Board assurance framework** MH noted that the residual risk rating on key strategic outcome KSO 3 (operational excellence), should read 15 not 20. Board members agreed that each KSO would benefit from a rationale for the current and residual scores as shown on KSO 4 (financial stability). In response to a question, MH explained that QVH does not need to run a PAS system at each spoke site but rather that the operational team need to understand how to access relevant and timely data from the PAS system at each spoke site. There is still more work to be done on this and the patient pathways involved.
73-18	**Finance and performance committee assurance report** JT described the considerable work done to ensure that the Trust had a detailed and credible plan for 2018/19; that there was more work to be done to understand how theatres efficiency would be improved; and that workforce remained a considerable challenge. The board discussed what level of assurance they had at the end of month 1 that the fundamental business challenges identified were being addressed; noting that there was still significant work to do around job planning, productivity and cost savings. At this stage the board noted the high level of risk to delivery of the plan, and the need for urgency in making changes in order to have an impact in the first quarter.
74-18	**Operational performance** MH explained that the NHS Improvement team were half way through their eight week programme at QVH and had been positively received by staff; the diagnostic target and two week cancer targets had been met although other targets remained a challenge; new staff in key operational performance roles were now getting a grip on waiting list management. MH noted that future reports would benefit from showing trend data rather than snapshots. BH commented that the slides used in the system assurance meeting had given a helpful visual representation of performance. An error was noted in the report figure for weekly average for day cases. Discussion included job planning for doctors which needs to ensure not just clarity about when doctors are working at QVH but alignment with the forward plan for delivery. RL noted that job planning for visiting doctors cannot be done by QVH unilaterally. The Medical director would be asked to take this forward with other trusts involved. **[Action: EP]** Responding to a question about outsourced activity, MH stated that all additional activity is an issue and we need to work to improve efficiency in core hours. The first theatre users group meeting was very positive and new clinical leadership of this group should help to maintain momentum for change. SJ and BH thanked MH for his contribution in this interim role at a very important time.
75-18	**Financial performance** MM explained that although the control total for 2017/18 had been achieved, income for month 12 had been significantly below plan, particularly in oral and plastics. The report set out the items which had enabled the control total to be achieved. The impact of annual leave in month 12 was significant and MM explained that she was working with business units to ensure planned activity for May 2018 reflected booked leave. GO explained that the

	implementation of Health Roster across the Trust would ensure visibility of booked leave as well as un-used hours and other metrics, supporting forward planning. Clear messages to staff about planning and using annual leave will be reinforced, with the policy being that leave in patient-facing areas must be signed off six weeks in advance. The board noted the expectation that clinical directors will support and deliver better planning of annual leave, including signing off leave for consultants in their areas. MM drew attention to apparent over performance against budgeted income in sleep, and explained that in future business plans agreed in year will be reflected in the budget so that performance can be more accurately assessed. In response to a question, MM said that month 1 activity was below plan, and that the finance and performance committee would be looking closely at this and the analysis of impact. RL said that she had received a 'flash report' and thought some training in how to interpret this would be helpful; MM explained that a report was being developed that would give more context and detail at business unit level, supporting accountability and action. It was noted that the mailing list for this report required updating **[Action: MM]**
76-18	**Ratification of 2018/19 business planning process** MM introduced this item talking the board through the cost improvement plans and setting out the importance this year of removing cost, not relying on increased income. At the system assurance meeting held at QVH earlier in the week NHS Improvement had made clear that the Trust would be funded for work done to reduce the waiting list, and the 2018/19 plan includes an additional £3m of income to achieve this but there remained a risk to QVH's capacity to deliver this work. In response to a question, MM confirmed that she was confident everything that should be capitalised had been. This plan was approved by the finance and performance sub-committee of the Board, with delegated authority. The Board ratified that approval.
Key strategic objective 5: organisational excellence	
77-18	**Board assurance framework** GO asked the board to note that the residual risk rating for KSO5 had been increased from 16 to 20.
78-18	**Workforce monthly report** GO presented a report which provided an update on key workforce indicators and information linked to performance; she noted that this had previously been reviewed by the Finance and performance committee at its meeting in April. In response to media reports of overseas clinical staff being denied visas by the Home Office, the board asked what impact this might have on the Trust. GO reported that this affected doctors more than nursing staff which was the key concern at present. She continued by apprising the board on proposals to collaborate with other trusts to recruit specialist nurses from overseas. The board raised concerns regarding sickness levels which had significantly deteriorated during the second half of the year. GO concurred that QVH generally reported low sickness rates but the impact of long term vacancies correlated directly with the higher levels of sickness. The board asked that this be carefully monitored through the Finance and performance committee **[Action: GO]** Whilst previously junior staff had been tasked with monitoring consultant annual leave, the board was assured that clinical directors would now authorise all requests to ensure minimum impact on activity. The board reviewed the evaluation report on the Leading the Way management development

	programme. It was noted that the improvement around management and leadership behaviours shown in the latest staff survey could be directly correlated to this programme. GO advised that an application for external funding to support continuation of the programme had been successful. SJ asked if there had been many management promotions within the Trust since the programme started. GO conceded that there were limited opportunities at QVH, however there could be potential for staff development within the wider STP. There were no further questions and the board **NOTED** the contents of the report.
Board governance	
79-18	**Leadership and governance developmental review** CP presented the final report resulting from the Trust's recent Well Led review. The review was now complete and in each of the eight key lines of enquiry QVH had demonstrated areas of good practice. Whilst there were also areas for improvement, there were no material issues of concern. In line with national guidance, the Chair had now written to NHS Improvement confirming this. The report included an action plan setting out the top ten recommendations from the review. CP asked the board to note that whilst several of these already formed part of existing work programmes, others would be reliant on additional funding and management resource. Discussing the recommendation to develop a stakeholder engagement plan, the board recognised that members already engaged with staff in a wide variety of ways although this was not formally captured. However, a lack of engagement correlated to the staff survey results and so should be made a priority. It was not felt that the organisation's current structure would support a triumvirate management model, and it may be necessary to review the existing directorates to achieve this. The board acknowledged that accountability for enhancing current board reports lay with the individual executive. Discussions focused on the merits of adding timescales to each action to enable progress to be tracked. It was agreed that timescales and monitoring of actions would be circulated to board members before the July board meeting. If required, an additional review could be scheduled in December.**[Action: CP]** There were no further comments, and the board **NOTED** the findings of the review.
80-18	**QVH self-certification 2018** CP reminded the board that it was required to make an annual declaration that it had complied with the NHS Provider Licence and NHS Acts, and had shown regard to the NHS Constitution. The board discussed the available evidence which would demonstrate it had taken all precautions necessary for compliance. CP reminded NEDs that in line with requirements, this item had also been considered in depth at the recent Council of Governors meeting. It was agreed that the draft minute from this discussion would be circulated to provide any additional clarification. **[Action: CP]** After due consideration, the board confirmed that: • It had complied with the NHS provider licence condition • It had taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • It had complied with required governance arrangements (Condition FT4(8))

	• It had 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
81-18	**Audit committee** The board received the assurance report in relation to matters discussed at the Audit committee meeting on 21 March 2018. There were no questions and the board **NOTED** the contents of the update.
82-18	**Board of director annual declarations** CP asked the board to note that the register of annual declarations of interest, including the Fit and proper test, had been completed for the current financial year.
Any other business	
83-18	There was none.
Questions from members of the public	
84-18	There were none.

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	June 2018	90-18	Operational plan	Trust annual plan	Board to be kept updated of progress and copied into all relevant correspondence to NHSI	MM	July		Pending
2	May 2018	62-18	Chief Executive's report	Standing items	STP governance arrangements to be presented to the board in July for approval	SJ	~~July~~ Sept	~~On July agenda~~ On Sept agenda pending local authority input	On Sept agenda
3	May 2018	63-18	FTSU	Standing items	NHSI guidance for boards to be reviewed and recommendations to be presented to board	GO	July	**15.05.18** Following consideration of guidance, email was circulated by CP to BoD advising of recommendations.	Closed
4	May 2018	64-18	BAF	KSO1	Status update of estates strategy and development control plan to be brought to board.	MM	July	On July agenda (commercial in confidence)	On July agenda
5	May 2018	65-18	CRR	KSO1	EMT to review all risks relating to recruitment and retention to ensure consistent scoring and an appropriate reflection of situation.	JMT	July	**25 06 18** Executive team reviewed.	Closed
6	May 2018	65-18	CRR	KSO1	Review of definitions/development of heat map for current and residual risk ratings.	JMT	~~July~~ Sept	**11 06 18** Moved to September agenda to enable risk management to be considered as a whole	On Sept agenda
7	May 2018	65-18	CRR	KSO1	EMT to undertake refresh of BAF, include risk appetite and return to board for approval	JMT	~~July~~ Sept	**11 06 18** Moved to September agenda to enable risk management to be considered as a whole BAF review due for completion August 2018	On Sept agenda
8	May 2018	67-18	Quality and safety	KSO1	Evaluation of facebook recruitment initiative to be undertaken and reported back to BoD (via F&PC)	GO	Sept	To be included as part of overall review of recruitment and retention report	On Sept agenda
9	May 2018	67-18	Quality and safety	KSO1	Investigation into frequency of CiP visits in burns and critical care	JMT	July	Confirmation that CIP visits are 3-monthly, as with all clinical areas	Closed
10	May 2018	71-18	MD report	KSO2	Outcome of forthcoming Deanery visit to be reported back to board	EP	Jan 19	Feedback scheduled for January 2019 BoD	On January 2019 agenda
11	May 2018	71-18	MD report	KSO2	Outstanding job plans to be followed up	EP	July		Pending

12	May 2018	71-18	MD report	KSO2	Board to be apprised of alternative definition of 'Firms' used in May board report	EP	July	Before the introduction of the European Working Time Directive and a shift system of junior doctors working replaced the old resident on-call system, junior doctors (particularly in surgery) worked in 'Firms', A firm was traditionally led by a one consultant, with a registrar, SHO and house officer connected specifically to that consultant for a period of time. They were responsible for looking after the patients of that consultant. This provided continuity of care and generally a close working relationship between the doctors of a firm, with educational and assessment continuity. The move to a maximum 13 hour shift and capped working hours of 48 hours / week changed the ability to work in firms. The QVH is attempting to regain the team structure associated with firms, so that educational advantages can be maximised.	**Closed**
13	May 2018	72-18	BAF	KSO3	Review of rationale for all current and residual scores (as reflected in current KSO4 BAF)	**All**	July	**18 06 18** All executive leads have now updated the BAFs	**Closed**
14	May 2018	74-18	Operational performance	KSO3	As job planning for visiting doctors cannot be done by QVH unilaterally, the medical director will be asked to take this forward with other trusts involved.	EP	July	The QVH should be responsible for job planning of a doctor for the time they are employed at the QVH, either through direct employment or SLA, and we would plan to do this on our systems. The doctor should be sharing this information with their predominant employer to ensure that their total job plan is manageable, without conflict of interest, and that enough time is allocated for supporting professional development and quality improvement.	**Closed**
15	May 2018	75-18	Finance	KSO4	Mailing list for financial 'flash report' to be updated	MM	ASAP	**15 05 18** Updated as requested	**Closed**
16	May 2018	78-18	Workforce	KSO5	Given recent significant deterioration, staff absence to be closely monitored through F&PC	GO	June	**25 06 18** Covered at June F&PC	**Closed**

17	May 2018	79-18	Leadership & governance developmental review	Board governance	Timescales and monitoring of actions to be shared with board members.	CP	July	Circulated to board members by email.	**Closed**
18	May 2018	80-18	QVH self certification	Board governance	Draft minute from April CoG to be circulated to provide additional clarification	CP	ASAP	**04 05 18** Circulated to BoD	**Closed**
19	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	**03 05 18** Not practical to obtain data from neighbouring trusts; however, more meaningful data is available through 6-monthly nursing workforce reports. In addition, STP priority to develop workforce plan across south east which will be more relevant.	**Closed**
20	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		**On Sept agenda**
21	March 2018	45-18	Medical Director's report	KSO2	Members of Clinical Research department to be invited to present at future Board seminar	EP	July	Provisionally booked for October board seminar; pending confirmation from EP	**Pending**
22	March 2018	48-18	Operational performance	KSO3	Revised trajectories to be prepared for F&PC, setting out worst case/good case/best case scenarios	~~SLJ~~ ~~MH~~ AJ	July	**03 05 18** Still ongoing. Reviewed at EMT and will be presented to F&PC in July	**Pending**

23	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). **03 05 18** Q&GC ToRs approved at board to reflect change in process	**Closed**
24	January 2018	23-18	Board governance	Board development	Proposals for further development opportunities to be considered following results of well-led review	CP	~~May~~ July	Suggestions were invited from Board members and this is now being managed on an ongoing basis. The next development item scheduled is a session on bribery to be delivered by our counter fraud lead in October.	**Closed**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/07/2018**		**Agenda reference:**	**101-18**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	BAF overview				
Executive summary					
Purpose of report:	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.				
Summary of key issues	• NHS celebrates its 70th birthday • CQC Adult in-patient survey found 8 Trusts including QVH categorised with the highest band, identified as 'much better than expected' • Re-submission of operating annual plan 2018/19 to NHSI				
Recommendation	For the Board to **NOTE** the report				
Action required				**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:	External issues will be considered as part of the BAF 'horizon scanning' section				
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date	25/06/18	Decision:	Review BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
JULY 2018

HAPPY BIRTHDAY NHS

Today the National Health Service is 70. It's the perfect opportunity to celebrate the achievements of one of the nation's most loved institutions, to appreciate the vital role the service plays in our lives, and to recognise and thank the extraordinary NHS staff – the everyday heroes – who are there to guide, support and care for us, day in, day out.

TRUST ISSUES

Care Quality Commission – 2017 Adult Inpatient Survey

The 2017 adult inpatient survey received feedback from 72,778 patients who received care in 148 NHS acute and NHS foundation trusts during July 2017. Each trust has been assigned one of five bands: 'much worse than expected', 'worse than expected'. 'about the same', 'better than expected', or 'much better than expected'.

Eight acute trusts were classed as 'much better than expected' in 2017 including QVH as shown below:

Trusts achieving 'much better than expected' results

Eight acute trusts were classed as 'much better than expected' in 2017. Six of these had the same banding in 2016, demonstrating consistently high levels of positive patient experience. Seven of these trusts are classed as specialist trusts.

	Historic results	Overall results				Core service		Overall CQC rating
	2016	2017	Most Negative (%)	Middle (%)[3]	Most Positive (%)	Medical care	Surgery	
Trust average			13	18	69			
The Christie NHS Foundation Trust	MB	MB	9	14	78	MB	B	O
The Clatterbridge Cancer Centre NHS Foundation Trust	MB	MB	7	12	81	MB	N/A	O
Liverpool Heart and Chest Hospital NHS Foundation Trust	MB	MB	8	12	80	MB	B	O
Papworth Hospital NHS Foundation Trust	B	MB	8	12	79	MB	S	G
Queen Victoria Hospital NHS Foundation Trust	MB	MB	8	12	80	MB	MB	G
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	MB	MB	7	12	81	MB	MB	RI
The Royal Marsden NHS Foundation Trust	MB	MB	7	12	81	MB	MB	G
The Royal Orthopaedic Hospital NHS Foundation Trust	S	MB	8	14	80	N/A	B	RI

Key: Trust performance - About the same (S) | Better (B) | Much better (MB)

CQC rating - Inadequate (I) | Requires Improvement (RI) | Good (G) | Outstanding (O)

[3] Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. For example, 'yes, sometimes' is the middle option (scored as 5/10) for the question *'When you had important questions to ask a doctor, did you get answers that you could understand?'*

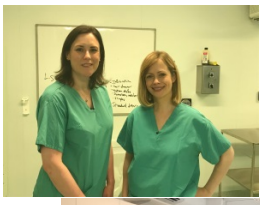
QVH is one of only five acute specialist trusts to have consistently maintained a 'much better than expected' rating over the last four years.

Revised annual operating plan 2018-19
Following an invitation from NHS Improvement, like many Trusts, QVH has re-submitted its operational plan for 2018/19. The plan, with finance, operational performance and workforce appropriately triangulated was approved by a Board teleconference on 19 June.

Staff Engagement

- A number of staff briefings have been held to discuss our collaboration with Brighton and Sussex University Hospital (BSUH) and Western Sussex Hospital Foundation Trust (WSHFT), in particular around paediatric burns and lower limb trauma.
- A charity quiz organised by our fundraiser Camilla Slattery was attended by approximately 10% of our workforce raising in excess of £500 for QVH Charity.
- Following feedback from previous staff briefings, staff members are being consulted on creating a couple of staff health and wellbeing hubs at the hospital.

Media
On Wednesday 4 July, to coincide with the NHS' 70th birthday week, BBC South East Today featured a piece filmed recently at QVH. Polly Evans, the BBC reporter, spent the morning finding out about how QVH's impressive heritage and pioneering techniques in plastic surgery have informed what it does today. She met Nora Nugent (top) consultant plastic surgeon, to find out about how we're treating patients in our burns unit and using treatments like Nexobrid, which is formed from an enzyme found in pineapples; spoke to a patient David who had received the nexobrid treatment and asked about his experience of the NHS; and also chatted to Simon Booth (bottom), burns researcher, about the scar study and how we're playing an important part in trying to make a scar free future a possibility for patients.



Annual Reporting
The annual report, annual accounts and quality report were all submitted on time and once again to a very high standard. The demands of external reporting are significant for a small trust and those involved rose to the challenge with professional publications.

Staff Awards
Nominations are now open for the QVH Staff Awards 2018 including three new categories, which play a role in motivating and rewarding staff with recognised benefits for patients supported by a grant from QVH Charity. The awards ceremony is being held on Thursday 4 October.

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

Recruitment and retention remains one of the most significant challenges facing the NHS and in particular at QVH in theatres and critical care. The trust is embarking on an international recruitment campaign to secure 20 nurses.

SECTOR ISSUES
Sussex & East Surrey Sustainability & Transformation Partnership (STP) – North Place
The North System Improvement Board and the Integrated Care Leadership Executive are to merge with the first reorganised board meeting taking place on the 16th July. The reason for this change is to allow for greater control, visibility and faster decision making for the system, and also promote and support stronger integration for the prioritised areas (and wider system strategic priorities).

The terms of reference for both groups have been reviewed alongside those of leading Integrated Care Systems nationally and the revised and blended approach has been discussed and broadly agreed. The membership of the Board will consist of a CEO for each partner in the North, Financial Director representation and senior clinical leadership.

NATIONAL ISSUES

NHS funding

The Prime Minister recently announced the NHS in England is to get an extra £20bn a year by 2023. It means the £114bn budget will rise by an average of 3.4% annually - although that is still less than the 3.7% average rise the NHS has had since 1948. This long-term funding commitment means the NHS has the opportunity to develop a 10-year plan. The plan will be developed by the NHS, working closely with government and be published later this year. The priorities include:

- getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care
- transforming cancer care so that patient outcomes move towards the very best in Europe
- better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health
- better integration of health and social care, so that care does not suffer when patients are moved between systems
- focusing on the prevention of ill-health, so people live longer, healthier lives

Health and Social Care Secretary, Jeremy Hunt said, "This historic long-term funding boost recognises the superhuman efforts made by staff over the last few years to maintain services in the face of rapidly growing demand. But it also presents a big opportunity for the NHS to write an entirely new chapter in its history."

Health and Social Care Select Committee

The Health and Social Care Select Committee has published the report of its inquiry into 'the development of new integrated ways of planning and delivering local health and care services'. This inquiry focusses on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs).

<u>Summary of key recommendations</u>

- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- DHSC, NHS England (NHSE), NHS Improvement (NHSI), Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC), should develop a joint national transformation strategy setting out how they will support STPs and ICSs.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies, if a decision is taken, following a careful evaluation of pilots, to extend their use. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.

- The greatest risks to accelerating progress are the lack of funding and workforce capacity to design and implement change. The Government must recognise the importance of adequate transformation and capital funding in enabling service change. The long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.

Steve Jenkin
Chief Executive

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 25 June 2018 alongside the corporate risk register. KSO 1 and 2 were reviewed 21 June at the Quality and Governance Committee. A more detailed review of KSO1 and 2 was presented at the Audit Committee 20 June 2018. KSO 3, 4 and 5 were reviewed 25 June at the 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. A paper on risk appetite will be presented at the September 2018 public board meeting. The residual risk has been replaced by the target risk on the BAF.

	Q2 2017/8	Q 3 2017/8	Q 4 2017/8	Q 1 2018/9	Target risk
KSO 1	12	15	15	15	9
KSO 2	12	12	12	12	8
KSO 3	20	20	20	20	15
KSO 4	20	20	20	20	16
KSO 5	16	16	20	20	16

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 19th June 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

Initial Risk	3(C)x 5(L)=15, moderate
Current Risk Rating	4(C)x 5(L)=20, major
Target Risk Rating	4(C)x 5(L) = 20, major

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 of Directors				
Meeting date:	5 July 2018		**Agenda reference:**	103-18	
Report title:	Workforce Report				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	David Hurrell, Deputy Director of Workforce				
Appendices:	None				
Executive summary					
Purpose of report:	The Workforce and OD report for June 2018 (May data) provides the Trust Board with a breakdown of key workforce indicators and information linked to performance.				
Summary of key issues	Ongoing challenges related to turnover and use of temporary staffing				
Recommendation:	The Board is asked to **NOTE** the contents of the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
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:	The challenges are reflected in KSO 5 Organisational Excellence				
Corporate risk register:	A number of risks on the Corporate risk register are specific to workforce challenges and in particular the level of vacancies and use of temporary staffing				
Regulation:	Workforce challenges will be implicit in all 5 domains of the CQC and in particular *are they well led*				
Legal:	No implications				
Resources:	The Workforce and OD team are trying to keep pace with demand and the need to support managers within existing resources				
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	25/06/18	Decision	Noted	
Next steps:					

Queen Victoria Hospital NHS
NHS Foundation Trust

Human Resources & Organisational Development

Workforce Report – June 2018

Reporting Period: May 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 decreased by 4.17wte, finishing at an in month position of 827.24wte. Leavers contributed to this by 7.77wte leaving and 8.43wte starting (excludes medical trainees). Increases in vacancies were seen most in Oral Services (+2.66%), followed by Corporate Services (+1.79%) and Operational Nursing (+0.57%). The vacancy level within Eyes improved by 1.93%, and within Clinical Support by 1.45%.
Turnover Section 3	Trust turnover increased for the seventh consecutive month, from 20.38% to 20.43%, more than the forecasted trajectory. This was prompted by increases in turnover within Oral Services of +3.96%, Corporate Services, of +1.91% and Plastics by 0.73%. Leavers from the Trust notably included 1.41wte qualified nurses / theatre practitioners within Perioperative Services / Critical Care and 1.97wte Medical Secretaries (headcount of 3).
Temporary Staffing Section 4	Total temporary staffing usage across the Trust increased by 12.61wte in month, caused by an increase in agency of 5.03wte and 7.58wte in bank usage. Increases were most notable in qualified nursing (+6.08wte total, 3.9wte of which was agency) and a further 2.03wte of medical agency usage (Plastics). There was a reduction in agency usage within the administration and clerical staff-group (variance of -2.26wte compared to last month), which was replaced with more bank usage to a new total of 30.63wte. Agency usage of health care assistants remains, although recent job offers to HCAs for the Trust bank should address this by July.
Sickness Section 5	Confirmed April sickness information shows a return to normal sickness rates at 2.74%, the seasonal winter peak finishing a month later than forecasted. The most notable change is the reduction in long-term absence occurances, from 1.77% of available working time to 1.11%. Absence rates reduced across all directorate which the exception of Eyes, which was an area that was already low (now at 1.5%). Days lost due to reasons of anxiety/stress/depression/other psychiatric illnesses reduced further, from 164 days to 132 dates lost; however this was the most common occurring reason for absence in month (15.1% of all absences).Staff suffering with gastrointestinal problems accounted for 123 days lost (14% of all absences), with the third highest category remaining as 'other (non-back related) musculoskeletal conditions' which accounted for 117 days lost (13.4%).
Appraisals Section 6	Appraisal compliance figures stayed relatively static, from 81.64% to 82.2%. Compliance gains were seen in Corporate Services (+2.69%), Plastics (+4.67%), plus Director of (+6.06%) and Operational Nursing (4.55%), whereas Eyes (-3.16%) and Sleep (-9.38%) continued a decline, with reductions also seen in Oral (-2.44%) and Clinical Infrastructure (-8.37%).
MAST Section 6	The Trust MAST compliance rates reduced marginally from 90.12% to 89.07%; Trust-wide rates have remained relatively constant since June 2017, fluctuating within 2% for this period. A cancellation report shows that 27% of staff continue to withdraw or do not attend bookings. No areas is currently meeting the Trust 95% target, although 5 directorates (Corporate Services, Clinical Support, Sleep, Director of Nursing and Operational Nursing) are reporting in excess of 90% compliance. Clinical Infrastructure have made some gains (+2.97%) meaning that Oral Services now have the lowest compliance area at 83.44%.

1.3 KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19			May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Compared to Previous Month
Establishment WTE *Note 1				969.76	969.76	969.76	980.46	980.46	955.65	955.65	955.65	955.65	955.65	955.65	955.65	**955.65**	◄►
Staff In Post WTE				834.28	837.51	831.88	840.54	843.26	859.91	856.13	845.60	841.32	838.58	845.26	831.41	**827.24**	▼
Vacancies WTE				135.48	132.25	137.88	139.92	137.20	95.74	99.52	110.05	114.33	117.07	110.39	124.24	128.41	▲
Vacancies %	>12%	8%<>12%	<8%	13.97%	13.64%	14.22%	14.27%	13.99%	10.02%	10.41%	11.52%	11.96%	12.25%	11.55%	13.00%	13.44%	▲
Agency WTE				15.15	17.38	25.64	28.60	28.53	28.12	30.96	26.95	33.76	38.28	42.51	45.58	**50.61**	▲
Bank WTE *Note 2				44.05	48.60	47.60	47.05	42.01	40.40	47.11	40.40	58.13	58.16	65.26	52.24	**59.82**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	17.09%	17.92%	18.98%	18.58%	18.92%	18.22%	18.41%	18.67%	18.87%	19.30%	19.57%	20.38%	**20.43%**	▲
Monthly Turnover				1.08%	2.11%	2.24%	1.02%	1.74%	1.00%	1.56%	1.80%	1.75%	1.47%	1.91%	2.24%	**1.00%**	▼
Stability %	<70%	70%<>85%	>=85%	99.1%	98.4%	98.5%	97.64%	98.77%	98.58%	98.61%	98.90%	98.68%	97.17%	98.78%	98.18%	**99.18%**	▲
Sickness Absence %	>=4%	4%<>3%	<3%	2.75%	2.04%	2.06%	2.61%	3.15%	3.59%	3.46%	2.66%	3.59%	3.73%	3.73%	2.74%	***3.00%***	***May-18 = Trend figure***
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	84.8%	83.5%	84.1%	86.27%	83.86%	81.24%	81.38%	81.00%	81.22%	78.58%	81.89%	81.64%	**82.20%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 3	<80%	80%<>95%	>=95%	81.6%	88.5%	89.2%	89.57%	89.94%	89.60%	88.81%	88.48%	89.97%	90.72%	89.59%	90.12%	**89.07%**	▼

Friends & Family Test - Treatment Quarterly staff survery to indicate likelihood of recommending QVH to friends & family to receive care or treatment	**Measure Extremely likely / likely % : Extremely unlikely / unlikely%**	2016-17 Quarter 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 survery to indicate likelihood of recommending QVH to friends & family as a place of work	**Measure Extremely likely / likely % : Extremely unlikely / unlikely%**	2016-17 Quarter 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

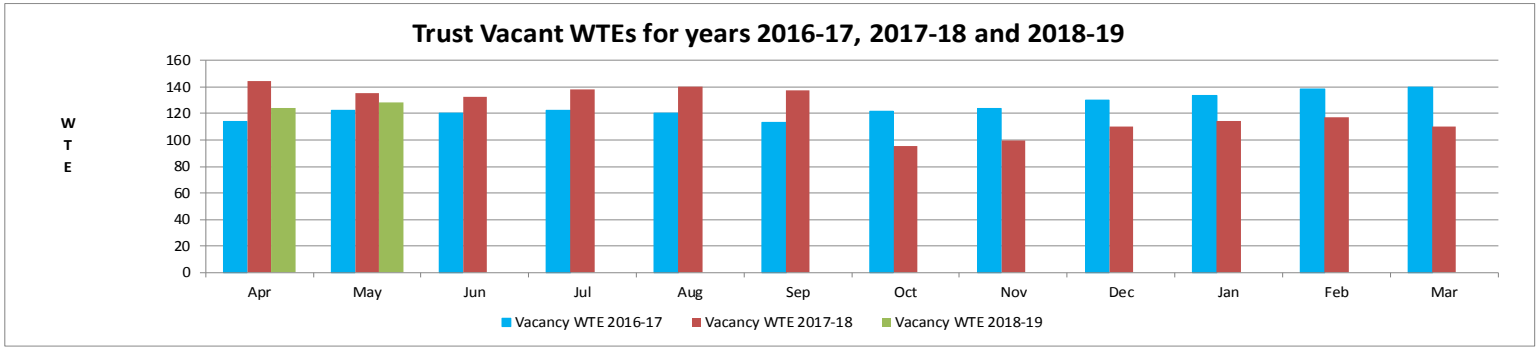
*Note 1 - 2018/19 Establishment not available in May 18 data reporting period . Establishment updated in August 2017 with nursing update in October 2017
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups.
*Note 3 - New RAG 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	Mar-18	Apr-18	May-18	Compared to Previous Month
Corporate	9.69%	11.27%	13.06%	▲
Eyes	8.75%	11.06%	9.13%	▼
Sleep	-18.12%	-16.16%	-12.06%	▼
Plastics	-0.89%	5.08%	5.26%	▲
Oral	8.85%	9.97%	12.63%	▲
Periop	24.84%	24.24%	24.36%	▲
Clinical Support	7.82%	8.64%	7.19%	▼
Clinical Infrastructure	12.13%	14.85%	14.85%	◄►
Director of Nursing	18.27%	16.03%	16.48%	▲
Operational Nursing	11.90%	14.02%	14.59%	▲
QVH Trust Total	11.55%	13.00%	13.44%	▲

NON-MEDICAL RECRUITMENT(WTE)	Posts advertised this month	Recruits in Pipeline
Corporate	4.01	6.00
Eyes	1.80	2.00
Sleep	1.00	1.00
Plastics	8.28	0.50
Oral	2.50	1.80
Periop	37.00	10.14
Clinical Support	2.00	7.00
Clinical Infrastructure	0.80	4.00
Director of Nursing	0.92	1.80
Operational Nursing	4.00	4.00
QVH Trust Total	*62.31*	38.24
of which Qual Nurses / Theatre Practs (external)	47.72	*4.80*
of which HCA's & Student/Asst Practs (external)	0.00	*4.00*

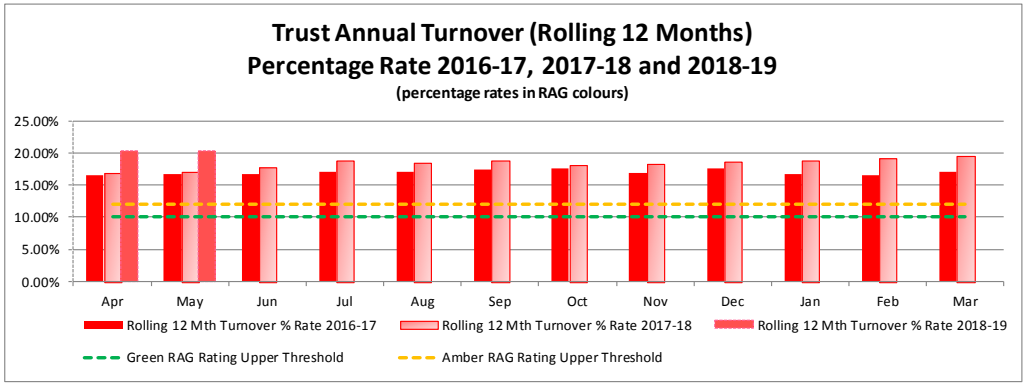
MEDICAL RECRUITMENT (WTE)	Posts advertised this month	Recruits in Pipeline
Clinical Support	0.00	0.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*0.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Plastics	0.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*1.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*1.00*
Eyes	0.00	4.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*4.00*
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	0.00	1.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*1.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Periop	0.00	1.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*1.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
QVH Trust Total	0.00	8.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*7.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*1.00*

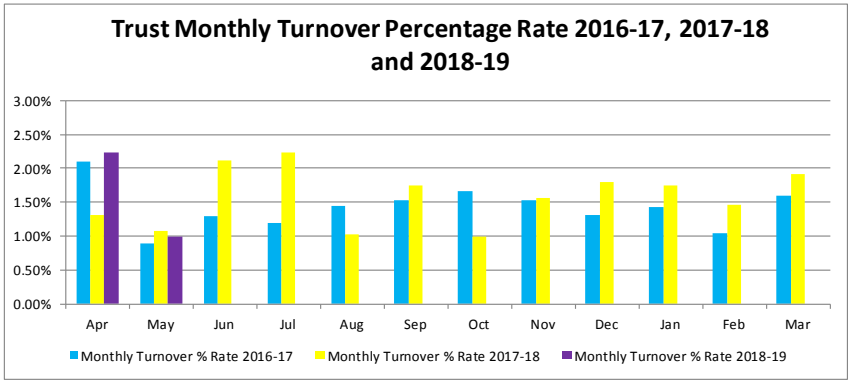


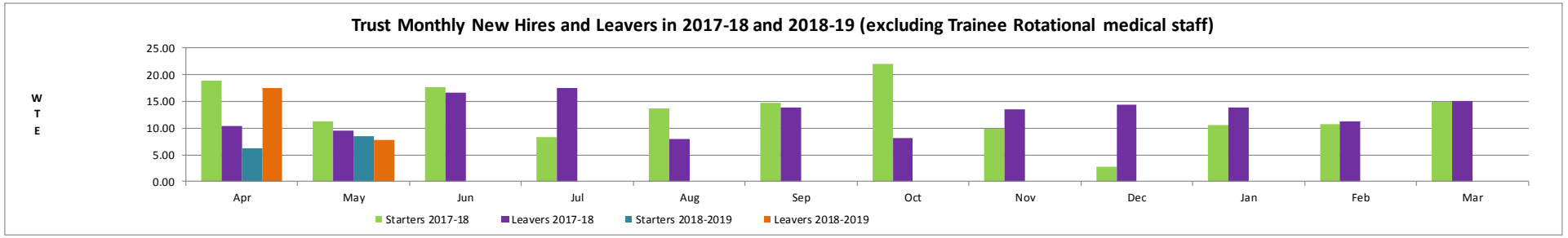
3. Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Mar-18	Apr-18	May-18	Compared to Previous Month	
Corporate %	17.00%	19.94%	21.85%	▲	1.91%
Eyes %	21.60%	21.53%	21.47%	▼	-0.06%
Sleep %	10.42%	12.29%	11.90%	▼	-0.39%
Plastics %	19.87%	18.93%	19.66%	▲	0.73%
Oral %	13.86%	15.34%	19.30%	▲	3.96%
Peri Op %	23.59%	25.29%	24.98%	▼	-0.31%
Clinical Support %	16.09%	15.28%	13.34%	▼	-1.94%
Clinical Infrastructure %	46.54%	43.70%	44.08%	▲	0.38%
Director of Nursing %	8.54%	12.07%	12.18%	▲	0.11%
Operational Nursing %	20.70%	19.80%	16.14%	▼	-3.66%
QVH Trust Total %	19.57%	20.38%	20.43%	▲	0.05%

MONTHLY TURNOVER excl. Trainee Doctors	Mar-18	Apr-18	May-18	Compared to Previous Month
Corporate %	2.12%	2.51%	1.75%	▼
Eyes %	2.11%	4.32%	0.00%	▼
Sleep %	0.00%	5.66%	0.00%	▼
Plastics %	2.50%	1.75%	1.84%	▲
Oral %	2.29%	3.06%	2.54%	▼
Peri Op %	1.99%	1.73%	0.88%	▼
Clinical Support %	0.81%	1.64%	0.00%	▼
Clinical Infrastructure %	3.17%	0.00%	2.55%	▲
Director of Nursing %	0.00%	3.53%	0.00%	▼
Operational Nursing %	2.83%	1.53%	0.00%	▼
QVH Trust Total %	1.91%	2.24%	1.00%	▼







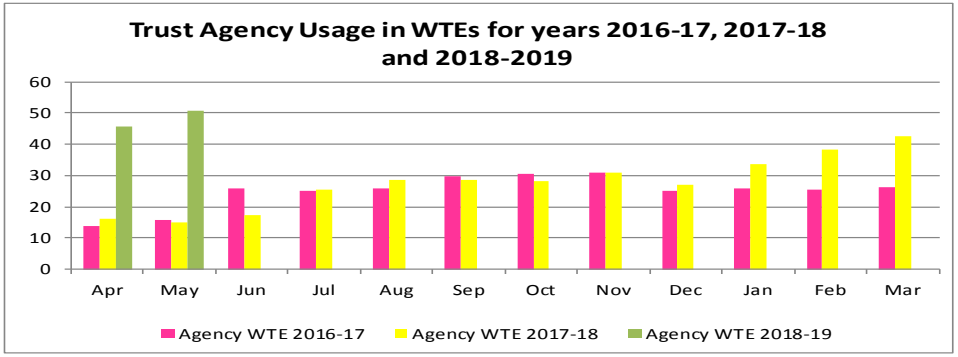
4. Temporary Workforce

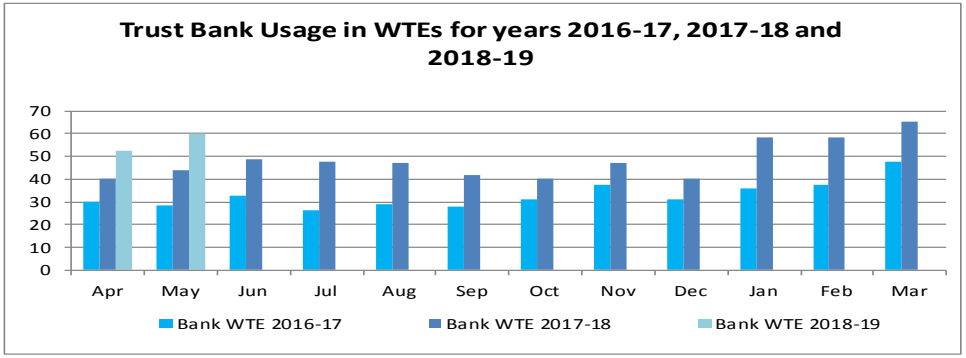
Agency				
BUSINESS UNIT (WTE)	Mar-18	Apr-18	May-18	Compared to Previous Month
Corporate	5.39	4.56	3.04	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.00	◄►
Plastics	2.07	5.21	8.53	▲
Oral	0.12	0.00	0.00	◄►
Periop	20.66	22.00	25.26	▲
Clinical Support	2.90	2.07	2.76	▲
Clinical Infrastructure	1.80	1.93	1.20	▼
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	9.58	9.81	9.82	▲
QVH Trust Total	42.51	45.58	50.61	▲

Bank				
BUSINESS UNIT (WTE)	Mar-18	Apr-18	May-18	Compared to Previous Month
Corporate	9.74	5.57	6.76	▲
Eyes	3.30	2.78	3.90	▲
Sleep	3.23	3.10	3.44	▲
Plastics	4.06	3.43	4.32	▲
Oral	2.98	2.80	3.24	▲
Periop	14.63	12.79	13.16	▲
Clinical Support	8.18	5.95	5.97	▲
Clinical Infrastructure	6.52	5.70	6.74	▲
Director of Nursing	2.63	2.10	1.98	▼
Operational Nursing	10.00	8.01	10.32	▲
QVH Trust Total	65.26	52.24	59.82	▲

Agency				
STAFF GROUP (WTE)	Mar-18	Apr-18	May-18	Compared to Previous Month
Qualified Nursing	29.07	30.30	34.20	▲
HCAs	3.06	2.90	3.57	▲
Medical and Dental	0.18	3.82	5.85	▲
Other AHP's & ST&T	2.90	2.07	2.76	▲
Non-Clinical	7.30	6.49	4.23	▼
QVH Trust Total	42.51	45.58	50.61	▲

Bank				
STAFF GROUP (WTE)	Mar-18	Apr-18	May-18	Compared to Previous Month
Qualified Nursing	21.12	17.46	19.64	▲
HCAs	6.90	5.46	6.51	▲
Medical and Dental	0.00	0.00	0.00	◄►
Other AHP's & ST&T	4.86	3.09	3.05	▼
Non-Clinical	32.38	26.22	30.63	▲
QVH Trust Total	65.26	52.24	59.82	▲



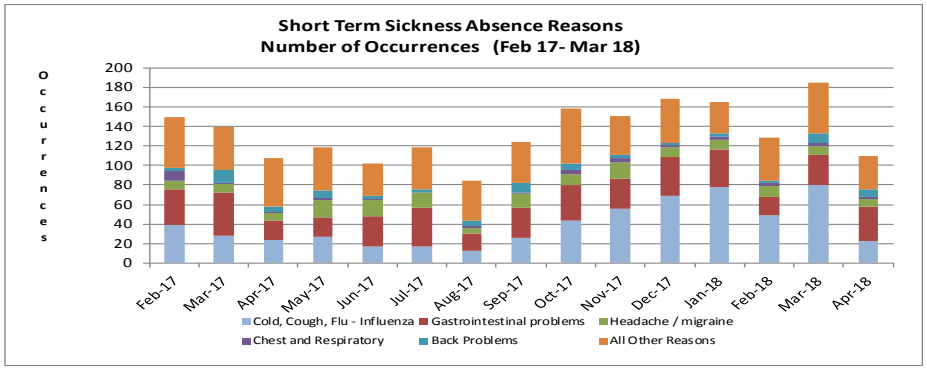


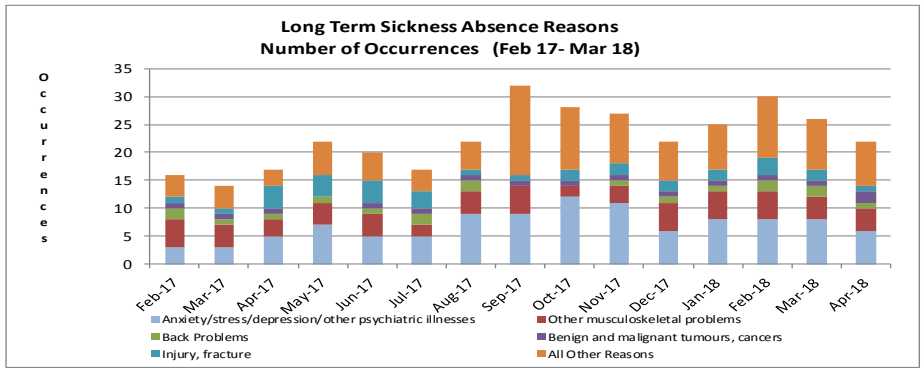
5. Sickness Absence

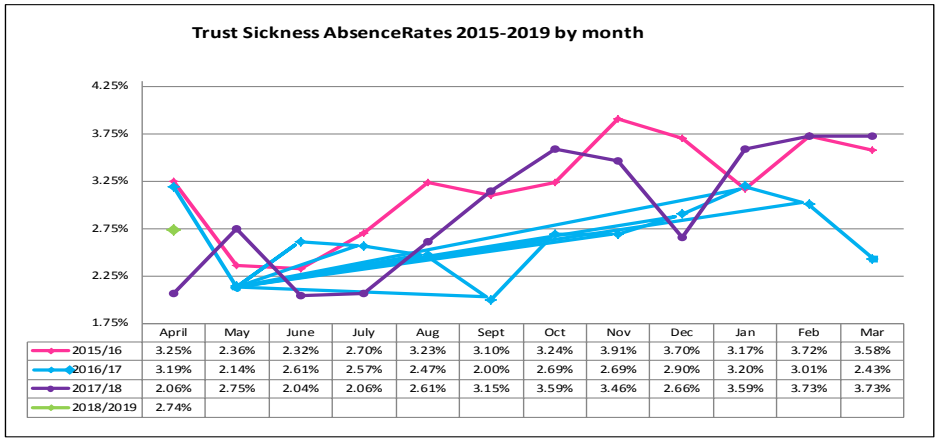
SHORT TERM SICKNESS	Feb-18	Mar-18	Apr-18	Compared to Previous Month
Corporate	0.70%	1.45%	0.43%	▼
Clinical Support	2.16%	2.51%	1.34%	▼
Plastics	0.88%	1.46%	0.65%	▼
Eyes	0.73%	1.04%	1.50%	▲
Sleep	0.60%	0.71%	0.10%	▼
Oral	1.19%	1.45%	1.13%	▼
Periop	1.59%	3.04%	1.76%	▼
Clinical Infrastructure	0.24%	2.94%	2.41%	▼
Director of Nursing	2.28%	1.19%	1.13%	▼
Operational Nursing	2.80%	1.87%	0.88%	▼
QVH Trust Total	1.38%	1.96%	1.11%	▼

LONG TERM SICKNESS	Feb-18	Mar-18	Apr-18	Compared to Previous Month
Corporate	0.57%	0.45%	0.52%	▲
Clinical Support	1.95%	1.22%	1.25%	▲
Plastics	1.70%	2.53%	2.06%	▲
Eyes	0.00%	0.00%	0.00%	◄►
Sleep	7.54%	5.25%	3.88%	▼
Oral	3.48%	1.54%	1.06%	▼
Periop	2.00%	1.74%	2.16%	▲
Clinical Infrastructure	7.09%	4.23%	3.67%	▲
Director of Nursing	0.00%	0.00%	0.00%	◄►
Operational Nursing	5.86%	4.24%	3.32%	▼
QVH Trust Total	2.35%	1.77%	1.62%	▼

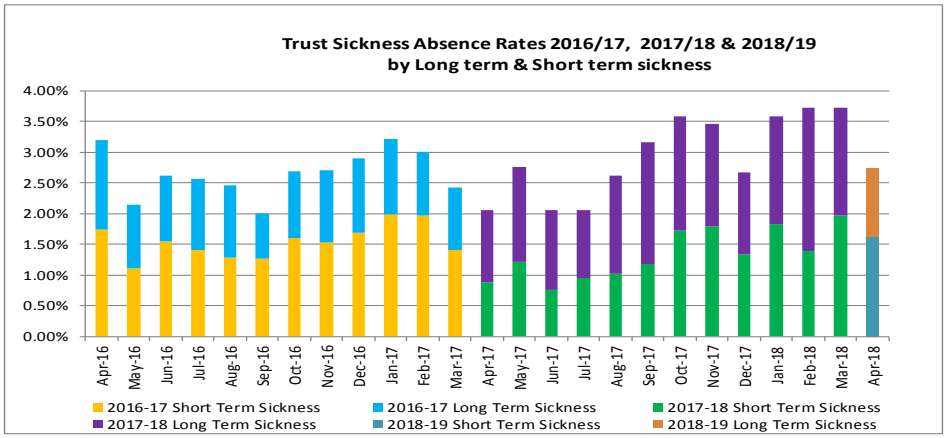
ALL SICKNESS (with RAG)	Feb-18	Mar-18	Apr-18	Compared to Previous Month
QVH Trust Total	3.73%	3.73%	2.74%	▼







	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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%	3.73%
2018/2019	2.74%											



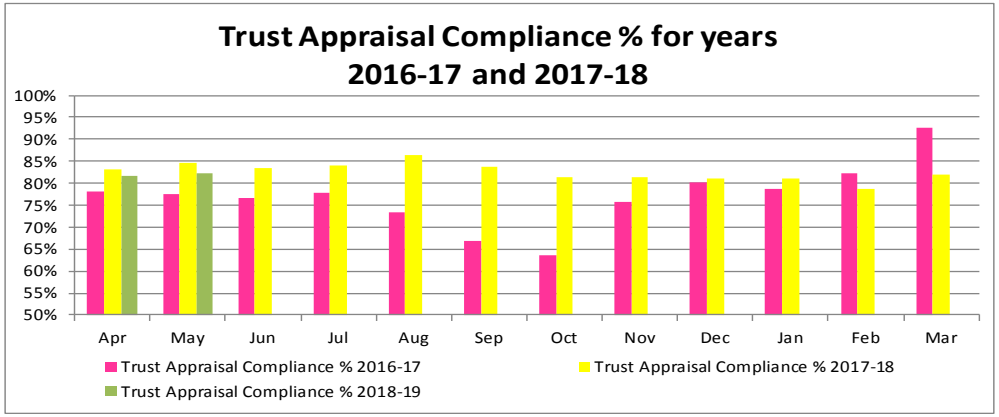
6. Training, Education and Development

New Targets/RAG ratings for 2017/18:

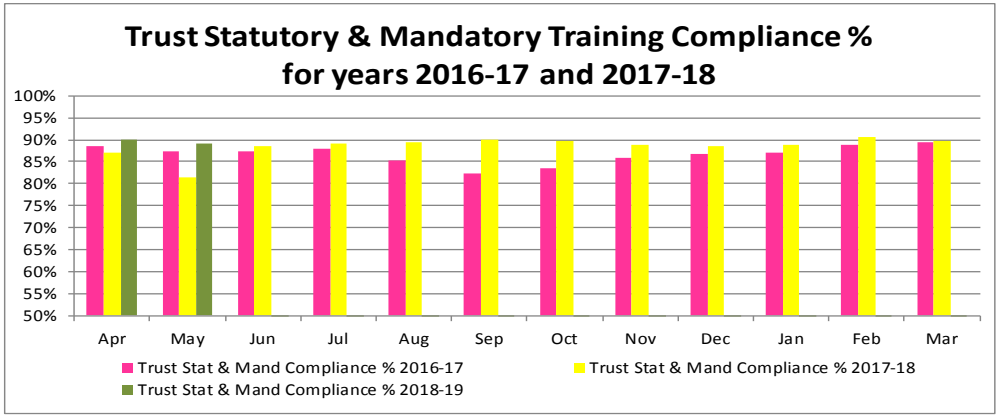
% staff - appraisal compliant	<80%	80%<>95%	>=95%
% staff - Statutory & Mandatory Training compliant	<80%	80%<>95%	>=95%

Performance:

APPRAISALS	May-17	Apr-18	May-18	Compared to Previous Month
Corporate	88.89%	79.25%	81.94%	▲
Clinical Support	91.67%	91.33%	91.45%	▲
Plastics	82.02%	74.77%	79.44%	▲
Eyes	90.63%	67.31%	64.15%	▼
Sleep	89.29%	84.38%	75.00%	▼
Oral	72.06%	85.42%	82.98%	▼
Periop	71.43%	77.35%	77.42%	▲
Clinical Infrastructure	90.15%	82.05%	73.68%	▼
Director of Nursing		90.91%	96.97%	▲
Operational Nursing		86.36%	90.91%	▲
QVH Trust Total	84.78%	81.64%	82.20%	▲



MANDATORY AND STATUTORY TRAINING	May-17	Apr-18	May-18	Compared to Previous Month
Corporate	84.45%	93.81%	94.75%	▲
Clinical Support	91.43%	95.49%	92.56%	▼
Plastics	65.77%	87.39%	87.02%	▼
Eyes	84.44%	90.72%	88.66%	▼
Sleep	89.91%	90.40%	92.17%	▲
Oral	79.69%	86.13%	83.44%	▼
Periop	78.87%	87.03%	85.10%	▼
Clinical Infrastructure	81.97%	82.87%	85.84%	▲
Director of Nursing		90.97%	90.65%	▼
Operational Nursing		92.33%	92.90%	▲
QVH Trust Total	81.57%	90.12%	89.07%	▼



7. Medical and Dental Workforce

Medical Workforce

- **Recruitment:** Recruitment continutes to be a challenge due to a shortage of UK doctors and difficulties in overseas doctors obtaining visas to work and this has resulted in an increased use of medical agency locums, an unusual position for QVH. Preparations are underway for August induction when 20-25 doctors are expected to join QVH.
- **Job Planning:** E Job Planning is continuing. All consultants were expected to be job planned by 31 May 2018, but this has been extended
- **Medic on Line and Medic on Duty:** The implementation of a new electronic system to record leave and availability for medical and dental staff commences in mid June 2018
- **Revalidation and Appraisal:** The second cycle of 5-year revalidation commenced on 1 April 2018 and 20% of doctors are due to revalidate in the period 2018-19. Appraisal rates for medical and dental staff has improved, with the Trust's month-end reportable position at 91.28.%.These figures now include HEE trainees.
-

Clinical Directorate	Headcount of medics	Number with in-date appraisal	Compliance rate
Clinical Support	9	9	100.00%
Eyes	12	11	91.67%
Oral	42	39	92.86%
Peri-Operative Services	31	26	83.87%
Plastics	51	50	98.04%
Sleep	4	1	25.00%
Grand Total	**149**	**136**	91.28%

Medical Education

Monthly update

- The GMC survey of doctors in training closed in May and the results are due out in July.
- The new procedures for study leave and relocation expenses for trainees are bedding in – they have required amendments to processes for the Medical Education team and information has been circulated to all trainees, educational supervisors and rota coordinators

Upcoming developments

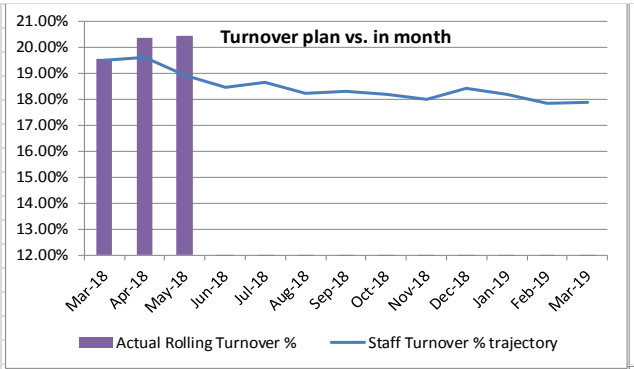
- Mr Andy Brown, a retired OMFS consultant, is speaking on "Why East Grinstead? The story of the WWII Maxillofacial Units and how they came about" in the Education Centre on Weds 27 June at 7pm.
- Preparations are underway for a School of Surgery visit to the Plastic Surgery and OMFS departments which will take place in September.

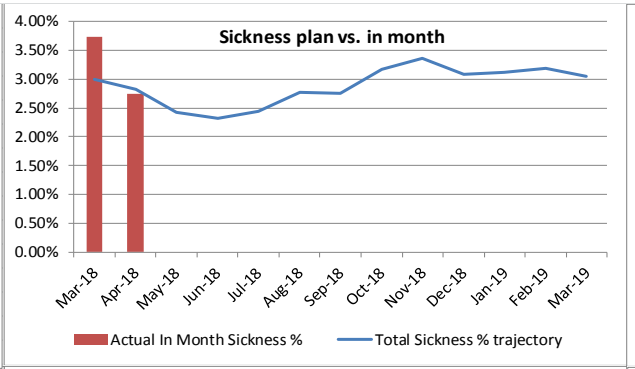
Statutory and mandatory training compliance

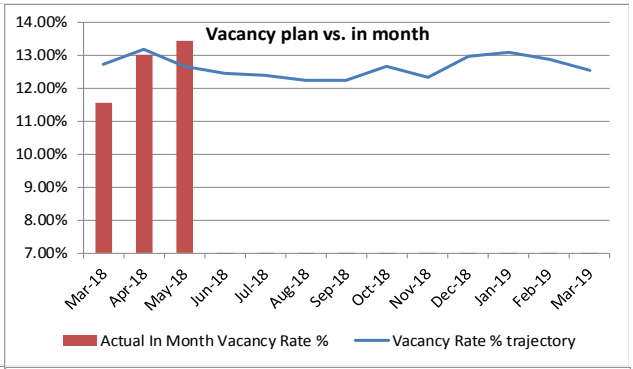
- Permanent/fixed term medical and dental employees are currently showing 84.3% compliant, which is around the same as the previous month.
- Medical and dental bank workers are showing as 70% compliant, which is an improvement on the previous month.

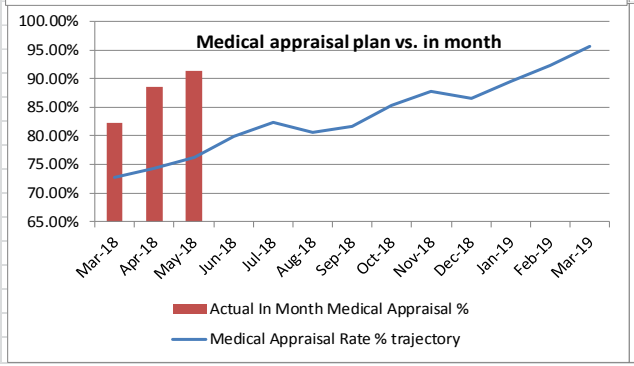
8. Trajectories

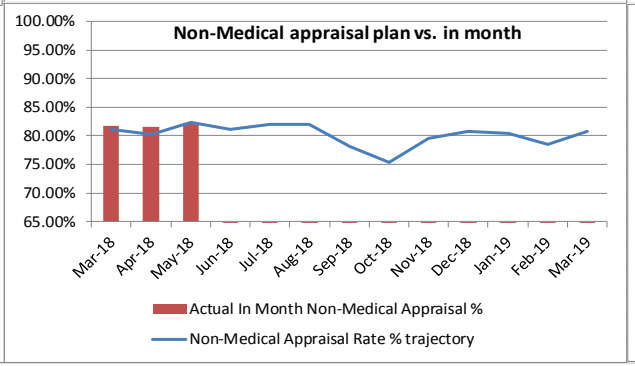
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Staff Turnover % trajectory	19.51%	19.62%	18.91%	18.46%	18.67%	18.24%	18.32%	18.18%	18.00%	18.41%	18.20%	17.84%	17.87%
Actual Rolling Turnover %	19.57%	20.38%	20.43%										
Total Sickness % trajectory	2.99%	2.83%	2.42%	2.32%	2.44%	2.77%	2.75%	3.17%	3.35%	3.09%	3.11%	3.19%	3.05%
Actual In Month Sickness %	3.73%	2.74%											
Vacancy Rate % trajectory	12.73%	13.17%	12.67%	12.46%	12.39%	12.23%	12.23%	12.68%	12.34%	12.97%	13.08%	12.88%	12.54%
Actual In Month Vacancy Rate %	11.55%	13.00%	13.44%										
Non-Medical Appraisal Rate % trajectory	81.16%	80.33%	82.37%	81.18%	81.99%	81.99%	78.22%	75.39%	79.50%	80.70%	80.39%	78.54%	80.77%
Actual In Month Non-Medical Appraisal %	81.81%	81.64%	82.20%										
Medical Appraisal Rate % trajectory	72.68%	74.29%	76.33%	79.86%	82.39%	80.63%	81.74%	85.28%	87.69%	86.52%	89.56%	92.37%	95.61%
Actual In Month Medical Appraisal %	82.35%	88.62%	91.28%										
Mandatory Training % trajectory	90.23%	89.76%	88.81%	89.24%	88.49%	88.52%	89.83%	89.32%	88.73%	88.34%	89.08%	91.09%	90.86%
Actual In Month Mandatory Training %	89.59%	90.12%	89.07%										

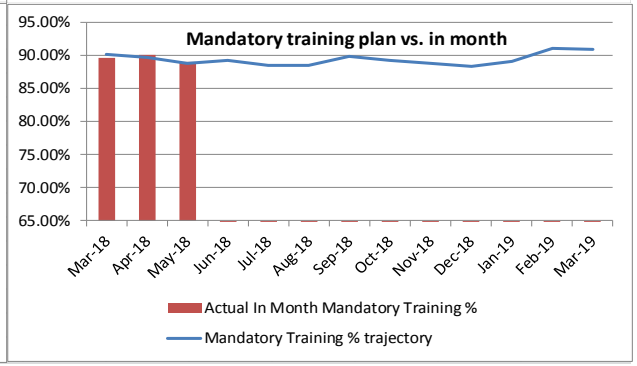












Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 July 2018**		**Agenda reference:**	**104-18**	
Report title:	**Staff Survey 2017**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	Annette Byers, Head of Organisational Development and Learning				
Appendices:	Appendix 1: Summary of Key Findings Appendix 2: Workforce Race Equality Standards (WRES)				
Executive summary					
Purpose of report:	The report provides the Board with an overview of the Key Findings from the 2017 NHS Staff Survey results. The report shows key themes arising from the staff survey in conjunction with the results of the Staff Friends and Family Test, stay and exit interviews and highlights areas for improvement.				
Summary of key issues	In the context of an increasingly challenging environment and a decline in staff engagement nationally, the Trust has seen a slight decline in response to the staff survey in its overall staff engagement score. We are slightly below average when compared with our comparator group (Acute Specialist Trusts). However, it is our aim to increase staff engagement and so our improvement themes are centred on those areas where we score below average against comparable trusts.				
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Action required			**Discussion**		
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:	The challenges are reflected in KSO 5 Organisational Excellence				
Corporate risk register:	A number of risks on the Corporate risk register are specific to workforce. The survey highlights challenges in relation to engagement of staff				
Regulation:	Workforce challenges will be implicit in all 5 domains of the CQC and in particular – Are they well Led?				
Legal:	No implications				
Resources:	The Workforce and OD team are trying to keep pace with demand and the need to support managers within existing resources				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	Reflected in last page of report				

Staff Survey Results 2017

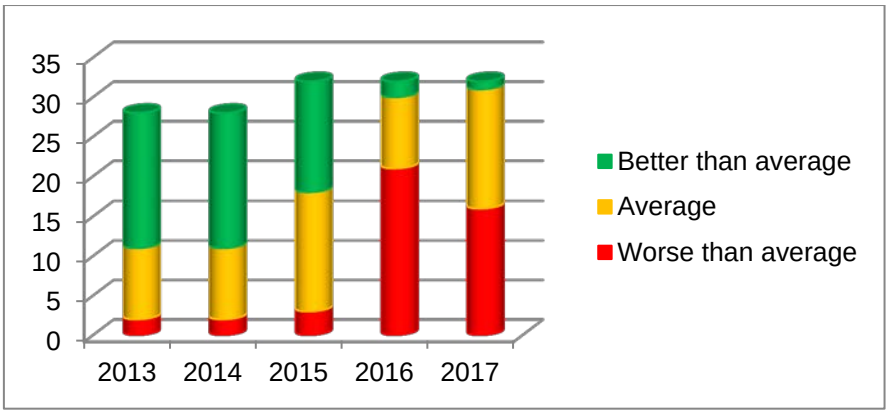
Introduction

1.1 The annual NHS staff survey provides an insight into staff views of the organisation and their experience of working within it. The survey is a key measure of staff engagement and wellbeing which are essential to the provision of high quality services. The survey also gives an insight into aspects of the organisations culture.

		Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	81%	86%	82%
Q21b	"My organisation acts on concerns raised by patients / service users"	75%	81%	78%
Q21c	"I would recommend my organisation as a place to work"	57%	72%	62%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	88%	89%	91%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.93	4.16	4.05

1.2 The 2017 NHS staff survey results for Queen Victoria Hospital NHS Foundation Trust (QVH) show that our results were broadly comparable to 2016. However, QVH's scores have slightly decreased compared to the previous year in an increasingly challenging national and regional context.

1.3 When compared with our comparator group of specialist Trusts, our scores remain lower with QVH ranking worse than average on 16, average on 15 and better than average on 1 of the 32 Key Findings. Since the 2016 survey, QVH have improved on 3, had no change on 27 and decreased on 1 Key Finding (see Appendix 1).



1.4 This year we surveyed 935 eligible staff. Of these, just over 513 responded making a 55% return. This is a small decrease from 56% the year before. The response rate for 2015 was 50%.

1.5 Nationally there was a 45% NHS Staff Survey return rate and an overall decrease in staff engagement scores.

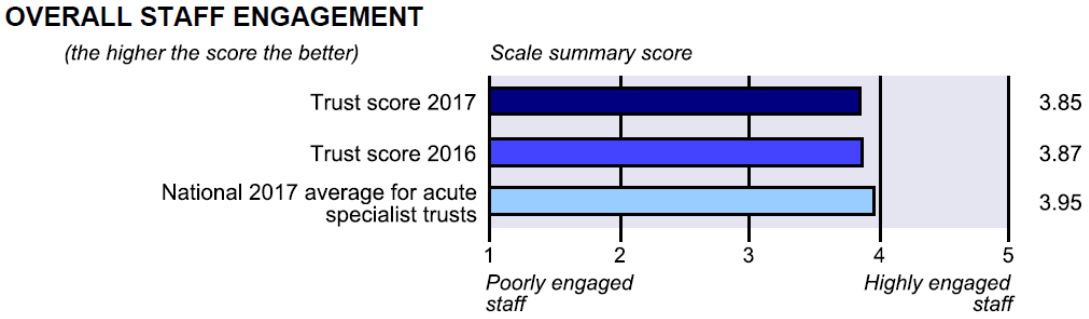
2. Headline Results

The 2017 NHS staff survey results put the Trust 12 out of 16 in the ranking of all Acute Specialist trusts with a slightly decreased staff engagement score.

2.1 Staff engagement score

Our engagement score has slightly decreased in comparison to last year and is **3.85 compared to 3.87 in 2016**. We score slightly lower than average in comparison with other Acute Specialist Trusts (3.95). This score is created from the following Key Findings (KF):

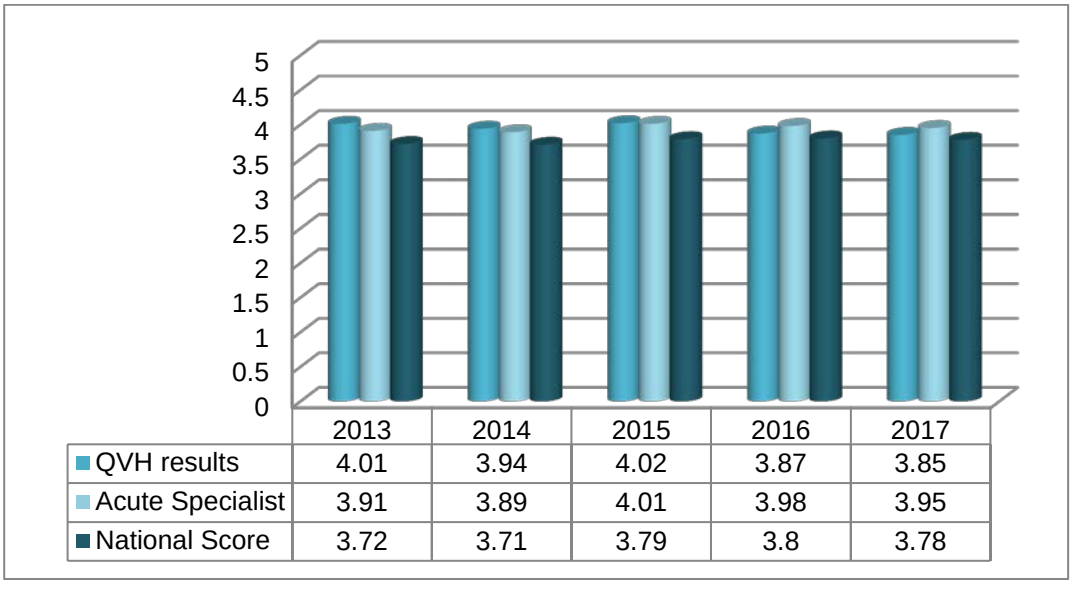
- KF 1 - Recommendation of the trust as a place to work or receive treatment
- KF 4 - Motivation at work
- KF 7 - Ability to contribute towards improvement at work.



This table shows the average data across all Trusts in 2017:

All Trusts	**Acute Trusts**	Combined Acute & Community Trusts	**Acute Specialist Trusts**	MH / LD Trusts	Combined MH / LD & Community Trusts	Community Trusts	Ambulance Trusts
3.78	3.79	3.78	**3.95**	3.79	3.79	3.78	3.45

In last 5 years the QVH engagement score has remained comparable to the average for Acute Specialist Trusts. This is slightly below average but remains in-line with the national picture.



	2013	2014	2015	2016	2017
QVH results	4.01	3.94	4.02	3.87	3.85
Acute Specialist	3.91	3.89	4.01	3.98	3.95
National Score	3.72	3.71	3.79	3.8	3.78

Significant changes
QVH has shown a significant improvement in three Key Findings since last year:

- KF10. Support from immediate managers (3.68 v 3.80 on a scale 0 - 5)
- KF19. Organisation and management interest in and action on health and wellbeing (3.59 v 3.73 on a scale 0 - 5)
- KF11. Percentage of staff appraised in last 12 months (82% v 87%)

2.2 **Key comparisons**[1]
The scores below show the result for QVH and the average result for Acute Specialist Trusts (QVH v Average). The top 5 scores overall are:

- KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (50% v 47%)
- KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (22% v 23%)
- KF32. Effective use of patient / service user feedback (3.84 v 3.83 on a scale 0 - 5)
  KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months (35% v 35%)
- KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (87% v 88%)

QVH's 5 lowest scores are below average for all Acute Specialist Trusts. A summary of the comparison in staff survey performance can be seen in Appendix 1.

3. Staff survey improvement themes

3.1 Overall the Trust has managed to maintain largely positive survey results in comparison to the national picture in a challenging environment. There are a number of areas that remain a focus for improvement in order to continue to enhance staff experience.

3.2 QVH will continue to triangulate Key Findings from the NHS staff survey report with the Picker report, Staff Friends and Family Test (SFFT) and the stay/exit interviews to ensure we effectively listen and respond to the needs of staff.

3.3 A Workforce Attraction and Retention Strategy was developed and agreed by the Board in September 2017 to support/develop on key areas across the trust. In order to support the plan for QVH to become an employer of choice and improve retention, the Trust aims to improve QVHs standing within the Acute Specialist Trust comparator group in the following key areas:

- Response rate to the NHS Staff Survey
- Recommendation of the trust as a place to work
- Management and leadership
- Specific locality based issues (effective team working)
- Job satisfaction

3.4 **Response rate to the 2017 NHS Staff Survey**
The Trust had a response rate of 55% in 2017, higher than the NHS average. We aspire to increase this to 58% or above in 2018. This will be achieved through continuous engagement with staff throughout the year about the link between the feedback received through the survey and actions to improve the experience of staff (You said we did!), as well as a clear focus on those areas and staff groups that have historically had low response rates (see table 3.2 on page 4).

Staff Survey 2017 - Acute Specialist Trust	Worst performing trust: 45.8%	Best performing trust: 62.0%	Average response rate: 52.6%

[1] When ranked against the other 16 Acute Specialist Trusts

3.5 **Recommendation of the trust as a place to work**

QVH has always been recognised as a place to work and receive treatment. The Trust is now seeing the results decline in line with the national picture. In particular we need to improve staff recommending QVH as a place to work.

From the SFFT and stay/exit interview comments we can clearly see there are a wide range of views from people who enjoy working at QVH and those that don't. This needs to be a focus for the trust moving forward to attract and retain staff at QVH.

In conjunction with the Attraction and Retention plan and the survey results, we will closely monitor the SFFT and stay/exit interviews to identify areas of improvement. The Trust needs to focus on improving staff experience through engagement interventions.

3.6 **Management and leadership**

Our leadership and management programme, Leading the Way (LTW) was introduced in 2017 across the Trust. A report was submitted to the board in May 2018 which highlighted the outcomes and impact of the programme to date and detailed the next steps for LTW.

With data extracted from the 2017 NHS Staff Survey, we have compared the results to look at local changes and improvements since the 2016 Survey further to the introduction of LTW which has had a positive impact on some key findings:

Key Finding	Area	QVH 2016	QVH 2017
5	Recognition and value of staff by managers and the organisation	*3.42	*3.51
6	% 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	% staff experiencing harassment, bullying or abuse from staff in last 12mths	24%	22%
19	Organisation & 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

From the 2017 NHS staff survey results it shows that the Trust is improving its management practices but there is still some way to go. For example support from managers has increased, but comments identified in the SFF test and stay/exit interviews we see that some areas report that a more supportive management approach is required. Other areas referred to include:

- More positive informal feedback
- Increased awareness and respect of others
- Supportive management
- A no blame culture/environment
- Taking responsibility/leading by example
- Training for managers to manage
- Clearer vision, forward planning and communication

We are currently working with NHS Elect to help deliver key management and leadership initiatives through the 2018/19 LTW programme including workshops on personal resilience, effective leadership, developing teams, communication, strategic planning, etc. We will cross reference the 2017 NHS Staff survey results, SFF test and stay/exit interviews to the on-going LTW portfolio to ensure it meets the needs of the trust.

3.7 **Specific locality based issues (effective team working)**

It has been identified through the 2017 NHS staff survey, SFF test and stay/exit interviews that the Trust needs to focus on some core departments/teams to highlight and address specific challenges in these areas. Some comments received consistently refer to:

- Old school attitudes
- Behaviours and attitudes of some staff members
- Low morale across teams
- Respecting colleagues
- Cliques in place, it's who you know not what you know
- Lack of cross team understanding/working

QVH will need to directly engage with the Director of Operations and the business units to identify areas for improvement and develop tailored plans to support and develop these areas.

3.8 **Job Satisfaction**

Another key area identified through the 2017 NHS Staff survey, SFF test and stay/exit interviews is around job satisfaction, this includes:

- Flexible working opportunities
- Workload concerns due to short-staffing
- Career progression
- Staff recognition/rewards
- Improving/adding staff incentives
- Appropriate training and development
- Mentoring/buddying opportunities

The Attraction and Retention plan has already identified some of these core areas and some changes have already been made. The Workforce and OD team regularly revisit the plan to cross reference outstanding actions and update any areas for improvement.

The verbatim comments from the 2017 NHS Survey were nominal. However we have extensive comments from the SFF test and stay/exit interviews which will be used as a resource to inform the actions to support the themes.

4. Key Questions Summary

We are proud that the QVH 2017 NHS staff survey results and the SFF test show that the organisation continues to be a place that staff would recommend as a place to receive care and treatment.

Staff recommending as a place to receive treatment	2013/14	2014/15	2015/16	2016/17	2017/18
Percentage extremely likely/likely to recommend	94%	91%	93%	91%	**88%**
Average (median) for acute specialist trusts	86%	87%	91%	88%	**89%**

Staff FFT 2017/18 Q4 Results

Extremely likely/Likely	89.87%

In terms of staff recommending as a place to work, the Trust needs to focus on improving the experience of existing staff through engagement and communication interventions.

Staff recommending as a place to work	2013/14	2014/15	2015/16	2016/17	2017/18
Percentage extremely likely/likely to recommend	81%	74%	76%	62%	57%
Average (median) for acute specialist trusts	74%	70%	71%	72%	72%

Staff FFT 2017/18 Q4 Results

Extremely likely/Likely	57.19%

The Trust recognises the link between the quality of staff experience and patient care and so will seek to build on the results above, to maintain and further improve those areas described in the report, to support staff to deliver excellent care at the heart of the community.

5. Summary Ongoing Actions:

Bringing together the key areas throughout the report the actions include:

- Phase 2 of Leading the way
- Continuing the delivery of all aspects of the Attraction and Retention Plan, including most recently the overseas nursing campaign
- Working with business units in relation to specific team interventions
- Ongoing promotion of a range of wellbeing events
- Promotion of Trust benefits
- Reinforce the importance of meaningful appraisals (AfC reforms)
- Launch of an Autumn campaign focused on the impact of negative behaviours and importance of respect for each other
- Ongoing promotion of education, learning and development
- Consulting on and implementing proposals to improve staff access to ‘time out’ space

Appendix 1: Summary of Key Findings

3.4. Summary of all Key Findings for Queen Victoria Hospital NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all acute specialist trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	✓ Increase (better than 16)	• Average
KF12. Quality of appraisals	• No change	• Average
KF13. Quality of non-mandatory training, learning or development	• No change	! Below (worse than) average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	• Average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Below (worse than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	• No change	• Average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	✓ Increase (better than 16)	• Average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	! Below (worse than) average
* *KF16. % working extra hours*	• No change	! Above (worse than) average

3.4. Summary of all Key Findings for Queen Victoria Hospital NHS Foundation Trust (cont)

	Change since 2016 survey	Ranking, compared with all acute specialist trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	! Decrease (worse than 16)	! Below (worse than) average
KF4. Staff motivation at work	• No change	• Average
KF7. % able to contribute towards improvements at work	• No change	! Below (worse than) average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	• Average
KF9. Effective team working	• No change	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	• No change	! Below (worse than) average
Managers		
KF5. Recognition and value of staff by managers and the organisation	• No change	• Average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	✓ Increase (better than 16)	• Average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	• No change	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	! Below (worse than) average
KF32. Effective use of patient / service user feedback	• No change	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	• Average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average

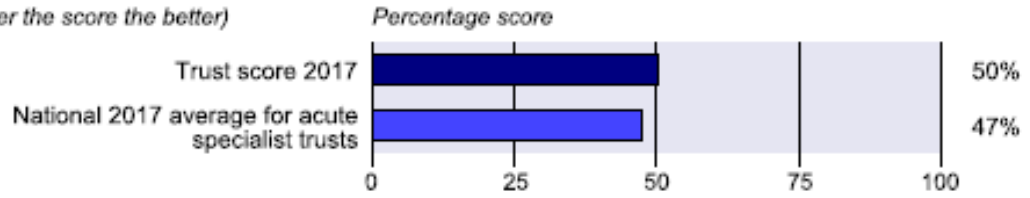
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which Queen Victoria Hospital NHS Foundation Trust compares most favourably with other acute specialist trusts in England.

TOP FIVE RANKING SCORES

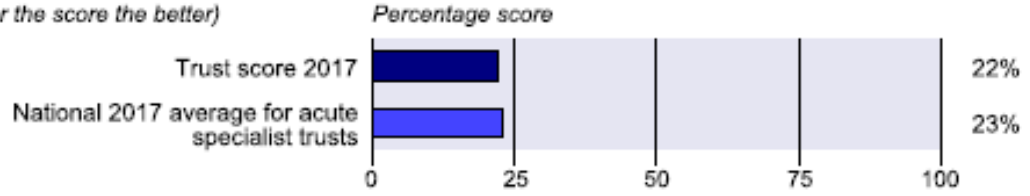
✓ KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



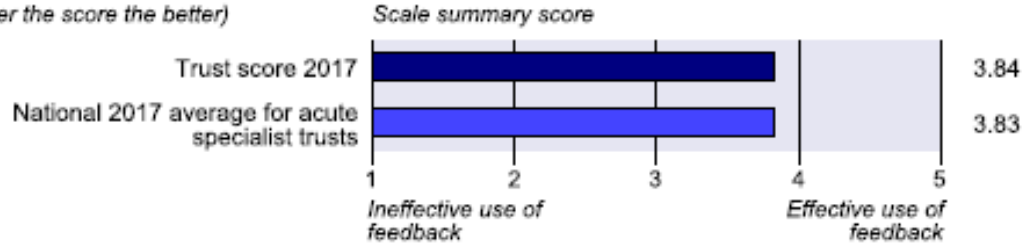
✓ KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



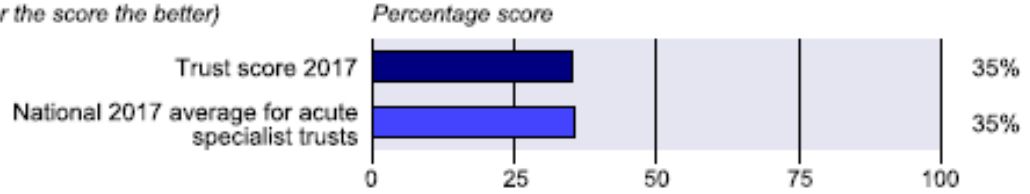
✓ KF32. Effective use of patient / service user feedback

(the higher the score the better)



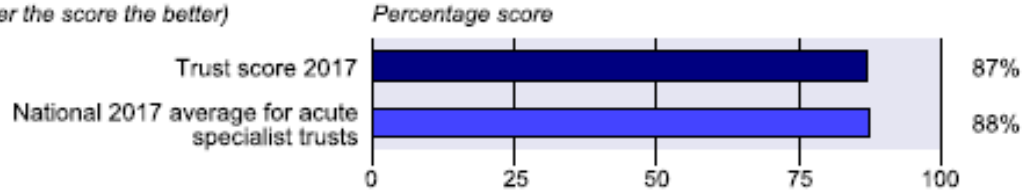
✓ KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



✓ KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

(the higher the score the better)



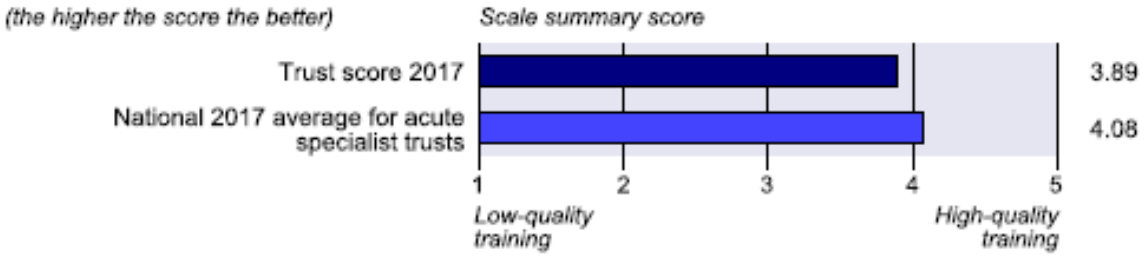
For each of the 32 Key Findings, the acute specialist trusts in England were placed in order from 1 (the top ranking score) to 16 (the bottom ranking score). Queen Victoria Hospital NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Queen Victoria Hospital NHS Foundation Trust compares least favourably with other acute specialist trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

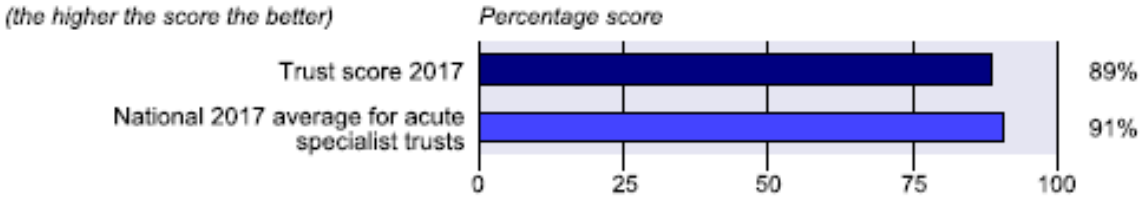
! KF13. Quality of non-mandatory training, learning or development

(the higher the score the better)



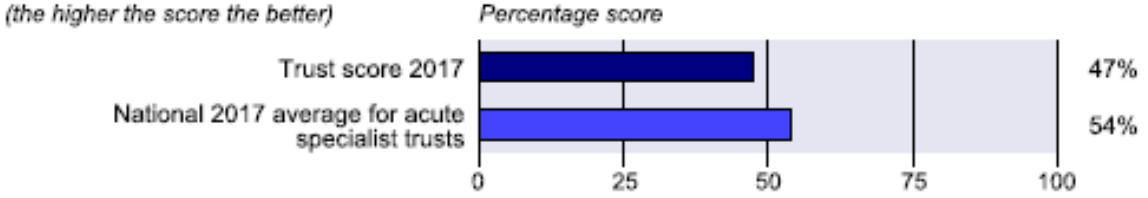
! KF3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



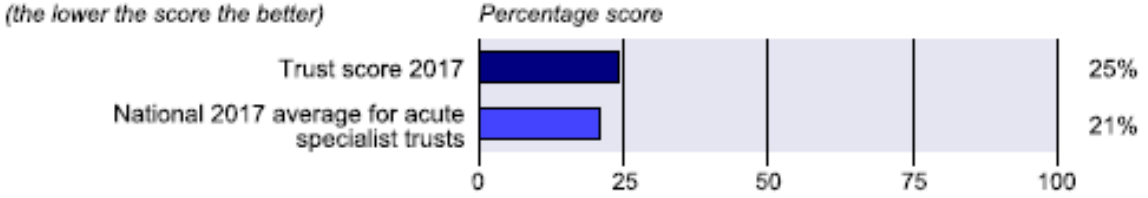
! KF15. Percentage of staff satisfied with the opportunities for flexible working patterns

(the higher the score the better)



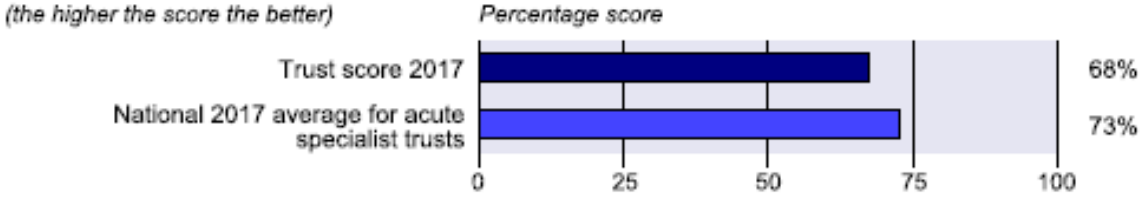
! KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



! KF7. Percentage of staff able to contribute towards improvements at work

(the higher the score the better)



Appendix 2: Workforce Race Equality Standards (WRES)

Ethnic background		
White	434	88%
Black and minority ethnic	58	12%
Did not specify	21	

			Your Trust in 2017	Average (median) for acute specialist trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	23%	22%	23%
		BME	30%	17%	26%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	22%	22%	25%
		BME	18%	26%	25%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	88%	88%	86%
		BME	83%	75%	86%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	6%	7%
		BME	16%	14%	12%

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed – 26/06/18

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

Initial Risk 5 (C) x 3 (L) = 15, moderate risk
Current Risk Rating 5 (C) x 4 (L) = 20, major risk
Target Risk Rating 5 (C) x 3 (L) = 15, moderate 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
Date last reviewed: 27th June 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

Initial Risk 3 (C) x 5(L) = 15,moderate
Current Risk Rating 4 (C) x 5(L)= 20 , major
Target Risk Rating 4(C) x 3(L) = 12, moderate

Rationale for current score (at Month 2)

- Deficit £1,436k/£946k deficit plan
- CIP forecast delivery - (current material gap £84k YTD variance on plan, yet to be identified £2.3m)
- Finance & Use of resources – 3 (planned 3)
    - Capital Service cover - 4
    - Liquidity -1
    - I&E Margin –4
    - I&E Margin Var from plan – 4
    - Agency Cap – 4

Rationale for residual score

- CIPP pipeline schemes to be identified to bridge the gap
- High risk factor – availability of staffing in particular nursing and non clinical posts
- Commissioner challenge and scrutiny
- Potential changes to commissioning agendas
- 2018/19 CIPP Gap and non delivery on M1 & M2
- Contracting alignment agreement
- Underperformance on activity plan
- Significant overspend on agency staffing, however clinical safety is requiring additional agency costs over and above ceiling

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
- ~~2 year tariff arrangements~~
- ~~Pay awards removal 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 model, strategic partnerships; increased trust resilience/ support 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 with amended levels of delegation in line with a turnaround environment to reduce levels of authorisation (June 18)
- 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)
- CIPP Governance processes
- Income/ Activity capture and coding processes embedded and regularly audited
- Weekly activity information per Business unit, specialty and POD
- Refreshed Operating Plan submitted (June 18)

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
- Finance and procurement training to budget holders

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	5 July 2018		**Agenda reference:**	106-18	
Report title:	Finance and operational performance assurance report				
Sponsor:	John Thornton, committee Chair				
Author:	John Thornton, committee Chair				
Appendices:	None				
Executive summary					
Purpose of report:	Board Assurance				
Summary of key issues	Major operational and staffing issues putting patient access and financial plans at risk				
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Action required	Approval	Information	Discussion	**Assurance**	Review
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:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:					

Report to: Board of Directors
Meeting date: 5 July 2018
Reference no: 106-18
Report from: John Thornton, committee chair
Report date: 26 June 2018

Finance and performance assurance report

1. Operational performance

AJ is undertaking a significant restructuring of the operational performance report, which she intends to use consistently across all reporting areas. She took the committee through the structure of the new report which is still work in progress and discussed the key areas of performance against targets. The committee strongly supported the approach she was taking which has been endorsed by NHSI.

Performance against access targets is still well below target especially in RTT. Committee took some assurance from the fact that the full picture of our total waiting list should be 80% available within a month and that a new trajectory for recovery will then be set. The committee expects this to show when we expect to reach the established targets.

2. Workforce performance

The main workforce issue remains the turnover of staff in key roles and the difficulty in recruiting. This is impacting all aspects of the Trusts performance.

The Trust's staff turnover figure increased again to its highest ever level. This includes some internal promotions but overall vacancy levels are still rising each month. A discussion took place on progress with plans for overseas recruitment, but this is some way off and the committee hasn't received any assurance that the level of vacancies is likely to be reduced in the near term.

As a direct consequence the number of agency staff also reached an all time high of 50 WTE. The cost of agency is significantly higher than budget and our externally set target. An exercise is being undertaken to review all agency staff and to tighten processes for approval but this isn't expected to make significant reductions.

3. Financial performance

May was budgeted to be effectively a break even month but generated a deficit of £500k due to a lack of patient activity income and significant overspend on agency and bank staff as discussed above.

Committee expressed concern that the Trust was now working more inefficiently and that less revenue was being generated at a higher cost that in previous periods.

Given the challenges with recruitment highlighted the challenge must be to deliver better levels of activity by more efficient use of our capacity while reducing our reliance on agency staff. There is significant room for improvement but changes will need to be made quickly.

4. Operating Plan Resubmission

Committee discussed the Trust's response to the recent NHSI letter which provided feedback on our plan and suggested areas for consideration. The response is in line with the EMT proposals that were endorsed at the board meeting convened on19 June.

Our response acknowledges the reality of where we are after two months and reschedules the plan to provide time to achieve the required operational efficiencies. This clearly increases the level of required delivery in the latter part of the year if we are to achieve our current control total.

5. EDM Update

The overall status of this project is now 'red' because rollout has been halted while an assessment is completed of progress to date and the learnings acquired. A new plan is being created to ensure the process is fully embedded in those areas which are live and to allow roll out to continue into key areas such as plastics.

Committee fully endorsed a slightly slower pace of roll out if this allowed the necessary cultural changes to be embedded alongside the technological changes. Without these it will never achieve its expected efficiencies and other benefits.

John Thornton
Chair

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05/07/18		**Agenda reference:**	**107-18**	
Report title:	Operational Performance Report				
Sponsor:	Abigail Jago, Director of Operations				
Author:	Abigail Jago, Director of Operations				
Appendices:	None				
Executive summary					
Purpose of report:	To update the Board regarding operational performance.				
Summary of key issues	Key items to note include: • Delivery of DM01 & MIU standards • On-going challenges with RTT18 and cancer standards • Programme of work to address access standards • Go live of eRS paper switch off • Theatre improvement programme of work				
Recommendation:	The Board is asked to **note** the operational performance position and challenges. The Board is asked to **note** that the attached revised reporting is work in progress and asked consider the content of the revised operational performance reporting.				
Action required	Approval	**Information**	Discussion	Assurance	Review
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:	The Board Assurance Framework will be updated in line with developments set out in the operational report.				
Corporate risk register:	The corporate risk register will be updated monthly to reflect the developments in regard to operational delivery.				
Regulation:	The report format and content has been reviewed by NHSI.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance & Performance Committee				
	Date:	25/06/18	Decision:	Noted	
Next steps:	Ongoing reporting of performance issues identified				

Operational Performance Report

Abigail Jago, Director of Operations

July 2018

Summary

This operational report sets out an update to board regarding operational performance and pressures pertaining to:

- Access standards
- Outpatients
- Theatres

The Board is asked to note that the format of this report is under development and has been reviewed initially at the Finance & Performance Committee.

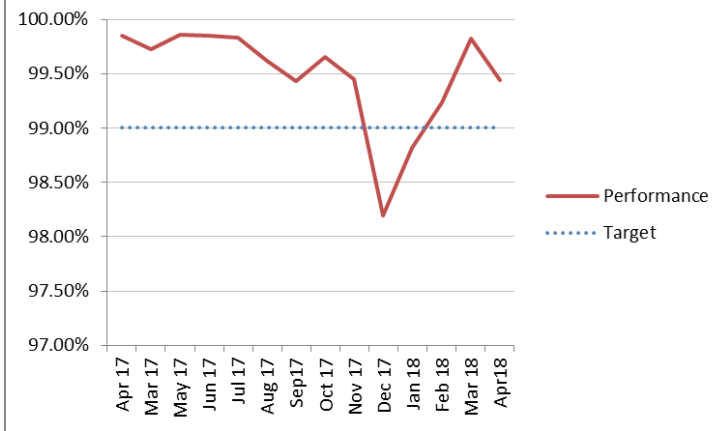
Key items to note include:

- Delivery of DM01 (diagnostics) and MIU standards
- On going challenges with RTT and cancer standards
- Programme of work to address access standards
- Go live of eRS (electronic referral) soft switch off 2 July with proposed hard switch off of 31 July 2018
- Theatre improvement programme of work

Contents

Diagnostic Waits (DM01)

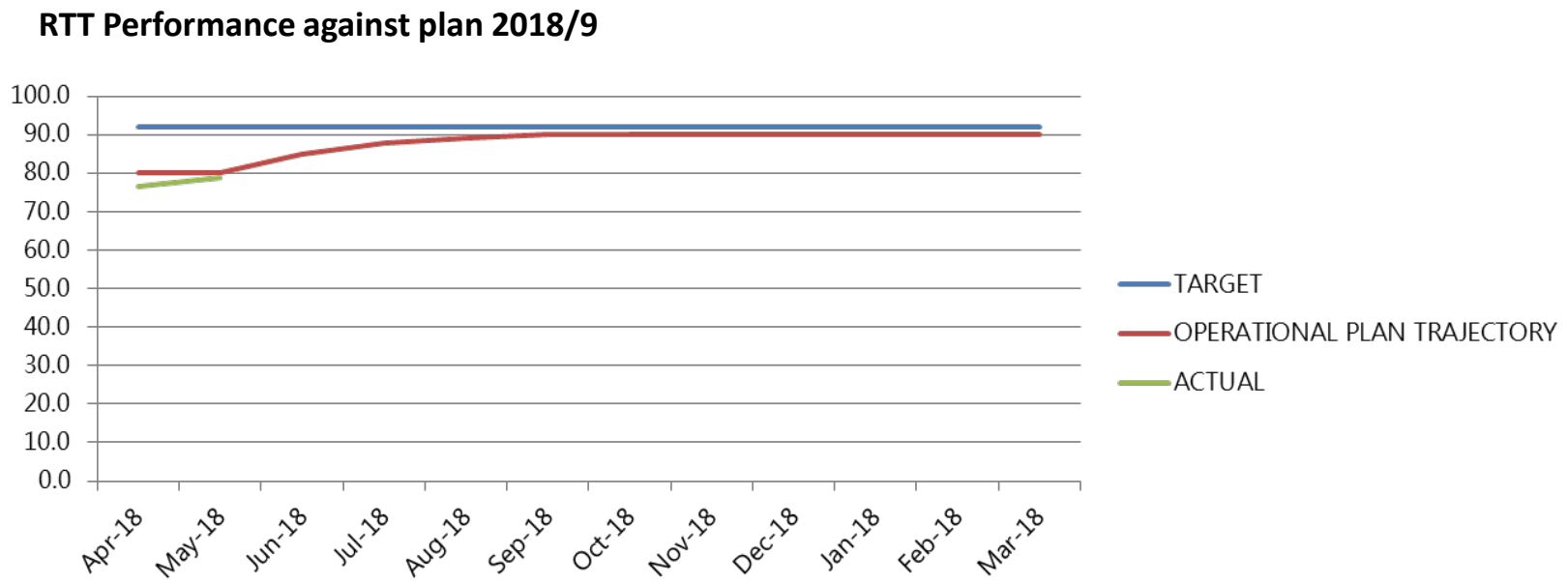
Diagnostic Waits > 6 Week Performance
Rolling 12 month Performance v Target



(Last reporting period – April 18)			(This reporting period – May 18)		
Modality /test	Breaches	Perf.	Modality / test	Breaches	Perf.
CT	1	99.17%	CT	3	97.5%
ECHOCARDIOGRAPHY	0	100%	ECHOCARDIOGRAPHY	0	100%
MRI	1	99.58%	MRI	0	100%
NON-OBSTETRIC ULTRASOUND	0	100%	NON-OBSTETRIC ULTRASOUND	0	100%
SLEEP STUDIES	0	100%	SLEEP STUDIES	3	95%

Performance commentary	Forward look / performance risks
• DMO1 specialities compliant • 3 breaches in Radiology due to CT outsource delays • 3 breaches in Sleep due to staffing and capacity.	• Outsource CT delays likely to continue until on-site CT delivered and operational – Aug/Sept 2018 • Sleep may continue to have some breaches due to current capacity.

RTT 18 – Performance against plan YTD



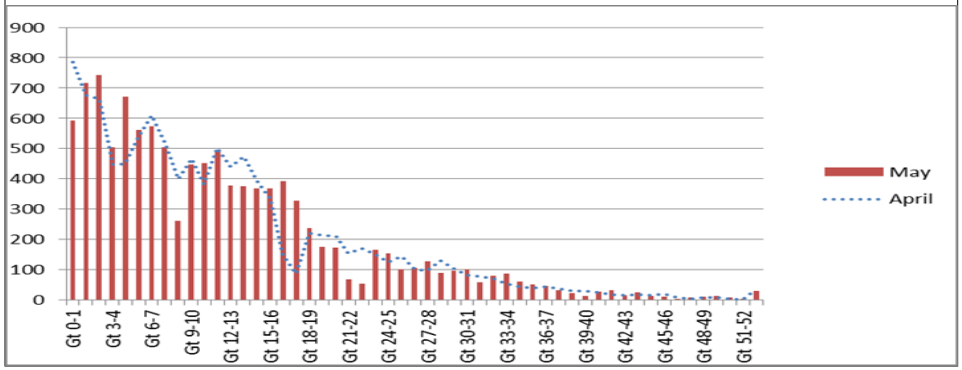
OVERALL INCOMPLETES PERFORMANCE												
MONTH	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18	Feb-18	Mar-18
TARGET	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0	92.0
OPERATIONAL PLAN TRAJECTORY	80.0	80.0	85.0	88.0	89.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0
ACTUAL	**76.6**	**78.9**										
TOTAL PTL SIZE	10,827	11,140										

[52 weekly performance against plan to be included following confirmation of trajectories]

RTT18: Incomplete Pathways

SUMMARY:RTT INCOMPLETE PATHWAYS (Rolling quarter)			
Weeks wait	Mar-18	Apr-18	May-18
0-17 (<18)	8355	8313	8737
18-30	1812	1830	1553
31-40	486	513	561
41-51	148	158	181
>52	24	36	30
Total Pathways	10825	10850	11062
Breaches	2470	2537	2325
Performance	77.18%	76.62%	78.98%

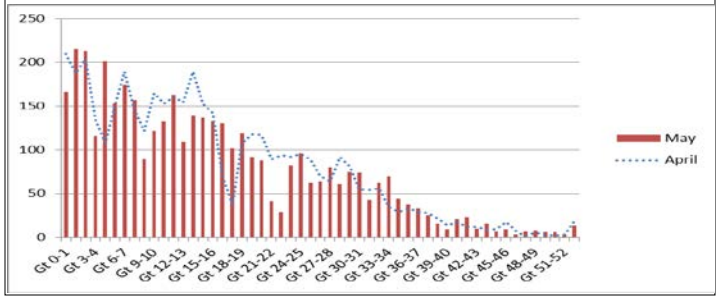
Incomplete distribution by weeks (trust level)
Latest & previous period



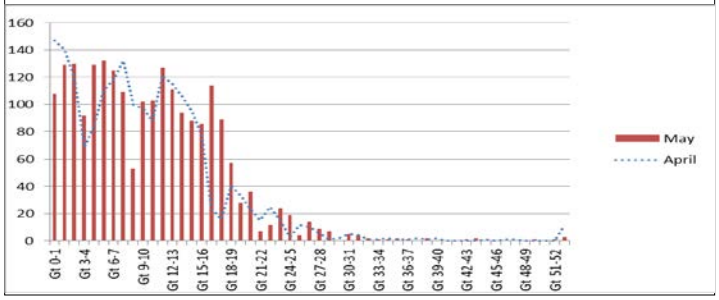
	SUMMARY:RTT INCOMPLETE PATHWAYS BY SPECIALITY (MAY 18)						
NON COMPLIANT	Speciality	<18	18-30	31-40	41-51	>52	Perf
	Oral Surgery	2651	889	414	119	14	64.86%
	Plastic Surgery	2588	407	127	53	11	81.23%
	Cardiology	59	7	1	1	0	86.76%
	Ophthalmology	1921	217	18	5	3	88.77%
COMPLIANT	Other	1103	27	1	2	2	97.18%
	Ear, Nose & Throat (ENT)	398	6	0	1	0	98.27%
	Trauma & Orthopaedics	7	0	0	0	0	100.00%
	Rheumatology	10	0	0	0	0	100.00%

RTT18: Incomplete Pathway Distribution

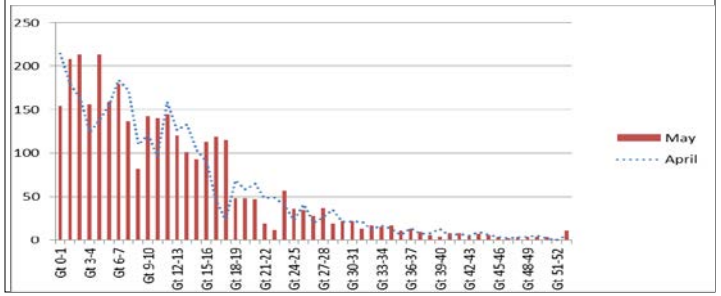
Incomplete pathway distribution by weeks (Oral Surg)



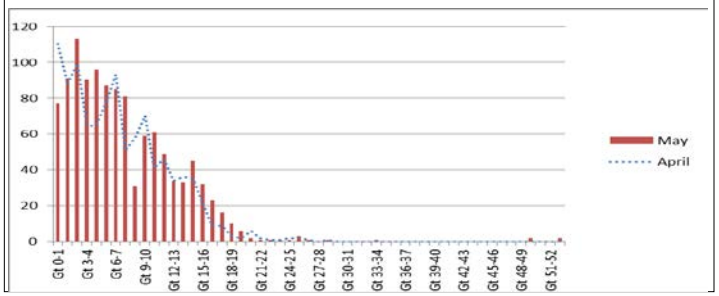
Incomplete pathway distribution by weeks (Ophthalmology)



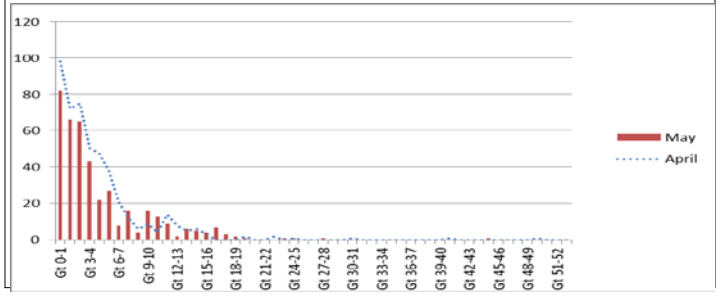
Incomplete pathway distribution by weeks (Plastics)



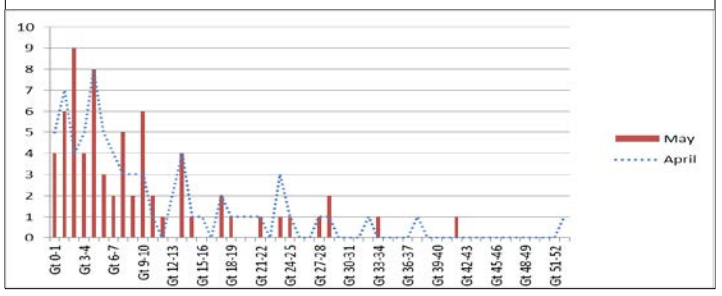
Incomplete pathway distribution by weeks (Other)



Incomplete pathway distribution by weeks (ENT)



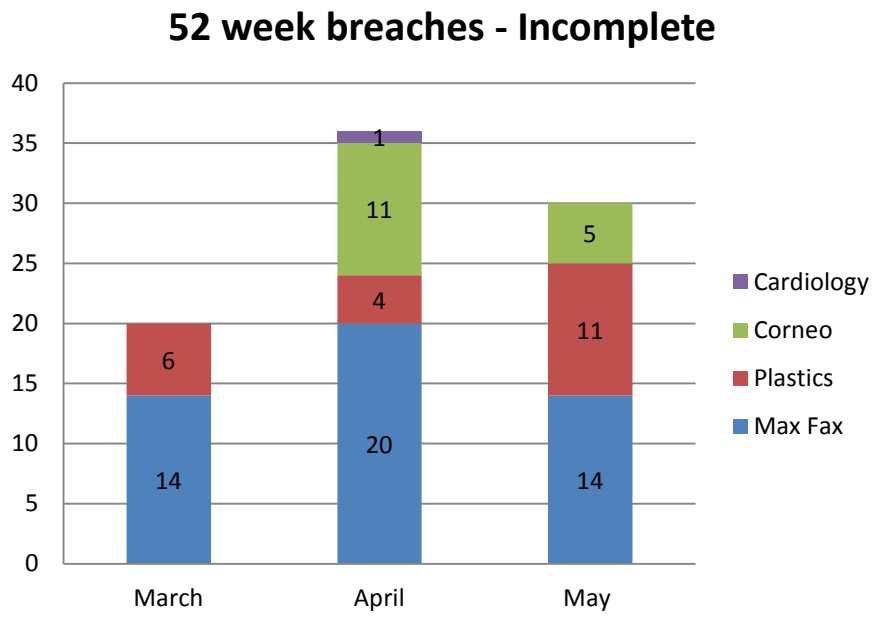
Incomplete pathway distribution by weeks (Cardiology)



RTT18: 52+ Week Incomplete Pathways

52 week breaches

52 week+ by future date status & speciality (May 2018)				
Speciality	Future date	No date	Past Date	Total
Max Fax	6	8		14
Plastic surgery	8	3		11
Corneo plastics	5			5



Performance overview / Forward look

Work has been ongoing in the trust with NHSI support to undertake a review of the Patient Tracking List (PTL) to ensure that all patients are being accurately recorded on a single source. This includes work in relation to patients being managed through planned pathways and also those treated at spoke sites. This includes work to enable access to spoke site patient data. The final position and impact should be known by the end of July (subject to spoke site data access).

RTT: Incomplete pathways – Commentary

Incomplete pathways

- OMFS, plastics and corneo are currently the most challenged specialities. Additional pressures in cataract surgery due to ability to use Rowntree day surgery theatres due to estates issues. This is being addressed by the estates team with an estimated completion date of in the first week of July.

PTL Management

- Weekly PTL meeting ongoing – patient level review of all patients >40 weeks
- Additional PTL reports created to help support the management of patients, for example patients <40weeks with the next activity over 52 weeks and patients <40weeks with no next activity
- Refined PTL is being developed with NHSI

Capacity & Demand Analysis

- NHSI continue to work with MaxFax re capacity and demand. Analysis to date demonstrates a capacity gap. Further information to follow.
- Plastics capacity and demand work has also commenced with NHSI

Trust Access Policy

- Access policy developed. Imminent approval awaited by the CCG. Included on Finance and Performance Committee agenda for approval

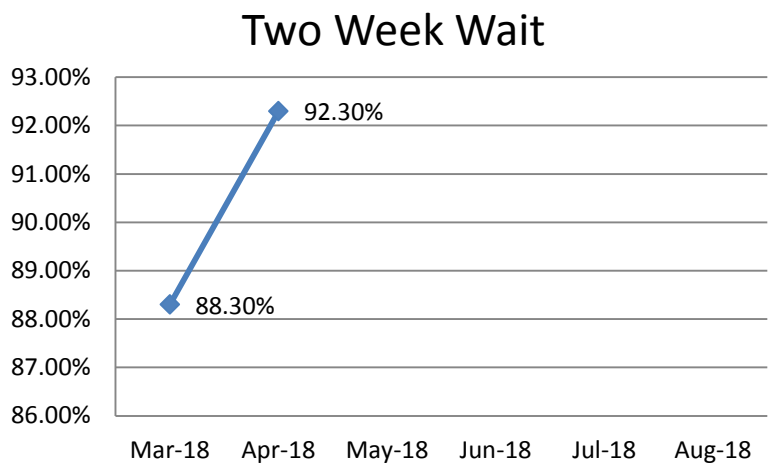
Recovery plan

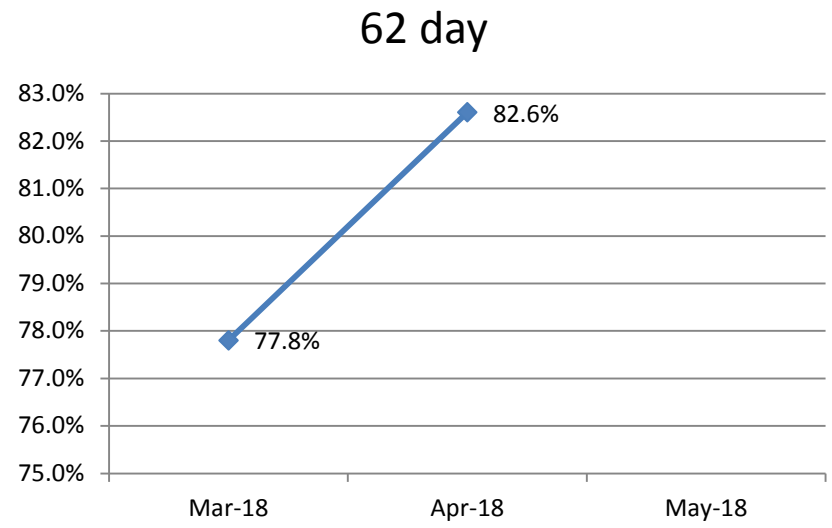
- Recovery planning underway. Awaiting baseline position from PTL review.

Challenges, risks to delivery and proposed mitigation

- **Theatre access** - Access to day surgery theatres for cataracts.
- **Theatre cancellations** due to staffing shortages is having a significant impact on RTT position and overall activity position. Work underway as part of theatre scheduling group to address.
- **PTL review –** consolidation of RTT patients is likely to increase active pathway patients.

Cancer Performance – 2WW & 62 day



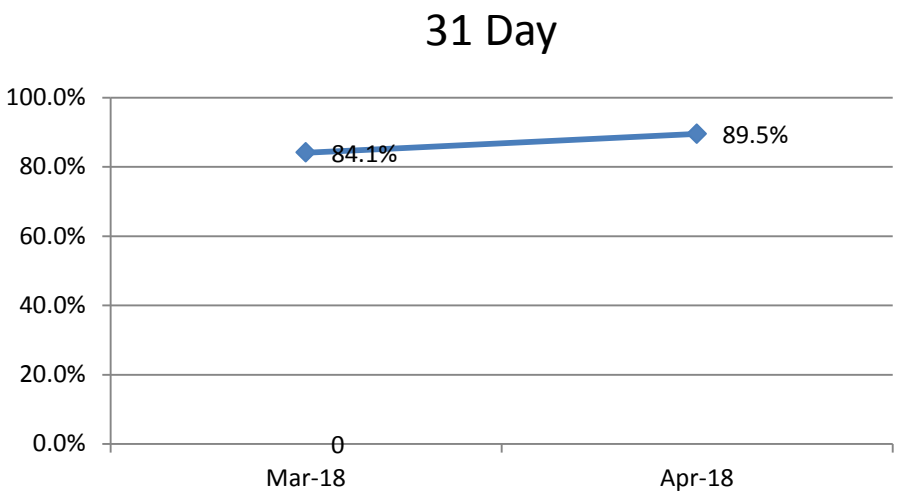


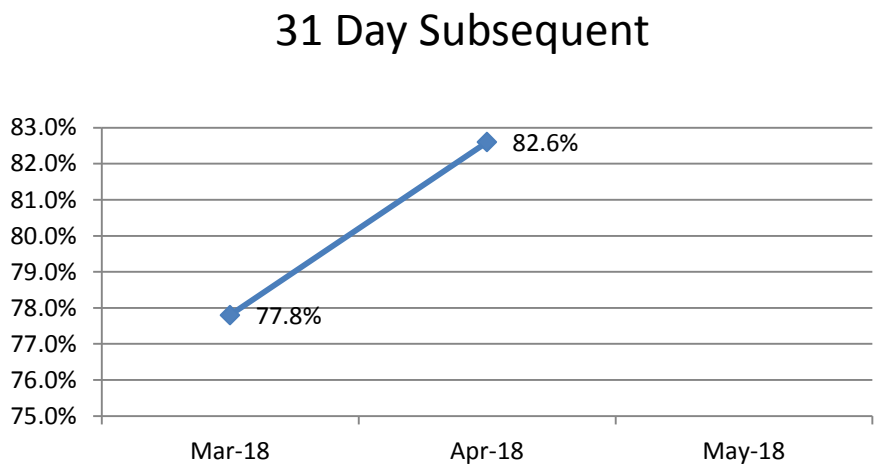
2WW Performance – Target 93%				
	Mar 18	**Apr 18 Total**	**Apr-18 Breach**	**Apr-18 Perf.**
Head & neck	85.6%	185	19	89.7%
Skin	92%	72	1	98.6%
Children's	100%	1	0	100%

62 day performance – Target 85%			
	Apr 18 Total	**Apr-18 Breach**	**Apr-18 Perf.**
Head and Neck	4.5	2	55.5%
Skin	5	2	60%
Breast	0	0	

[Rolling 12 month trends to be included in future reporting]

Cancer Performance – 31 day



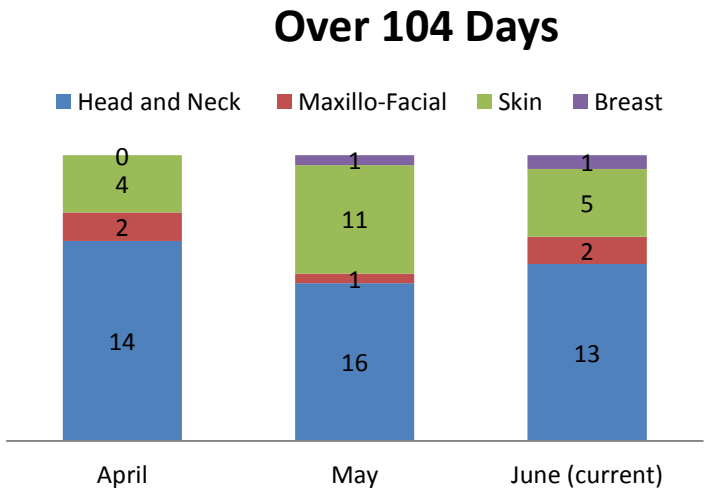


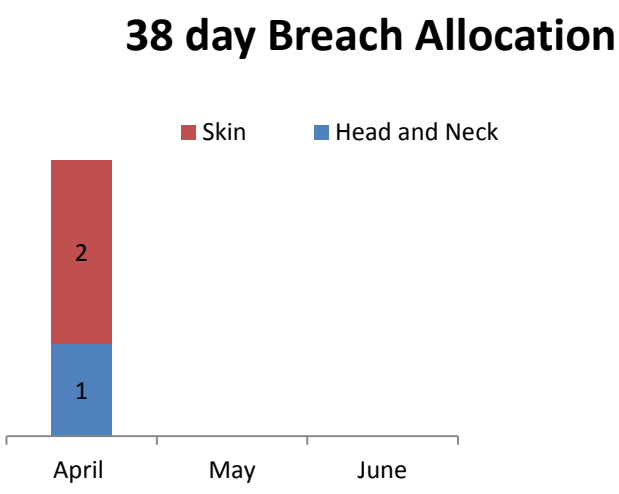
31 day performance – Decision to first treatment (Target 96%)			
	Apr 18 Total	**Apr-18 Breach**	**Apr-18 Perf.**
Head & neck	6	0	100%
Skin	26	0	100%
Breast	6	4	33.3%

31 day performance – decision to subsquent treatment (94%)			
	Apr 18 Total	**Apr-18 Breach**	**Apr-18 Perf.**
Head & neck	3	0	100%
Skin	19	3	84.2%
Breast	1	1	0%

[Rolling 12 month trends to be included in future reporting]

Cancer Performance
104 days, 38 day shadow allocation





Performance commentary	Forward look / performance risks
Over 104 Days • Reducing the number of patients waiting over 104 days on a 62 day pathway is a priority • Work underway to address pathways in regard to patients waiting for non clinical reasons • Priority of clinicians to review their patients over 104 days **38 Day Breach Allocation** • Challenges remain around the 38 day breach allocation and treating within 24 days of receiving the Inter Provider Transfer - Capacity - Referral process	• 104 day clinical harm review – need to agree a process for clinical harm review for any patient over 104 days, regardless if they have a cancer diagnosis. • Sentinel node biopsy capacity

Cancer Performance - commentary

Cancer breaches
Increase of 1.5 breaches due to the non-compliance with the 24 day target for patients on a 62 day pathway, this will impact on performance.

PTL Management
Improved PTL meeting, with new terms of reference (approved by NHSI). The PTL is widely distributed to the clinical and admin teams to increase engagement and visibility of patients on a pathway.

Central Oncology Hub
Development of an oncology hub – all 2WW referrals and oncology referrals will go through one hub to ensure consistent management of oncology referrals. Process mapping taking place to improve the efficiency of booking oncology referrals.

Timed pathways
Developing timed pathways for Skin and Head and Neck.

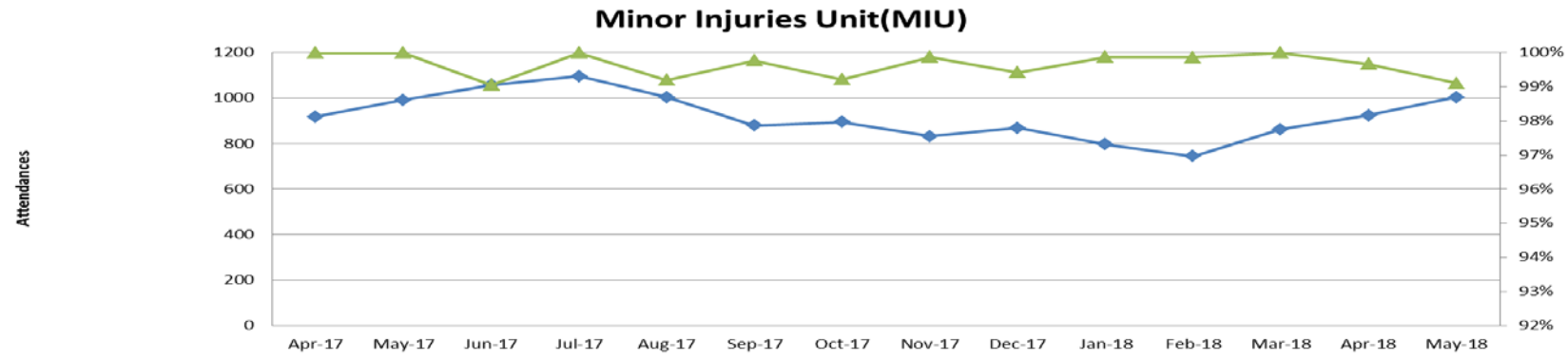
Increased communication
Improved communication with referring trusts – weekly conference calls with Medway and Conquest, this will be expanding to include other trusts. This ensures we are working collaboratively to improve the transfer of patients between trusts and reduce the risk of breaching.

Training
IST have done 2 training sessions with QVH staff. This will continue with the Access and Performance manager

Challenges and risks to delivery
Capacity for follow-up appointments to achieve the new 28 day diagnosis target. To tackle this, specialties to develop notes review clinics or virtually clinics.
Capacity challenges for some procedures for skin including MOHS and LOPAS
Capacity for Sentinel Lymph Node Biopsy skin patients . Currently only two consultants can see these referrals.

Minor Injuries Unit (MIU)

MIU Performance v Target



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
breaches	0	0	10	0	8	2	7	1	5	1	1	0	3	9
Attendances	919	993	1058	1097	1004	880	895	832	869	797	745	863	924	1005
Performance(target 95%)	100%	100%	99%	100%	99%	100%	99%	100%	99%	100%	100%	100%	100%	99%

Performance commentary	Forward look / performance risks
• Recent seasonal increase in MIU attendances • 4 hour breaches due to unplanned staff sickness and capacity	GP urgent access hub in place and working well. Looking to use GP lead to provide additional governance to MIU staff. Liaising with extended access GP provider to explore 5pm-8pm options.

Outpatients

Total referrals by source (including eRS)
[Data to incorporated in July report]

Uncashed up clinics (total by speciality)
[Data to incorporated in July report]

eRS (electronic referral) utilisation – CCG & Trust

	Last 7 days	Last Month
QVH	22%	27%
CRAWLEY CCG	18%	12%
MEDWAY CCG	63%	56%
HORS & MID Sx CCG	13%	12%
W KENT CCG	52%	55%
HWLH CCG	29%	33%

Outpatients commentary

Outpatient performance
Referral process backlogs are currently being addressed within the departments to support readiness for eRS. Outpatient dashboard is being compiled to enable the establishment and monitoring of process KPIs.

Evolve
EDM Project Resource Cost Options paper submitted to IM&T Strategy Group 12 June. Clinical Safety Review completed by clinical chief information officer and submitted to IM&T Strategy Group. Action plan to follow. Full report within DoF F& P report.

eRS paper switch off
Work continues at pace with internal project plan and external weekly telecoms monitoring progress against national checklist.
NHSE have agreed soft paper switch off 2 July with hard paper switch off from 31 July in line with SASH. We will have a joint review of utilisation rates on 17 July prior to final sign off for hard paper switch off.

Key risks to delivery include:
Capacity – QVH needs to ensure that there is adequate capacity available online before paper switch off to ensure minimal levels of appointment slot Issues.

GP use of eRS
Local CCGs have been amongst the lowest for eRS utilisation rates nationally. Low utilisation would present an additional burden on QVH resource to manage the manual return of paper referrals and increase the level of patients experience delays in obtaining first appointments.

Operational readiness – trust standard operating procedures (SOPs)
Trust revised SOPs will be developed prior to paper switch off to ensure a safe transition. SOPs will include an agreed process for the return of paper (non-eRS) referrals to GPs .

System readiness
To enable the eRS service on a desktop PC a client software called Identity Agent (IA) is required that works in conjunction with a smart card. The latest version of the IA requires a version of internet explorer (IE11) that is not supported with the Evolve EDM (Electronic Document Management) system, therefore the IT team are working on a solution that utilises Google Chrome Browser for spine ERS access, this option requires configuration and testing prior to rolling out, IT are currently in the configuration stage.

Theatres

[Dataset under development]

Cancelled Operations on the day

Total theatres running per week

Theatre utilisation – trust position

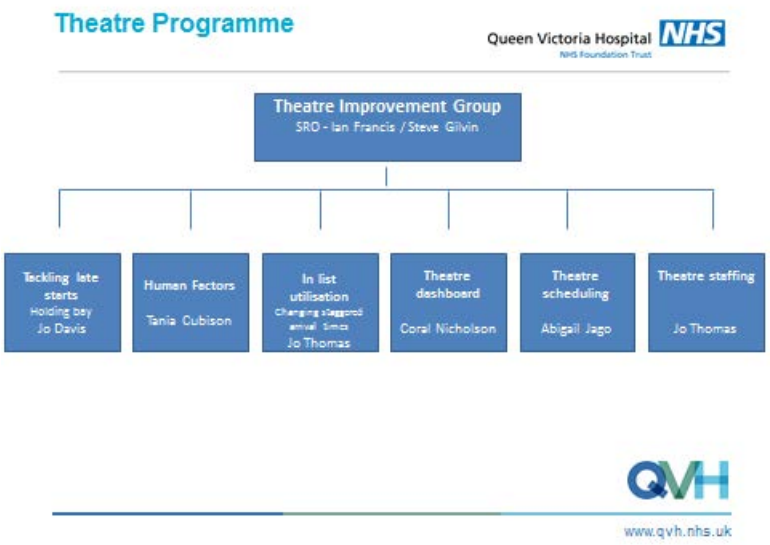
Theatre utilisation – speciality hot spots

[Data to incorporated in July report]

Theatre commentary

Performance update
Ongoing challenge with the ability to staff theatres. Late locking down of lists is resulting in last minute cancellations and list changes which is being addressed through a newly established theatre scheduling group.

Theatre Improvement Group update
Theatre improvement group is in place with a suite of workstreams to improve overall theatre efficiency.



Workstream update
Tackling late starts – holding bay initiative. Now underway to ensure first patient of the day is available in the holding bay ahead of the list start. First evaluation to be considered within June meeting.
In list utilisation – changes to patient arriving at staggered times which can impact on in list utilisation.
Staffing – work on international recruitment has commenced. Additional review of staffing of day surgery lists underway.
Theatre dashboard- dashboard development underway and review planned for June theatres improvement group meeting
Theatre scheduling - weekly meeting now in place with a work plan agreed to look at process redesign for scheduling (first session complete on 8 June) and 12 week forward look to maximise theatres in relation to staffing, RTT, cancer and activity pressures

Business Unit Updates - Commentary

OMFS / Oral Surgery

- OMFS / Oral Surgery remains challenged with RTT . Capacity and Demand model in progress with clinical buy in . NHSI involved and supporting this work

Ophthalmology

- Outpatient wait times have increased due to lack of medical workforce (now resolved) but backlog needs to be cleared . Actions in place to address .
- Theatre capacity has been reduced significantly due to an estates issue with day treatment centre which will be resolved in July. Planning is underway to ensure we can treat the resulting backlog of cataract patients. This totals 100 patients , 30 over 18 weeks and 70 below (the majority waiting at c 14 weeks)

Sleep

- Consultant interview panel set up for early July. Hub and spoke clinics working well with increased activity. Recruitment of clinical staff remains a challenge. Sleep review of workforce has been considered and approved by executive management team.

Business Unit Updates - Commentary

Plastics

- Activity in May continued to be hampered by limited theatre capacity resulting in a significant number of lost operating lists. Further operational difficulties have been related to vacant posts within core trainees and registrars, partly compensated by agency locum support.
- The outsourcing of the routine hands work to Horder continues and is working well. Discussions are in process to explore the addition of routine breast patients with a start date to be confirmed.
- With the support of the Business Intelligence team, demand and capacity models have been developed for both inpatient and outpatient plastics pathways. Further meetings are now required with the wider operational team to use these models to identify specific theatre and outpatient capacity requirements to develop an achievable RTT18 recovery plan.
- A full review of all Plastics spoke sites is currently in progress to initially identify any contractual discrepancies but to also review the effectiveness and benefit of each site in conjunction with the demand and capacity findings mentioned above.

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 up to 10 sessions a week of GP capacity with excellent patient and staff feedback.
- Following the recruitment of a GP with special interest in rheumatology, the RTT18 position for rheumatology has now recovered to above 92% and to a sustainable waiting list size.
- Demand continues to increase for diagnostic imaging services across modalities causing pressures on the ultrasound and general radiography team. CT capacity has become increasingly difficult to source, however we anticipate the roll out of the QVH CT scanner to take place in August.
- Significant operational capacity in radiology and histopathology has been diverted to the Order Comms project with imminent testing of histopathology and radiology before going live. Both teams should be recognised for the speed at which that have implemented a significant project in conjunction with the IT team.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	5 July 2018		**Agenda reference:**	108-18	
Report title:	**Finance Report M2 May 2018**				
Sponsor:	Michelle Miles, Director of finance and performance				
Author:	Jason McIntyre, Deputy director of finance				
Appendices:	None				
Executive summary					
Purpose of report:	To highlight the Financial position of the Trust to Month 2 (May)				
Summary of key issues	As at month 2 (May) the Trust has delivered a deficit of £486k in month, £1,436k YTD, this is a variance to plan of £475k in month deficit and £490k YTD deficit. The main area of underperformance is patient activity in month due to plastics, eyes and OMSF. Pay currently stands at £215k in month and ££496k YTD in deficit due to the increasing use of agency staff in some areas and also some areas of overestablishement which is currently being identified. Non Pay is underspent due to the achievement of procurement CIP's and a drop in activity. CIPP achievement in month is behind plan due to a number of the targets not yet being developed into plans and under delivery on existing plans. An additional meeting has been scheduled for an in-depth CIP and activity reviews with all areas on a monthly basis, this is in addition to the monthly performance reviews which happen per area. Therefore the Trust is focusing on CIP and activity achievement on a two weekly basis to aid focus and delivery. From the revision of the operating plan an increase requirement of £600k is needed from non pay to offset the increase in costs that the Trust is suffering in pay. Capital is currently in line with plan and this will continue to be monitored over the coming months to ensure that each of the work streams are delivering to timetable. Debtors significantly decreased in month due to a successful review of aged debt which delivered c£900k of payment for +90days outstanding invoices. The Trust is still yet to receive 17/18 STF Q4 payments, this is in line with NHSI guidelines. Due to the Trusts deficit positon, cash is £0.3m behind plan due to additional payments for temporary staffing and the reduction in income. The finance team are working with budget holders to clear old creditor invoices which require investigation. The main areas of issue are Medway, BSUH and agency invoices. Finance use of resources rating is currently 3, this is in line with the plan submitted to NHSI. Agency spend for month 2 has yet again increased from month 1 to £295k, this is £159k above plan, however the Trust has noted to NHSI that patient safety will not be compromised by the delivery of the agency cap but non clinical agency spend is being reviewed.				
Recommendation:	To **note** the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
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:	KSO4 Financial Sustainability			
Corporate risk register:	Risks Non achievement of the Trusts agreed control total and non achievement of STF.			
Regulation:	Monthly reporting to NHSI on progress on all financial elements of the Trust including capital, cash, CIP delivery and the financial income and expenditure position The Finance Use of Resources rating is 3			
Legal:	The NHS Constitution to deliver financial balance			
Resources:				
Assurance route				
Previously considered by:	Finance and Performance Committee			
	Date:	25th June	Decision:	Noted
Previously considered by:	EMT			
	Date:	18th June draft, 25th June full	Decision:	Noted
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
May 2018

Executive Director: Michelle Miles

Contents

Queen Victoria Hospital
NHS Foundation Trust

Summary Position – YTD M2 2018/19

Queen Victoria Hospital NHS
NHS Foundation Trust

Table 1 – Financial Performance

Financial Performance			In Month £'000			Year to Date £'000		
Income and Expenditure		Annual Budget	Budget	Actual	Favourable/ (Adverse)	Budget	Actual	Favourable/ (Adverse)
Income	Patient Activity Income	66,896	5,684	5,329	(355)	10,446	10,335	(111)
	Other Income	4,377	324	337	13	645	698	53
Total Income		**71,272**	**6,008**	**5,666**	**(341)**	**11,091**	**11,033**	**(58)**
Pay	Substantive	(44,640)	(3,845)	(3,654)	191	(7,690)	(7,208)	482
	Bank	(80)	(7)	(140)	(133)	(13)	(466)	(452)
	Agency	(273)	(23)	(295)	(272)	(45)	(571)	(526)
Total Pay		**(44,993)**	**(3,874)**	**(4,090)**	**(215)**	**(7,749)**	**(8,245)**	**(496)**
Non Pay	Clinical Services & Supplies	(12,870)	(1,075)	(944)	131	(2,149)	(2,020)	129
	Drugs	(1,553)	(129)	(137)	(8)	(259)	(253)	6
	Consultancy	(79)	(7)	(37)	(30)	(13)	(45)	(32)
	Other non pay	(6,162)	(562)	(592)	(30)	(1,123)	(1,199)	(76)
Total Non Pay		**(20,664)**	**(1,772)**	**(1,709)**	**63**	**(3,544)**	**(3,517)**	**27**
Financing		(4,714)	(393)	(374)	19	(786)	(747)	39
Total Expenditure		**(70,372)**	**(6,040)**	**(6,172)**	**(133)**	**(12,078)**	**(12,509)**	**(430)**
Surplus / (Deficit)		**900**	**(32)**	**(506)**	**(474)**	**(987)**	**(1,475)**	**(488)**
Adjust for Donated Depn.		(274)	(20)	(20)	1	(41)	(39)	2
NHSI Control Total Excluding STF		**626**	**(11)**	**(486)**	**(475)**	**(946)**	**(1,436)**	**(490)**

YTD Performance

- The Trust is £490k adverse to plan YTD. The main driver is pay where the cost of temporary staffing (bank and agency) materially exceeds vacancies funding available.
- Income has under recovered by £58k YTD, which is due to patient activity income of £111k with other income over recovered by £53k.
- Patient activity income: Non Elective is the main driver of the under performance, £309k adverse YTD, Elective & Day cases slightly above plan by £17k YTD. Outpatients activity is above plan by £98k YTD. There is a provision of £36k YTD for CQUIN and Challenges. The main area of under performance is Plastics. Sleep services are over performing YTD £204k. Oral is favourable YTD by £74k, which is mainly in Elective & Day case activity, £52k YTD.
- The YTD pay position is very concerning as temporary staffing costs have increased dramatically over recent months and is the key driver of YTD over spend.
- Non pay & Financing is underspent by £66k in month within clinical supplies and financing being the main drivers.

Summary - Plan Performance

- The Trust delivered a deficit of £486k in month, £475k below plan. The YTD deficit is £1,436; £490k adverse to plan.
- The main driver of the YTD position is pay pressures.

In Month Performance

- Income has under-performed in month by £341k, driven by patient activity Income. The main areas of the in month adverse position is within Plastics at £270k which is mainly non elective activity below plan of £165k and Elective & Day case spells below plan by £89k. Oral is £143k adverse position, which is a combination of Elective and Day cases £61k adverse, Non elective adverse to plan by £45k and outpatients adverse by £36k.
- Substantive pay is underspent due to a number of vacancies in Admin and Clerical (£118k underspent in month) and Qualified nurses (£114k underspent) This underspend partially offset the overspend in Bank and Agency. Substantive medical consultants are £70k adverse, this is due to a £43k non recurrent settlement. There is also £23k CEA awards funding within other income which mitigates the remaining variance.
- Bank: 78% of the adverse bank variance is due to qualified nursing (£62k overspent) and admin and Clerical (£42k overspend) due to covering the substantive vacancies.
- Agency 80% of the agency usage was driven by Nursing (£217k), a proportion of which was covering vacancies however the most significant nursing demand, over and above current establishment, was due to the Canadian Wing (£40k), Burns centre (£17k) and critical care unit (£42k) facing RMN and high patient acuity pressures. Theatres agency has also contributed to the over spend (£112k) due to covering current vacancies.
- Non pay is underspent by £63k in month which is mainly due to clinical supplies savings due to underperformance. This has been partially offset by outsourcing costs.
- Financing is under spent in month by £19k which is due to a reduced capital expenditure in previous periods, resulting in a lower than planned depreciation charge.

I&E Trend Position – M2 2018/19

Queen Victoria Hospital NHS Foundation Trust

Board Line	Actual M10 17/18	Actual M11 17/18	Actual M12 17/18	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Plan 18/19 In Month	Actuals 18/19 In Month
Patient Activity Income	5,389	4,811	5,051	5,006	5,329	6,112	5,784	5,111	5,914	5,982	6,312	4,613	5,784	5,254	5,584	5,684	5,329
Other Income	429	496	898	361	337	324	324	322	823	324	324	321	324	322	323	324	337
Total Income	**5,818**	**5,307**	**5,949**	**5,367**	**5,666**	**6,435**	**6,108**	**5,434**	**6,737**	**6,306**	**6,636**	**4,934**	**6,108**	**5,576**	**5,907**	**6,008**	**5,666**
Substantive	(3,468)	(3,415)	(3,497)	(3,553)	(3,654)	(3,845)	(3,739)	(3,739)	(3,739)	(3,648)	(3,648)	(3,648)	(3,648)	(3,648)	(3,648)	(3,845)	(3,654)
Bank	(122)	(132)	(139)	(326)	(140)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(140)
Agency	(205)	(251)	(289)	(276)	(295)	(23)	(23)	(23)	(23)	(23)	(23)	(23)	(23)	(23)	(23)	(23)	(295)
Total Pay	**(3,794)**	**(3,798)**	**(3,925)**	**(4,155)**	**(4,090)**	**(3,874)**	**(3,769)**	**(3,769)**	**(3,769)**	**(3,677)**	**(3,677)**	**(3,677)**	**(3,677)**	**(3,677)**	**(3,677)**	**(3,874)**	**(4,090)**
Clinical Services & Supplies	(1,054)	(1,025)	(301)	(1,076)	(944)	(1,074)	(1,074)	(1,074)	(1,074)	(1,071)	(1,071)	(1,071)	(1,071)	(1,071)	(1,071)	(1,075)	(944)
Drugs	(118)	(105)	(126)	(116)	(137)	(129)	(129)	(129)	(129)	(129)	(129)	(129)	(129)	(129)	(129)	(129)	(137)
Consultancy	(17)	-	(83)	(8)	(37)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(37)
Other non pay	(562)	(595)	(484)	(607)	(592)	(521)	(513)	(504)	(503)	(500)	(500)	(500)	(500)	(500)	(499)	(562)	(592)
Total Non Pay	**(1,750)**	**(1,726)**	**(993)**	**(1,807)**	**(1,709)**	**(1,731)**	**(1,723)**	**(1,714)**	**(1,713)**	**(1,707)**	**(1,707)**	**(1,707)**	**(1,707)**	**(1,707)**	**(1,706)**	**(1,772)**	**(1,709)**
Financing	(345)	(345)	(421)	(373)	(374)	(393)	(393)	(393)	(393)	(393)	(393)	(393)	(393)	(393)	(393)	(393)	(374)
Total Expenditure	**(5,890)**	**(5,869)**	**(5,340)**	**(6,336)**	**(6,172)**	**(5,999)**	**(5,885)**	**(5,876)**	**(5,875)**	**(5,777)**	**(5,777)**	**(5,777)**	**(5,777)**	**(5,777)**	**(5,776)**	**(6,040)**	**(6,172)**
Surplus / (Deficit)	**(72)**	**(561)**	**609**	**(969)**	**(506)**	**437**	**223**	**(442)**	**862**	**530**	**860**	**(842)**	**331**	**(201)**	**130**	**(32)**	**(506)**
Donated Depreciation	(19)	(19)	124	(20)	(20)	(20)	(20)	(20)	480	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)
NHSI Contol Total Excluding STF	**(52)**	**(542)**	**485**	**(950)**	**(486)**	**457**	**243**	**(422)**	**383**	**550**	**880**	**(822)**	**351**	**(180)**	**151**	**(11)**	**(486)**

Summary

The above table details in month actuals, including quarter 4 of 17/18 and compared to planned income and expenditure for the remainder of the year. It provides a helpful analysis of income and expenditure relative to actual performance year to date.

The Income plan in month 1 & 2 are relatively low in relation to the remainder of the year. The Income plan significantly ramps up in over the next 3 months.

Activity Performance by POD – M2 2018/19

Queen Victoria Hospital NHS Foundation Trust

Table 1 - Performance by POD

Activity Performance		In Month			In Month			Year To Date			Year To Date		
POD	Currency	Plan Acty	Act Acty	Acty Var	Plan £k	Actual £k	Var £k	Plan Acty	Act Acty	Acty Var	Plan £k	Actual £k	Var £k
Minor injuries	Attendances	942	1,005	63	68	72	5	1,854	1,929	75	133	139	5
Elective (Daycase)	Spells	1,156	918	(238)	1,268	1,030	(238)	2,062	1,876	(186)	2,277	2,128	(150)
Elective	Spells	345	331	(14)	812	806	(6)	606	650	44	1,449	1,616	167
Non Elective	Spells	496	443	(53)	1,174	975	(199)	976	895	(81)	2,310	2,000	(309)
XS bed days	Days	56	166	110	16	43	28	106	238	132	29	63	34
Critical Care	Days	77	51	(26)	80	55	(25)	152	148	(4)	158	141	(16)
Outpatients - First Attendance	Attendances	3,847	4,197	350	532	575	43	6,925	7,815	890	953	1,066	112
Outpatients - Follow up	Attendances	11,188	11,007	(181)	797	818	22	20,227	20,998	771	1,435	1,575	140
Outpatient - procedures	Attendances	2,539	1,255	(1,284)	336	159	(177)	4,473	3,371	(1,102)	591	437	(154)
Other	Other	3,878	3,873	(5)	581	617	36	242,444	243,129	686	1,062	1,182	120
Prior Period Adjustments and WIP					23	180	157				49	(11)	(60)
					5,684	**5,329**	**(355)**				**10,446**	**10,335**	**(111)**

Summary

Minor Injuries has over performed by 63 attendances in month, YTD at 75 attendances above plan, which is giving a in month & YTD over performance of £5k.

Daycases have under performed in month by 238 spells and £238k below plan, this is mainly within Eyes in month 107 spells below plan & £103k, which reduced the over performance from previous month to £60k below plan YTD. Plastics is the other main area of under performance in month, 79 spells & £96k below plan in month, YTD under performance of £97k.

Elective have under performed in month by 14 spells, £6k under performance. This has reduced the over performance YTD to 44 spells, £167k above plan. Main area of under performance is Oral services, 15 spells and £21k below plan in month.

Table 2 - Performance by Service Line

Activity Financial Performance	In Month			Year to Date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Perioperative Care	82	48	(34)	162	136	(25)
Clinical Support	586	589	3	1,099	1,122	23
Eyes	579	499	(80)	999	1,045	45
Oral	1,218	1,075	(143)	2,138	2,212	74
Plastics	2,787	2,518	(270)	5,297	4,921	(376)
Sleep	404	413	9	693	897	204
Other incuding WIP/ coding	28	187	160	58	2	(56)
Grand Total	**5,684**	**5,329**	**(355)**	**10,446**	**10,335**	**(111)**

Non Elective has under performed in month by 53 spells, £199k below plan. Year to date is 81 spells & £309k below plan. This is mainly within Plastic services which is 57 spells & £165k below plan in month, YTD 96 spells & £296k below plan.

Excess Bed days have over performed in month by 110 days & £27k. YTD by 132 days & £34k above plan. The over performance is mainly within Plastic services and Elective excess Bed days.

Critical care is under performing by 26 days, which is £25k in month, however there is 51 bed days that have not been included in these figures for WIP, which brings the YTD position over performance of £104k, which is reflective in the Business units figures.

Outpatients in month is under performing to plan by 1115 attendances & £112k and YTD over performance by 558 attendances & £98k which is mainly driven by Oral services. There is a timing delay in the completion of coding of outpatient procedures , the anticipated value of the coding gain is accrued into the in month position and reflected within Prior Period Adjustments & WIP category as an estimate.

Other is above plan by £36k in month, £120k year to date. This is mainly from excluded devices in particular CPAP devices within Sleep services.

Within **services lines** over performance within eyes, oral and sleep have offset under recovery within mainly plastics.

NB

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

** Further activity trend analysis is included on the next page.

*** Total in month and YTD service line performance does not reconcile to activity income analysis by business unit page 7 as non SLAM activity income has not been disaggregated to business unit.

Activity Trends by Pod

Queen Victoria Hospital NHS Foundation Trust

	Activity Trend																
POD	Actual M10 17/18	Actual M11 17/18	Actual M12 17/18	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	PLAN 18/19 In Month	Actuals 18/19 In Month
Minor injuries	798	745	863	924	1,005	912	942	942	912	942	912	942	942	851	942	942	924
Elective (Daycase)	1,107	992	905	958	918	1,302	1,186	993	1,248	1,240	1,356	854	1,162	1,078	1,156	1,156	958
Elective	284	297	317	319	331	404	357	290	388	373	420	245	353	325	345	345	319
Non Elective	418	399	386	452	443	480	496	496	480	496	480	496	496	448	496	496	452
XS bed days	33	52	98	72	166	58	57	53	57	58	59	50	56	52	56	56	72
Critical Care	126	81	49	97	51	75	77	77	75	77	75	77	77	70	77	77	97
Outpatients - First Attendance	3,763	3,153	3,644	3,618	4,197	4,241	3,932	3,347	4,064	4,109	4,421	2,906	3,876	3,575	3,807	3,847	3,618
Outpatients - Follow up	10,480	9,107	10,132	9,991	11,007	12,186	11,404	9,794	11,672	11,918	12,708	8,542	11,237	10,368	11,049	11,188	9,991
Outpatient - procedures	2,737	2,233	1,565	2,116	1,255	2,952	2,623	2,140	2,833	2,742	3,071	1,817	2,605	2,385	2,523	2,539	2,116
Other	4,288	3,826	3,142	3,941	3,873	4,036	3,917	3,477	3,860	4,093	4,216	3,082	3,916	3,561	3,737	3,878	3,941
	24,034	20,885	21,101	22,488	23,246	26,645	24,991	21,609	25,588	26,049	27,718	19,012	24,721	22,712	24,189	24,524	22,488

	£'000 Trend																
POD	Actual M10 17/18	Actual M11 17/18	Actual M12 17/18	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	PLAN 18/19 In Month	Actuals 18/19 In Month
Minor injuries	59	55	64	67	72	66	68	68	66	68	66	68	68	61	68	68	72
Elective (Daycase)	1,329	1,186	1,014	1,098	1,030	1,404	1,296	1,099	1,345	1,355	1,463	953	1,266	1,179	1,268	1,268	1,030
Elective	765	780	746	809	806	914	833	697	876	871	952	600	816	757	812	812	806
Non Elective	1,056	996	951	1,026	975	1,136	1,174	1,174	1,136	1,174	1,136	1,174	1,174	1,060	1,174	1,174	975
XS bed days	9	15	27	20	43	16	16	15	16	16	16	14	16	14	16	16	43
Critical Care	189	87	54	87	55	77	80	80	77	80	77	80	80	72	80	80	55
Outpatients - First Attendance	518	419	501	491	575	592	544	460	567	569	617	398	536	495	528	532	575
Outpatients - Follow up	799	691	768	756	818	876	814	694	840	850	914	603	799	740	791	797	818
Outpatient - procedures	363	300	210	279	159	390	347	283	374	362	405	240	344	315	333	336	159
Other	430	410	494	565	617	619	590	517	594	615	645	458	584	536	570	581	617
Work in progress and coding adjustment				(191)	180											23	180
	5,518	4,939	4,829	5,006	5,329	6,090	5,762	5,087	5,892	5,960	6,291	4,587	5,683	5,230	5,639	5,684	5,329

Financial Position by Business Unit – M2 2018/19

Variance by type: in £ks	Patient Activity Income		Other Income		Pay		Non Pay		Position	In Month				Year to Date			
performance against financial plan	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Budget	Actual	Variance	% Contribution	Budget	Actual	Variance	Contribution
Operations																	
1.1 Plastics	(203)	(392)	12	24	(113)	(185)	(42)	(123)	23,347	2,034	1,688	(345)	65%	3,798	3,122	(675)	63%
1.2 Oral	(177)	61	41	81	(63)	(89)	(46)	(58)	7,397	616	371	(245)	34%	941	936	(5)	41%
1.3 Eyes	(69)	42	20	52	(1)	(9)	(21)	4	3,642	302	232	(70)	43%	449	537	89	48%
1.4 Sleep	29	210	(40)	(40)	(9)	(35)	89	59	2,430	201	269	68	70%	288	483	194	57%
1.5 Clinical Support	65	38	(13)	(32)	54	86	24	36	(2,546)	(195)	(65)	130		(459)	(331)	128	
1.6 Perioperative Care	104	49	8	(1)	(84)	(188)	58	30	(11,584)	(1,023)	(937)	86		(2,049)	(2,159)	(110)	
1.7 Operational Nursing	3	4	(2)	(4)	(22)	(78)	0	5	(3,685)	(307)	(328)	(21)		(614)	(687)	(73)	
Operations Total	**(248)**	**12**	**25**	**80**	**(236)**	**(497)**	**63**	**(47)**	**19,000**	**1,628**	**1,231**	**(397)**		**2,354**	**1,902**	**(452)**	
Nursing & Clinical Infrastructure																	
2.1 Clinical Infrastructure	-	-	-	-	(3)	(13)	20	3	(1,107)	(92)	(76)	17		(184)	(195)	(10)	
2.5 Director Of Nursing	-	-	(11)	(25)	(2)	(11)	(9)	(29)	(2,862)	(239)	(260)	(22)		(477)	(542)	(65)	
Nursing & Clinical Infrastructure	**-**	**-**	**(11)**	**(25)**	**(6)**	**(24)**	**11**	**(26)**	**(3,969)**	**(331)**	**(336)**	**(5)**		**(662)**	**(737)**	**(75)**	
Corporate Departments																	
3.1 Non Clinical Infrastructure	-	-	(2)	9	7	(1)	(23)	5	(4,393)	(369)	(387)	(18)		(739)	(726)	13	
3.2 Commerce & Finance	-	-	0	1	6	17	7	(23)	(2,778)	(232)	(218)	13		(463)	(469)	(5)	
3.4 Finance Other	(107)	(122)	6	(3)	(7)	(13)	43	152	(2,727)	(486)	(551)	(64)		(992)	(979)	13	
4.1 Human Resources	-	-	(1)	(3)	13	12	14	22	(1,010)	(84)	(58)	26		(168)	(137)	31	
5.4 Corporate	-	-	(4)	(7)	7	11	(33)	(16)	(1,897)	(158)	(187)	(29)		(316)	(329)	(13)	
Corporate Total	**(107)**	**(122)**	**(1)**	**(3)**	**27**	**26**	**9**	**139**	**(12,805)**	**(1,329)**	**(1,401)**	**(72)**		**(2,679)**	**(2,640)**	**39**	
Surplus / (Deficit)	**(355)**	**(111)**	**13**	**53**	**(215)**	**(496)**	**82**	**66**	**2,225**	**(32)**	**(506)**	**(474)**		**(987)**	**(1,475)**	**(488)**	

Summary

Patient Activity Income: The main areas of key concern is Plastics, which is mainly driven from under performance of Non Elective activity, Oral services which has seen a large movement in under performance from previous month which is a mixture of Elective, Daycases, Non Elective and Outpatients below plan in month. Eyes have seen a reduction in performance in month mainly in Daycases, which is being slightly offset by Elective spells.

Other income: In month is above plan by £13k, YTD £53K. This is due to increase in clinical excellence awards income, which is offsetting some of the over spend within pay. Plastics is mainly due to reclassification for supporting Brighton Hospital services, which is partially offsetting over spend within Medical spend in pay. Oral above plan is mainly due to additional income from NHS England Education and cleft lip services from Guy's & St Thomas's. Eyes is mainly due to increase in our supply of pre-cut corneal tissue to various providers. Sleep services has seen a one off issue relating to a failure to secure funding from HEE, which is non recurrent. The below plan in Clinical support is being reviewed, this is mainly in Radiography & Histopathology.

Pay: In month is over spent by £215k in month, £496k YTD. The main areas of concern are Plastics, which some is offset by additional other income, with increase usage of agency medical staff. Perioperative is over by £188k YTD which is a mixture of high agency usage and also payment for super saturdays. In month 2 there was an increase in RMN's hours of 470 hours in Burns & critical care.

Non Pay: In month has seen a reduction in spend, £82k below plan in month, £66k below plan YTD. Plastics is above plan which is mainly due to outsourcing of activity to McIndoe which is being recovered through Patient Activity Income. Oral is mainly due to an increase spend in Implants & Prosthesis Appliances. Eyes in month adverse position is due to a catch up of contact lenses supplies. Work is ongoing with procurement looking into reducing spend in stock items and renegotiating contracts.

Cost Improvement Plan (CIP) – M2 2018/19 (1)

Queen Victoria Hospital NHS Foundation Trust

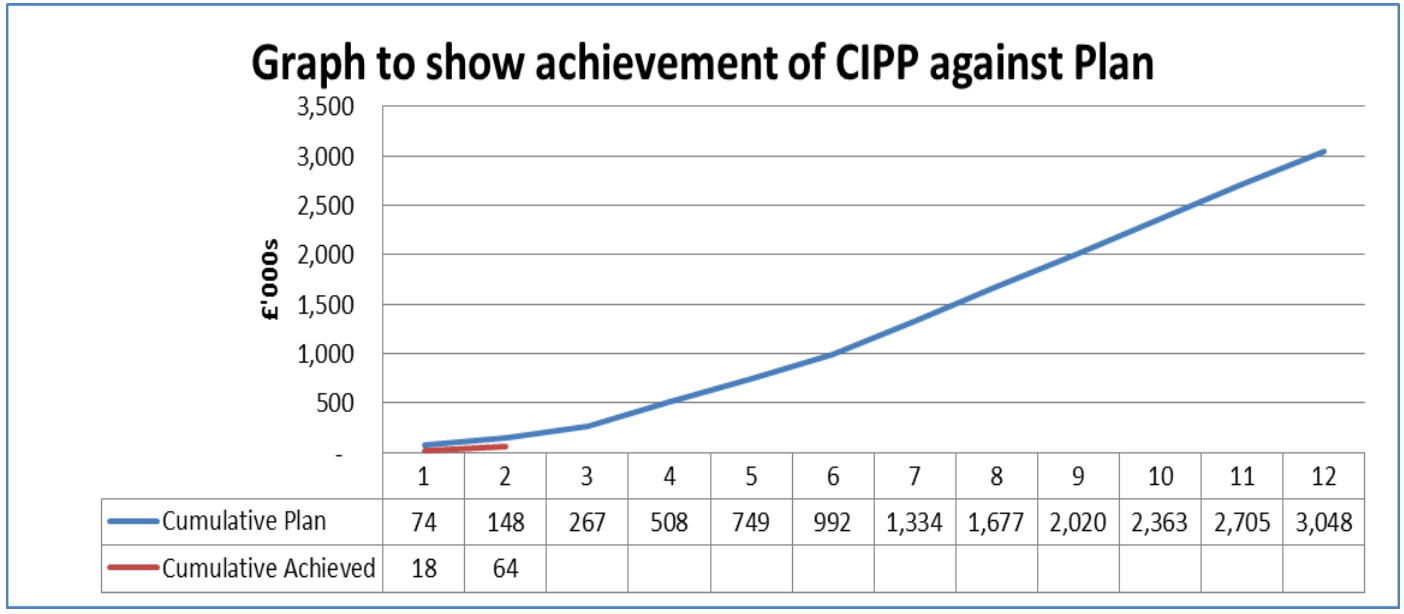
Cost Improvement Programme	Annual			In Month			Year to Date		
Business Unit	NHSI Planned Savings £	CIPP 2018/19 Contribution / Cost Saving (Gross CIPP identified) £	Risk assessed CIPP £ based on RAG	Planned Savings	Actual Savings	Favourable / (Adverse)	Planned Savings	Actual Savings	Favourable / (Adverse)
1.1 Plastics	(461,621)	(82,872)	(41,436)	(8,763)	-	(8,763)	(17,525)	-	(17,525)
1.2 Oral	(365,162)	(10,000)	(10,000)	(2,574)	-	(2,574)	(5,149)	-	(5,149)
1.3 Eyes	(170,687)	-	-	(837)	-	(837)	(1,673)	-	(1,673)
1.4 Sleep	(48,272)	(88,320)	(49,053)	(8,787)	(2,861)	(5,926)	(17,574)	(4,720)	(12,854)
1.5 Clinical Support	(429,084)	(327,589)	(203,085)	(12,921)	(7,610)	(5,311)	(25,842)	(11,638)	(14,205)
1.6 Perioperative Care	(646,490)	(174,352)	(87,176)	(16,844)	(23,416)	6,572	(33,687)	(27,000)	(6,687)
1.7 Operational Nursing	(182,391)	(15,000)	(1,500)	(1,286)	(708)	(578)	(2,572)	(833)	(1,739)
2.1 Performance & Access	(50,977)	(10,000)	(1,000)	(1,034)	-	(1,034)	(2,068)	-	(2,068)
2.5 Director of Nursing	(172,735)	(89,000)	(62,900)	(7,513)	(5,000)	(2,513)	(15,027)	(10,000)	(5,027)
3.1 Non Clinical Infrastructure	(240,528)	(61,340)	(45,234)	(939)	-	(939)	(1,878)	0	(1,878)
3.2 Commerce & Finance	(135,847)	(406,120)	(207,320)	(8,178)	(5,984)	(2,194)	(16,356)	(9,286)	(7,070)
4.1 Human Resources	(55,100)	(53,599)	(5,360)	(4,474)	-	(4,474)	(8,948)	(447)	(8,501)
5.4 Corporate	(89,106)	-	-	168	-	168	337	-	337
Targets in Op Plan	-	(200,000)	(20,000)	-	-	0	-	-	-
Grand Total	**(3,048,000)**	**(1,518,192)**	**(734,064)**	**(73,982)**	**(45,579)**	**(28,403)**	**(147,964)**	**(63,924)**	**(84,040)**

Summary

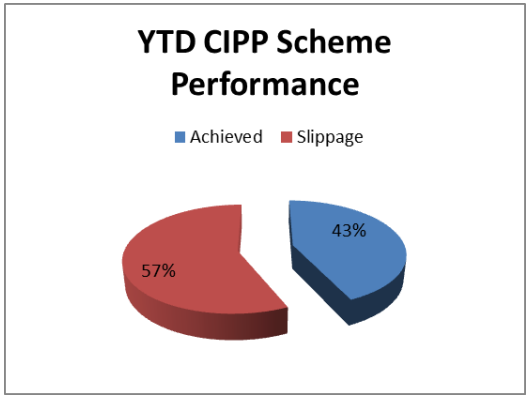
- In Month £46k savings were achieved against a plan of £74k, i.e. under achievement of £28k, YTD savings of £64k against a plan of £148k, which leaves a YTD under plan of £84k.
- Unidentified has reduced by £94k from the previous month due to an increase in procurement plans being identified.
- Slippage on identified schemes has reduced from 74% to 57%.
- Further work is being undertaken as to why such a shortfall is still occurring in the larger areas.

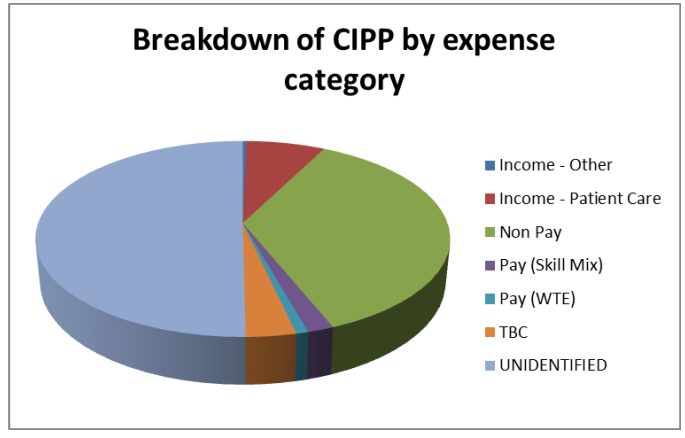
Cost Improvement Plan (CIP) – M2 2018/19 (2)

Queen Victoria Hospital
NHS Foundation Trust



	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative Plan	74	148	267	508	749	992	1,334	1,677	2,020	2,363	2,705	3,048
Cumulative Achieved	18	64										





Balance Sheet – M2 2018/19

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet as at the end of May 2018	2017/18 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	47,588	47,304	47,400
Other Receivables	-	-	-
Sub Total Non-Current Assets	47,588	47,304	47,400
Current Assets			
Inventories	1,178	1,181	1,179
Trade and Other Receivables	8,217	7,492	8,148
Cash and Cash Equivalents	8,914	7,913	7,969
Current Liabilities	(8,893)	(8,361)	(8,662)
Sub Total Net Current Assets	9,416	8,225	8,634
Total Assets less Current Liabilities	57,005	55,528	56,034
Non-Current Liabilities			
Provisions for Liabilities and Charges	(665)	(665)	(665)
Non-Current Liabilities >1 Year	(5,823)	(5,823)	(5,823)
Total Assets Employed	**50,517**	**49,040**	**49,546**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	26,100	24,623	25,129
Revaluation Reserve	12,180	12,180	12,180
Total Tax Payers' Equity	**50,517**	**49,040**	**49,546**

Summary

- Capital asset value has decreased in month by £0.1m due to capital spend profile .
- Net current assets have decreased in month by £0.4m:
- Inventories are planned to monitored on a quarterly basis.
- Trade and other receivables have decreased by £0.7m due to the recovery of some older debts.
- Cash has decreased by £0.1m.
- Current liabilities have decreased by £0.3m due to a high level of payments being made for trade creditors in month.

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 – M2 2018/19

Queen Victoria Hospital NHS
NHS Foundation Trust

Month 2 - May 2018	Annual Plan £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Full Year Forecast £000s	Full Year Variance £000s
Estates projects						
Backlog maintenance - Energy Management	216	-	-	-	216	-
Backlog maintenance - Health & Safety	105	-	4	(4)	105	-
Backlog maintenance - Fire Safety	145	-	11	(11)	145	-
Backlog maintenance - Internal Accommodation	234	-	5	(5)	234	-
Backlog maintenance - External Works	180	-	-	-	180	-
Other projects	384	26	58	(32)	384	-
Estates projects	**1,264**	**26**	**78**	**(52)**	**1,264**	-
Medical Equipment	**1,033**	**116**	**64**	**52**	**1,038**	**(5)**
Information Management & Technology (IM&T)						
Ordercomms	120	40	39	1	120	-
Infrastructure strategy - hardware	170	-	-	-	170	-
Infrastructure strategy - end user reconfiguration	150	-	-	-	150	-
Infrastructure strategy - desktop/mobile	100	-	-	-	100	-
Health & Social Care Network	150	-	16	(16)	150	-
Vital Sign mplementation (Eobservation)	108	-	-	-	108	-
EDM	108	-	-	-	108	-
Other projects	534	24	19	5	534	-
Information Management & Technology (IM&T)	**1,440**	**64**	**74**	**(10)**	**1,440**	-
Commitments	**-**	**-**	**-**	-	**-**	-
Contingency	**113**	**-**	**-**	**-**	**108**	5
Total	**3,850**	**206**	**216**	**(10)**	**3,850**	**-**

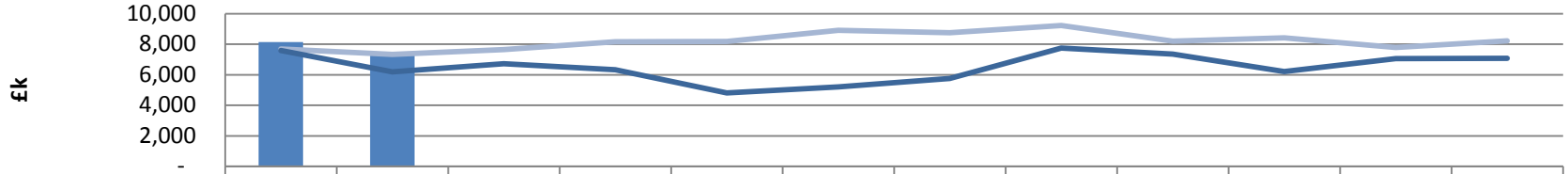
Summary

- The Capital plan for 2018/19 is a total of £3,850k . This includes the CT scanner project for which a donation of £400k has been agreed.
- The capital programme has been developed through the 2018/19 business planning process via the Capital Planning Group and with EMT and Board approval. The distribution of the plan total between the main expenditure categories and the contingency provision has been amended since the previous report to reflect approved backlog maintenance and IM&T Strategy projects.
- The largest element of the Estates programme is backlog maintenance. The Trust is in year 3 of a 5 year programme. There was slippage in 17/18 which is causing an overspend against plan in the early months but which will be handled within budget during the year.
- The IT programme is largely based on the IM&T Strategy. The EDM project is continuing. The Evolve product is fully live in Sleep and OFMS services and due to be deployed in Eyes; the implementation within Plastics is later than expected.
- Capital full year expenditure is forecast to be to plan.

Debtors – M2 2018/19

Queen Victoria Hospital NHS Foundation Trust

Debtor Trend



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total 2018/19	8,147	7,492										
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	8,217
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

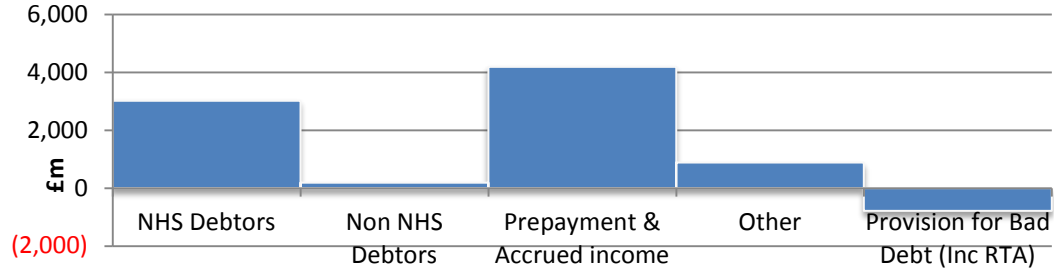
Summary

- The debtor balance decreased by £0.7m (8%) from month 01. This is due largely to recovery of aged debt relating to prior months over performance invoices.
- Prepayments and accrued income of £4.2m includes £0.9m of accrued income for activity over-performance and NCAs, £1.5m for the final STF for 2017/18 (expected to be paid in July/August). It also includes other income accruals and £1.1m of prepayment timing adjustments.
- The aged debtors total has decreased significantly by £1.3m from last month, with £0.9m of this being in the 90day+ category.

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 2018/19

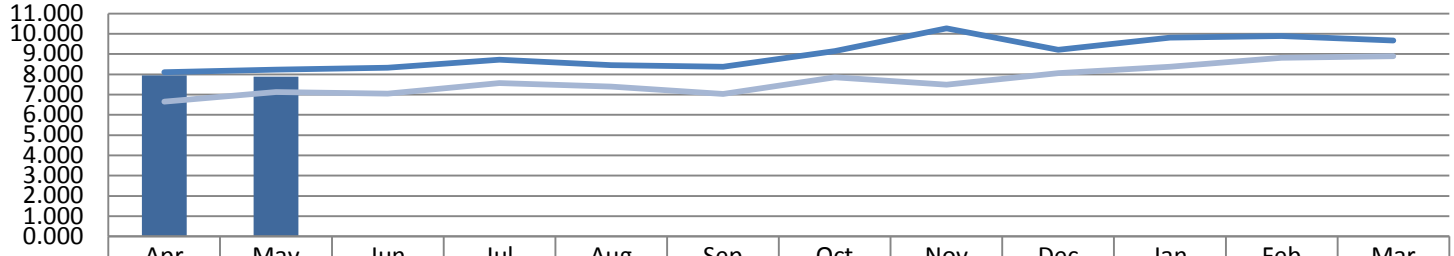


Aged Debtors				
POD	30 Days	60 Days	90 Days	90+ Days
NHS	1,138,927	423,298	266,715	1,246,430
Non NHS	35,814	14,394	15,932	74,971
Total	1,174,740	437,692	282,647	1,321,400

Cash – M2 2018/19

Queen Victoria Hospital NHS Foundation Trust

Cash Balances Summary



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 Actual	7.948	7.890										
18/19 NHSI Plan	8.108	8.225	8.333	8.725	8.452	8.365	9.151	10.267	9.202	9.809	9.883	9.668
2017/18 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

Cash Balance 2018/19	Actual (£m)		*Forecast:*									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Opening Balance	**8.89**	**7.95**	*7.89*	*7.68*	*7.93*	*8.57*	*8.83*	*9.53*	*10.65*	*9.83*	*10.65*	*10.94*
Receipts from invoiced income	5.77	6.42	*5.67*	*5.78*	*5.42*	*6.45*	*6.11*	*6.67*	*5.38*	*6.53*	*6.00*	*6.42*
Receipts from non-invoiced income	0.16	0.15	*0.15*	*0.15*	*1.35*	*0.65*	*0.15*	*0.15*	*0.15*	*0.15*	*0.15*	*0.15*
Total Receipts	**5.93**	**6.57**	*5.82*	*5.93*	*6.77*	*7.10*	*6.26*	*6.82*	*5.53*	*6.68*	*6.15*	*6.57*
Payments to NHS Bodies	(0.62)	(0.52)	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*	*(0.51)*
Payments to non-NHS bodies	(2.55)	(2.41)	*(1.28)*	*(1.34)*	*(1.37)*	*(1.84)*	*(1.24)*	*(1.37)*	*(1.54)*	*(1.53)*	*(1.53)*	*(1.63)*
Net payroll payment	(2.08)	(2.08)	*(2.08)*	*(2.14)*	*(2.39)*	*(2.14)*	*(2.14)*	*(2.14)*	*(2.14)*	*(2.14)*	*(2.14)*	*(2.14)*
PAYE, NI & Levy payment	(1.03)	(1.03)	*(1.03)*	*(1.06)*	*(1.18)*	*(1.06)*	*(1.06)*	*(1.06)*	*(1.06)*	*(1.06)*	*(1.06)*	*(1.06)*
Pensions Payment	(0.60)	(0.59)	*(0.60)*	*(0.62)*	*(0.69)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*
PDC Dividends Paid	-	-	-	-	-	*(0.67)*	-	-	-	-	-	*(0.67)*
Commercial Loan Repayment	-	-	*(0.54)*	-	-	-	-	-	*(0.48)*	-	-	-
Total Payments	**(6.88)**	**(6.63)**	(6.04)	(5.67)	(6.14)	(6.84)	(5.57)	(5.70)	(6.35)	(5.86)	(5.86)	(6.64)
Actual Closing Balance	**7.95**	**7.89**										
Forecast Closing Balance			*7.68*	*7.93*	*8.57*	*8.83*	*9.53*	*10.65*	*9.83*	*10.65*	*10.94*	*10.87*
NHSi Plan	**8.11**	**8.23**	**8.33**	**8.73**	**8.45**	**8.37**	**9.15**	**10.27**	**9.20**	**9.81**	**9.88**	**9.67**
Variance to NHSi plan	(0.16)	(0.33)	(0.66)	(0.79)	0.11	0.47	0.38	0.38	0.63	0.84	1.06	1.20

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 2 has an adverse variance of £0.3m against the plan submitted to NHSI. On balance this is due to increased payments for bank and agency staff .
- Cash balances are forecast to be above or in line with plan when the planned surplus is achieved.

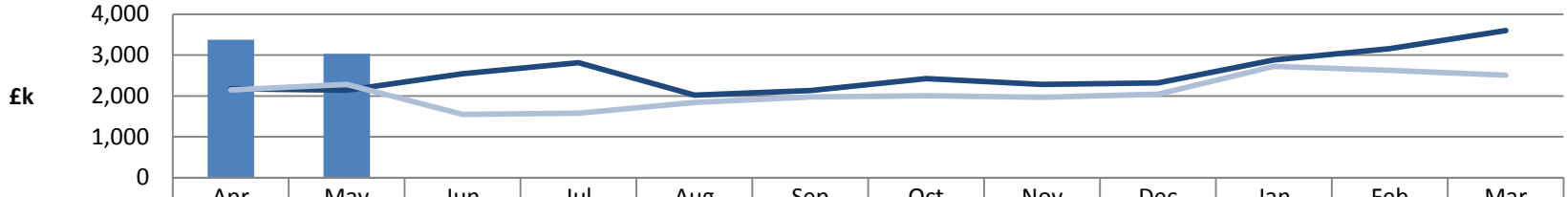
Next Steps

- 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 – M2 2018/19

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	3,377	3,033										
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
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 2 is £3.0m compared to an average of £2.5m during 2017-18.
- There is a decrease £0.4m in month, due to the payment of high value invoices authorised in month.
- The Trust's BPPC percentage has decreased in month by 4% 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 (18/19) May	2017/18 Outturn No Invs	2017/18 Outturn £k	Current Month No Invs	Current Month £k	YTD No Invs	YTD £k
Total **Non-NHS** trade invoices paid	20,090	21,583	1,906	3,316	3,631	7,132
Total **Non NHS** trade invoices paid within target	17,585	18,501	1,583	2,911	3,095	6,468
Percentage of Non-NHS trade invoices paid within target	**88%**	**86%**	**83%**	**88%**	**85%**	**91%**
Total **NHS** trade invoices paid	884	4,181	93	268	189	720
Total **NHS** trade invoices paid within target	521	2,020	52	103	99	284
Percentage of NHS trade invoices paid within target	**59%**	**48%**	**56%**	**39%**	**52%**	**39%**

Next Steps

- Financial services are continuing to review areas where invoice authorisation is delayed in order to target and support training needs.
- Current issues include: some delays in purchase order receipting, a backlog of staff agency invoices awaiting authorisation, outstanding Medway SLA disputes and BSUH balances negotiation.

Aged Creditors				
POD	30 Days	60 Days	90 Days	90+ Days
NHS	115,450	224,607	261,413	1,336,263
Non NHS	903,767	281,371	281,452	182,865
Total	1,019,217	505,978	542,865	1,519,129

Appendices

Appendix 1: Finance Score (Single Oversight Framework)

Table 1

Single Oversight Framework						
Finance Score: May 2018						**Plan**
	Metrics £k	Measure	Rating	Weight	Score	
Continuity of Services:						
Capital Service Cover						
Operating surplus (Adj YTD) / Capital Servicing Obligation YTD	(722) / 255	-2.83	4	20%	0.80	4
Liquidity						
Working Capital / Operating Costs (per day)	7,002 / 193	36.3	1	20%	0.20	1
Financial Efficiency:						
Control Total Margin (%)						
Adj. Surplus (deficit) YTD / Adj. Income year to date	(1,436) / 11,032	-13.02%	4	20%	0.80	4
Margin Variance From Plan						
Adj. Actual surplus margin / Adj. Plan surplus margin	-13.02% / -7.28%	-5.74%	4	20%	0.80	1
Agency Cap						
Agency Spend / Agency Cap	571 / 272	109.93%	4	20%	0.80	3
Finance Score: May 2018			3			3

Table 2

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

Summary

- The use of resources score is a 3 due to the current deficit both in plan and actual.
- Table 2 details a definition of each of the metrics and the scoring mechanism.

Appendix 2 - Agency Ceiling & Analysis

	Month 1 £'000	Month 2 £'000	Month 3 £'000	Month 4 £'000	Month 5 £'000	Month 6 £'000	Month 7 £'000	Month 8 £'000	Month 9 £'000	Month 10 £'000	Month 11 £'000	Month 12 £'000	Total £'000	YTD £'000
Agency Ceiling	136	136	136	136	136	136	136	136	136	135	135	135	1,628	272
Agency Actuals	276	295												571
Variance	(140)	(159)												(299)

Agency Spend by Business Unit	In Month						Year to Date					
Staff Group	Medical	Nursing & Healthcare Asstistant	AHP & Healthcare Scientists	Admin & Clerical	Support Staff	Grand Total	Medical	Nursing & Healthcare Assistant	AHP & Healthcare Scientists	Admin & Clerical	Support Staff	Grand Total
1.1 PLASTICS	13	34	0	0	0	47	25	61	0	0	0	85
1.2 ORAL	0	0	0	1	0	1	0	0	0	0	0	0
1.3 EYES	0	0	0	0	0	0	0	0	0	0	0	0
1.4 SLEEP	0	0	0	0	0	0	0	0	0	0	0	0
1.5 CLINICAL SUPPORT	9	0	0	1	0	10	24	0	0	1	0	25
1.6 PERIOPERATIVE CARE	0	155	0	0	0	155	0	280	0	0	0	280
1.7 OPERATIONAL NURSING	0	44	0	0	0	44	0	96	0	0	0	96
2.1 CLINICAL INFRASTRUCTURE	0	0	0	12	0	12	0	0	0	26	0	26
2.5 DIRECTOR OF NURSING	0	0	0	0	0	0	0	0	0	1	0	1
3.1 NON CLINICAL INFRASTRUCTURE	0	0	0	1	(1)	0	0	0	0	7	(0)	6
3.2 COMMERCE & FINANCE	0	0	0	26	0	26	0	0	0	53	0	53
3.4 FINANCE OTHER	0	0	0	0	0	0	0	0	0	0	0	0
4.1 HUMAN RESOURCES	0	0	0	0	0	0	0	0	0	0	0	0
5.4 CORPORATE	0	0	0	0	0	0	0	0	0	0	0	0
Total	**22**	**233**	**0**	**41**	**(1)**	**295**	**49**	**436**	**0**	**88**	**(0)**	**571**

Summary

NHSI has allocated each NHS provider an agency cap as a mechanism to reduce agency expenditure across the provider sector. QVH has been allocated an agency cap of £1.628m for the year. The cap is monitored on a monthly basis via the monthly financial monitoring returns.

The in Month agency expenditure of £295k is £159k more than the QVH NHSI ceiling. Year to date agency expenditure is £299k above the agency ceiling

Performance on the agency ceiling is one of the 5 metrics included within the Use of Resources measure in the single oversight framework.

The year to date Agency expenditure on Clinical Operations is £269k in month, £511k YTD. Corporate £27k in month, £60k YTD. Nursing is the largest area of Agency spend £203k in month, Theatres being the main area.

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Date last reviewed: 05 June 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.

Initial Risk	4(C) x 2(L) = 8, low
Current Risk Rating	3(C) x 5(L) = 15, moderate
Target Risk Rating	3(C) x 3(L) = 9 , low

Rationale for current score

Positives:
Compliance with regulatory standards
Meeting national quality standards and bench marks
Very strong FFT recommendations
Excellent performance in CQC 2017 inpatient surveys, sustained significantly better than national average.
Patient safety incidents triangulated with complaints and outcomes monthly no early warning triggers

Negatives:
Finance for modernisation of the estate
Lack of London/southeast pay weighting
Recruitment and retention challenges, high nursing vacancy rates
National shortages of nurses and practitioners in theatres, critical care impacting on service provision .
Brexit
Staff survey
Performance against access standards

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY

Burns and Paediatric services don't meet all of the national guidance and recommendations. Commissioners and Regulators fully aware of this, mitigation in place.
STP, 5YFV – impact of integration and commissioning intentions.

COMPETITION

Patient choice -services closer to home.
National staff shortages and difficulties in attracting and retaining at QVH competing with local hospitals paying London and South East weighting.

INNOVATION

Patient experiences shared at public board
Developing new health care roles to respond to national workforce challenges

RESILIENCE

Many services single staff/small teams that lack capacity and agility.
Generational workforce analysis shows high nos. of nursing staff could retire in next 5 years

Controls / assurance

Estates plan and maintenance programme
Clinical quality standards and outcomes managed and monitored at the Q&GC, CGG and the JHGM, safer nursing care metrics, FFT and annual CQC audits , 1/4 CIP
External assurance and assessment undertaken by regulator and commissioners
Quality Strategy, Quality Report, CQUINS, low complaint numbers
Benchmarking of services against NICE guidance, and priority audits undertaken
Sub group for theatre workforce/recruitment, proposals approved at HMT June 2017, new theatres safety lead in post Feb 2017
Trust recruitment and retention strategy mobilised, NHSI nursing retention initiative
SOC for inpatient paed burns being taken forward by Darzi Fellow who starts in post April 2018
MOU with BSUH
Developing QVH simulation faculty to enhance safety and learning culture

Gaps in controls / assurance

Vacancies in theatres, critical care and C-Wing, national and south east shortage of nurses in theatres and critical care. Controls implemented have not yet improved the position Links to CRR 1094,1093,1077,1035,1097
Increase in negative FFT comments re appointments/waiting times Links to CRR1097,1083,1081,949
More evidence of embedded learning from serious incidents being shared throughout the trust.

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 13th June 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.

Initial Risk Rating 5(C)x3(L) =15, moderate
Current Risk Rating 4(C)x3(L)=12, moderate
Target Risk Rating 4(C)x2 L) = 8, low

Rationale for current score
ITU compliance and burns derogation.
Paediatric inpatient standards 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. (RR955)
Coroner's PFD report and never event reporting.
Induction and training processes for dual site junior doctors and dentists. (CRR1079)
Culture of safe and collaborative practice.
Sleep disorder centre medical staffing and succession planning.

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) (RR845)
Plan for sustainable ITU on QVH site (CRR1059)
Recruitment challenges
Achieving sustainable research investment
Balance service delivery with medical training cost (CRR789)
Job planning (RR955)
Fully addressing GMC National Training Survey results (CRR789)
Detailed partnership agreement with acute hospital (CRR1059)
Sleep disorder centre sustainable medical staffing model

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	5 July 2018		**Agenda reference:**	110-18	
Report title:	Quality and governance assurance report				
Sponsor:	Ginny Colwell, committee Chair				
Author:	Ginny Colwell, committee Chair				
Appendices:	None				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the Quality and governance committee meeting on 21 June 2018				
Summary of key issues					
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Action required				**Assurance**	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:			
	Outstanding patient experience	*World-class clinical services*			
Implications					
Board assurance framework:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	05 July 2018
Reference number:	110-18
Report from:	Ginny Colwell, committee chair and NED
Author:	Ginny Colwell, committee chair and NED
Appendices:	None
Report date:	27 June 2018

Quality and Governance Committee (Q&GC) Assurance Report
Meeting held on 21 June 2018
Areas of particular note for assurance

1. Risk exception Report- no SIs in this period. Assurance Reports from the CCG were received following 2 visits to theatres.

2. Corporate Risk Register- continues to show movement and assures the committee of it's on going management.

3. NICE Guidance implementation Report. This is a recent addition and shows excellent progress on our understanding and management of this area.

4. The Quality and Safety strategy continues to evolve and will present to EMT for further development.

5. A concise updated action plan was received following the inquest last year. All short term actions are now complete. Some longer term action continues.

6. Patient Experience- We continue to receive excellent feedback. There was some discussion about the criteria used as to whether a complaint is upheld or not and this will be looked at.

7. Following the committees evaluation some changes will take place to the annual plan.

8. CQUINS Q4- we have secured 99% of our target £892,138 and £241.243 for the local dental scheme.

9. The new Safeguarding Matrix was discussed and will be further developed.

10. The Clinical Audit programme was received and discussed. Further work is needed to show we are improving patient care as a result.

11. Policy for the Redistribution of Commercial Income was ratified.

12. Other reports received and are either covered by the executive report or had no significant assurance issues;

    - Compliance in practice
    - PLACE
    - Clinical Audit programme
    - Quality priorities
    - Clinical Governance Group
    - Strategic Safeguarding group
    - Health and Safety group
    - Infection prevention and control group
    - Patient experience group

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 July 2018**		**Agenda reference:**	**111-18**	
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 of report:	For assurance that the trusts risk management process is being followed with new risks are being identified and current risks are being reviewed and updated in a timely way.				
Summary of key issues	The key changes are four new corporate risks added, three re-scored and three corporate risks closed. A CRR 'heat map' has been included to provide a visual summary.				
Recommendation:	The Board is asked to **NOTE** the Corporate Risk Register information and the progress from the previous report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
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:	The entire BAF has been reviewed by EMT alongside the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	The Corporate Risk Register is considered monthly by the Executive Management Team.				
	Date:	25 06 18	Decision:	Reviewed and updated	
Previously considered by:	Quality and governance committee				
	Date:	21 06 18	Decision:	Reviewed and for assurance	
Next steps:					

Report to: Board of Directors
Meeting date: 05 July 2018
Reference number: 111-18
Report from: Jo Thomas, Director of nursing
Author: Karen Carter-Woods, Head of risk and patient safety
Appendices: None
Report date: 27 June 2018

Corporate Risk Register Report
01April to 31 May 2018 Data

Corporate Risks added:

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
4x4=16	1105	Ventilation within Burns, EBAC and CCU	IPACT / Estates January 2018 (Added to system 11/04/2018)
3x5=15	1110	Some patient pathways not visible in reports, patient care may become 'lost'	NHSI
4x4=16	1111	Loss of resilience in reporting from Business Intelligence Unit	Information Management and Technology
3x5=15	1112	Copying of CT images for MaxFax & Orthognathic patients	Clinical Support Services Meeting

Corporate Risks closed: 3

Risk ID	Risk Description	Rationale for Rescore	Committee where change(s) agreed/ proposed
1015	Patient safety due to lack of junior doctors in plastics particularly at weekends	All issues addressed	Plastics Governance meeting
844	Medical cover out of hours	Effective controls and actions successfully mitigate this risk	R/v with MD
884	Potential for Unauthorised Data Breaches	Two risks that have different actions to manage. Close risk and 2 new risks created by IG lead.	Information Governance Group

Corporate risks reviewed and re-scored: 3

Risk ID	Risk Description	Previous Risk Score	Updated Risk Score	Rationale for Rescore	Committee where change(s) agreed/ proposed
1100	National directive to ensure WRAP training uptake over 85% by end of March 2018	3x4=12	3x3=9	Uptake currently 74%	Reviewed by Handler & 'Prevent' Regional Co-ordinator
1101	Potential loss of sonography staff if recruitment	4x3=12	3x3=9	Letter to all sonographers re: recognition of issue and	EMT review

Risk ID	Risk Description	Previous Risk Score	Updated Risk Score	Rationale for Rescore	Committee where change(s) agreed/ proposed
				solution	
1094	Canadian Wing Staffing	5x3=15	3x4=12	Effective controls in place	EMT review

Review of the CRR by the executive management team on 25 June agreed consolidation of the 5 risks relating to access and performance issues (949, 1081, 1083, 1097, and 1110). This will be reflected in the July CRR.

CRR: grading heat map

Initial

	No harm	Minor	Moderate	Major	Catastrophic
Rare	**0**	**0**	**0**	**0**	**0**
Unlikely	**0**	**0**	**0**	**0**	**0**
Possible	**0**	**0**	**1**	**5**	**2 ID: 1093, 1094**
Likely	**0**	**0**	**11**	**1 ID: 1105**	**1 ID: 1059**
Certain	**0**	**1**	**3 ID: 789, 949, 1110**	**3 ID: 1081, 1083, 1111**	**0**

Current

	No harm	Minor	Moderate	Major	Catastrophic
Rare	**0**	**0**	**0**	**0**	**0**
Unlikely	**0**	**0**	**0**	**0**	**0**
Possible	**0**	**0**	**0**	**8**	**0**
Likely	**0**	**0**	**10**	**4 ID: 1105, 1111, 1035,**	**0**
Certain	**0**	**0**	**3 ID: 789, 949, 1110**	**3 ID: 877, 1081, 1083**	**0**

Six of the initial red risk scores remain on the unchanged on the current risk heat map despite mitigating actions. Four of these relate to access and performance (949, 1110, 1081 and 1083).

Implications of results reported

1. The register demonstrates that the trust is aware of key risks that affect the organisation and that these are reviewed and updated accordingly.

2. No specific group/individual with protected characteristics is identified within the risk register.

3. Continuous review of existing risks and identification of new or altering risks via governance processes at departmental and organisational governance meetings.

4. Corporate risks have been cross referenced with the Trust's Board Assurance Framework five key strategic objectives. The Corporate Risk Register and BAF is reviewed monthly at Executive Management Team meetings and bimonthly at Quality & Governance Committee meetings for assurance. It is also scheduled bimonthly in the public section of the Trust Board.

5. The attached risk register and mitigating actions does not have any significant impact on our ability to comply with CQC authorisation and regulatory requirements of NHSI and commissioners and does not indicate that the Trust is not Safe; Well led; Effective; Responsive or Caring

Recommendation:

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	Target	Progress & updates	BAF / KSO
1112	25/05/2018	Copying of CT images for MaxFax & Orthognathic patients	Third party companies contact QVH radiology requesting patient images / data to be shared directly with them for surgery planning (prosthetics / implants) Pressures on radiology staff to provide images to avoid surgery cancellations / delays There is no agreed process and no data sharing agreement in place at QVH for radiology to copy secure images for 3rd party independent companies. Images have left QVH in unencrypted CDs that are holding patient data.	None generally Minimal controls for one company who has agreed to get CDs encrypted by QVH IT - however there is still no agreed process in place For one company images are encrypted by IT upon request, but requests are always made last minute and there is also no data sharing agreement in place for this company.	Abigail Jago	Dominic Bailey	Information Governance	15	6	**03/06/18**: Service has been suspended pending satisfactory technical and organisational measures being put in place with third party suppliers, (encryption of mobile media and evidenced data processing agreements in place). Clinical lead for the service is now Jag Dhanda who will coordinate directly with IG/IT/Radiology and Business Manager.	KSO 1, 2, 3
1111	11/05/2018	Loss of resilience in reporting from BIU	Inability to produce stable reliable reports to internal and external customers Risk of not meeting mandatory requirements for reporting timeliness , completeness or quality	Engaged Integris as Technical partners to provide initial stabilisation around Monthly RTT and other mandatory reports . Seeking authority to extend this relationship for 3 days per week to end of june to embed and improve reporting structure to reduce instability and Maintenance overhead. Then to address larger new work requests as defined and costed work packages as part of a long term and stable solution for the Trust. 31/05/2018 SJJ joined team permanently from work trial(redeployment) experience matches with IST and ESR burden and provides resilience with RTT gaps. Warehouse Developer gap remains 06/06/2018 awaiting proposal from BI(EK) and Integris to frame business case	Michelle Miles	Rob Lock	Information Management and Technology	16	8	17/04/2018 SJJ offered on work trial from Operations directorate 31/05/2018 SJJ joins team permanently 06/06/2018 RL expecting response today from service partners to address skills provision , which will support business proposal for longer term solution.	KSO 3, 4
1110	11/05/2018	Some Patient pathways not visible in reports, patient care may become 'lost'	NHSI have observed risks in process and reporting that present risk to patients being lost in the system or left untreated beyond target . May lead to patient harm and reputational damage if a referral is not tracked or not visible in routine monitoring and reporting	1. Daily reporting of all patients on RTT pathway 2. New reports being developed to identify planned patients not on RTT pathway 3. propose additional resource to develop new reports and reconcile process flows. 4. linked with risk 1111, awaiting proposal form service providers	Michelle Miles	Rob Lock	Patient Safety	15	4	**06/06/18** Build reports to provide visibilty of panned patient currently not shown in daily PTL "Planned PTL" is built Currently addressing issues in RTT standard reports : RL to arrange resource with Dir Ops and RTT teams to validate 'planned patients without an RTT pathway'	KSO 1, 2, 3

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
1105	11/04/2018	Ventilation within Burns, EBAC and CCU	There is a high risk to patients having surgery, dressing changes and invasive procedures undertaken in areas that the air has not been filtered and is not being moved around. This potentially can lead infection being spread or given to patients. Infection can cause increased length of stay in a hospital environment, or a new admission, slow healing wounds, the need for antibiotic therapy, surgery, increased pain, patient becoming acutely un well and potentially death.	1. Ventilation system currently in place in Burns is being maintained and monitored by the estates department. 2. Daily checks of all ventilation alarms 3. All duct are to be cleaned in 2018 4. All staff in the operating theatre wear clean scrubs, hats, masks, gowns and gloves minimising the amount of exposed	Michelle Miles	Stephen Dunmall	Estates Infrastructure & Environment	16	8	**14/6/18**: r/v at E&FSG - paper with 7 options submitted to DoN 14/5: DoN to escalate to DoF re: delays & request confirmation of project proceeding 11/04/2018 - No funding allocated for either of the current two actions	KSO 1, 4
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	Abigail Jago	Victoria Worrell	Patient Safety	12	4	14/5 (CGG): CEO and Head of Patient Safety meeting with Medway CEO & Director Elective Services June 18th 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	KSO 1
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	KSO 4

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
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)Update 12/4/18 - starting 16/4/18 2. Recruitment for part-time assistant underway - interviewed. Update 12/4/18 started 5/2/18 3. Recruitment for band 8a pharmacist underway. Update 12/4/18 appointed, waiting HR clearance 4. Some part-time staff willing to work more hours. 5. Locum pharmacist agreed Update 12/4/18 - locum in place 6. Direct clinical work is the priority	Abigail Jago	Judy Busby	Patient Safety	12	4	14/5 (CGG): currently worsening situation; one new long term sick & locum has given notice. HR to be requested to prioritise and expedite pharmacy recruitment processes. 12/4/18. recruitment underway for all vacancies. 1x started, 1xdue to start, 2x appointed awaiting HR clearance, 1x being advertised. 2 members of staff on restricted duties due to illness	KSO 1, 2, 3
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 Occasionally unable to book sufficient agency staff to cover the shortfall On occasions 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	12	12	14/5 (CGG): some success with international recruitment, minimal success with social media campaign 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	KSO 1, 2
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	**12/6/18:** Update - R&R ongoing 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	KSO 1

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
1083	22/09/2017	Deterioration in 18RTT performance	The trust's 18RTT position has deteriorated and is not meeting the target of 95%. This will mean that patients will wait longer, regulators are QVH more attention and our reputation will suffer. June 2018: on-going challenges with theatre access	June 2018: *weekly PTL meeting in place (Chair: DOO) *NHSI supporting capacity & demand *additional capacity identified for MF/plastics *recovery plan under development *review of PTL baseline underway with NHSI Additional validators in post Cancer data manager and Performance and Access Manager appointed & in post. IST working with Trust to review capacity and demand	Abigail Jago	Paula Smith	Compliance (Targets / Assessments / Standards)	20	15	**June 2018**: access policy updated with CCG's: currently ahead of planned sign-off June F&P 9/4/18: Theatre nursing vacancies continue to increase Anaesthetic appointments in post x3, 4th to start in May	KSO 1
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	* Process redesign work planned * NHSI support for capacity / demand * Staffing models to be reviewed with process redesign	Abigail Jago	Rob Lock	Compliance (Targets / Assessments / Standards)	20	12	9/4/18: Update - acting service manager working with appointments team to improve understanding & ensure the booking process meets the Access Policy	KSO 1, 3
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	14/5 (CGG): to be reviewed after September intake 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	KSO 1, 2
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 June 2018: * loss of theatre lists due to staff vacancies	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. Assessment of agency nurse skills to improve safe transition for working in QVH theatres 7. Management of activity in the event that staffing falls below safe levels.	Jo Thomas	Nicola Reeves	Patient Safety	16	6	**12/6/18**: further work on theatre establishment & budget. Testing feedback from staff re: skill mix 14/5 (CGG): Pre-assessment almost at full establishment 12/2/18: recruitment to pre-op assessment plus social media recruitment drive January 2018 update:all HCA's now in post	KSO 1, 2, 3, 4, 5

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
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	**14/5 (CGG):** some progress re: discussions between sites - joint (BSUH & QVH)programme board established and CT procurement process underway	KSO 1, 2, 3
1040	13/02/2017	Age of X-ray equipment in radiology	All X-Ray equipment is reaching end of life. No Capital Replacement Plan in place at QVH for radiology equipment	All equipment is under a maintenance contract, and is subject to QA checks by the maintenance company and by Medical Physics. Plain Film-Radiology has 3 CR x-ray rooms and therefore patients capacity can be flexed should 1 room breakdown. Fluoroscopy- was leased by the trust in 2006 and is included in 1 of these general rooms. Control would be to outsource all Fluoroscopy work to suitable hospitals during periods of extended downtime. Ultrasound- 3 US units are over the Royal College of Radiologists (RCR)5 year's recommended life cycle for clinical use. Plan is to replace 1 US machine in 2017-2018. Should machines fail, then clinical service will be compromised. Cone Beam CT installed in 2008- RCR recommends that all CT machines are on a replacement programme every 7 years. The CBCT machine at QVH is showing end of life tendencies, and had significant down-time in Sept 2016. All CBCT services had to be suspended, and patients breaching the 6 week diagnostic target were out-sourced to other hospitals and modalities where possible - plan to replace in the financial year 2017-2018	Abigail Jago	Sheila Black	Patient Safety	12	2	14/5 (CGG): procurement process continues 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	KSO 1, 2
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	16	9	**12/6/18**: necessity for substantive staff to change / cover shifts at short notice resulting in impact upon health & wellbeing. 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	KSO 1, 2, 3, 4, 5

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
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	**Update 02/06/18**: the two ARC servers operating system has now be upgraded to windows 2008 R2. Recommendation this risk is now closed.	KSO 4, 5
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	**Update 02/06/18**: there have been a number of issues scheduling the installation. The Charge Advisory Board has now approved Request for Change and all communication has been sent to mangers of affected areas, all work is scheduled out of hours with minimal impact to service. Installation is scheduled to be completed by 11/06/18.	KSO 4, 5
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	-Potential increase in the risk to patient safety -on-call paediatrition is 1 hour away in Brighton -Potential loss of income if burns derogation lost -no dedicated paediatric anaesthetic lists	*Paeds review group in place *Mitigation protocol in place surrounding transfer in and off site of Paeds patients *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely *Robust clinical support for Paeds by specialist consultants within the Trust *All registered nursing staff working within paediatrics hold an appropriate NMC registration *Robust incident reporting in place *Named Paeds safeguarding consultant in post *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age. *Surgery only offered at selected times based on age group (no under 3 years OOH) *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age. *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	**12/6 update**: Darzi fellow in post, reviewing paediatric inpatient burns 14/5 update: position paper presented at March HMT - nil new changes	KSO 1,2,3

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
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	Abigail Jago	Victoria Worrell	Compliance (Targets / Assessments / Standards)	15	6	**June 2018:** NHSI review of PTL to include spoke sites 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	KSO 1
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.	Abigail Jago	Fiona Lawson	Estates Infrastructure & Environment	12	6	Update 9/1/18: Capital funding application submitted	
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	16	**05/06/18**: Reviewed; updated target risk to reflect BAF 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.	KSO 4

ID	Opened	Title	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target	Progress & updates	BAF / KSO
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	22/1/18: Plastics currently fully recruited, OMFS vacancies until April 2018. GMC survey results disappointing; Deanery visit awaited	KSO 2, 5

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	05/07/2018		**Agenda reference:**	112-18	
Report title:	**Quality and Safety Report** (July 2018 Board, covering April and May and including Safe Staffing Workforce Report**)**				
Sponsor:	Jo Thomas, Director of Nursing & Quality Ed Pickles, Medical Director				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	Ward metrics				
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The report details the Trust's position on key indicators and workforce. The report now has a new format which combines updates from both the Director of Nursing and Quality and the Medical Director. It seeks to provide more assurance and benchmarking of key quality and safety indicators.				
Recommendation:	The Board is asked to review and seek assurance that the contents of the report reflect the quality and safety of care provided by QVH				
Action required	Approval	Information	Discussion	Assurance	Review
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:	BAF has been reviewed as part of the process of compiling this report.				
Corporate risk register:	Corporate risk register reviewed as part of the process for compiling this report and reflects new risk on CRR.				
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 new implications for current use of resources.				
Assurance route					
Previously considered by:	Quality & Governance Committee				
	Date:	21/06/18	Decision:	Noted	
Next steps:					

Executive Summary - Quality and Safety Report, July 2018

Domain	Highlights
Director of Nursing and Quality	The CQC national NHS inpatient survey 2017 was published 13 June. This shows that Queen Victoria Hospital (QVH) continues to achieve some of the best feedback from patients in the country. The annual national survey of inpatients at all NHS hospital trusts in England covers all aspects of patients' care and treatment. This year's survey carried out by the Care Quality Commission (CQC) surveyed 72,778 patients who received care in 148 NHS acute and NHS foundation trusts during July 2017. The findings help the NHS to continually improve, enabling hospitals to see how they are doing year-on-year and how they compare with others. The data is also used by CQC as part of its regulating, monitoring and inspecting NHS acute trusts in England. Overall, QVH scored better across almost all measures than other trusts. QVH scored significantly better than other trusts for 45 of the 61 questions asked. It's one of only five acute specialist trusts to have consistently maintained a 'much better than expected' rating over the last four years. The reputation of Queen Victoria Hospital as a centre of excellence comes from both our highly skilled clinicians and the individual attention and care shown to each patient by the whole team. I'd like to thank all of our staff for their ongoing commitment and dedication to our patients particularly during this challenging time for the NHS. Another example of our staffs commitment to care if the nomination of Danny Favour, our ophthalmic nurse specialist for the NHS 70 Preliminary Awards- Care and Compassion. This nomination was made by the Rt, Hon, Sir Nicholas Soames MP and is fitting recognition of both Danny and the ophthalmic teams determination to deliver outstanding patient experience.
Medical Director	The Clinical and Professional Cabinet of the STP continues to meet monthly. The STP Clinical Case for Change has had one completed draft and has been presented to the STP executive board. The main themes of the case for change are workforce, communication between primary, social and secondary care, digital maturity, unwarranted variation, a mismatch between demand and capacity, and financial sustainability. There is little detail in the case for change relating to the configuration of secondary acute care. The Programme Board between Western Hospital, Brighton and Sussex University Hospitals and QVH has had two meetings. An individual to act as project manager has been identified, though not yet appointed. A Darzi Leadership Fellow is currently working on a revised strategic outline case for a model of shared care between RACH and QVH for the provision of paediatric burns. The first meeting between operational managers and clinicians from both trusts is scheduled for July 2018.

Report by Exception - Key Messages

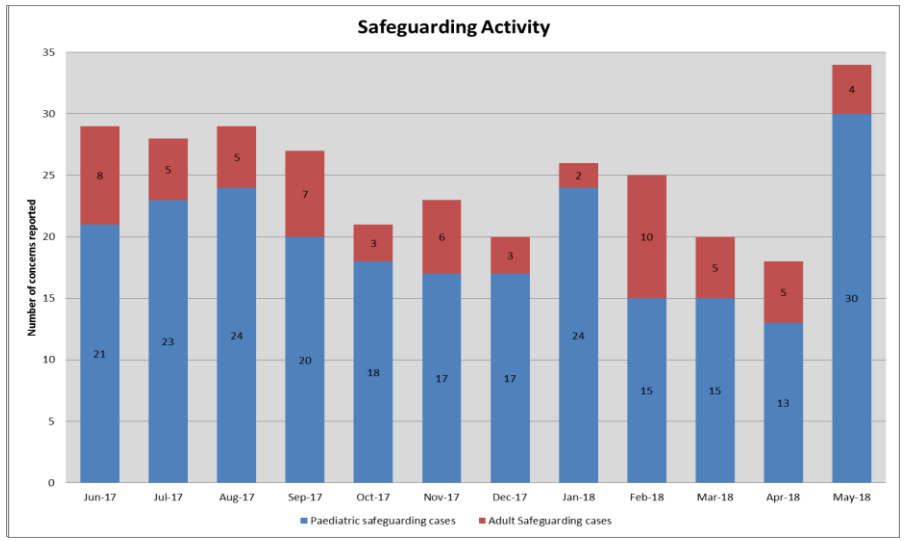
Domain	Issue raised	Action taken
Safe: Infection control	What we expect – zero bacteraemia What happened – One positive MRSA bacteraemia in May 2018	What we learnt - The post infection review was lead by the Director for Infection Prevention and Control. The policy for taking blood cultures was not followed .The positive result was a contaminated specimen, not a true bacteraemia. This was supported by subsequent pathology results and clinical assessment. Three key actions were identified which will be monitored to completion at the infection and prevention and control group. This is the first MRSA bacteraemia in the Trust since 2012.
CQC	CQC Provider Engagement Meeting	The last meeting was held in February 2018 an focussed on paediatric services and a staff focus group was held. No concerns were raised by the CQC. The next meeting is scheduled to occur on 26th June 2018 with a planned focus on workforce and critical care and a consultants meeting.
Evolve	Clinical safety issues identified with Trust's Evolve electronic document management system.	Evolve, the QVH Electronic Document Management system, commenced rollout in the summer of 2015, and is now in use across sleep, maxillofacial and corneoplastic surgery. A recent review has been carried out due to hazards identified, including partial roll out and mixed systems, availability at spoke sites, integration with other systems, system speed and accessibility. The Trust's Clinical Lead for IT has produced a detailed review of risks and associated action plan which will be reviewed through both the IM&T and Informatics Clinical Advisory Group. Completion of roll out of EDM would address many of the risks related to mixed systems.

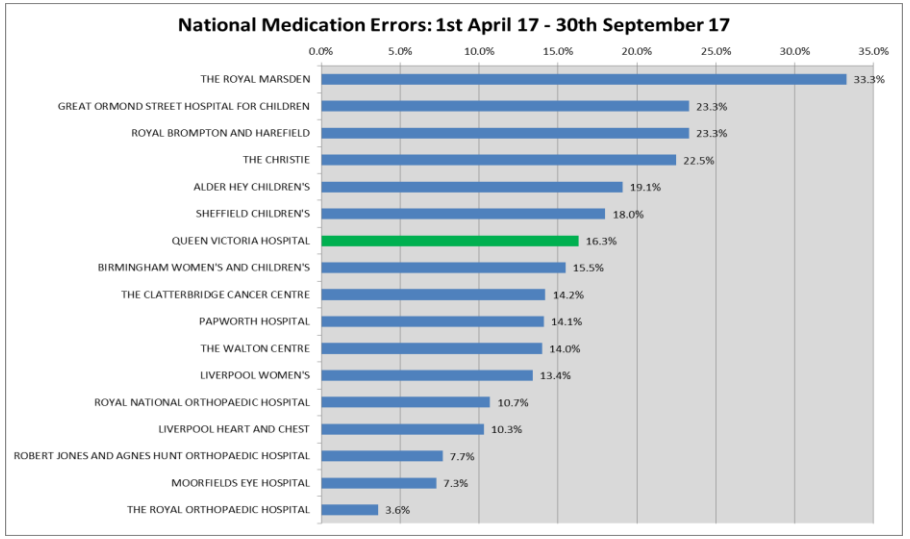
Sleep Disorders Centre - Clinical Staffing	Shortage of clinical medical staffing to cover current activity.	A new risk has been added to the corporate risk register which will replace several local risks regarding staffing in the Sleep Disorder Centre. The one current full time substantive consultant is hoping to reduce his commitment to part time, and the resignation of a respiratory physician from his one clinic per week will significantly strain the medical staffing in a difficult to recruit to area. Actions and mitigations are detailed in the risk register.

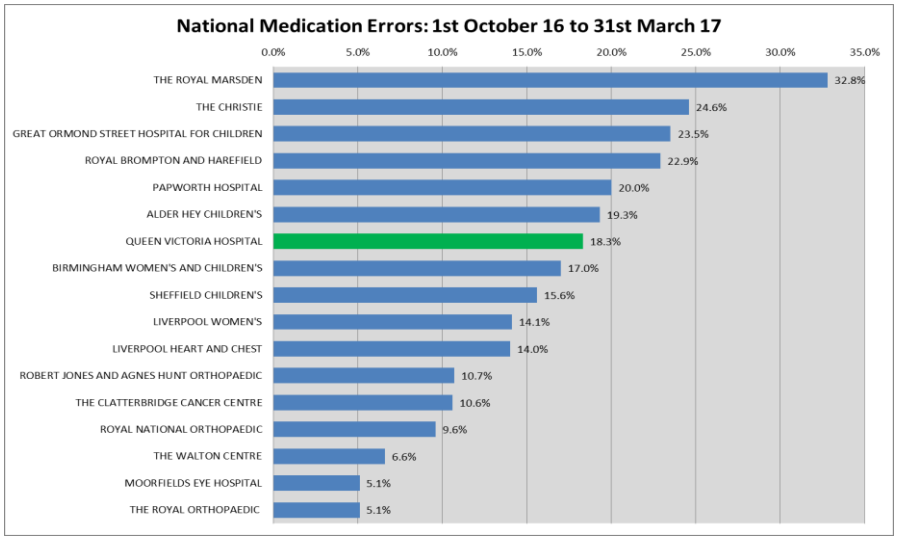
Safe - Performance Indicators

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)	Target	Quarter 1 2017/18	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2018/19		12 month total/ rolling average
		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Infection Control														
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	>95%	97%	99%	99%	99%	97%	98%	96%	97%	97%	98%	98%	98%	98%
MRSA screening - trauma	>95%	96%	94%	97%	95%	96%	96%	96%	97%	96%	98%	97%	95%	96%
Incidents														
Never Events	0	0	0	1	0	1	0	0	0	0	0	0	0	2
Serious Incidents	0	0	0	0	1	0	0	0	0	0	0	0	0	1
OOH inductions:														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	5	8	2	5	3	4	3	4	2	5	6	5	52
Paediatrics under 3 years: : Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Paediatric transfers out (<18 years)		1	0	2	0	0	2	0	0	0	0	0	0	5
Medication errors														
Total number of incidents involving drug / prescribing errors		8	4	8	9	20	16	16	10	9	13	6	12	131
No & Low harm incidents involving drug / prescribing errors		8	4	8	9	20	16	16	10	9	13	6	12	131
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		0.5	1.7	0.5	2.2	2.4	1.2	0.6	1.1	3	1.2	1.8	0.6	1.4
Harm free care rate (QVH)	>95%	100%	98%	97%	100%	100%	97%	100%	100%	97%	96%	98%	100%	99%
Harm free care rate (NATIONAL benchmark) - one month delay	>95%	94.1%	94.2%	94.1%	94.3%	94.3%	94.2%	94.4%	94.2%	94.2%	94.0%	93.9%	94.0%	
Pressure Ulcers														
Hospital acquired - category 2 or above	15	2	1	0	3	0	0	1	0	0	0	1	1	9
VTE initial assessment	>95%	100%	100%	100%	100%	100%	100%	94.7%	95.1%	97.3%	96.4%	97.6%	97.4%	98.2%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	>95%	100%	100%	100%	100%	100%	97%	87%	98%	92%	96%	94.6%	100%	96.73%
Patient Falls resulting in no or low harm (inpatients)		6	4	4	1	2	8	4	7	8	2	3	2	51
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	1	1
Patient Falls per 1000 bed days		4.86	3.09	3.19	0.79	1.75	5.84	3.42	5.67	6.67	1.66	2.22	2.08	3.44

Safe - Benchmarking Performance Indicators



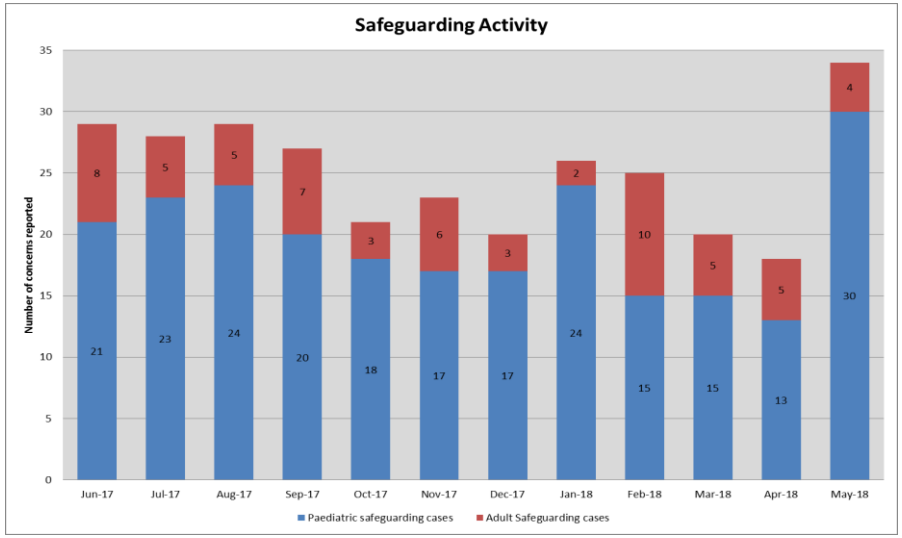


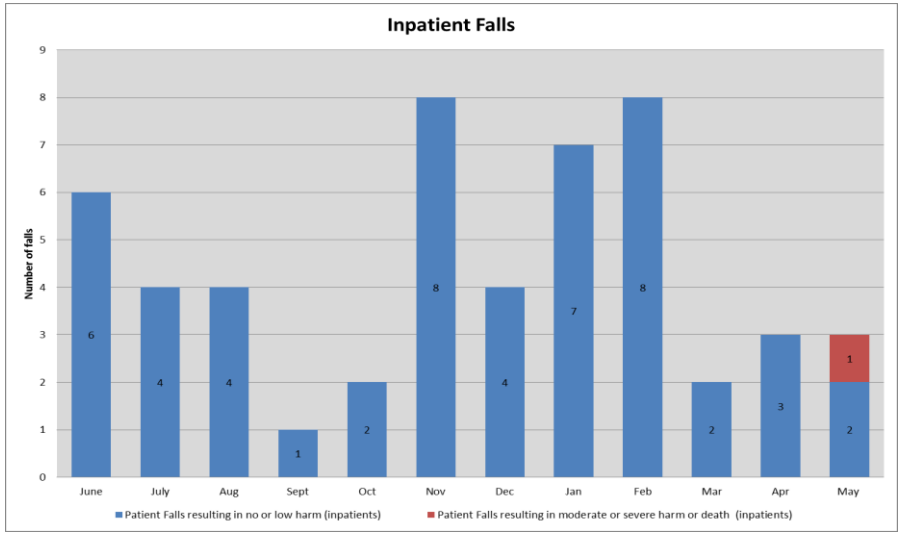


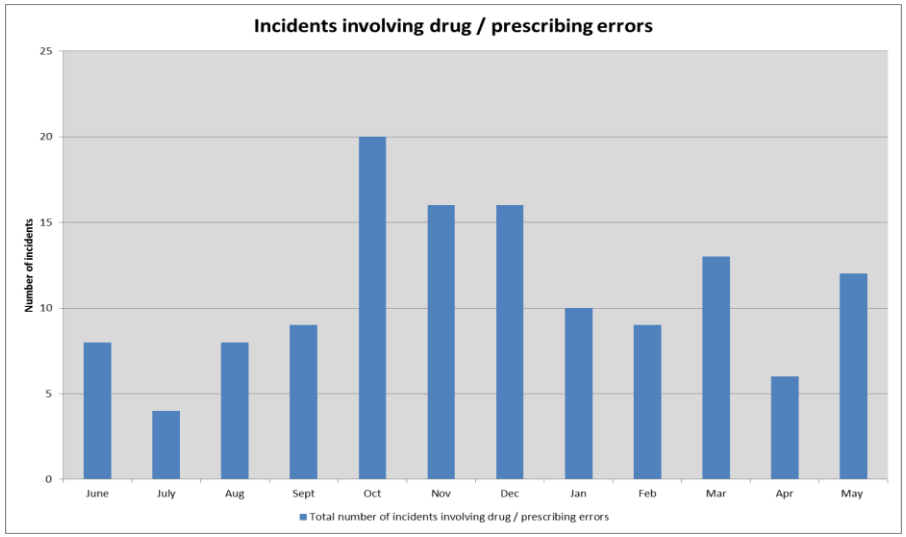
Medication incidents

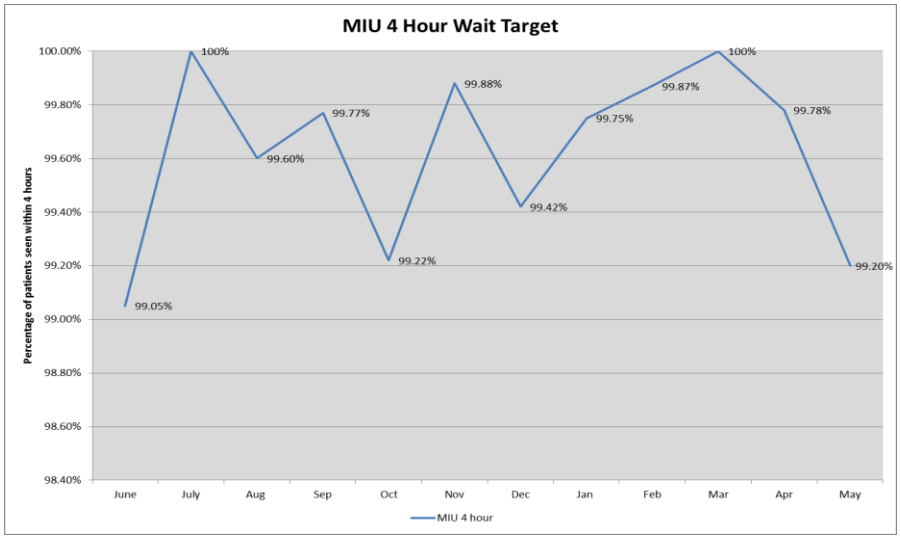
All medication incidents reported via the Datix system are reviewed monthly by the Medicines Management Optimisation and Governance Pharmacy Sub Group. Each incident is discussed with a recommendation for either any further actions and investigations to be undertaken or closure. The aim is to look for lessons in order to try and reduce medication errors going forward. Reporting is encouraged as an indicator of patient safety; high reporting with a low proportion of harmful medication incidents is seen as a mark of a 'high reliability' organisation. In line with national directive the Trust has a Medication Safety Officer (MSO). One of the MSOs' key roles is to be promote the safe use of medicines across the organisations. The MSO is responsible for presenting a quarterly report on medication incidents to the Medicines Management Optimisation and Governance Group.

Safe - Performance Indicators









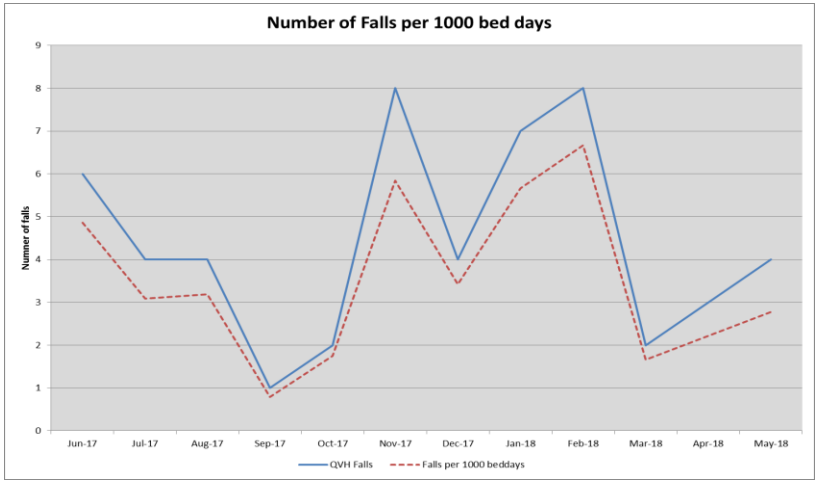
Safe - Falls Performance Indicators

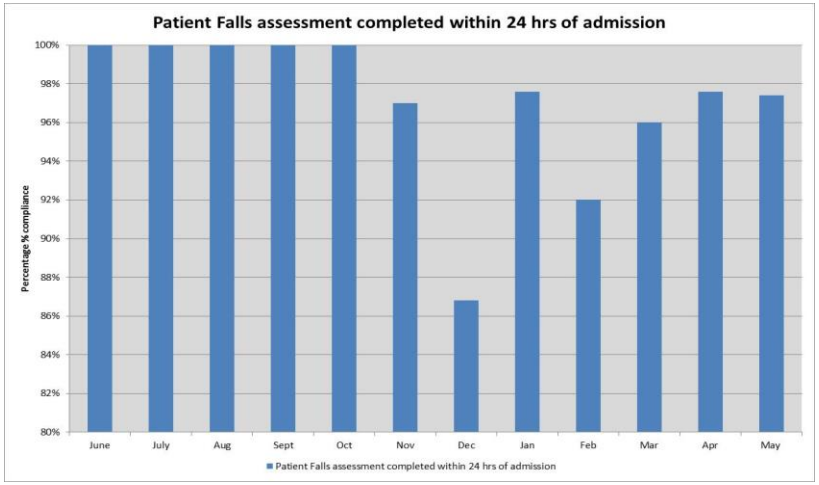
What are the current challenges?

- Three inpatient falls occurred in April and four in May 2018
- Trust compliance with the completion of the patient falls assessment within 24 hours of admission is not consistently above 95%

What we are doing about them?

- Review of current processes to aid completion of the patient falls assessment - drive to increase compliance
- Implementation of the leaf symbol in inpatient areas
- Falls screensavers imitative to raise awareness
- Drugs which contribute to falls and standing and sitting blood pressures added folders to prompt staff when undertaking the risk assessments
- Charitable funding secured for falls sensors on Burns (response to fracture) which address issues with patients being in side rooms and complaince with requests to ask for assistance
- Currently exploring falls sensors options to be added to new bed stock





CQUIN - Performance Indicators

Commissioning for Quality and Innovation payment framework

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon achieving certain improvement goals. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers.

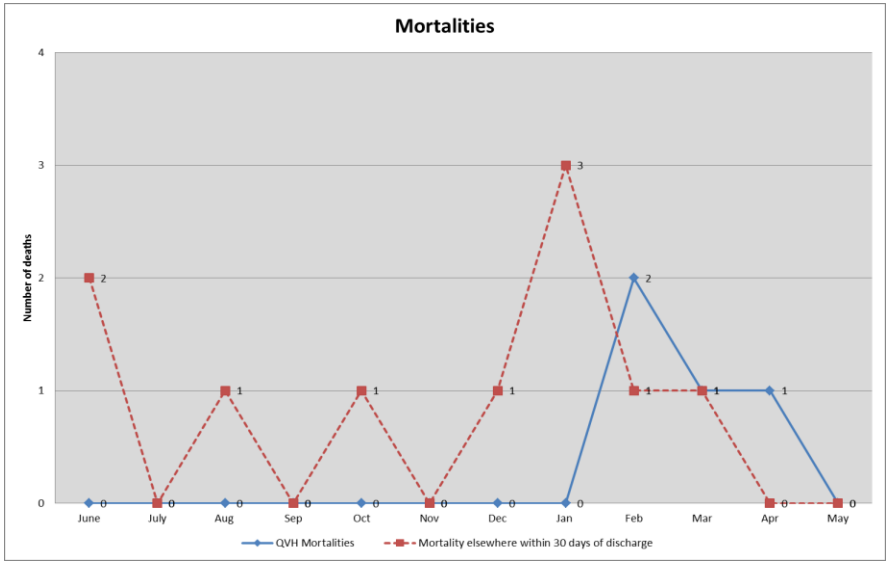
A proportion of QVH income in 2017/18 was conditional on achieving number of national and local CQUIN goals. We secured 99% of our CQUIN targets generating £892,138 of income.

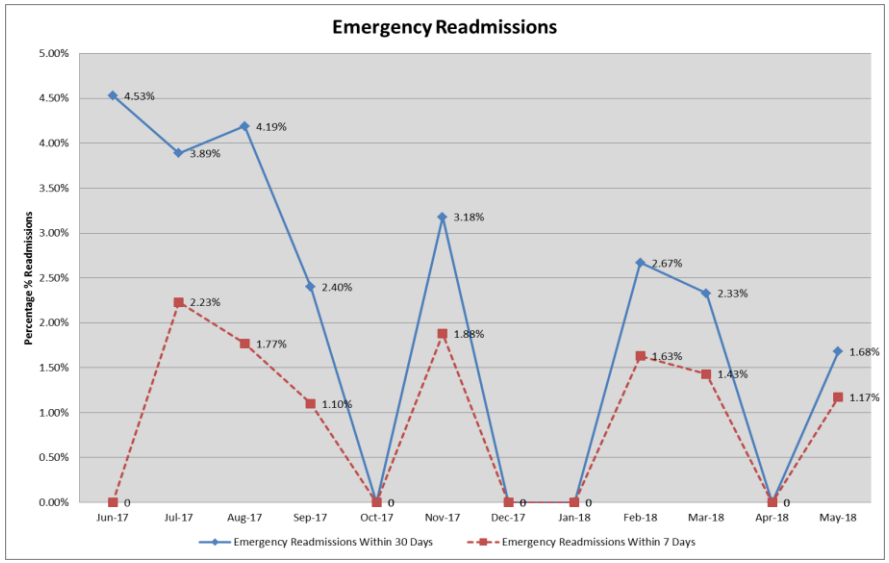
For our local dental schemes, we achieved 100% our local targets generating £241,243 of income.

No.	Schemes for 2017/19	Scheme 2017/18	Q1	Q2	Q3	Q4	Total %
1a	Continued	Health and wellbeing	Yes	Yes	Yes	Yes	100
1b	Continued	Healthy food	Yes	Yes	Yes	Yes	100
1c	Continued	Flu vaccinations	Yes	Yes	Yes	Yes	100
2a	Continued	Timely identification of sepsis	Yes	Yes	Yes	Yes	100
2b	Continued	Timely treatment of sepsis	Yes	Yes	Yes	Yes	100
2c	Continued	Antibiotic review	Yes	Yes	Yes	Yes	100
2d	Continued	Reduction in antibiotic consumption	Yes	Yes	Yes	Yes	100
4	Continued	Offering advice and guidance	Part	Yes	Yes	Yes	87.5
5	N/A - completed in 2017/18	NHS e-Referrals	Part	Yes	Yes	Part	83.8
6	N/A - suspended nationally	Supporting proactive and safe discharge	Yes	Yes	Yes	Yes	100
Local	Continued	Specialised commissioning: dental	Yes				100
						Overall CQUIN Total:	**99%**
9	**New** for 2018/19	Preventing ill health by risky behaviours					
Local	**New** for 2018/19	Currently discussing with commissioners a quality initative to improve QVH's mental health pathway and the appropriate use of RMN nurses					

The CQUIN schemes for 2017-19 have been updates to reflect changes made by NHS England. The focus remains the same as last year: to deliver improvements in clinical quality, drive transformational change and align the schemes with the Five Year Forward View's next steps. The value of the 2018/19 schemes is: £1,130,404.

Effective - Performance Indicators

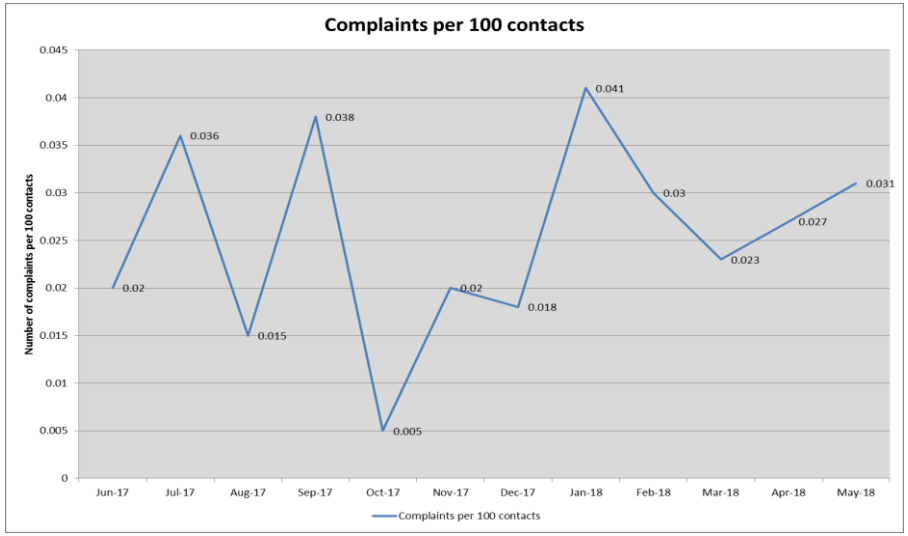


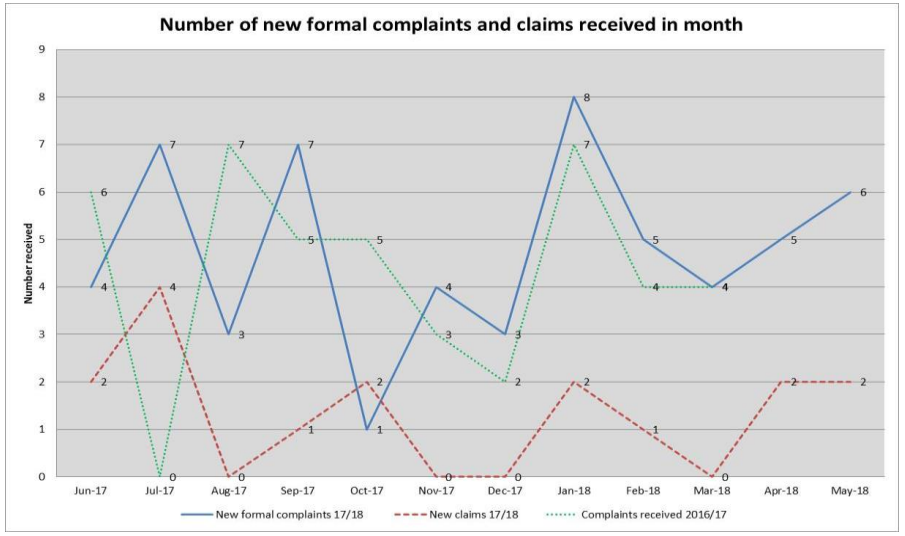


	Quarter 3 2017/18			Quarter 4			Quarter 1 2018/19	
	Oct-17	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**
Number of QVH patient deaths	0	0	0	0	2	1	1	0
Number of off-site deaths (within 30 days)	1	0	1	3	1	1	0	0
Preliminary review completed	1	0	1	3	3	2	1	0
Structured judgement review	0	0	0	0	2	1	Undertaking	0
Number of patients with a learning disability	0	0	0	0	0	0	0	0

Learning from deaths	All off site deaths are subject to preliminary review, and all deaths on-site, or where a concern has been raised, are subject to structured judgement review. The opinions of families and general practitioners are sought to check for concerns. The most recent QVH death is the subject of an root cause analysis, which will report to the Clinical Governance Group in July. An annual report of 'Learning from Deaths' will report to Quality and Governance Committee annual reports meeting, and be presented at Joint Hospital Governance Meeting.

Caring - Current Compliance - Complaints and Claims





	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Contacts (IP+OP+MIU, all sites)	19808	19548	19485	18613	20142	20402	16412	19319	16797	17670	18224	19437
Complaints	4	7	3	7	1	4	3	8	5	4	1	6
Complaints per 100 contacts	0.02	0.036	0.015	0.038	0.005	0.02	0.018	0.041	0.03	0.023	0.027	0.031
Number of complaints referred to the Ombudsman for 2nd stage review	1	0	0	1	0	0	0	0	0	0	1	0
Number of complaints re-opened	0	0	1	0	0	0	0	0	0	0	1	0

Caring - CQC National NHS Inpatient Survey 2017

CQC national NHS inpatient survey 2017

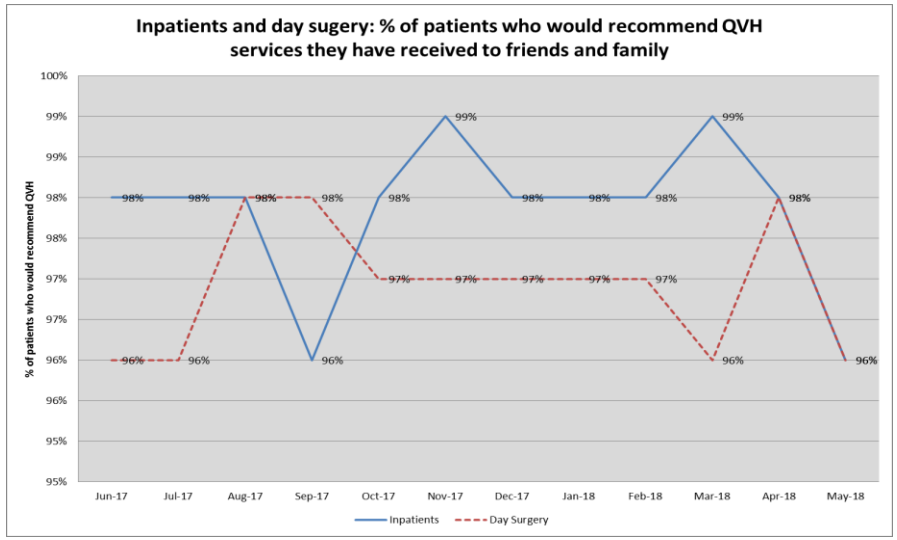
Overall, QVH scored better across almost all measures than other trusts. QVH scored significantly better than other trusts for 45 of the 61 questions asked. It's one of only five acute specialist trusts to have consistently maintained a 'much better than expected' rating over the last four years.

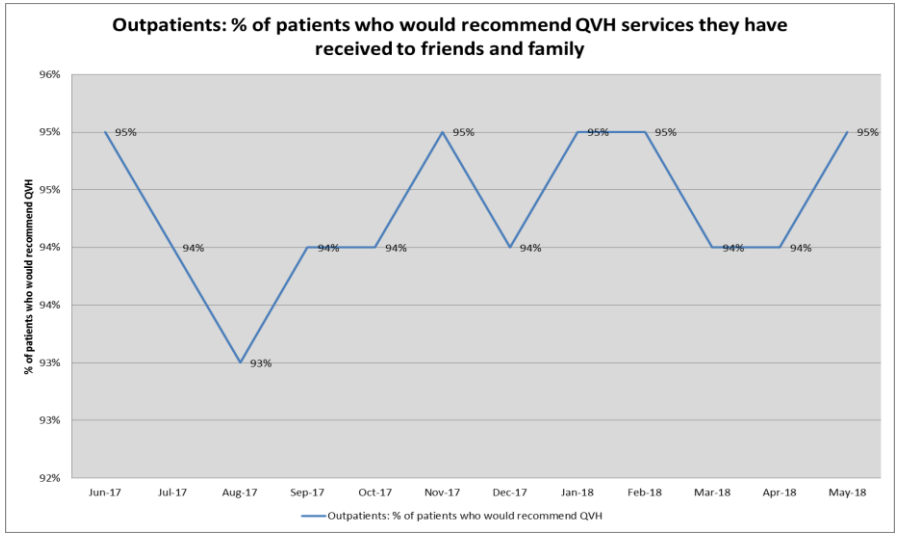
Some examples from the CQC national NHS inpatient survey 2017 where QVH performed better than expected:

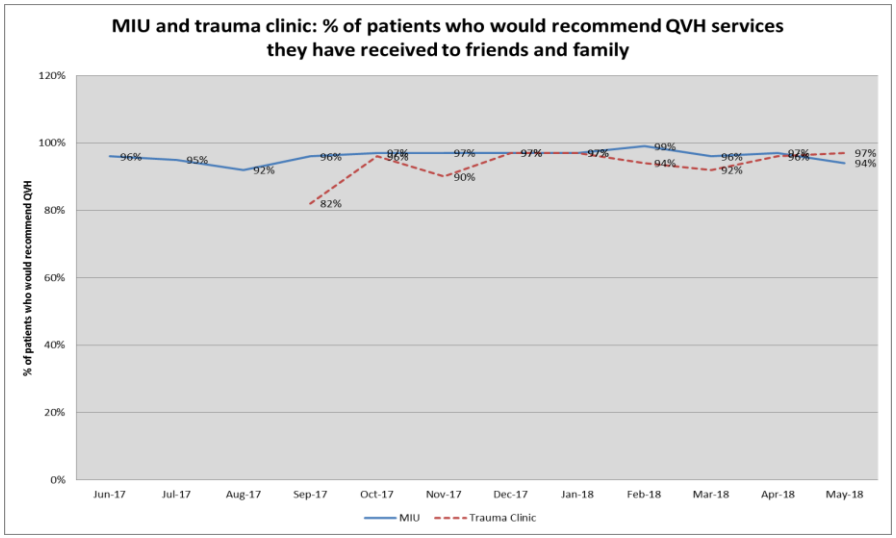
- Patients feeling they waited the right amount of time on the waiting list before being admitted and also not having to wait too long to get a bed on a ward
- Privacy, respect and dignity
- Whether they felt they were well looked after by hospital staff
- Having confidence and trust in the doctors, nurses and other clinical staff treating them
- Doctors answering their questions in a way they could understand
- Having enough to drink whilst in hospital
- Information about the purpose, side effects and how to take medication they were given to take home
- Whether staff did all they could to control pain
- Staff providing a quiet environment at night
- Being involved in decisions around care and treatment, and having confidence about decisions made by staff

Link: http://www.cqc.org.uk/surveys/inpatient

Caring - Current Compliance - FFT







Nursing Workforce - Current Compliance

Domain	Compliance	Actions
Ross Tilley	During April and May there were 9/122 occasions where staffing numbers did not meet planned levels (9/118 in February and March). All escalated to site practitioner as per trust protocol. Staffing primarily reflected lower patient numbers on those shifts.	Staffing according to bed occupancy and acuity with additional staff deployed on high acuity days and resources redeployed from other areas. Below template shift dates 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.
Margaret Duncombe	During April and May there were 5/122 occasions where staffing numbers did not meet planned levels (15/118 in February and March). All escalated to the site practitioner as per trust protocol.	Staffing according to bed occupancy and acuity with additional staff deployed on high acuity days and resources redeployed from other areas. One shift , due to short notice sickness was led by an agency nurse with support from the site practitioner. Below template shift dates 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 there were 4/122 occasions where staffing numbers did not meet planned levels (17/118) in February and March). 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. Below template shift dates 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 April and May there were 3/122 (10/118 in February and March) occasions where planned numbers did not meet actual. All escalated to site practitioner as per trust protocol. In April there were two nights when the ward closed at 19:30 due to staffing levels. There were 8 nights with inpatients and 20 nights when the ward closed at midnight as no patients. In May there was one night when the ward closed at 1930 due to staffing levels. There were 22 nights with inpatients and eight nights when the ward closed at midnight due to no inpatients. No patients were transferred or refused admission as a result of ward being closed.	Staffing according to bed occupancy and acuity. Below template shift dates 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.
Critical Care (ITU)	During April and May there were 3 /122 occasions where staffing numbers did not meet planned levels (7/118) in February and March). All were escalated to site practitioner as per trust protocol. The acuity and dependency of the patients affects the number of beds which can safely be staffed within the establishment, this is further adjusted to allow for agency fill rate. This has resulted in beds being closed and cancellation of patients. All escalated to the site practitioner as per trust protocol.	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 decision is made by the multidisciplinary team at the morning hospital handover meeting. This continues to be monitored throughout the day by the site and senior nursing teams.
Site Practitioner Team	During April and May there were 36/122 occasions where actual did not meet planned levels of two staff on duty (45/118 February and March). Reasons for not meeting planned staffing were 2 staff on supernumerary orientation, vacancy and short term sickness.	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 of the shift. Improving position in May as one site practitioner completed orientation.

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	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Compared to Previous Month
Establishment WTE		257.21	257.21	257.21	253.30	253.30	253.28	253.28	253.28	253.28	253.28	253.28	253.28	253.28	◄►
Nursing Headroom		*18.22*	*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)		238.99	238.99	238.99	235.08	235.08	235.06	235.06	235.06	235.06	235.06	235.06	235.06	235.06	◄►
Staff In Post WTE		199.66	200.21	201.53	201.35	199.35	199.44	198.44	193.82	189.62	190.34	194.66	189.21	188.22	▼
Vacancies WTE		39.33	38.78	37.46	33.73	35.73	35.62	36.62	41.24	45.44	44.72	43.01	45.85	49.45	▲
Vacancies %	>12% / 8%<>12% / <8%	16.46%	16.23%	15.67%	14.35%	15.20%	15.15%	15.58%	17.54%	19.33%	19.02%	18.30%	19.51%	21.04%	▲
STARTERS WTE (Excluding rotational doctors)		2.00	1.64	0.76	1.10	1.00	2.24	2.00	0.00	0.72	0.00	4.00	1.00	0.00	▼
LEAVERS WTE (Excluding rotational doctors)		2.85	2.00	0.80	1.00	4.26	3.28	3.00	6.31	2.26	2.61	3.40	2.68	1.40	▼
Starters & Leavers balance		-0.85	-0.36	-0.04	0.10	-3.26	-1.04	-1.00	-6.31	-1.54	-2.61	0.60	-1.68	-1.40	
Agency WTE		9.55	12.58	18.05	21.41	21.78	19.69	23.58	20.02	24.14	24.91	29.07	30.30	34.20	▲
Bank WTE		12.97	13.30	10.78	11.48	8.90	10.99	11.86	11.08	19.13	19.03	21.12	17.46	19.64	▲
Trust rolling Annual Turnover %	>=12% / 10%<>12% / <10%	20.32%	19.95%	19.57%	18.58%	18.70%	16.76%	15.67%	16.95%	16.11%	15.95%	16.97%	17.41%	16.76%	▼
Monthly Turnover		1.42%	0.99%	0.40%	0.50%	2.14%	1.64%	1.51%	3.25%	1.22%	1.36%	1.75%	1.41%	0.74%	▼
Sickness Absence %	>=4% / 4%<>3% / <3%	2.56%	1.90%	2.22%	3.97%	4.79%	4.56%	4.17%	3.29%	3.34%	4.01%	5.24%	4.89%	4.00%	May Indicative Figure

Unqualified Nursing Workforce - Performance Indicators

Unqualified Nursing

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17			May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Workforce KPIs (RAG Rating) 2017-18				May-18	Compared to Previous Month
Establishment WTE				99.54	99.54	99.54	107.92	107.92	107.92	107.92	107.92	107.92	107.92	107.92	107.92				*Note 1*	107.92	◄►
Nursing Headroom				8.33	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)				91.21	91.21	91.21	99.59	99.59	99.59	99.59	99.59	99.59	99.59	99.59	99.59					99.59	◄►
Staff In Post WTE				77.13	82.13	81.19	81.81	78.25	84.33	85.64	81.64	83.83	80.83	79.33	80.44					82.51	▲
Vacancies WTE				14.08	9.08	10.02	17.78	21.34	15.26	13.95	17.95	15.76	18.76	20.26	19.15					17.08	▼
Vacancies %	>12%	8%<>12%	<8%	15.44%	9.96%	10.99%	17.85%	21.43%	15.32%	14.01%	18.02%	15.82%	18.84%	20.34%	19.23%	>12%	8%<>12%	<8%		17.15%	▼
STARTERS WTE (Excluding rotational doctors)				2.85	2.80	0.80	1.00	3.00	7.61	1.00	1.00	2.80	1.00	0.00	0.00	TARGETS: XXX				2.00	▲
LEAVERS WTE (Excluding rotational doctors)				1.00	2.20	2.73	0.00	5.00	2.19	0.46	1.00	2.00	3.61	1.61	0.00					0.00	◄►
Starters & Leavers balance				1.85	0.60	-1.93	1.00	-2.00	5.42	0.54	0.00	0.80	-2.61	-1.61	0.00					2.00	
Agency WTE				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.31	1.34	1.51	3.06	2.90					3.57	▲
Bank WTE *Note 2*				2.81	4.79	4.59	4.92	4.12	4.40	5.35	4.87	5.58	5.78	6.90	5.46					6.51	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	18.46%	19.85%	22.10%	20.83%	23.19%	25.18%	####	21.26%	24.61%	29.45%	30.16%	29.64%	>=12%	10%<>12%	<10%		27.14%	▼
Monthly Turnover				2.60%	2.66%	3.42%	0.00%	5.93%	2.69%	0.56%	1.18%	2.38%	5.02%	2.05%	0.00%					0.00%	◄►
Sickness Absence %	>=4%	4%<>3%	<3%	1.49%	0.91%	1.39%	1.77%	3.93%	6.78%	5.70%	3.16%	6.59%	5.77%	4.46%	1.23%	>=4%	4%<>3%	<3%		2.56%	May Indicative Figure

Medical Workforce - Performance Indicators

Metrics	2017/18 total / average	Target	Quarter 1 2017/18	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2018/19		Year to date actual
			Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	
Medical Workforce															
Turnover rate in month, excluding trainees	13.98% 12Mth rolling	<1%	2.18%	2.13%	0.00%	3.96%	0.98%	2.04%	1.01%	1.01%	0.00%	0.00%	85.00%	0.95%	5.63%
Turnover in month including trainees 9%	51% 12Mth rolling		2.10%	2.24%	13.89%	2.11%	5.32%	2.17%	2.15%	0.73%	10.21%	0.00%	6.09%	2.12%	8.23%
Management cases monthly		0	0	0	0	0	0	0	0	1	0	0	1	1	3
Sickness rate monthly on total medical/dental headcount	2.77%		1.70%	1.58%	1.14%	0.33%	0.73%	1.27%	0.75%	0.61%	0.46%	1.29%	1.03%	0.55%	0.79%
Appraisal rate monthly (exclude deanery trainees)	88.80% Mar 17		83.22%	82.39%	82.98%	80.33%	82.39%	90.63%	86.00%	86.30%	81.76%	75.56%	82.35%	83.60%	
Mandatory training monthly		95%	83.1%	83%	81%	83%	85%	84%	84%	84%	85%	82%	85%	84%	83.5%
Exception Reporting – Education and Training			7	0	0	0	0	0	0	0	0	0	1	0	8
Exception Reporting – Hours			0	0	0	0	0	0	0	0	5	0	0	0	5

Medical & Dental Staffing

There are currently 102 doctors for whom the QVH is their designated body. The completed appraisal rate for 2017/18 was 89.8%. All doctors are revalidated with a licence to practice. The appraisal and revalidation group, with lay representation, is now acting as an advisory group to revalidation recommendations, strengthening the rigour around the decision making of the Responsible Officer. We have just entered the second 5 year cycle of Revalidation, and following the GMC commissioned Pearson report, the requirements around appraisal and revalidation remain subject to changing emphasis.

An AAC for a consultant appointment in Sleep Studies is scheduled for 2nd July, to substantiate long standing locum positions which equate to one whole time equivalent.

Education

The GMC National Training Survey was completed in April, with results expected in July 2018. The 2017 results were disappointing for plastic surgery higher training and core surgical training. A new clinical tutor is in place and action plans implemented maximising training and teaching opportunities. The balance of training and service delivery in the context of difficult recruitment remains challenging. A new rota coordinator, supported by Colonel Cubison, has been appointed. A Health Education Visit is scheduled for 10th September 2018.

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	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	139	_	6	5	8	13	13	14	9	7	19	8	11	8	121		
2		Total reported - Patient safety	45	_	3	1	3	4	6	5	3	3	8	2	7	2	47		
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	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	12	0	0	0	0	0	1	0	1	1	5	1	1	0	10		
6		Falls - With harm	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1		
9	**MRSA Screening**	Elective patients	99.5%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	93%	100%	99%		improvement noted
10		Trauma patients	99.3%	95%	100%	100%	100%	100%	91%	100%	100%	100%	100%	100%	100%	100%	99%		
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1		PIR showed contaminated specimen not actual bacteraemia
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%	96%		93%		73%		100%	90%		100%	100%	94%		
14		Bare below the elbows	100%	95%	100%	100%		100%		100%		100%	100%		100%	100%	100%		
15	**Drug Assessments**	% staff compliant	97%	100%	93%	93%	89%	89%	100%	100%	100%	100%	100%	100%	85%	87%	95%		
16	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	9	0	1	1	1	2	2	2	0	0	0	0	1	0	10		
20	**Safety Thermometer**	Harm Free Care %	98.3%	95%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	97%		improvement noted
21		New Harm Free %	100%	95%	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%	86%	100%	100%	100%	99%		
23		24 hour follow up (S. Therm)	95.5%	95%	100%	100%	100%	n/a	100%	100%	100%	67%	83%	100%	100%	100%	95%		
24		Monthly screening % (Informatics)	100%	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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		
30	**Shift meets requirement** Day %	RN	96.7%	95%	94%	98%	99%	98%	99%	93%	97%	91%	96%	98%	98%	97%	97%		
31		HCA	96.6%	95%	95%	98%	98%	100%	100%	95%	84%	98%	100%	100%	100%	100%	97%		
32	**Shift meets requirement** Night %	RN	95.7%	95%	102%	100%	97%	95%	94%	90%	98%	82%	97%	102%	95%	98%	96%		
33		HCA	106.3%	95%	100%	100%	100%	100%	100%	100%	100%	100%	175%	100%	100%	163%	112%		
EFFECTIVE																			
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	83%	99%		1 patient, Ward Matron, aware improvement requested
35		7 day review (Safety Thermometer)	100%	95%	100%	100%	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%		
36	**Compliance in Practice** (CiP)	Inspection score		80%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

CARING																			
37	**Friends & Family Test**	Patient numbers (eligible to respond)	652	_	61	56	44	41	57	52	64	62	62	56	69	65	689		
38		% return rate	45%	40%	73%	20%	36%	100%	37%	31%	38%	16%	42%	21%	6%	31%	38%		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%	92%	100%	100%	100%	96%	100%	92%	100%	85%	97%		
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** Establishment=	Full Team WTE															#DIV/0!		Total establishment for ward = 30.72 WTE
43		Vacancy WTE	6.43	10%	8.84	8.84	9.92	7.91	2.88	1.91	2.51	6.12	5.43	6.03	7.05	6.72	6.2		
44		Vacancy (hrs)	1044.88	10%	1436	1436	1612	1285	468	310	407	994.5	882	979	1145	1092	1003.9		
45	**Temporary Staffing** excluding RMN	Agency Use	99.1	10%	178	92	23	69	121	46	11.5	69	161	384	226	425	150.46		
46		Bank Use	360.1	10%	372	337	513	426	447	249	200	279	444	384.5	233	349	352.79		
47	**Sickness**	Hours															#DIV/0!		
48		%	3.1%	2%	1.1%	3.8%	2.3%	3.8%	3.1%	2.9%	4.3%	6.6%	1.7%	4.6%	1.6%	1.0%	3.1%		All sickness managed via policy currently
49	**Maternity**	Hours															#DIV/0!		
50	**Budget Position**	YTD Position		>0	38138	31005	-2798	-1539	26714	55353	70673	85983	166689	249483	41143	62409	823253		
51	**Statutory & Mandatory**	Mandatory training	89.6%	95%	87%	87%	88%	92%	90%	82%	93%	93%	91%	89%	91%	89%	89%		Discussed with Ward Matron ways to improve compliance of both appraisal and CMTD
52		Appraisal	87.1%	95%	81%	83%	93%	93%	87%	92%	84%	84%	90%	90%	79%	82%	87%		
53	**Uniform Audit**	Total no. of staff audited		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
54		No. of staff compliant		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
55		Compliance with uniform policy %		95%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING

CORNEOPLASTIC OPD

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	86	_	11	6	3	4	4	6	6	11	5	11	6	8	81		
2		Total reported - Patient safety	29	_	2	1	3	0	1	4	3	4	2	4	5	2	31		
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	0	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	0		
6		Falls - With harm	0	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	0		
8	**Inoculation Injury**	Reported incidents	0	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	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	100%	95%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%		
14		Bare below the elbows	100%	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			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	18	0	2	0	1	0	1	1	3	1	1	2	4	2	18		This relates to doctors prescribing
20	**Safety Thermometer**	Harm Free Care %		95%													#DIV/0!		
21		New Harm Free %		95%													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%													#DIV/0!		
23		24 hour follow up (S. Therm)		95%													#DIV/0!		
24		Monthly screening % (Informatics)		95%													#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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#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%	ported 1	Reported 1/4ly			80.1%			Reported 1/4ly			90.7%		85%		

CARING																		
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_						1663	1667	2081	1633	1819	2007	2165	13035	
38		% return rate	22.8%	20%	22%	22%	27%	22%	22%	24%	26%	23%	22%	20%	21%	21%	23%	Unit staff to raise awareness to patients to increase response rate. Matron to disseminate to team
39		% recommendation (v likely/likely)	94.7%	90%	96%	95%	95%	95%	94%	96%	93%	94%	95%	94%	92%	93%	94%	
40		% unlikely/extremely unlikely	1.3%	0%	1%	1%	1%	2%	1%	1%	2%	2%	0%	2%	3%	2%	2%	
RESPONSIVE																		
41	**Complaints**	No. recorded	4	0	0	1	0	0	0	1	0	0	0	1	0	1	4	Response provided - late clinic cancellations
WELL-LED																		
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!	
43		Vacancy WTE		10%									1.91	1.91	3.11	2.8	2.4	Nursing establishment = 20.12 WTE
44		Vacancy (hrs)		10%									310.4	310.4	505.4	455	395.3	
45	**Temporary Staffing** excluding RMN	Agency Use		10%									0	0	0	0	0	
46		Bank Use		10%									407.4	206.5	125.5	173.5	228.23	
47	**Sickness**	Hours															#DIV/0!	
48		%		2%													#DIV/0!	
49	**Maternity**	Hours															#DIV/0!	
50	**Budget Position**	YTD Position		>0									92109	117732	19631	34880	264352	
51	**Statutory & Mandatory**	Mandatory training		95%									97%	97%	96%	94%	96%	
52		Appraisal		95%									95%	95%	100%	95%	96%	
53	**Uniform Audit**	Total no. of staff audited		_									20				20	
54		No. of staff compliant		_									20				20	
55		Compliance with uniform policy %		95%									100%				100%	

NURSING METRICS - 12 MONTH ROLLING

CRITICAL CARE UNIT

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	147	_	11	24	18	8	6	12	14	16	13	9	16	11	158		
2		Total reported - Patient safety	100	_	9	18	11	6	4	6	8	11	8	5	10	6	102		
3		Internal investigation (Amber or Red)	4	0	2	0	0	1	0	0	0	0	0	0	1	0	4		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	2	0	0	2	0	0	0	0	0	0	0	0	1	0	3		
6		Falls - With harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
7	**Pressure Damage**	G2 or above (hospital acquired)	4	0	2	0	0	1	0	0	1	0	0	0	0	1	5		I have one for a burns patient in critical care in APRIL
8	**Inoculation Injury**	Reported incidents	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
9	**MRSA Screening**	Elective patients	100%	95%	100%	n/a	n/a	n/a		100%	n/a	100%	100%	n/a	100%	100%	100%		
10		Trauma patients	89.1%	95%	100%	100%	100%	100%		100%	100%	0%	80%	100%	n/a	100%	88%		
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	90.4%	95%	n/a	n/a	97%	81%	87%	100%	100%	90%	78%	90%	100%	100%	92%		Hand hygiene results inadequate compliance - Ward Matron to monitor this and challenge appropriately
14		Bare below the elbows	98.8%	95%	n/a	n/a	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%	99%		
15	**Drug Assessments**	% staff compliant	95.9%	100%	100%	100%	100%	100%	81%	88%	88%	94%	100%	100%	100%	100%	96%		
16	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	4	0	0	0	0	0	0	0	1	1	0	0	0	2	4		
20	**Safety Thermometer**	Harm Free Care %	92.5%	95%	100%	100%	100%	100%	100%	100%	100%	100%	67%	50%	100%	100%	93%		
21		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	95.5%	95%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	96%		
23		24 hour follow up (S. Therm)	80%	95%	0%	100%	100%	100%	n/a	100%	100%	100%	100%	0%	33%	0%	67%		
24		Monthly screening % (Informatics)	100%	95%	100%	100%	100%	100%	n/a	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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		
30	**Shift meets requirement** Day %	RN	96.8%	95%	97%	97%	95%	99%	92%	96%	92%	100%	98%	96%	90%	96%	96%		
31		HCA	96.1%	95%	90%	100%	88%	94%	100%	97%	93%	92%	95%	104%	94%	118%	97%		Additional HCA support staff have been booked to support patient acuity
32	**Shift meets requirement** Night %	RN	88.5%	95%	92%	95%	88%	83%	69%	94%	81%	94%	90%	91%	89%	99%	89%		
33		HCA	90.0%	95%	100%	100%	100%	100%	125%	65%	53%	71%	86%	80%	400%	113%	116%		Additional HCA support staff have been booked to support patient acuity
EFFECTIVE																			
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	90.9%	95%	50%	100%	100%	100%	100%	100%	100%	100%	100%	50%	67%	100%	89%		Compliance improved and noted
35		7 day review (Safety Thermometer)	89.3%	95%	n/a	100%	100%	100%	n/a	75%	n/a	50%	n/a	100%	100%	n/a	89%		
36	**Compliance in Practice** (CiP)	Inspection score		80%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

CARING																			
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_													0		
38		% return rate		40%													#DIV/0!		
39		% recommendation (v likely/likely)		90%													#DIV/0!		
40		% unlikely/extremely unlikely		0%													#DIV/0!		
RESPONSIVE																			
41	**Complaints**	No. recorded	2	0	0	0	0	0	0	0	0	0	1	1	0	0	2		
WELL-LED																			
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!		
43		Vacancy WTE	9.32	10%	9.02	9.02	13.28	11.28	5.65	5.01	6.01	9.16	9.16	11.97	9.66	9.59	9.1		Ward Establishment = 29.37 WTE
44		Vacancy (hrs)	1514.2	10%	1465	1465	2158	1833	918	814	976	1488	1488	1945	1570	1558	1473.2		
45	**Temporary Staffing** excluding RMN	Agency Use	595.5	10%	265	586	825.5	839.5	444	827.5	482	689	641	846	950	1035	702.54		
46		Bank Use	222.9	10%	169	189	179	182.5	175	223	149	316	410	353.5	226	246	234.83		
47	**Sickness**	Hours															#DIV/0!		
48		%	1.9%	2%	0.9%	0.7%	0.0%	2.2%	2.3%	2.5%	4.1%	1.7%	3.0%	3.2%	7.7%	7.5%	3.0%		Long term sickness staff, being managed within policy, alongside the short term sickness
49	**Maternity**	Hours															#DIV/0!		
50	**Budget Position**	YTD Position		>0	-58686	-894	-20940	9594	-943	11190	25981	93023	93265	69733	-91455	-30308	99560		
51	**Statutory & Mandatory**	Mandatory training	88%	95%	89%	88%	92%	93%	89%	88%	90%	90%	90%	87%	85%	86%	89%		Due to vacancies difficult to release staff, to identify a way of how to better manage this is required
52		Appraisal	90.8%	95%	100%	90%	100%	100%	94%	91%	91%	91%	86%	72%	68%	77%	88%		
53	**Uniform Audit**	Total no. of staff audited		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
54		No. of staff compliant		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
55		Compliance with uniform policy %		95%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING
MAIN OUTPATIENTS

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	134	_	9	12	7	8	8	8	10	12	24	16	11	7	132		
2		Total reported - Patient safety	28	_	1	2	4	2	0	5	1	2	4	3	2	2	28		
3		Internal investigation (Amber or Red)	1	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	0		
5	**Falls**	Falls - All	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1		
6		Falls - With harm	1	0	0	0	0	0	0	0	0	0	1	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	0		
8	**Inoculation Injury**	Reported incidents	3	0	0	0	0	0	0	0	2	1	0	0	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	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	84.8%	95%	100%	97%	97%	94.7%	93%	56%	70%	56%	70%	86%	100%	89%	84%		This is dependant upon MDT collaboration. Departmental Matron working with staff to increase compliance and
14		Bare below the elbows	96.3%	95%	100%	100%	100%	100%	77%	89%	90%	100%	100%	100%	100%	100%	96%		
15	**Drug Assessments**	% staff compliant		100%													#DIV/0!		
16	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1		
20	**Safety Thermometer**	Harm Free Care %		95%													#DIV/0!		
21		New Harm Free %		95%													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%													#DIV/0!		
23		24 hour follow up (S. Therm)		95%													#DIV/0!		
24		Monthly screening % (Informatics)		95%													#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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#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%			Reported 1/4ly		86%		

CARING																			
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_						11446	11458	13356	11446	11984	12479	12729	84898		
38		% return rate	16.3%	20%	15%	17%	16%	17%	16%	16%	17%	18%	17%	18%	17%	16%	17%		Matron working closely with staff to increase compliance and response rate
39		% recommendation (v likely/likely)	94.4%	90%	95%	94%	93%	94%	94%	95%	94%	95%	95%	94%	94%	95%	94%		
40		% unlikely/extremely unlikely	2.3%	0%	2%	2%	3%	2%	2%	2%	3%	2%	2%	3%	2%	2%	2%		
RESPONSIVE																			
41	**Complaints**	No. recorded	4	0	0	0	1	1	0	0	0	1	1	0	0	0	4		
WELL-LED																			
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!		
43		Vacancy WTE		10%										1.26	1.22	1.18	1.2		Establishment = 15.50 WTE
44		Vacancy (hrs)		10%										204.75	198.25	191.7	198.23		
45	**Temporary Staffing** excluding RMN	Agency Use		10%										0	0	0	0		
46		Bank Use		10%										304.5	231.25	310.5	282.08		
47	**Sickness**	Hours															#DIV/0!		
48		%		2%										5.3%	5.7%	8.9%	6.6%		Long term sickness as well as short term, all being managed within the policy appropriately
49	**Maternity**	Hours															#DIV/0!		
50	**Budget Position**	YTD Position		>0										117894	-7780	-6392	103722		
51	**Statutory & Mandatory**	Mandatory training		95%										90%	91%	90%	90%		Matron working with team to ensure compliance is increased
52		Appraisal		95%										85%	90%	90%	88%		
53	**Uniform Audit**	Total no. of staff audited		_		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
54		No. of staff compliant		_		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
55		Compliance with uniform policy %		95%		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING
MARGARET DUNCOMBE

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	Incidents	Total reported - All incidents	180	_	11	11	20	15	14	18	18	17	15	12	14	13	178		
2		Total reported - Patient safety	118	_	9	6	16	7	10	11	9	12	12	7	9	11	119		
3		Internal investigation (Amber or Red)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	Falls	Falls - All	14	0	2	0	2	0	0	1	2	2	1	1	0	2	13		
6		Falls - With harm	4	0	0	0	2	0	0	0	0	0	1	0	0	1	4		
7	Pressure Damage	G2 or above (hospital acquired)	1	0	0	1	0	0	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	0		
9	MRSA Screening	Elective patients	97.4%	95%	100%	100%	98%	98%	93%	94%	91%	100%	100%	97%	100%	98%	97%		
10		Trauma patients	95.4%	95%	93%	94%	97%	94%	98%	93%	92%	93%	97%	100%	94%	93%	95%		Matron leading on discussions with staff. Educator involved. HoN reviewing data
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	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
14		Bare below the elbows	94.7%	95%	100%	100%	100%	100%	100%	100%	93%	100%	60%	100%	100%	80%	94%		Matron leading on discussions with staff.
15	Drug Assessments	% staff compliant	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%		
16	Medication Audit	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	Medication Errors	Reported errors	34	0	1	0	5	4	8	6	1	2	2	1	3	4	37		
20	Safety Thermometer	Harm Free Care %	99.4%	95%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%		
21		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
22	VTE (Venous thromboembolism)	Assessment of patients (S. Therm)	99.1%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%	92%	98%		
23		24 hour follow up (S. Therm)	89.3%	95%	100%	100%	90%	100%	100%	89%	92%	54%	67%	80%	73%	42%	82%		Matron leading on discussions with staff. Educator involved. HoN reviewing data
24		Monthly screening % (Informatics)	97.4%	95%	99%	97%	100%	99%	100%	96%	96%	99%	98%	86%	99%	96%	97%		
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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		
30	Shift meets requirement Day %	RN	97.3%	95%	97%	99%	97%	100%	98%	98%	95%	98%	97%	90%	96%	98%	97%		
31		HCA	99.5%	95%	90%	97%	94%	100%	105%	102%	100%	104%	93%	107%	100%	102%	100%		
32	Shift meets requirement Night %	RN	94.8%	95%	97%	94%	91%	96%	93%	98%	88%	95%	97%	94%	101%	100%	95%		
33		HCA	86.4%	95%	100%	73%	84%	90%	68%	77%	88%	91%	88%	85%	94%	103%	87%		
EFFECTIVE																			
34	Nutrition Assessment (MUST)	Initial (Safety Thermometer)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
35		7 day review (Safety Thermometer)	70.8%	95%	100%	100%	100%	100%	100%	0%	67%	50%	100%	0%	100%	100%	76%		
36	Compliance in Practice (CiP)	Inspection score		80%	80.1%	Reported 1/4ly			87.4%			86.8%			Reported 1/4ly		87%		

CARING																			
37	**Friends & Family Test**	Patient numbers (eligible to respond)	1737	_	169	160	145	144	139	146	122	129	133	109	144	124	1664		
38		% return rate	60.8%	40%	47%	47%	68%	54%	49%	31%	77%	78%	63%	76%	63%	71%	60%		
39		% recommendation (v likely/likely)	98.1%	90%	96%	99%	99%	96%	100%	100%	95%	99%	96%	99%	100%	99%	98%		
40		% unlikely/extremely unlikely	0.1%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%		
RESPONSIVE																			
41	**Complaints**	No. recorded	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1		
WELL-LED																			
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!		
43		Vacancy WTE	8.2	10%	6.29	8.99	11.13	11.82	5.62	6.55	7.41	9.79	8.92	10.02	11.46	11.21	9.1		
44		Vacancy (hrs)	1332.9	10%	1022	1460	1808	1921	913	1064	1204	1590	1450	1628	1862	1822	1478.7		
45	**Temporary Staffing** excluding RMN	Agency Use	546.7	10%	115	173	333.5	464.5	331	799	968	1045	874	1229	1522.5	1464	776.54		maternity not taken into account. In addition staffing above template required during busier than normal shifts
46		Bank Use	485	10%	555	407	424.5	360.5	541.5	732	302	557	553	827.5	736	940	578		
47	**Sickness**	Hours															#DIV/0!		
48		%	3.7%	2%	3.5%	2.6%	2.9%	0.5%	4.9%	3.6%	3.9%	5.4%	6.3%	5.6%	3.7%	2.0%	3.7%		
49	**Maternity**	Hours															#DIV/0!		
50	**Budget Position**	YTD Position		>0	-28289	-33744	47435	47794	63502	72524	61585	36168	36	-20622	-49366	-72573	124450		
51	**Statutory & Mandatory**	Mandatory training		95%	91%	94.5%	94.6%	95%	95%	94.8%	91%	93%	95%	96%	93%	95%	94%		Ongoing work to improve - Matron leading
52		Appraisal		95%	98%	94%	96%	91%	94%	94%	100%	98%	82%	83%	88%	95%	93%		
53	**Uniform Audit**	Total no. of staff audited		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
54		No. of staff compliant		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
55		Compliance with uniform policy %		95%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING

ROSS TILLEY

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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 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May						
SAFE																						
1	**Incidents**	Total reported - All incidents	194	_	18	22	8	10	16	24	21	26	16	12	11	15	199					
2		Total reported - Patient safety	111	_	6	8	5	5	8	14	14	20	8	9	7	7	111					
3		Internal investigation (Amber or Red)	1	0	0	0	0	0	0	0	0	1	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	0					
5	**Falls**	Falls - All	19	0	2	1	0	0	0	5	1	4	2	0	1	1	17					
6		Falls - With harm	1	0	1	0	0	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	1	0	1					
8	**Inoculation Injury**	Reported incidents	2	0	1	0	0	0	0	1	0	0	0	0	0	0	2					
9	**MRSA Screening**	Elective patients	97.8%	95%	98%	96%	99%	100%	98%	100%	100%	98%	94%	95%	97%	94%	97%					Matron leading on discussions with staff. Educator involved. HoN reviewing data
10		Trauma patients	97.2%	95%	96%	93%	96%	96%	96%	98%	100%	99%	96%	99%	99%	97%	97%					
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	100%	95%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%					
14		Bare below the elbows	97.4%	95%	100%	100%	100%	100%	100%	100%	87%		100%	100%	87%	80%	96%					Matron leading on discussions with staff.
15	**Drug Assessments**	% staff compliant	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%					
16	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0					
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0					
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0					
19	**Medication Errors**	Reported errors	40	0	3	1	1	2	4	5	6	3	3	5	3	2	38					
20	**Safety Thermometer**	Harm Free Care %	99.4%	95%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	99%					
21		New Harm Free %	99.4%	95%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	99%					
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	98.6%	95%	100%	100%	100%	100%	100%	100%	94%	89%	100%	100%	100%	100%	99%					
23		24 hour follow up (S. Therm)	87.8%	95%	100%	100%	100%	100%	100%	71%	88%	83%	60%	50%	93%	53%	83%					Matron leading on discussions with staff. Educator involved. HoN reviewing data
24		Monthly screening % (Informatics)	97.8%	95%	99%	93%	99%	99%	99%	98%	96%	99%	99%	94%	98%	96%	97%					
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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!					
30	**Shift meets requirement** Day %	RN	97.8%	95%	100%	100%	98%	99%	102%	99%	91%	95%	97%	93%	98%	96%	97%					
31		HCA	97.3%	95%	100%	98%	94%	100%	100%	93%	96%	91%	102%	96%	102%	96%	97%					
32	**Shift meets requirement** Night %	RN	93.1%	95%	83%	99%	91%	104%	93%	95%	89%	89%	95%	96%	93%	93%	93%					Mixture of no show agency on the night as well as shifts not filled. Managed on the night and agencies followed
33		HCA	86.0%	95%	95%	85%	84%	81%	67%	79%	73%	86%	96%	100%	100%	90%	86%					
EFFECTIVE																						
34	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	98.9%	95%	100%	100%	100%	100%	100%	93%	100%	100%	94%	100%	100%	100%	99%					
35		7 day review (Safety Thermometer)	84.5%	95%	100%	100%	100%	75%	100%	50%	80%	100%	100%	25%	100%	100%	86%					
36	**Compliance in Practice** (CiP)	Inspection score		80%	ported 1	Reported 1/4ly			90.6%			86.6%			Reported 1/4ly		89%					

CARING																			
37	**Friends & Family Test**	Patient numbers (eligible to respond)	2418	_	212	234	227	199	209	219	181	215	174	174	174	193	2411		
38		% return rate	47.1%	40%	32%	41%	35%	54%	56%	24%	79%	55%	43%	58%	60%	39%	48%		
39		% recommendation (v likely/likely)	97.9%	90%	99%	97%	96%	97%	97%	98%	99%	97%	99%	99%	95%	100%	98%		
40		% unlikely/extremely unlikely	0.3%	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	2%	0%	0%		
RESPONSIVE																			
41	**Complaints**	No. recorded	2	0	0	0	0	0	1	0	0	0	0	1	0	1	3		
WELL-LED																			
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!		
43		Vacancy WTE	8.2	10%	6.29	8.99	11.13	11.82	5.62	6.55	7.41	9.79	8.92	10.02	11.46	11.21	9.1		
44		Vacancy (hrs)	1332.9	10%	1022	1460	1808	1921	913	1064	1204	1590	1450	1628	1862	1822	1478.7		
45	**Temporary Staffing** excluding RMN	Agency Use	546.7	10%	115	173	333.5	464.5	331	799	968	1045	874	1229	1522.5	1464	776.54		maternity not taken into account (will be amended going forward). In addition staffing above template required
46		Bank Use	485	10%	555	407	424.5	360.5	541.5	732	302	557	553	827.5	736	940	578		
47	**Sickness**	Hours															#DIV/0!		
48		%	3.7%	2%	3.5%	2.6%	2.9%	0.5%	4.9%	3.6%	3.9%	5.4%	6.3%	5.6%	3.7%	2.0%	3.7%		
49	**Maternity**	Hours															#DIV/0!		
50	**Budget Position**	YTD Position		>0	-28289	-33744	47435	47794	63502	72524	61585	36168	36	-20622	-49366	-72573	124450		
51	**Statutory & Mandatory**	Mandatory training		95%	91%	94.5%	94.6%	95%	95%	94.8%	91%	93%	95%	96%	93%	95%	94%		
52		Appraisal		95%	98%	94%	96%	91%	94%	94%	100%	98%	82%	83%	88%	95%	93%		Ongoing work to improve - Matron leading
53	**Uniform Audit**	Total no. of staff audited		_	eported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
54		No. of staff compliant		_	eported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
55		Compliance with uniform policy %		95%	eported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#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	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	30	_	3	1	0	4	3	4	3	2	5	5	4	5	39		
2		Total reported - Patient safety	8	_	0	1	0	1	2	1	2	0	0	1	2	1	11		
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	0	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	0		
6		Falls - With harm	0	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	0		
8	**Inoculation Injury**	Reported incidents	2	0	1	0	0	0	0	0	0	1	0	0	0	1	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	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	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	99%		
14		Bare below the elbows	100%	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			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	2	0	0	0	0	0	1	0	1	0	0	0	0	1	3		
20	**Safety Thermometer**	Harm Free Care %		95%													#DIV/0!		
21		New Harm Free %		95%													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%													#DIV/0!		
23		24 hour follow up (S. Therm)		95%													#DIV/0!		
24		Monthly screening % (Informatics)		95%													#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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#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%			90.4%		87%		

CARING																		
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_						1440	1238	1379	1302	1436	1542	1589	9926	
38		% return rate	17.9%	20%	18%	18%	19%	18%	18%	17%	18%	19%	17%	17%	18%	18%	18%	Discussed with team, aware to encourage patients to complete to improve this data and understand where
39		% recommendation (v likely/likely)	92.3%	90%	95%	94%	88%	91%	91%	92%	91%	95%	94%	91%	91%	92%	92%	
40		% unlikely/extremely unlikely	3.1%	0%	3%	2%	4%	5%	4%	2%	4%	2%	2%	4%	4%	2%	3%	
RESPONSIVE																		
41	**Complaints**	No. recorded	13	0	2	1	1	1	0	1	0	3	2	0	1	2	14	
WELL-LED																		
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!	
43		Vacancy WTE		10%									0.79	2.39	0.76	1.76	1.4	Departmental Establishment = 21.37 WTE
44		Vacancy (hrs)		10%									128.37	388	123.5	286	231.47	
45	**Temporary Staffing** excluding RMN	Agency Use		10%									0	0	0	0	0	
46		Bank Use		10%									274.37	24	177	214	172.34	
47	**Sickness**	Hours															#DIV/0!	
48		%		2%									5.5%	0.5%	5.0%	2.2%	3.3%	
49	**Maternity**	Hours															#DIV/0!	
50	**Budget Position**	YTD Position		>0									8270	22807	-4197	-913	25967	
51	**Statutory & Mandatory**	Mandatory training		95%									93%	90%	92%	89%	91%	Ward Matron aware compliance is required to improve with immediate effect, working closely with the team to do
52		Appraisal		95%									85%	85%	100%	88%	90%	
53	**Uniform Audit**	Total no. of staff audited		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0	
54		No. of staff compliant		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0	
55		Compliance with uniform policy %		95%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!	

NURSING METRICS - 12 MONTH ROLLING

PEANUT WARD

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	100	_	7	9	6	11	11	14	9	10	13	2	7	30	129		
2		Total reported - Patient safety	26	_	4	3	1	3	1	3	2	3	2	0	0	4	26		
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	0	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	1	1		
6		Falls - With harm	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	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	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	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	98.8%	95%		100%			94%			100%					98%		
14		Bare below the elbows	98.2%	95%		100%			91%			100%					97%		
15	**Drug Assessments**	% staff compliant	99.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	99%		
16	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	5	0	1	1	0	0	1	0	1	0	0	0	0	1	5		
20	**Safety Thermometer**	Harm Free Care %	100%	95%	n/a	100%	100%	n/a	100%	n/a	n/a	100%	n/a	n/a	100%	100%	100%		
21		New Harm Free %	100%	95%	n/a	100%	100%	n/a	100%	n/a	n/a	100%	n/a	n/a	100%	100%	100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%													#DIV/0!		
23		24 hour follow up (S. Therm)		95%													#DIV/0!		
24		Monthly screening % (Informatics)		95%													#DIV/0!		
25	**BMI Monthly**	Total no. of ward patients		_							189	180	194	176	178		917		
26		No. patients screened & documented		_							171	172	187	171	171		872		
27		Patients with documented BMI %		95%							90%	96%	96%	97%	96%		95%		
28	**WHO Checklist**	Qualitative %		95%													#DIV/0!		
29		Quantitative %		95%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		
30	**Shift meets requirement** Day %	RN	96.8%	95%	90%	99%	98%	99%	101%	93%	87%	100%	99%	96%	94%	100%	96%		
31		HCA	98.0%	95%	97%	103%	94%	97%	91%	100%	100%	91%	103%	100%	108%	97%	98%		
32	**Shift meets requirement** Night %	RN	61.9%	95%	51%	59%	44%	49%	67%	45%	55%	92%	88%	93%	83%	98%	69%		
33		HCA	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
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%	84.0%	Reported 1/4ly			88.7%			88.1%			91.1%		89%		

CARING																			
37	**Friends & Family Test**	Patient numbers (eligible to respond)	2340	_	205	222	205	196	191	195	181	173	192	171	172	224	2327		
38		% return rate	28.2%	40%	12%	33%	36%	30%	18%	31%	33%	31%	34%	40%	42%	37%	31%		
39		% recommendation (v likely/likely)	99.3%	90%	100%	99%	100%	100%	97%	98%	97%	100%	100%	100%	99%	93%	99%		
40		% unlikely/extremely unlikely	0.2%	0%	0%	0%	0%	0%	0%	0%	2%	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** Establishment=	Full Team WTE															#DIV/0!		
43		Vacancy WTE	3.3	10%	6.5	6.5	4.89	3.89	2.45	2.45	0.93	0	0	0	0.24	1.24	2.4		
44		Vacancy (hrs)	542.9	10%	1056	1056	795	632	398	398	151	0	0	0	39	201.5	393.88		
45	**Temporary Staffing** excluding RMN	Agency Use	92.2	10%	46	210	213	236	197	17.5	57	22.5	10	1	28	110	95.667		
46		Bank Use	273.8	10%	381	373	253	324.5	369	437.5	168	229	217	34	192	413	282.58		
47	**Sickness**	Hours															#DIV/0!		
48		%	5.5%	2%	3.1%	3.7%	4.8%	8.7%	12.0%	5.6%	7.9%	4.5%	6.8%	3.6%	4.0%	1.0%	5.5%		
49	**Maternity**	Hours															#DIV/0!		
50	**Budget Position**	YTD Position		>0	5910	11060	-1469	-6253	1682	23045	811	-13480	-14325	-6784	99	5968	6264		
51	**Statutory & Mandatory**	Mandatory training		95%	90%	91%	90%	86%	86%	84%	83%	83%	88%	88%	92%	92%	88%		Discussed with Matron who is working to improve this.
52		Appraisal		95%	84%	83%	83%	83%	79%	75%	75%	75%	77%	72%	80%	83%	79%		Discussed with Matron who is working to improve this.
53	**Uniform Audit**	Total no. of staff audited		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly					0		
54		No. of staff compliant		_	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
55		Compliance with uniform policy %		95%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#DIV/0!		

NURSING METRICS - 12 MONTH ROLLING

SLEEP DC

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No.	Indicator	Description	2017/18 total/ average	Target	Quarter 1	Quarter 2 2017/18			Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	26	_	2	3	4	3	2	2	0	2	3	3	3	0	27		
2		Total reported - Patient safety	9	_	1	0	1	1	1	1	0	0	0	2	1	0	8		
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	0	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	0		
6		Falls - With harm	0	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	0		
8	**Inoculation Injury**	Reported incidents	0	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	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	100%	95%	100%		100%	100%	100%	100%	100%	100%			100%	100%	100%		
14		Bare below the elbows	98.9%	95%	100%		100%	100%	90%	100%	100%	100%			100%	100%	99%		
15	**Drug Assessments**	% staff compliant		100%													#DIV/0!		
16	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
17		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
18		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		0		
19	**Medication Errors**	Reported errors	2	0	0	0	0	0	1	0	0	0	0	1	0	0	2		
20	**Safety Thermometer**	Harm Free Care %		95%													#DIV/0!		
21		New Harm Free %		95%													#DIV/0!		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)		95%													#DIV/0!		
23		24 hour follow up (S. Therm)		95%													#DIV/0!		
24		Monthly screening % (Informatics)	100%	95%	100%	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%	ported 1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		#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%	87.4%	Reported 1/4ly			84.4%			89.0%			Reported 1/4ly		87%		

CARING																	
37	**Friends & Family Test**	Patient numbers (eligible to respond)		_						890	641	829	610	903	988	851	5712
38		% return rate	22.8%	20%	25%	26%	20%	20%	24%	21%	23%	21%	21%	21%	17%	18%	21%
39		% recommendation (v likely/likely)	95.3%	90%	93%	93%	95%	98%	99%	96%	95%	96%	94%	93%	93%	99%	95%
40		% unlikely/extremely unlikely	1.7%	0%	2%	4%	1%	1%	0%	2%	1%	0%	3%	4%	4%	0%	2%
RESPONSIVE																	
41	**Complaints**	No. recorded	3	0	0	1	0	1	0	0	0	1	0	0	0	0	3
WELL-LED																	
42	**Vacancy** Establishment=	Full Team WTE															#DIV/0!
43		Vacancy WTE		10%													#DIV/0!
44		Vacancy (hrs)		10%													#DIV/0!
45	**Temporary Staffing** excluding RMN	Agency Use		10%													#DIV/0!
46		Bank Use		10%													#DIV/0!
47	**Sickness**	Hours															#DIV/0!
48		%		2%													#DIV/0!
49	**Maternity**	Hours															#DIV/0!
50	**Budget Position**	YTD Position		>0													0
51	**Statutory & Mandatory**	Mandatory training		95%													#DIV/0!
52		Appraisal		95%													#DIV/0!
53	**Uniform Audit**	Total no. of staff audited		_													0
54		No. of staff compliant		_													0
55		Compliance with uniform policy %		95%													#DIV/0!

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 July 2018**		**Agenda reference:**	113-18	
Report title:	**Audit Committee Assurance update**				
Sponsor:	Kevin Gould, Audit Committee Chair				
Author:	Kevin Gould, Audit Committee Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board in relation to matters discussed at the Audit Committee meeting on 20 June 2018				
Summary of key issues	The Committee received assurance on KSO1 and KSO2, and received updates from External and Internal Audit.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Action required *[highlight **one** only]*				**Assurance**	
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* √	KSO2: *World-class clinical services* √	KSO3: *Operational excellence* √	KSO4: *Financial sustainability* √	KSO5: *Organisational excellence* √
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	None				

Report to:	Board of Directors
Meeting date:	5 July 2018
Reference number:	113-18
Report from:	Kevin Gould, Chair
Author:	Kevin Gould, Chair
Appendices:	N/A
Report date:	25 June 2018

Audit Committee report
Meeting held on 20 June 2018

1. The Committee received an assurance update on KSO1 and KSO2 from the Director of Nursing and Medical Director. The Chair of Q&G also provided assurance on the work of that committee in relation to the KSOs.

2. The Committee reviewed changes to Standing Orders, Reservations of Powers/Schemes of Delegation and Standing Financial Instructions, and recommended the revised documents to the Board for approval.

3. KPMG provided its update and a draft of the presentation for the AGM on the Annual Report and Accounts and audit report.

4. A revised Internal Audit Plan for 2018/19 was considered and approved. This reflected comments made by the Committee in March and by EMT

5. Mazars advised that two internal audit reports have been issued since the last meeting. Information governance Toolkit was rated "Substantial Assurance" and Assurance Framework & Risk Management was rated "Satisfactory". No Priority 1 recommendations were raised. It was noted that 4 audits on the 2017/18 plan are still to be completed.

6. The Committee received a report on the progress of counter fraud activity.

7. The Counter Fraud Annual Plan was considered and approved.

8. The Committee agreed to start the process of tendering for Internal Audit and Counter Fraud services rom 1 April 2019, when the contract with Mazars expires.

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/07/18**		**Agenda reference:**	**114-18**	
Report title:	**Annual review of corporate governance documentation**				
Sponsor:	Michelle Miles, Director of finance and performance Clare Pirie, Director of communications and corporate affairs				
Author:	Hilary Saunders, Deputy company secretary				
Appendices:	A: Document highlighting relevant changes				
Executive summary					
Purpose of report:	The purpose of this report is to provide the Board with an overview of proposed changes to corporate governance documentation following the annual review by the Audit committee in June 2018.				
Summary of key issues	As required under S.12.3 of the Trust's current standing orders, a review of corporate governance documentation is undertaken each year, with recommendations for any changes submitted to the Audit committee prior to formal approval by the Board of Directors. Standing orders: Only minor amendments have been made in order to differentiate between voting and non-voting executive directors. Reservation of powers and Scheme of delegation: Changes to financial limit delegation; clarification that the appointment of the external auditor is made by the Trust's Council of governors not the audit committee. Standing financial instructions: adjustments have been made to the procurement quotation limits to be consistent to the changes in the financial level delegation limits as highlighted				
Recommendation:	The Board is asked to **APPROVE** the 2018 Standing orders, Standing financial instructions and Reservation of powers/scheme of delegation documentation as recommended by the Audit committee at its meeting in June 2018.				
Action required	**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:	These documents are integral parts of the Trust's primary governing documents and are required by the regulator.				
Legal:	These documents were reviewed in detail by the Trust's legal advisors in 2016 and incorporated their advice and good practice recommendations. Changes to date do not have any legal implications				
Resources:	None				
Assurance route					
Previously considered by:	Audit committee				
	Date:	20/06/18	Decision:	Recommended for approval	
Next steps:	Assuming Board approval, the Standing orders, Standing financial instructions and Reservation of power/scheme of delegation document will be implemented with immediate effect. The next review will take place in July 2019.				

Report to:	Board of directors
Meeting date:	5 July 2018
Reference number:	114-18
Report from:	Michelle Miles, Director of finance and Clare Pirie, Director of communications
Authors:	Michelle Miles, Director of finance Hilary Saunders, Deputy company secretary
Appendices:	Appendix A: detail of proposed changes.
Report date:	22 June 2018

Annual review of corporate governance documentation

Background

1. As required under S.12.3 of the Trust's current standing orders, a review of corporate governance documentation is undertaken each year, with recommendations for any changes submitted to the Audit committee prior to formal approval by the Board of Directors.

2. For the purpose of this report, corporate governance documentation comprises Standing Financial Instructions, Standing Orders and the Reservation of Powers and Scheme of Delegation.

3. All members of the board are issued with corporate governance documentation when they join. Current versions are published to the QVH website and also on the Trust's intranet (Qnet). Additional copies are available from the Deputy company secretary on request.

Amendments

1. **Standing orders**: Only minor amendments have been made to the standing orders in order to differentiate between voting and non-voting executive directors.

2. **Reservation of powers and Scheme of delegation**:
   - Item 2.6.3: clarification that the appointment of the external auditor is made by the Trust's Council of governors and not the audit committee.
   - Item 3.4.2.2: minor changes to wording to reflect compliance is required with essential *regulatory and* professional standards;
   - Changes to financial limit delegation as shown in the attached appendix A.

3. **Standing financial instructions**
   - Sections 9.3.1, 9.8.1 and 9.15.1 adjustments to the procurement quotation limits to be consistent to the changes in the financial level delegation limits as shown in Appendix A.

Recommendation

The Board is asked to **APPROVE** the revised standing orders, reservation of powers/scheme of delegation and standing financial instructions at its meeting on 5 July 2018.

Appendix A

Annual review of corporate documentation 2018:

Proposed amendments to Reservations of power and scheme of delegation

2 approval of business cases and service developments (Does not include setting of pay and non-pay budgets as part of annual planning process) **Note: Applies to self-funding business cases and service developments and those within budgetary limits only.**		
2.1	**Revenue expenditure (5 year value)** Up to £20.00 £20.01 to £1,000,000 Over £1,000,000	 Executive Management Team Hospital Management Team Board of Directors
3.1	**Capital/revenue expenditure** Up to £5,000 £5,001 to £50,000 £50,001 to OJEU Threshold (contact procurement department for current value) Over OJEU threshold (see note below – threshold is different for works and non-works)	**Minimum requirements** 1 Written quote (Authorised by Budget Manager) 3 Written quotes (Authorised by Budget Manager) Competitive Tender Exercise (Level 2 Manager AND Director of Finance) EU Directive Requirements (Relevant Director AND Director of Finance)

4 Committing expenditure		
4.1	**Revenue and non-capital works expenditure within approved financial plans or business**	
	Up to £5,000	Budget Manager
	Up to £10,000	Level 2 Manager (Officer)
	Up to £50,000	Responsible Director
	Up to £250,000	Director of Finance
	Up to £1,000,000	Director of Finance AND Chief Executive
	Over £1,000,000	Board of Directors
4.2	**Approval of purchase invoices**	
	Up to £5,000	Budget Manager
	Up to £10,000	Level 2 Manager (Officer)
	Up to £50,000	Responsible Director
	Up to £250,000	Director of Finance
	Up to £1,000,000	Director of Finance AND Chief Executive
	Unlimited	Chief Executive on behalf of Board of Directors

4.4	**Agreements and licences**	
	Letting or licencing of premises to or from other organisations (see also section 5 below for guidance on who can sign these agreements)	Associate Director of Estates
	Where annual charge does not exceed £10,000 and term does not exceed five years	Associate Director of Estates
	Where annual charge exceeds £10,000 or term exceeds 5 years	Director of Finance
	Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	Associate Director of Estates & Director of Finance
4.5	**Condemning and disposal**	
	Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively	Responsible Director
	Up to £5,000 (carrying value)	Director of Finance (may be delegated in specific cases in writing, but no lower than to a level 2 manager)
	Over £5,000 (carrying value)	Director of Finance
	Transfer or sale of assets to another organisation	Director of Finance

4.6.2	Fruitless Payments (including abandoned capital schemes) Up to £10,000 Up to £50,000 Over £50,001	 Deputy Director of Finance Director of Finance Board of Directors
4.6.7	Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors. Up to £20,000 Over £20,000 **Note:** All special payments require Treasury approval and shall be submitted via the Director of Finance to the Regulator for Treasury approval.	 Director of Workforce Chief Executive

Appendix A

5.4	Signature of other contracts or other legally binding documents not required to be executed as a deed (see Standing Orders for guidance on documents to be executed as a deed), the subject matter and nature of which has been approved by the Board or committee to which the Board has delegated appropriate authority.	
	Up to £10,000	Budget Manager
	Up to £50,000	Level 2 Manager (Officer)
	Up to £100,000	Responsible Director
	Up to £2,500,000	Director of Finance
	Up to £1,000,000	Director of Finance AND Chief Executive
	Over £1,000,000	Board of Directors

Appendix A

Proposed amendments to Standing financial instructions

9.3 Quotations: competitive and non-competitive

General position on quotations

9.3.1 Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is not reasonably expected to exceed £50,000. Quotes are required on the following basis:

	Threshold Values	Quotes
Works ,Goods & services	Up to £5,000	Best value, supported by 1 written quote
	£5,001 to £50,000	3 written quotes
	£50,001 to OJEU threshold	Competitive tender exercise
	Over OJEU Threshold	EU Directive requirements

9.8 Instances where formal competitive tendering or competitive quotation are not required

9.8.1 Where competitive tendering or a competitive quotation is not required (contracts expected to be less than £5,000) the Trust should adopt one of the following alternatives…….

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/07/18**		**Agenda reference:**	**115-18**	
Report title:	**Board level governance: engagement with governors**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Author:	Hilary Saunders, Deputy company secretary				
Appendices:	A – Board level governance engagement agreement B – Lead governor job description				
Executive summary					
Purpose of report:	The purpose of this report is to review the function of governor representatives on board committee meetings to ensure they remain appropriate and that clarity of role is maintained.				
Summary of key issues	A recommendation of the Well Led review was that the Trust should undertake a review of the function of the governor representative on board committees. Whilst the roles are established as an effective means of engagement between governors and the Board, the current agreement includes areas of ambiguity This report recommends steps to remove these ambiguities and avoid any potential conflicts of interest.				
Recommendation:	The Board is asked to **APPROVE** the recommended amendments to the current agreement				
Action required	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:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	Assuming Board approval, this report and proposed amendments will be presented to the Council of Governors at its meeting on 30 July.				

Report to:	Board Directors
Agenda item:	115-18
Date of meeting:	05 July 2018
Report from:	Clare Pirie, Director of communications and corporate affairs
Report author:	Hilary Saunders, Deputy company secretary
Date of report:	12 June 2018
Appendix:	A: Board-level governance: engagement with governors B: Lead governor job description

Review of board level governance arrangements

Introduction

This report is a review the function of governor representatives on board committee meetings to ensure they remain appropriate and that clarity of role is maintained.

Executive summary

This report describes how governor representative roles came into effect and explains the benefits this particular function brings both Council and the Board in enabling governors to carry out their statutory duties.

Whilst setting out the parameters within which the role operates, the report also notes areas of ambiguity and recommends steps to remove these and avoid any potential conflicts of interest.

Context

One recommendation of the recent Well Led review is that the Trust should undertake a review of the function of the governor representative on board committees. The Board was reminded that governors have a joint, not singular, responsibility and should not be able to influence the decision making process of a board committee. It was felt by the reviewers that current arrangements could lead to a confusion of the role, and create conflicts of interest.

Governors are clearly expected to challenge NEDs at Council meetings but to do so at a Board committee could be seen to influence the decision-making process and would not be appropriate given their joint, not singular responsibility.

Review of current arrangements

The *'Board-level governance: engagement with governors*' agreement between governor representatives and the Board of Directors at QVH were established by the Council and the Board in 2015. This was last reviewed by Council at its meeting in October 2016 (**See appendix A**).

These roles are established as an effective means of open and honest engagement between governors and the Board and play an important part in enabling governors to carry out their duty to hold non-executive directors (NEDs) to account for the performance of the Board. They provide opportunities for governors to see NEDs at work on a regular basis, and as a result better equip governors to appraise the performance of the NEDs and hold them to account.

All governor representative positions are available by invitation of the Board of Directors and are not defined or protected by statute. Neither are they defined in the

NHS FT Code of Governance nor the Trust's constitution (with the exception of the Lead Governor role). It is made clear under the terms of engagement that governors do not share the duties, powers and liabilities of directors.

A job description for the role of Lead Governor is attached (Appendix B). Whilst there are no job descriptions for the remaining governor representative roles, the principles set out within *'Board-level governance: engagement with governors*' document stipulate that Governor Representatives must:

- observe and maintain confidentiality as directed by the Board of Directors;
- Act professionally, collaboratively and in a way which is consistent with the Trust's values and the Council of Governors' code of conduct.
- Feed back to governor colleagues openly, honestly and share observations about the effectiveness of the Board and its committees and the performance of the non-executive directors and the Board in order to inform the Council's statutory duties.

It should also be noted, however, that

- Section 3.3 of the agreement states that 'governor representatives to the Board of Directors and its sub-committees are invited to act as partners in debate and challenge…..', and
- Section 4.1 states that 'governor representatives are expected to engage with the Board according the following principles: actively engaging in debate and challenge'.

The Governor Representative roles are established as an effective means of engagement between governors and the Board and play an important part in supporting governors in their statutory duty to hold non-executive directors (NEDs) to account for the performance of the Board. They provide more opportunities for governors to see NEDs at work on a regular basis, and as a result better prepare governors to appraise the performance of NEDs and hold them to account.

These roles are a significant commitment for individual governors who volunteer their time and expertise, and if downgraded there is a real risk that levels of engagement could fall. This in turn could impact on governors' ability to carry out their statutory duties.

Terms of reference

A description of governor representative membership is included in the Terms of Reference for each individual committee.

Committee	Membership
Audit	*Ex-officio attendees without voting rights: Representative of the QVH Council of Governors*
Finance and	*In attendance with no voting rights: The following bodies*

Committee	Membership
performance	*shall be invited to nominate an ex-officio member of the F&PC to represent their interests:* • *Council of Governors* •
Quality & governance	*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.*
QVH Charity	*Ex-officio attendees without voting rights;* • *Chairperson of the QVH League of Friends* • *1 x public governor* • *1 X staff governor*

Proposals

- To ensure membership status is clear, all board and charity committees' terms of reference should be updated in line with the individual committee's work programmes, (not exceptionally) to reflect a consistent approach and remove any uncertainty.

- Minutes should clearly show governors as being 'in attendance' and not 'present' at each meeting, and committee secretaries will be notified of this change.

- To remove ambiguity:
    - Section 3.3 of the agreement should be amended to read: *Governors may be invited to give their views at a committee meeting, and are welcome to ask questions of clarification. However, they should not be considered as partners in debate and challenge, and are reminded that they do not share the duties, powers and liabilities of directors'.*

    - Section 4.1: Reference to 'actively engaging in debate and challenge' should be removed and amended to read ; *Giving their views when invited to do so and to ask questions of clarification as appropriate*

- That these changes be submitted to the Council of Governors on 30 July for approval and to alert all governors to this change.

Recommendation

The Board is asked to **APPROVE** the proposals contained within this report.

Board-level governance: engagement with governors

1. Status

1.1. The principles of engagement between governor representatives and the Trust's board-level structures and mechanisms were agreed by both the Council of Governors and Board of Directors in 2015, and are now due for their review.

2. Background

2.1. QVH has a long-standing practice of appointing a nominated representative of the Council of Governors, to join the Board as an ex officio, non-voting member. This practice was subsequently extended to establish governor representatives to the main sub-committees of the Board, who are elected to the role by the Council of Governors. (The outcome of this year's elections and a review of the process followed is subject to a separate report which will presented later on at this meeting).

2.2. The role of governor representatives, pioneered by QVH, is appreciated by the Trust as an established and effective means of open and honest engagement between governors and the Board.

2.3. Since the Health and Social Care Act 2012, the governor representative roles have become particularly significant as they play an important part in governors' duty to hold non-executive directors (NEDs) to account for the performance of the Board.

2.4. The roles foster closer working relationships between governors and NEDs and provide more opportunities for governors to see NEDs at work on a regular basis. As a result, governors are better able to appraise the performance of the NEDs and hold them to account.

3. Guiding principles of engagement

3.1. All governor representative positions are available by invitation of the Board of Directors and are not defined or protected by statute. Neither are they defined in the NHS FT *Code of Governance* (with the exception of the Lead Governor role) nor the Trust's constitution, (with the exception of the Lead Governor and Vice Chair roles).

3.2. The Trust is committed to its governor representative model but will continue to review its effectiveness in the context of routine annual effectiveness reviews, periodic independent reviews as required by the NHS improvement *Well-Led Framework for Governance Reviews* or any other circumstances that make it necessary to do so.

3.3. Governor representatives to the Board of Directors and its sub-committees are invited to act as partners in debate and challenge but do not share the duties, powers and liabilities of directors.

3.4. Governor representatives must observe and maintain confidentiality as directed by the Board of Directors. This will include information that may not be disclosed to other

governors and/or to trust staff, foundation trust members and members of the public and press. Advice and support regarding confidentiality can be sought at any time from the Trust Chair/sub-committee chair(s) and corporate affairs team.

3.5. Governor representative roles are a significant commitment for individual governors who volunteer their time and expertise. Therefore:

3.5.1. The Chair should consider, when requested, opportunities for governors to share roles, establish deputies and shadow one-another as a means to share responsibilities and plan for succession.

3.5.2. The Council of Governors should support individual governors to fulfil their duties as representatives and encourage all governors to understand and engage with the representative roles and consider themselves for nomination.

3.5.3. Governors who nominate themselves for governor representative roles should be able to commit to prepare for and attend routine meetings and to engage with fellow governors to represent them and provide feedback.

3.5.4. When requesting additional support from governor representatives, the Trust Chair, chairs of sub-committees, the executive team and corporate affairs team should be mindful of the significant commitments inherent in the role and keep additional requests clear and focused.

3.5.5. Methods to help representatives to feedback to governor colleagues will be facilitated by the corporate affairs team and include less formal methods such as the 'Governor Monthly Update' bulletin and formal methods such as reports to Council meetings.

4. Engagement with the Board: principles for governor representatives

4.1. Governor representatives are expected to engage with the Board according to the following principles:

- By committing to the role for the appointed term and attending as many routine meetings of the Board/sub-committee as possible.
- Actively engaging in debate and challenge.
- Acting professionally, collaboratively and in a way which is consistent with the Trust's values and the Council of Governors' code of conduct.

5. Engagement with the Council: principles for governor representatives

5.1. Governor representatives are expected to engage with the Council according to the following principles:

- By representing the interests of the Council of Governors and members of the Trust faithfully and proportionately
- Feeding back to governor colleagues openly, honestly and regularly to:
  - Inform them of important decisions and developments.
  - Complete the loop of information on matters governors have raised with them as their representatives.
  - Share observations about the effectiveness of the Board and its sub-committees and the performance of the non-executive directors and the Board in order to inform the Council's statutory duties.

6. Engagement with governor representatives: principles for the Board

6.1. The Board of Directors, particularly the Chair and non-executive directors, is expected to engage with governor representatives according to the following principles:

- By engaging openly and honestly.
- Chairing meetings and / or participating in them in ways which are inclusive of and respectful to lay representatives.
- Including governor representatives in all aspects of Board/committee work including Board/committee development and informal or seminar meetings. Exclusion of the governor representative should be by exception.
- Encouraging and supporting governor representatives to share feedback with the Council on the effectiveness of the Board and its sub-committees and the performance of non-executive directors.

7. Review

7.1. This document shall be reviewed by the Council of Governors and Board of Directors annually or more frequently if necessary. The next scheduled review will take place in October 2017.

ROLE PROFILE AND PERSON SPECIFICATION

TITLE: **Lead governor**

ACOUNTABLE TO: **The Council of Governors**

PURPOSE

To facilitate communication and decision making at a strategic level ensuring integrated and effective governance. Key elements of the role involve:

- Point of contact for the regulator (Monitor, working as NHS Improvement) in the event that it would be inappropriate for the regulator to contact the Chair; point of contact for any governor wishing to raise concerns about the Chair to the regulator;
- Attending all Board of Director meetings as Council of Governor's representative on the Board;
- Acting as the link between the Board of Directors and the Council of Governors;
- Promoting effective communication and decision making;
- Providing advice to individual governors and to the Chair as required;
- Chairing Council meetings in the event that neither Chair nor Deputy Chair (SID) are available;
- Chairing Governors' Steering Group meetings;
- Working with the Chair, director of corporate affairs and the deputy company secretary to develop Council governance arrangements, including development of any QVH constitutional amendments;
- Providing a statement on the annual report and accounts, and
- Actively protecting and enhancing QVH's reputation.

NB:

- This is an ex-officio non-voting member on the Board of Directors.
- Attendance by a governor at the Board of Directors, or any of its sub-committees is not an entitlement but at the Board's discretion.

	Essential	Desirable
Qualifications and knowledge		• Good knowledge and understanding of the principles of corporate governance • Understanding of the principles of the NHS
Skills, special aptitudes Experience	Good presentation and communication skills Experience of fostering strong working relationships	• Ability to chair meetings in public as appropriate • Board level/Trustee experience • Leadership of a team
Interpersonal skills	Commitment to the role Tactful and diplomatic Team player	• Good listener • Confident • Flexible • Self sufficient • Computer literate

TERMS OF APPOINTMENT

This position is reviewed annually. Each year when governor elections to Committees are held, governors are also invited to nominate themselves to be considered for this role. Nominations are reviewed in consultation with the Chair and Board of Directors and a recommendation is made to the Council of Governors.

This role description last reviewed and approved by Council of Governors at its meeting on 19 January 2017.