Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 2 May 2019

Session in public
10am - 1pm

Education Centre
Queen Victoria Hospital
Holtye Road
East Grinstead
West Sussex
RH19 3DZ

Queen Victoria Hospital
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 2 May 2019

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 (minutes)	-	Hilary Saunders
Lead Governor	-	John Belsey

Annual declarations by directors 2019/20

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, Longmeadow Views Management Co Ltd	Part owner of Professional Governance Services Ltd	NA	Nil	PGS charity clients may contract with NHS organisations, (not QVH)	Nil	Nil
Kevin Gould Non-Executive Director	• Director, Sharpthorne Services Ltd. • Director CIEH Ltd	Nil	Nil	• Trustee and Deputy Chair, Chartered Institute of Environmental Health • Independent member of the Board of Governors at Staffordshire University	Nil	Nil	Nil
Gary Needle Non-Executive Director	• Director, Gary Needle Ltd, (management consultancy) • Director, T& G Property Ltd	Nil	Nil	• Chair of Board of Trustees at East Grinstead Sports Club Ltd (registered sport and lifestyle activities charity)	Nil	Nil	Nil

Karen Norman Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Nl
John Thornton Senior Independent Director	Chair: Golden Charter Ltd	Nil	Nil	Nil	Nil	Nil	Nil
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	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 provide some perioperative and anaesthetic care to patients in local independent sector hospitals. This is predominantly private patients, but may include NHS patients where QVH or other trust has commissioned NHS care to be provided by an independent hospital. Time spent working in the independent sector is clearly delineated in my QVH job plan.	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

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
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
Karen Norman 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

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.
Clare Pirie Director of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA

Business meeting of the Board of Directors
Thursday 2 May 2019
10:00 – 13:00
Education Centre, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
72-19	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
73-19	**Patient story** *Jo Thomas, Director of nursing*	*assurance*	-
74-19	**Draft minutes of the meeting held in public on 7 March 2019** *Beryl Hobson, Chair*	*approval*	11
75-19	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	21
76-19	**Chair's report** *Beryl Hobson, Chair*	*assurance*	22
77-19	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	25
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
78-19	**Board Assurance Framework** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*assurance*	34
79-19	**Quality and governance assurance** *Kevin Gould, Non-executive director*	*assurance*	36
80-19	**Corporate risk register (CRR)** *Jo Thomas, Director of nursing*	*review*	39
81-19	**Quality and safety report** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*assurance*	46
82-19	**Paediatric burns business case** *Ed Pickles, Medical director*	*decision*	77
83-19	**6-monthly nursing workforce review** *Jo Thomas, Director of nursing*	*assurance*	143

84-19	**7-day hospital services board assurance framework** *Ed Pickles, Medical director*	*information*	157
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
85-19	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	162
86-19	**Financial, operational and workforce performance assurance** *John Thornton, Committee chair*	*assurance*	164
87-19	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	167
88-19	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	193
89-19	**Ratification of 2019/20 business planning process** *Michelle Miles, Director of finance*	*assurance*	205
Key strategic objective 5: organisational excellence			
90-19	**Board assurance framework** *Geraldine Opreshko, Director of workforce and OD*	*assurance*	211
91-19	**Workforce monthly report** *Geraldine Opreshko, Director of workforce and OD*	*assurance*	212
Governance			
92-19	**QVH self-certification of NHS Provider licence conditions** *Clare Pirie, Director of communications and corporate affairs*	*approval*	223
93-19	**Brighton and Sussex University Hospitals NHS Trust, Western Sussex Hospitals NHS Foundation Trust and Queen Victoria Hospital NHS Foundation Trust Collaboration: Final approval of ToRs** • Joint Executive Programme Board • Joint Programme Steering Group *Clare Pirie, Director of communications and corporate affairs*	*approval*	227
94-19	**Annual declarations of interest** *Clare Pirie, Director of communications and corporate affairs*	*information*	-
95-19	**Audit committee** *Kevin Gould, Non-executive director and committee chair*	*assurance*	234
Any other business (by application to the Chair)			
96-19	*Beryl Hobson, Chair*	*discussion*	-

Questions from members of the public			
97-19	*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*	-

Date of the next meetings	
Board of directors: **Public**: 4 July 2019 at 10:00	**Council of governors** **Public**: 29 July 2019 at 15:00

Please note that item 40-19 was taken out of sequence and after item 56-19.

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 7 March 2019, 10:00 – 13:00, Education Centre, QVH site**	
Present:	Beryl Hobson, (BH)	Trust chair (voting)
	Ginny Colwell (GC)	Non-executive director (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Michelle Miles (MM)	Director of finance (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Ed Pickles (EP)	Medical director (voting)
	Geraldine Opreshko (GO)	Director of workforce and OD (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:	Hilary Saunders (HS)	Deputy company secretary (minutes)
	Nicolle Ferguson (NF)	Patient Experience Manager **(item 40-19)**
	Sheila Perkins (SP)	Freedom to speak up guardian **(item 45-19)**
Apologies:	Abigail Jago (AJ)	Director of operations (non-voting)
Public gallery:	One member of staff and three public governors	

Welcome

39-19 **Welcome, apologies and declarations of interest**

The Chair opened the meeting and welcomed members of the public, in addition to Sheila Perkins the new Freedom to speak up (FTSU) guardian. She asked the board to note that the patient experience story [item 40-19] would be taken towards the end of the meeting.

Apologies were recorded as above, and it was noted that SJ would present the operational report on behalf of AJ. There were no new declarations of interest.

Standing items

40-19 **Patient story**

The Patient experience manager joined the meeting with a patient (also known to the board in his capacity as a governor), who had been invited to tell his story following his formal complaint raised in 2018.

BH invited the patient to describe his experience. He explained that he had begun to suffer toothache in December 2017 and visited his local dentist. He was initially scheduled for extraction in January 2018 but due to his co-morbidities (rheumatoid arthritis) and range of medication the dentist decided that it was in the patient's best interests that this should be performed in hospital. A referral was made the same day. After waiting a month, the patient contacted QVH. He was advised that the referral had been received and logged, but he would just have to wait. The patient felt that this was unhelpful. He then spoke to one of the medical secretaries who made him feel he was being a nuisance (she also instructed him not to call back). In March the patient developed a chest infection and had to cease rheumatoid arthritis medication. By April he was experiencing severe pain as a result of arthritis flare up (infection and arthritis is inflammatory linked). In June the patient's condition deteriorated further. Having still not heard from QVH he contacted the Trust and was advised it would be easier for the dental practice to submit another referral. This time an appointment came through quickly and treatment was scheduled for in June 2018. The patient explained powerfully how the delay in receiving treatment had hugely impacted on both his physical and mental health.

	The Chair asked NF to set out what action had been taken since this event. NF explained that the patient pathway had been inadvertently closed down, but there was no record as to why this action had been taken. As a result of this issue any future decisions to close a patient pathway must be recorded to show details of why and who has made the decision. In addition, further training has been given regarding management of the RTT pathway. Teams involved have also been made fully aware of the severe impact this delay had had on the patient. The Chair thanked the patient for sharing his story and on behalf of the Board apologised for the distress which had been caused. He thanked the Chair, noting that he was aware of the stress within the NHS system at present which had probably contributed, but had also appreciated the way in which the Trust handled his complaint, in particular the Chief Executive's response. The Board observed that patients might often feel unable or unwilling to raise a complaint and considered how best the Trust could support them. It also noted that clinical harm assessments undertaken on patients experiencing lengthy delays did not take into account overall impact, as described today. There were no more questions and the Board again thanked the patient for attending.
41-19	**Draft minutes of the meeting session held in public on 3 January 2019** The minutes of the meeting held in public on 3 January were **APPROVED** as a correct record.
42-19	**Matters arising and actions pending** The board received and approved the current record of matters arising and actions pending.
43-19	**Chair's report** BH highlighted that this would be GC's last public board meeting and thanked her for her invaluable support since she joined the Trust in 2013. BH also expressed her gratitude to the corporate affairs and HR teams for the programme of work undertaken in respect of the current NED recruitment campaign, and was confident that this had attracted a high calibre of candidates. There were no further comments and the Board **NOTED** the contents of the latest report.
44-19	**Chief executive's report** Opening with an overview of the Board assurance framework (BAF), SJ reported that key risks remained RTT18 and 52-week wait list performance, workforce and finance. He asked the Board to note the rescoring of the KSO4 from 20 to 25 due to the deteriorating financial position and revised forecast. He continued by updating the Board on progress since the last meeting, highlighting in particular: • Care Quality Commission (CQC) Well-led review: CQC had undertaken an unannounced inspection of three core services at the end of January prior to the planned inspection of 'well led' in February. Feedback to date had been generally positive, and SJ thanked all staff involved, in particular JMT and the Head of Quality and Compliance, Kelly Stevens. An early draft should be available (for factual accuracy checking only) in early April. • The theatre utilisation programme had now concluded, and it was noted that January theatre activity had been the highest for several years. A business case for a similar programme of work in outpatients was being developed. • At an extraordinary general meeting in January, the board had approved a reforecast of a £5.9m deficit. SJ assured the board that the Trust was working closely with NHSI and commissioners regarding 2019/20 business planning, and the recovery plan. Two recent performance reviews had focused on cost improvement plans.

	• Whilst QVH was one of eight trusts nationally identified as having a high number of 52 week waits, NHSI was assured of the Trust's grip on the situation and progress made to date. • Above average levels of recruitment continued throughout December, January and February with the highest number of substantive staff now in post for several years. • The Trust was continuing to develop its business case to reconfigure the paediatric burns service and secure improvements in compliance with national service standards. SJ advised that both locally and nationally the number of paediatric and adult burn cases had fallen in recent years and the business case had highlighted financial and clinical sustainability issues. A further update was due at the May Board meeting. • The Trust's three priorities for 2019/20 were partnership, productivity and people. QVH partnership working with Western and Brighton continued; a seminar on the 'patient first' initiative was scheduled for later in the month and work continued on the outpatient productivity business case. • Integrated Performance Dashboard Summary: This had been included as an appendix to the main report and, despite the current challenges, SJ noted clear evidence that areas such as staff turnover and statutory and mandatory training were moving in the right direction. • The 'Population Health Check' for Sussex and East Surrey, attached as an appendix, had been developed by the Sussex and East Surrey Sustainability Transformation Partnership (STP) Clinical and Professional Cabinet. The Board noted that the aim of this strategy aimed to end clinical variation, and were assured that its priorities were closely aligned to the NHS long term plan. All boards within the STP were required to note and endorse the document. • The latest media update was also attached as an appendix, with SJ noting the positive coverage which the Trust continued to achieve. The Board sought and received additional clarification with regard to the following: • The next stage of the 'population health check' document. SJ was optimistic that engagement with the local authorities was improving, and confirmed that any service change would require public engagement. The publication of the clinical strategy scheduled for three months' time would provide additional clarity. • The Trust has a Brexit working group addressing the impact of a potential no-deal Brexit; challenges within medicines and procurement had been identified, although the message from central government continued to advise against stockpiling. The deputy director of nursing was drafting a business plan to mitigate against fuel shortages, and MM added that all maintenance areas were reviewed regularly in particular checks on generators. • Following the Kark review into the current Fit and proper persons test (FPPT), the Board noted that two of the seven recommendations had been accepted immediately by the Health Secretary. The Chair of NHSI was considering the remaining five recommendations and how they could be implemented. The Board agreed to review the regulations again at a future seminar, pending further guidance from NHSI. This item would be added to the board work programme **[Action: CP]** There were no further questions and the Board: • **NOTED** the contents of the Chief executive report and supporting appendices. • **NOTED** and **ENDORSED** the Sustainability Transformation Partnership (STP) Clinical and Professional Cabinet 'Population Health Check' for Sussex and East Surrey.
45-19	**Freedom to speak up (FTSU)** The Chair welcomed SP to her first meeting as FTSU guardian, assuring her of the Board's support for the FTSU initiative. She went on to remind the Board that there was potential for identification of individuals and cases due to the size of the Trust, so asked for members to remain mindful of this when raising any queries. The Board considered the report prepared by SP and sought assurance with regard to the following: • Whilst SP felt her role was received positively, some staff still remained reticent about speaking up. She would continue to liaise with staff groups about ways in which to offer support. She also

	found that informal approaches were useful, and she could often signpost staff in the right direction if their concerns did not fit the remit of the FTSU role. • SP's report had identified a need for mediation training for the FTSU, and GO agreed to provide information on training. • A previous FTSU report had identified staff experiencing repercussions after speaking out, and the Board asked how this was being managed. SP was still new to the role, but felt this would evolve over time. • Whilst the current number of speaks ups was low, the Board asked for the evaluation questionnaire to be reintroduced once numbers increased. • GO noted that once a full breakdown of the staff survey questions became available, she and SP would meet to review and identify recurrent themes. There were no further questions and the Chair thanked SP for her update.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
46-19	**Board assurance framework(BAF)** SJ noted the comments made by CQC that our Board Assurance Framework was structured in a unique style which facilitated oversight of existing strategic objectives. The KSO3 BAF had most recently been reviewed at the end of February; the only change to note at this stage was planned outpatient improvement programme (controls and assurances). MM presented the KSO4 BAF confirming that the current risk rating now stood at 25, as a result of the £4.6m deficit and non-delivery of activity and cost improvement plans. There were no further comments and the Board **NOTED** the contents of the update.
47-19	**Financial, operational and workforce performance assurance** JT provided an update on matters discussed at the recent Finance and performance committee (F&PC), highlighting that whilst progress had been made on theatre utilisation and patient waiting lists, more work was required within outpatients. JT reiterated that the increase in substantive staff was yet to be reflected in reduced numbers of bank and agency staff. In response to a question raised by the lead governor, JT was able to offer only limited assurance on plans to reduce costs in line with the 2019/20 business plan, and was not confident that the current budget would support our stated objective of breaking even in 2020/21. The Trust had to significantly improve its current run rate to achieve this. The Chair reminded the Board that all members had been invited to attend the F&PC meeting on 25 March to agree the 2019/20 financial plan. The Board went on to discuss JT's report at length, seeking assurance in respect of the following: • Noting that even if commissioner-agreed trajectories were met, the Trust will be fined for missing waiting list targets from 01 April. MM confirmed that estimated financial penalties had been built into next year's budget. • That the Trust was managing risks associated with known financial challenges and was clear on milestones to evidence it was moving in the right direction. Assurance was provided by management that key milestones would be monitored at F&PC. The committee would also be leading on transformational change. • Next year's plan assumed growth in income, including the additional work to achieve improvement in waiting times, but this was still to be agreed with commissioners. The Board was assured of concerted efforts being made to achieve this prior to the F&PC on 25 March, notwithstanding the

	complexities of dealing with multiple CCGs and specialist commissioners. • The plan included c£2m of cost reductions and £1m of cost savings (CIP) and there were concerns that these had not yet been fully identified. The Board was assured that significant progress had been made at two recent performance review meetings where at least 35% of achievable CIPs had been identified; however, concern remained around increasing cost pressures. • Management priority was focused on achieving agreement of the 2019/20 position before focusing on the wider transformational plan. In response to concerns expressed at signing off a plan without taking into this into account, management explained why it would not be appropriate to overlay a transformational plan before being assured of delivery of the £8.6m deficit. There remained, however, the option to reforecast later in the financial year if appropriate. • Concerns were raised that the Trust did not have sufficient resource to address the current situation. Two members of NHSI team had been allocated to identify additional actions the Trust could take to improve the position, but this work was still at a very early stage. The Board also noted that whilst the Patient First initiative would help support cultural change and lean methodology, any impacts would take time to take effect and could not be relied upon in 2019/20. There were no further comments and the Board **NOTED** the contents of the update.
48-19	**Operational performance** SJ presented the operational performance report on behalf of AJ, drawing the Board's attention to the following: • Recent challenges with diagnostic waits were being addressed and now appeared to be going in the right direction. • The plan for RTT18 included an increase of 1% activity to March 2020, (although details were still to be finalised with commissioners). • 52-week targets had been achieved, and there had been a significant drop in the number of patients waiting (falling from a peak of 145 in July to 68 in February). Although the Trust remained an outlier, this was still a great achievement. • Whilst the 62-day cancer target was met in December, 2-week and 31-day waits were not. • Compared to previous years' activity there had been a large increase in patients treated in the Minor Injuries Unit (MIU), averaging 1,000 patients per month. • Pending approval from NHSI, the Trust planned to implement an outpatient improvement programme. This was designed to improve patient experience, quality of care, waiting list management and increase efficiencies. Success would be measured through a variety of KPIs. • Theatre activity in January had exceeded all months year to date, with a total of 1061 cases. The Board considered the contents of the update, noting in particular the following: • Of those 68 patients waiting over 52 weeks, 30 had requested appointments be delayed (as permitted through patient choice). The Board briefly considered the challenges of managing those patients who had chosen to defer treatment and of those who had been overlooked. QVH was in discussion with commissioners on how these cases might be presented. • The trend for the number of cancellations was increasing and the Board sought clarification as to why. It was agreed that a report would be fed back through F&PC. **[Action: AJ]** • 14 cancellations had been due to theatre closures due to low temperatures. The Board was assured that work was scheduled to address boiler failure. • With regard to the outpatients improvement programme KPIs, the Board suggested a workforce metric be included to identify improvements in skill mix **[Action: AJ]** The lead governor sought and received clarification regarding activity, noting the forward trajectory for RTT.

	There were no further comments and the Board **NOTED** the contents of the update.
49-19	**Financial performance** Following the prolonged discussion under 47-19, MM presented a brief overview of the Trust's financial position. Highlights included that: • Pay was underspent this month as a result of vacancy control. • Income had improved following a reclassification of AfC income to patient activity income. • The Trust delivered the £5.9m forecast deficit (excluding assets) • Cash had decreased and action was being taken to ensure robust cash management. • The Trust had appointed two programme managers to support the work on capital projects, but progress had been delayed due to one contractor going into liquidation. Whilst mitigations were now in place, this would result in delays and potential cost increases. The Board commended MM on the clarity of the finance reporting; there were no further comments and the contents of the update were **NOTED**.
Key strategic objective 5: organisational excellence	
50-19	**Board assurance framework** GO presented the latest version of the KSO5 BAF, asking the Board to note changes under controls and assurance including work underway to enhance the Electronic Staff Record (ESR) system and the results of the 2018 staff survey. There were no comments and the Board **NOTED** the contents of the update.
51-19	**Workforce monthly report** GO presented the workforce reporting, asking the Board to note in particular the following: • The high level overview and update on ongoing terms and conditions changes for staff on Agenda for Change (AfC), and its implications (set out in appendix 1 of the report) • An increase in the number of substantive staff. • The slight reduction in the annualised rolling turnover of staff. • Sickness levels which remained at below 3% The Board considered the report seeking the following additional further clarification: • Data presented as part of the international recruitment report included a caveat that '50% of staff offered would be expected to be unsuccessful during the recruitment process, or withdraw'. The Board asked if this had been included as a KPI when the contract was agreed. It was agreed that a response would be reported back through F&PC. **[Action: GO]** • With reference to the increase in substantive staff appointments, the Board noted the challenges of maintaining tight cost control against achieving performance and asked how this was monitored. Assurance was provided that the Deputy Director of Nursing was sighted on ensuring that any reduction in staff would not adversely impact on safe patient care. • Discussing the implications of the revised AfC terms and conditions, the Board noted a new appraisal policy was in development (in full consultation with staff side) and which would be monitored through F&PC. This would also align to the Well Led action plan addressing the need for a more devolved framework of accountability. • Whilst the recently announced increase in NHS pensions employer contributions was outside tariff inflation, it was anticipated this would be included in future tariff assumptions. There were no further comments and the Board **NOTED** the contents of the update.
52-19	**Staff survey results** GO presented an overview of the high level results of the 2018 NHS staff survey. She asked the

	Board to note that as the embargo on findings had been lifted only recently her priority had been to prepare a high level summary in preparation for the CQC inspection; however, she would be able to provide more detailed analysis in the coming weeks. GO explained how the format of this year's report had changed; it was now based around 10 key themes. She asked the Board to note in particular that: • When compared with the 2018 benchmarking group for acute specialist trusts, QVH scores were average overall. • There had been improvement in scores for equality and diversity, health and well-being, immediate managers, quality of appraisals, quality of care and experience of violence, but also deterioration in bullying and harassment. • A new theme introduced this year scored QVH as below average on staff morale. • The report summarised ongoing actions with GO reminding the Board that the Best Place to Work initiative would be launched shortly, which should provide further insight into staff views. Board members voiced disappointment at achieving only average ratings overall, but noted that the organisational development strategy should help support improvement. They went on to seek additional assurance in respect of the deterioration in the bullying and harassment score. GO agreed that specific feedback on this issue would be provided to F&PC. **[Action: GO]** Whilst only a small improvement was shown regarding to safety culture, the Board was assured that any significant improvement would take around three to five years to develop and this showed movement in the right direction. The Board sought clarification as to why a question regarding the number of times staff had experienced bullying and harassment in the last 12 months had been expressed in percentage rather than numerical terms. GO agreed to investigate and report back to Board. **[Action: GO]** There were no further comments and the Board **NOTED** the contents of the update.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
53-19	**Board assurance framework** The Board **NOTED** the current BAFs for KSO1 and KSO2.
54-19	**Quality and governance assurance** GC presented an update following the latest Quality and governance committee (Q&GC) meeting on 21 February. This included details of an audit of surgical site infections, which had revealed a higher than expected infection rate. However, the Board was assured that numbers were low with nothing statistically significant about the findings. A follow-up audit would take place in May. The Board was advised that action was being taken to improve the number of committee members attending local governance and departmental meetings, noting that this played a key role in providing assurance of trustwide clinical governance process. The Board noted positive feedback in response to the volunteer 'hand-holding' initiative, which provided patients with support during eye procedures. There were no further comments and the Board **NOTED** the contents of the update.
55-19	**Corporate risk register** JMT presented the latest corporate risk register reminding the Board that this had been subject to careful scrutiny at both Q&GC as well and executive management team.

	Two new risks had been added since the last Board meeting; one related to the implementation of the electronic document management system EDMS, and the other related to patients with complex open lower limb fractures. The risk relating to financial sustainability had been re-scored, increasing from 20 to 25. The Board noted that progress was being made in respect of EDMS (as reported through F&PC), but this risk would remain under scrutiny for the time being. There were no further comments and the Board **NOTED** the contents of the update.
56-19	**Quality and safety report** JMT reminded the Board that the Trust was continuing to sustain safe staffing levels and high quality care, despite the on-going challenges. The Board asked if risks associated with continued provision of paediatric burns services, (currently under consideration as part of a partnership working business case) should be included on the corporate risk register. Although not necessary at this stage, it was agreed it would be reconsidered in May. **[Action: EP]** The Board briefly discussed the Trust's flu immunisation programme for 2018/19. Whilst 80.1% of frontline staff had either taken up the vaccine or opted out, there remained 20% of staff who had not taken part in the programme. In response to a query, the Board was advised that, given the size of QVH, it would not be appropriate to extract additional detail around specific staff groups; however, JMT agreed to identify national uptake/opt-out rates to establish if QVH was an outlier **[Action: JMT]** As part of the KSO2 update, the medical director drew the Board's attention to the Trust's clinical strategy. This had been developed with senior clinical leaders and through the Hospital Management Team, and was aligned to the Trust's three priorities for 2019/20, (ie. partnership, performance and people). The Board sought additional clarification in the following areas: • Assurance of a safe IT solution for eye surgery diagnostics. EP explained that this issue was linked to the previously discussed EDM risks, but that work was ongoing to reduce risk. • Further work on the strategy included building on the patient engagement approach • The clinical strategy was well aligned to the operational plan. • Work on establishing priorities would be overseen by Q&GC; an interim update would be provided in July. **[Action: EP]** The Board expressed its overall support for the document but felt it required further development including measurable action plans. EP advised clinical directors were responsible for formulating the action plan, and agreed to update the Board on progress in September. **[Action: EP]** There were no further comments and the Board **NOTED** the contents of the update.
Governance	
57-19	**QVH/WSHT/BSUH Joint executive programme board update and approval of ToRs** SJ updated the Board on the programme of work associated with the partnership between Brighton and Sussex university hospitals trust (BSUH), Western Sussex hospital foundation trust (WSHT) and QVH, noting that this had been discussed previously at Board during a recent closed session. SJ explained that a Joint Executive Programme Board (JEPB) had been established to oversee the programme, with specific management of the projects overseen by a Joint Programme Steering Group (JPSG) and individual working groups. The Board would today be asked to approve formally the terms

	of reference for the JEPB and the terms of reference for the JPSG. The Board noted that BSUH would be undertaking the same process on 27 March, with WSHT scheduled to do the same on 28 March. After reviewing documentation, the Board **APPROVED** the terms of reference for the Joint Programme Executive Board (noting the programme of work to be overseen by this Board) and **APPROVED** the proposed terms of reference for the Joint Programme Steering Group.
58-19	**Nomination and remuneration committee (N&RC)** The Board **NOTED** the contents of the Chair's report of the recent N&RC meeting.
59-19	**Annual review of board performance** The Board had last considered its overall performance in January 2018 and CP provided a review of activity since that time. The format of this year's report was structured around the CQC's well led eight key lines of enquiry. This report also aimed to identify additional work required to ensure the Board retained appropriate skills, experience and approach. (As agreed under item **[44-19]** the Board was reminded that once further guidance was available from NHSI, a review of the Fit and proper person test (FPPT) regulations would be included in the seminar programme.) The Board considered the report, noting in particular: • The high volume of work undertaken through its seminar work programme in the last year • The benefits of inviting board members of external organisations to a joint seminar, inviting QVH senior managers to a joint seminar and observing public boards of neighbouring NHS organisations. • When agreeing programmes, the importance of differentiating between education and development. • That two new NEDs would join the Board later this year, (following the departure of GC and JT), which would alter the current dynamic. • That the April seminar was scheduled to include a session on legal issues for foundation trusts with regard to various forms of collaborative partnerships. There were no further comments and the Board **AGREED** the contents of the evaluation, noting detail would be included in the 2018/19 annual report and accounts. Members would also consider areas for further development work, advising CP as appropriate.
60-19	**Annual review of board committee terms of reference** The board unanimously approved the latest terms of reference for the following committees: • Audit • Nomination and remuneration • Finance and performance • Quality and governance These would remain current for the next twelve months, notwithstanding any updates during the year.
Any other business	
61-19	There was none.
Questions from members of the public	

62-19	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	March 2019	44-19	CEO report	Standing items	Board to review FPPT regulations at future seminar, pending further guidance from NHSI. This to be added to the board work programme	CP	ASAP	Now included on board seminar work programme for 2019/20	Closed
2	March 2019	48-19	Operational report	KSO3	F&PC to receive update on reasons for the trend in increase of cancellations	AJ	?		Pending
3	March 2019	48-19	Operational report	KS03	Workforce metric to be added to KPIs to outpatients improvement programme to identify any improvements in skill mix	AJ	?		Pending
4	March 2019	51-19	Workforce	KSO5	F&PC to receive confirmation as to whether caveat on international recruitment drop-out rates was agreed as a KPI before the contract was agreed.	GO	Mar-19	**Update 26 March 2019** We have over offered due to expected attrtition rate. Contract is focused on outcome not drop out rate; Yeovil will recruit 20 nurses for QVH. This is being closely monitored.	Closed
5	March 2019	52-19	Staff survey results	KSO5	Bullying and harassment scores to be reviewed and reported to F&PC.	GO	May-19	**Update 26 March 2019** This will be included in report to Board in May. Although bullying and harrassment scores have deteriorated by less than 1% we take this topic very seriously. It has been highlighted as an area of ongoing attention and will be a focus for business units further broken down by professional groupings for analysis.	Pending
6	March 2019	52-19	Staff survey results	KSO5	Board to receive explanation of how percentage score for 'bullying and harassment in the last 12 months' is calculated.	GO	May-19	**Update 26 March 2019** The detailed report states '% of staff saying they experienced at least one incident of bullying, harrassment or abuse'.	Closed
7	March 2019	56-19	Quality and safety	KSO2	Board to reconsider if risks associated with continued provision of paediatric burns services should be included on the corporate risk register.	EP	May-19		Pending
8	March 2019	56-19	Quality and safety	KSO1	Board to be advised if QVH is an outlier regarding national uptake/opt-out rates of flu immunisation programme .	JMT	May-19		Pending
9	March 2019	56-19	Quality and safety	KSO2	Board to receive update on clinical strategy priorities	EP	Jul-19		Pending
10	March 2019	56-19	Quality and safety	KSO2	Clinical strategy action plan to be developed and returned to BoD for review in September.	EP	Sep-19		Pending
11	Jan 2019	07-19	Patient story	Standing items	Proposals from Patient Experience lead for improving board engagement to be progressed	CP	Jul-19		Pending
12	Jan 2019	14-19	CRR	KSO1	More detailed information with regard to mitigation of risks to be included in future CRRs	JMT	Mar-19	Confirmed this will be an iterative process. BoD confirmed it was assured by action taken.	Closed
13	Jan 2019	22-19	Estates strategy	KSO4	Options appraisal to be prepared. This should be presented to January F&PC, Board will be updated at the February seminar. Formal decision to be made at March public meeting	MM	~~March 2019~~ May 2019	On May agenda	Pending
14	Jan 2019	23-19	BAF	KSO5	Timeline for overseas recruitment to be amended to reflect that the first influx did not arrive in Q3 2018	GO	Mar-19	BoD notes that BAF will be updated as information is received	Closed
15	Jan 2019	24-19	Workforce report	KSO5	Additional section detailing external hires & internal moves, based on WTE by staff group & department (fro Aug 2018) to be included in workforce reporting to F&PC	GO	Mar-19	Will be monitored by F&PC on a quarterly basis (to be added to F&PC work programme)	Closed
16	Nov 2018	171-18	Q&GC assurance	KSO1	Review of RTT18 waiting list issue to be included as part of BoD seminar work programme	CP	Feb-19	Scheduled for February 2019	Closed

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**76-19**	
Report title:	**Chair's Report**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:					
Executive summary					
Purpose of report:	To update the Board of Directors on the Chair, NED and governors activities since the last board meeting				
Summary of key issues					
Recommendation:	For the Board to **NOTE** the report				
Action required *[highlight **one** only]*	Approval	**Information**	**Discussion**	Assurance	Review
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:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to:	**Board of Directors**
Meeting date:	Thursday 02 May 2019
Agenda item reference no:	76-19
Report from:	Beryl Hobson, Chair
Date of report:	Wednesday 24 April 2019

Chair's Report

Overview

1. Over recent months, significant Board time has been spent discussing our financial and operational position for the last financial year and as part of the business planning round. It was an extremely challenging year and it is a matter of great regret to us that the year has closed with a financial deficit and that some patients have waited longer than they should for treatment. We have spent time reflecting on the lessons learned and action we need to take in future years as a board. We can no longer depend on increases in activity to produce a financial surplus and we are increasing our focus on cost reduction combined with improved efficiency and productivity.

2. We have however continued to provide our high standards of service to patients and continue to receive excellent feedback. I am also delighted to see that there is a significant increase in the number of staff recommending QVH as a place to work (referred to in the Workforce monthly report).

Chair's activities

3. I am delighted to report that Professor Karen Norman has accepted the offer by the Governors to become a Non-Executive Director of QVH, and will be joining us for this board meeting. Karen has a wealth of experience as a Director of Nursing in the UK and in Gibraltar. She is currently Visiting Professor at the Faculty of Health, Kingston University & St Georges University London and also Visiting Professor & Research Supervisor at University of Hertfordshire Business School. On behalf of the board and Council of Governors I extend a warm welcome to Karen.

4. We have another round of NED recruitment in May to recruit a replacement for John Thornton when he leaves us in September.

5. The Sustainability and Transformation Programme (STP) Oversight Group met in March and we were updated on the development of the Health and Care Strategy and the STP Priorities programme.

6. Since the last board meeting, I have attended a number of meetings and walk rounds including:
    a. Trust induction
    b. Visits to:
        - Corneo
        - Outpatients trauma clinic
        - The Appointments Team
        - Psychological Therapies

These visits are invaluable in enabling me to understand the work of the Trust and the challenges facing our teams in their day to day work.

c. Chair and CEO breakfast and afternoon tea (one per month). Staff members are becoming more aware of these sessions and pop in to raise concerns, say hello or give us their views which are always helpful.
d. Meeting with the Chair and Secretary of the League of Friends
e. When I first arrived at the trust there was a regular programme of individual meetings between the Chair and Consultants. In the last couple of years, I have replaced this by meeting consultants in situ ie at clinics or in theatres. This allows me to meet the consultant as well as the rest of the team, as well as seeing some of the amazing work that happens here. Notwithstanding this, I have recently had meetings with four consultants which provided me with updates on the Head and Neck cancer services and the Orthoplastics service provided to BSUH.

7. As part of our board seminar programme we have had presentations on the Quality Improvement System, Patient First, used by BSUH NHS Trust and Western NHS FT and a presentation on the legal options available to Foundation Trusts when considering partnership working.

External engagements

8. In my 'ambassadorial' role I gave a short speech at a concert by the Conchord Big Band at Chequer Mead Theatre on a beautiful Sunday afternoon in March. The event raised over £2,700 for QVH charity and the band has offered to do another concert next March. Thank you to the charity team for developing this connection.

Governor Activity

9. The Council of Governors met in April and as always provided a high level of challenge to the Non-Executive Directors as part of their duty of holding the NEDs to account. The Council received a presentation from Abigail Jago explaining the NHS constitutional standards regarding waiting times, and how the Trust is addressing the issues which have arisen over the last year.

Beryl Hobson
Chair

Board Assurance Framework – Risks to achievement of KSOs

KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
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.	We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative R&D.	We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner	We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.	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 at the Executive Management Team meeting 25 /02/18 alongside the corporate risk register. KSO 1 and 2 were also reviewed at the Quality and Governance Committee, 21 /02/19. KSO 3, 4 and 5 were reviewed 25/02/19 at the Finance and Performance Committee. Changes since the last report are shown in underlined type on the individual KSO sheets. The key risks to outstanding patient experience remains workforce , the key risk to financial sustainability is underperformance against income plan, cost improvement plan and the underlying financial deficit and the key risk to operational excellence remains RTT 18 and the 52 week breach position . The Board is asked to note the rescoring of the KSO4 from 20 to 25 due to the deteriorating financial position and revised forecast. Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the March trust board .

	Q 1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Target risk
KSO 1	15	15	15	15	9
KSO 2	12	12	12	12	8
KSO 3	20	20	20	20	15
KSO 4	20	20	20	25	16
KSO 5	20	20	20	20	15

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**77-19**	
Report title:	**Chief Executive's Report**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Steve Jenkin, Chief Executive				
Appendices:	1) Integrated Performance Dashboard Summary 2) QVH media update February and March 2019				
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	• Integrated Performance Dashboard Summary • Update on estates strategy • NHS Improvement has released the quarter three (Q3) finance and operational performance figures for the provider sector				
Recommendation:	For the Board to **NOTE** the report				
Action required	Approval **Y/N**	**Information Y/N**	Discussion **Y/N**	Assurance **Y/N**	Review **Y/N**
Link to key strategic objectives (KSOs): [Tick which KSO(s) this recommendation aims to support]	KSO1: **Y/N**	KSO2: **Y/N**	KSO3: **Y/N**	KSO4: **Y/N**	KSO5: **Y/N**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date	24/04/19	Decision:	Review BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
MAY 2019

TRUST ISSUES

Year end

The Trust is reporting a year-end deficit of £6.1m (including donated asset adjustments). In year, the Trust has earned £0.9m of Provider Sustainability Fund (PSF) income, including £0.5m of Incentive bonus from the PSF general distribution, meaning the underlying deficit is £5.1m. The reported position is in line with the re-forecast approved by the Finance and Performance Committee during January. The finance use of resources rating is a '3'. The financial position remains subject to audit and the final reconciliation of 2018/19 activity and income with commissioners.

Care Quality Commission (CQC)

CQC carried out an unannounced inspection of three of our core services on 29 and 30 January prior to a planned provider level inspection of 'well led' on 26 and 27 February 2019. We expect CQC to publish their report later this month.

Board Seminars

At our bi-monthly seminar, the Board received a presentation from Peter Edwards, partner of legal firm Capsticks on management agreements and hospital groups, popular in today's NHS. QVH has been working closely over the past fifteen months Western Sussex Hospitals Foundation Trust (WSHFT) and Brighton & Sussex University Hospital Trust (BSUH).

At an additional board event in March, Pete Landstrom Chief Delivery and Strategy Officer for WSHFT and BSUH presented Patient First, which is their long-term approach to transforming hospital services for the better. We have seen the positive improvements the Patient First initiative has had in BSUH, it is in line with our partnership working with BSUH/WSHFT, and we have agreed this is the quality improvement methodology we will use at QVH. We will be arranging a workshop for our senior leaders next month where we will agree the timeline for roll out across all our wards and departments; as a small trust we expect to be able to proceed with this at pace and deliver clear benefits for patients and staff within 2019/20.

Update on estates strategy

As the Board is aware, QVH is working with a local firm of architects on achieving planning permission on a plot of land at the rear of the site which is not used for healthcare. Due to constraints in planning legislation, the completion of the land sale was not possible in 2018/19. In private session in March the Board agreed to continue to pursue this land sale seeking best value for the NHS; this discussion was held in private due to the commercial confidentiality of the discussion around the possible value of the land. The ecology surveys required to commence the planning application will be underway shortly and QVH is commissioning a site agent to work alongside the Trust providing specialist support on marketing the land.

Integrated Performance Dashboard Summary

Our Integrated Performance Dashboard summary (Appendix 1) as part of my report highlighting at a glance the key indicators from all areas within the Trust including safety and quality, finance and operational performance, and workforce, against each Key Strategic Objective. Of particular significance, the improved Staff Friends and Family Test for the last quarter which saw both measures for QVH as a place to receive care and as a place to work increase.

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

The entire BAF was reviewed by the executive management team on 24 April 2019 alongside the corporate risk register. The key risk to outstanding patient experience remains workforce although we now have the highest number of substantive staff in posts for many years. Key risks to operational excellence remain our referral to treatment 18 week standard and the 52 week breach position, and the financial deficit challenges our long-term sustainability.

Media
Appendix 2 shows a summary of QVH media activity during February and March 2019.

SECTOR ISSUES

Sussex and E Surrey Sustainability Transformation Partnership (STP)
Karen Breen has been appointed to the Deputy Chief Executive role with Sussex and E Surrey Clinical Commissioning Groups. For the past year Karen has been the STP's Programme Director.

NATIONAL ISSUES

NHS Improvement (NHSI) has released the quarter three (Q3) finance and operational performance figures for the provider sector. These figures cover the period 1 October 2018 to 31 December 2018. The key headlines were:

- At Q3 the provider sector is forecasting to deliver a deficit of £661m, up from £558m at quarter two (Q2). Since Q2, NHSI has adjusted the sector plan from a £439m to a £394m deficit position. Against this lower plan, the sector will overspend by £269m.
- However this forecast includes £256m of technical adjustments which were not added in at Q2. This is for "donated asset income" resulting from Carillion collapse, and two private finance initiative assets being brought onto trust books.
- Without these technical adjustments the provider sector would be forecasting a £917m deficit – a slight improvement on the £931m deficit forecast at Q3 last year but a significant deterioration on Q2.
- The year to date deficit is unchanged on the previous quarter at £1.2bn. This is despite providers delivering efficiency savings worth £2.3bn so far this year.
- Workforce pressures remain a significant challenge, with 100,500 vacancies in the provider sector. This represents a decrease of around 5,000 whole time equivalent staff since Q2, but this was the expected impact of new graduate intakes.
- 134 (58%) of 230 trusts are reporting a deficit at Q3, including PSF. This is an improvement on the 155 providers that reported at deficit at Q2. The deficit remains heavily concentrated in the acute sector, with 78% of acute providers currently in deficit.

Other pertinent financial data at Q3
- Non-pay cost pressures. Providers are overspent on non-pay costs by £396m. Almost half of this is accounted for by the purchase of healthcare from other providers (a £183m overspend), mostly from non-NHS providers. There were also significant overspends on clinical supplies and premises.
- CIP delivery. Total CIP delivery for the first nine months of the year was £2.1m, representing 3.1% of total spend. Planned CIP delivery for Q3 had been £2.3m (3.5%) and providers are expected to deliver £3.6bn savings by the end of the year. This compares with the £3.2bn delivered in 2017/18.

- Agency and bank expenditure. In the face of growing demand and increasing staff vacancies, trusts are continuing to rely on the temporary workforce. Providers spent £1.8bn on agency staff during the first nine months of the year, which is £139m above the ceiling set by NHSI and a marginal increase on last year. The provider sector is forecasting it will miss its target by £170m – although the proportion of income spent on agency staff is still expected to fall to its lowest recorded level.

Key performance information at Q3

- Performance against the 18 week referral to treatment (RTT) standard was 86.6%, down from 88.2% at Q3 2017/18.
- The number of patients waiting longer than 52 weeks has begun to fall. At the end of Q3 2018/19, 2,237 patients were waiting over a year for treatment. That is an increase on last year, but a major reduction from the 3,156 patients waiting over 52 weeks in Q2.

Source: NHS Providers

Steve Jenkin
Chief Executive

Integrated Dashboard Summary
Key indictators at a glance

NHS
Queen Victoria Hospital
NHS Foundation Trust

KSO1 Outstanding Patient Experience & KSO2 World Class Clinical Services	
C-Diff	0
MRSA	0
E-coli	0
Gram-negative BSI	0
Serious Incidents	0
Never Events	0
No of QVH deaths	1
No of off-site deaths (within 30 days)	0
Contacts	18210
Complaints	6
Closed <30 days	2
FFT	
In-patient	99%
Day surgery	98%
MIU	94%
Trauma	95%
O/Ps	95%

KSO3 Operational Excellence	
MIU <4hrs	98.50%
RTT 18 weeks	78.47%
Cancer 2ww	94.60%
Cancer 62 day	87.00%
Diagnsotics <6weeks	99.82%
52ww	62
Referrals via eRS	99.00%

KSO4 Financial Sustainability	M11*
Financial plan in month	(£653k)
Variance to plan in month	£6k
Patient activity income in month	(£76k)
CIP delivery YTD	£917k
Agency spend % of pay bill in month	6.20%

M11* re-forecast

KSO5 Organisational Excellence	
Vacancy rate	11.79%
Turnover rate	17.67%
Sickness rate	3.55%
Appraisal rate	86.81%
MAST	91.96%
Staff FFT (work at QVH)	73.62%
Staff FFT (care at QVH)	96.15%

Activity - M12	Plan	Actual	2017/18
MIU attendances	943	**1,057**	863
Elective (day case)	1,381	**962**	905
Elective	413	**301**	317
Non-elective	497	**397**	386
Critical care	78	**32**	49
O/P first attendance	3,773	**3,455**	3,644
O/P follow up	10,941	**10,193**	10,132
O/P procedures	2,524	**1,877**	1,565
Other	3,722	**2,936**	3,142

Key	Improved Performance	Deteriorating Performance	Remains the same

QVH Media Update – February and March 2019

New CT scanner unveiled at QVH

The **East Grinstead Gazette** and **More Radio** covered the unveiling of our new CT scanner – the first to have been installed on site in East Grinstead.

The new scanner, which uses spinning tubes to create detailed images of the body, was funded entirely by the League of Friends. The League's chair StJohn Brown was quoted along with QVH chief executive Steve Jenkin.

Pictured: Helen Joy, CT Superintendent in the Radiology department

A new CT scanner has been unveiled this week at Queen Victoria Hospital in East Grinstead this week.

Thanks to a £420,000 donation from the charity League of Friends.

The scanner uses a spinning X-ray tube to create detailed images of the body.

It is the first to be installed in the Radiology department on site in East Grinstead, according to the hospital.

Having the new equipment at QVH will mean in patients needing a CT scan will no longer have to be transferred elsewhere.

Friends' donation sees new scanner installed

Local kebab shop celebrates silver jubilee with donation to QVH Charity

Restaurant celebrates 25 years in business

A popular restaurant in East Grinstead has celebrated its 25th year by making a £250 donation to QVH Charity.

The Charcoal Grill in Railway Approach is owned and run by Mustafa Dilek.

QVH Director of Nursing, Jo Thomas, is pictured with him in the **East Grinstead Gazette** alongside the Mayor of East Grinstead.

Nervous patients get reassuring hand to hold

A new scheme launched by QVH to comfort and reassure nervous patients undergoing cataract surgery under local anaesthetic was featured heavily on both **BBC Sussex** and **BBC Surrey** radio stations.

QVH volunteer Liz Colenutt was interviewed on the breakfast shows of both stations. The coverage was particularly positive on BBC Sussex as the presenter used our story as a key theme throughout the programme, encouraging people to call in with their own stories. There are also plans in place for **BBC South East Today** to film this story. We have already been contacted by at least one person wishing to volunteer as a QVH hand holder as a result of this coverage.

Meet the QVH mother and daughter feeling at home

The March edition of **RH Uncovered** featured a full page article (left) about Queen Victoria Hospital's mother and daughter team, Elaine and Emily Ratcliffe. The story, published to coincide with Mothering Sunday, quoted the pair extensively. The magazine also ran a piece about Call the Midwife actor Jack Ashton being named as QVH Charity's first ambassador (right).


QVH charity to benefit from will writing offer

QVH charity to benefit from will writing offer

The **East Grinstead Gazette** published a half page story about local solicitors Buss Murton Law, who teamed up with QVH Charity to offer will writing appointments during March in return for a donation to the charity.


HELPING OUR LOCAL QUEEN VIC

Going to hospital can be daunting, especially for children, so to help make the experience more positive QVH Charity set up a fundraising appeal last year to transform the children's waiting areas – readers may remember the feature covering the appeal. Thanks to donations from the local community and supporters of the hospital, QVH now has a new dedicated play area in the main outpatient department, complete with toys, books and interactive games to help entertain the hospital's youngest visitors.

Feedback has been overwhelmingly positive with one patient's family saying, "Wonderful staff, friendly and informative. Excellent facilities for my son, it put him at ease and made the whole experience less stressful."

Over the last year, the charity was able to fund £172,000 worth of improvements at the hospital, including purchasing medical equipment not routinely paid for by the NHS, supporting research to find new treatments, as well as improving other patient areas.

Camilla Slattery, Head of Fundraising for QVH Charity said "We want to thank everyone who has supported us over the last year. It is only thanks to the generosity of supporters including the readers of East Grinstead Living that we can fund these truly wonderful initiatives. These improvements have already made a real difference to QVH and its patients."

There are still many projects QVH Charity would like to fund with your support. If you are interested in fundraising or finding out more about how you can support the QVH Charity please email Camilla.slattery@nhs.net or phone 01342 414170. More fundraising initiatives will be announced in the East Grinstead Living during the course of the year.

Helping our local Queen Vic

A lovely article appeared in the March edition of **East Grinstead Living** about the dedicated play area in main outpatients which was funded by QVH Charity. The article went on to describe how the charity had been able to fund £172,000 worth of improvements at the hospital over the past year. Our head of fundraising, Camilla Slattery,was quoted.

QVH received a mention on **BBC Radio 1** after DJ Danny Howard came into the hospital with a broken finger.

The Health Service Journal published an article raising concerns about the Trust's predicted financial deficit for next year. In response to the story, which was taken from board papers, the Trust said it had been looking into its theatre productivity and was now planning to investigate its productivity within outpatients. QVH also said it was planning to work closer with neighbouring Brighton and Sussex University Hospitals Trust on the provision of paediatric burns care, plastic surgery, dermatology, and head and neck care.

The West Sussex County Times included QVH Charity's "When swing was king" concert at the Chequer Mead theatre at number five in a list of 10 things to see in West Sussex.

QVH on social media


Pinned Tweet

Jack Ashton @Jackjashton · Mar 5

It was an honour to visit specialist departments at the @qvh last Friday. Meeting patients like Richard (pictured) & his speech therapist Claire & Karan Kapoor his ENT Consultant. I sat in on some impressive eye surgery with Opthalmic Surgeon Gok Ratnarajan too! @QVHcharity

2 4 83


Jack Ashton @Jackjashton · Mar 14

This summer I'm going to try and raise as much money as possible for this brilliant Hospital! Come join the muddy fun! @mudmonstersrun

Queen Victoria Hospital @qvh

Our @QVHcharity ambassador @Jackjashton is taking on a slightly different role this summer as he heads up our @mudmonstersrun team - and you could join him!

Find out how: qvh.nhs.uk/2019/03/actor-...

1 1 39

QVH Charity ambassador Jack Ashton met staff and patients at QVH, describing the visit on Twitter as "an honour".

The actor, who's best known for his role in "Call the Midwife" was introduced to the work in theatres and watched a glaucoma surgery, tweeting later to his 12,000 followers he had sat in on some "impressive eye surgery with Opthalmic Surgeon Gok Ratnarajan".

One of our most popular social media posts was this photograph on Facebook thanking volunteers for their contributions to a bake sale in aid of QVH Charity.

The sale raised £505 with the money being spent on books for the QVH library.

The MP for Mid Sussex, **Nicholas Soames**, tweeted to his 54,800 followers regarding a meeting he'd had on site with Beryl Hobson and Steve Jenkin.

The tweet read: "Excellent visit to Queen Vic for useful meeting with Chairman and Chief Executive #challengingtimesbutbigopportunitiesforfuture"

If you use Facebook and Twitter please follow us on Facebook and Twitter

Press releases

We issued the following information to the public which you can read via these links:

- New CT scanner unveiled at QVH
- Signage improvements for hospital site
- Nervous eye patients get reassuring hand to hold
- East Grinstead law firm supports QVH Charity with will promotion
- Refurbishment work on hospital corridor due to begin
- QVH staff champion National Apprenticeship Week
- Actor Jack Ashton gets muddy for Queen Victoria Hospital
- People with swallowing difficulties can have their cake and eat it too

For more information… please contact Kathryn Langley, communications manager, at kathryn.langley1@nhs.net or call x4508.

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed: 9th April 2019

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.

Risk Appetite The Trust has a **moderate appetite** for risks that impact on patient experience but it is higher than the appetite for those that impact on patient safety. This recognises that when patient experience is in conflict with providing a safe service safety will always be the highest priority

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

Rationale for risk current score

- Compliance with regulatory standards
- Meeting national quality standards/bench marks
- Very strong FFT recommendations
- Excellent performance in CQC 2017 inpatient survey, sustained better than national average.
- Patient safety incidents triangulated with complaints and outcomes monthly no early warning triggers
- International recruitment- 48 posts offered 36 accepted
- National staff shortages of nurses and practitioners in theatres, critical care impacting on service provision and agency usage
- Not meeting RTT18 and 52 week Performance and access standards but meeting agreed recovery trajectories

Future risks

- Unknown impact on patients waiting longer than 52 weeks, CHR in progress
- Future impact of Brexit on workforce
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- STP strategic plans not fully developed

Future Opportunities

- Further international recruitment with another local Trust

Controls / assurance

- Estates plan and maintenance programme
- Robust Governance and clinical quality standards managed and monitored at the Q&GC, CGG and the JHGM, safer nursing care metrics, FFT and annual CQC audits , 6/12 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
- Burns and Paediatric services not currently meeting all national guidance. CCG and Regulators fully aware of this, mitigation in place. 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
- Clear written guidance for safe staffing levels in theatres and critical care

Gaps in controls / assurance

- International recruitment material benefits to workforce anticipated in Q2 and Q3 2019/20 Controls implemented to date have not fully addressed workforce issues Links to CRR 1094,1077,1035,1035,1126
- Increase in negative FFT and PALS contacts re appointments/waiting times Links to CRR 1125,
- 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: 8th April 2019

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.

Risk Appetite. The trust has a **low appetite for risks that impact on patient safety**, which is of the highest priority. The trust has a moderate appetite for risks in innovation of clinical practice, research and education methodology, if patient safety is maintained.

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

- Adult burns ITU and paediatric burns derogation
- Paediatric inpatient standards and co-location
- Incomplete compliance with 7 day services standards
- Junior doctors – tension between service delivery and training & supervision needs, particularly at spoke sites
- Spoke site clinical governance.
- Sleep disorder centre staffing of medical staff and sleep physiologists
- Histopathology medical staffing
- Difficulties in recruitment in nursing, administrative and PAM staff resulting in poor efficiency of medical workforce.
- Non-compliant RTT 18 week and 52 week position.
- Commissioning and STP reconfiguration of head and neck services
- Lower limb orthoplastic service provided by QVH and BSUH – inability to meet BOAST4 and NICE guidance.
- CCU – network arrangements for CPD and support require further development

Future Risks

- STP and NHSE re-configuration of services
- Commissioning risks to lower priority services– sleep, orthognathic surgery
- Commissioning risks to major head and neck surgery

Future Opportunities

- Private practice
- MoU and collaboration with BSUH
- STP networks and collaboration
- Efficient team job planning
- Research collaboration with BSMS
- New CEA scheme and potential for incentive
- New services – glaucoma & sentinel node expansion
- Multi-disciplinary education, human factors training and simulation

Controls and assurances:
Clinical governance leads and reporting structure
Clinical indicators ,NICE reviews and implementation
~~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
Local Academic Board, Local Faculty Groups and Educational Supervisors
Electronic job planning
Harm reviews of 52+ week waits

Gaps in controls and assurances:
Limited extent of reporting /evidence on internal and external standards
Limited data from spokes/lack of service specifications
Scope of delivering and monitoring seven day services (OOH) (RR845)
Plan for sustainable ITU on QVH site (CRR1059)
Achieving sustainable research investment
Balance service delivery with medical training cost (CRR789)
~~Fully addressing GMC National Training Survey results (CRR789)~~
Detailed partnership agreement with acute hospital (CRR1059)
Sleep disorder centre sustainable medical staffing model & network

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**79-19**	
Report title:	**Quality and Governance Assurance report**				
Sponsor:	Kevin Gould, Non Executive Director				
Author:	Ginny Colwell, Committee Chair				
Appendices:	N/A				
Executive summary					
Purpose of report:	To provide assurance to the Board to matters discussed at the QGC meeting on 17 April 2019				
Summary of key issues	Good assurance was received for most areas.				
Recommendation:	The Board is asked to **NOTE** the contents of the report				
Action required *[highlight **one** only]*	Approval	Information	Discussion	Assurance	Review
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:	No additional areas identified				
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to: Board of Directors
Meeting date: 02 May 2019
Reference no: 79-19
Report from: Kevin Gould, Non-Executive Director
Report date: 24 April 2019

Quality and Governance Committee Assurance Report
Meeting held on 17 April 2019

1. A light touch review has taken place and the results collated. The new Chair of Q&G will agree any actions to be taken forward

2. Risk exception report- No serious incidents or never events were reported in Feb/March. An incident investigation report was received on the two dermatone incidents. Further actions have been introduced to reduce the risk of error.

3. Corporate risk register- assurance was received that the CRR continued to be used appropriately with 1 risk rescored. There are currently 15 risks on the CRR.

4. Patient experience report-one complaint was re-opened; investigation on going. No complaints were referred to the Ombusman.

5. National Inpatient Survey 2018- Overall an excellent result. Food is still a challenge. An Action plan will be drawn up and monitored by the Patient Experience Group. The survey will come to the Board

6. Local Governance meetings attendance- As part of the assurance activity for Q&G this activity has not been maintained at the agreed level. The new Chair and DoN will agree the way forward.

7. Quality Report 2018/19 An early draft of the report was received. The committee were unable to recommend the report as there were still sections missing and some waiting for updating.

8. Quality report Priorities update 2018/19- updates were received on two, the other one, theatre productivity, was discontinued due to the commissioned efficiency work. The committee asked for the never event to be recorded within the report.

9. CQUINs- A verbal report was received on progress. It was noted that the CQUIN around the reduction of antibiotic usage was not likely to be achieved.

10. Other reports received and are either covered by the executive report to the Board or had no significant assurance issues;
    - KSOs 1&2
    - Infection prevention and control update
    - Six monthly workforce review- with Board papers
    - Quality and safety Board report
    - Quality impact assessments
    - Safe working hours
    - Getting it Right Frist Time

- Clinical Governance Group Minutes
- Patient Experience Group

11. The committee received 3 local governance reports and will assign members further visits as we are behind schedule

12. 7 Day Service Board Report- clarification and assurance was given on some areas and further detail will be written

13. CQUIN- Good progress in most areas. Waiting confirmation of payments for Q2&3. Full year value £1.4 million

14. Compliance in Practice Q3 report- Noted that actions on improving noticeboards and increasing the availability of wheelchairs was being taken forward;

    - Quality account and quality priorities update
    - NatSSiPs report- National Safety Standards for Invasive Procedures
    - Safeguarding
    - Clinical governance Group
    - Medicines management and optimisation group
    - Infection prevention and control group
    - Health and safety group
    - Nursing quality forum
    - Strategic safeguarding group

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**80-19**	
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 Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues	The Committee is requested to note the Corporate Risk Register information and the progress from the previous report. There was one key change to the CRR in March: ➢ One Local Risk increased in score from 9 to 12				
Recommendation:	Quality & Governance Committee 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 Q&GC				
	Date:	18/4/19	Decision:	Reviewed and updated	
Previously considered by:					
	Date:		Decision:	For assurance	
Next steps:					

Corporate Risk Register Report
February and March 2019 Data

Key updates:

Corporate Risks added between 01/2/2019 and 31/03/2019: 1

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x4=12	1117	Inability to meet legislative requirements of the Falsified Medicines Directive	Discussed at Clinical Support Service meeting: became Law in February 2019. This is a national issue and all Trusts are now non-compliant as the required software is not available, work underway externally to devise programme, will not be before December 2019

No Corporate Risks were rescored or closed in this period

The Corporate Risk Register is reviewed monthly at Executive Management Team meetings (EMT), quarterly at Hospital Management Team meetings (HMT) and presented at Quality & Governance Committee meetings for assurance. It is also scheduled bimonthly in the public section of the Trust Board.

Implications of results reported
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. Failure to address risks or to recognise the action required to mitigate them would be key concerns to our commissioners, the Care Quality Commission and NHSI.

Action required
4. Continuous review of existing risks and identification of new or altering risks through improving existing processes.
Link to Key Strategic Objectives
- Outstanding patient experience
- World class clinical services
- Operational excellence
- Financial sustainability
- Organisational excellence

5. The attached risks can be seen to impact on all the Trust's KSOs.

Implications for BAF or Corporate Risk Register
6. Significant corporate risks have been cross referenced with the Trust's Board Assurance Framework.

Regulatory impacts
7. The attached risk register would inform the CQC but does not have any impact on our ability to comply with CQC authorisation and does not indicate that the Trust is not:
- Safe
- Effective
- Caring
- Well led
- Responsive

Risk Register management:

There are 95 risks currently on the Trust Risk Register as at 5th April 2019, of which 15 are Corporate, with the following modifications occurring during this reporting period (February/March):

- 1 new risks added: Local
- 9 risks closed: all Local
- 1 Risk scores increased to 12 and Risk added to Corporate Register

Risk Registers are reviewed & updated at the Business Unit Meetings, Team Meetings and with individual Risk Owners; updates include regrading of scores and closures.
Risk Register management shows ongoing improvement as staff own & manage their respective risks accordingly.

Corporate Risk Register Heat map:

Five of the fifteen Corporate Risks remain within the higher grading category:

	No harm	Minor	Moderate	Major	Catastrophic
Rare	**0**	**0**	**0**	**0**	**0**
Unlikely	**0**	**0**	**0**	**0**	**0**
Possible	**0**	**0**	**0**	**4** ID: 968, 1059, 1126, 1133	**0**
Likely	**0**	**0**	**6** ID: 1040, 1094, 1116, 1117, 1122, 1139	**3** ID: 1035, 1136 1077,	**0**
Certain	**0**	**0**	**0**	**1** ID: 1125,	**1** ID: 877

Recommendation: The Board is asked to **note** the contents of the report.

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
1139	14/01/2019	Risk to patients with complex open lower limb fractures	Patients with open complex lower limb fractures require time-critical shared care between plastics & orthopaedic service, in line with BOAST 4 and NICE recommendations.□ This is sometimes not achievable with the current configuration of services and available personnel & equipment plus theatre time.	Current SLA in place for plastic surgery provision to BSUH:□ -onsite plastic provision most weekdays□ -when possible, patients receive orthopaedic treatment in BSUH prior to transfer to QVH for soft tissue surgery□ □ Planned SLA: by end of 2019□ - 24/7 cover at BSUH for plastic surgery provision to achieve joint operating to comply with BOAST 4 & NICE recommendations□ - Interim SOP in development for lower limb patients to be transferred to QVH□ Equipment required: 'C-Arm' in Capital Planning 2019/20	Dr Edward Pickles	Paul Gable	Patient Safety	12	6		**March update**: R/V by Medical Director - BC in development for 24/7 Plastics cover. BOAST 4 compliance remains poor; presentation to April Board Seminar	KSO1 KSO2 KSO3
1136	20/12/2018	Evolve: risk analysis has identified current risk within system processes and deployment	There are a significant risk with the current provision of the EDM service within the Trust. The Chief Clinical Information officer has completed a risk analysis which has identified current risk within system processes and deployment.□ □ There are hazards which remain at level 4 and above using the NHS digital clinical risk management risk matrix indicating the need for: "mandatory elimination or control to reduce risk to an acceptable level".□ □ Unacceptable level of risk have been identified in the following areas:□ • documentation availability and scanning quality□ • partial rollout of EDM - operating a hybrid model□ • event packs not sent for scanning□ • system speed□ • E form instability□ • incorrect patient data being uploaded to EDM (internal scanning)	An urgent clinical safety review of EDM was undertaken in May 2018 (version 1.1), this review (version 2.3) is a follow-up from that document. A new project manager was appointed in August 2018, analysis was undertaken of the extent of the hazards within EDM, and a new team has been built to manage the business as usual, and to plan further rollout of EDM. A project remediation plan has been developed to address critical issues and to roll out EDM to all remaining areas.□ Quality assurance of scanning now in place improved administration process. Frequency of notes has now been increased to every week day.□ On-site Documentation availability process has improved with centralisation of pre scan preparation however further work needed to increase collection frequency.□ Off-site availability of clinical documentation there has been a rollout of laptops with 4G functionality and remote access in place for those sites that do have native connectivity through the host network. □ Incorrect patient data being uploaded to EDM (Evolve system). Recent centralisation of EDM process has achieved greater quality assurance of scanning, and has significantly reduced human error of the wrong referral letter being uploaded to evolve 2: introduction of order communications system is such that there is no longer a requirement for reports to be uploaded to evolve.□ Event packs - With the existing scanning pickup service only being 2 days a week on Tuesday and Thursday it is almost inevitable that notes will not be available in time for review following discharge from surgery. To avoid the notes not being available, the event packs are not sent for scanning and made available physically.□ System speed. There are series of measures being evaluated to address this includes the log on times to system could be dramatically reduced by the user of single sign on in "kiosk mode" , the roll out of faster pc to clinical areas and longer term the upgrade operating system to windows 10.□ Eform instability. It is possible for a user to finalise the living form at the end of a treatment episode. The Trust has worked closely with Kainos the provider of the EDM software to develop fixes for the Eform instability. The fixes have been tested and have been uploaded to the live environment. Testing being completed to verify instability issues have been addressed.□ Update 14/02/19 - Collections are now being undertaken on a week day basis (Monday to Friday each day)	Michelle Miles	Jason Mcintyre	Patient Safety	16	6		14/02/19 5 days a week collection now in place - System speed. There are series of measures being evaluated to address this including the longer term upgrade of operating system to windows 10.- □ 28/1/19 Update: EDM Project Board reviewing options □ Event packs - With the existing scanning pickup service only being 2 days a week on Tuesday and Thursday it is almost inevitable that notes will not be available in time for review following discharge from surgery. To avoid the notes not being available, the event packs are not sent for scanning and made available physically.	KSO3 KSO4
1133	21/11/2018	Inability to provide full pharmacy services due to vacancies and sickness	Delays to indirect clinical services (e.g. updating policies / guidelines / audit/ training)□ Pharmacy vacancy rate is increasing□ Lack of trained bank staff to cover□ Unable to move forward with non-clinical initiatives e.g JAC (pharmacy IT system) upgrade, compliance with falsified medicines directive	1. Previous band 2 assistant and pharmacy clerk on bank and working part-time. Band 6 technician also on bank and helping to cover some days□ 2. Locum pharmacist covering band 7 post □ 3. Some part-time staff willing to work additional hours at plain rate.□ 4. Locum technician helping to cover pharmacist sickness with audits and will also help to cover some of band 6 vacancy.□ 5. Forward planning for holidays□ 6. Direct clinical work is priority□ 7. Medicines management technician working on wards supporting pharmacists□ 8. Planning for maternity cover -but will vary depending on vacancies.	Abigail Jago	Judy Busby	Patient Safety	12	6	Recruitment underway for all posts - 1 out to advert, 2 waiting on HR Planing for maternity leave - post to be advertised. Waiting on HR	**19/3 r/v at CSS meeting:** out to recruitment - substantive pharmacist will be in post from July & a technician joins the team 25th March□ Some cover secured part time for maternity leave; nil for senior post - plan for locum cover□ Update: planning underway for x2 maternity leave after March 2019	KSO1 KSO3 KSO5
1126	14/09/2018	Recruitment and workforce team constraints and limitations	Hazards are:□ □ 1)Lack of compliance with internal recruitment KPIs, affecting time-to-hire and possible impact on clinical services / staffing levels□ 2)Non-delivery / infeasibility of £55k CIPP□ 3)Insufficient specialist / strategic support with recruitment and retention□ 4)Lack of coordination with outsourced Yeovil Healthcare NHS Trust and international campaign candidates	1)An audit was undertaken revealing areas for improvement in recruitment KPI delivery. TRAC have provided some short-term assistance and an improvement plan has been agreed with good progress made. TRAC are providing tailored training to current recruitment team members 25/26 Sept 2018.□ 2)Discussion with Director of Finance and cost pressures defined.□ 3)External support for international recruitment through Yeovil Healthcare NHS Trust agreed□ 4)Cost pressure for additional part-time Band 7 Nursing Workforce Lead agreed until end of 2018/19 financial year to provide additional support	Geraldine Opreshko	David Hurrell	Compliance (Targets / Assessments / Standards)	12	9	1)Monitoring of performance improvement plan 2)DoF monitoring pressures with DoW 3)Business case for additional fixed-term / permanent strategic resourcing expertise to be made. External support / expertise for accommodation to be sought.	**14 March 2019 update**: Band 6 Recruitment Manager extended until 31 Sept 2019, pending permanent approval for post. Workload is currently manageable with this additional resource in place. 2 internal promotions and 1 leaver across the recruitment and workforce services team within the next month increases risk due to reliance on bank staff cover; to be kept under review Dec 2018 Update: Improvement evident around recruitment administration; review on-going □ Band 6 Recruitment Manager in post until 31/3/19 (Nov 18) - case submitted for permanent resource to manage long term risk (Nov 18)□ □	KSO3 KSO5
1125	30/08/2018	RTT Delivery and Performance	- The Trust's RTT position is significantly below the national standard of 92% of patients waiting <18 weeks on open pathways. This position has reduced further in July following the identified of a cohort of patients that have historically not been included in the RTT waiting list position□ - 52 week position has deteriorated following identification of additional patients	July 18□ -Comprehensive review of spoke site activity has taken plan to identify all patients that should be included in the Trust RTT position□ Data upload now in place to enable the reporting of PTL data from Dartford spoke site that was previously not identified□ Weekly PTL meeting in place (Chair DOO)) that reviews patient level data for all patients >38 weeks for each speciality□ - Additional theatre capacity is being identified through PS (McIndoe) and NHS (ESHT Uckfield theatres)□ Recovery plan in place □ -4 additional validators to start in post 29th August□ -IST supporting capacity and demand work□ - commissioners have identified capacity outside of the trust for dental T1/T2 referrals□ - commissioner are in the process of identifying capacity for other long wait patients	Abigail Jago	Victoria Worrell	Compliance (Targets / Assessments / Standards)	20	9		**8/3/19:** 2019/20 capacity planning underway including potential independent sector activity - on track with performance plan□ 14/2/19: Exec lead r/v - RTT plan agreed with commissioners and on track re: 52 wk waits and percentage performance□ Update (Oct '18): RTT validation programme complete. RTT Action Plan in place & being monitored through fortnightly System Task & Finish group, weekly assurance call with NHSI & via internal assurance processes. Revised trajectories being agreed with Commissioners. Clinical Harm Reviews underway.	KSO1 KSO2 KSO3 KSO4 KSO5

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
1122	16/08/2018	Sentinel Node Biopsy: increase in demand	Rise in demand to perform Sentinel Lymph Node Biopsy for skin cancer□ Not enough capacity in theatres & clinics to undertake them all□	* Extra Clinics□ * Three procedures per week to be undertaken in the McIndoe Unit from September 14th 2018□ *Weekly review of cancer PTL□ * additional capacity in place	Abigail Jago	Paul Gable	Patient Safety	12	9		**8/3/19**: PoaP being developed for substantive capacity□ 14/2/19: Clarity sought regarding clinical harm monitoring for these patients: advised that the melanoma has already been removed and QVH are providing the secondary surgery.□ The patients where there is a potential risk are the 'incompletely excised' ones - those are tracked and prioritised□ February 7th update: Summary Business case to EMT for 1wte skin consultant□ □ Oct update: outsourced capacity to McIndoe	KSO1 KSO2 KSO3 KSO5
1117	26/06/2018 on local risk register rescored 19/03/19	Inability to meet legislative requirements of the Falsified Medicines Directive	Falsified Medicines directive due to come into force in February 2019, Trust will be unable to comply with the legislation when first in place.□ Under the Directive, all new packs of prescription medicines placed on the market in Europe from February 2019 onwards will have to bear two safety features: a unique identifier (UI) in the form of a 2D data matrix (barcode) and an anti-tamper device (ATD).□ □ Anti-tampering device□ □ Pharmacies, and those who are authorised to supply medicines to the public, will be required to authenticate products, which means visually checking the ATD and performing a verification and decommissioning scan, "at the time of supplying it to the public".	1. Information on actions being gathered.□ 2. On-going discussions at KSS Chief Pharmacists meetings and concerns being fed back to NHS England.□ 3. Nov 18 Quote has been sent form JAC regarding implementation. Included in business planning. □ 4. Planning underway for upgrade to current JAC version. Will include ability to link FMD software although may not initially be switched on.□ □	Abigail Jago	Judy Busby	Compliance (Targets / Assessments / Standards)	12	2		**19/0 3/119** Software currently not available, this is an issue for all Trusts nationally: work underway externally to devise programme, will not be before December 201`9. 1/10/18 - Information is still being gathered. Concern by all KSS Chief pharmacists that there is not enough information available. Brexit may also affect the data□ 21/11/18 - controls updated - JAC has sent quote for software. Included in business planning	KSO2 KSO3
1116	26/06/2018	Inability to provide sufficient medical provision to the Sleep Disorder Centre	Potential loss of medical outpatient capacity within the Sleep Disorder Centre, with associated effects on waiting list and income. Possible detriment to follow up of existing patients, particularly those requiring non-invasive ventilation for sleep disorders with a respiratory background.	1) Forthcoming AAC appointment process to substantiate 1 WTE post (currently locum basis)□ 2) Approval of funding for clinical fellow post	Dr Edward Pickles	Sue Aston	Patient Safety	12	4		**26/3/19 r/v at Sleep BU Meeting**: x2 applications - neither on Specialist Register. One may be of interest but not as consultant post□ 28/1/19: reviewed at EMT - update requested □ November update: advertisement for consultant in sleep medicine closed beginning Dec 18 - no applications received.□ To be re-advertised in January 2019 plus explore staffing and other options. □ □ October update: Substantive Consultant leaving post February 2019; worsening picture. Going out to advert November 2018 - partnership working with other Trusts being explored □ Current discussions with other potential candidates□ Medical management structure under review.	KSO1 KSO2 KSO3 KSO4 KSO5
1094	15/12/2017	Canadian Wing Staffing	Current vacancy 12.12 wte in total registered and unregistered workforce □ Requiring significant resource from ward matron and bank office to cover shifts with qualified nurses leading to constant micro management of off duty rotas. □ Unable to recruit staff to fill all 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 and maintain safe care.	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. Tailoring trauma and elective demand to establishment available	Jo Thomas	Nicola Reeves	Patient Safety	12	12	Discussion with Director of Nursing wc 18th December Proactive management of bed booking Line booking agency staff Planning further in advance to get increased choice of agency.	**11/03/2019:** Vacancy rate improved to 5.89. All HCA positions filled. Ophthalmic technician post now filled. Band 5 recruitment remains very slow**.** Currently orientating 2 bank RGN's and one RGN 0.61 WTE has been offered a position.□ 28.1.19: Improvement in vacancy rate, 9 vacancies, band 5 recruitment ongoing.□ 6-11-18: Update, remains similar situation□ 12-10-18: update, vacancies remain around 12WTE, some recruitment successful, turnover remains. national & domestic recruitment continues.□ 11-9-18: update, 12.12 vacancies, recruitment ongoing with some success.□ 13/8/18: +/- 45 posts offered: awaiting uptake and detail□ 4/7/18 - some further leavers but some recruited staff starting. □ 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	KSO1 KSO2

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
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.	Abigail Jago	Sue Aston	Patient Safety	16	6	Actions to date	**March update**: four overseas recruits due to start April / May plus four local recruits by end of May □ February update:□ International recruit gained NMC PIN, further posts offered with start dates April 2019□ October update: some success with recruitment. CCG reviewed Theatre services 11/10/18 - no safety or quality issues were identified written report awaited.□ 13/8/18: x4 WTE Staff Nurse posts recruited to, all with theatre experience.□ Dubai recruitment: +/- 45 posts offered: awaiting uptake and detail□ 9/7/18: TUG agreed to pilot different minor procedure staffing model from July '18□ Practice Educator in Dubai to interview potential staff□ □ 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	KSO1 KSO2
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	Actions to date PEG service review	**March 2019 update**: BC for shared paediatric inpatient Burns Service near completion; to go to Board May '19. Alternative patient pathways may need to be explored with commissioners and Burns Network October update: CT onsite will be operational December 2018 -joint programme manager commenced in post September 2018□ 13/8/18: reviewed at CGG - plan for instalment September□ 14/5/2018 (CGG): some progress re: discussions between sites - joint (BSUH & QVH)programme board established and CT procurement process underway	KSO1 KSO2 KSO4
1040	13/02/2017	Age of X-ray equipment in radiology	Significant numbers of Radiology equipment are reaching end of life with multiple breakdowns throughout the last 2 year period.□ □ 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 now 1 CR x-ray room and 1 Fluoroscopy /CR room therefore patients capacity can be flexed should 1 room breakdown, but there will be an operational impact to the end user as not all patients are suitable to be imaged in the CR/Flouro room. These patients would have to be out-sourced to another imaging provider.□ □ Mobile - QVH has 2 machines on site. Plan to replace 1 mobile machine for 2019-2020□ □ □ 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. Plan to replace Fluoro/CR room in 2019-2020□ □ Ultrasound- 2 US units are over the Royal College of Radiologists (RCR)7 year's recommended life cycle for clinical use. Plan to replace 1 US machine for 2019-2020□	Abigail Jago	Paul Gable	Patient Safety	12	2		**19/3: r/v at CSS meeting** - outcome awaited re: Capital bids□ 8/3/19: CBCT replaced in August 2018. CT installed & operational in Dec 2018. New fluoro room, a new US machine and 1 new portable xray machine highlighted for capital funding - response awaited.□ 28/01/2019 - For business planning 2019/2020 QVH radiology has prioritised key pieces of equipment that require capital investment this financial year.□ 1- Replace the Fluoroscopy/CR room - current room has had multiple failures this year. □ 2- Replace one mobile X-Ray machine- QVH has 2 mobile machines, both are currently broken (extended period) and one has been replaced by a loan machine supplied by the maintenance company. This loan machine has also recently failed. □ 3- Replace one of the Ultrasound - the oldest machine that is used for Head & Neck work is showing image quality resolution □ □ October update - included within capital bids for 2018/19□ 17/7/18: reviewed at CSS meeting - new capital now available for this□ 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	KSO1 KSO2 KSO3
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□ * potential for cases to be cancelled	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□ 6. International recruitment undertaken, appropriate staff moving through required checks. Continue to advertise registered staff positions.□ 7. Paper agreed at HMT to support current staffing issues in CCU. Vacancy remain high with long term sickness and maternity leave. Must ensure 50:50 split between CCU substantive staff and agency. Staff aware of the action.	Jo Thomas	Nicola Reeves	Patient Safety	16	9	Actions update	**March update**: staff member commencing ITU course Sept 2019 Additional substantive staff due to start in April 2019.□ January 2019: • Increase in staffing moving from agency to bank □ • International recruitment plan continues, awaiting dates for candidates to complete required process - recruitment delays evident□ • 6 new trained staff appointed □ • Re-advertise for Band 6 positions to enhance senior leadership within the team□ • Enhanced bank rates continue for both full and part time staff □ Dec update: further success with agency staff nurses recruiting into Bank and substantive posts.□ October update: Good uptake of offers from Dubai recruitment; continued scrutiny around use of agency & skill mix to ensure safe care.□ 13/8/18: Dubai recruitment: +/- 45 posts offered: awaiting uptake and detail□ 16/7/18: Paper to HMT to agree Risk Appetite for agency usage in Critical Care□ 9/7/18: Update - Practice Educator in Dubai to interview potential staff□ 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	KSO1 KSO2

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
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 paediatrician 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	To be reviewed in July following Clinical Cabinet discussions Paper to be presented at Clinical Cabinet in June 2016 Paediatric review group met in August, paper to private board in September 2016.	**March 11th update**: Paeds BC discussed at private board - formal decision awaited from BSUH□ January 2019:□ Process underway to finalise business case; currently working through the financial model. □ Plan to present business case to commissioners in February and final business case to the Trust Board in March.□ October update: Business case to be developed, activity data available and workforce plans underway.□ 13/8/18: sub-group convened and meetings commenced□ 12/7/18: meeting held with Brighton to progress pathway□ 12/6 update: Darzi fellow in post (1yr), reviewing paediatric inpatient burns□ 14/5 update: position paper presented at March HMT - nil new changes	KSO2 KSO3 KSO5
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	25	16	1) Development and implementation of delivery plan to address forecast underformance. Review of performance against delivery plan through PR framework with appropriate escalation policies. 2) Development of multi-year CIP/ transformational programme which complies with best practice guidelines. 3)Development and embedding of integrated business planning framework	**March 2019** □ NHSI review of Draft operating plan £8.6m deficit with Trust senior executives.□ □ □ February 2019□ 2019/20 Draft Operating plan submitted £8.6m deficit.□ □ □ January 2019:□ R/V by Exec Lead: increased forecast deficit to 5.9M□ Oct update: reviewed - nil change□ 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.	KSO4

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**81-19**	
Report title:	Quality & Safety Board Report				
Sponsor:	Jo Thomas, Director of Nursing and Quality, Ed Pickles, Medical Director				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	1. 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 Committee's attention should be drawn to the following key areas detailed in the reports: • Progress with clinical harm reviews • Actions taken in preparation for Brexit • The healthcare assistants (HCAs) national care certificate				
Recommendation:	The Committee is asked to be assured 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:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The Quality and Safety Report was produced using existing resources.				
Assurance route					
Previously considered by:	Q&GC				
	Date:	18/4/19	Decision:	Recommended to the Board	
Next steps:					

Executive Summary - Quality and Safety Report, May 2019

Domain	Highlights
Director of Nursing and Quality	The Trust is currently awaiting the draft CQC report which is now expected 11th April. The Trust will have 10 working days to check this for factual accuracy and following a further CQC panel review we anticipate the final report to be published mid to late May. The focus within the Trust remains the provision of safe, high quality care and outstanding patient experience. Whilst the most significant risks to safe provision of care and patient experience remain the trusts workforce recruitment and retention challenges and RTT 52 week breaches progress continues to be made on continuous quality improvements. Making decisions about optimal ward staffing is complex. There is a large body of evidence, including recent UK research, demonstrating a positive relationship between the number of registered nurses in hospital wards and patient safety. The evidence suggests the relationship is not linear and there is no 'one size' optimum staffing levels in individual wards. A number studies have looked at different support roles and identified lack of clarity around role boundaries. Research suggests that the contribution of registered nurses is distinct from that of healthcare assistants (HCA) or support workers. However, the roles do overlap. The Trust has been developing different career pathways for nurses, nursing associates and practitioners and HCAs as well as incorporating retention initiatives into these roles. A recent success in developing and retaining the heath care assistant workforce has been the launch of the new Care Certificate Programme. QVH supports all HCAs to achieve the national care certificate to ensure patients are supported consistently by caring and competent staff. This year five HCAs successfully completed their care certificates, they were awarded the certificates and congratulated on their achievements by The Director of Nursing and Quality. The HCAs shared their experiences of the course and the difference this has made for the patients and themselves. One of the HCAs said that gaining the care certificate has enabled her to develop her career by successfully apply for the nurse associate training which she has just commenced, and this had also improved her confidence in being able to advocate for the patient. Another HCA said that although she had been in the role for a few years she learnt a lot about patient centred care which she has been able to put into practice caring for her patients and this had directly improved the quality of her reporting to the nurses. The training starts again this month with eight HCAs register onto the programme. The Trust HCA vacancy rate has moved from red to amber, which is a significant achievement.

Medical Director	Discussions between WSHT / BSUH and QVH continue regarding clinical pathways. The business case for a shared paediatric burns service with the Royal Alexandra Children's Service has been completed and will be submitted to board in May 2019. The BSUH business case for plastic surgery service to the Major Trauma Centre remains under negotiation. Job plans for a QVH maxillofacial surgery network to cover ESHT, BSUH and QVH are completed and awaiting final agreement from the three trusts. The 'Getting it Right First Time' (GIRFT) programme has seen a significant increased relevance to the QVH with recent 'deep dive' visits regarding perioperative care, breast surgery and hospital dentistry. The main themes have reflected very positively on outcomes for QVH patients, although full summary reports are awaited. A summary report will be shared with Q&GC, although in main the actions will be followed up in the Hospital Management Team meeting where the membership of business managers and clinicians is best suited to the operational, financial and clinical improvement suggestions made by the programme. Medical examiners will be introduced across the country from April 2019 to ensure accurate death certification across a local area, provide much-needed support for bereaved families and improve patient safety. Medical examiners will be doctors registered with the GMC holding a current licence to practise. This national, initially non-statutory process, has been introduced following recommendations from the Shipman, Morecombe Bay and Mid-Staffordshire inquiries, and aims to deliver a system that will provide proportionate scrutiny to all non-coronial deaths in secondary care by March 2020. 2019/20 job planning is nearing completion, with the addition of a new annual leave allocation and booking system.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Safe: Clinical harm reviews	Clinical Harm Review meetings: Trust continues to manage down the 52 week breaches against an agreed trajectory with regulators and commissioners to achieve zero 52 week breaches by September 2019.	Clinical Harm Review meetings were established from July 2018 for patients waiting over 52 weeks and cancer patients waiting over 104 days as per the national guidance 'Delivering Cancer Waiting Times' Membership includes Head of Risk & Patient Safety, Director of Nursing and Medical Director with clinical team representation, this is usually the CD. The majority of cases are Max Fax (Dental) and Plastics and any that cannot be confirmed at the time of review as 'no harm' are followed up until point of treatment to ascertain if any harm has been caused: there have been nil harms identified so far with 43 patients listed as under surveillance. To the end of March 430 reviews have been undertaken. There were a total of 21 patients under surveillance in plastics and 14 in MaxFax. To date, 19 have been confirmed as no harm in plastics and all 14 in MaxFax. Monthly CHR assurance meetings are to be arranged from April between the Head of Risk & Patient Safety and the CCG.

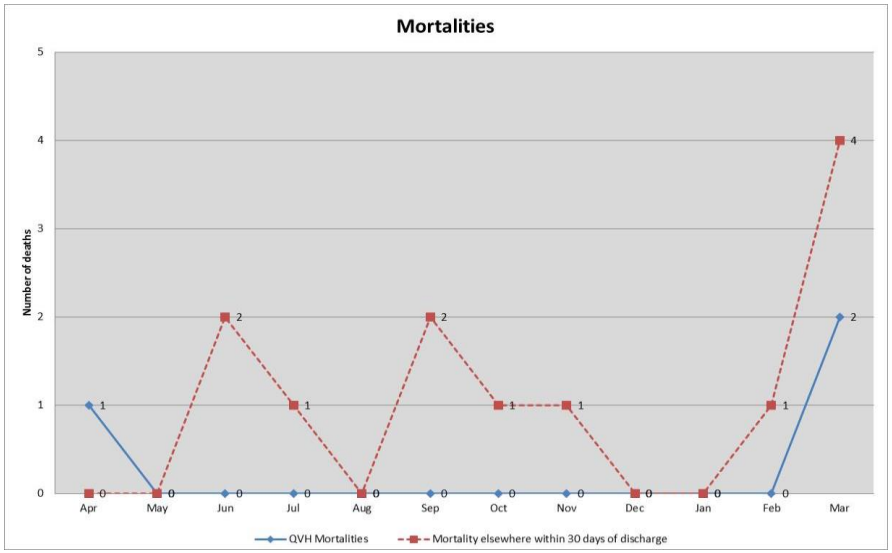
Safe: 6 month nursing workforce review	National quality board requirement that the Trust Board receive a nursing workforce paper twice a year to demonstrate safe staffing levels using national benchmarks, guidance and professional judgement.	In 2016 the NHS spent £73.8 billion on hospital services, with staffing accounting for 70% of the costs. Across the NHS, registered nurses and midwives make up 26.8% of all staff with healthcare support staff making up a further 15%. NHS hospitals have to balance staffing levels needed to deliver care that is safe and effective with the constraints of finite funding. New roles and changing relationships between professional groups can potentially help or hinder that balance, as can the way ward staff are managed. The 6 monthly nursing workforce paper in the May Board pack reviews the nursing staffing levels required in order to provide safe high quality affordable care. The paper details improvements in many of the clinical areas but challenges remain in theatres and critical care which mirror national trends. Safe provision of care is evidenced in this paper which is achieved though enhanced scrutiny and support from senior nursing team, effective use of resources and temporary staffing solutions though agency usage is decreasing.
Well-led: healthcare assistants (HCAs) national care certificate	The QVH supports all healthcare assistants (HCAs) to achieve the national care certificate to ensure patients are supported consistently by caring and competent staff.	The QVH supports all healthcare assistants (HCAs) to achieve the national care certificate to ensure patients are supported consistently by caring and competent staff. At the beginning the year five HCAs successfully completed their care certificates, they were awarded the certificates and congratulated on their achievements by the Director of Nursing and Quality. One of the HCAs said that gaining the care certificate has enabled her to develop her career by successfully apply for the nurse associate training which she is now on. Another HCA said that although she had been in the role for a few years she learnt a lot about patient centred care which she has been able to put into practice caring for her patients. The training starts again this month with eight HCAs register onto the programme.

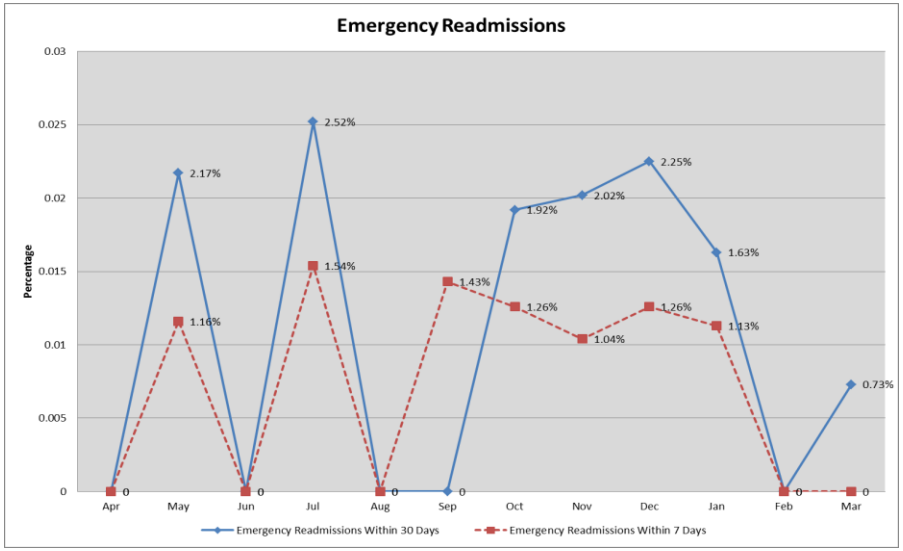
Caring - patient experience	QVH to sustains its outstanding patient experience in national surveys.	The Trust received the executive summary of the NHS Inpatient Survey 2018 undertaken by the Picker Institute. Early indication from the findings of the report show that QVH has sustained its outstanding patient experience. The report also compared QVH to the other hospitals using the Picker Institute. The preliminary findings were presented to the Trust Quality and Governance Committee for review. Once the full CQC report is published it will be presented to the public Trust Board, this is expected June 2019.
Well-led: Brexit Emergency Planning Update	QVH's Emergency Planning lead has attended a range of external meetings, teleconferences and planning scenarios regarding Brexit run by the Local Health Resilience Partnership these have included provides from both Sussex and Surrey.	QVH has held a number of Brexit preparation meetings chaired by the Chief Executive and the Trust has completed a table top scenario based exercise on 26th March 2019 (appendix a) involving a number of senior managers and executive from within the organisation to review our preparation and identify actions moving forwards In addition to internal planning, QVH has made a number of external returns to provide upwards assurance as to our levels of preparation. QVH submitted a RAG rated self assessment on 25th March 2019. We are submitting a daily Situation report (SITREP) and are also required to complete a weekly SITREP on a Monday. At the moment, the SITREPs are completed on weekdays and Friday's summary covers weekend requirements. Should it be required, QVH would run its Major Incident Control room to ensure command and control of the situation is maintained and a rota for weekend cover would be created if required. QVH has reviewed, in line with national guidance a range of possible scenarios to test our resilience in the event of a disordered Brexit. At the time of writing, QVH has demonstrated substantial assurance however this has to be seen within the context of an fast moving, changeable situation. QVH has an agile Executive Team who are able, if required to review and manage situations at very short notice which will support continued delivery of safe and efficient care at QVH.

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 2018/19			Quarter 2			Quarter 3			Quarter 4			12 month total/ rolling average
		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Infection Control														
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	1	0	0	0	0	0	0	0	0	0	0	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
Gram negative bloodstream infections (including E.coli)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA screening - elective	>95%	98%	98%	98%	97%	98%	97%	98%	99%	96%	96%	97%	97%	97%
MRSA screening - trauma	>95%	97%	95%	97%	96%	95%	96%	95%	96%	95%	96%	96%	96%	96%
Incidents														
Never Events	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Serious Incidents	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Theatre metrics														
All patients: Number of patients operated on out of hours 22:00 - 08:00	5	6	5	5	5	5	4	8	3	2	1	1	4	46
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	0	0	1	0	0	0	0	0	0	1
WHO quantitative compliance		99%	99%	98%	98%	98%	99%	99%	98%	99%	98%	99%	99%	99%
Non-clinical cancellations on the day		8	13	18	9	6	7	22	14	18	22	22	11	137
Needlestick injuries								4	2	1	1	3	3	11
Pressure sores								1	0	0	1	0	0	2
Paediatric transfers out (<18 years)		0	0	0	0	0	0	0	2	0	1	0	4 (TBC)	3
Medication errors														
Total number of incidents involving drug / prescribing errors		6	12	7	8	8	7	16	13	9	7	16	10	119
No & Low harm incidents involving drug / prescribing errors		6	12	7	8	8	7	16	13	9	7	16	10	119
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		1.8	0.6	0.6	1.2	1.2	0.6	2.2	2.2	0	0.5	1.1	1.2	1.1
Harm free care rate (QVH)	>95%	98%	100%	97%	98%	100%	93%	100%	100%	100%	96%	97%	100%	98.3%
Harm free care rate (NATIONAL benchmark) - one month delay	>95%	93.9%	94.0%	94.1%	94.1%	93.9%	94.3%	94.1%	94.3%	94.3%	N/A	N/A	94%	94%
Pressure Ulcers														
Hospital acquired - category 2 or above	15	1	1	0	1	0	0	0	1	0	1	0	0	5
VTE initial assessment (Safety Thermometer)	>95%	100.0%	97.4%	97.1%	88.1%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	99.0%	100.0%	98.2%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	>95%	95%	100%	100%	95%	98%	100%	97%	100%	100%	100%	89%	100%	98.0%
Patient Falls resulting in no or low harm (inpatients)		3	3	4	2	3	3	4	5	2	3	3	2	37
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	1	0	0	0	0	0	0	0	0	0	0	1
Patient falls per 1000 bed days		2.31	2.24	3.31	1.61	2.6	2.62	3.05	3.79	2.11	3.03	2.97	1.82	2.63

Effective - Performance Indicators



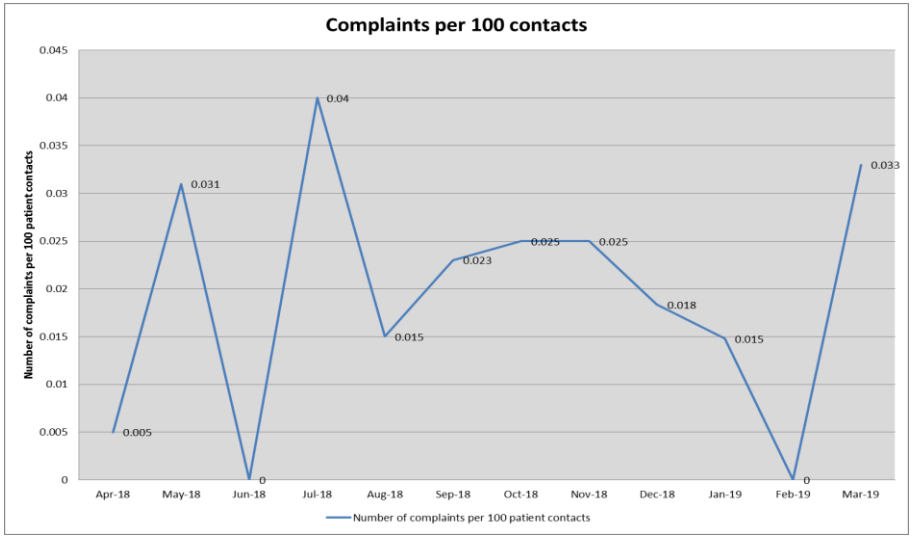


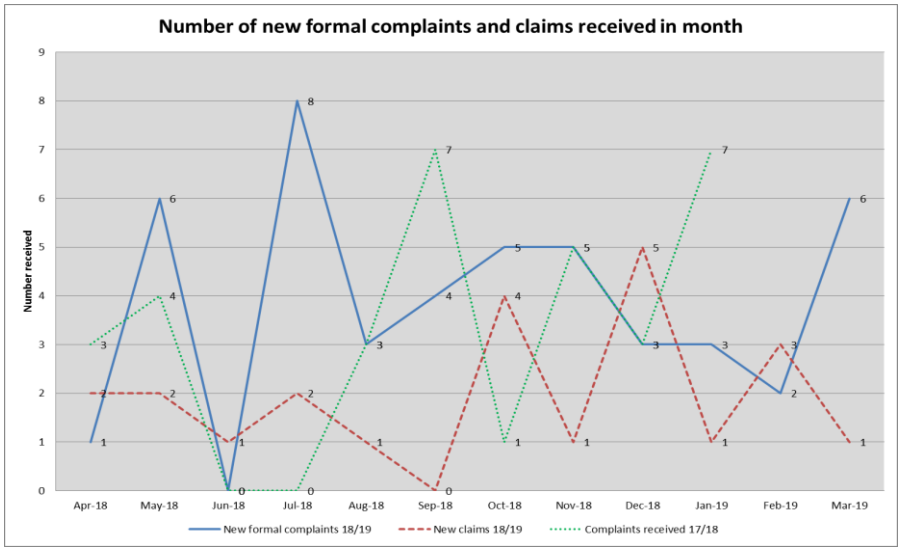
	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Number of deaths on QVH site	0	0	0	0	0	0	1	0	1	2
Number of deaths off- site within 30 days of IP or OP procedure	2	1	0	2	0	2	1	0	0	2
No of completed preliminary reviews	2	1	0	2	0	2	1	0	1	2
No of deaths subject to a Structured Judgement Review	0	0	0	1	0	0	1	0	0	1
No of deaths in patients with co-existing learning difficulties	0	0	0	0	0	0	0	0	0	0

Learning from deaths

All off site deaths are subject to preliminary review of the case notes and enquiries with the GP and responsible clinicians. All deaths on the QVH site, or where a concern has been raised, are subject to a Structured Judgement Review (SJR) of the case notes. The type of SJR differs if the patient had learning difficulties. Where concerns are identified through preliminary case note review or SJR, these are investigated through the Datix and risk mechanisms.

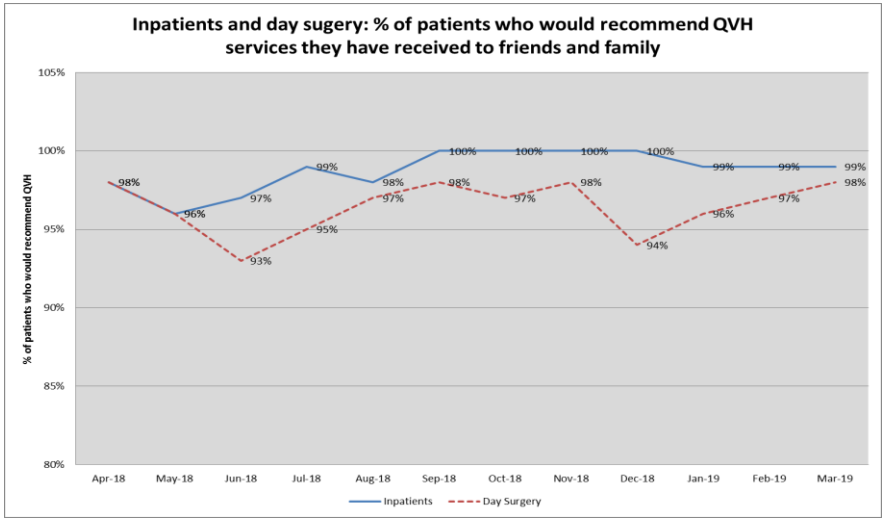
Caring - Current Compliance - Complaints and Claims

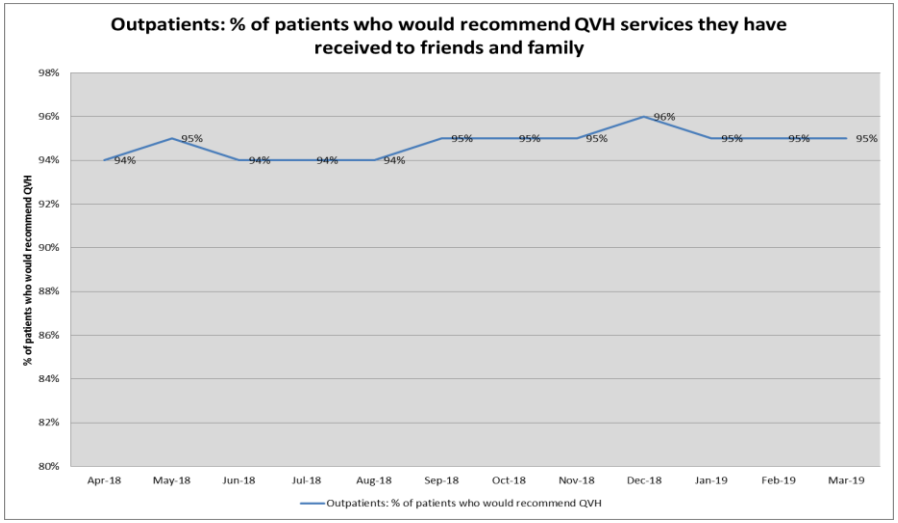


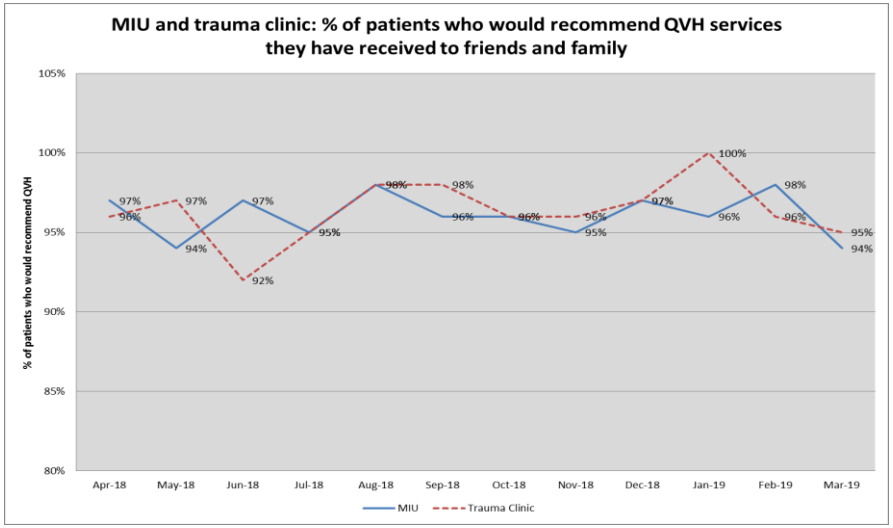


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Contacts (IP+OP+MIU, all sites)	18284	19661	19342	20035	19406	17496	20263	20100	16374	20479	18100	18210
Complaints	1	6	8	8	3	4	5	5	3	3	2	6
Complaints per 100 contacts	0.005	0.031	0.041	0.04	0.015	0.023	0.025	0.025	0.018	0.015	0.011	0.033
Number of complaints referred to the Ombudsman for 2nd stage review	1	0	0	0	1	0	0	0	0	0	0	0
Number of complaints re-opened	1	0	0	1	0	0	0	0	0	0	1	0

Caring - Current Compliance - FFT







Nursing Workforce - Current Compliance

Domain	Compliance	Actions
Ross Tilley	During February and March there were 3/118 occasions where staffing numbers did not meet planned levels (2/124 in December and January). All escalated to 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 area on one occasion. Below template shift dates have been triangulated with Datix safety incidents, ward FFT scores and complaints information. There were no patient safety incidents, falls, pressure ulcers or nursing medication errors on these shifts.
Margaret Duncombe	During February and March there were 6/118 occasions where staffing numbers did not meet planned levels (2/124 in December and January). 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 or on 3 occasions patients requiring enhanced recovery care were looked after on CCU. Below template shift dates have been triangulated with Datix safety incidents, ward FFT scores and complaints information. There were no falls, pressure ulcers or nursing medication errors on these shifts.
Burns	During February and March there were 3/118 occasions where staffing numbers did not meet planned levels 5/124 in December and January). All escalated to site practitioner as per trust protocol.	Staffing according to bed occupancy and acuity resources redeployed to and 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 February and March there was 8/118 occasion where staffing numbers did not meet planned levels (9/124 in December and January). All escalated to site practitioner as per trust protocol.	The ward was closed on 2 nights in February and 4 nights in March due to staff availability. In February the ward had 18 inpatients requiring overnight stay on 12 nights. In March the ward had 15 patients requiring overnight stay on 11 nights. Staffing is allocated according to bed occupancy and acuity. Below template shift have been triangulated with Datix safety incidents, ward FFT scores and complaints information, no harms or related complaints to this date.
Critical Care (ITU)	During February and March there was 1/118occasions where staffing numbers did not meet planned levels(6/124 in December and January). All were escalated to site practitioner as per trust protocol. All escalated to the site practitioner as per trust protocol.	Staffing according to bed occupancy and acuity resources redeployed to and from other areas where template was below planned and additional staff required. There were no shifts in February that fell below the agreed staffing levels of not more than 50% agency staff on any shift. There were no Datix safety incidents relating to the one shift below template ward FFT scores and complaints information. 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 February and March there were 9/118 occasions where staffing numbers did not meet planned levels (8/124 in December and January).	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. All new site practitioners have completed supernumerary placements and are now fully orientated to the role.

Data extracted from the workforce score card in appendix 1

Qualified Nursing Workforce - Performance Indicators

QUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17 & 2017-18			Mar-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	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				253.28	253.28	253.28	253.28	253.28	253.28	246.76	246.76	246.76	246.76	246.76	246.76	**246.76**	◄►
Nursing Headroom				*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*18.22*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	***N/A***	
Adjusted Establishment (removed Headroom til 31/8/18. From 1/9/18 12% headroom included in establishment)				235.06	235.06	235.06	235.06	235.06	235.06	246.76	246.76	246.76	246.76	246.76	246.76	**246.76**	◄►
Staff In Post WTE				194.66	189.21	188.22	187.74	187.82	186.19	183.31	184.96	186.27	186.72	185.92	185.96	**189.72**	▲
Vacancies WTE				43.01	45.85	49.45	49.93	49.85	51.48	63.45	61.80	60.49	60.04	60.84	60.80	**57.04**	▼
Vacancies %	**>12%**	**8%<>12%**	**<8%**	18.30%	19.51%	21.04%	21.24%	21.21%	21.90%	25.71%	25.04%	24.51%	24.33%	24.66%	24.64%	**23.12%**	▼
STARTERS WTE (Excluding rotational doctors)				4.00	1.00	0.00	0.00	1.00	3.68	0.51	3.64	3.23	3.81	1.41	0.60	**5.61**	▲
LEAVERS WTE (Excluding rotational doctors)				3.40	2.68	1.40	0.81	1.97	6.00	7.60	2.80	1.43	3.93	1.00	0.64	**1.00**	▲
Starters & Leavers balance				0.60	-1.68	-1.40	-0.81	-0.97	-2.32	-7.09	0.84	1.80	-0.12	0.41	-0.04	**4.61**	
Agency WTE				29.07	30.30	34.20	31.53	35.09	36.29	36.06	35.35	32.92	23.88	26.10	26.79	**24.21**	▼
Bank WTE				21.12	17.46	19.64	21.09	17.23	18.77	17.73	20.74	23.92	19.02	23.59	25.10	**30.11**	▲
Trust rolling Annual Turnover %	**>=12%**	**10%<>12%**	**<10%**	16.97%	17.41%	16.76%	16.35%	17.06%	19.77%	21.72%	21.83%	21.16%	19.73%	19.01%	17.87%	**16.51%**	▼
Monthly Turnover				1.75%	1.41%	0.74%	0.43%	1.05%	3.20%	3.42%	1.57%	0.52%	2.00%	0.57%	0.37%	**0.56%**	▲
Sickness Absence %	**>=4%**	**4%<>3%**	**<3%**	*5.24%*	*4.89%*	5.97%	*6.12%*	6.50%	*4.26%*	3.33%	3.11%	*3.60%*	3.21%	4.20%	3.74%	***4.50%***	**Mar Indicative Figure**

Unqualified Nursing Workforce - Performance Indicators

Unqualified Nursing

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2017-18			Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Workforce KPIs (RAG Rating) 2018-19				Mar-19	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				107.92	107.92	107.92	107.92	107.92	107.92	100.79	100.79	100.79	100.79	100.79	100.79				*Note 1	100.79	◄►
Nursing Headroom				8.33	8.33	8.33	8.33	8.33	8.33	N/A	N/A	N/A	N/A	N/A	N/A					N/A	
Adjusted Establishment (removed Headroom (removed Headroom til 31/8/18. From 1/9/18 12% headroom included in establishment))				99.59	99.59	99.59	99.59	99.59	99.59	100.79	100.79	100.79	100.79	100.79	100.79					100.79	◄►
Staff In Post WTE				79.33	80.44	82.51	83.51	84.94	86.30	82.52	83.91	85.38	84.55	81.07	82.65					87.93	▲
Vacancies WTE				20.26	19.15	17.08	16.08	14.65	13.29	18.27	16.88	15.41	16.24	19.72	18.14					12.86	▼
Vacancies %	>12%	8%<=12%	<8%	20.34%	19.23%	17.15%	16.15%	14.71%	13.34%	18.13%	16.75%	15.29%	16.11%	19.57%	18.00%	>18%	12%<>18%	<12%		12.76%	▼
STARTERS WTE (Excluding rotational doctors)				0.00	0.00	2.00	2.00	2.00	1.00	0.61	2.00	3.47	2.00	0.00	3.84	TARGETS: XXX				2.00	▼
LEAVERS WTE (Excluding rotational doctors)				1.61	0.00	0.00	0.00	0.00	0.00	1.57	1.00	1.00	2.49	1.00	1.00					0.00	▼
Starters & Leavers balance				-1.61	0.00	2.00	2.00	2.00	1.00	-0.96	1.00	2.47	-0.49	-1.00	2.84					2.00	
Agency WTE				3.06	2.90	3.57	1.76	0.00	1.62	2.19	2.19	2.40	0.94	0.00	0.35					0.00	▼
Bank WTE *Note 2				6.90	5.46	6.51	7.96	10.07	8.13	7.76	7.95	7.29	5.92	7.80	8.75					8.05	▼
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<=12%	<10%	30.16%	29.64%	27.14%	25.08%	21.08%	20.26%	16.74%	14.51%	15.23%	16.16%	14.97%	12.08%	>=12%	10%<>12%	<10%		9.85%	▼
Monthly Turnover				2.05%	0.00%	0.00%	0.00%	0.00%	0.00%	2.02%	1.28%	1.26%	1.97%	1.34%	1.44%					0.00%	▼
Sickness Absence %	>=4%	4%<=3%	<3%	4.46%	1.23%	1.23%	2.43%	2.00%	4.33%	3.97%	8.87%	6.14%	4.08%	4.49%	6.85%	>=4%	4%<>3%	<3%		4.50%	March Indicative Figure

Medical Workforce - Performance Indicators

Metrics	2017/18 total / average	Target	Quarter 1 2018/19			Quarter 2			Quarter 3			Quarter 4			Year to date actual/ average
			April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Medical Workforce															
Turnover rate in month, excluding trainees	13.98% 12Mth rolling	<1%	85.00%	0.95%	0%	1.31%	1.60%	2.42%	0%	0%	1.16%	3.44%	0.96%	3.97%	20.60% 12 mth Rolling
Turnover in month including trainees 9%	51% 12Mth rolling		6.09%	2.12%	0.71%	10.76%	3.15%	2.10%	1.35%	0.68%	2.79%	2.77%	8.85%	2.46%	45.44% 12 mth rolling
Management cases monthly		0	1	1	3	3	1	1	1	1	1	0	0	0	5
Sickness rate monthly on total medical/dental headcount	2.77%		1.03%	0.55%	0.88%	0.86%	2.05%	1.18%	0.94%	1.19	1.09	1.19%	1.59%	Available May 19	1.20%
Appraisal rate monthly (exclude deanery trainees)	88.80% Mar 17		82.35%	83.60%	90.38%	87.90	82.83%	79.38%	83.54	89.09	88.13%	84.62%	79.73%	85.16%	82.04%
Mandatory training monthly		95%	85%	84%	83%	84%	81%	77%	78.7%	83%	84%	84%	87%	87%	83%
Exception Reporting – Education and Training			1	0	0	0	0	0	0	0	0	1	0	0	2
Exception Reporting – Hours			0	0	0	1	0	0	0	0	0	0	0	1	2

There are currently 103 doctors for whom the QVH is their designated body. The current appraisal rate is 86%. All doctors are revalidated with a licence to practice. Two positive recommendations for revalidation have been submitted in the previous two months, following a panel discussion at the Appraisal and Revalidation Group. No doctors are under a deferred decision.

Medical & Dental Staffing

A Mazars audit of the Consultant Contracts has concluded there is a satisfactory level of assurance regarding the standards of job planning and consultant contracts. There are 4 recommendations at level 2 and 3.

Applications for award of local Clinical Excellence Awards (LCEAs) have closed and a panel has been convened to meet on the 15th April 2019.

Education	12 new doctors in OMFS, plastic surgery and radiology joined the trust in April 2019. Induction feedback of the trust and departmental was excellent. The QVH hosted a core surgical plastics training day on the 14th March. The day included lectures and practical sessions on nail bed and tendon repair, with suturing tuition utilising pigs trotters. We also hosted the Trauma and Burns Course on the 27th March, teaching regional trainees and paramedics the skills required for the immediate treatment of burn injuries. The appreciated shown for the teaching on both courses was gratifying. On the 24th April, Mr Mike Williams will be delivering an evening lecture on the military history of maxillofacial surgery. The GMC National Trainee and Trainer surveys are currently open for responses.

NURSING METRICS - 12 MONTH ROLLING

BURNS WARD

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1	Rolling Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	**Incidents**	Total reported - All incidents	106	_	8	12	17	6	8	12	9	8	6	6	3		95		
2		Total reported - Patient safety	53	_	2	7	4	2	4	8	6	3	5	3	2		46		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	7	0	0	1	0	1	0	1	0	1	1	1	0		6		
6		Falls - With harm	3	0	0	1	0	0	0	1	0	0	0	1	0		3		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	0	1	0	0	0	0	0	0		1		
9	**MRSA Screening**	Elective patients	99.0%	95%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%		99%		
10		Trauma patients	99.0%	95%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%		99%		
11		Reported cases	1	0	1	0	0	0	0	0	0	0	0	0	0		1		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene	98%	95%	100%	100%	N/S	80%	100%	100%	100%	100%	100%	100%	100%		98%		
14		Bare below the elbows	100%	95%	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%		100%		
15	**Drug Assessments**	% staff compliant	92%	100%	87%	100%	100%	93%	100%	85%	92%	90%	80%	90%	100%		92%		
16	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
17		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
18		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
19	**Medication Errors**	Reported errors	8	0	0	1	0	0	1	1	2	1	1	0	0		7		
20	**Safety Thermometer**	Harm Free Care %	97.0%	95%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%		98%		
21		New Harm Free %	99%	95%	100%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%		98%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	96%	95%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%		
24		Monthly screening % (Informatics)	99%	95%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%		99%		
25	**Shift meets requirement** Day %	RN	97.0%	95%	97%	96%	97%	96%	97%	99%	101%	99%	98%	96%	91%		97%		Off set by additional HCA shifts
26		HCA	94.0%	95%	100%	64%	97%	93%	97%	84%	94%	95%	100%	100%	103%		93%		Additonal HCA hours used in place of registered due to patient dependancy
27	**Shift meets requirement** Night %	RN	98.0%	95%	98%	100%	97%	97%	97%	100%	100%	97%	100%	96%	98%		98%		
28		HCA	105.0%	95%	163%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		106%		
EFFECTIVE																			
29	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	99%	95%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%		
30		7 day review (Safety Thermometer)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
31	**Compliance in Practice** (CiP)	Inspection score	92%	80%	92.1%		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				#DIV/0!		
CARING																			
32	**Friends & Family Test**	Patient numbers (eligible to respond)	433	_	65	74	52	16	17	23	20	24	30	24	19		364		
33		% return rate	60%	40%	31%	7%	31%	100%	100%	62%	100%	100%	60%	75%	47%		65%		
34		% recommendation (v likely/likely)	98.0%	90%	85%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%		98%		
35		% unlikely/extremely unlikely	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%		

RESPONSIVE																			
36	**Complaints**	No. recorded	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
WELL-LED																			
37	**Vacancy** Establishment=	Full Team WTE	31.2										32.46		29.99		31		
38		Vacancy WTE	8.1	10%	6.72	6.72	6.48	7.77	7.51	9.02	8.12	9.02	9.3	9.86	9.25		8		
39		Vacancy (hrs)	1311.1	10%	1092	1092	1053	1263	1220	1465.8	1319.5	1465.8	1511.3	1602.3	1503.1		1326		
40	**Temporary Staffing** excluding RMN	Agency Use	301.8	10%	425	107.5	266.25	280	345	302.25	346.75	382.25	406.75	324.75	200.5		308		
41		Bank Use	465.98	10%	349	418	587.75	343.8	274.5	332	373.75	418.25	592.5	746.15	923		487		
42	**Sickness**	Hours	79.65			103.5	79.25	90	41.5	94.75	154	36.5	170	5	22.25		80		
43		%	1.6%	3%	1.0%	2.1%	1.6%	1.9%	0.9%	1.9%	3.2%	0.7%	3.5%	0.1%	0.5%		2%		All current sickness managed via HR policy
44	**Maternity**	Hours											0	0	0		0		
45	**Budget Position**	YTD Position	-86992	>0	62409	-39429	-44803	-40236	-10887	-704	-10195	354	-49955	5311					
46	**Statutory & Mandatory**	Mandatory training	93.0%	95%	89%	89%	91%	92%	93%	96%	97%	94%	94%	95%	94%		93%		Matron continues to work with staff to ensure increased training compliance.
47		Appraisal	89.0%	95%	82%	93%	92%	84%	88%	92%	79%	92%	88%	100%	96%		90%		Improving picture
48	**Uniform Audit**	Compliance with uniform policy %	98%	95%						100%	100%	100%	100%	100%	90%		98%		Ward matron to work with IPACT regarding trends

NURSING METRICS - 12 MONTH ROLLING

CRITICAL CARE UNIT

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20	Rolling Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	**Incidents**	Total reported - All incidents	181	_	11	16	8	18	25	17	15	7	15	16	17		165		
2		Total reported - Patient safety	145	_	6	11	8	17	23	13	12	7	10	16	12		135		
3		Formal internal investigation	1	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	5	0	0	1	0	0	1	0	2	0	0	0	0		4		
6		Falls - With harm	1	0	0	0	0	0	0	0	1	0	0	0	0		1		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	1	0	0	0	0	0	0	0	0	0	0		1		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	0	1	0	0	0	0	0	0		1		
9	**MRSA Screening**	Elective patients	100%	95%	100%	n/a	n/a	n/a	100%	100%	n/a	n/a	100%	n/a	n/a		100%		
10		Trauma patients	99.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	n/a	89%	100%		99%		
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene	97.0%	95%	100%	90%	93%	100%	N/S	100%	100%	100%	92%	87%	100%		96%		
14		Bare below the elbows	97.0%	95%	100%	100%	93%	100%	N/S	100%	89%	100%	100%	89%	100%		96%		
15	**Drug Assessments**	% staff compliant	98.0%	100%	100%	88%	93%	100%	93%	100%	100%	100%	100%	100%	100%		98%		
16	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
17		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
18		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
19	**Medication Errors**	Reported errors	6	0	2	0	0	0	1	0	0	0	0	1	2		6		Same patient ID21390 (02/03/2019) medication administered twice. ID21391 (02/03/2019) unable to locate precscribed medicine in pharmacy
20	**Safety Thermometer**	Harm Free Care %	96.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%		95%		
21		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	100.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
24		Monthly screening % (Informatics)	99%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%		99%		
25	**Shift meets requirement** Day %	RN	96.0%	95%	96%	99%	90%	99%	98%	94%	100%	90%	100%	99%	100%		97%		Shifts are met in accordance with patient numbers and acuity to ensure safety and quality care and staffing is maintained.
26		HCA	98.0%	95%	118%	91%	96%	100%	96%	96%	105%	96%	100%	91%	100%		99%		
27	**Shift meets requirement** Night %	RN	94.0%	95%	99%	96%	88%	95%	88%	89%	93%	87%	100%	100%	100%		94%		
28		HCA	115.0%	95%	113%	50%	50%	100%	100%	113%	100%	88%	91%	87%	100%		90%		
EFFECTIVE																			
29	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	97.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
30		7 day review (Safety Thermometer)	83.0%	95%	n/a	0%	n/a	n/a	n/a	n/a	100%	100%	100%	100%	na	na	80%		
31	**Compliance in Practice** (CiP)	Inspection score		80%	Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				#DIV/0!		
CARING																			

RESPONSIVE																			
32	**Complaints**	No. recorded	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
WELL-LED																			
33	**Vacancy** Establishment=	Full Team WTE	28								29.25		27.57	27.57	27.57		28		
34		Vacancy WTE	10.5	10%	9.59	11.01	10.48	10.98	11.02	11.92	11.73	10.73	9.44	9.44	9.44		11		Ward Establishment = 29.37 WTE
35		Vacancy (hrs)	1699	10%	1558	1789	1703	1784	1791	1937	1906	1743	1534	1534	1534		1710		
36	**Temporary Staffing** excluding RMN	Agency Use	751.7	10%	1035	976.5	918	965	940.5	884.5	828	218	347.5	437	520.5		734		
37		Bank Use	414.4	10%	246	172	171	271	327.5	432.25	691.05	667.25	591.75	499.5	677.75		432		
38	**Sickness**	Hours	301.4				360.5	221	187.5	423.5	357	362.5	416.5	223.5	160.5		301		
39		%	6.5%	3%	7.5%	5.0%	7.7%	4.6%	3.9%	8.9%	7.5%	7.6%	9.3%	5.0%	3.6%		6%		Long term sickness staff remains, with short term sickness. All managed within Trust policy
40	**Maternity**	Hours															#DIV/0!		
41	**Budget Position**	YTD Position	-217834	>0	-30308	-33259	-108905	51653	56696	11881	-2451	-118838	30575	16517			-62872		
42	**Statutory & Mandatory**	Mandatory training	89%	95%	86%	86%	87%	86%	88%	87%	84%	90%	96%	96%	94%		89%		Ward matron has plan in place to address
43		Appraisal	83.0%	95%	77%	81%	90%	85%	84%	89%	80%	89%	90%	81%	75%		84%		Ward matron has plan in place to address 2 staff outstanding
44	**Uniform Audit**	Compliance with uniform policy %	76%	95%						93%	64%	91%	92%	50%	69%		76%		HoN and Ward matron to discuss with IPACT regarding themes

NURSING METRICS - 12 MONTH ROLLING
MAIN OUTPATIENTS

Contact Nicky Reeves on 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20	Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	**Incidents**	Total reported - All incidents	155	_	7	14	12	16	12	15	18	10	20	12	19		155		
2		Total reported - Patient safety	42	_	2	1	3	4	2	7	5	5	2	6	5		42		
3		Formal internal investigation	2	0	0	0	0	0	0	0	1	0	0	0	1		2		ID21470 (18/03/2019): Infection Control Nurse investigating
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	1	0	0	0	1	0	0	0	0	0	0	0	0		1		
6		Falls - With harm	1	0	0	0	1	0	0	0	0	0	0	0	0		1		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	0	1	0	0	0	0		1		
8	**Inoculation Injury**	Reported incidents	3	0	0	0	0	0	1	0	0	1	1	0	0		3		
9	**MRSA**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
10	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
11	**Hand Hygiene**	Hand hygiene	89.0%	95%	89%	N/S	80%	100%	100%	90%	80%	60%	N/S	100%	100%		89%		
12		Bare below the elbows	100.0%	95%	100%	N/S	100%	100%	100%	100%	100%	100%	N/S	100%	100%		100%		
13	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			eported 1/4ly				0		
14		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			eported 1/4ly				0		
15		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			eported 1/4ly				0		
16	**Medication Errors**	Reported errors	2	0	0	0	0	0	0	1	0	0	0	1	0		2		
EFFECTIVE																			
17	**Compliance in Practice** (CiP)	Inspection score	90%	80%	90.3%		Reported 1/4ly			90.4%			eported 1/4ly				90%		
CARING																			
18	**Friends & Family Test**	Patient numbers (eligible to respond)	136854	_	12729	12866	12975	12813	11732	11983	13846	11143	14050	10465	12252		136854		
19		% return rate	17.0%	20%	16%	16%	16%	16%	17%	18%	16%	17%	18%	16%	17%		17%		Staff continue to respond to encourage patients to complete FFT
20		% recommendation (v likely/likely)	95.0%	90%	95%	94%	94%	94%	96%	95%	95%	96%	95%	95%	95%		95%		
21		% unlikely/extremely unlikely	2.0%	0%	2%	2%	2%	3%	2%	2%	2%	2%	2%	2%	2%		2%		

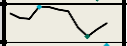
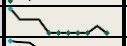
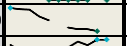
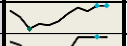
RESPONSIVE																			
22	**Complaints**	No. recorded	2	0	0	1	0	1	0	0	0	0	0	0	0		2		
WELL-LED																			
23	**Vacancy** Establishment=	Full Team WTE	15.4										15.37	15.37	15.37		15.4		
24		Vacancy WTE	1.4		1.18	1.18	1.81	1.82	1.76	1.32	1.32	1.25	1.25	1.25	1.6		1.4		
25		Vacancy (hrs)	232.5		191.7	191.7	294.12	295.7	286	214.5	214.5	203.12	203.1	203.1	260		232.5		
26	**Temporary Staffing** excluding RMN	Agency Use	0		0	0	0	0	0	0	0	0	0	0	0		0		
27		Bank Use	201.9		310.5	321.75	192.75	287.7	276	184	120.25	91.95	94.95	165	175.9		201.89		
28	**Sickness**	Hours	75.7			139	48	32	0	144	236.5	38	37.5	32	50		75.7		
29		%	3.6%	3%	8.9%	5.5%	1.9%	1.3%	0.0%	5.8%	9.5%	1.5%	1.5%	1.3%	2.0%		3.56%		
30	**Maternity**	Hours	0.0%		0	0	0	0	0	0	0	0	0	0	0		0		
31	**Budget Position**	YTD Position	-130815	>0	-6392	-12043	-8463	-11769	-12216	-8281	-15901	-6350	-25810	-23590			-112380		
32	**Statutory & Mandatory**	Mandatory training	94%	95%	90%	94%	97%	98%	92%	91%	92%	96%	98%	94%	93%		94%		matron working towards compliance
33		Appraisal	96%	95%	90%	80%		94%	95%	100%	100%	100%	100%	100%	100%		96%		
34	**Uniform Audit**	Compliance with uniform policy %	76%	95%						70%	80%	90%	N/S	70%	70%		76%		Requires further and sustained improvement. Matron monitoring all members of the MDT to ensure uniform policy is adhered to. Will raise issues with individuals to further address as required.

NURSING METRICS - 12 MONTH ROLLING

MARGARET DUNCOMBE

Contact Nicky Reeves on ext. 6607 for any formatting queries

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1	Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	**Incidents**	Total reported - All incidents	180	_	13	8	13	14	9	15	20	17	17	19	12		157		
2		Total reported - Patient safety	118	_	11	4	9	10	6	13	15	11	10	13	9		111		
3		Formal internal investigation	5	0	1	0	2	0	0	1	1	0	0	0	0		5		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	14	0	2	0	2	2	0	1	1	1	1	2	0		12		
6		Falls - With harm	4	0	1	0	0	1	0	0	0	1	0	0	0		3		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	2	0	0	0	0	0	0	0	0		2		
8	**Inoculation Injury**	Reported incidents	0	0	0	0	0	1	0	1	0	0	0	0	0		2		
9	**MRSA Screening**	Elective patients	97.4%	95%	98%	98%	98%	100%	91%	96%	98%	98%	96%	94%	97%		97%		
10		Trauma patients	95.4%	95%	93%	96%	100%	94.8%	97%	96%	93%	95%	96%	100%	95%		96%		Improvement from last month.
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene	100%	95%	100%	100%	100%	N/S	100%	100%	100%	100%	90%	90%	80%		96%		Matron doing "on the spot" checks. HoN to work with IPACT and matron to identify common themes.
14		Bare below the elbows	94.7%	95%	80%	100%	100%	N/S	100%	78%	80%	90%	85%	80%	80%		87%		Matron doing "on the spot" checks. HoN to work with IPACT and matron to identify common themes.
15	**Drug Assessments**	% staff compliant	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
16	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
17		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
18		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
19	**Medication Errors**	Reported errors	32	0	4	2	0	4	2	3	4	5	1	3	1		29		ID21441 (12/03/2019) - Oxynorm administerd beyond one month of opening and 11ml measurement discrepancy
20	**Safety Thermometer**	Harm Free Care %	97.0%	95%	100%	100%	93%	100%	85%	100%	100%	100%	100%	86%	100%		97%		Technical issue with establishing this metric for March, will be updated following liaison with national team
21		New Harm Free %	99%	95%	100%	100%	93%	100%	92%	100%	100%	100%	100%	100%	100%		99%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	98.0%	95%	92%	100%	87%	100%	100%	100%	100%	100%	100%	100%	100%	88%	97%		April 1 pt not screened although prescribed prophylaxis
23		Monthly screening % (Informatics)	97.0%	95%	96%	99%	99%	97%	97%	97%	93%	96%	92%	95%	100%		96%		
24	**Shift meets requirement** Day %	RN	98.0%	95%	98%	99%	99%	98%	97%	96%	97%	101%	100%	96%	99%		98%		
25		HCA	99.0%	95%	102%	104%	98%	102%	100%	95%	93%	96%	100%	100%	98%		99%		
26	**Shift meets requirement** Night %	RN	99.0%	95%	100%	96%	96%	98%	97%	102%	100%	100%	98%	97%	98%		98%		
27		HCA	92.0%	95%	103%	86%	82%	100%	88%	90%	88%	90%	100%	90%	91%		92%		Dependant upon patient acuity
EFFECTIVE																			
28	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	97%	95%	100%	92%	80%	100%	100%	93%	100%	100%	100%	100%	100%	100%	97%		
29		7 day review (Safety Thermometer)	92.0%	95%	100%	100%	80%	33%	100%	100%	100%	100%	100%	93%	100%	100%	92%		
30	**Compliance in Practice** (CiP)	Inspection score		80%	Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				#DIV/0!		
CARING																			
31	**Friends & Family Test**	Patient numbers (eligible to respond)	1624	_	124	125	128	131	111	140	147	159	144	132	139		1480		
32		% return rate	55.0%	40%	71%	55%	58%	57%	60%	41%	41%	47%	61%	49%	60%		55%		
33		% recommendation (v likely/likely)	99.0%	90%	99%	99%	100%	97%	100%	98%	100%	100%	100%	100%	98%		99%		
34		% unlikely/extremely unlikely	0.0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		0%		

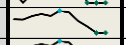
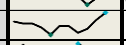
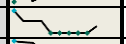
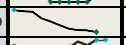
RESPONSIVE																			
35	**Complaints**	No. recorded	6	0	0	0	1	1	2	1	1	0	0	0	0		6		Ward matron regularly reviews complaints
WELL-LED																			
36	**Vacancy** Establishment=	Full Team WTE	49.2		49.08	48.67	49.04	49.54	49.54	49.54	49.54	49.54	48.66	48.66	48.66		49.1		
37		Vacancy WTE	11		11.21	11.13	12.16	12.74	12.12	13.72	13.22	10.67	9	7.16	7.16		10.9		
38		Vacancy (hrs)	1784		1822	1808	1976	2070	1970	2229.5	2148.3	1733.9	1462.5	1163.5	1164		1777.1		
39	**Temporary Staffing** excluding RMN	Agency Use	1258		1464	1242.5	1207	1789	1775.8	1642.8	1566.5	814	369.5	713.5	994		1234.4		We have used 304hrs of bank and agnecy over our vacancy.
40		Bank Use	856		940	899	901	823.5	673	851.75	847.3	717	794.75	970.2	1119		867.0		
41	**Sickness**	Hours	216.2		121	306	132	165	193	157.75	180.5	310.5	261.5	177.75	277		207.5		
42		%	2.7%	3%	1.5%	3.8%	1.6%	2.0%	2.4%	2.0%	2.2%	3.9%	3.3%	2.3%	3.5%		2.6%		2 people on long term sick
43	**Maternity**	Hours			127	69	69	69	0	0	0	0	0	37.5	0		#######		
44	**Budget Position**	YTD Position		>0	-72573	-96771	-102720	-214295	-273162		-391542	-419366	-420659	-450392			-2441480		
45	**Statutory & Mandatory**	Mandatory training	94%	95%	95%	93%	90%	91%	91%	92%	94%	96%	95%	96%	96%		94%		
46		Appraisal	93%	95%	95%	94%	88%	92%	90%	86%	90%	98%	98%	98%	98%		93%		
47	**Uniform Audit**	Compliance with uniform policy %	87%	95%						89%	80%	80%	95%	90%	87%		87%		Ward Matron to reguarly spot check staff in relation to complinace with uniform policy.

NURSING METRICS - 12 MONTH ROLLING

ROSS TILLEY

Contact Nicky Reeves on 6607 for any formatting queries

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19 May	June	Quarter 2 2018/19 July	Aug	Sept	Quarter 3 2018/19 Oct	Nov	Dec	Quarter 4 2018/19 Jan	Feb	Mar	Quarter 1 2019/20 Apr	Year to Date Actual	Trend	Comments
SAFE																			
1	**Incidents**	Total reported - All incidents	155	_	15	10	18	10	12	20	12	12	9	13	13		144		
2		Total reported - Patient safety	96	_	7	9	8	2	8	15	8	8	7	10	7		89		
3		Formal internal investigation	1	0	0	0	0	0	0	0	0	0	0	0	1		1		ID21464 (16/03/2019) - issue with use of CT scanner out-of-hours.
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	12	0	1	2	0	0	2	1	2	0	1	0	2		11		ID21403 (05/03/2019) Fall from bed ID21492 (20/03/2019) - Fall from commode
6		Falls - With harm	1	0	0	0	0	0	1	0	0	0	0	0	0		1		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	1	0	0	0	0	0	0	0		1		
9	**MRSA Screening**	Elective patients	98.0%	95%	94%	100%	100%	98%	94.9%	100%	97%	97%	98%	97%	100%		98%		
10		Trauma patients	96.0%	95%	97%	97%	95%	94%	94.9%	93.4%	94.7%	92.9%	98.0%	95.0%	97.0%		95%		
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
13	**Hand Hygiene**	Hand hygiene	97%	95%	100%	100%	100%	N/S	100%	100%	90%	90%	100%	100%	90%		97%		Matron completing spot checks for hand hygiene. HoN to liaise with IPACT to review trends
14		Bare below the elbows	93.0%	95%	80%	100%	100%	N/S	100%	100%	70%	90%	100%	100%	100%		94%		
15	**Drug Assessments**	% staff compliant	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
16	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
17		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
18		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
19	**Medication Errors**	Reported errors	31	0	2	1	3	1	2	7	4	3	0	2	3		28		ID21379 (01/03/2019): Dispensing error (Non-Pharmacy staff) ID21422 (08/03/2019): Prescribibg error ID21551 (29/03/2019): Patient forgot to take their own medicines home Staff encouraged to reoprt incidents. Individual staff members spoken to about errors.
20	**Safety Thermometer**	Harm Free Care %	100.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%		100%		
21		New Harm Free %	100.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	98.0%	95%	100%	93%	95%	100%	100%	100%	100%	94%	100%	95%	100%	94%	98%		April 1 patient not screened
23		Monthly screening % (Informatics)	95.0%	95%	96%	94%	97%	94%	94%	94%	94%	92%	97%	91%	97%		95%		
24	**Shift meets requirement** Day %	RN	98.0%	95%	96%	98%	100%	98%	97%	97%	97%	99%	100%	97%	98%		98%		
25		HCA	98.0%	95%	96%	98%	96%	102%	96%	92%	98%	100%	98%	98%	102%		98%		
26	**Shift meets requirement** Night %	RN	95.0%	95%	93%	90%	88%	97%	99%	99%	98%	98%	94%	97%	93%		95%		ward staffing risk assessmed and support give by site team as required
27		HCA	92.0%	95%	90%	97%	88%	85%	90%	97%	100%	68%	100%	100%	89%		91%		ward staffing risk assessmed and support give by site team as required
EFFECTIVE																			
28	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	100.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
29		7 day review (Safety Thermometer)	97.0%	95%	100%	n/a	75%	100%	100%	100%	100%	100%	100%	95%	100%	100%	97%		
30	**Compliance in Practice** (CiP)	Inspection score	88%	80%	Reported 1/4ly		Reported 1/4ly			88.2%			ported 1/4ly				88%		
CARING																			
31	**Friends & Family Test**	Patient numbers (eligible to respond)	2254	_	193	203	196	194	204	190	173	184	166	199	178		2080		
32		% return rate	40.0%	40%	39%	39%	29%	43%	31%	37%	39%	40%	48%	35%	44%		38%		Matron continues to promote the importance of this
33		% recommendation (v likely/likely)	99.0%	90%	100%	95%	100%	100%	98%	99%	100%	100%	97%	99%	99%		99%		
34		% unlikely/extremely unlikely	0.0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	1%	0%	0%		0%		

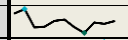
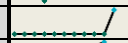
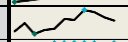
RESPONSIVE																			
35	**Complaints**	No. recorded	3	0	1	0	0	0	1	1	0	0	0	0	0		3		
WELL-LED																			
36	**Vacancy** Establishment=	Full Team WTE	49.2		49.08	48.67	49.04	49.54	49.54	49.54	49.54	49.54	48.66	48.66	48.66		49.1		
37		Vacancy WTE	11	10%	11.21	11.13	12.16	12.74	12.12	13.72	13.22	10.67	9	7.16	7.16		10.9		
38		Vacancy (hrs)	1784	10%	1822	1808	1976	2070	1970	2229.5	2148	1734	1463	1164	1163.5		1777.1		
39	**Temporary Staffing** excluding RMN	Agency Use	1258	10%	1464	1242.5	1207	1789	1776	1643	1566.5	814	369.5	713.5	994		1234.5		We have used 304hrs of bank and agnecy over our vacancy.
40		Bank Use	856	10%	940	899	901	823.5	673	851.8	847.3	717	794.75	970.2	1118.5		866.91		
41	**Sickness**	Hours	216.2		121	306	132	165	193	157.75	180.5	310.5	261.5	177.75	277		207.45		
42		%	2.7%	3%	1.5%	3.8%	1.6%	2.0%	2.4%	2.0%	2.2%	3.9%	3.3%	2.3%	3.5%		2.6%		Sickness managed as per policy
43	**Maternity**	Hours	50.6%		127	69	69	69	0	0	0	0	0	37.5			37.15		
44	**Budget Position**	YTD Position		>0	-72573	-96771	-102720	-214295	-273162	-333679	-391542	-419366	-420659	-450392			-2775159		
45	**Statutory & Mandatory**	Mandatory training	94.0%	95%	95%	93%	90%	91%	91%	92%	94%	96%	95%	96%	96%		94%		
46		Appraisal	93.0%	95%	95%	94%	88%	92%	90%	86%	90%	98%	98%	98%	98%		93%		
47	**Uniform Audit**	Compliance with uniform policy %	95%	95%						100%	90%	90%	100%	100%	90%		95%		Ward Matron undertaking spot checks with uniform compliance.

NURSING METRICS - 12 MONTH ROLLING
MAX FAC OUTPATIENTS

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1	Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	**Incidents**	Total reported - All incidents	50	_	5	5	3	4	1	3	4	3	5	7	6		46		
2		Total reported - Patient safety	19	_	1	0	0	2	1	3	1	2	1	2	4		17		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
6		Falls - With harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	**Inoculation Injury**	Reported incidents	2	0	1	0	0	0	0	0	0	1	0	0	0		2		
9	**MRSA**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
10	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
11	**Hand Hygiene**	Hand hygiene	99%	95%	100%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%		100%		
12		Bare below the elbows	100%	95%	100%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%		100%		
13	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
14		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
15		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
16	**Medication Errors**	Reported errors	3	0	1	0	0	0	1	0	0	0	0	0	1		3		ID21550 (29/03/2019) - Dispencing issue (Non-Pharmacy staff)
EFFECTIVE																			
17	**Compliance in Practice** (CiP)	Inspection score		80%	90.4%		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				#DIV/0!		
CARING																			
18	**Friends & Family Test**	Patient numbers (eligible to respond)	17136	_	1589	1378	1477	1442	1371	1683	1524	1107	1464	1191	1368		15594		
19		% return rate	18.0%	20%	18%	17%	17%	19%	16%	19%	17%	17%	17%	18%	18%		18%		Team aware to encourage patients to complete FFT, patients are contacted via text or phone now
20		% recommendation (v likely/likely)	93.0%	90%	92%	93%	94%	93%	94%	94%	93%	95%	96%	92%	93%		94%		
21		% unlikely/extremely unlikely	2.0%	0%	2%	1%	1%	3%	1%	3%	2%	1%	3%	4%	4%		2%		

RESPONSIVE																			
22	**Complaints**	No. recorded	8	0	2	1	2	0	0	0	2	0	0	0	0		7		
WELL-LED																			
23	**Vacancy** Establishment=	Full Team WTE	21.4						21.37	21.37	21.37	21.37	21.37	21.37	21.37		21.4		
24		Vacancy WTE	1.9		1.76	1.76	1.76	1.76	1.34	3.34	2.42	2.42	3.22	1.72	0.72		2.0		
25		Vacancy (hrs)	311.2		286	286	286	286	218	543	393.25	393.25	523.25	279.5	117		328.3		
26	**Temporary Staffing** excluding RMN	Agency Use	0		0	0	0	0	0	0	0	0	0	0	0		0		
27		Bank Use	153.9		214	245	115.5	120.75	162	169.25	117.9	76.75	149.55	140.15	158.75		151.78		
28	**Sickness**	Hours	139.7			120.5	133.8	33.75	198.5	55.5	171.25	62	219.25	313.67	89.25		139.75		
29		%	3.9%	3%	2.2%	3.5%	3.8%	0.9%	5.7%	1.6%	4.9%	1.8%	6.3%	9.0%	2.6%		3.8%		All monitored and correct action taken in adherence with Trust policy.
30	**Maternity**	Hours	12.5%		0	0	0	0	0	0	0	0	0	0	150		13.636		
31	**Budget Position**	YTD Position		>0	-913	1333	3754	6041	7423	14672	17258	27014	37739	44777			159098		
32	**Statutory & Mandatory**	Mandatory training	92%	95%	89%	92%	88%	89%	90%	94%	93%	97%	96%	94%	93%		92%		Matron wprking with all staff to improve compliance
33		Appraisal	97%	95%	88%	90%	92%	96%	100%	100%	100%	100%	100%	96%	100%		96%		
34	**Uniform Audit**	Compliance with uniform policy %	100%	95%						100%	100%	100%	100%	100%	100%		100%		

NURSING METRICS - 12 MONTH ROLLING

PEANUT WARD

Contact Nicky Reeves on 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4			Quarter 1	Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	**Incidents**	Total reported - All incidents	179	_	30	28	25	11	11	16	10	11	13	8	9		172		
2		Total reported - Patient safety	20	_	4	3	1	1	2	1	1	1	1	4	1		20		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	**Falls**	Falls - All	1	0	1	0	0	0	0	0	0	0	0	0	0		1		
6		Falls - With harm	1	0	1	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	0		0		
8	**Inoculation Injury**	Reported incidents	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	**MRSA**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
10	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
11	**Hand Hygiene**	Hand hygiene	78.0%	95%	N/S	70%	44%	N/S	70%	90%	90%	90%	80%	90%	80%		78%		Ward matron to address with staff, review trends.
12		Bare below the elbows	97.0%	95%	N/S	90%	100%	N/S	100%	100%	90%	90%	100%	100%	100%		97%		The matron is consistently asking the medical team to follow this rule.
13	**Drug Assessments**	% staff compliant	93.0%	100%	100%	94%	94%	100%	100%	93%	93%	84%	85%	87%	87%	93%	93%		Slight imporvement, staff member remains off sick
14	**Medication Audit**	Missed dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
15		Omitted dose			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
16		Total doses			Reported 1/4ly		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				0		
17	**Medication Errors**	Reported errors	4	0	1	1	0	0	0	0	1	0	0	1	0		4		
18	**Safety Thermometer**	Harm Free Care %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	92%		
19		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	92%		
20	**BMI Monthly**	Total no. of ward patients	2398	_	226	145	213	210	188	243	199	165	217	199	215		2220		Matron currently absent so unable to obtain accurate data.
21		No. patients screened & documented	2263	_	208	143	202	201	174	236	194	151	210	168	205		2092		
22		Patients with documented BMI %	94%	95%	92%	99%	95%	96%	93%	97%	97%	92%	96%	93%	97%		94%		Unable to enter %
	VTE (Venous Thrombo Embolism)	Assessment of patients (S. Therm)		95%												na			VTE screening applies to 16 and over from April 2019
		Monthly screening % (Informatics)		95%															
25	**Shift meets requirement** Day %	RN	98.0%	95%	100%	95%	98%	98%	99%	101%	98%	97%	98%	97%	96%		98%		
26		HCA	98.0%	95%	97%	103%	96%	100%	96%	97%	97%	97%	95%	97%	88%		97%		Safety maintianed
27	**Shift meets requirement** Night %	RN	86.0%	95%	98%	84%	85%	90%	80%	70%	70%	81%	97%	100%	95%		86%		
28		HCA	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
EFFECTIVE																			
29	**Compliance in Practice** (CiP)	Inspection score	91%	80%	91.1%		Reported 1/4ly			Reported 1/4ly			ported 1/4ly				#DIV/0!		
CARING																			
30	**Friends & Family Test**	Patient numbers (eligible to respond)	2242	_	224	199	201	199	164	200	185	152	189	170	187		2070		
31		% return rate	34.0%	40%	37%	33%	28%	38%	45%	31%	32%	36%	49%	23%	17%		34%		Staff are reminded regularly to give out FFT.
32		% recommendation (v likely/likely)	98.0%	90%	93%	98%	98%	95%	100%	100%	100%	98%	99%	100%	100%		98%		
33		% unlikely/extremely unlikely	0.0%	0%	0%	0%	1%	0%	0%	0%	0%	2%	0%	0%	0%		0%		

RESPONSIVE																			
34	**Complaints**	No. recorded	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
WELL-LED																			
35	**Vacancy** Establishment=	Full Team WTE	20.2								19.71			20.37	20.37		20.2		
36		Vacancy WTE	0.6		1.24	1.5	1.18	1.18	1.08	-0.08	-0.08	-1.08	0.38	0.3	0.94		0.6		
37		Vacancy (hrs)	92.11		201.5	244	191.75	191.8	175.5	-13	-13	-175.5	61.75	48.75	152.75		96.936		
38	**Temporary Staffing** excluding RMN	Agency Use	60.52		110	71	92.5	68.5	69.5	74	69.5	0	48.5	41.5	53.25		63.477		
39		Bank Use	309.8		413	472.5	488.4	366.5	284.5	339.55	321.25	223	189	238.75	189.5		320.54		
40	**Sickness**	Hours	130.1			161.5	84	24	40	96	181	76	220.25	205.95	212		130.07		
41		%	3.7%	3%	1.0%	4.9%	2.6%	0.7%	1.2%	3.0%	5.7%	2.4%	6.7%	6.2%	6.4%		3.7%		1 staff member on long term sickness.
42	**Maternity**	Hours															#DIV/0!		
43	**Budget Position**	YTD Position		>0	5968	7514	4051	2932	7797	13962	17375	11940	30457	33223			135219		
44	**Statutory & Mandatory**	Mandatory training	93%	95%	92%	93%	93%	91%	94%	95%	94%	94%	93%	92%	91%		93%		Ward matron emailing individuals
45		Appraisal	88%	95%	83%	91%	91%	91%	96%	96%	92%	92%	83%	92%	71%		89%		One staff member on long term sick.
46	**Uniform Audit**	Compliance with uniform policy %	88%	95%						100%	100%	90%	70%	80%	90%		88%		Spot checks. Ward matron to identify trends

NURSING METRICS - 12 MONTH ROLLING

SLEEP DC

Contact Nicky Reeves on 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19		Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4			Quarter 1	Year to Date Actual	Trend	Comments
					May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr			
SAFE																			
1	Incidents	Total reported - All incidents	25	_	0	2	3	2	1	1	2	4	1	1	5		22		
2		Total reported - Patient safety	9	_	0	0	0	2	0	0	1	2	1	1	1		8		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
5	Falls	Falls - All	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
6		Falls - With harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
7	Pressure Damage	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
8	Inoculation Injury	Reported incidents	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
9	MRSA	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
10	C Difficile	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0		0		
11	Hand Hygiene	Hand hygiene	100%	95%	100%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%		100%		
12		Bare below the elbows	100.0%	95%	100%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%		100%		
13	Medication Errors	Reported errors	4	0	0	0	0	1	0	0	1	1	0	0	1		4		ID21494 (18/03/2019): Prescribing error
14	VTE	Monthly screening % (Informatics)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
EFFECTIVE																			
15	Compliance in Practice (CiP)	Inspection score	91%	80%	Reported 1/4ly		Reported 1/4ly			90.6%			eported 1/4ly				91%		
CARING																			
16	Friends & Family Test	Patient numbers (eligible to respond)	10086	_	851	919	896	792	653	921	907	559	939	794	867		9098		
17		% return rate	19.0%	20%	18%	17%	22%	24%	19%	19%	16%	22%	22%	16%	19%		19%		
18		% recommendation (v likely/likely)	97.0%	90%	99%	96%	97%	97%	97%	98%	97%	95%	96%	98%	98%		97%		
19		% unlikely/extremely unlikely	1.0%	0%	0%	2%	1%	1%	1%	1%	2%	2%	2%	1%	0%		1%		
RESPONSIVE																			
20	Complaints	No. recorded	1	0	0	0	0	0	0	0	1	0	0	0	0		1		
WELL-LED																			
21	Vacancy Establishment=	Full Team WTE															#DIV/0!		
22		Vacancy WTE		10%													#DIV/0!		
23		Vacancy (hrs)		10%													#DIV/0!		
24	Temporary Staffing excluding RMN	Agency Use		10%													#DIV/0!		
25		Bank Use		10%													#DIV/0!		
26	Sickness	Hours															#DIV/0!		
27		%		3%													#DIV/0!		
28	Maternity	Hours															#DIV/0!		
29	Budget Position	YTD Position		>0													0		
30	Statutory & Mandatory	Mandatory training		95%													#DIV/0!		
31		Appraisal		95%													#DIV/0!		
32	Uniform Audit	Compliance with uniform policy %	100%	95%						100%	100%	100%	100%	100%	100%		100%		

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**82-19**	
Report title:	**Business Case for the Development of Paediatric Burns Services**				
Sponsor:	Dr Ed Pickles, Medical Director				
Author:	Emer Keating, KSS Darzi Clinical Leadership Fellow				
Appendices:	5 Appendices to report				
Executive summary					
Purpose of report:	To discuss options to improve inpatient paediatric burns services in Kent, Surrey and Sussex, in particular the preferred option of a shared inpatient and outpatient services with the Royal Alexandra Children's Hospital, Brighton				
Summary of key issues	BoD to note operational, clinical and financial risks of proposal				
Recommendation:	BoD to support collaborative working with London and South East Burns Network and Commissioners to seek alternative mitigation of the current service risks, whilst exploring further options with BSUH.				
Action required *[highlight **one** only]*	Approval	Information	**Discussion**		
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:	KSO2 BAF				
Corporate risk register:	CRR 968; CRR 1059				
Regulation:	Burns Care Standards 2013, 2018, CQC, NHSE Spec Comm				
Legal:	Nil				
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

BUSINESS CASE FOR THE DEVELOPMENT OF PAEDIATRIC BURNS SERVICES

Version 1

Date: 23 April 2019

Approvals Process

This case has been approved by the following individuals and groups:

(Subject to Trust governance processes)

Contents

1. Executive Summary 6
2. Introduction and background 7
3. Strategic Context and Drivers for Change 8
3.1. Strategic Context 8
3.2. Drivers for Change 10
4. Service Objectives 12
5. Current Service 12
6. Future Service 13
6.1. Future service specification 14
6.2. Activity Profile 16
7. Delivery Model 18
7.1. Future service delivery model - options 18
7.2. Preferred delivery model 20
8. Implementation Plan 28
9. Financial Analysis 31
10. Benefits of the future service proposed 31
10.1. Intended benefits 31
10.2. Benefits measures 32
11. Risks 32
12. Conclusion and recommendation 35
13. APPENDICIES 37

1. Executive Summary

This business case sets out the options for improving burn care services for children within Kent, Surrey and Sussex (KSS). Currently, Queen Victoria Hospital (QVH) provides burns care services for Paediatric and Adult patients from the South East of England. Over the last 15 years a number of service reviews have made recommendations for the improvement burns care in the South East. In 2013 newly issued National Burns Care Standards specified that burns units must be co-located with a number of other clinical services, which are not available on the QVH site. Meeting the Burns Care Standards by providing these additional services would require significant infrastructure changes, which are not considered possible on the QVH site.

The London and South East Burns Network (LSEBN) agreed that as an interim measure burns services should continue to operate at QVH with derogation against a number of standards. NHS England (NHSE) asked QVH to consider an alternative service model working with partners to ensure future compliance with Burns Care Standards.

The current lack of compliance affects all three-quality indicator domains (NHS England, 2018):

1. Treating and caring for people in a safe environment and protecting them from avoidable harm
2. Ensuring that people have a positive experience of care
3. Enhancing quality of life for people with long-term conditions.

QVH have put in place extensive controls and mitigations to address the insufficiencies in the current service model including adjusting the clinical criteria for admission to the service to mitigate clinical risk. However, managing the service in this way increases quality; safety and patient experience risks and has an impact on the sustainability of the service. The clinical criteria now in place and a national downward trend have resulted in a decreasing number of paediatric inpatient burn patients attending QVH, reducing affordability and further increasing the risks to service sustainability. Specifically, higher numbers of patients are currently unsuitable for admission to the service and have to travel out of area for emergency burn care treatment. There has also been an impact on the Trust's ability to recruit, retain and maintain the skills of the staff that deliver this service. Following the derogation there was an increased turnover of nursing staff and whilst the reasons for this are multifactorial the mitigations required and uncertainty about the future of the service may have contributed. Changes to clinical thresholds have reduced training opportunities and exposure to more complex burn injuries for staff at QVH further impacting on recruitment and retention.

It was therefore agreed with commissioners that options for the future provision of the paediatric burns service should be considered with the aim of:

1) Ensuring increased compliance with the requirements of the National Burns Care Standards 2018 (British Burn Association, 2018) and NHSE specialist commissioning specification for Burns.
2) Retaining burn care services within Kent Surrey and Sussex providing access for a population of 4.6million
3) Ensuring the future provision of paediatric burns is clinically, operationally and financially sustainable
4) Aligning the future provision of paediatric and adult burns services.

In order to develop a service model that could better meet the Burns Care Standards and address the service risks outlined above a number of options, were developed and evaluated including:

- Do nothing.
- QVH investing in meeting service specifications/standards.
- Divestment of paediatric services to other partners in the network.
- QVH developing an acute inpatient paediatric burn service in collaboration with a District General Hospital (DGH) within KSS.
- QVH developing an acute inpatient paediatric burns service in collaboration with Royal Alexandra Children's Hospital (RACH).
- QVH developing an acute inpatient paediatric burns service with an outpatient provision for the local population in collaboration with RACH.

The preferred option identified following initial evaluation (as detailed in the 2016 Strategic Outline Case), was for QVH to develop an acute inpatient paediatric burn service with an outpatient provision for the local population in collaboration with RACH. The RACH is the only children's hospital in the South East, with an age appropriate A & E and trauma unit status and provides a comprehensive range of paediatric services including a paediatric High Dependency Unit (HDU). The preferred option would utilise the expertise and resources of QVH's

burns/plastics surgeons who currently provide a plastic surgery service at Bright and Sussex University Hospitals (BSUH) maximising resource utilisation and cost effectiveness. The option also builds on an existing clinical arrangement where medically unwell paediatric burn patients are transferred to the RACH meaning the RACH paediatricians have experience in caring for this patient group. Offering additional outpatient provision at the RACH would increase patient choice and reduce travel times, therefore improving patient experience.

In order to ensure the evaluation of the options was robust, future inpatient numbers were estimated based on past activity and underlying trends. This analysis concluded that the future annual inpatient numbers would be approximately 40 with an average length of stay of 3 days. This level of activity significantly impacts on the viability of the preferred option. Whilst all the standards applicable to a Burn Facility can be met, full compliance with Burn Unit standards cannot be achieved without significant additional resources which will not be matched by additional income. Nevertheless, the preferred model can significantly improve the care of deteriorating patients and will better meet service standards; resulting in a reduced number of out of region transfers.

The preferred model splits the provision of paediatric burns from adults and paediatric inpatients from outpatients. The geography means that it would be difficult to utilise scarce specialist burns staff effectively across both the QVH and RACH sites. This will result in duplication of some roles and extensive part time working. It is unlikely that this will reduce the current recruitment, training and retention risks for these staff.

Financial evaluation of the preferred model has demonstrated that the service cannot be provided within current resources. There is a £116k capital requirement to set up the service at BSUH. Whilst the preferred option will generate £373k income per annum, the revenue costs are expected to be £660k in the first year including the revenue costs of implementation. This would result in a loss of £287k in the first year of operation reducing to £245k thereafter providing activity levels remain constant. The increase in cost is driven by additional staffing costs incurred by both QVH and BSUH to create the service and staffing infrastructure required to support delivery at the RACH.

In order to mitigate additional staffing costs as much as possible joint work between RACH and QVH identified the optimal delivery and staffing model for the specialist services required to support the preferred option. The provision of outpatient services at RACH helps to maximise the use of the additional specialist staff required as well as increasing opportunities for skill retention and improving patient satisfaction.

In addition to the financial risks, the preferred option generates a number of operational and clinical risks related to the need to provide highly specialised treatment and skilled staff to a low volume of patients with unpredictable levels of activity. Mitigations to these new risks have been explored but it is not considered sufficiently robust to reduce the risks to acceptable levels.

In conclusion, the preferred option of developing an acute inpatient paediatric burn service at the RACH has been fully risk assessed and is not considered sufficiently viable to be approved by the Board for implementation.

It is therefore recommended that the Board agrees that the next step is to further engage with commissioners to seek their support in either providing additional mitigations or in identifying whether any other option can be implemented with reduced levels of risk.

2. Introduction and background

2.1 Background

QVH provides burns care services for Paediatric and Adult patients across the South East of England. The burns service consists of: referral and assessment, acute care, follow up care, rehabilitation and reconstruction. Over the last 15 years there have been numerous reviews, which have made recommendations to improve burns care services in the South East. QVH has responded to each of the reviews to date making the recommended service improvements without needing to radically change the configuration of burns services provided by its Specialised Burns Unit. However, in 2013 National Burns Care Standards specified that burns units must be co-located with a number of other clinical services which are not available on the QVH site. Meeting the Burns Care Standards by providing these additional services would require significant infrastructure changes at QVH, which are not possible on the current site.

The London and South East Burns Network (LSEBN) agreed that as an interim measure the burns service should continue to operate at QVH and a derogation was agreed against a number of standards. NHSE asked

QVH to consider an alternative service model working with partners to ensure future compliance. Existing services were assessed as being safe and able to deliver clinical appropriate care/outcomes under the derogation. Maintaining the current position was supported by LSEBN and NHSE.

In March 2016, a Strategic Outline Case (SOC) was developed, including an assessment of the options for meeting the required burns standards. The SOC identified the preferred option as a joint working model between the RACH and QVH to provide elements of the paediatric burn service. The financial impact of the new service model was significant and a request made to NHSE to assist with meeting these costs was not agreed. The preferred solution was not progressed and the paediatric burns service continued to operate at QVH under a derogation.

2.2 Scope of the case

In 2018, it was agreed that further work should be undertaken to progress the preferred option for the provision of paediatric burns services. This document sets out the proposed new model of care for the Paediatric Burns service which will be delivered through a collaborative arrangement between QVH and BSUH. The care model will be based on inpatient care, with elements of outpatient's provision for the local population being provided by RACH.

2.3 Adult Burns

Whilst the adult burns service at QVH receives very positive patient feedback and achieves high standards in terms of clinical outcomes, it does not meet the national burns standards for adult burns services. The adult burns service is outside the scope of this business case and would require a separate business case. However, it is relevant to this business case that there may be potential in the longer term for elements of both adult and paediatric burns services to be co-located geographically on the Royal Sussex County Hospital / Royal Alexandra Children's Hospital site.

3. Strategic Context and Drivers for Change

3.1. Strategic Context

3.1.1 Clinical context

Most burn injuries occur in the home with the most common cause being a scald from a hot drink. People in the lowest socio-economic groups are at greatest risk of sustaining a burn injury and children are more likely to suffer a burn injury than other age groups. A burn injury can have a variety of aetiologies including thermal (flash, contact, scald, radiation), electrical (low voltage, high voltage) and chemical (acid, alkali).

The severity of a burn is dependent on size, the anatomical site of the injury, the depth of the burn, the age of the patient and the presence of an inhalation injury or other significant co-morbidities. All of these factors influence morbidity and mortality. Infection is a major complication of burn injury. Burn injuries can have a significant, sustained and profound physical, psychological and social effect on the patient, family and carers. It can be one of the most severe forms of trauma and therefore treatment in specialised services is required.

Treatment factors that impact on outcomes include early fluid resuscitation, prompt wound care, and timely access to effective surgical and therapeutic management (including surgical excision). Quality indicators for burn care include surgical management, adequate analgesia, optimising psychological well-being, optimising functional outcomes, patient safety, mortality, survival and compliance with National Burn Care Referral Guidance (NHS England, 2018).

3.1.2 National context

The complexity and rarity of burn injuries makes delivering burn care a specialised service. Although significant advances have been made in burn care over recent decades, it is recognised that to achieve the best possible clinical outcome for burn injured patients, burn care must be delivered by expert multidisciplinary teams (MDT) in specialised burn services. Burn care services and burn care networks have developed organisational processes

to meet the complex needs of these patients while at the same time ensuring care is delivered as close to home as soon as possible.

In England and Wales, burn care services are organised on a tiered model of care:

- **Burn Centre**: This level of in-patient burn care is for the highest level of injury complexity and offers a separately staffed, geographically discrete ward. The facilities are up to highest level of critical care and have immediate operating theatre access.

- **Burn Unit**: This level of in-patient burn care is for the moderate level of injury complexity and offers a separately staffed, discrete ward.

- **Burn Facility**: This level of in-patient burn care equates to a standard plastic surgical ward for the care of non-complex burn injuries.

There are four Operational Delivery Networks for specialised burns across England and Wales. The London and South East Burns Network (LESBN) serves a population of around 21 million people, living in London, the East of England, Kent Surrey and Sussex, Thames Valley and Wessex.

Hospitals within the LSEBN	Designation
St Andrew's Burn Centre, Broomfield Hospital, Chelmsford	Centre for adults and children
Chelsea and Westminster Hospital, London	Centre for adults, Unit for children.
Queen Victoria Hospital, East Grinstead	Unit for adults and children
Royal London Hospital	Facility for adults and children
Stoke Mandeville Hospital, Aylesbury	Unit for adults and children
John Radcliffe Hospital, Oxford	Facility for adults and children.

The LSEBN aims to broaden the network and include other hospitals in the provision of specialist burn care and reduce the need for patients and families to travel long distances for specialist care for less severe injuries.

3.1.3 Local context

QVH

The QVH service is a key part of the LSEBN. It covers Kent, Surrey, Sussex and parts of South London and serves a population of 4.6 million. Children from this area are also referred to Chelsea and Westminster or Broomfield Hospital in Chelmsford depending on their location and/or the severity of their burn. The service at QVH is multidisciplinary and includes inpatient care, outpatient clinics, physiotherapy, occupational therapy, psychological support, rehabilitation services and reconstruction clinics.

The QVH Outreach Burns Service also provides specialist care for burn patients within the region that cannot be transferred to the Burns Unit or with smaller burns who can be managed as out-patients nearer home.

BSUH

The RACH is commissioned to provide local paediatric services by all Sussex CCGs and a range of specialised services by NHSE. It provides outpatient services, day surgery and inpatient facilities, high dependency care and has the only dedicated children's emergency department and trauma unit in the South East Coast region. The service is supported 24/7 by a team of paediatric anaesthetists and paediatric radiologists.

The RACH currently provides the following aspects of paediatric burn care:

- Assessment and treatment of emergency patients who present to the emergency department with appropriate onward referral to a Burn Centre or Unit.
- High dependency care and stabilisation of medically deteriorating paediatric burns patients transferred from QVH.
- A location for consultant led paediatric burn and plastic outpatient clinics for local patients, delivered by the QVH team.

3.2. Drivers for Change

3.2.1. Burn Care Standards

Burn care standards were developed following the National Burn Care Review in 2001 as a tool to assess the capability of burn care services, the quality of burn care and ensure equity in specialised burn care provision. Over the last 15 years a number of key policy documents have been published, which have continued to challenge commissioners and providers alike to provide adequate solutions.

In 2013 the National Burn Care Standards were revised and all specialised burn care services were required to perform a self-assessment (British Burn Association, 2013). QVH produced a compliance gap analysis against the standards demonstrating that the service was not fully compliant with the standards required for a paediatric Burns Unit. Specific gaps in on-site services were identified including:

- 24/7 paediatric cover from a Consultant Paediatrician who can attend within 30 minutes and does not have responsibilities on other hospital sites.
- Emergency department provision.
- Trauma unit provision.
- 24/7 pathology (including microbiology and transfusion services).
- 24/7 radiology including CT, MRI, USS and Doppler.
- Paediatric HDU provision
- Access to critical care services for neonates.
- Additional clinical services on site including: paediatric surgery, trauma and orthopaedics, renal services, liaison mental health, neurology, neurosurgery, cardiothoracic surgery, dermatology, urology and ENT.

Access to Paediatric Medical Cover

Many children who have burn injuries are under 2 and/or have complex social or complex medical issues. Children with burns, also have a high risk of wound infection and toxic shock syndrome and can become acutely unwell very quickly, requiring paediatric medical input as well as access to high dependency care.

Whilst appropriate admission thresholds and transfer criteria for paediatric burns patients are well established and can mitigate some of the potential clinical risk, there is still a requirement to transfer some children to other providers so that they can receive the specialist paediatric medical care and access to other clinical services that are not available QVH site.

Co-location with the support services of an acute hospital

The standards dictate that, all specialised burn services (Centres, Units and Facilities) need the full range of support services on site including: emergency departments (EDs), general surgery, orthopaedics, blood bank and advanced scanning.

The lack of on-site services can pose a potential risk to patients. For example, unexpected complications can occur whilst patients are waiting to transfer to another hospital, owing to the lack of immediate access to onsite services.

QVH does not have the full range of onsite facilities as an acute hospital. For example there is currently no co-located ED, blood transfusion laboratories, surgical services, orthopaedic, surgical or paediatric provision. In addition, access to a range of clinical services should be available at all times on the same site as burns care services. The existing gaps in service availability are in the following additional areas: emergency medicine; general/paediatric surgery; general/paediatric medicine; neurology; neurosurgery; cardiothoracic surgery; renal services; orthopaedic surgery; radiology and advanced scanning- Computerised Tomography (CT) and Magnetic Resonance Imaging(MRI); microbiology; transfusion services.

Co-location of Burns services with a Major Trauma Centre/unit

The standards identify the co-location of adult and paediatric burn services with a major trauma unit as essential and major trauma centre as desirable. Although the incidence of patients with major trauma injury and severe burn injury is rare, when they occur these are very serious injuries and patients have very complex care needs.

To provide the full range of burns care, co-location with trauma facilities on a site that has the capability and capacity to treat both major trauma and major burn injuries is seen as important. The advantage of co-location includes;

- Onsite access to a full complement of disciplines (workforce and facilities) to support patients (e.g. radiology, renal medicine, cardiothoracic surgery, and neurosurgery);
- Major Trauma Centres / units providing a 24/7 consultant led emergency department service and similar key support services;
- Benefit from clinical processes and pathway management for major trauma patients that have similar characteristics as that for burns patients.

The lack of compliance with the burn care standards affects all three-quality indicator domains (NHS England, 2018) as follows.

1) **Treating and caring for people in a safe environment and protecting them from avoidable harm.**

    a) The lack of supporting services and the requirement to transfer deteriorating patients can lead to treatment delays and risks avoidable harm. 18% of QVH inpatient paediatric burns patients have required an emergency transfer in the past year.

2) **Ensuring that people have a positive experience of care.**

    a) Treatment delays can also impact on patient and carer experience; as do transfers due to loss of continuity of care.

3) **Enhancing quality of life for people with long term conditions**

    a) For some children, particularly those with a higher percentage burn, a burn is a long term condition. Patients with higher burn percentages have to travel further for emergency treatment and aspects of ongoing care which can impact on their quality of life.

Amended National Burn Care Standards were issued in November 2018. An initial assessment against these standards demonstrates that the paediatric burns service provided by QVH remains non- compliant against 61 of the 353 standards for burns facilities and units including essential and desirable standards. The significant areas of non-compliance remain the provision of co-located services as set out above. The Burns Standard Review Group advise that services self-assess every two years and that formal peer review and designation take place every four to five years. QVH last completed a self-assessment in 2014 and had a peer review in 2009.

3.2.2 Current service risks that we are intending to address

By failing to meet the burn care standards both the organisation and patients are at risk. The key risks that we are aiming to address through a revised service model include:

- Transfers due to acute deterioration.
- Delays in access to care because patients cannot be accepted at their nearest burns service.
- Patients travelling long distances for care
- Avoidable harm to patients due to treatment delays and emergency transfers.
- Poor patient and family experience due to the above.

4. Service Objectives

4.1 Objectives of the future provision

Objectives	Why?
1. To achieve compliance with the nationally mandated standards for burn care.	• To improve the quality of service provided by: • Reducing the number of unnecessary transfers • Reducing the number of patients who are refused admission to the service. • Reducing delays in accessing care. • Reducing the risk of avoidable harm to patients. • Improving patient experience and outcomes.
2. To retain burn care services within Kent Surrey and Sussex providing access for a population of 4.6m	• To ensure equity of access to specialised burn care services. • Minimise travel times for the catchment population • Improve patient experience and quality of life.
3. To ensure the future provision of paediatric burns is clinically, operationally and financially sustainable	• To ensure the future service is affordable and does not present a increased level of financial risk • To maintain all relevant clinical skills and experience for burns provision • To ensure the future service can recruit appropriate staff • To ensure the service meets operational requirements and targets
4. To align the future provision of paediatric and adult burns services	• To deliver economies of scale and a centre of excellence for burns provision in Kent, Surrey and Sussex

5. Current Service

Burn care inpatient activity is predominantly driven by emergency admissions and a small number of elective cases for reconstructive surgery. The specialised care pathway (Appendix 1) includes emergency assessment and treatment; follow up assessment and treatment and surgical reconstruction. Emergency referrals to QVH are assessed and triaged against the agreed clinical threshold as; requiring advice only, being accepted by the service or as above the threshold requiring onward referral.

If accepted the patient will be booked in for an assessment in the Paediatric Assessment Unit (PAU) or admitted onto the children's ward (Peanut). Patients who do not require immediate review e.g. new burns of less than 5% will be reviewed in the PAU within 24 hours of their burn; all others will be transferred directly to the ward for inpatient care. PAU is a dedicated nurse led outpatient unit providing assessment and treatment to burns and plastics patients.

The goal is for patients to be healed within 21 days; some patients require surgery for this goal to be met. Patients are discharged from PAU as soon as their burn has healed or are referred to the paediatric scar management clinic (PSCAR) fur further management. Patients are referred to the consultant Paediatric Burn

Clinic (PBC) if conservative treatment is not effective or a consultant opinion is required. The PBC is a consultant led clinic for patients who take longer than three weeks to heal. They are reviewed at least annually, patients requiring further treatment move onto the plastics pathway as plastics patients.

BSUH provides critical care for the stabilisation and treatment of medically deteriorating paediatric burns patients transferred from QVH.

5.1. Gap analysis of the current service.

The service does not meet 50 of the essential and 11 of the desirable standards (See Appendix 1 - Self-assessment) when measured against Facilities and Units. The gaps in compliance with Burns Standards, which have potential to significantly impact patient care, are the lack of provision of:

- 24/7 paediatric cover from a Consultant Paediatrician who can attend within 30 minutes and does not have responsibilities on other hospital sites. A Service Level Agreement (SLA) with BSUH provides paediatric cover but the clinicians have responsibilities for the RACH and only routinely attend QVH for four hours on a Monday, Wednesday and Friday Outside these hours telephone support is provided and deteriorating patients are transferred to RACH if appropriate.
- Emergency department provision.
- Trauma unit provision.
- HDU provision
- 24/7 pathology (including microbiology and transfusion services). A SLA with BSUH is in place for the provision of these services. This provides seven sample pick-ups between 07:30 and 23:30 with urgent requests requiring taxi transport to the laboratories at either the Royal Sussex County Hospital (RSCH) or Princess Royal Hospital (PRH).
- 24/7 radiology including CT, MRI, Ultrasound and Doppler. MRI is available at QVH in hours three days a week. Plain x-ray, ultrasound, Doppler and cone beam CT are available daily in hours. An on call service operates out of hours.
- Burn care ward specifically for burn injured patients. The paediatric ward at QVH has all single cubicles but covers all specialities; current volumes of paediatric burn patients have not been sufficient to justify a dedicated ward.
- 75% or more Nurses at Band 6 and above who have undertaken a formal period of accredited academic study in burn care. 50% of nurses have undertaken formal accredited study.
- Treatment for the minimum number of patients. A designated children's Burn Unit is expected to treat at least 30 patients requiring unit level care a year. The number of referrals for inpatients greatly reduced last year due to a fall in the overall numbers of paediatric burns patients, cautious triage and reduced staffing. There is also an impact because the service is currently operating below the official unit threshold due to the derogation

Whilst QVH have implemented strict controls and put in place extensive mitigations to address the insufficiencies in the service model, there is a higher risk in managing the service in this way. These strict control and mitigations have resulted in higher numbers of patients being refused by the service and having to travel out of area for emergency burn care treatment. By removing patients at the upper limit of the threshold and those with co-morbidities it has reduced training opportunities and exposure to more complex burn injuries for staff at QVH. There was a loss of nursing staff during this period, whilst the cause was multifactorial the mitigations and uncertainty of the future of the service may have contributed to this. These mitigations along with a national trend have resulted in a decreasing number of paediatric burn patients attending QVH, resulting in reduced affordability and ultimately the sustainability of the service.

Without an alternative solution the provision of a paediatric burns unit service in the Kent, Surrey and Sussex region will be unsustainable. Redesigning the delivery model offers a significant opportunity to further improve and retain this service within the region by ensuring not only improved compliance with National Standards but also the ability to the meet the services objectives. Although not part of this business case it is worth noting that an adult burns is also in agreed derogation of the National Burns Standards due to the lack of co-location of services/ facilities. There may be potential in the longer term for elements of both adult and paediatric burn services to be co-located geographically on the Royal Sussex County Hospital / RACH site.

6. Future Service

6.1 Future service specification

6.1.1 Vision/intention for the new service

The intention is that QVH will continue to provide a paediatric burns service with changes being made to the location of emergency inpatient care to ensure that it is compliant with the requirements of the National Burns Care Standards 2018 (British Burn Association, 2018) and NHS England specialist commissioning specification for Burns.

6.1.2 Key elements of the future service

Key to ensuring the future service objectives are met are:

- An ability to recruit and retain a full complement of staff required to deliver the service, with appropriate training or willingness to be trained in burns specific skills.
- Appropriate training programmes for staff to maintain burn specific skills.
- Paediatricians to form part of the MDT
- On-site support services that meet the service standards and the needs of inpatients.
- Location within KSS.
- Suitable bed and theatre capacity to provide:
- Emergency and elective inpatient paediatric admissions
- Elective and urgent day case patients risk assessed to need increased medical support during surgery or post operatively.
- An affordable service that is financially sustainable.
- No change is required for lower risk day case surgery or the outpatient provision.
- Suitable space / capacity for adults burn provision in the future to ensure co-location of the burns service.

In addition, it would be desirable to provide an outpatient provision at another site within KSS. However, this would require sufficient outpatient activity and capacity for three times a week dressing clinics, access to paediatric scar management clinics and consultant review clinics with full MDT input.

6.1.3 Gap analysis between the current service and the specification

Future service	Current service gap	Impact of gap
An ability to recruit and retain a full complement of staff with appropriate training or willingness to be trained in burns specific skills	Difficulty in retaining and recruiting nursing staff has led to shortages in nursing staff, resulting in ward closures overnight.	Patients having to travel out of area if they are refused or wait in the referring centre overnight, delaying their treatment.
Paediatricians form part of the MDT	Paediatricians only on site for 4 hours on a Monday, Wednesday and Friday.	This means that current case triage is cautious and if patients are medically unwell they will often be refused and sent to a service out of area, resulting in less complex patients being seen by the service. If patients are admitted and acutely deteriorate whilst an inpatient in QVH they have to be transferred to the RACH to be managed under the paediatricians.
On-site support services that meet the service standards	Emergency department provision.	Patients cannot directly attend QVH they must go via another hospital. This can

and the needs of inpatients.	Trauma unit provision including trauma and orthopaedic surgery. HDU provision 24/7 pathology (including microbiology and transfusion services. 24/7 radiology including CT, MRI, USS and Doppler. Limited capacity for MRI and no access to medical grade CT scans. No access to additional clinical services e.g, paediatric surgery, renal services, liaison mental health, neurology,neurosurgery, cardiothoracic surgery, dermatology, urology and ENT.	result in delays in treatment due to the availability of transport. Trauma injuries are associated with burns, it is best practice is to have trauma and burn specialities on the same site to allow treatment of both injuries simultaneously. Cautious triage resulting in patients being re-directed to alternative providers out of area or patients being transferred to the RACH with an acute deterioration. These emergency transfers often incur a delay due to unavailability of ambulances and risk avoidable harm. Delays in diagnostics result in delays to treatment, negatively impacting patient care and increasing chance of avoidable harm. Those children with multiple needs may miss out / incur a delay with getting a specialist opinion due to services not being able on the same site.
Situated within KSS	Met for the majority of patients, 10 patients refused in the past year and required to travel out of area for emergency treatment.	Negative impact on patient experience due to increased travel distance. Strain on the ambulance service to have to transport these patients out of area.
Suitable bed / theatre capacity to provide: Emergency and elective inpatient paediatric admissions Elective and urgent day case patients risk assessed to need increased medical support during surgery or post operatively	Bed capacity can be impacted by lack of staffing resulting in ward closures. No problems with current theatre capacity.	Inability to accept patients who meet criteria. Resulting in patients having to travel out of area.
Appropriate training programme to maintain burn specific skills.	All training needs met currently however there has been reduced exposure to patients who are medically unwell or at the higher end of the burn percentage threshold.	More cautious triage of patients resulting in patients being sent out of area or patients being transferred if they become unwell.

An affordable service which is sustainable.	Current service is unsustainable; reducing patient numbers due to cautious triage secondary to the risk of managing patients in a service that does not meet burn care standards.	Patients having to travel out of area for emergency burn care treatment. Cost of providing the service is more than the income generated, resulting in a financial risk to the trust.
Suitable space/ capacity for adult burns in the future.	Adult burns service at QVH is in agreed derogation of the National Burns Standards due to the lack of co-located services.	This lack of compliance has the potential to affect the quality of care provided to patients. Despite mitigations there is potentially a higher risk to managing patients in this way.
Desirable		
Two outpatient locations with capacity for three times a week dressing clinics.	Full outpatient pathway at QVH. Limited outpatient's provision at RACH – Once a week consultant review clinic. No dressing clinics / scar management clinics or therapy provision.	Limited capacity therefore the majority of Brighton patients travel to QVH. (Approx 20% of outpatient workload is Brighton based patients). If the patients require physio input they have to travel to QVH and have an extra appointment or they miss out on that aspect of their treatment.

6.1.4 Future pathways or referral routes

The changes in the location of the above services will not change the clinical pathway. However these changes will allow the clinical thresholds for acceptance by the service to be adjusted (See Appendix 2).

6.1.5 Future vs current service

The future service will allow children less than 6 months to be admitted to the service, this patient group are currently excluded due to the absence of paediatricians on site 24/7 and co-located paediatric services. This service will provide a higher level of support, enabling the acceptance of those who would have previously been refused, for example those who had a question over their medical stability.

It would be desirable for the future service to provide two locations for outpatient treatment including access to the MDT, dressing clinics three times a week, paediatric scar management and consultant review clinics. Currently this comprehensive pathway is only offered at QVH, if available at two sites within the region it would increase choice and reduce travel times.

6.2 Activity Profile

6.2.2 Activity trends

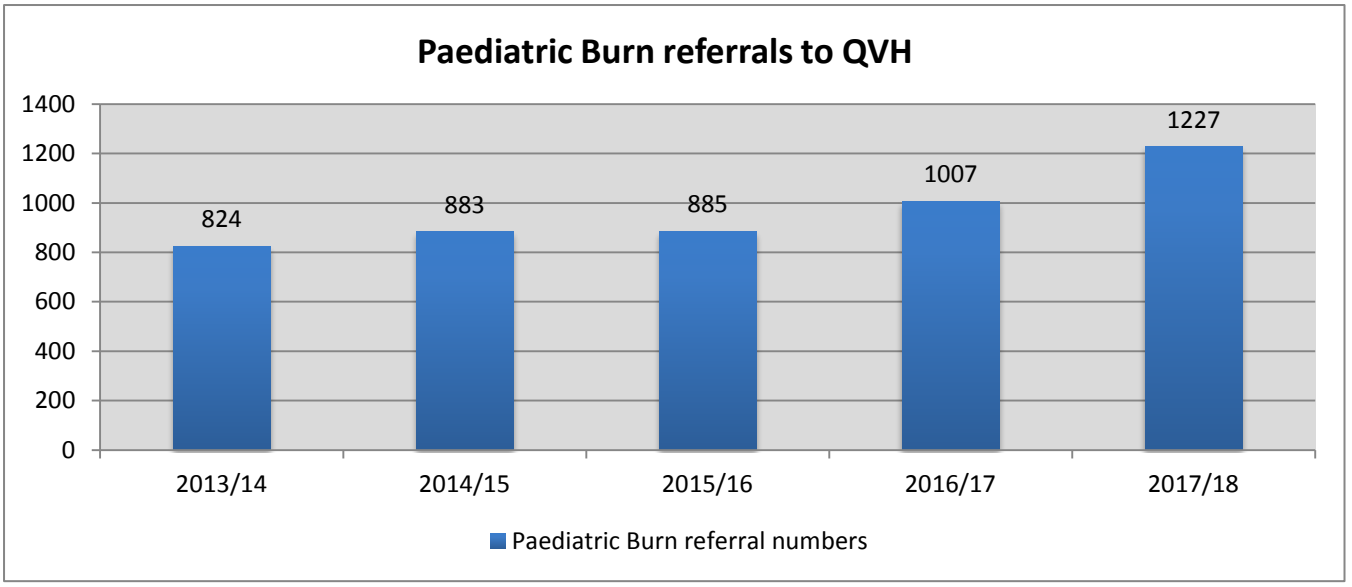
Nationally over the past five years there has been an increasing trend in new attendances for paediatric burn injuries but a decreasing trend in inpatient admissions. This is thought to be due to changes in clinical practice (converting inpatients to outpatients) as well as improvements in health and safety awareness resulting in less severe burns.

In the most part, paediatric burns activity at QVH has mirrored this trend although it is difficult to compare referral numbers over the past five years due to incomplete/inaccurate data on advice only calls and cases that were not admitted due to the clinical threshold or staffing shortfalls.

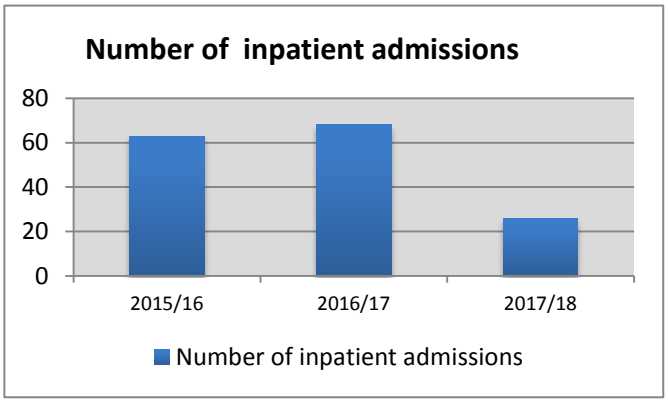
QVH inpatient data for the last three years shows a 60% reduction in the number of paediatric burn patients admitted to QVH in 2017/18 compared to the two previous years. Healthcare Evaluation Data (HED) shows a

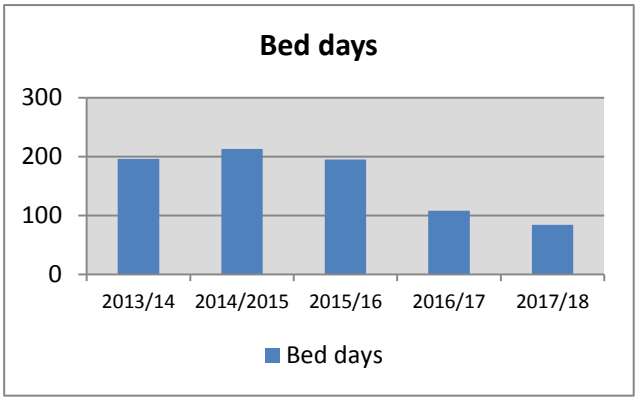
35% downward trend in inpatient and day case paediatric burns activity across the KSS region over the past four years. The decline in admissions at QVH is thought to be multifactorial; contributing factors include:

- Staffing shortfalls with a 16% nursing vacancy rate in 2017/18.
- The change in clinical thresholds made to mitigate the gaps in achievement of burns standards.
- The local impact of a national downward trend in inpatient activity.
- Changes in clinical practice meaning some patients, who would have previously been as admitted, received outpatient only care; HED shows that there was a 12% increase in QVH paediatric burn outpatient activity in 2017/18 compared to previous years.



Referral data before 2016/17 is incomplete/inaccurate





6.2.3 Predicted activity and assumptions

In order to right size future capacity, future inpatient numbers have been estimated based on past activity and underlying trends. On the basis of these assumptions it is anticipated that in the future annual inpatient numbers will be approximately 40 with an average length of stay of 3 days. With approx. 220 patients deemed as local population (BN and PO postcodes) requiring outpatient assessment and follow up care (See Appendix 3 - Activity Model and Appendix 4 - Service Map).

The predicted inpatient activity number of approximately 40 is based on data provided by QVH and HED over the past five years. A number of assumptions have been made in reaching this figure:

- The baseline number of inpatient admissions has been adjusted, to include patients who were previously refused but would be accepted with the future specification. These include: patients who were refused

due to lack of staffing (7), patients who were held at the referring hospital overnight due to ward closures / medical concerns (4) and patients who were refused due to being medically unwell (1) equalling 39 potential patients.

- The downward trend was factored in and it was assumed that the number of inpatient admissions will reduce by 15% over the next 5 years. Whilst HED data has a shown a decrease of 35% it is unlikely that the incidence of burns can continue on this trajectory, therefore, it was felt this was not a good basis for predicting future levels and so the percentage was lowered.
- Demographic shift has also been taken into consideration, it has been assumed that the population of children will grow by 1%, therefore the number of children with burns will grow 1% year on year.
- That a small number of patients will still be refused as they will continue to fall outside of the proposed service's acceptance criteria (3) e.g. those requiring intubation and with burns of above 30%.
- That outpatient activity will continue to increase, with 96.6% of patients accepted into the service requiring an outpatient assessment or follow up.
- That surgery rates will remain stable, as they have done so over the past four years (between 45-50 emergency and elective procedures per year).
- It has not been assumed that changing the threshold (moving to full Unit threshold) accepted would have a significant effect on activity as the numbers of these patients across the country is low.

7 Delivery Model

7.1 Future service delivery model options

<table>
<tr><td colspan="2">Option 1: Do nothing</td></tr>
<tr><td colspan="2">Brief explanation of option: Continue to provide the current service with mitigations in place due to the derogation.</td></tr>
<tr><td><u>Advantages/benefits</u>

• No additional infrastructure costs
• Keep the service in KSS for the short to medium term depending on provider and commissioner agreement.
• Service in provided in the same location as the adult burns service allowing sharing of specialist staff, skills and equipment.</td><td><u>Disadvantages/risks</u>

• Governance implications for the trust for continuing to provide a service that does not meet the standards.
• Governance implications for the commissioners for allowing QVH to continue to provide the service.
• Risk of avoidable harm to patients.
• Continuing uncertainty over the long-term future provision/sustainability of the service with consequent impact of recruitment and retention and potential additional cost/loss of revenue due to the requirement to use higher cost agency staff or temporarily close inpatient services.
• Loss of reputation
• Patient experience and quality of care would remain reduced.
• Continuing falls in patient numbers below Burns Unit thresholds with a consequent impact on opportunities for staff training and skill maintenance.</td></tr>
<tr><td colspan="2">Conclusion: This is an unfavourable option. Without change the service will become increasingly unsustainable with no improvement, and a potential deterioration, in the ability to recruit staff and sustain their skills. QVH would continue to be providing a service that doesn't meet agreed standards. With the associated risk of patient harm/adverse outcomes.</td></tr>
<tr><td colspan="2">Option 2: QVH invest in Paediatric Burns Services to meet Burns Specification/ Standards.</td></tr>
</table>

Brief explanation of option: This would require QVH to establish Accident and Emergency (A&E) provision with Major Trauma Unit status along with access to comprehensive clinical specialties and diagnostics 24 hours a day.

Advantages/benefits	**Disadvantages/risks**
• Would meet the burn care standards with associated benefits for patient outcomes. • Service is provided in the same location as the adult burns service allowing sharing of specialist staff, skills and equipment.	• Significant investment in infrastructure required. • Additional activity is unlikely and would not support the level of additional cost or support the sustainability of the service • Provides significant additional service capacity which is not required in the local system • There is no demand for an additional paediatric emergency unit/ trauma unit in KSS.

Conclusion: This is the least favourable option there is no other requirement within the health care system for the additional services or infrastructure that are required to deliver this option. There is no capacity within the QVH site to deliver without substantial additional infrastructure/build costs.

Option 3*:* QVH divestment of paediatric burns services to another burns provider in London or elsewhere out of region.

Brief explanation of option: QVH chooses to stop providing acute paediatric burns services and patients are therefore relocated within the network.

Advantages/benefits	**Disadvantages/risks**
• Would result in patients attending a service that is more compliant with the burn care standards. • Consolidation of activity may improve paediatric burns service sustainability across the network/nationally • Reduced risk to QVH, as they would no longer be providing a non-compliant service.	• Potential to destabilise adult burn services at QVH. • Potential to destabilise the provision of outpatient paediatric burn services at QVH • Loss of paediatric burns care in KSS. Resulting in patients having to travel further for acute care and an adverse impact on patient experience. • Implications to the ambulance service with increased drive times to other providers out of area. Potential to create a shortfall in paediatric burn bed numbers within the network.

Conclusion: This is a less favourable option as it reduces equity of access to specialised burn care services for the KSS population.

Option 4*:* QVH would develop an acute inpatient paediatric burn service in collaboration with a District General Hospital (DGH) within KSS e.g. Maidstone and Tunbridge Wells.

Brief explanation of option: QVH would collaborate with a DGH within KSS to provide inpatient admissions with co-located services. QVH continue to provide outpatient services**.**

Advantages / benefits	**Disadvantages / risks**
• Retain the service in KSS. • Reduced risk as no longer providing a non-compliant service. • Potential to improve sustainability and stability of the paediatric burn service through a new model of care working in partnership with a local DGH. • Some improvement in the number of burn cares standards achieved.	• No alignment with other burns or plastics emergency/inpatient provision needing minimum of 6 consultants to create an on call rota. • May not provide age appropriate A&E and trauma unit/centre services • Lack of continuity for inpatients, as they would need to travel to QVH for elements of their outpatient care. • May increase travel times for some patients

	depending on their location within the region • Staff providing an outreach service will have increased time travelling until/if adult burns moves. • Unpredictable workload makes it difficult to staff accurately • Low volume will potentially make it difficult to train and maintain competence in burn care particularly for nursing staff. • Doubling up of equipment required • No paediatric HDU support so high risk and medically unwell patients may still require transfer • Would be unable to meet all unit level burns standards
Conclusion: This is a less favourable option as it does not provide access to paediatric HDU and is not linked to any existing Trauma related plastics provision meaning that it will not be as cost effective as Option 5.	
Option 5a: QVH would develop an acute inpatient paediatric burn service in collaboration with the RACH.	
Brief explanation of option: QVH move the inpatient paediatric burn provision to RACH where they will be co-located with Major Trauma and paediatric support services including HDU. Outpatient services would be retained at QVH.	
Advantages/benefits • Significantly increase compliance with burn care standards resulting in improved quality for inpatients. • The RACH has an age appropriate A& E and trauma unit status. • Co-located with paediatric services including HDU. • Burn consultants / plastic surgeons will be on site already as providing the BSUH plastic surgery service, maximising resource utilisation and cost effectiveness. • Paediatricians at the RACH site have experience in managing medical care for children with burns. • Would be able to accept children less than 6 months. • Reduced risk as no longer providing a non-compliant service. • Potential to improve the stability of the burn service through a new model of care working in partnership with BSUH. • Aligned to the potential for a networked QVH/BSUH approach to adult burns once 3Ts building complete. The potential co-location of elements of adult and paediatric burns services on the BSUH/RACH site could allow for greater utilisation of resources in the long term. • Greater stability and direction for QVH staff.	**Disadvantages/risks** • Lack of continuity for inpatients, as they would need to travel to QVH for their outpatient care. • May increase travel times for some patients depending on their location within the region • Staff providing an outreach service will have increased time travelling until/if potential co-location of elements of paediatric and adult burns services on the BSUH/ RACH site. • Unpredictable workload makes it difficult to staff accurately • Low volume will potentially make it difficult to recruit, train and maintain competence in burn care particularly for nursing staff. • Doubling up of equipment required. • Will be unable to meet all Unit level standards.
Conclusion: This is a more favourable option. It provides QVH the opportunity to continue to deliver the service and meet a significantly higher number of the standards. However this option is unlikely to increase the numbers of patients or the predictability of inpatient activity meaning difficulties with staffing and skill retention are likely to remain.	

Option 5b*:* QVH would develop an acute inpatient paediatric burn service with an outpatient provision for the local population in collaboration with the RACH.	
Brief explanation of option: QVH move the inpatient paediatric burn provision to RACH where they will be co-located with Major Trauma and paediatric support services including HDU. Outpatient services would be retained at QVH and additional services would be provided at RACH for patients within the local area.	
Advantages/benefits As Option 5a benefits plus • Improved patient experience as increased choice and decreased travel time for patients with two sites for outpatients. • Increased continuity for patients with Brighton patients having access to outpatients on the same site. . • Increased opportunity for staff to maintain competence with more access to burn patients – inpatients and outpatients. • Better use of specialist skills /outreach staffing model as workload will be more predictable and they can attend on planned occasions for most of their work. • It will enhance the current limited burn service at BSUH to include all aspects of outpatient care including MDT support. • Maximise expensive resources e.g. equipment, clinical time – by seeing inpatients and outpatients.	**Disadvantages/risks** • Slightly more expensive than Option 5a as more staff required. • Will be unable to meet all of the Unit Burn Care Standards. • May increase travel times for some patients depending on their location within the region • Doubling up of equipment.
Conclusion: This is a more favourable option. It provides QVH the opportunity to continue to deliver the service and meet a significantly higher number of the standards. This option is also unlikely to increase the numbers of patients or the predictability of inpatient activity but difficulties with staffing and skill retention may be addressed in part by providing enhanced outpatient (OP) services on the RACH site and utilising specialist staff across inpatient and outpatient services. It also provides opportunity to improve patient experience by providing patients with choice and decreased travelling times.	

7.1.2 Criteria for options appraisal

A range of options were developed when considering the possible ways to address the drivers for change and meet the national care standards for paediatric burns care.

Each option was assessed against their ability to deliver:

(i) the strategic objectives for paediatric burns:

- To achieve compliance with the nationally mandated standards for specialised burn care
- To retain burn care services within KSS providing access for a population of 4.6 million.
- To ensure the future provision of paediatric burns is clinically, operationally and financially sustainable.
- To align the future provision of paediatric and adult burns services

(ii) the future specification for paediatric burns and in particular the key elements of the service that are considered to be essential or desirable:

- Full complement of staff across all professions, with appropriate training or willingness to be trained in burns specific skills.
- Full membership of the MDT

- On-site support services that meet the service standards and the needs of inpatients.
- Is situated within KSS.
- Suitable bed and theatre capacity to provide:
  - Emergency and elective inpatient paediatric admissions
  - Elective and urgent day case patients risk assessed to need increased medical support during surgery or post operatively.

Desirable elements:

- To provide an outpatient provision at another site within KSS.

(iii) an agreed set of critical success criteria as set out below:

Critical Success Factors	The extent to which the option:
Strategic fit	Delivers a sustainable service configuration retaining access for the respective catchment populations of each service
Achievability	Causes minimum disruption to existing services and Can be delivered by a strategic partnership model Without structural change
Value for money	Maximize the use of existing resources and delivers an efficient clinical Service model
Affordability	Can be delivered within agreed resource envelope available to commissioners and providers

7.1.2 Options Appraisal

Options	Do nothing	QVH invest in Paediatric Burns Services to meet Burns Specification/ Standards	QVH divestment of Paediatric Burns services to another Burns provider in London or elsewhere out of region	QVH develop an acute inpatient paediatric burn service in collaboration with a DGH within KSS e.g. Maidstone and Tunbridge Wells	Develop an acute inpatient paediatric burns service in collaboration with RACH.	Develop an acute inpatient paediatric burns service with an outpatient provision for the local population in collaboration with RACH.
Objectives						
To achieve compliance with the nationally mandated standards for burn care.	No	Yes	Yes	No	Yes	Yes
To retain burn care services within Kent Surrey and Sussex providing access for a population of 4.6m	Yes	Yes	No	Yes	Yes	Yes
To ensure the future provision of paediatric burns is clinically , operationally and financially sustainable	No	No	Yes	No	No	Yes
To align the future provision of paediatric and adult burns services	No	No	No	No	Yes	Yes
Future service specification						
Achieves essential criteria	No	No	No	No	Yes	Yes
Achieves desirable criteria	No	No	Yes	No	No	Yes
Criteria						
Strategic fit	No	No	No	No	Yes	Yes
Achievability	No	No	Not known	No	Not known	Not known
Value for money	Yes	No	Yes	No	No	No
Affordability	Yes	No	No	No	No	No
Attractiveness	No	No	No	No	Yes	Yes

7.2 Preferred delivery model

Following an assessment against the above criteria the preferred delivery option was identified as Option 5b: To develop an acute inpatient paediatric burns service with an outpatient provision for the local population in collaboration with RACH.

Within this option the service delivery model would include the following components:

Acute Care	
QVH	**BSUH**
Regional referral and assessment Centre. Referrals continue to be triaged by QVH.	Emergency admissions will be admitted to the RACH under the care of the Burns Consultants. - On-site support services that meet the service standards and the needs of inpatients will be provided at RACH. - There will be Burns and Plastic consultant support 24/7. - Medical cover will be provided by the paediatricians. - Full MDT support provided by BSUH and or/ QVH outreach.
Planned day case surgery for stable patients will continue to take place.	Urgent day case patients risk assessed to need increased medical support during surgery or post operatively will also be admitted to the RACH
No inpatients to stay at QVH.	Planned inpatient surgery to take place at RACH
New burn assessments will continue in PAU 7 days a week.	New burn assessments for patients local to Brighton will occur x 3 a week on L6 day surgery.
Burn MDT weekly	Burn MDT weekly

Follow up care	
QVH	**RACH**
Nurse led outpatient follow up and review 6 days a week in PAU with MDT input.	Nurse led outpatient follow up and review 3 days a week on L6 surgery with MDT input.
PSCAR clinics	PSCAR support by outreach from QVH PT/OT
Consultant review with MDT input	Consultant review with support from outreach PT/OT.

Specialist reconstruction	
QVH	**RACH**
All specialist reconstruction to take place at QVH	Patients to be referred to QVH for reconstruction.

7.2.1 Future service gap analysis

The proposed service will meet all the standards applicable to a Burn Facility but may not meet the following Burn Unit standards. This is primarily because the low numbers of patients cannot sustain this level of specialist provision. Areas of future non-compliance are detailed below

The following standards are currently not met and are unlikely to be met by the future service:

- 75% of burn nurses have undertaken a formal period of accredited study
- Burn care ward specifically for burn injured patients
- Thermally controlled cubicles.
- Burn specific follow up – consultant review will be joint burns and plastics.
- At least 30 patients requiring unit level care annually – over 10%

The following standards are currently met but may not be met by the future service:

- Registered nurse available at all times who has completed the Emergency Management of the Severe Burn (EMSB) or accredited academic course in Burn care.
- Integrated pain management provision
- Specialist burn consultant care 5 days a week
- Band 6 or 7 burn dietician funded at 0.5wte on the BSUH site

Ability to meet the above standards is dependent on activity levels, levels of investment and ability to maintain skills.

By moving the service to the RACH the following previously unmet standards will be met:

- 24/7 paediatric cover from a Consultant Paediatrician who can attend within 30 minutes and does not have responsibilities on other hospital sites.
- Emergency department provision.
- HDU provision
- Trauma unit provision.
- 24/7 Pathology (including microbiology and transfusion services).
- 24/7 radiology including CT, MRI, USS and Doppler.

This will significantly improve the care of deteriorating patients by and will better meet service standards; resulting in a reduced number of out of region transfers.

7.2.2 Workforce requirements

Due to the complexities involved in splitting paediatric burns from adults and inpatients from outpatients along with the small number of patients and geography involved. It was established that the service could not be provided within current resources and that additional resources would be required. Existing staffing arrangements were reviewed and a set of staffing requirements were developed by QVH in accordance with the National Burn Care Standards and clinical experience. Options were explored for providing each profession in terms of the roles and responsibilities, whole time equivalent requirement, Agenda for Change banding and provider e.g. QVH outreach or BSUH. The option that was most cost effective and best met the Burn Care Standards was chosen in each case. This process resulted in the majority of the workforce being provided by BSUH with training support from QVH with the exception of Physiotherapy / Occupational therapy, Burns consultants / Plastic Surgeons and Psychological Therapists for training.

QVH provision of outreach Physiotherapy and Occupational Therapy was preferred due to the level of specialist expertise required and the reduced costs of provision. Currently there is no paediatric Occupational Therapy service at the RACH and the Physiotherapy requirements could not be met by the RACH without additional recruitment and significant additional training making the costs significantly higher. The provision of an outreach service from QVH for delivering psychological training for the MDT was also preferred due to the, extensive nature of this training. It was also agreed that QVH will provide the burns consultant cover as this allows the consultants already contracted to provide a plastics service at BSUH to deliver this service in and out of hours.

7.2.3 Sets out the workforce model

The workforce requirements are summarised below

Provider	Profession	Recommendation	Requirement of service
QVH	Burn /Plastic surgery Consultants	0.51wte	• A Consultant Burn/Plastic Surgeon is available 24 hours a day, 7 days per week to provide: on call, ward round, theatre and outpatient review. • At least 50% should have special interest/fellowship in burns so burns consultant opinion available within 48-72 hours
BSUH	Trauma fellows and plastic juniors	TBC	• To support day to day management of burns patients at the RACH (inpatients and outpatients) e.g. discharge letters TTOs, prescribing, imaging, discussion with patients and attend the MDT meeting.
BSUH	Paediatric Medicine Support	Additional 6 hours per annum	• Medical Paediatric support available as needed e.g. sepsis, HDU support, medical advice. • Ward/overnight cover required.
BSUH	Nursing - Ward	1 wte Band 6 1.59 wte Band 5 -To cover the opening of an additional bed and unpredictable workload.	• 2 Registered nurses on duty at all times (B.18) • Flexibility to provide 1:1 care for the first 2 hours post admission or where complex dressings are required. • A nurse to attend weekly Burns MDT meetings (1 hour) to discuss IP. • Lead nurse has completed EMSB course or accredited academic course in burn care (Min).Or a registered nurse who has completed the above courses and is available at every shift.(B.23 & 24).
	Nursing outpatients	0.4wte Band 7 Clinical Nurse Specialist/ Educator. 0.3wte Band 2 HCA	• Nurse led burn assessment and follow up clinics three times a week, Band 6 or above. • Attendance at Burns MDT meetings to discuss OP (1 hour). • Liaison with burn care nurse specialists at QVH • Analgesia administration, dressing removal & application, wound cleaning. • Arranging onward MDT referrals.

QVH Outreach model	Physiotherapy / Occupational therapy.	1.0wte B6 OT -To offer access to PT/OT 5 x a week -To maintain minimum staffing levels at QVH.	PT/ OT who have specific training and experience in burn care are available five days a week to:(B.25.J &K) • Attend weekly burn MDT meetings (1 hour) • Assessment of all inpatient paediatric burn patients including respiratory function (within 24 hours), ROM, strength, cardiovascular fitness and mobility function (within 72 hours). • To provide input for inpatients, dressing clinic patients and consultant reviews as well as running PSCAR clinic.
BSUH	Physiotherapy	Cover within existing resources	• On call respiratory physiotherapist accessible at all times (B.25.F)
BSUH	Play therapy	0.4 wte Band 4	Access to a play service for inpatients and outpatients at least 5 days a week To provide generic play specialist service plus: • Distraction during dressings • Support with physio exercises and 'play therapy' • Identifying suitable children and young people for camps/days out etc. • Liaison with play specialist at QVH who will continue to co-ordinate burn camp activities.
Via SLA with SPFT	Psychological Therapies	0.35 wte Band 7 Psychological therapist	A psychological care service available to patients their families and/or carers five days a week, to include: • To screen inpatients and provide assessment / treatment to those patients/ families who require it. • Have a presence at dressing clinic to screen patients. • To liaise with and provide support to staff working in paediatrics burns. • Attend weekly burn MDT meetings (1 hour)
QVH outreach		0.05 wte Band 7	• To be provide training to the MDT at BSUH on psychological care using a tiered approach
BSUH	Admin	0.1wte Band 3	• Generic admin support for inpatients and outpatient clinics. • To input patient details onto the National Burns Injuries and Mortality Database (IBID). • Governance of IBID will remain under QVH and support will be provided.

BSUH	Safeguarding	0.2 wte Band 7	• To work with the Burns team to provide safeguarding input into the risk assessment and management of paediatric burns patients including input into the weekly Burns MDT (1 hour).
BSUH	Pain management	0.11wte Pain Nurse Band 6 0.05wte Consultant Anaesthetist	• Pain assessment, review and advice on pain management supported by the QVH team • The QVH pain team provides specific pain assessment, advice on medications, local anaesthetic techniques, nurse training and discharge planning
BSUH	Medical photography	0.2wte Band 5	• Required to photograph all inpatients and outpatients in dressing clinic, PSCAR and consultant review.
BSUH	Dietetics	0.1wte Band 7	• All patients with ≥ 5% TBSA burn in children are referred to the Dietitian on admission. All resus patients are to be seen within 1 working day of receipt of referral and reviewed as clinically appropriate.

7.2.4 Additional requirements

Clinical support services to be provided by BSUH include:

- Pharmacy – generic pharmacy advice and support for medication and dressings.
- Generic anaesthetics and theatre support (Inpatient and day case procedures.).
- Infection control– initial assessment swabs required for all new referrals and if clinically indicated after this.
- Pathology and Transfusion - no change to support requirement as this service is already provided by BSUH.
- Portering support for inpatients/outpatients.
- Radiology support for inpatients
- Speech and language support – access to a generic service.

Bed capacity	2018/19
Number of inpatients	39
Number of bed days	121
Number of beds required	<1 with the flexibility to increase to 2 beds when required (14 occasions in 17/18)
Occupancy rate	0.33
Day case procedures (require general anaesthesia so will also require a bed.	7

Bed requirements
• The standards require a bed to be available for the admission of a paediatric patient 96% of the time. • Beds should ideally be provided in a cubicle with ensuite facilities. • HDU beds should be available to support the management of paediatric burns patients when required.

Theatre Capacity	2018/19
Number of emergency inpatient operations within 24 hours of admission/burn	10
Number of elective inpatients (1 to 4 weeks post injury)	3
Number of emergency day case procedures within 24-72 hours of admission/burn.	1
Number of elective day cases (1 to 4 weeks post injury)	6
Total number of operations	13
Average length of operation	82mins
Total operating hours per annum.	27.5

Theatre requirements
• Timely access to CEPOD list • Ability to warm theatre

Outpatients capacity	2018/19
New patient attendances in dressing clinic (45 minutes per patient)	212
Follow up attendances (30mins per patient)	551

PSCAR new attendances (30mins per patient)	22
PSCAR follow up (30mins per patient)	32
Consultant review new attendances (15mins per patient) NB This number excludes Brighton plastic patients who attend this clinic	61
Consultant review follow up (15mins per patient) NB This number includes plastic patients who would also attend this clinic	76
New patient attendances in dressing clinic (45 minutes per patient)	212

Outpatient requirements

- Dressing clinic will need to run three times a week because dressing changes need to be scheduled for every 48-72 hours.
- The dressing clinic will require access to two rooms with a bed/ plinth for a nurse to be treating a patient in one and a doctor / therapist treating to be treating in the other.
- Access to a bath/ shower or baby bath in the dressing clinic.
- Consultant review clinic will be a burns and plastic clinic. Can run once a weeks for hand injuries, elective plastic surgery patients such as congenital lesions, vascular anomalies and also scars (burns or other).
- The consultant review clinic will also require access to a second room for the therapist to treat patients as required.
- Computer / Printer and phone to be available
- 1x room with splinting area with 3 chairs and an adjustable height table
- Rehabilitation gym with parallel bars / stairs / exercise bike/ treadmill / weights
- Play room / gym with Xbox / Wii fit.
- Private consultation space for inpatients / outpatients for psychology.
- Space for data inputting clerk to work (if the ward is unavailable) in the outpatients department with the burns clinic to develop relationships with the team and to provide easy access to information.

Equipment Required

- Dermatome Air
- Skin graft mashers
- Cutter
- Diathermy - monopolar and bipolar
- Monopolar diathermy pads
- Watson knives
- Versajet
- Laser Doppler

7.2.4 Operational management of the service

The guiding principle underpinning the delivery of the new service model is that it will not require any structural reorganisation, thereby minimising disruption to the operational delivery of services on both sites.

The model for the delivery of paediatric burns services will be based on contractual service arrangements with QVH providing the service at the RACH. Whilst patients will be recorded on the Brighton Patient Administration System income and activity for the specialised burns service will continue to be attributable to QVH. The intention is that QVH will commission the BSUH elements of the service through a SLA, which will cover all workforce, infrastructure and support associated with BSUH's contribution to delivering the service specification. The SLA will cover the service standards that will need to be met including maintaining clinical areas to a good standard and continued investment that supports excellence in patient care, research and education.

QVH will be responsible for all items of equipment required to provide specialised burns care and to ensure that they meet all decontamination, servicing and maintenance standards. If items require replacement QVH will need to

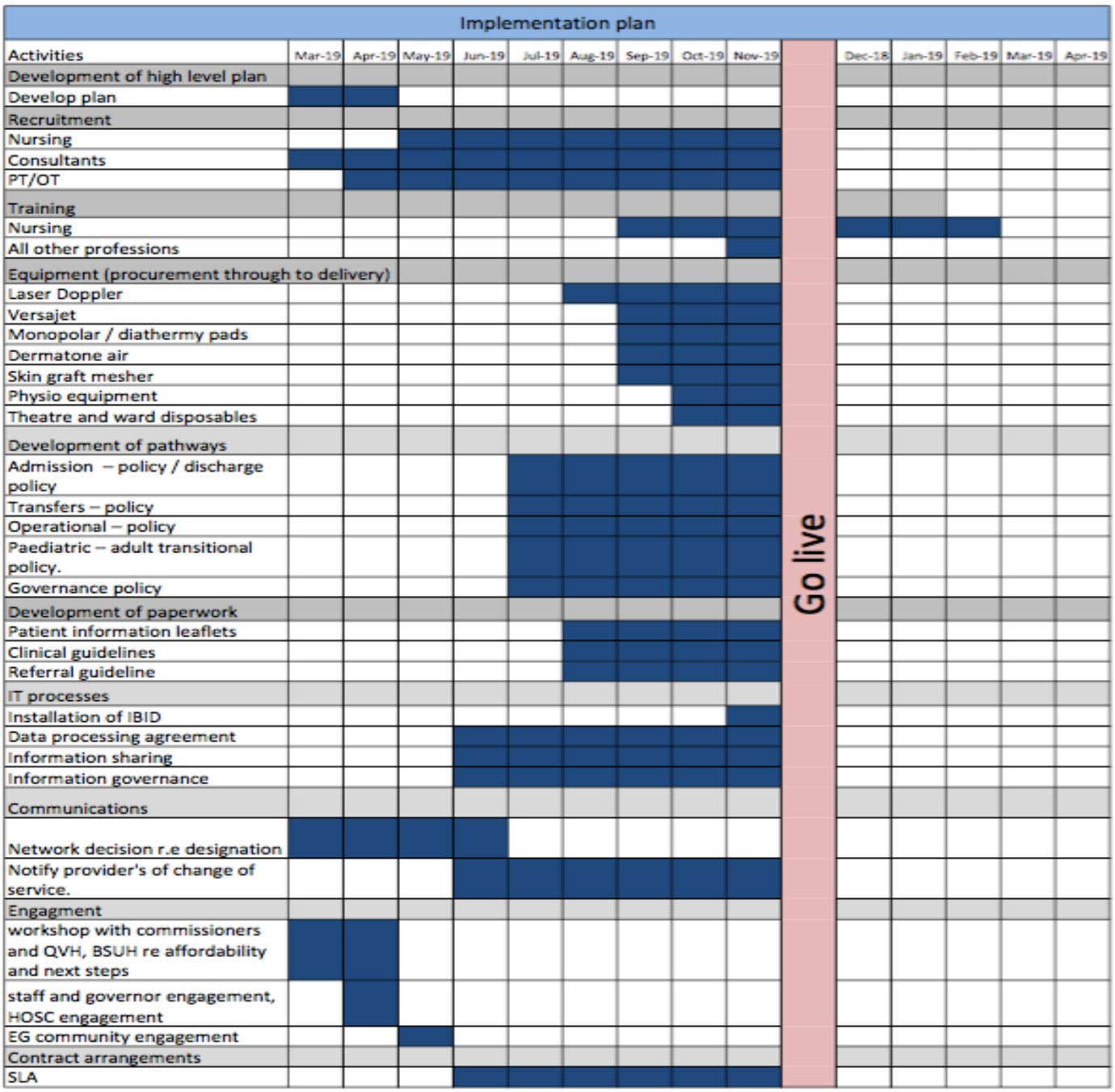
be notified by BSUH and replacement items purchased. High cost and burn specific consumables that BSUH will be required to buy will be chargeable as pass through costs to QVH.

QVH will be responsible for all operational and quality standards applicable to specialised burns patients, which are seen, treated and managed within BSUH.

Efficient delivery of the service will be supported by a data sharing agreement. BSUH staff will have access to the same TRIPS system (Telemedicine referral system) as QVH enabling both parties to view referrals and will also have access to the IBID, QVH will provide support from a governance and data quality perspective.

8 Implementation Plan

A provisional implementation timetable has been developed for transition to the new service model. This timetable may vary depending on the timing of the business case approval and the requirement for further patient engagement or consultation. This will be determined in consultation with stakeholders during the assurance process for agreeing the business case and implementing the new proposal. A key dependency within the plan is the time for recruitment of critical posts. Successful recruitment will allow timelines to be expedited.



8.1 Implementation risks

Risk Area	Specific risk	Risk score	Mitigation / Counter measure
Business case rejection	Failure to gain approval for the business case by the board and or commissioners. This would result in a failure to achieve the benefits described by the new model of care. Loss of paediatric burns service for QVH and potential reputational damage for providers involved.	**Medium**	Continued engagement and discussion with commissioners.
Clinical	Burn care standards stipulate that there needs to be a nurse on every shift who has completed the Emergency Management of the Severe Burn (EMSB) course. This would be difficult initially as staff would need to attend QVH training first and gain experience with burns before attending as the course requires a baseline of knowledge and experience	**Medium**	By providing work experience sessions at QVH and 1:1 coaching for those required to attend the EMSB course and sit the exam
Clinical	Unable to comply with all unit level standards.	**Medium**	Identify all potential gaps and plan accordingly. Allow adequate implementation time for training and recruitment. Discuss gaps with LSEBN and commissioners. Currently operate at a Facility plus.
Clinical	Delay in delivery of equipment required for the running of the service. Resulting in a delay in transfer of paediatric burn service.	**Low**	Ensure adequate time planned for procurement and delivery of equipment required.
Communications	Failure to deliver the required stakeholder support from patients, the public and the Health Adult Social Care Committee (HASC) in supporting the changes.	**Low**	To continue with HASC discussions and scrutiny. Engagement events as required. Patient engagement and utilise feedback in the development of the case.
Communications	In an environment of uncertainty QVH staff become concerned about future security	**Medium**	To continue to ensure open dialogue with QVH staff, especially those directly involved with burns patients.
Financial	The scheme is unaffordable for commissioners and/ or the provider board are unable to support making changes to the service without adequate investment.	**High**	Ensure costs for change and rationale are clearly articulated. Including the efficiencies of cross cover.
Financial	BSUH unable to support Adult Burns service; servicing clinically and financially unsustainable split in long term. Could result in reduced or restricted service provision and failure to meet 2018 Burn Care Standards resulting in the loss of inpatient paediatric burns services in the South East.	**Medium**	Continue with discussions with BSUH regarding Adult Burn Service move. Ensure that the staffing provided is adequate to cover paediatric burns. Ensure that the paediatric service is sustainable in the long term without adult burns.
Operational	There is a risk that BSUH are unable to backfill nursing staff to be released for essential training.	**Low**	Work with QVH to make training programme as flexible as possible. Review use of wider nursing pool to support. Extend implementation period if required.

Risk Area	Specific risk	Risk score	Mitigation / Counter measure
Operational	QVH will be unable to provide sufficient training to support BSUH.	**Low**	Robust training plans and backfill arrangements. Telephone support as required.
Operational	Inability to recruit to specialist posts e.g. Nursing and OT. Known difficulty in recruiting to specialist area. Could result in reduced or restricted service provision and failure to meet Burn Care Standards 2018 or delay in transfer of inpatient paediatric burn services to RACH.	**High**	Robust recruitment plan, with a need to allow a minimum of 6 months from advertisement to starting.
Operational	There is a risk that BSUH cannot support IBID database	**Medium**	To engage IT team to review to provide confirmation that the database can be supported by BAU
Operational	There is a risk that BSUH cannot appoint to positions required due to WTE required	**Medium**	Where possible extend contracted hours of existing staff. Appoint into supervised roles where appropriate (e.g. play worker under supervision of play specialist). Review notice periods for new starters. Contractual mechanism to be agreed to obtain support from QVH if required.
Operational	Delay in Recruitment of Plastic Surgeons for BSUH Orthoplastics/Trauma on call Service. Could result in delay in transfer of inpatient paediatric burn services to RACH.	**High**	Recruitment across UK. Allow up to 9 months from advertisement to consultants starting.

9 Financial Analysis

9.1 Revenue income and expenditure

The proposed clinical pathway will generate a loss of £287k in the first year of operation, which will reduce to a deficit of £245k in year 2. Further details are included in Table 1 below.

The income and costs of the pathway have been determined from a detailed review of the specification of the service required and input by QVH and BSUH clinical, operational and corporate staff.

Table 1 Revenue Overview

Description	**Year 1 £**	**Year 2 £**
Revenue income	372,621	372,621
Recurrent costs		
Pay expenditure	344,194	344,194
Non pay expenditure	273,783	273,783
Total recurrent expenditure	617,977	617,977
Non-recurrent costs - implementation		
Pay expenditure	19,759	
Non pay expenditure	22,213	
Total non-recurrent expenditure	41,972	
Total expenditure	659,949	617,977
(Deficit)	**(287,328)**	**(245,356)**

The pathway will generate revenue income of £373k per annum. This comprises inpatient spell income of £111k, outpatient attendances income of £235k and critical care bed day income of £27k. This is based on maintaining current activity levels.

The revenue costs are expected to be £660k in year 1. This includes £42k of non-recurrent implementation costs. The recurrent revenue costs are £618k.

The non-recurrent implementation costs include training and backfill costs. This includes £20k pay expenditure and £22k non-pay expenditure. The costs will be incurred in the first year of implementation of the new pathway only.

The recurrent costs of £618k comprise £344k pay expenditure and £274k non-pay expenditure. These costs include additional costs of £158k incurred by QVH and £459k costs at BSUH to create the service infrastructure at the RACH. Further details are included in the Appendix 5.

9.2 Capital Costs

The service will require £116k of capital to fund the setup of the clinical pathway. This is principally comprised of a laser Doppler £81k and a Versa jet £7.2k and misc. equipment of £28k. These assets will be depreciated in line with QVH accounting policies.

10 Benefits of the future service proposed

10.1 Intended benefits and measures.

Delivering a new model of care for paediatric burns as set out in this case will mean that QVH will be able to improve compliance with Nationally Mandated Standards for Burn Care and therefore provide a higher quality service to its patients. It will also establish a new model for the provision of inpatient and outpatient care which can be further developed in the future, potentially for the provision of adult burns services. The strategic partnership and delivery of the proposed new model will, importantly, retain burns in the South of England.

Key outcome	When will the outcome start to be realised?	How will we measure if the outcome has been achieved?
To achieve all Facility level burn care standards and greatly improve adherence to Unit level standards.	Within a year of transfer	Self-assessment against burn care standards. Approval by LSEBN and NHSE. Service currently at derogation to the standards and expected to find an alternative service provision route
A reduction in the number of unnecessary transfers.	6 months – 1 year	Measure against current rate approx. 18%(5) of inpatients were transferred in 2017/18.
A reduction in the number of patients refused by the service	6 months – 1 year	Measure against current rate approx. 27%(10) of potential inpatients were refused in 2017/18
A reduction in the number of patients who experienced a delay in accessing care.	6 months – 1 year	Measure against current rate approx.13% (4) of potential inpatients were kept at the referring hospital overnight due to ward closures in 2017/18.
Reduction in travel time and cost for some patients by providing two outpatient locations at RACH and QVH	Within 2 months of service go live.	Measure against current rate approx. 18% of outpatients who could be seen at RACH are travelling to QVH. .
Enhanced service for patients being seen at BSUH with therapy input now included.		Measure against current rate approx. 2% of patients currently being seen at Brighton for OP care. These patients miss out on any therapy input
Enhanced patient experience.	6 months – 1 year	Compare interviews with patients pre-move to follow up patient interviews post service implementation.
Affordable paediatric burn service.	Within a year	Measure actual activity against predicted work. Income vs. spend
Sustainable paediatric burn service		% Vacancies Increase in overall %of patients in the region being treated by the service.
Staff on both sites maintain all relevant skills and experience for burns.	First competence signs off after 2-3months.	Competence review annually.
Ability to recruit staff to cover the burn service	By go live.	Vacancy rate
An ability to deliver economies of scale and a centre of excellence for burns provision in Kent, Surrey and Sussex	By 2021/22	Networking of adult burns with BSUH. Finances Patient Outcomes e.g.21 day healing rate.

11 Ongoing delivery risks

Following a review by the BSUH board they have highlighted that the BSUH elements of the service would present a number of high risks for which acceptable mitigations cannot be identified. Overall these risks are driven by the low volume of inpatient activity and the intention to provide a burns service across two sites (Paediatric at RACH and adult at QVH). It was thought that the clinical risks were particularly difficult to mitigate and had a high likelihood of occurring namely recruiting and retaining staff to specialist posts as well maintaining skill and competence with non-specialist staff. The view was that compliance with clinical standards, patient safety and patient experience would be adversely impacted should these risks materialise.

Risk Area	Specific risk	Risk score	Mitigation / Counter measure
Clinical	The intended benefits are not realised e.g. improved quality of service - less transfers / refusals.	**Medium**	Ensure adequate staff recruited and trained to carry out roles. Ensure adequate capacity to admit and manage patients. Ensure appropriate thresholds decided before service opens.
Clinical	To be able to maintain adherence to the burn care standards.	**Medium**	Extensive requirements for Burn Care Standards both physical and personnel. Careful workforce planning and service provisions. Discussion and agreement with the network around areas of non-compliance
Financial	There is a risk that BSUH cannot agree a funding stream that offsets cost to nursing increase resulting in unfunded capacity or inadequate cover	**High**	QVH to fund entire nursing requirement
Financial	There is a risk that the service cannot accurately capture pass through cost to QVH resulting in a cost pressure to BSUH	**Medium**	Design robust process and resource support
Financial	There is a risk that there is not a consistent or agreed approach to costing principle. Overcosting will make implementation prohibitive. Undercosting creates financial risk to BSUH	**Medium**	Costing principles agreed and to be consistently used.
Financial	There is a risk that the costings are not accurate. Any reduction to assumed costs will increase financial risk to BSUH	**Low**	Costings include all known costs and where cost assumptions have been made (e.g. non pay costs for theatre, wards and outpatients) head room has been built in. Contractual mechanisms for reviewing on a frequent basis and corrective action agreed to address this to be developed
Financial	Workload is lower than predicted - resulting in financial risk to QVH and an unsustainable service	**Medium**	Robust activity modelling. Moving an element of the outpatient service along with inpatient activity to maximise use of resources and training opportunities. To be managed contractually.
Financial	Increased cost in delivering the service in this way, effectively double running of equipment and staffing where unavoidable.	**High**	Ensure all costs are scrutinised and all options explored for delivery of the service. To ensure cost effectiveness as well as quality provision.
Operational	Maintaining skills and competence of BSUH staff with such a low volume of patients. Could result in reduced or restricted service provision and failure to meet Burn Care Standards 2018.	**High**	Include role of Clinical Nurse Specialist(CNS) educator - To ensure adequate training with regular updates and Continuous Professional Development. Close liaison with QVH and annual updates. Use of Network education events.
Operational	Workload is higher than predicted resulting in inadequate staff provision and capacity (ward, outpatients and theatre.) Could result in reduced or restricted service provision and failure to meet Burn Care Standards 2018.	**High**	Ensure adequate workforce planning in business cases and adequate recruitment and training of staff. Identify ring-fenced ward and clinic space for paediatric burns patients; put in place CEPOD/theatre list arrangement/Standard Operating Procedure for paediatric burns. Ensure mechanisms in place to review demand against capacity.

Risk Area	Specific risk	Risk score	Mitigation / Counter measure
Operational	Inability to retain trained staff and subsequent recruitment to specialist posts.	**High**	Robust recruitment plans. Training for bank staff to allow cover. CNS educator will train new staff if appointed. If CNS post holder is not retained then contractual mechanism for on-going training support from QVH
Operational	There is a risk that BSUH may not be able to provide cover for specialist posts due to annual leave and short-term sickness which would impact on service provision and continuity	**High**	21% uplift applied to all roles to cover short-term absence. Identify individuals within existing staff pools who can be trained to an adequate level to provide cover roles when required.
Operational	Inconsistent service provision whilst split with adult burns. BSUH rota does not include specialist burns consultants on call. Could result in reduced or restricted service provision and failure to meet Burn Care Standards 2018 or delay in transfer of inpatient paediatric burn services to RACH	**Medium**	Clinical thresholds for severity of paediatric burns treated at RACH to be decided by commissioners and adhered to. Availability of Burns consultants on QVH Adult Burns Rota for advice including out of hours.
Operational and financial	There is a risk that the service may not be able to provide cover for specialist posts due to prolonged periods of absence e.g. maternity leave and long-term sickness which would impact on service provision and continuity	**High**	Contractual mechanism established to address cost implications. Ongoing training support from QVH if necessary (e.g. CNS on long-term sickness)
Operational and Financial	Some patients currently in QVH catchment area may be nearer to London based Burn Care Provider than to RACH. Potential loss of patients to other services. Risk to sustainability of service and to maintenance of staff competencies.	**Medium**	Only inpatient admissions will need to be seen in Brighton. These patients are likely to be transported by Secamb therefore should remain in area. Patients will still be offered day case and outpatient procedures at QVH.
Operational and Financial	There is a risk that future changes to service specification that render undeliverable, unaffordable or decommissioned.	**High**	Notice of termination of SLA to be issued

12 Conclusion and recommendation

In conclusion this business case sets out the options and identifies the preferred option for improving paediatric burn care in KSS through an alternative delivery model that improves compliance with the mandated Standards for Burn Care. The preferred option identified (Option 5b) is for QVH to work collaboratively with BSUH/RACH to develop an acute inpatient paediatric burn service with RACH. This option keeps the service within KSS and has the potential to align the future provision of adult and paediatric burn services. Whilst it will not fulfil all of the Unit Burn Care Standards it improves compliance and subsequently the quality of care that patients would receive. However this model is associated with costs significantly over and above those of the current service.

The intention was to identify an option that was clinically, operationally and financially sustainable and had the potential to align the future provision of paediatric and adult burns services. However, the preferred option cannot address the following key risks to sustainability:

- The risk that the service will become unsafe/ ineffective due to the difficulty with recruiting and retaining staff.
- That workload is lower than predicted resulting in a financial risk to QVH.
- The risk that interim/locum/bank or agency staff will not be available when required to back fill vacancies in key specialist positions resulting in patients being diverted to other hospitals.

In addition the preferred option generates a number of additional risks:

Financial

- The risk that the additional costs inherent in providing the service in the proposed way across two organisations would add unaffordable cost to commissioners and currently agreed tariffs would not enable QVH to recover these costs making the service unviable financially with limited opportunity for BSUH to support cost mitigation and deliver the service specification.
- The risk of needing to pay high premium costs to fill vacancies in critical specialist roles.
- The risk that providing the additional capacity required to accommodate paediatric burns patients results in an unacceptable level of additional staffing costs/inefficiency because it requires an additional member of ward nursing staff and this is sufficient to staff three additional beds when paediatric burns requires an average of 0.33 beds/day.
- The risk that the future requirement for equipment replacement results in a cost pressure for BSUH.

Operational

- The risk that activity levels could fluctuate and/or increase/decrease in a way that impacts on BSUH performance for example by impacting on capacity to admit non-burns patients.

Clinical risks

- The risk that elements of the service will be unsustainable due to the requirement to provide small numbers of highly specialist staff working across two distant sites to provide care to a low volume of patients. Recruiting and retaining staff in these circumstances and/or when full time roles are not available may lead to vacancies and high levels of turnover in staff critical to safe and effective service provision.
- The risk that the service will become unsafe because it is not possible to provide cover for key specialist staff during times of leave or sickness.
- The risk that staff will have insufficient experience and opportunities to practice their skills due to low volumes of patients. This includes non-specialist ward based staff and general paediatric clinicians who will be required to deliver the non- specialist clinical care for paediatric burns patients; resulting in an unsafe service.
- The risk that the requirement to admit paediatric burns patients as a priority has a negative impact on patient flow and results in adverse outcomes for non-burns patients.

The QVH Executive team notes the concerns of the BSUH Executive team and agrees that the risks are significant. To date, it has not proved possible to identify sufficient mitigations to reduce these risks to acceptable levels meaning the QVH Executive team do not believe the preferred option is viable, in its current format as it cannot be delivered without the manifestation of these risks.

The Executive therefore recommends that the Board agrees that the next step is to further engage with commissioners and the LSEBN to seek their support in either providing additional mitigations or in identifying whether any of the other options can be implemented with reduced levels of risk compared to Option 5b.

In the meantime more immediate pathways will be explored with LSEBN regarding inpatient paediatric burns. However, this may have consequences as explored in option 3.

13 APPENDICIES

Appendix 1

BCSO STANDARD REFERENCE	CHILDREN	ADULTS	LEVEL OF CARE	BCSO STANDARD	ESSENTIAL	DESIRABLE	Steps to achieve compliance at BSUH.	Current service COMPLIANT Y/N	Future service COMPLIANT Y/N	
A.01			-	**Information for Patients, their Families and/or Carers**	**-**	**-**		-		
A.01.A	Y	Y	CUF	Members of the burn care team.	**Y**		To produce documentation	N	Y	
A.01.B	Y	Y	CUF	How to contact the burn area service.	**Y**		To produce documentation	Y	Y	
A.01.C	Y	Y	CUF	Ward layout and routines.	**Y**		To produce documentation	Y	Y	
A.01.D	Y	Y	CUF	Burns and the likely physical, nutritional and psychological implications.	**Y**		To produce documentation	N	Y	
A.01.E	Y	Y	CUF	Support services and groups available.	**Y**		To produce documentation	Y	Y	
A.01.F	Y	Y	CUF	Where to go for further information, including useful websites.	**Y**		To produce documentation	N	Y	
A.02			-	**Plan of Care**	**-**	**-**		-		
A.02.A	Y	Y	CUF	The name of the Consultant responsible for their care.	**Y**		To produce documentation	N	Y	
A.02.B	Y	Y	CUF	Plans for therapeutic interventions and rehabilitation, including physical, nutritional and psychological therapies.	**Y**		To produce documentation	N	Y	
A.02.C	Y	Y	CUF	Potential treatment outcomes.	**Y**		To produce documentation	N	Y	
A.02.D	Y	Y	CUF	The consequence of accepting or declining any of the available treatment options.	**Y**		To produce documentation	N	Y	
A.02.E	Y	Y	CUF	Expected discharge date.	**Y**		To produce documentation	N	Y	
A.03			-	**Acute & Follow-Up OP Care**	**-**	**-**		-		

A.03.A	Y	Y	CU	Patients have access to burn-specific acute and follow-up OP clinics.	**Y**		Consultant review will be burns and plastics	N/A	N	
A.03.B	Y	Y	F	Patients have access to acute and follow-up OP clinics.	**Y**		Will be available at QVH and RACH	Y	Y	
A.03.C	Y	Y	CUF	After discharge, burns patients should have unrestricted access, for life, to the burns MDT in relation to sequelae of their burns or scars, through a streamlined referral pathway.	**Y**			Y	Y	
A.04			-	**Discharge Information Following IP or OP Care**	**-**	**-**		-		
A.04.A	Y	Y	CUF	Resuming activities of daily living.	**Y**		To produce documentation	N	Y	
A.04.B	Y	Y	CUF	Recognition of complications, including sepsis, associated with a burn injury.	**Y**		To produce documentation	N	Y	
A.04.C	Y	Y	CUF	Aftercare of the burn wound (scar management and protection).	**Y**		To produce documentation	Y	Y	
A.04.D	Y	Y	CUF	Pain and itch.	**Y**		To produce documentation ? Already available.	Y	Y	
A.04.E	Y	Y	CUF	Psychological care, information and support available.	**Y**		To produce documentation	Y	Y	
A.04.F	Y	Y	CUF	Key contact details (including 24-hour access to the clinical team).	**Y**		To produce documentation	Y	Y	
A.04.G	Y	Y	CUF	Patient support resources.	**Y**		To produce documentation	Y	Y	
A.04.H	Y	Y	CUF	Follow-up appointment information such as date, time and location.	**Y**		To produce documentation	Y	Y	
A.04.I	Y	Y	CUF	Nutritional care and recommendations post discharge from hospital.	**Y**		To produce documentation	N	Y	
A.05	Y	Y	CUF	**Support Resources**	**Y**		To produce documentation	Y	Y	
A.06	Y	Y	CUF	**Return to Education, Employment and Independent Living**	**Y**		To produce documentation	Y	Y	
A.07			-	**Burns Camp / Club**	**-**	**-**		-		
A.07.A	Y	Y	CUF	Free to participants.	**Y**		BSUH patients will attend service run by QVH	Y	Y	

A.07.B	Y	Y	CUF	Accommodates patients up to the age of 25.	**Y**		Can attend the burns support group run by adults burns service	Y	Y	
A.07.C	Y	Y	CUF	Adheres to the appropriate national standards.	**Y**			Y	Y	
A.07.D	Y	Y	CUF	Staff from the Burn Care Service are given the time to participate and manage these activities.	**Y**		BSUH staff will give information to QVH staff who run service.	Y	Y	
A.08	Y	Y	CUF	**Transition of Care between Children's and Adult Services**	**Y**		Produce documentation - paeds who are seen at BSUH will have to be seen at QVH as adults.	Y	Y	
A.09	Y	Y	CUF	**Patient Reported Experience Measures (PREMS)**	**Y**		Pick measure and ensure part of the running of the service. Ensure same one used at QVH and BSUH.	Y	Y	
A.10			-	**Repatriation Information**	**-**	**-**		-		
A.10.A	Y	Y	CUF	Name of new Consultant responsible for their care.	**Y**		To produce documentation	N	Y	
A.10.B	Y	Y	CUF	Summary of plans for continued therapeutic interventions and rehabilitation.	**Y**		To produce documentation	N	Y	
A.10.C	Y	Y	CUF	Details about the receiving burns service (location, contact numbers, etc).	**Y**		To produce documentation	N	Y	
A.10.D	Y	Y	CUF	The rehabilitation prescription, if appropriate *(see E.10).*	**Y**		To produce documentation	N	Y	
B.01	Y	Y	CUF	**Clinical Lead / Head of Burn Care Service**	**Y**		Nora	Y	Y	
B.02	Y	Y	CUF	**Nursing Lead for Burn Care Service**	**Y**		TBC at BSUH	Y	Y	
B.03			-	**Allied Health Professional (AHP) Leads for Burn Care Service (Centres and Units)**	**-**	**-**		-		
B.03.A	Y	Y	CU	Physiotherapy.	**Y**		Sarah Holdsworth	Y	Y	

B.03.B	Y	Y	CU	Occupational Therapy.	**Y**		Louise Rodgers	Y	Y	
B.03.C	Y	Y	CU	Psychological care.	**Y**		TBC at BSUH	Y	Y	
B.03.D	Y	Y	CU	Dietetics.	**Y**		Jane Gordan at BSUH	Y	Y	
B.03.E	Y		CU	Play Services.	**Y**		TBC at BSUH	Y	Y	
B.04			-	**Allied Health Professional (AHP) Leads for Burn Care Service (Facilities)**	**-**	**-**		-		
B.04.A	Y	Y	F	Physiotherapy.	**Y**		Sarah Holdsworth	Y	Y	
B.04.B	Y	Y	F	Occupational Therapy.	**Y**		Louise Rodgers	Y	Y	
B.04.C	Y	Y	F	Psychological care.	**Y**		TBC	Y	Y	
B.04.D	Y	Y	F	Dietetics.	**Y**		Jane Gordon	Y	Y	
B.04.E	Y		F	Play Services.	**Y**		TBC	Y	Y	
B.04.F	Y	Y	F	Each Professional Lead has time allocated for team leadership, in addition to clinical responsibilities.		**Y**		Y	Y	
B.05	Y	Y	CU	**Research and Development Lead (R & D) – Centres and Units**	**Y**		Will be based at QVH	Y	Y	
B.06			-	**Consultant Surgeons – Centres**	**-**	**-**		-		
B.06.A	Y	Y	C	Have at least three Direct Clinical Care PA's per week allocated to caring for patients with burns. Consultants working in both adult and children's services have at least one DCC PA per week in each of these areas.	**Y**		N/A	N/A	N/A	
B.06.B	Y	Y	C	Have been employed in a recognised burns fellowship or have equivalent proven experience.	**Y**		N/A	N/A	N/A	
B.06.C	Y	Y	C	Have successfully completed an EMSB course.	**Y**		N/A	N/A	N/A	
B.06.D	Y	Y	C	Participate in CPD relating to burn care.	**Y**		N/A	N/A	N/A	
B.06.E	Y	Y	C	Are competent in the recognition and management of non-burn conditions causing skin loss e.g. Toxic Epidermal Necrolysis (TENS).	**Y**		N/A	N/A	N/A	
B.06.F	Y	Y	C	Participate in network and national M&M audit meetings.	**Y**		N/A	N/A	N/A	
B.07			-	**Consultant Surgeons – Units**	**-**	**-**		-		
B.07.A	Y	Y	U	Have at least two DCC PAs per week allocated to caring for patients with burns. Consultants working in both adult and children's services have at least one Direct Clinical Care PA per week in each of these areas.	**Y**		? TBC may be covered by plastic surgeons.	Y	?	
B.07.B	Y	Y	U	Have been employed in a recognized burns fellowship or have equivalent proven experience.	**Y**		? TBC may be covered by plastic	Y	?	

							surgeons.			
B.07.C	Y	Y	U	Have successfully completed an EMSB course.	**Y**			Y	Y	
B.07.D	Y	Y	U	Participate in CPD relating to burn care.	**Y**			Y	Y	
B.07.E	Y	Y	U	Participate in network and national M&M audit meetings.	**Y**			Y	Y	
B.08			-	**Consultant Surgeons – Facilities**	**-**	**-**		-		
B.08.A	Y	Y	F	Has at least one Direct Clinical Care PA per week in burn care.	**Y**			Y		
B.08.B	Y	Y	F	Has successfully completed an EMSB course.	**Y**			Y		
B.08.C	Y	Y	F	Participates in CPD relating to burn care.	**Y**			Y		
B.08.D	Y	Y	F	Participates in network and national M&M audit meetings.	**Y**			Y		
B.09	Y	Y	CUF	**Other Surgical Staffing**	**Y**					
B.10			-	**Critical Care Medicine (Paediatrics)**	**-**	**-**		-		
B.10.A	Y		CUF	Have regular, ongoing experience in burn care.	**Y**		Yes attend QVH and treat patients already/	N	Y	
B.10.B	Y		CUF	Have completed higher or advanced modules in burn care during training.		**Y**		N	N	
B.10.C	Y		CUF	Participate in CPD related to burn care.	**Y**			N	Y	
B.10.D	Y		CUF	Have a nominated lead for burns, who participates in network and national M&M audit meetings.	**Y**		Designate a lead	N	Y	
B.14			-	**Emergency Anaesthetic Support – Children**	**-**	**-**		-		
B.14.A	Y		CUF	Consultant Paediatric Anaesthetist.	**Y**		No additional work required	N	Y	
B.14.B	Y		CUF	An Anaesthetist who has achieved basic / initial competencies is available immediately.	**Y**		No additional work required	Y	Y	
B.16	Y	Y	CU	**Planned Anaesthetic Support - Centres and Units**	**Y**		N/A	N/A	N/A	
B.17			-	**Paediatric Medical Staffing**	**-**	**-**		-		
B.17.A	Y		CUF	The paediatric Burn Care Service provides 24-hour cover by a Consultant Paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites (PICS 2015 *Std CA-202*).	**Y**			N	Y	
B.17.B	Y		CUF	A clinician with competences in resuscitation, stabilisation and intubation of children is available on site at all times (PICS 2015 *Std HW-204*).	**Y**			Y	Y	

B.17.C	Y		CUF	There is 24-hour resident cover by a clinician trained to, or training at, the equivalent of paediatric medicine RCPCH level 1 competences or above. For doctors in training, this will normally be ST3 or above (PICS 2015 *Std CA-203*).	**Y**			Y	Y	
B.18			-	**Registered Nurses – Children**	**-**	**-**				
B.18.A	Y		CUF	IP services for children have at least two Registered Children's Nurses on duty at all times (PICS, 2015 *standard L1-207*).	**Y**			Y	Y	
B.18.B	Y		CUF	Children needing high dependency care should be cared for by a Children's Nurse with training and competences in providing high dependency care (PICS, 2015 standard L1-207).	**Y**			N	Y	
B.18.C	Y		CUF	Registered Nurse staffing ratios for children requiring high dependency care should be 1 nurse to 2 children unless physical layout (e.g. cubicles) requires consideration of 1:1 nursing.	**Y**			Y	Y	
B.20	Y	Y	CU	**Theatre staff – Centres and Units**	**Y**		Theatre staff need to attend burn training annually to comply for scheduled and unscheduled. Risk that this wouldn't be possible for all unscheduled operations.	N/A	Y	
B.21	Y	Y	F	**Theatre Staff – Facilities**	**Y**		Theatre staff need to attend burn training annually to comply for scheduled operations only/.	Y	Y	
B.22			-	**Training**	**-**	**-**		-		
B.22.A	Y	Y	CUF	Statutory and mandatory training in line with their Trust's policy (NHSC, 2010).	**Y**		Should not require additional input	Y	Y	
B.22.B	Y	Y	CUF	Level 1 Safeguarding (Children and Adults) for all non-clinical staff (RCPCH, 2010).	**Y**		As above	Y	Y	
B.22.C	Y	Y	CUF	Level 2 Safeguarding (Children and Adults) for all clinical staff (RCPCH,	**Y**		As above	Y	Y	

				2010).						
B.22.D	Y		CUF	Level 3 Safeguarding (Children) for clinical staff working with children, young people and/or their parents/carers as described in the Intercollegiate Document (RCPCH, 2010).	**Y**		As above	Y	Y	
B.23			-	**Education and Training - EMSB**	**-**	**-**		-		
B.23.A	Y	Y	CUF	Facilitating appropriate members of their MDT to attend courses.	**Y**		Nurses will need to attend	Y	Y	
B.23.B	Y	Y	CUF	Supporting members of staff, who are on the EMSB course faculty, to teach on courses.	**Y**		This will be covered by QVH	Y	Y	
B.24			-	**Education and training for Registered Nurses – Centres and Units**	**-**	**-**		-		
B.24.A	Y	Y	CU	Undertaken burn care specific training which takes in to account all stages of care, the age of the patients cared for and the severity of their injuries.	**Y**		All nurses will need to complete burn training. Risk wont be able to train all nurses.	Y	?	
B.24.B	Y	Y	CU	Completed burn care competencies relevant to their role and been successfully assessed as being competent by the end of their second year in the speciality.	**Y**		All nurses will need competence to be ticked off but have 2 years to complete.	Y	?	
B.24.C	Y	Y	CU	In addition, there is a Registered Nurse available at all times that has successfully completed an accredited academic course in Burn Care or the Emergency Management of Severe Burns course (EMSB) to provide advice and assistance to referring services and clinical expertise on the ward.	**Y**		Need 6 nurses to agree and be funded for EMSB.	Y	?	
B.24.D	Y	Y	CU	In addition to this training, at least 75% of band 6 and above nurses have undertaken a formal period of accredited academic study in burn care.	**Y**		Will be unable to achieve- workload too low to justify.	N	N	
B.25			-	**Education and Training for Registered Nurses – Facilities**	**-**	**-**		-		
B.25.A	Y	Y	F	All members of the Nursing team (bands 2 to 8) have completed burn-specific training annually. This is organised and delivered either within the Burn Care Network or the Burn Care Service.	**Y**		Achievable	Y	Y	
B.25.B	Y	Y	F	The Lead Nurse for the Burn Care Service has completed burn-specific competencies and been successfully assessed as being competent in burn care.	**Y**		Achievable	Y	Y	

B.25.C	Y	Y	F	The Lead Nurse for the Burn Care Service has completed an accredited academic course in burn care or the Emergency Management of Severe Burns course (EMSB).	**Y**		Achievable	Y	Y	
B.26			-	**Physiotherapy and Occupational Therapy Services (Centres, Units and Facilities)**	**-**	**-**		-		
B.26.A	Y	Y	CUF	PT and OT staff are members of the burn MDT.	**Y**		PT/OT to be provided on outreach basis	Y	Y	
B.26.B	Y	Y	CUF	PT and OT staff have specific training and experience in the care of patients with burns.	**Y**			Y	Y	
B.26.C	Y	Y	CUF	Staff with appropriate training and expertise are available to cover for absence.	**Y**			Y	Y	
B.26.D	Y	Y	CUF	The number of therapists in the burn care team is reviewed regularly to ensure an appropriate skill mix for the complexity, dependency and caseload.	**Y**			Y	Y	
B.26.E	Y		CUF	Therapists caring for children have competency in treating children with burn injuries.	**Y**			Y	Y	
B.26.F	Y	Y	CU	An on-call respiratory PT service is accessible at all times.	**Y**		To be provided by BSUH.	N/A	Y	
B.26.G	Y	Y	F	An on-call respiratory PT service is accessible at all times.		**Y**		Y	Y	
B.26.H	Y	Y	CU	There is access to therapy services seven days a week for patients at risk of deterioration without intervention.	**Y**			N/A	N/A	
B.26.I	Y	Y	F	There is access to therapy services seven days a week for patients at risk of deterioration without intervention.		**Y**		Y	Y	
B.26.J	Y	Y	CUF	PT services are available for all burn patients 5 days a week.	**Y**			Y	Y	
B.26.K	Y	Y	CUF	PT services are available for all burn patients 7 days a week.		**Y**		N	N	
B.26.L	Y	Y	CUF	OT services are available for all burn patients 5 days a week.	**Y**			Y	Y	
B.26.M	Y	Y	CUF	OT services are available for all burn patients 7 days a week.		**Y**		N	N	
B.27			-	**Dietetic Services – Centres and Units**	**-**	**-**		-		
B.27.A	Y	Y	CU	Is part of the Burn MDT and provides a dietetic service, 5 days per week at a minimum of 0.5 WTE (ideally allocated at 0.1 WTE per day). A minimum ratio of 0.1 WTE Dietitians per burn ICU bed alone is recommended (FICM/ICS, 2015).	**Y**		Workload too small to justify 0.5 wte	Y	N	
B.27.B	Y	Y	CU	Provides a dietetic service, as described in B.27.A above, 7 days per week.		**Y**		N	N	

B.27.C	Y	Y	CU	Undertakes clinical care of burn injured people and leads on burn nutritional care, service development, teaching, research and audit.	**Y**		Likely this will remain with QVH	Y		
B.27.D	Y	Y	CU	Ensures a burn-specific out-of-hours enteral feeding protocol is in place for when the Dietitian is unavailable.	**Y**		In the process of writing at QVH	N	Y	
B.27.E	Y	Y	CU	Cover for absence, at an equivalent band level and clinical experience, is available for the Burn Dietitian.	**Y**		No other dietician in QVH	N	Y	
B.28			-	**Dietetic Services – Facilities**	**-**	**-**		-		
B.28.A	Y	Y	F	Access to a dietetic service, 5 days per week.	**Y**			Y	Y	
B.28.B	Y	Y	F	Access to a dietetic service, 7 days per week.		**Y**		N	N	
B.28.C	Y	Y	F	Dietitians providing this service have a minimum 1-year practical and relevant clinical experience.	**Y**		Training to be provided however clinical experience will be limited.	Y	Y	
B.28.D	Y	Y	F	Cover for absence, at an equivalent band level and relevant clinical experience, is available for the Burn Dietitian.	**Y**		As above	Y	Y	
B.29			-	**Play Services – Centres, Units and Facilities**	**-**	**-**		-		
B.29.A	Y		CUF	Are members of the burn MDT.	**Y**			Y	Y	
B.29.B	Y		CUF	Have specific training and experience in the care of children with burns.	**Y**		Will attend nurses training	Y	Y	
B.29.C	Y		CUF	In addition, cover for absences is available from staff with appropriate expertise.	**Y**		??	Y		
B.29.D	Y		CUF	There is access to a play service 7 days per week.		**Y**	Not available in current service	N	N	
B.30			-	**Provision of a Psychological Care Service for Patients, their Families and/or Carers**	**-**	**-**		-		
B.30.A	Y	Y	CUF	Staff providing psychological care have specific time allocated to their work with the Burn Care Service and are members of the burn MDT.	**Y**		Yes - employed for the role	Y	Y	
B.30.B	Y	Y	CUF	A psychological care service for patients, their families and/or carers is available 5 days per week and throughout the whole of the burn pathway, in accordance with national standards and guidelines (Blakeney *et al*, 2008; Phillips and Rumsey, 2008; Davis and Sheely-Adolphson, 1997).	**Y**			Y	Y	
B.30.C	Y	Y	CUF	A psychological care service for patients, their families and/or carers is available 7 days per week.		**Y**		N	N	

B.30.D	Y	Y	CUF	Staff providing this service have appropriate training in the care of people with burns.	**Y**		Training from QVH staff ? Risk	Y	Y	
B.30.E	Y	Y	CUF	Staff providing this service are led by a Consultant Clinical Psychologist with training and experience of working in physical health settings.	**Y**		Training from QVH staff ? Risk	Y	Y	
B.30.F	Y	Y	CUF	All members of the wider MDT receive training in psychological care appropriate to their role, using a tiered approach (Borwick, 2010).	**Y**		QVH to provide once a month	Y	Y	
B.31			-	**Psychiatric Assessment / Intervention**	**-**	**-**		-		
B.31.A	Y	Y	CUF	Urgent referrals should receive a response the same day, with an assessment/initial care plan by the next working day.	**Y**			Y	Y	
B.31.B	Y	Y	CUF	Routine referrals should receive a response within 3 working days and an assessment/initial care plan within a week.	**Y**			Y	Y	
B.32	Y	Y	CUF	**Psychological Support Services for Members of the Burn Care Team**	**Y**			N/A	N/A	
B.33			-	**Social Care Support**	**-**	**-**		-		
B.33.A	Y	Y	CUF	There is an identified member of the team, with specialist knowledge of health and social care systems, available to patients and their families to assist with social and welfare issues.	**Y**		Safeguarding provision	Y	Y	
B.33.B	Y	Y	CUF	The worker is part of the burn care team and attends the burn MDT Meetings.	**Y**			Y	Y	
B.33.C	Y	Y	CUF	Arrangements for cover during periods of absences are in place.	**Y**			Y	Y	
B.34			-	**Burn Care Outreach Service (Centres and Units)**	**-**	**-**		-		
B.34.A	Y	Y	CU	Provision of expert clinical advice.	**Y**		To be provided by QVH	Y	Y	
B.34.B	Y	Y	CU	Provision of specialised burn care including wound management, scar therapies, social and functional rehabilitation and psychological care, in an environment which best facilitates their recovery (Esselman *et al*, 2007).	**Y**		To be provided by QVH	Y	Y	
B.34.C	Y	Y	CU	Support and training for community health care professionals working with burn injured patients.	**Y**		To be provided by QVH	Y	Y	
B.35	Y	Y	CUF	**Administrative and clerical support**	**Y**			N/A	N/A	
B.36	Y	Y	CUF	**Work Force Review**	**Y**			N/A	N/A	
C.02			-	**Access to Critical Care Services - Children**	**-**	**-**		-		
C.02.A	Y		C	The Burn Care Service is co-located with a PICU and PHDU facilities.	**Y**			N	N/A	
C.02.B	Y		U	The burn service is co-located with PHDU facilities and has access to Adult ICU facilities.	**Y**			N	Y	
C.02.C	Y		U	Children requiring ventilatory support for > 24 hours are cared for in a PICU.	**Y**			N	N/A	

C.02.D	Y		F	The Burn Care Service has access to ICU and HDU facilities at all times.	**Y**		Via Brighton	Y	Y	
C.02.E	Y		CUF	The critical care service adheres to relevant national guidelines associated with the provision of burn care and critical care (PICS, 2015).	**Y**		No PICU at Brighton	N	N	
C.02.F	Y		CUF	Children requiring critical care are managed jointly by burn specialists and intensivists with input from paediatricians.	**Y**		No PICU at Brighton	N	N	
C.03	Y		CUF	**Access to Critical Care Services – Neonates**	**Y**			N/A	N/A	
C.04			-	**Integration with Major Trauma Network**	**-**	**-**	N	-		
C.04.A	Y	Y	CUF	The Burn Care Service is co-located with an MTU.	**Y**			N	Y	
C.04.B	Y	Y	CUF	The Burn Care Service is co-located with an MTC.		**Y**		N	N	
C.05			-	**Additional Clinical Services**	**-**	**-**		-		
C.05.A	Y	Y	CUF	Emergency Medicine.	**Y**			N	Y	
C.05.C	Y		CUF	Paediatric Surgery (NCEPOD, 2011).	**Y**			Y	Y	
C.05.E	Y		CUF	Paediatric Medicine (NCEPOD, 2011).	**Y**		Apply to adults only.	N	Y	
C.05.F	Y	Y	CUF	Trauma and Orthopaedic Surgery.	**Y**			N	Y	
C.05.H	Y	Y	CU	Radiology with Advanced Scanning Facilities (e.g. Computed Tomography Scan (CT)).	**Y**			N/A	Y	
C.05.I	Y	Y	F	Radiology.	**Y**			Y	Y	
C.05.J	Y	Y	CUF	Integrated (Acute and Chronic) Pain Service.	**Y**		At BSUH will be covered by anaesthetics with training and support from QVH.	Y	N	
C.05.K	Y	Y	CUF	Respiratory Physiotherapy Service.	**Y**			Y	Y	
C.05.L	Y	Y	CU	Renal services (including replacement therapy).	**Y**		Service covered by Evelina not on site	N	N	
C.05.M	Y	Y	F	Renal services (including replacement therapy).		**Y**		N	N	
C.05.N	Y	Y	CUF	Infection Prevention and Control (IPC) Services.	**Y**			Y	Y	

C.05.O	Y	Y	CUF	Liaison Mental Health Service (Acute and Community).	**Y**		No community service. MHL for Brighton and hove patients.	Y	Partially met	
C.05.P	Y	Y	CUF	Transfusion Service.	**Y**			N	Y	
C.05.Q	Y	Y	CUF	Biochemistry.	**Y**			N	Y	
C.05.R	Y	Y	CUF	Haematology.	**Y**			N	Y	
C.06			-	**Additional Clinical Services**	**-**	**-**		-		
C.06.A	Y	Y	CUF	Neurology.	**Y**		Paediatricians with special interest	N	Y	
C.06.B	Y	Y	CUF	Neurosurgery.	**Y**		Covered by Kings	N	N	
C.06.C	Y	Y	CUF	Cardiothoracic surgery.	**Y**		Covered by the evelina	N	N	
C.06.D	Y	Y	CUF	Ophthalmology.	**Y**			Y	Y	
C.06.E	Y	Y	CUF	Maxillofacial surgery.	**Y**			Y	Y	
C.06.F	Y	Y	CUF	Dermatology.	**Y**			N	Y	
C.06.G	Y	Y	CUF	Speech and language therapy.	**Y**			Y	Y	
C.06.H	Y	Y	CUF	ENT.	**Y**			N	Y	
C.06.I	Y	Y	CUF	Medical illustration/photography.	**Y**			Y	Y	
C.06.J	Y	Y	CUF	Microbiology.	**Y**			Y	Y	
C.06.K	Y	Y	CUF	Prosthetic service.	**Y**			Y	N	
C.06.L		Y	CUF	Obstetrics and Gynaecology.	**Y**			N/A	N/A	
C.06.M	Y	Y	Y	Urology.	**Y**			N	Y	
C.07			-	**Scar Management Services**	**-**	**-**		-		
C.07.A	Y	Y	CUF	Education and advice for patients and their families / carers.	**Y**		Draft BSUH version	Y	Y	
C.07.B	Y	Y	CUF	Pressure therapy.	**Y**		Will be provided at BSUH garments at QVH	Y	Y	

C.07.C	Y	Y	CUF	Silicone therapy.	**Y**		?	Y	Y	
C.07.D	Y	Y	CUF	Splinting.	**Y**		Will be provided at BSUH	Y	Y	
C.07.E	Y	Y	CUF	Intra-lesional steroid injections.	**Y**		Will be provided	Y	Y	
C.08			-	**Scar Management Services**	**-**	**-**		-		
C.08.A	Y	Y	CUF	Cosmetic camouflage.	**Y**			Y	Y	
C.08.B	Y	Y	CUF	Medical tattooing.	**Y**		External providers within the network	Y	Y	
C.08.C	Y	Y	CUF	Laser therapy.	**Y**		External providers within the network	Y		
C.08.D	Y	Y	CUF	Hair restoration.	**Y**			Y	Y	
C.09	Y	Y	C	**Services for Toxic Epidermal Necrolysis (TEN) and Stevens-Johnson syndrome (SJS) (all ages).**	**Y**			N/A	N/A	
D.01	Y	Y	CU	**Burn Care Beds – Centres and Units**	**Y**			N	N	
D.02	Y	Y	F	**Burn Care Beds – Facilities**	**Y**		?Depends on interpretation - surgical ward.	Y	Y	
D.03			-	**Availability of Emergency Burn Care Beds**	**-**	**-**		-		
D.03.A	Y	Y	F	The Burn Care Service maintains a record of all patients for whom an appropriate bed was unavailable because of lack of capacity or capability, and the patient was referred to another burn service for admission.	**Y**		Record to be kept by QVH and BSUH	Y	Y	
D.03.B	Y	Y	CU	The Burn Care Service maintains a record of all patients for whom an appropriate bed was unavailable because of lack of capacity or capability, and the patient was referred to another burn service for admission. And additionally, including information about the final receiving hospital (the burns centre or unit accepting the referral).	**Y**		Record to be kept by QVH and BSUH	N/A	Y	
D.03.C	Y	Y	CUF	All Burn Care Services provide a quarterly report to the ODN Board, with details of the refused cases *(see G.11).*	**Y**		? Ownership with QVH	Y		
D.03.D	Y	Y	CU	All Burn Care Services submit twice daily bed utilisation data to the National Directory of Services Pathways (DOS) system *(see E.01.C).*	**Y**		If beocmes a unit	N/A	Y	
D.04			-	**Thermally Controlled Cubicles – Centres and Units**	**-**	**-**		-		
D.04.A	Y	Y	CU	There is access to sufficient single-bedded thermally controlled cubicles to care for burn injured patients.	**Y**			N	N	

D.04.B	Y	Y	CU	There is access to sufficient single-bedded thermally controlled cubicles, with an anteroom, to care for burn injured patients.		**Y**		N	N
D.04.C	Y	Y	CU	There is access to sufficient single-bedded thermally and pressure-controlled cubicles to care for burn injured patients.		**Y**		N	N
D.05			-	**Theatre Environment for Burn Patients**	**-**	**-**		-	
D.05.A	Y	Y	CU	There is timely access to a burn operating theatre at all times. The theatre is in reasonable proximity to the burn ward & ICU/PICU, to ensure that patients can be transferred between sites without deterioration in their temperature or general condition.	**Y**			Y	Y
D.05.B	Y	Y	C	There is timely access to a burn theatre at all times. The operating theatre is within 50 metres of the burn ward or ICU.		**Y**	Potential risk	Y	Y
D.06	Y	Y	CUF	**Skin Products and Substitutes**	**Y**		Allograft will need to be ordered on the day of procedure	Y	Y
D.07			-	**Telemedicine System**	**-**	**-**		-	
D.07.A	Y	Y	CUF	The Burn Care Service utilises the ODN approved telemedicine system.	**Y**		QVH will remain triage service	Y	Y
D.07.B	Y	Y	CUF	All local emergency hospitals have facilities for the secure transfer of digital images to the local specialised Burn Care Service.	**Y**		Current system will remain unchanged BSUH will be able to view.	Y	Y
D.07.C	Y	Y	CUF	There are formal processes in place for the safe and secure storage of digital images and patient information.	**Y**			Y	Y
D.08			-	**Rehabilitation Services – Centres and Units**	**-**	**-**		-	
D.08A	Y	Y	CU	An area within / in close proximity to the burns ward suitable for rehabilitation.	**Y**			N/A	N/A
D.08.B	Y	Y	CU	A rehabilitation area away from the ward.	**Y**			N/A	N/A
D.08.C	Y	Y	CU	Access to an area for the assessment and training in activities of daily living.	**Y**			N/A	N/A
D.08.D	Y	Y	CU	Equipment appropriate to enable patients to return to previous life roles.	**Y**			N/A	N/A
D.08.E	Y	Y	CU	Strength training equipment.	**Y**			N/A	N/A
D.08.F	Y	Y	CU	Cardiovascular equipment.	**Y**			N/A	N/A
D.08.G	Y	Y	CU	Access to off-site activities as appropriate to the needs of the patient.	**Y**			N/A	N/A

D.09			-	**Rehabilitation Services - Facilities**	**-**	**-**		-		
D.09.A	Y	Y	F	An area suitable for rehabilitation.	**Y**			Y	Y	
D.09.B	Y	Y	F	Access to an area for the assessment and training in activities of daily living.	**Y**			Y	Y	
D.10	Y	Y	CUF	**Rehabilitation Services (Other Residential)**	**Y**			N/A	N/A	
E.01			-	**Operational Policy**	**-**	**-**		-		
E.01.A	Y	Y	CUF	The composition of the MDT.	**Y**		To be written	Y	Y	
E.01.B	Y	Y	CUF	Arrangements for MDT meetings, including expected frequency and attendance.	**Y**		To be written	Y	Y	
E.01.C	Y	Y	CU	Twice daily submission to the National Pathways DOS system.	**Y**		To be written	N/A		
E.01.D	Y		CUF	Arrangements for shared care with Paediatricians.	**Y**		To be written	Y	Y	
E.01.F	Y	Y	CUF	The management of whole families that have sustained burn injuries in a single incident.	**Y**		To be written	Y	Y	
E.01.G	Y	Y	CUF	Communication with GPs and community teams (including notification of the death of a patient).	**Y**		To be written	Y	Y	
E.01.H	Y	Y	CUF	Communication with GPs and community teams related to long stay patients (at least monthly during their inpatient stay).		**Y**	To be written	Y	Y	
E.01.I	Y	Y	CUF	Notification to GPs and community teams within 48 hours of the death of a patient.		**Y**	To be written	Y	Y	
E.01.J	Y	Y	CUF	A means of reviewing staffing levels based on activity and patient complexity.	**Y**		? Review current document	Y	Y	
E.01.K	Y	Y	CUF	A process for monitoring and managing bed capacity, and for escalating this issue within the organisation.	**Y**		? Review current document	Y	Y	
E.01.L	Y	Y	CUF	Submission of data to the approved national burns clinical data registry and other relevant national clinical databases.	**Y**		To be written	Y	Y	
E.02			-	**Burn Care Service Major Incident Plan (MIP)**	**-**	**-**		-		
E.02.A	Y	Y	CUF	The Burn Care Service and burn care is included in the Trust's MIP.	**Y**		To be added to RACH policy	Y	Y	
E.02.B	Y	Y	CUF	The Burn Care Service has conducted a MIP practice exercise within the last 2 years.	**Y**		As above			
E.02.C	Y	Y	C	The Burn Care Service has identified appropriate members of staff who can form a BIRT and keeps a detailed contact list.	**Y**		As above	N/A	N/A	
E.02.D	Y	Y	UF	The Burn Care Service has identified appropriate members of staff who can form a BIRT and keeps a detailed contact list.		**Y**	With QVH	Y	Y	

E.02.E	Y	Y	C	Plans are in place regarding the provision of appropriate psychological support for members of the BIRT and wider burn care team post major incident.	**Y**		With QVH	N/A	N/A	
E.02.F	Y	Y	UF	Plans are in place regarding the provision of appropriate psychological support for members of the BIRT and wider burn care team post major incident.		**Y**	With QVH	Y	Y	
E.03			-	**Guidelines for Referring Services**	**-**	**-**		-		
E.03.A	Y	Y	CUF	Contact details for the Burn Care Service.	**Y**		Need to add RACH	Y	Y	
E.03.B	Y	Y	CUF	Airway management (anaesthetic assessment prior to transfer).	**Y**			Y	Y	
E.03.C	Y	Y	CUF	Thresholds for seeking advice from a Burn Care Service, including the assessment and management of patients with non-survivable burns (NHS Specialised Commissioning, 2012).	**Y**			Y	Y	
E.03.D	Y	Y	CUF	Initial assessment and management of burn injured patients.	**Y**			Y	Y	
E.03.E	Y	Y	CUF	Treatment of minor burns.	**Y**			Y	Y	
E.03.F	Y	Y	CUF	Fluid resuscitation.	**Y**			Y	Y	
E.03.G	Y	Y	CUF	Need for surgery (escharotomy) prior to transfer.	**Y**			Y	Y	
E.03.H	Y	Y	CUF	Transfer policy including the resources required (equipment and staffing).	**Y**			Y	Y	
E.03.I	Y	Y	CUF	Guidelines on referral to an appropriate Burn Care Service (including provision for long travel times or where long waits for an appropriate bed are anticipated) (NHS Specialised Commissioning, 2012).	**Y**			Y	Y	
E.03.J	Y	Y	CUF	Patient retrieval.	**Y**			Y	Y	
E.03.K	Y	Y	CUF	Pain and itch management.	**Y**		Needs to be added ? Have already.	N	Y	
E.03.L	Y	Y	CUF	Wound management.	**Y**			Y	Y	
E.03.M	Y	Y	CUF	Procedure to be followed if patient is not appropriate for admission or a bed is not available.	**Y**			Y	Y	
E.03.N	Y	Y	CUF	Transition from children/young people's services to adult services.	**Y**		Need to be written/ changed	Y	Y	
E.03.O	Y	Y	CUF	Repatriation *(see A.10).*	**Y**			Y	Y	
E.03.P	Y	Y	CUF	Discharge information and arrangements for patients and families following admission or attendance.	**Y**			Y	Y	

E.04			-	**Admission policy**	**-**	**-**		-		
E.04.A	Y	Y	CUF	Compliance with agreed burn severity thresholds (NHS Specialised Commissioning, 2012).	**Y**		To be decided and written	Y		
E.04.B	Y	Y	CUF	Allocation of patients to a named Consultant.	**Y**		To be decided and written	Y		
E.04.C	Y		CUF	Referral of children to a named Paediatrician.	**Y**		To be decided and written	N		
E.04.D	Y	Y	CUF	Photography on first presentation.	**Y**		To be decided and written	Y		
E.04.E	Y	Y	CUF	The patient's General Practitioner is informed of their admission within two working days.	**Y**		To be decided and written	N		
E.04.F	Y	Y	CUF	Psychosocial screening of patients admitted for > 24hrs, completed as soon as is clinically appropriate.	**Y**		To be decided and written	Y		
E.04.G	Y	Y	CUF	Functional screening of patients admitted for > 24hrs, completed as soon as is clinically appropriate.	**Y**		To be decided and written	Y		
E.04.H	Y	Y	CUF	Nutritional screening within 24 hours of admission.	**Y**		To be decided and written	N		
E.05			-	**Clinical Guidelines**	**-**	**-**		-		
E.05.A	Y	Y	CUF	Wound assessment and initial management.	**Y**		To be shared with BSUH	Y	Y	
E.05.B	Y	Y	CUF	Intravenous (IV) fluid resuscitation.	**Y**		To be shared with BSUH	Y	Y	
E.05.C	Y	Y	CUF	Recognition and management of the acutely unwell patient (including transfer to a higher level of care).	**Y**		To be shared with BSUH	Y	Y	
E.05.D	Y	Y	CUF	Nutrition assessment and management.	**Y**		To be shared with BSUH	Y	Y	
E.05.E	Y	Y	CUF	Management of burn wound infections.	**Y**		To be shared with BSUH	Y	Y	
E.05.F	Y	Y	CUF	Management of toxic shock syndrome (TSS).	**Y**		To be shared with BSUH	Y	Y	
E.05.G	Y	Y	CUF	Analgesia and use of pain assessment tools for background and breakthrough pain.	**Y**		To be shared with BSUH	Y	Y	
E.05.H	Y	Y	CUF	Analgesia or anaesthesia for painful procedures.	**Y**		To be shared with BSUH	Y	Y	
E.05.I	Y	Y	CUF	Management of itch.	**Y**		To be shared with BSUH	Y	Y	

E.05.J	Y	Y	CUF	Mental health problems including self-harm and substance misuse.	**Y**		To be shared with BSUH	Y	Y	
E.06			-	**Psychological Care Guidelines**	**-**	**-**		-		
E.06.A	Y	Y	CUF	IP assessment, monitoring and delivery of psychological care.	**Y**		Share QVH document with BSUH ? adapt	Y	Y	
E.06.B	Y	Y	CUF	OP assessment, monitoring and delivery of psychological care.	**Y**		As above	Y	Y	
E.06.C	Y	Y	CUF	Patients and family involvement in psychological aspects of care.	**Y**		As above	Y	Y	
E.07	Y	Y	CUF	**Rehabilitation Guidelines**	**Y**		As above	Y	Y	
E.08			-	**Infection Prevention and Control (IPC)**	**-**	**-**		-		
E.08.A	Y	Y	CUF	Patients colonised with multi-drug resistant organisms (MDROs).	**Y**		Share policy from QVH with BSUH	Y	Y	
E.08.B	Y	Y	CUF	The admission of patients from overseas.	**Y**			Y	Y	
E.09			-	**Transfer of Patients between Burn Care Services**	**-**	**-**		-		
E.09.A	Y	Y	CUF	Transfers are arranged in a timely manner according to clinical need.	**Y**		To be written / adapted	Y	Y	
E.09.B	Y	Y	CUF	Transfer of Care documents are sent with the patient.	**Y**			Y	Y	
E.09.C	Y		CUF	Transfer of critically ill children complies with PICS guidelines (RCA, 2018).	**Y**			Y	Y	
E.09.D		Y	CUF	Transfer of critically ill adults complies with ICS guidelines (RCA, 2018).	**Y**			N/A	Y	
E.09.E	Y	Y	CUF	The transferring service discusses the transfer with the patient and family.	**Y**			Y	Y	
E.09.F	Y	Y	CUF	Communication with the patient's GP regarding the transfer.	**Y**		Via EDN	Y	Y	
E.09.G	Y	Y	CUF	Communication with Social Services regarding the transfer, where there are safeguarding concerns.	**Y**			Y	Y	
E.09.H	Y	Y	CUF	When relevant, the transferring service discusses recent microbiology culture reports with the receiving hospital's infection control team.	**Y**			Y	Y	
E.09.I	Y	Y	CUF	A named Consultant in the receiving Burn Care Service.	**Y**			Y	Y	
E.09.J	Y	Y	CUF	A rehabilitation prescription of planned on-going care.	**Y**			Y	Y	
E.09.K	Y	Y	CUF	Thresholds of transfers between centres to units and centres/units to facilities.	**Y**			Y	Y	
E.10			-	**Rehabilitation Prescription (In-Patients)**	**-**	**-**		-		

E.10.A	Y	Y	C	All patients with a centre-level injury, have a first rehabilitation assessment within 48-72 hours of the patient's admission to the Burn Care Centre. The Rehabilitation Prescription is completed for all of those patients who need rehabilitation at discharge / transfer.	**Y**		N/A	N/A	N/A	
E.10.B	Y	Y	CUF	All patients have a first rehabilitation assessment within 48-72 hours of the patient's admission to the Burn Care Service. The Rehabilitation Prescription is completed for all patients who need rehabilitation at discharge / transfer.		**Y**		Y	Y	
E.11			-	**Discharge Guidelines**	**-**	**-**		-		
E.11.A	Y	Y	CUF	Information for patients, their families and/or carers.	**Y**		Via EDN	Y	Y	
E.11.B	Y	Y	CUF	Information to be provided for the patient's GP. This includes contact details for the clinical team and is sent within 2 working days of discharge.	**Y**		Via EDN	Y	Y	
E.11.C	Y	Y	CUF	The plan of care and or discharge documentation includes current and future physical, nutritional, social and psychological care.	**Y**		Via EDN	Y	Y	
E.11.D	Y	Y	C	E.11.A to E.11.C are included in the Rehabilitation Prescription (see E.10).	**Y**			N/A	N/A	
E.12	Y	Y	CUF	**End of Life Care**	**Y**			Y	Y	
F.01	Y	Y	CUF	**Active Involvement in the Burn Care Operational Delivery Network (ODN)**	**Y**		Lead Nurse Meetings, Network Audit Meetings,	Y	Y	
F.02	Y	Y	CUF	**Research**	**Y**		RACH to participate in research as required but to be led by QVH.	Y	Y	
F.03	Y	Y	CUF	**Data Collection**	**Y**		To be overseen by governance and data quality lead	Y	Y	
F.04	Y	Y	CUF	**Activity Coding**	**Y**		Codes to be shared with BSUH	Y	Y	
F.05			-	**Activity Levels**	**-**	**-**				
F.05.C	Y		U	**Children's Burn Units** manage a minimum of 100 acute burn patients (new referrals) annually: - At least 30 require unit level care.	**Y**		Unlikely to have over 30 unit level patients.	N	N	

F.05.E	Y	Y	F	Children's and Adult Burn Facilities manage at least 100 acute burn patients (new referrals) annually, averaged over a three-year period either as IP's or as OP's. The activity data can be associated with adults, children or both.	**Y**		Yes if OP is transferred also.	Y	Y	
F.05.F	Y	Y	CUF	All Burn Care Services monitor activity and complexity of admissions over a rolling average five-year period. The activity data is produced each year and is presented annually to the ODN Board and at the Network Audit meeting(s).	**Y**			Y		
F.05.G	Y	Y	CUF	Variable Life Adjusted Display (VLAD) and/or another assessment tool is used to monitor activity and potentially trigger an external review if concerns arise.	**Y**		?	Y		
F.05.H	Y	Y	CUF	Services that do not meet the expected number of cases (F.05.A to E) inform the ODN and to make arrangements for burn MDT members to maintain their clinical competencies.	**Y**		Will need to if only inpatients go.	N	Y	
F.06			-	**Audit**	**-**	**-**		-		
F.06.A	Y	Y	CUF	Compliance with national burn care referral guidance.	**Y**			Y	Y	
F.06.B	Y	Y	CUF	A self-assessment and review of compliance with Burn Care standards and outcomes.	**Y**		Will take place every 2 years as per guidelines.	Y	Y	
F.06.C	Y	Y	CUF	Mortality, to include all deaths.	**Y**			Y	Y	
F.06.D	Y	Y	CUF	Unexpected survivors or positive outcomes.	**Y**			Y	Y	
F.06.E	Y	Y	CUF	Network and national audit meetings.	**Y**			Y	Y	
F.07	Y	Y	CUF	**Service Development Plan (SDP)**	**Y**			Y	Y	
F.08			-	**Annual Service Report (ASR)**	**-**	**-**		-		
F.08.A	Y	Y	CUF	The Burn Care Service produces an ASR.	**Y**		To be written by QVH	Y	Y	
F.08.B	Y	Y	CUF	The Burn Care Service contributes to the Burns ODN Annual Report *(See G.15)*.	**Y**			Y	Y	
F.09			-	**Continuous Service Improvement**	**-**	**-**		-		
F.09.A	Y	Y	CUF	Clinical audit.	**Y**		Via network Meetings	Y	Y	
F.09.B	Y	Y	CUF	Review of M&M.	**Y**		Via network Meetings	Y	Y	
F.09.C	Y	Y	CUF	Review of complaints.	**Y**		via Paediatric Governance Meeting and Burns open	Y	Y	

							Meetings			
F.09.D	Y	Y	CUF	Review of patient feedback.	**Y**		via Paediatric Governance Meeting and Burns open Meetings	Y	Y	
F.09.E	Y	Y	CUF	Review of Serious Incidents (SIs) and trends.	**Y**		via Paediatric Governance Meeting and Burns open Meetings	Y	Y	
F.09.F	Y	Y	CUF	Review of staff feedback.	**Y**		Monthly team meetings	Y	Y	
F.09.G	Y	Y	CUF	Participation at Network and National Audit meetings.	**Y**		Lead Nurse Meetings, Network Audit Meetings,	Y	Y	
H.01			-	**Adequate Nutrition**	**-**	**-**		-		
H.01.A	Y	Y	CUF	All patients nutritionally screened, using an appropriate tool, within 24 hours of presentation. Patients requiring dietetic assessment, e.g. if concerns identified, are to be referred same day.	**Y**			Y	Y	
H.01.B	Y	Y	CU	All patients with ≥ 5% TBSA burn in children or ≥ 10% TBSA burn in adults are referred to the Dietitian on admission. All resus patients are to be seen within 1 working day of receipt of referral and reviewed as clinically appropriate.	**Y**		Yes if aiming for unit.	N/A	Y	
H.01.C	Y	Y	CUF	All patients' weights are measured and documented weekly, or if clinical picture changes, with noted consideration of burn dressings/ oedema/ amputations. When weight cannot be measured, a mid-upper arm circumference (MUAC) is measured and documented.	**Y**			Y	Y	
H.01.D	Y		CUF	Paediatric patients: Maintain weight throughout recovery until wounds fully healed. Growth chart centiles, for both weight and height/length, should be plotted from admission until wounds fully healed. E.g. weekly to monthly, as clinically appropriate.	**Y**			Y	Y	

H.01.F	Y	Y	CUF	Enteral nutrition is recommended for all ≥ 10% TBSA burn in children, ≥ 15% TBSA burn in adults and for those unable to take oral diet. Early initiation of enteral feeding e.g. within 6-12 hours of injury, is strongly advised for all patients with a major burn injury (Rousseau *et al*, 2013).	**Y**			Y	Y	
H.02			-	**Optimising psychological well-being**	**-**	**-**				
H.02.A	Y	Y	CUF	All patients/families (parents plus or minus child) screened or assessed using locally agreed protocol as soon as clinically appropriate and prior to discharge.	**Y**			Y	Y	
H.02.B	Y	Y	CUF	Level of psychological risk or distress is identified and recorded in patient notes.	**Y**			Y	Y	
H.02.C	Y	Y	CUF	Level and type of intervention or action indicated is identified, recorded and provided as required.	**Y**			Y	Y	
H.02.D	Y	Y	CUF	Where areas of concern are identified evidence-based treatment should be offered and evaluated by the use of condition-specific and age appropriate outcome measures, as clinically appropriate, at various time points in the patient's treatment and rehabilitation.	**Y**			Y	Y	
H.03	Y	Y	CUF	**Minimising Unplanned ICU Re-admissions**	**Y**			N/A	Y	
H.04	Y	Y	CUF	**Minimising Complication Rates**	**Y**			Y	Y	
H.05	Y	Y	CUF	**Effective Clinical Management**	**Y**			Y	Y	
H.06	Y	Y	CUF	**Optimal IV Fluid Resuscitation**	**Y**			Y	Y	
H.07	Y	Y	CUF	**Prompt Wound Care**	**Y**			Y	Y	
H.08	Y	Y	CUF	**Effective Surgical Management**	**Y**			Y	Y	
H.09			-	**Optimising Functional Recovery**	**-**	**-**		-		
H.09.A	Y	Y	CUF	All patients screened for functional morbidity using a locally agreed screening protocol within 24 hours of presentation to the Burn Care Service.	**Y**		To be provided by PT/OT	Y	Y	
H.09.B	Y	Y	CUF	All patients identified as having functional morbidity assessed by an Occupational Therapist and/or Physiotherapist within 72 hours of presentation to the Burn Care Service.	**Y**			Y	Y	
H.09.C	Y	Y	CUF	Repeated measures using a tool selected to reflect the agreed goals identified by the patient in conjunction with the therapist, are completed at agreed intervals until one of the following is achieved: - Normal values for age or population. - Pre-burn functional status. - Patient self-perception of outcome is within a range acceptable to them.	**Y**			Y	Y	

H.09.D	Y	Y	CUF	The score obtained by the selected measurement tool demonstrates that the patient's goals have been met and/or an improvement over time has occurred.	**Y**			Y	Y	
H.10	Y	Y	CUF	**Adequate Control of Procedural Pain**	**Y**		Training to be provided by QVH	Y	Y	
H.11	Y	Y	CUF	**Adequate Background & Breakthrough Analgesia**	**Y**		Training to be provided by QVH	Y	Y	
H.12			-	**Vulnerable Patients Safeguarded**	**-**	**-**		-		
H.12.A	Y	Y	CUF	Patients are screened for safeguarding concerns at presentation (PROCESS).	**Y**			Y	Y	
H.12.B	Y	Y	CUF	Those at risk referred to appropriate agencies (CLINICAL).	**Y**			Y	Y	

Appendix 2

There will be two options for clinical thresholds of acceptance this will be dependent on the adherence to standards.

Option 1 would exclude:

- children under 1 <10% burn,
- 1-5 years <15% burn
- 5-16 years < 20% burn
- intubated or likely to need ventilating,
- with inhalation injuries,
- with significant co-morbidities likely to require paediatric intensive care.

Option 2 would exclude children who are:

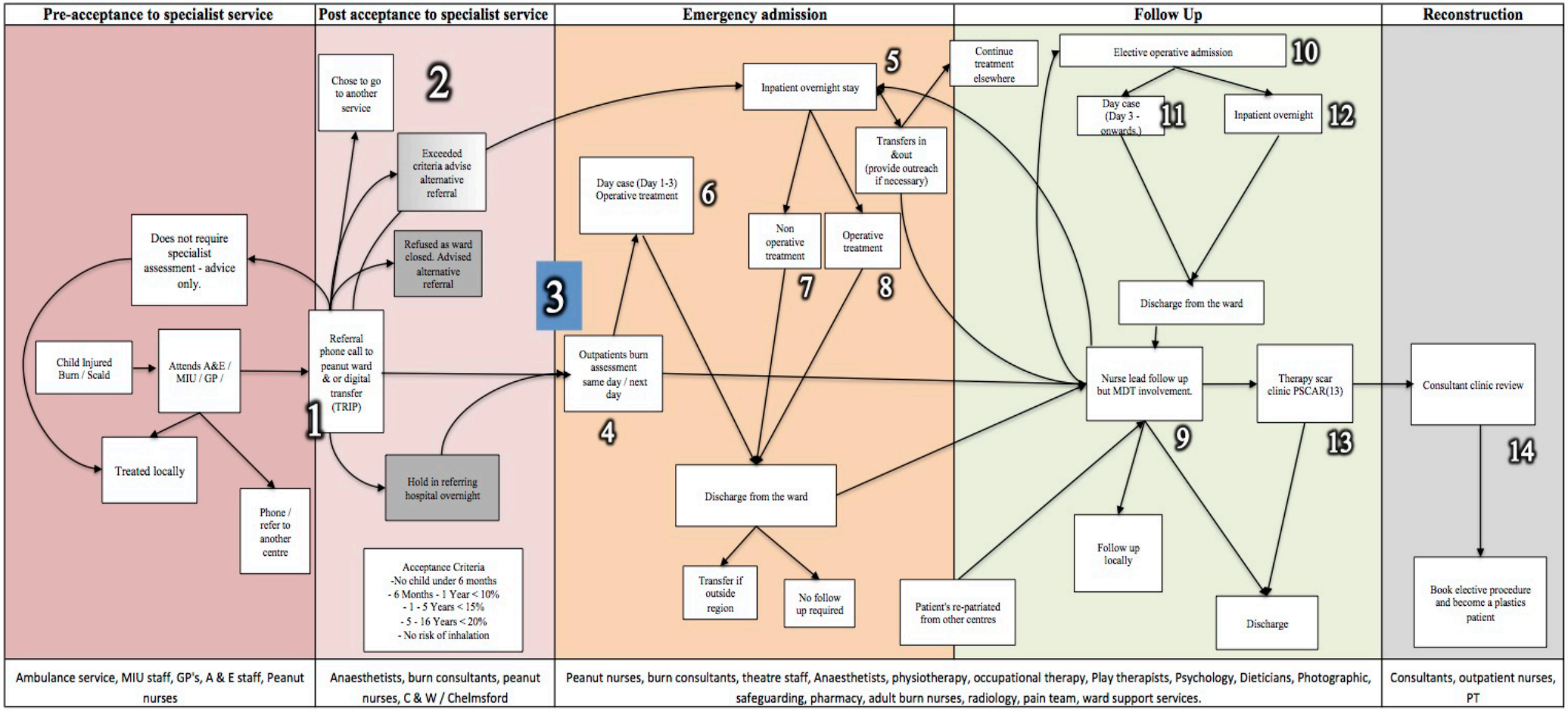
- under 1 with <10% burn,
- 1-5 years <20% burn
- 5-16 years <30% burn
- intubated or likely to need ventilating,
- with inhalation injuries with significant co-morbidities likely to require paediatric intensive care.

Appendix 3

	Activity	2017/18 data	2017/18 Baseline figures	2018/19 1%	19/20 1%	20/21 1%	21/22 1%	22/23 1%
Point 1 pathway - referrals include- advice only calls, those that choose to go elsewhere, those that were refused and those that attended.	Referrals	1,228	1,248	1,260	1,273	1,286	1,299	1,312
Point 2 pathway - Referrals that require specialist input - 85%of refs reach this stage.(excludes advice only calls.)	Post acceptance	1,045	1,067	1,071	1,082	1,093	1,104	1,115
Point 3 of pathway - 99.4% of accepted patients will go on to attend with new criteria including: those previously refsued due to staffing and those held at other centres.	Patients that actually attend	1,031	1058	1,065	1,076	1,086	1,097	1,108
Point 4 on the pathway -New Outpatient attendences - (Non operative day caseincluded in the numbers as seen in PAU) Day case element reduced by 3% otherwise increased by 1%	**New OP Attendances**	**1,002**	**1,022**	**1,059**	**1,068**	**1,076**	**1,085**	**1,093**
Point 9 of pathway - After IP or OP require 2.6 x dressing FU.	Dressing clinic follow up	2,582	2,751	2,846	2,868	2,888	2,910	2,930
Point 14 in the pathway - 9% of patients who actual attendance the service require (IP and OP) need long term follow up.	New in Consultant clinic	90	95	96	97	98	99	100
1.24* ratio of N/FU in consultant clinic	F/UP in Consultant Clinic	112	118	119	120	121	122	123
Point 13 in the pathway - 11.3% of actual attends will require PSCAR appointment	New in PSCAR	117	120	120	122	123	124	125
1.5 * ratio of N/FU in PSCAR	PSCAR clinic F/UP	177	180	181	182	184	186	188
Point 5 of the pathway - 3.4 % of accepts that did NOT go to OP - reduced by 3%	**In-patient overnight admissions**	24	36	**36**	**35**	**35**	**34**	**34**
Point 8 of pathway -29% of inpatient admissions require an operation	Operative	7	10	10	10	10	10	10
Point 7 of the pathway - 71% of inpatient admissions do not require an operation.	Non operative	17	**26**	25	25	25	24	24
Point 6 of pathway - Accepts that DID go to OP first (0.5%of OPA) require an admission for a day case operation	**Day case operation**	**5**	**5**	**5**	**5**	**5**	**5**	**6**
Point 10 of the pathway- 3% of patients who attend the service will require elective surgeryat some point in their journey	Total Elective theatre admissions	32	32	32	32	33	33	33
Point 11 - 91% of elective admissions will be for a day case	Day case admission	29	29	29	29	30	30	30
Point 12 of the pathway - 9% of elective admissions will require an overnigtht stay	Inpatient admission	**3**	3	3	3	3	3	3
Total theatre procedures including emergenecy day case, overnight as well as elective day case and overnight.	Total procedures in theatre	44	47	48	48	48	48	49
	Capacity							
	Theatres							
as average 82 minutes *total procs	Hours per annum in theatre	57	64	65	65	66	66	66
	Beds							
Based on an average of 3.1 days * Emergency inpatient admissions and elective inpatient admissions.	Total bed days		120	119	118	117	116	114

NB - Difference between 17/18 and baseline. Baseline includes Brighton burn patients who would have attended the dressing clinic and the inpatients who were refused due to staffing who would now be accepted.

Appendix 4 – Activity Map



Appendix 5 – Analysis of recurrent income and expenditure revenue

Category	Type	Detail	wte	£
Income	Spells	Inpatient income		110,620
Income	Attendances	Outpatient income		235,122
Income	Beddays	Critical Care income		26,880
Income Sub total				372,621
QVH				
Pay	Medical	Consultant	0.51	69,537
Pay	AHPs/ HCS	Occupational therapist (Band 6)	1.00	41,432
Pay	AHPs	Pyschologist (Band 7)	0.05	2,324
Pay Sub total			1.56	113,293
Non pay	Travel	Consultant Travel		4,449
Non pay	Travel	Occupational Therapist Travel		6,944
Non pay	Travel	Pyschologist Travel		434
Non pay	Travel	Data and governance lead		1,736
Non pay	Overhead	Overhead		31,714
Non pay sub total				45,276
QVH Total pay and non pay			1.56	158,569
BSUH				
Pay	Medical	Consultant anaesthetist	0.05	6,000
Pay	Medical	Consultant time for discharges		343
Pay	AHPs/ HCS	Dietician B7 0.1	0.10	5,165
Pay	Nursing	Theatres Staff		2,262
Pay	Nursing	L8 nursing B6	1.00	47,050
Pay	Nursing	L8 nursing B5	1.59	60,771
Pay	Nursing	CNS/Educator B7	0.40	21,738
Pay	Nursing	HCA B2	0.30	7,798
Pay	Nursing	Play specialist B4	0.40	12,879
Pay	Nursing	Safeguarding nurse B7	0.20	11,291
Pay	Admin	Admin B3	0.20	5,173
Pay	Medical	Medical Secretary B3	0.20	5,173
Pay	AHPs/ HCS	Psychology (via SLA with SPFT) B7	0.35	29,466
Pay	Nursing	Pain nurse B6	0.20	8,652
Pay	AHPs/ HCS	Medical Photography B5	0.20	7,140
Pay Sub total			5.19	230,901
Non pay	Rechanrge	Inpatient emergency operations		1,508
Non pay	Rechanrge	Cost of 39 inpatients for 3.1 bed days		33,400
Non pay	Rechanrge	HDU for Critical care		4,623
Non pay	Rechanrge	outpatients		53,424
Non pay	Travel	Training Mileage for experience days		459
Non pay	Overhead	Capital Charges		38,648
Non pay	Clinical supplies	Dressings costs		4,420
Non pay	Overhead	Overhead		92,024
Non pay sub total				228,507
BSUH Total pay and non pay				459,408
Total Expenditure (QVH &BSUH)			6.75	617,977
(Deficit)				**(245,356)**

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**83-19**	
Report title:	**Six Monthly Workforce Review Board Report**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Nicky Reeves, Deputy Director of Nursing				
Appendices:	None				
Executive summary					
Purpose of report:	The six-monthly workforce Review is a National Quality Board requirement to provide assurance that safe staffing is evidenced and nursing establishments are reviewed on a 6 monthly basis.				
Summary of key issues	In 2016 the NHS spent £73.8 billion on hospital services, with staffing accounting for 70% of the costs. Across the NHS, registered nurses and midwives make up 26.8% of all staff with healthcare support staff making up a further 15%. NHS hospitals have to balance staffing levels needed to deliver care that is safe and effective with the constraints of finite funding. New roles and changing relationships between professional groups can potentially help or hinder that balance, as can the way ward staff are managed. The 6 monthly nursing workforce paper details reviews of the nursing staffing levels required in order to provide safe high quality affordable care. The paper shows some improvement in workforce in many of the clinical areas but challenges remain in theatres and critical care which mirror national trends. Safe provision of care is evidenced though enhanced scrutiny and support from senior nursing team continues. There is effective use of resources and temporary staffing solutions and agency usage is decreasing.				
Recommendation:	Q&GC is requested to **approve** the report to forward to the May Board.				
Action required	Approval	Information	Discussion	Assurance Y	Review
Link to key strategic objectives (KSOs):	KSO1: Y *Outstanding patient experience*	KSO2: Y *World-class clinical services*	KSO3: Y *Operational excellence*	KSO4: Y *Financial sustainability*	KSO5: Y *Organisational excellence*
Implications					
Board assurance framework:	Links to all 5 KSOs				
Corporate risk register:	Workforce risk is on CRR and relates to nursing in 3 separate risks				
Regulation:	Compliance with regulated activities in Health & Social Care Act 2008				
Legal:	As above				
Resources:					
Assurance route					
Previously considered by:	EMT Q&GC				
	Date:	15/4/19 18/4/19	Decision:	Recommend to Board safe staffing achieved	
Next steps:					

Report to: Board of Directors
Meeting date: 02 May 2019
Reference no: 83-19
Report from: Jo Thomas, Director of Nursing and Quality
Report date: 24 April 2019

6 Monthly Nursing Workforce Review, 1 October 2018 to 31 March 2019

1. Purpose

This paper provides assurance that the National Quality Board; Safe sustainable and productive staffing paper, an improvement resource for adult inpatient wards in acute hospitals (Edition 1, January 2018)" has been reviewed and referenced against QVH nursing workforce deployment as appropriate.

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

2. Background

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

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

The data in this report is based on information available covering the 6 months from 1st October 2018 to 31st March 2019 inclusive. This data is based on a number of sources including finance ledgers, ESR, Safe Staffing, local templating and establishment information.

3. Recruitment and Retention

As previously reported leadership from the human resources and organisational development team is aimed at facilitating managers and team leads to focus on all Trust staff to feel valued and supported. Increased rates of bank pay are still in place to incentivise all trained nurses and theatre practitioners to cover more shifts in theatres, critical care and Canadian wing.

The 2018 National NHS staff survey identified an improvement in the numbers of staff recommending QVH as a place to work. The most recent (Q4) staff friends and family (FFT) data has seen a marked increase in recommendations to work at QVH up to 73.62% from 61.59% in Q3 and as a place for a friend or relative to be treated of 96.15% from 91.39% in Q3.

QVH actively seeks opportunities to promote the Trust at schools, colleges, universities and other careers events and has recently attended Sackville and Oxted schools to promote healthcare job opportunities, although inspiring the students to go on to healthcare, QVH is focussing on the university careers events which are aimed at graduate nurses and allied health professionals. We attended such an event at Kings College Hospital and QVH charity has agreed to fund a range of "QVH branded" pens and pads to encourage prospective

candidates to chat to our representatives at careers fairs and ensure they remember us in the future.

The recruitment of a Trust Nursing education lead has given full time support to deliver the ongoing practice requirements of the existing workforce and student nurses and start to assess the needs of the organisation from a nurse education perspective. The impact of this post is already being seen in a range of educational opportunities and supportive interactions including the delivery of the Care Certificate to health care assistants, apprenticeship training, maths and English support, preceptorship support for newly qualified staff and a range of short courses in health and social care at Crawley College. Feedback from the Care Certificate attendees has been positive with HCA's feeling empowered to challenge and advocate for the patients in their care and to improve communication to the registered workforce.

The international recruitment process continues with a number of nurses in the pipeline. 1 wte has already commenced in theatre. 2 are within 6 week of starting in theatre and a further 7 are in the process of obtaining certificates of sponsorship and should be with us within 2 months.

1st October 2018 to 31st March 2019 2018 leaver and starter data for information.

Registered

Trust Workforce KPIs	Workforce KPIs (RAG Rating) ***2016-17 & 2017-18***	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
STARTERS WTE (Excluding rotational doctors)		3.64	3.23	3.81	1.41	0.60	**5.61**
LEAVERS WTE (Excluding rotational doctors)		2.80	1.43	3.93	1.00	0.64	**1.00**
Starters & Leavers balance		0.84	1.80	-0.12	0.41	-0.04	**4.61**

Unregistered

Trust Workforce KPIs	Workforce KPIs (RAG Rating) ***2016-17***	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
STARTERS WTE (Excluding rotational doctors)		2.00	3.47	2.00	0.00	3.84	**2.00**
LEAVERS WTE (Excluding rotational doctors)		1.00	1.00	2.49	1.00	1.00	**0.00**
Starters & Leavers balance		1.00	2.47	-0.49	-1.00	2.84	**2.00**

Sourced via ESR data

QVH patient satisfaction has been sustained and is amongst the best in England benchmarking against the national CQC Inpatient Surveys and FFT scores. Patient experience is a key measure of quality and deterioration in this can be an early warning indicator that there are safety issues so the nursing directorate and the patient safety team continues with enhanced surveillance and triangulation of daily staffing levels, DATIX, complaints, safe care metrics and bank and agency usage to identify potential early warning signs.

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

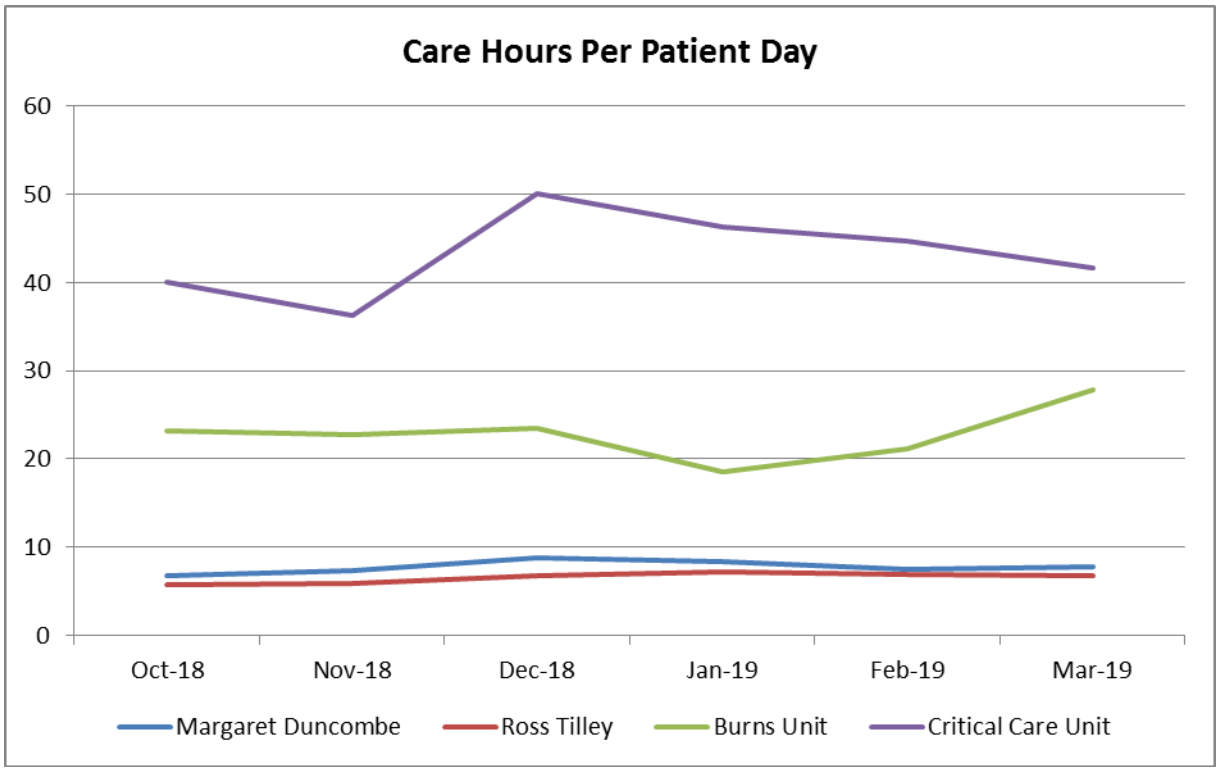
continues to be a feature at every public board which includes details on nursing recruitment and retention triangulated with patient safety metrics and complaints information.

4. Care Hours Per Patient Day (CHPPD) and safe staffing metrics

CHPDD was developed to provide a single national consistent, comparable way of recording and reporting deployment of staff on inpatient wards.

CHPPD give a different perspective on the assessment of "safe staffing" numbers across the inpatient areas and is used to look at trends over time and comparisons of ward areas. QVH excludes paediatrics at the moment due to the number of nights the ward is closed with no inpatients which impacts adversely on the metric.

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Margaret Duncombe	6.7	7.3	8.8	8.3	7.5	7.7
Ross Tilley	5.8	5.9	6.7	7.2	6.9	6.8
Burns Unit	23.1	22.7	23.5	18.5	21.2	27.8
Critical Care Unit	40.0	36.2	50.0	46.3	44.6	41.6



Safe staffing metrics

The CHPPD methodology supports the NICE benchmarking tools and the graph and data above supports the consistent approach within the Trust. It should be noted that CCU data will always have variability due to the varying complexity of the patient cohort and Burns is also influenced by the level of burns injury and also the peaks and troughs in activity.

The CHPPD are displayed on our website (appendix 1) as required following the Francis report. Moving forwards we intend to benchmark against Model hospital CHPPD data sets to inform safe staffing ratios and identify potential efficiencies without impacting on the quality of care. In addition to CHPPD, monthly staffing levels are reviewed as per example below.

Combined Staffing exc. Site			MARCH 2019			Target 95%				
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	5474	2277	5313	2220	Total Hrs Planned and Actual	NIGHT	4290	701.5	4129	644
			97.1%	97%	% Planned Hrs Met				96.2%	91.8%
		7751		7533	Total Hrs Planned & Actual - Combined reg & support			4991		4773
				97.2%	% Planned Hrs Met - Combined reg & support					95.6%

The full 6 months data is in appendix 2. Staffing levels have fallen below the 95% target in Q3 at night although no Datix or safety concerns were raised at the time and they have remained above 90% throughout. Some of the decrease in staffing reflects ward activity and there is evidence of appropriate escalation and redeployment of resources by the site practitioners to ensure patient safety is maintained at all times. Of note, Q4 has seen the target consistently met on day and night.

5. Establishment review findings

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

Nurse staffing across the whole site is reviewed in real time by the ward matrons and heads of nursing, and out of hours by the Site Practitioner. The staffing establishments have been benchmarked as described in previous workforce papers against national standards, AFPP theatre guidance, RCN guidance, Intensive Care Society standards and surrounding burns services.

Ward and Outpatient areas as at 31st March 2019 (excl Ward clerk and admin posts)

The table below is a summary of staffing establishments including registered and non-registered workforce, excluding non-clinical, admin and clerical posts. During October a number of budget alterations were made and where there is variance these figures are included in brackets. The percentages of vacancy have been RAG rated as follows:

Department	Total Recruitable (Substantive WTE incl 12% uplift)	Staff in post October 2018	Number of WTE in post 31 March 2019	Change in staff in post Increase Decrease	Number of vacant posts 31 March 2019	% Vacant posts 31st March 2019
Burns Ward	21.3	16.2	**16.2**	**0**	5.1	24%
Canadian Wing	42.7	33.2	**36.2**	**+3.0**	6.5	15%
Corneo OPD	18.0	17.0	**15.5**	**-1.5**	2.5	14%
Critical Care	25.4	17.4	**16.9**	**-0.5**	8.5	33%
Max Fax OPD	21.3	20.0	**19.6**	**-0.4**	1.7	8%
Peanut Ward	16.8	16.0	**16.5**	**+0.5**	0.3	2%
Peri Op*	131.9	106.3	**99.6**	**-6.7**	32.3	24%
Plastics OPD	14.3	12.6	**12.7**	**+0.1**	1.6	11%
Totals Oct 2018	**291.7 (297.0)**	238.8	**233.2**		**58.5 (58.23)**	**20% (19.6%)**

These numbers exclude non clinical support roles and pre assessment for the purposes of comparison

Key:

% Vacancy	RAG
Less than 12%	Green
12.1% to 18%	Amber
Above 18.1%	Red

Peri Op including Pre assessment
Theatres continue to actively recruit mainly band 5 registered staff and continue to line book agency theatre staff with an average of 10 to 15 agency theatre nurses per day to provide safe staffing in theatres. The "regular" agency staff receive local induction and orientation to the department. Staffing is risk assessed on a daily basis reviewing the impact of agency staff on the skill mix within theatre. There has been an increase in agency usage in some theatres following competency assessment of staff to improve productivity since the four eyes work was completed.

Canadian Wing
Canadian Wing continues to run a rolling advert and there are possible international recruits in the pipeline however at this point, none confirmed for C wing. The ward has successfully recruited 3.0 new staff in the last 6 months.

Burns Ward
Burns is continuing to recruit staff to address its staffing shortage, due to the variability of activity, staffing is deployed across the week to minimise the use of bank/agency. 3.0 wte will commence within the department in April.

Critical Care
Critical Care is having some success in attracting agency staff on to our bank which is having a positive impact on the safety and consistency of the workforce. In addition on a daily basis the split of agency to substantive staff is monitored to ensure safe staffing levels are maintained. Critical Care is continuing to actively recruit, there are 3.0 wte starting during April and a number of international recruits to start over the next 3 months.

Paediatrics
The paediatric ward establishment has been set using RCN guidance for staffing paediatric units. The ward continues to run an on call service at night and will only open in the event that a patient requires overnight care otherwise staff go off duty at 00.00. The establishment remains stable.

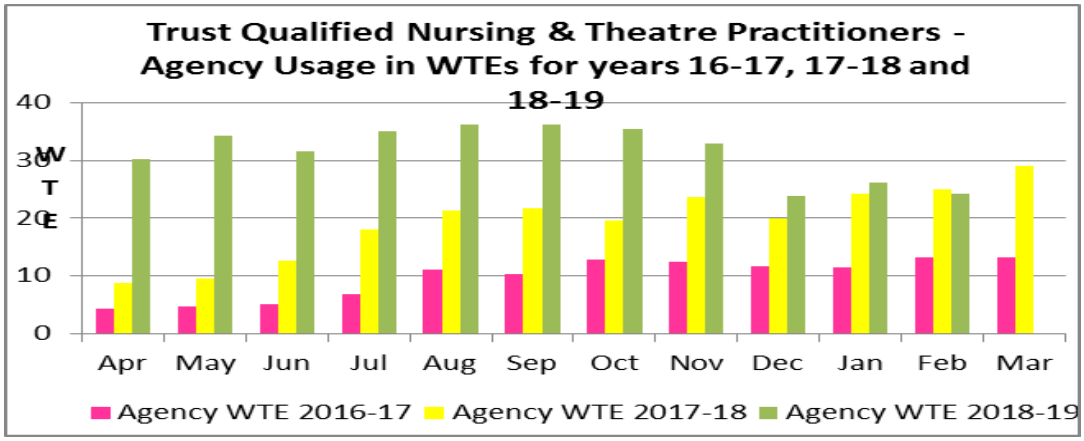
Corneo Out Patients Department
Corneo has positive retention of staff and has developed a range of specialist roles to meet the needs of their patient group.

Max Fax Out Patients Department
Max Fax is working hard to improve the recruitment and retention position.

Plastics Out Patients Department
Plastics Outpatients has improved its recruitment and continues to maintain a stable workforce.

6. Temporary Staff usage
The graphs below demonstrate a decrease in agency usage and therefore cost to the organisation, this can be attributed to increased management of agency usage and more effective deployment of staff around the organisation. Nursing vacancies make it necessary

to use temporary staffing however all areas are striving to reduce the agency burden and maintain safe staffing levels and delivery of quality care.



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

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

In addition as assurance, the director and deputy director of nursing attend the 08.00 trauma meeting to ensure staffing levels are safe at the start of the day. Monthly triangulation of actual staffing against planned is carried out and measured against incidents raised via datix and safer nursing metrics.

7. Retirements
The table below indicates the numbers qualified Nurses/theatres practitioners who could retire in the next 2 years. Included is anyone aged 53 and over for any NMC registered staff and anyone 58 and over for any HCPC registered staff.

Payscale	2 Years
Review Body Band 5	29
Review Body Band 6	26
Review Body Band 7	13
Review Body Band 8 - Range A	1
Review Body Band 8 - Range B	1
Review Body Band 8 - Range C	1
Trust Director	1

8. Maternity Leave and Sickness
4.17 WTE registered nurses are currently as at 1st April 2019 on maternity leave across the nursing areas reviewed as part of this paper, a small decrease from the October review

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

Registered

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17 & 2017-18			Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness Absence %	>=4%	4%<>3%	<3%	3.11%	*3.60%*	3.21%	4.20%	3.74%	***4.50%***

Unregistered

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2016-17			Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness Absence %	>=4%	4%<>3%	<3%	8.87%	6.14%	4.08%	4.49%	6.85%	***4.50%***

ESR data

9. Assurance

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

Staffing levels continue to be reviewed regularly using evidence based tool and there is a clear governance process for monitoring and escalation. In addition, all vacancies, bank and agency requests are reviewed by the Executive team weekly to ensure safe staffing and effective use of resources.

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

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

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

10. Recommendations

The Board is asked to:

- note the 6 monthly establishment review
- note that we meet the benchmarks recommend by RCN, ICS, NICE and AfPP
- note the staffing levels and skill mix are effectively reviewed
- note that safe, high quality care is being delivered due to staff pride in their work and flexibility.
- note the key area of concern remains the high vacancy rate particularly within theatres and critical care
- Further detailed review on sickness and age to be undertaken to look for any correlation between rising sickness rates and the raising of the retirement age
- note the actions being taken to address the recruitment and retention challenges
- To utilise the CHPPD data in comparison with the model hospital to benchmark accurately.

Nicky Reeves
Deputy Director of Nursing
April 2019

Appendix 1

Organisation:	RPC	Queen Victoria Hospital NHS Foundation Trust

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

http://www.qvh.nhs.uk/for-patients/safe-staffing/

Only complete sites your organisation is accountable for

Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
					Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
RPC04	VICTORIA HOSPITAL (EAST GRINSTEAD) -	Margaret Duncombe	160 - PLASTIC SURGERY	145 - ORAL & MAXILLO FACIAL SURGERY	1288	1231	160	437	989	1012	345	310.5	95.6%	273.1%	102.3%	90.0%	445	5.0	1.7	6.7
RPC04	VICTORIA HOSPITAL (EAST GRINSTEAD) -	Ross Tilley	160 - PLASTIC SURGERY	145 - ORAL & MAXILLO FACIAL SURGERY	1346	1300	552	506	989	977.5	333.5	322	96.6%	91.7%	98.8%	96.6%	535	4.3	1.5	5.8
RPC04	VICTORIA HOSPITAL (EAST GRINSTEAD) -	Burns Unit	160 - PLASTIC SURGERY		1035	1024	356.5	299	713	713	0	0	98.9%	83.9%	100.0%	-	88	19.7	3.4	23.1
RPC04	VICTORIA HOSPITAL (EAST GRINSTEAD) -	Critical Care Unit	160 - PLASTIC SURGERY	145 - ORAL & MAXILLO FACIAL SURGERY	1196	1127	276	264.5	1242	1104	92	103.5	94.2%	95.8%	88.9%	112.5%	65	34.3	5.7	40.0

Appendix 2

Below is an example of the summary metric taken from the Safe Staffing tool. This demonstrates percentages per month staffing did not meet meet the expected target of 95% . This information is reviewed on a monthly basis by the Director of Nursing.

Combined Staffing exc. Site					OCTOBER 2018					Target 95%
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	5888	1978	5716	1829	Total Hrs Planned and Actual	NIGHT	4623	770.5	4290	747.5
			97.1%	92%	% Planned Hrs Met				92.8%	97.0%
		7866		7544	Total Hrs Planned & Actual - Combined reg & support			5394		5037
				95.9%	% Planned Hrs Met - Combined reg & support					93.4%

Combined Staffing exc. Site					NOVEMBER 2018					Target 95%
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	5658	2185	5578	2105	Total Hrs Planned and Actual	NIGHT	4704	770.5	4382	736
			98.6%	96%	% Planned Hrs Met				93.2%	95.5%
		7843		7682	Total Hrs Planned & Actual - Combined reg & support			5474		5118
				97.9%	% Planned Hrs Met - Combined reg & support					93.5%

Combined Staffing exc. Site					DECEMBER 2018					Target 95%
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	5244	2093	5095	2024	Total Hrs Planned and Actual	NIGHT	3991	701.5	3703	575
			97.1%	97%	% Planned Hrs Met				92.8%	82.0%
		7337		7119	Total Hrs Planned & Actual - Combined reg & support			4692		4278
				97.0%	% Planned Hrs Met - Combined reg & support					91.2%

Combined Staffing exc. Site					JANUARY 2019					Target 95%
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	5118	2116	5072	2082	Total Hrs Planned and Actual	NIGHT	3899	713	3807	713
			99.1%	98%	% Planned Hrs Met				97.6%	#####
		7234		7153	Total Hrs Planned & Actual - Combined reg & support			4612		4520
				98.9%	% Planned Hrs Met - Combined reg & support					98.0%

Combined Staffing exc. Site					FEBRUARY 2019					Target 95%
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	4830	2001	4681	1955	Total Hrs Planned and Actual	NIGHT	3841	782	3657	747.5
			96.9%	98%	% Planned Hrs Met				95.2%	95.6%
		6831		6636	Total Hrs Planned & Actual - Combined reg & support			4623		4405
				97.1%	% Planned Hrs Met - Combined reg & support					95.3%

Combined Staffing exc. Site			MARCH 2019			Target 95%				
	Planned staff		Actual staff				Planned staff		Actual staff	
	RN	HCA	RN	HCA			RN	HCA	RN	HCA
DAY	5474	2277	5313	2220	*Total Hrs Planned and Actual*	NIGHT	4290	701.5	4129	644
			97.1%	97%	*% Planned Hrs Met*				96.2%	91.8%
		7751		7533	*Total Hrs Planned & Actual - Combined reg & support*			4991		4773
				97.2%	*% Planned Hrs Met - Combined reg & support*					95.6%

Appendix 3

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

Information is clearly displayed about nurses and care staff on duty in each ward on each shift.	All ward areas have status boards in public areas stating expected number and actual number of nurses and care staff on duty. When there are variations on this, the ward matron will review and escalate via agreed processes to ensure safe staffing maintained. The DoN will review this escalation and triangulate with safer care metrics and complaints data to ensure staffing levels allow provision of quality care
Providers take an active role in securing staff in line with workforce requirements	Recruitment days for general and theatre staff have taken place in the last 12 months. Staff are supported to undertake specialist modules for development and enhanced care. Director of HR reviewing recruitment processes. Part of the theatre productivity work has a workforce subgroup. Different recruitments campaigns have been instigated in the last 4 months. This has results in increased interest in post however the trust is experiencing difficulty in recruiting to some posts mainly in Theatres and ITU (significant national shortages in these areas).
Commissioners actively seek assurance that the right people with the right skills are in the right place at the right time with the providers with who they contract.	DoN meets monthly with the CCG Chief Nurse. Staffing levels discussed at these meeting. The commissioners are aware of the nurse staffing levels and the actions the trust is taking to optimise recruitment and retention.

Recommendations.

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**84-19**	
Report title:	**Seven Day Services (7DS) – Board Assurance Framework (BAF)**				
Sponsor:	Dr Ed Pickles, Medical Director				
Author:	Dr Ed Pickles, Medical Director				
Appendices:	N/A				
Executive summary					
Purpose of report:	Mandatory BAF 7DS report, replacing national reporting of 7DS standards compliance				
Summary of key issues	Note full compliance of priority standards (agreed with NHSI), with caveat that achievement is dependent on partnership working with other trusts, and development of local standards of timely consultant review.				
Recommendation:					
Action required *[highlight **one** only]*	Approval ✓	Information ✓	Discussion ✓	Assurance ✓	Review
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*		KSO5: ✓ *Organisational excellence*
Implications					
Board assurance framework:	BAF KSO2				
Corporate risk register:	CRR 1059; RR845				
Regulation:	NHS Improvement				
Legal:					
Resources:					
Assurance route					
Previously considered by:	Quality and Governance Committee (draft)				
	Date:	Feb 2019	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:					

7 Day Hospital Services Self-Assessment

Organisation	**Queen Victoria Hospital NHS FT**
Year	**2018/19**
Period	**Autumn/Winter**

Queen Victoria Hospital NHS FT: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Previous audits done through Natcansat national tool. September 2016 45% of 'emergency admissions' had documented review by consultant within 14 hours, March 2017 - 51%; September 2017 72%; June 2018 76% - Weekends 82%; Weekdays 71% Local Audit Dec 2018 77% Agreement from NHSI 7DS that local pathway development appropriate to reflect specialist case mix. Pathway agreed at CGG, Q&GC and JHCGM and principle accepted at CGG - further audit traunch to be submitted to CQPRM in May 2019. Compliance with locally agreed pathway - 92% (Jun 2018) and 94% (Dec 2018) Consultant job plans in anaesthetics, burns and plastic surgery now allow for full compliance with national targets for Clinical Standard 2 and 8 seven days per week, and job plans in oral and maxillofacial and ophthalmic surgery allow for full compliance with national standards 5 days per week and with locally agreed standards seven days per week. Full pharmacy services are only provided 5 days per week, and there is ambition to increase this when recruitment allows. The risk is mitigated through site practitioner access to pharmacy and telephone advice available from GSTT 24/7 when pharmacy is closed. there is no evidence that safer staffing levels on wards and critical care are influenced by the day of the week. In the 2018 GMC survey, out of hours clinical supervision showed improvement in all 4 clinical specialties. We did however get 2 pink flags (lower quartile) in higher plastics and OMFS, and we shall monitor this in the 2019 survey. We monitor deaths on site, and off site within 30 days of surgery. Low mortality numbers do not allow for conclusions on any weekend effect. We transfer out proportionally fewer patients at a weekend than on a weekend. (57 patients Monday to Friday; 15 patients Saturday and Sunday in 2018)	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available off site via formal arrangement	
		Ultrasound	Yes available on site	Yes available on site	
	Formal network agreement for medical referral and review, for pathology and radiology via BSUH SLA. Memorandum of Understanding with aspirations to increase clinical and managerial collaboration between two trusts. Likley partnership with supporting trust by 2020. Note CT now on-site, but currently only 5 day working hours service. SLA in place for out of hours. Business plan for translocatable MRI in progress.	Echocardiography	Yes available on site	Yes available off site via formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available off site via formal arrangement	
		Upper GI endoscopy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
	Formal network agreement for medical referral and review, for pathology and radiology via BSUH SLA. Memorandum of Understanding with aspirations to increase clinical and managerial collaboration between two trusts. Likley partnership with supporting trust by 2020.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available off site via formal arrangement	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	All patients with Level 2 or 3 critical care needs reviewed twice daily, and as required. Anaesthetic and critical care consultant out of hours job planning enables twice daily consultant review across seven days in these areas. Recent changes in documentation to better capture twice daily critical care review and, in particualt, weekend handover. Recently reviewed escalation protocols in critical care. CCU consultant present at morning and evening handover meetings with trauma and hospital at night teams Day time consultant cover of ICM is limited to 2 consultants / week, working in 2 – 3 day blocks, plus on-call cover at weekend. Consistency of ST5-7 cover is also limited to 2 -3 registrars / week. Ward transfers at nights and weekends only in very exceptional cases. Critical care inspected by CQC and SECCCN in Feb / April 2019 - reports awaited. We do not meet all critical care service specifications in terms of 24/7 FICM accredited critical care consultants or co-location, but mitigation to the satisfaction of network and CQC. Formal audit of twice daily review and escalation to be completed in 2019/20. Once daily review of all non-elective patients in QVH on daily ward round well-embedded (100% on 2018 audit data). NEWS2 utilised for escalation protocols. Plan for electronic observation NEWS2 system, with automatic escalation, AKI and sepsis alerts in 2019/20. Board rounds daily in plastics surgery trauma and maxillofacial surgery, with radiology and photography available, and with suitable delegation of review where appropriate. Capture of board round information into patient record not achieved. Live, direct entry forms for electronic patient record in development.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
See 7DS action plan. Standard 1 - Excellent Friends and Family feedback, however, not yet split into collection on weekday versus weekend - priority for 2019/20 Stabdard 3 - Professions Allied to Medicine, including SALT, OT, Dietetics, Pharmacy, Psychology, are generally provided on a 5 day / week basis. QVH specialist case mix does not require full MDT review for vast majority of cases admitted at weekend. Physiotherapy is available 24/7. Standard 4 - MDT handover well embedded for wards, critical care and whole hospital, with high satisfaction in GMC training survey. Capture of handover information, including delegation of review, to form part of patient record not yet finalised, and remains priority for 2019/20. Standard 7 SLA with Sussex Partnership NHS Foundation trust for 24/7 mental health needs, plus on-site psychological services department (5 days/week). Particular requirements of reconstruction and burns patients considered and well catered for. Standard 9 Infrequent delayed transfers of care for our patient cohort, which are generally ambulatory. Discharge planning begins on admission. Access to community of all QVH urgent services via specialty consultants on-call. Standard 10 QI detailed in Annual Quality Report and Quality and Safety Strategy. All pillars of clinical governance and clinical risk managemtn provided and adhered. Trainee feedback regularly collected. Main Workstreams for 2019/20 1) Consultant job planning • Trust has moved to electronic job planning. • Purchase of Allocate Activity Manager in 2019 will improve team job planning capability 2) BSUH Partnership & STP • Memorandum of understanding with BSUH agreed June 2017

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
N/A

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed 18 April 2019

Strategic Objective
We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.

Risk Appetite The trust has a **low appetite** for risks that impact on operational delivery of services and is working with a range of stakeholders to redesign and improve effectiveness and efficiency to improve patient experience, safety and quality.

Initial Risk	5 (c) x3 (L) =15, moderate
Current Risk Rating	5 (C) x 4 (L) = 20, major
Target Risk Rating	3 (C) x 3 (L) = 9, low

Risk
Sustained delivery of constitutional access 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.

Rationale for current score
- Waiting list size and challenge with long wait patients
- Performance challenges across OMFS, plastics and eyes
- Spoke site links and pathways
- Vacancy levels in theatre staffing and theatre capacity
- Vacancy levels in sleep
- Specialist nature / complexity of some activity
- Administrative vacancies including appointments team
- Variable trust wide processes including booking and scheduling
- Late referrals from referring organisations
- Vacancies in non consultant level medical staff
- Initial recruitment to breast locum not successful

Future risks
- 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;
- Future impact of Brexit on workforce
- Reputation as a consequence of RTT

Future Opportunities
- Spoke sites offer the opportunity for further partnerships
- Closer working between providers in STP – networked care
- Partnership with BSUH/WSHFT

Controls / Assurance
- Weekly RTT and cancer PTL meetings
- Revised PTL in place & ongoing work to developed a non RTT PTL
- Revised access and cancer policies
- RTT recovery plan in place and system task and finish group (now monthly)
- Trajectories developed for delivery of RTT position for 18/19 and 19/20
- Development of revised operational processes underway to enhance assurance and grip
- Monthly business unit performance review meetings & dashboard in place with a focus on exceptions, actions and forward planning;
- Documentation of all booking and scheduling processes underway to inform process redesign
- Theatre improvement programme ingoing and work to date has established revised planning arrangements
- Mobilisation of outpatient improvement programme

Gaps in controls / assurance
- Variable trust wide processes for booking and scheduling
- Not all spoke sites on QVH PAS so access to timely information is limited
- Shared pathways for cancer cases with late referrals from other trusts
- Late referrals for 18RTT and cancer patients from neighbouring trusts
- High vacancy rate in theatre nursing/OPD
- Capacity challenges for both admitted and non admitted pathways
- Informatics capacity
- Impact of patient choice that is a risk to delivery of plan to eliminate RTT waits > 52 weeks

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Finance & Performance
Date last reviewed: 18h April 2019

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

Risk Appetite The Trust has a **moderate appetite** for risks that impact on the Trusts financial position. A higher level of rigor is being placed to fully understand the implications of service developments and business cases moving forward to ensure informed decision making can be undertaken.

Initial Risk 3 (C) x 5(L) = 15, moderate
Current Risk Rating 5 (C) x 5(L)= 25, catastrophic
Target Risk Rating 4(C) x 3(L) = 12, moderate

Rationale for current score (at Month 12 – pre Audit Provisional)

- Deficit £5.9m deficit reforecast achieved (excluding donated adjs)
- CIP forecast delivery - (gap - £2m)
- Finance & Use of resources – 3 (planned 1)
- CIP pipeline schemes to be identified for the new financial year
- High risk factor –availability of staffing - nursing and non clinical posts
- Commissioner challenge and scrutiny
- Potential changes to commissioning agendas
- 2019/20 CIPP Gap and non delivery YTD
- Contracting alignment agreement
- Significant underperformance on activity plan c£4m
- Significant overspend on agency staffing, however clinical safety is requiring additional agency costs over and above ceiling c£0.6m premium
- Reforecast Submitted to NHSI post Board Approval of £5.9m Deficit excluding donated adjs and achieved
- Agenda for change increase in costs £0.2m
- 2019/20 Operation plan submission (April) –£8.6m deficit – with Board agreement

Future Risks
NHS Sector financial landscape Regulatory Intervention

- Autonomy
- Capped expenditure process
- Single Oversight Framework
- Commissioning intentions – Clinical effective commissioning
- Sustainability and transformation footprint plans
- Planning timetables–Trust v STP

Future Opportunities

- 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
- Improved vacancy levels and less reliance on agency staffing
- Increase in efficiency and scheduling through whole of the patient pathway
- Spoke site activity repatriation
- Strategic alliances \ franchise chains and networks

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)
- CIP Governance processes
- Income / Activity capture and coding processes embedded and regularly audited
- Weekly activity information per Business unit, specialty and POD
- NHSI options appraisal & NHSI review of the Operating plan for 19/20

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Model Hospital Review and implementation
- ~~Costing Transformation Programme - Implementation Q4 2017/18 –~~ roll out of management information, development into service line reporting.
- Enhanced pay and establishment controls including performance against the agency cap
- Increased levels of Finance and procurement training to budget holders – Possible development of Mandatory
- Establishment review and reconciliation between the ledger and ESR – This has been completed within the 19/20 budget setting, ESR will have a time lag to update
- Additional Financial Resources required

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**2 May 2019**		**Agenda reference:**	**86-19**	
Report title:	**Financial, operational and workforce performance assurance**				
Sponsor:	John Thornton, Non-Executive Director				
Author:	John Thornton, Non-Executive Director				
Appendices:	n/a				
Executive summary					
Purpose of report:	Board Assurance				
Summary of key issues	Progress on patient waiting lists. But limited assurance on plans to improve capacity utilisation to drive activity levels.				
Recommendation:					
Action required *[highlight **one** only]*	Approval	Information	Discussion	Assurance	Review
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: x *Operational excellence*	KSO4: x *Financial sustainability*	KSO5: x *Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to: Board of Directors
Meeting date: 02 May 2019
Reference no: 86-19
Report from: John Thornton, Committee Chair
Report date: 24 April 2019

Finance and performance assurance report

1. Operational performance

The percentage of patients being treated in 18 weeks continues to improve and we are achieving our agreed trajectory. The number of 52 week waits also continues to reduce and committee received assurance that continued improvements can be maintained in line with the agreed plans in both areas.

Patient activity levels in March were below plan which had a direct impact on our income for the month. Our 2019/20 budget is based on an increased level of patient activity and committee intends to increase its focus on plans for improvement of utilisation of our capacity.

Committee requested more detailed monthly information on the number of sessions run in theatres and the utilisation of available time in each session. Committee also intends to monitor closely the findings and action plans from the current review of Outpatient processes.

2. Workforce performance

Recruitment was again positive in the month and numbers of staff in post increased. However we still have a large number of vacancies and little improvement has been achieved in reducing the number of temporary staff. Progress is being made on the recruitment of identified overseas nurses and ten are now well advanced.

Given the generally positive movement in several of our key workforce objectives there was a preliminary discussion on whether the risk rating on the BAF was too high. The conclusion was that it was too soon to make any change.

3. Financial performance

Performance within month allowed us to achieve our reforecast budget for the year. Although this was of course well below our original budget and prior years performance. This being principally due to flat income and increased costs.

It was agreed that any diversion from our current year cost budgets would need to be addressed immediately.

In response to our submitted budget for 2019/20 NHSE&I have written to ask for our plans to close the financial gap. Due to the deadline for a response SJ had replied prior to our meeting. The response set out a few technical adjustments that could be made to

improve our position and said that we would be willing to try to drive further CIP improvements but we would require input and support from the centre. Committee supported this positive but realistic approach. We await a response to our suggestions.

It is likely that the anticipated fines of £800k for RTT and Cancer waits that we had included in our budget will not be imposed. This effectively improves our budget deficit by £800k. It is accepted that the hospital can invest this money to further improve its performance in these areas. But committee agreed that this money should be ring fenced and only used for identified investments. It should not be used to subsidise any shortfall against our operational budget.

4. Business Planning

Good progress has been made in completing the activity/income agreements with our various commissioners. Committee received assurance that the remaining discrepancies were not material to our budget.

The committee discussed in some detail how the budget has been allocated and cascaded through the organisation to the different business units. Although the committee was assured that the process had been inclusive and there was good buy in from the service lines, it was concerned that individual budgets had not all been signed off. Committee also requested that the budgets were signed off by the relevant medical directors and not only the unit business managers. Committee will track this to conclusion.

John Thornton
Chair

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**87-19**	
Report title:	**Operational Performance**				
Sponsor:	Abigail Jago, Director of Operations				
Author:	Operations Team				
Appendices:					
Executive summary					
Purpose of report:	To provide an update regarding operational performance				
Summary of key issues	Key items to note in the operational report are: • Delivery of diagnostic waiting time standards • Delivery of RTT open pathway performance in month target • Patients waiting greater than 52 weeks was 2 above in month target • Delivery of 62 day and 2 week wait cancer standard. Under target for 31 day standard. • Delivery of MIU 4 hour standard • Ongoing delivery of theatre improvement programme • Launch of outpatient improvement programme				
Recommendation:	To **note** the report				
Action required	~~Approval **Y**~~	~~Information **Y**~~	~~Discussion **Y**~~	Assurance **Y**	~~Review **Y**~~
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: **Y** *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*

Implications	
Board assurance framework:	**Controls / Assurance** • Weekly RTT and cancer PTL meetings • Revised PTL in place & ongoing work to developed a non RTT PTL • Revised access and cancer policies • RTT recovery plan in place and system task and finish group (now monthly) • Trajectories developed for delivery of RTT position for 18/19 and 19/20 • Development of revised operational processes underway to enhance assurance and grip • Monthly business unit performance review meetings & dashboard in place with a focus on exceptions, actions and forward planning; • Documentation of all booking and scheduling processes underway to inform process redesign • Theatre improvement programme ingoing and work to date has established revised planning arrangements • Mobilisation of outpatient improvement programme
Corporate risk register:	**Risks** • Variable trust wide processes for booking and scheduling • Not all spoke sites on QVH PAS so access to timely information is limited • Shared pathways for cancer cases with late referrals from other trusts • Late referrals for 18RTT and cancer patients from neighbouring trusts • High vacancy rate in theatre nursing/OPD

	• Capacity challenges for both admitted and non admitted pathways • Informatics capacity • Impact of patient choice that is a risk to delivery of plan to eliminate RTT waits > 52 weeks • Breast capacity			
Regulation:	CQC – operational performance covers all 5 domains and in particular:- • Are they effective? • Are they responsive to people's needs? • Are they well-led?			
Legal:	The NHS Constitution, states that patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, (i.e. patients should wait no longer than 18 weeks from GP referral to treatment) or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.			
Resources:	Nil above current resources			
Assurance route				
Previously considered by:	Finance and Performance Committee – 23 April 2019 EMT – 24 April 2019			
	Date:	N/A	Decision:	Noted
Previously considered by:				
	Date:		Decision:	
Next steps:				

Operational Performance Report

Abigail Jago, Director of Operations

Board of Directors
May 2019

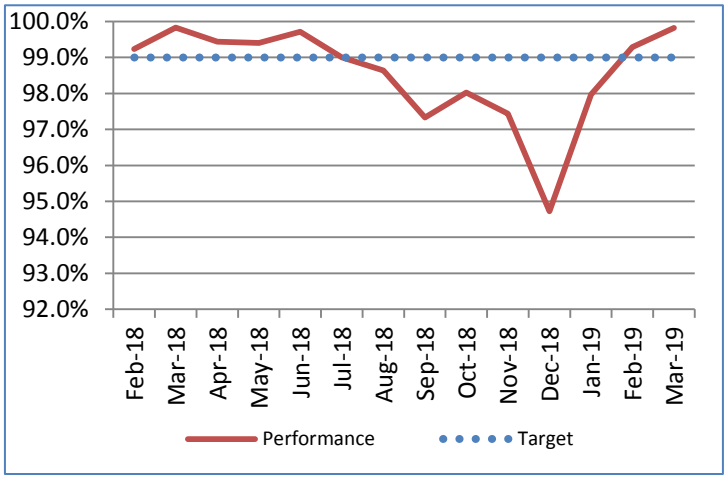
Summary

Key items to note in the operational report are:

- Delivery of diagnostic waiting time standards
- Delivery of open pathway performance plan
- Patients waiting greater than 52 weeks was 2 above agreed plan
- Delivery of 62 day and 2 week wait cancer standard. Under target 31 day standard.
- Delivery of MIU 4 hour standard
- Ongoing delivery of theatre improvement programme
- Launch of outpatient improvement programme

Diagnostic Waits (DM01)

Queen Victoria Hospital NHS
NHS Foundation Trust



(Last reporting period – Feb19) 99.29%			(This reporting period – Mar19) 99.82%		
Modality / test	Breaches	Perf.	Modality / test	Breaches	Perf.
CT	0	100.00%	CT	0	100.00%
ECHOCARDIOGRAPHY	0	100%	ECHOCARDIOGRAPHY	0	100%
MRI	1	99.20%	MRI	0	100.00%
NON-OBSTETRIC ULTRASOUND	7	99.13%	NON-OBSTETRIC ULTRASOUND	1	99.88%
SLEEP STUDIES	0	100.00%	SLEEP STUDIES	1	97.82%

Performance commentary	Forward look / performance risks
Diagnostic Imaging • Ultrasound performance has improved with the implementation of waiting list initiative lists . **Sleep Studies** • The service are continuing to map patients against available capacity, bringing forward patients where possible to minimise breaches.	**Diagnostic imaging** • Ultrasound remains a risk area due to staffing capacity and vacancies. Alternative options for cover are being reviewed, however due to vacancies and inability to secure agency there is a high risk of April breaches. **Sleep Studies** • Recruitment process underway for a Consultant • Staffing/skill mix service review undertaken • No anticipated breaches for April

Histology

Queen Victoria Hospital NHS
NHS Foundation Trust

	TOTAL SPECIMENS RECEIVED	<7 days	<7 day % (Target 80%)	7<10 days	<10 day % (Target 90%)	Total Cases Reported
SEP	1310	503	61%	77	70%	829
OCT	1635	685	57%	160	71%	1196
NOV	1518	680	59%	157	73%	1144
DEC	1433	908	79%	87	87%	1149
JAN	1519	849	89%	42	93%	954
FEB	**1413**	**895**	**89%**	**68**	**96%**	**1004**
Target			80%		90%	

Performance commentary	Forward look / performance risks
• Workload distribution re-structure continues to show a positive effect on our turn-around times.	• One Consultant Pathologist has reduced hours to 1 PA from 1st April but continues to cover their workload on an extra sessions basis. • The is a 10PA Consultant Histopathologist vacancy which is out to advert. • The service is continuing to work on a new Histopathology reporting strategy which involves the training of a senior (Band 7) Biomedical Scientist (BMS) to report straightforward cases as part of a conjoint Royal College of Pathologists/ Institute of Biomedical Sciences qualification. This will provide some mitigation of workforce/ caseload mismatch but is only for skin.

RTT Performance against plan – 18/19

Trust wide	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	**Mar-19**
RTT plan							74.1%	74.6%	74.6%	75.3%	76.2%	**77.3%**
RTT Actual	73.98%	75.92%	74.36%	74.48%	74.66%	74.04%	75.58%	75.86%	74.48%	75.87%	76.61%	**78.47%**
52 weeks plan					136	127	125	113	100	91	68	**60**
52 weeks actual Oct				145	135	127	120	95	92	81	68	**62**

Ophthalmology	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	**Mar-19**
RTT Plan							76.8%	76.6%	76.6%	77.2%	77.9%	**78.5%**
RTT Actual	88.92%	88.77%	83.54%	80.99%	79.64%	78.40%	78.02%	76.63%	76.01%	76.31%	76.68%	**76.15%**
52 weeks plan								12	12	6	0	**0**
52 weeks actual Oct							14	8	8	5	2	**0**

OMFS	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	**Mar-19**
RTT Plan							64.5%	65.3%	65.3%	66.4%	67.7%	**69.2%**
RTT Actual	62.8%	64.1%	63.7%	63.5%	64.6%	64.0%	65.53%	65.49%	63.03%	66.27%	68.03%	**72.46%**
52 weeks plan								56	48	45	34	**30**
52 weeks actual							61	46	45	42	32	**32**

Plastics	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	**Mar-19**
RTT Plan							77.3%	77.2%	77.2%	77.3%	77.4%	**77.7%**
RTT Actual	76.0%	79.5%	77.8%	78.0%	77.8%	77.5%	79.36%	79.95%	79.07%	79.16%	80.0%	**80.05%**
52 week plan								45	38	36	32	**28**
52 weeks actual							45	41	39	34	34	**30**

Sleep	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	**Mar-19**
RTT Plan							92.7%	91.6%	91.6%	90.3%	89.0%	**87.8%**
RTT Actual	98.1%	97.9%	95.7%	95.3%	94.5%	93.8%	91.8%	92.42%	91.06%	92.44%	90.65%	**93.09%**
52 weeks plan							0	0	0	0	0	**0**
52 weeks actual							0	0	0	0	0	**0**

Clinical Support	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	**Mar-19**
RTT Plan							95.9%	95.9%	95.9%	95.9%	95.9%	**95.9%**
RTT Actual	95.38%	97.14%	91.25%	96.27%	95.94%	94.88%	94.74%	95.00%	96.31 %	96.41%	95.27%	**95.92%**
52 weeks								0	0	0	0	**0**
52 weeks actual							0	0	0	0	0	**0**

The trust missed the 52 week target by 2 patients in month. This was due to a combination of patient cancellations, an HMP arrived not starved and consultant emergency leave. Open pathway performance was delivered at trust and speciality level with the exception of eyes where performance deteriorated marginally due to medical staffing challenges.

RTT18 – Incomplete pathways

Trust level performance

Weeks wait	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar 19	Change
0-17 (<18)	10977	10862	10823	11389	11078	10401	10056	9621	9895	↑
18-30	2390	2211	2477	2425	2420	2412	2175	1983	1891	↓
31-40	821	896	827	809	697	734	694	695	598	↓
41-51	405	445	363	325	313	325	248	191	164	↓
>52	145	135	127	120	95	92	81	68	62	↓
Total Pathways	14738	14549	14617	15068	14603	13964	13254	12558	12610	↑
Breaches	3761	3687	3794	3679	3525	3563	3198	2937	2715	↓
Performance	74.48%	74.66%	74.04%	75.58%	75.86%	74.48%	75.87%	76.61%	78.47%	↑
Clock starts		3339	3132	3870	3272	2493	3395	2849	3349	↑

In month there has been a further fall in patients waiting over 18 weeks and patients waiting greater than 52 weeks.

The total waiting list size increased marginally.

SUMMARY:RTT INCOMPLETE PATHWAYS (Mar 19)									
Speciality	<18	18-30	31-40	41-51	>52	Total	Perf This Month Mar19	Perf Last Month Feb19	Perf Change
Plastic Surgery	3033	517	158	51	30	3789	80.05%	80.00%	→
Ophthalmology	1928	444	120	40	0	2532	76.15%	76.68%	↓
Oral Surgery	3291	840	306	73	32	4542	72.46%	68.03%	↑
Sleep	1065	68	11	0	0	1144	93.09%	90.65%	↑
Clinical Support	447	17	2	0	0	466	95.92%	95.27%	↑

RTT18 – Incomplete pathways – patients waiting 40 weeks +

Patients 40wks+ with Open Pathways

Reported Speciality	August			September			October			November			December			January			Febuary			March		
	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA	Total 40 wks+	With DTA	No DTA
Oral Surgery	407	236	171	362	220	142	298	174	124	274	137	137	285	160	125	202	119	83	151	78	73	114	47	67
Plastic Surgery	143	92	51	147	107	40	119	80	39	141	90	51	147	104	43	131	91	40	102	77	25	89	71	18
Opthamology	22	20	2	36	31	5	28	27	1	36	33	3	40	37	3	47	43	4	45	42	3	52	39	13
ENT	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0						
Cardiology	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				1	0	1
Trauma & Othopaedic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						
Rheumatology	1	0	1	1	0	1	0	0	0	1	0	1	0	0	0	0	0	0						
Other	4	0	4	1	0	1	0	0	0	0	0	0	1	0	1	0	0	0						
Total	**580**	**348**	**232**	**548**	**359**	**189**	**445**	**281**	**164**	**452**	**260**	**192**	**473**	**301**	**172**	**380**	**253**	**127**	**298**	**197**	**101**	**256**	**157**	**99**
% patients over 40 weeks with DTA		60.00%			65.51%			63.15%			57.52%			63.64%			66.58%			66.11%			61.33%	

Reported Speciality	August			September			October			November			December			January			Febuary			March		
	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date	Total 40 wks+	With TCI date	No Date
Oral Surgery	407	93	314	362	79	283	*298*	125	173	274	93	181	285	123	162	202	48	154	151	45	106	114	30	84
Plastic Surgery	143	56	87	147	68	79	119	51	68	141	61	80	147	61	86	131	54	77	102	51	51	89	47	42
Opthamology	22	10	12	36	19	17	28	16	12	36	23	13	40	31	9	47	28	19	45	28	17	52	26	26
ENT	1		1	1	1		0	0	0	0	0	0	0	0	0	0	0	0						
Cardiology	2		2	0			0	0	0	0	0	0	0	0	0	0	0	0				1	0	1
Trauma & Othopaedic	0			0			0	0	0	0	0	0	0	0	0	0	0	0						
Rheumatology	1		1	1		1	0	0	0	1	0	1	0	0	0	0	0	0						
Other	4	1	3	1		1	0	0	0	0	0	0	1	0	1	0	0	0						
Total	**580**	**160**	**420**	**548**	**167**	**381**	**445**	**192**	**253**	**452**	**177**	**275**	**473**	**215**	**258**	**380**	**130**	**250**	**298**	**124**	**174**	**256**	**103**	**153**
% patients over 40 weeks with TCI		27.59%			30.47%			43.15%			39.16%			45.45%			34.21%			41.61%			40.23%	

Total patients waiting > 40 weeks has reduced at trust level and in OMFS and plastics. There has been an increase in eyes due to staffing challenges. There is ongoing identification of additional capacity. There has been a slight fall in the % of patients waiting that have a decision to admit and a confirmed TCI (confirmed date for surgical treatment).

RTT18 – Incomplete pathways – patients waiting 18 weeks +

MARCH 2019 – PATIENTS WAITING WITH A DECISION TO ADMIT (DTA)		Weeks Wait					Grand Total Open Pathways
		< 18W	18-30	31-40	41-51	52+	
Oral Surgery	**Total open pathways**	**3291**	**840**	**306**	**73**	**32**	**4542**
	With DTA	217	178	114	26	18	553
	No DTA	3074	662	192	47	14	3989
	% with DTA	***6.59%***	***21.19%***	***37.25%***	***35.62%***	***56.25%***	***12.18%***
Plastic Surgery	**Total open pathways**	**3033**	**517**	**158**	**51**	**30**	**3789**
	With DTA	717	303	110	42	23	1195
	No DTA	2316	214	48	9	7	2594
	% with DTA	***23.64%***	***58.61%***	***69.62%***	***82.35%***	***76.67%***	***31.54%***
Opthamology	**Total open pathways**	**1928**	**444**	**120**	**40**	**0**	**2532**
	With DTA	592	283	97	31	0	1003
	No DTA	1336	161	23	9	0	1529
	% with DTA	***30.71%***	***63.74%***	***80.83%***	***77.50%***	***0.00%***	***39.61%***
All	**Total open pathways**	8252	1801	584	164	62	10863
	With DTA	1526	764	321	99	41	2751
	No DTA	6726	1037	263	65	21	8112
	% with DTA	***18.49%***	***42.42%***	***54.97%***	***60.37%***	***66.13%***	***25.32%***

MARCH 2019 – PATIENTS WAITING WITH / WITHOUT A CONFIRMED TCI (CONFIRMED TO COME IN DATE FOR SURGERY)		Weeks Wait					Grand Total Open Pathways
		Under 18W	18-30	31-40	41-51	52+	
Oral Surgery	**Total open pathways**	**3291**	**840**	**306**	**73**	**32**	**4542**
	With TCI	78	71	74	15	14	252
	No TCI	3213	769	232	58	18	4290
	% with TCI	***2.37%***	***8.45%***	***24.18%***	***20.55%***	***43.75%***	***5.55%***
Plastic Surgery	**Total open pathways**	**3033**	**517**	**158**	**51**	**30**	**3789**
	With TCI	277	113	60	26	18	494
	No TCI	2756	404	98	25	12	3295
	% with TCI	***9.13%***	***21.86%***	***37.97%***	***50.98%***	***60.00%***	***13.04%***
Opthamology	**Total open pathways**	**1928**	**444**	**120**	**40**		**2532**
	With TCI	51	56	67	20		194
	No TCI	1877	388	53	20		2338
	% with TCI	***2.65%***	***12.61%***	***55.83%***	***50.00%***		***7.66%***
All	**Total open pathways**	8252	1801	584	164	62	10863
	With TCI	406	240	201	61	32	940
	No TCI	7846	1561	383	103	30	9923
	% with TCI	***4.92%***	***13.33%***	***34.42%***	***37.20%***	***51.61%***	***8.65%***

RTT Clock starts and stops by month

In Month Clock Stops Admitted								
Reported Specialty	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar 19**
Plastic Surgery	432	369	519	491	445	565	503	359
Ophthalmology	240	240	224	213	221	298	301	213
Oral Surgery	177	179	230	278	181	304	287	309
Other	107	100	111	127	103	127	123	150
Ear, Nose & Throat (ENT)	7	20	10	8	11	10	11	5
Total	**963**	**908**	**1094**	**1117**	**961**	**1304**	**1225**	**1036**

In Month Clock Stops Non Admitted								
Reported Specialty	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar 19**
Oral Surgery	726	819	859	805	605	938	832	858
Plastic Surgery	477	381	434	485	354	461	356	368
Other	194	136	169	137	165	274	171	255
Ear, Nose & Throat (ENT)	151	299	262	359	291	365	277	271
Ophthalmology	120	111	103	103	91	175	113	103
Cardiology	35	17	43	47	39	73	29	38
Trauma & Orthopaedics	5	6	5	2	1	3	5	4
Rheumatology	5	8	9	20	12	12	10	19
Total	**1713**	**1777**	**1884**	**1957**	**1558**	**2301**	**1793**	**1916**

In Month RTT Clock Starts								
Reported Specialty	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar 19**
Oral Surgery	1176	1072	1306	960	681	1002	891	1127
Plastic Surgery	1051	917	1066	971	810	1038	925	1015
Ophthalmology	414	530	581	546	408	567	457	523
Other	337	390	420	373	276	473	373	470
Ear, Nose & Throat (ENT)	307	181	445	337	267	275	190	183
Cardiology	39	33	37	76	42	28	7	19
Trauma & Orthopaedics	9	1	4	3	5	3	5	6
Rheumatology	6	8	11	6	7	9	1	6
Total	**3339**	**3132**	**3870**	**3272**	**2496**	**3395**	**2849**	**3349**

Admitted RTT clock stops have fallen in month resulting from a fall in theatre activity.
Non admitted clock stops have increased.

Clock starts have increased in month.

RTT18 – Key actions

Reporting, governance and grip

- System task and finish group has now been stood down and system assurance calls have moved to monthly as RTT plan is on track and delivered as business as usual.

Capacity and pathways

- Additional capacity ongoing for OMFS at Uckfield and McIndoe. Plans to mobilise additional capacity at Sidcup are still under negotiation in regard to costs.
- Additional OMFS outpatient clinics are ongoing at Maidstone, Dartford and Medway.
- Plans in place to use the McIndoe for eye lists
- Breast locum was advertised but not appointed to. Further plans are currently being reviewed
- Dental triage work is continuing and a review of the programme is planned for April.

Theatre Efficiency

- Theatre utilisation programme is continuing post the departure of Fours Eyes and is being led within the operations business management team. This includes continue the project approach for the late start and clinic cancellation task and finish groups and business as usual elements.
- Trust reporting dashboard continues to be developed

Outpatient Improvement

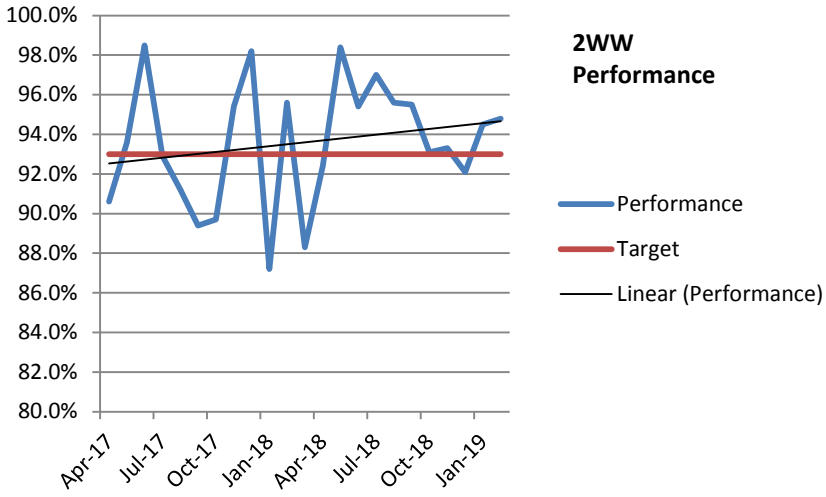
- Outpatient efficiency programme has now launched. A key focus of the programme is maximising activity and capacity to support RTT delivery.

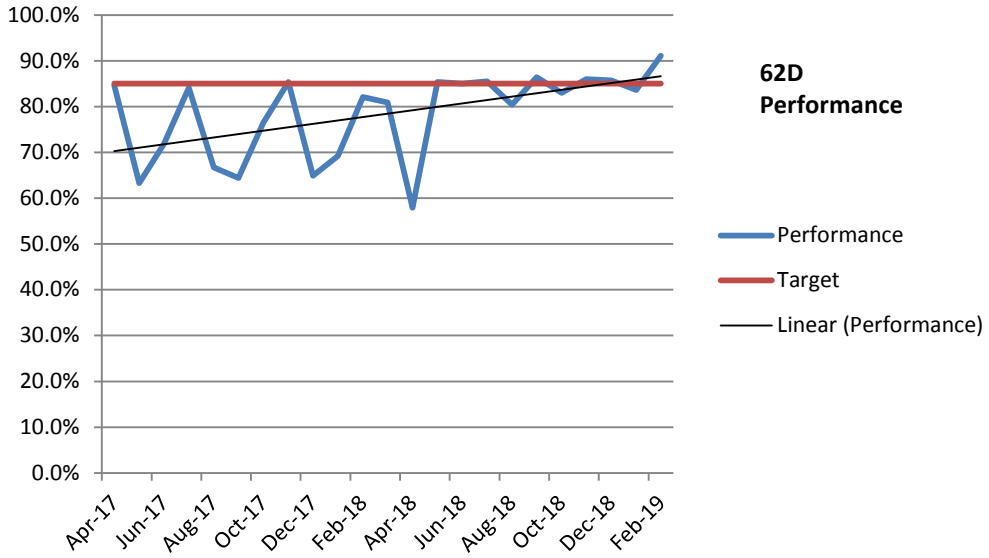
1920 plans

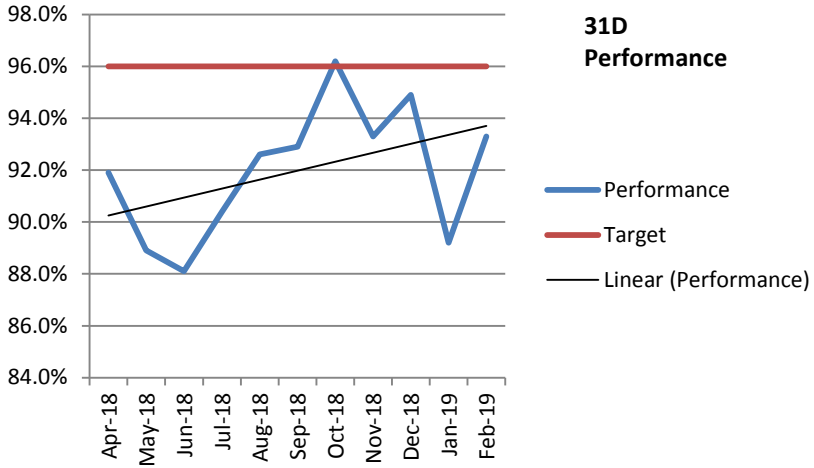
- Specialty level delivery plans are under development to deliver 1920 trajectory following commissioner sign off of activity

Trust wide	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RTT plan	78.3%	79.2%	80.0%	81.3%	81.3%	82.3%	83.8%	85.3%	85.3%	87.7%	90.3%	92%
52 weeks plan	50	40	30	20	10	0	0	0	0	0	0	0

Cancer standards







The 62 day target was met in the reporting month (Feb). Head & Neck achieved 100% for a second month.

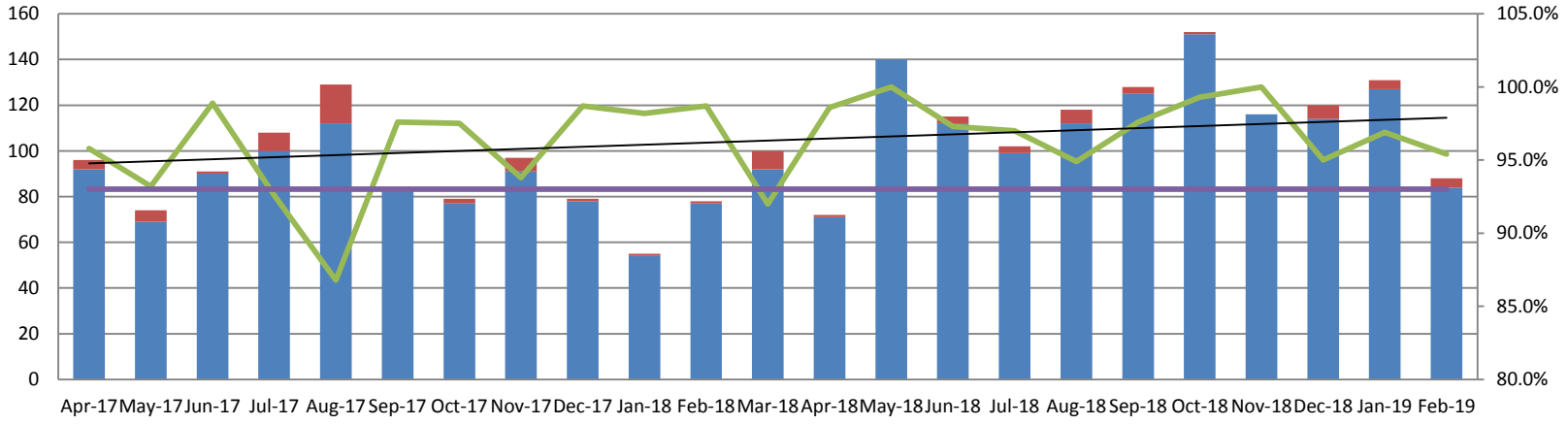
The 2WW target was met in the reporting month (Feb). Currently YTD the trust are averaging 295 referrals per month. Year to date QVH have seen 642 more 2WW referrals than 2017-18.

The 31D target was not met in month (Feb) due to capacity and complex medical reasons. Work is progressing to improve performance through the improvement of scheduling, more robust cancer pathway tracking and clinical engagement.

Cancer Quarter Performance

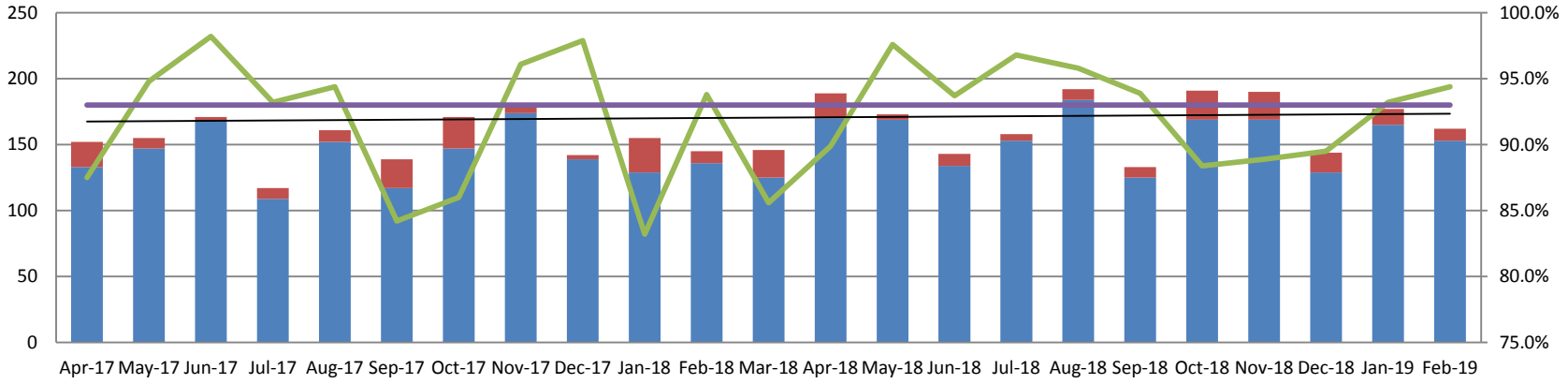
Quarter Performance	2017-18					2018-19				
	QTR 1	QTR 2	QTR 3	QTR 4	YTD	QTR 1	QTR 2	QTR 3	QTR 4 (QTD)	YTD
Two Week Wait	94.3%	91.1%	94.3%	90.3%	92.5%	95.6%	95.9%	93.0%	94.6%	94.7%
62 Day Referral to Treatment	73.5%	73.7%	76.4%	77.0%	75.0%	80.3%	84.0%	85.0%	87.0%	84.2%
62 Day Screening	33.3%	50.0%	100.0%	N/A	55.5%	66.6%	100.0%	0.0%	50.0%	60.0%
62 Day Upgrade	98.3%	98.3%	90.4%	60.0%	96.6%	100.0%	100.0%	95.4%	66.6%	94.5%
31 Day Decision to Treat	96.5%	95.6%	95.6%	86.4%	94.0%	89.3%	91.8%	94.8%	91.2%	92.2%
31 Day Subsequent Treatment	95.4%	95.3%	90.5%	82.6%	90.6%	88.5%	88.1%	80.0%	93.3%	86.6%

Skin Two Week Wait Performance



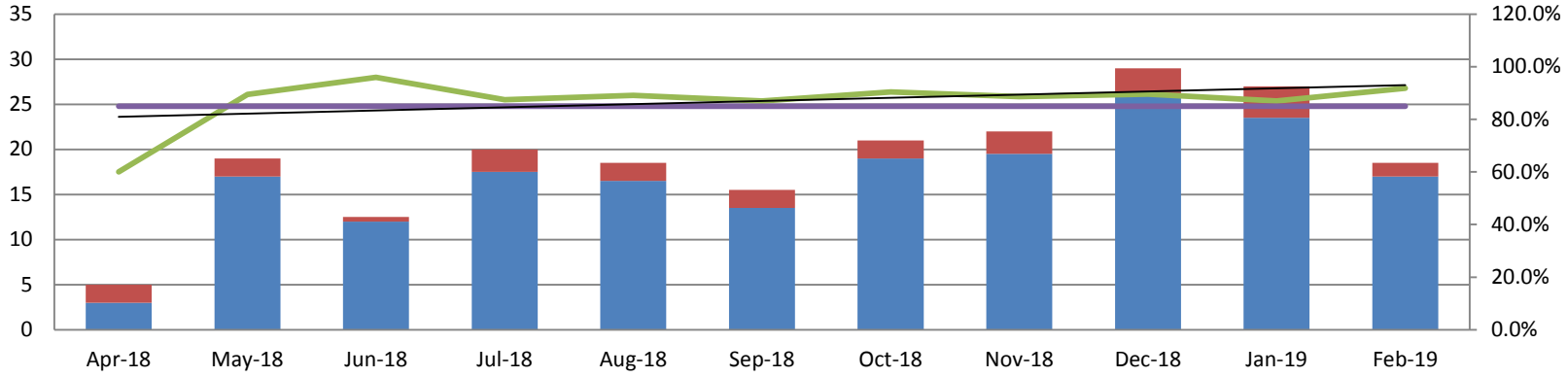
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Breaches	4	5	1	8	17	2	2	6	1	1	1	8	1	0	3	3	6	3	1	0	6	4	4
Total	92	69	90	100	112	82	77	91	78	54	77	92	71	140	112	99	112	125	151	116	114	127	84
Performance	95.8%	93.2%	98.9%	92.6%	86.8%	97.6%	97.5%	93.8%	98.7%	98.2%	98.7%	92.0%	98.6%	100.0%	97.3%	97.0%	94.9%	97.6%	99.3%	100.0%	95.0%	96.9%	95.4%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

Head and Neck Two Week Wait Performance



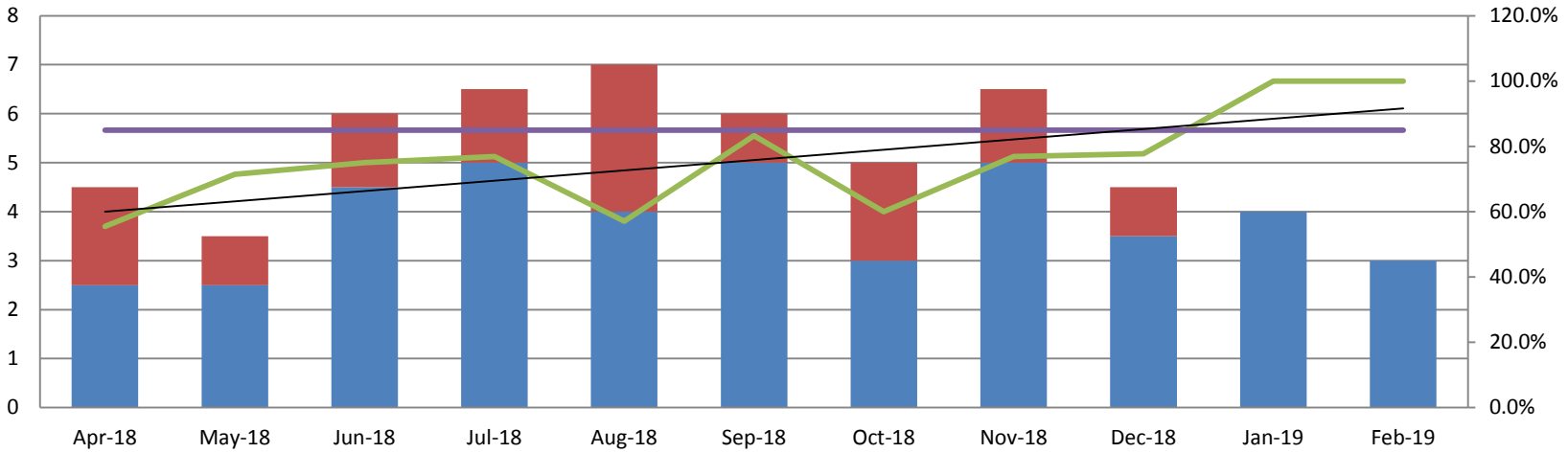
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Breaches	19	8	3	8	9	22	24	7	3	26	9	21	19	4	9	5	8	8	22	21	15	12	9
Total	133	147	168	109	152	117	147	174	139	129	136	125	170	169	134	153	184	125	169	169	129	165	153
Performance	87.5%	94.8%	98.2%	93.2%	94.4%	84.2%	86.0%	96.1%	97.9%	83.2%	93.8%	85.6%	89.9%	97.6%	93.7%	96.8%	95.8%	93.9%	88.4%	88.9%	89.5%	93.2%	94.4%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

Skin 62 Day Referral to Treatment



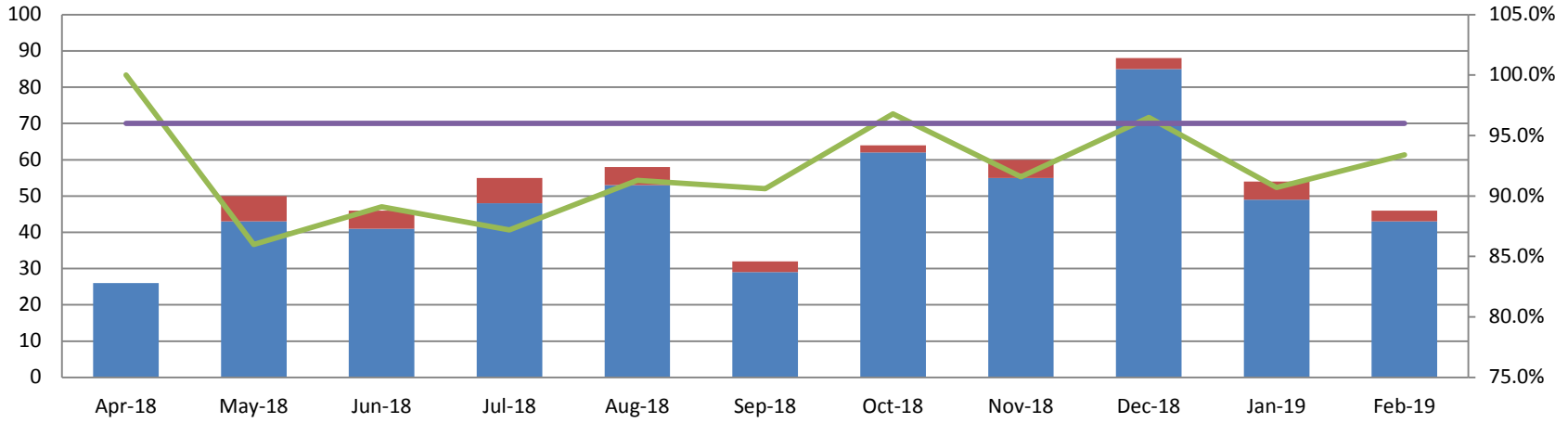
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Breached	2	2	0.5	2.5	2	2	2	2.5	3	3.5	1.5
Compliant	3	17	12	17.5	16.5	13.5	19	19.5	26	23.5	17
Performance	60.0%	89.4%	96.0%	87.5%	89.1%	87.0%	90.4%	88.6%	89.6%	87.0%	91.8%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Head and Neck 62 Day Referral to Treatment



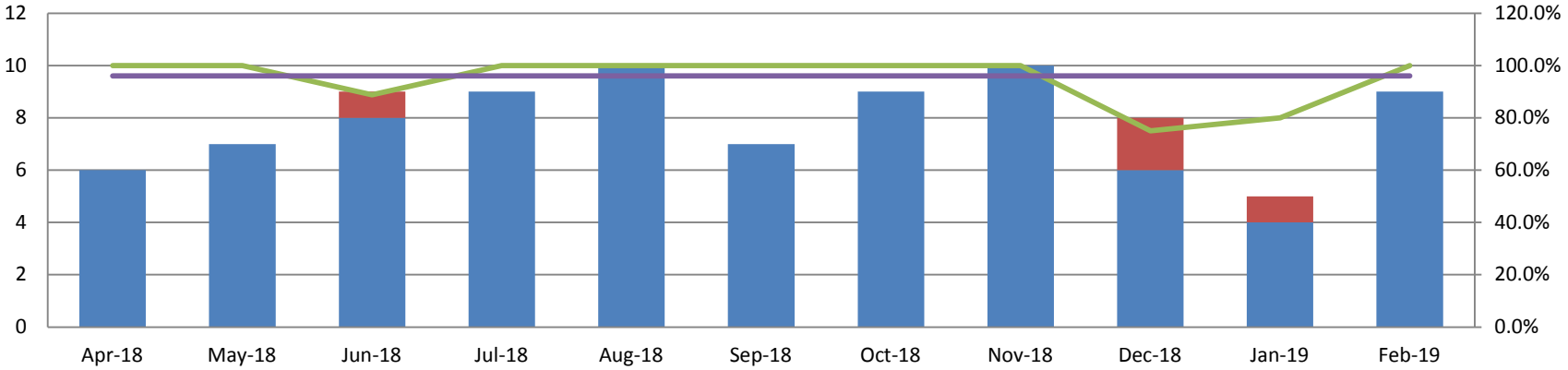
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Breached	2	1	1.5	1.5	3	1	2	1.5	1	0	0
Compliant	2.5	2.5	4.5	5	4	5	3	5	3.5	4	3
Performance	55.5%	71.4%	75.0%	76.9%	57.1%	83.3%	60.0%	76.9%	77.7%	100.0%	100.0%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Skin 31 Day Decision to Treat



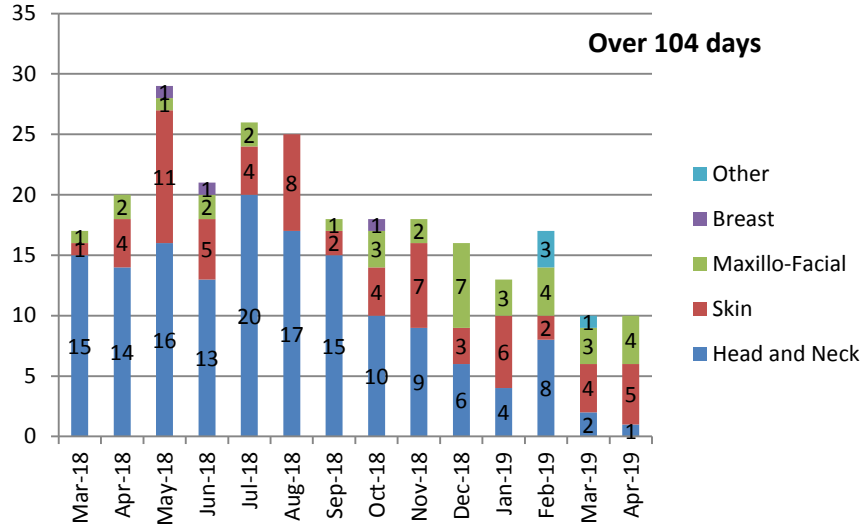
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Breached	0	7	5	7	5	3	2	5	3	5	3
Compliant	26	43	41	48	53	29	62	55	85	49	43
Performance	100.0%	86.0%	89.1%	87.2%	91.3%	90.6%	96.8%	91.6%	96.5%	90.7%	93.4%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

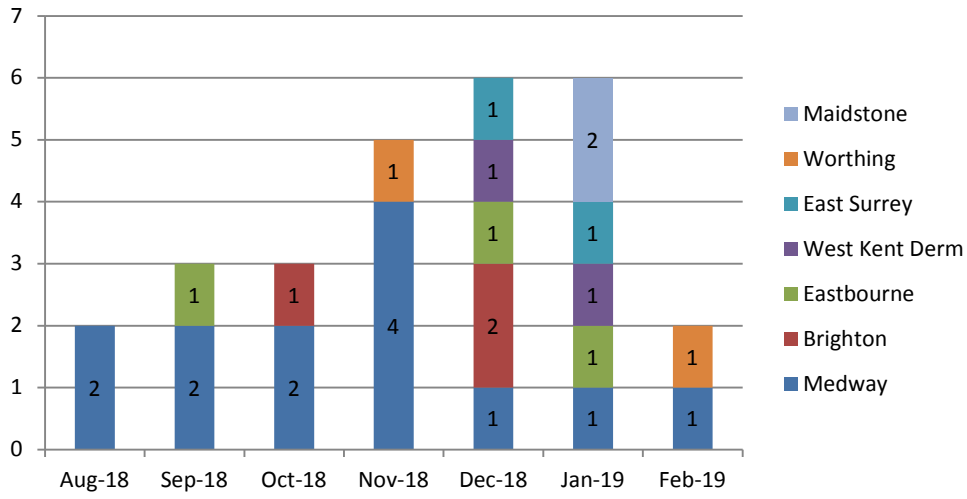
Head and Neck 31 Day Decision to Treat



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Breached	0	0	1	0	0	0	0	0	2	1	0
Compliant	6	7	8	9	10	7	9	10	6	4	9
Performance	100.0%	100.0%	88.8%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	80.0%	100.0%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Performance 104 days and 38 days allocation





Over 104 Days

- Reducing the number of patients waiting over 104 days on a 62 day pathway remains a priority.
- Work underway to address pathways in regard to patients waiting for non clinical reasons

Head and Neck/Maxillo-Facial

- H&N: the patient over 104 days is due to complex pathways,
- Maxillo-Facial: combination of complex diagnostic pathways and patient choice.
- Challenges remain in capacity for follow-up appointments
- Complex diagnostic pathways

Plastics

- All four patients over 104 days are due to patient choice.
- Number of late referrals from other hospital trusts over 62 days
- Seeing an increase in the number of complex patients, number of comorbidities
- Patient choice remains a challenge

Breach Allocation – 38 days (new rules are being applied as of Apr 19)

Head and Neck

- Challenges remain in referring patients for oncology treatment by day 38 to the treating trust. So far this year H&N have sent 9 late referrals. Through the project management support from Surrey and Sussex Cancer Alliance a timed pathways are being designed to help become compliant with the 38 day rule.
- H&N referrals receiving into the trust, for treatment are consistently being treated within 24 days. QVH has received 5 late referrals this year, all past 62 days – all 5 were treated within 24 days.

Plastics

- Challenges remain in receiving late referrals and treating within 24 days. In the month of Dec we treated 6 patients who were referred to QVH past 38 days, 4 were past 62 days.
- Within this number only 2 were treated within 24 days. Bottlenecks remain in outpatient capacity. Going forward Plastics are looking at having dedicated oncology tertiary referral slots to improve waits to outpatient appointment.

Cancer Performance

62 Day Performance
YTD performance is 84.2% (achieving 7 months of the year, not achieving in 4 months of the year). This compares to 74.5% at this point last year (achieving 1 month out of 9).

2WW Performance
QVH to move towards an internal 7 day target for 2WW referrals. This is to allow for a more sustainable 2WW performance and to help achieve the 62 day target. Booking at 7 days instead of 14 days enables the ability to rebook within 14 days following a patient cancellation. In Dec 11 patients cancelled their appointment. Due to the appointment being booked between days 9-14, to rebook within the 14 days is challenging as there are limited options available . In routinely booking within 7 days, this gives more time to treat the patient and achieve the 62 day standard. Through looking at the H&N breaches this year, 5 patients could have achieved the 62 day standard if they were seen within the first 7 days.
Currently H&N are booking, on average at day 11 and Skin are booking on average at day 8. Extra capacity is being identified within H&N to reduce the day to first appointment, so far an extra 9 2WW H&N slots have been added.

Breach Allocation (38 day rule)
The new breach allocation rules have been postponed until April 2019.

Increased communication
Improved communication with referring trusts – weekly conference calls in place with Medway, Conquest, Brighton, and Kent and Canterbury and taking affect as of Feb West Kent Dermatology. Regular attendance at both the Kent and Medway Cancer Alliance and the Surrey and Sussex Cancer Alliance.

28 Day Diagnosis
Data collection on the new faster to diagnosis standard will start as of April 2019, reporting of the standard will start as of April 2020.
Challenges for this standard are diagnostic capacity and follow-up capacity., especially within H&N. Working with clinicians to ensure they are requesting diagnostics under the correct priority to ensure the admin booking teams book timely and appropriately.

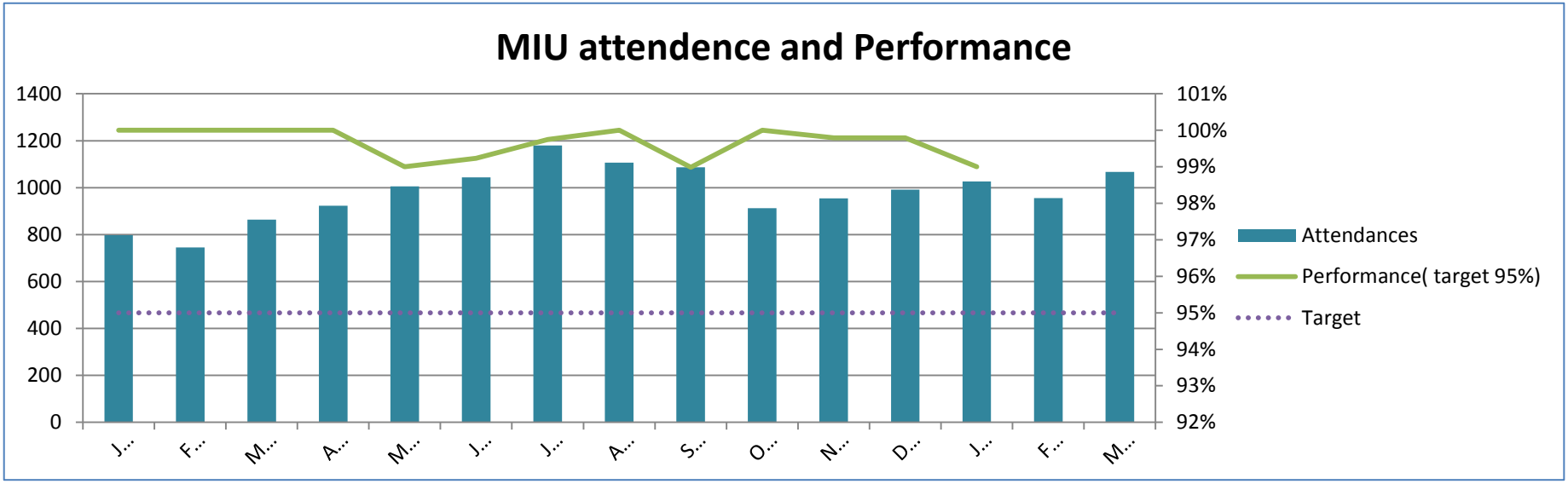
31 day action plan
31 day action plan is being implemented and further developed to support compliance.

Cancer Board
The draft terms of reference has been agreed at HMT. First meeting is planned for Q1.

Cancer Recovery Plan
A new cancer recovery plan for 2019/20 is being developed and will be included in the May Finance and Performance Committee papers.

Minor Injuries Unit (MIU)

MIU Performance v Target

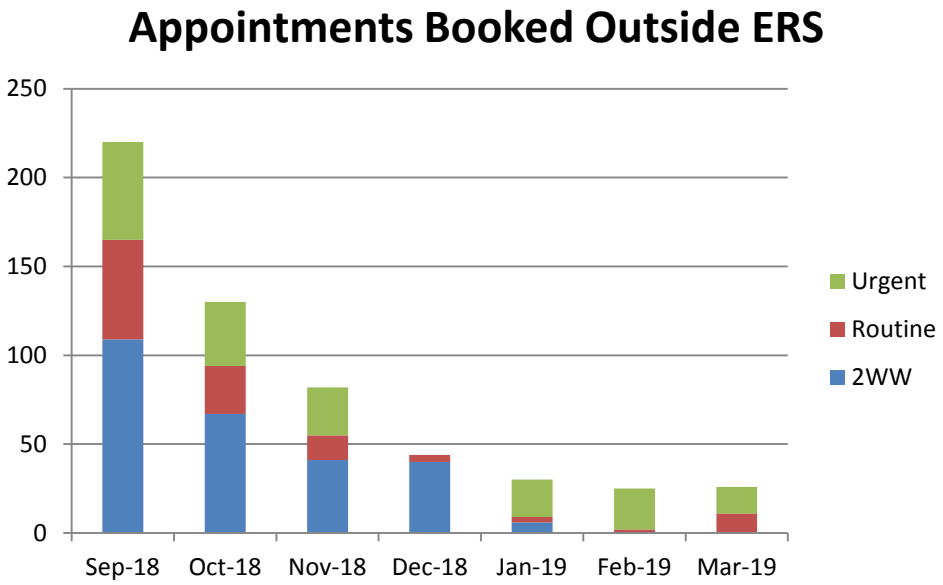


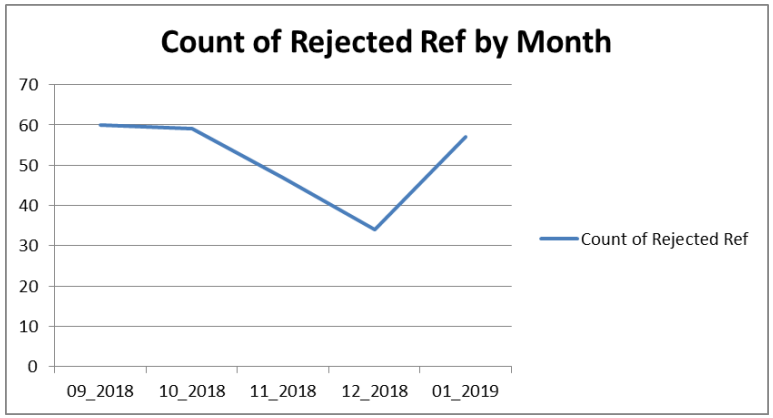
Performance commentary	Forward look / performance risks
• Increase in walk in patients compared to previous years activity • Paediatric activity now has further documentation completed to ensure all aspects of the child are considered in line with updated guidelines.	• No risks identified currently.

Outpatients - Electronic Referrals

eRS Hard Paper Switch Off

- eRS Bookings for GP referrals consistently hit 99%.
- Advice and guidance CQUIN met for Q3
- eRS is a specific workstream within OPD Improvement Programme – KPIs based on national best practice





DeRS system

- E- vetting launched on Monday 19th November for dental referrals. This has included working with commissioner to agree a new clinical Standard Operating Procedure (SOP), revised admin SOP and communications to primary care providers. Project to be reviewed in April for consideration of net steps.
- To date around 19% of referrals have been deemed as suitable for primary care treatment and the work is ongoing. The project has been shared with the Chief Dental Officer.
- A programme of work is ongoing to identify subspecialty level on the PTL going forward to include oral surgery, oral medicine, orthodontics, restorative and OMFS to enable greater transparency.

Outpatient Improvement Programme

The outpatient improvement programme launched in March with support from FourEyesInsight and the first Steering Group took place on 2nd April.

Four Task and Finish Groups have been established with Terms of reference and agreed KPIs. The task and finish update is as follows:

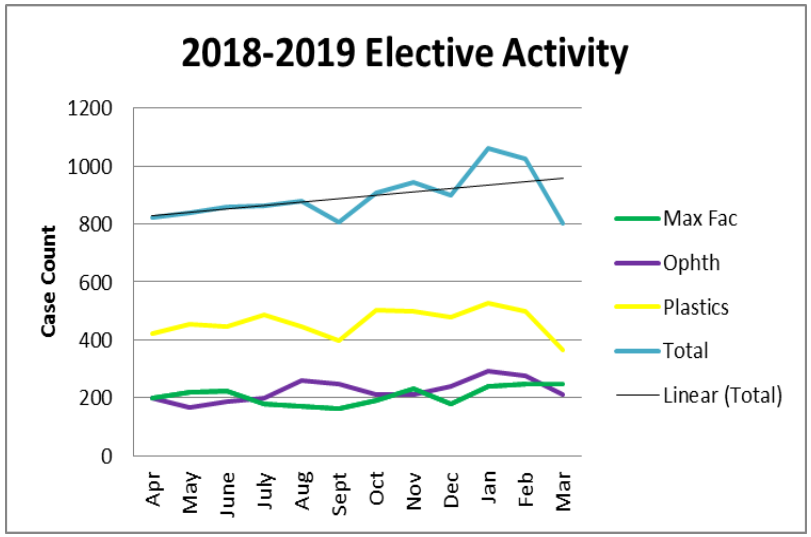
Communication
- Review of current practice for production and distribution of letters across QVH is underway
- Option assessment for dictation/voice recognition system is being compiled

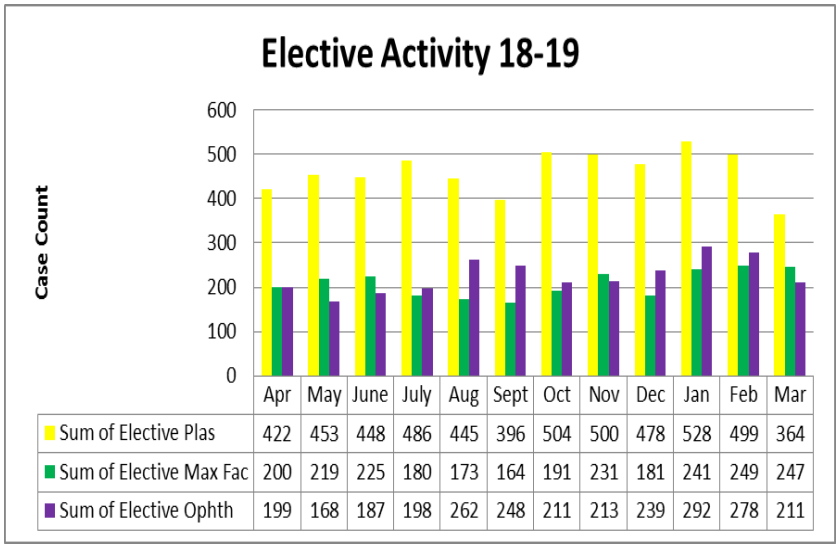
Productivity
- Outpatient dashboard is being developed and currently being validated
- Capacity planning exercise is underway including the mapping of clinics against job plans and the development of future slot reporting
- Text messaging options are being reviewed

Virtual clinics
- Diagnostic results review clinics are being scoped with an initial review for OMFS
- Pathway redesign identified with glaucoma and project plan is under development
- Policy and operational procedure for Skype Clinics is under development

eRS /DeRS optimisation
- Action plan to update all Directories of Service is being implemented
- Potential processed for e-vetting are being scoped
- Suite of regular reports to support improved performance are being developed

Theatre Activity – Case Count





	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Sum of Elective Plas	422	453	448	486	445	396	504	500	478	528	499	364
Sum of Elective Max Fac	200	219	225	180	173	164	191	231	181	241	249	247
Sum of Elective Ophth	199	168	187	198	262	248	211	213	239	292	278	211

Performance commentary

Total Activity: 10,730

- Plas Total : 5523
- OMFS Total : 2501
- Ophthalmology Total : 2706

- The 6-4-2 meeting is embedded
- Scheduling continues to develop and embed. Further work is required re lockdown for both plastics and OMFS.

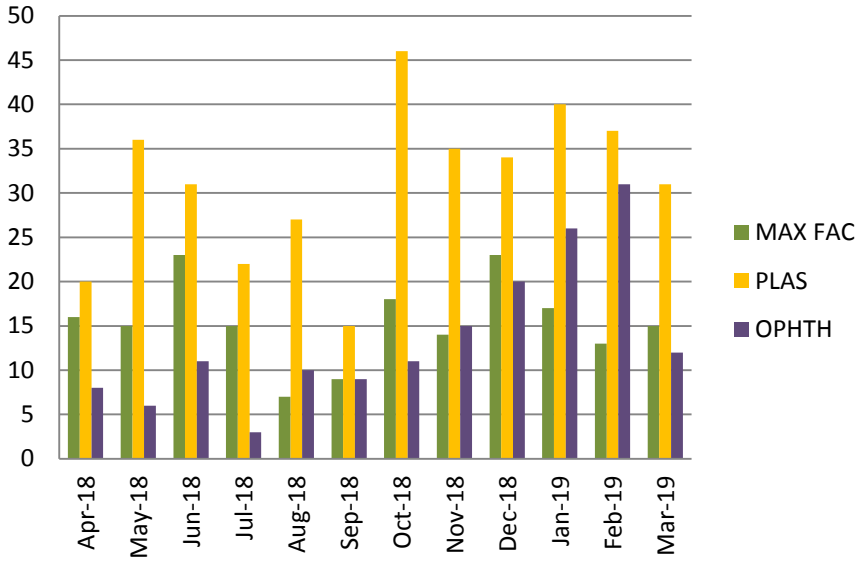
- Significant issues during March relating to end of financial year annual leave surgical vacancies and sickness resulting in a substantial drop in elective cases through theatres.

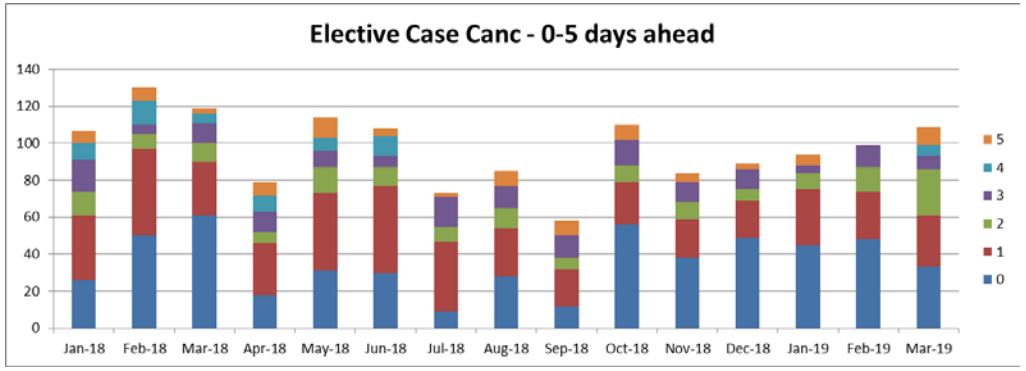
- High number of DTC sessions cancelled in addition to main theatres

Forward look / performance risks

- Recovery have highlighted challenges with the increased level of patient throughput on particular days
- On-going focus and oversight of list lock down which continues to impact utilisation. Metric to be included in next months report
- KPI's agreed at Theatre user group (TUG):
  - Theatre Utilisation by speciality
  - Elective activity case count
  - Reduced cancellations (target to be agreed at the next TUG)
  - Number of elective theatre sessions
  - Reduction in late starts (The reporting of this metric is under development) .

Case cancellations on the day

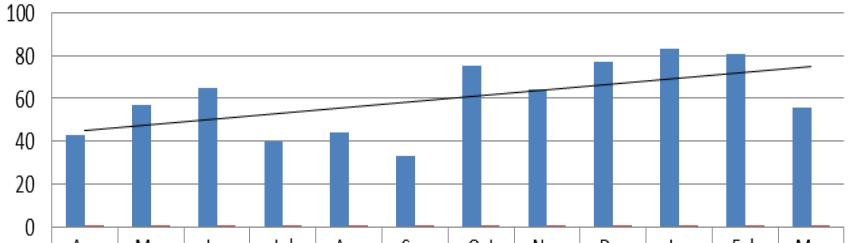




Performance commentary	Forward look / performance risks
Cancellations are now being reviewed and validated on a weekly level. **Non- Clinical Hospital Cancellations: 11 in March** - 2 admin error , 1 insufficient time, 7 staffing, 1 patient transport failed **Hospital Clinical Cancellations: 22 in March** - 6 operation not required, 12 pre existing condition, 2 pre op guidance not followed, 2 unfit **Action underway to reduce cancellations** • On-going work to lock down lists and list ordering to improve call out impact • Reducing cancellations Task & Finish group is on-going • Introduced new cancellation data form: Improve accuracy for cancellation reason	• Audit of new cancellation data form • List lock down and ordering • Review: Mini RCA's by pre assessment staff • Reviewing cancellations/DNA's by patients: Correlation with RTT/wait time

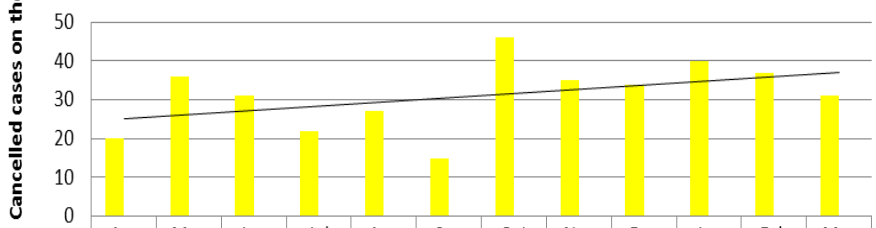
Theatre on the day cancellation trends

2018-2019 Elective Cases Cancelled on the Day: 718
Average: 60 - 6.28%



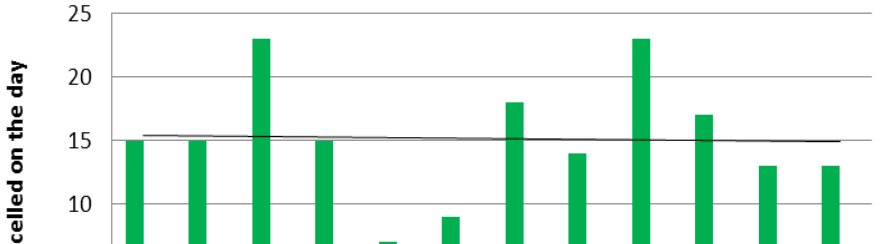
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Series1	43	57	65	40	44	33	75	64	77	83	81	56
Series2	4.98%	6.35%	7.03%	4.42%	4.76%	3.92%	7.65%	6.35%	7.90%	7.26%	7.32%	6.52%

2018-2019 Plastics
Cancelled Cases on the Day: 374
Average: 31-6.34%



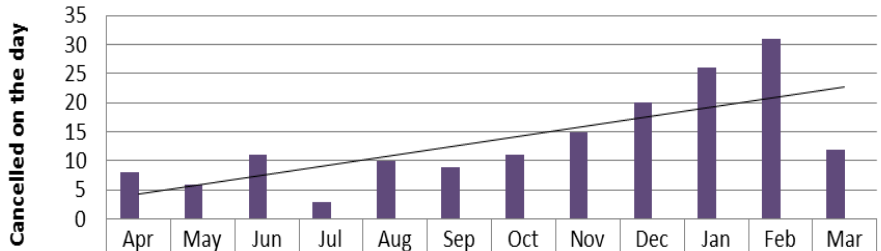
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Series1	20	36	31	22	27	15	46	35	34	40	37	31
Series2	4.52%	7.36%	6.47%	4.33%	5.72%	3.65%	8.36%	7.00%	7.11%	7.58%	7.41%	7.85%

2018-2019 Max Fac Cancelled on the Day:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Series1	15	15	23	15	7	9	18	14	23	17	13	13
Series2	6.98%	6.41%	9.27%	7.69%	3.89%	5.20%	8.61%	5.71%	11.27	6.59%	4.96%	5.00%

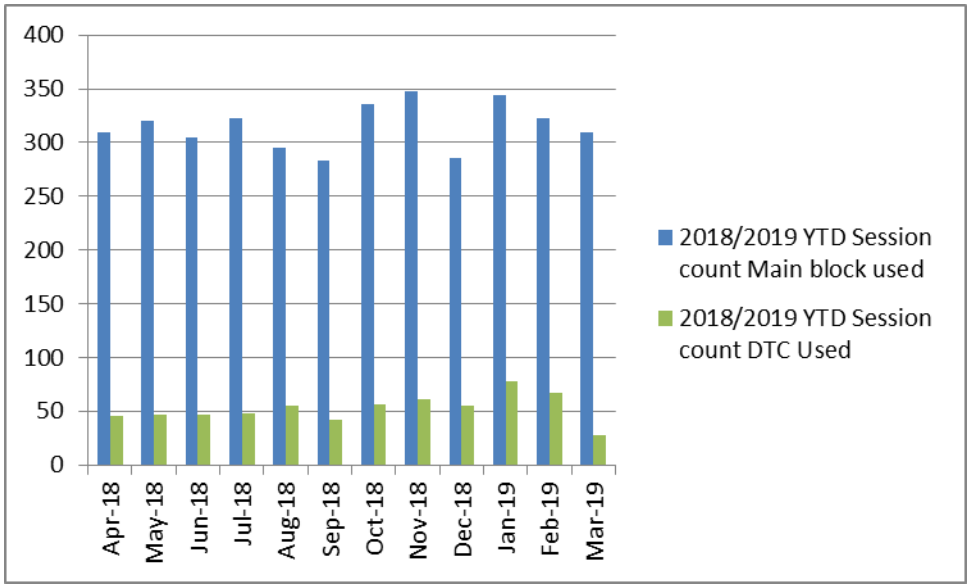
2018-2019 OPHTH
Cancelled on the Day: 162
Average: 13.5 - 5.69%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Series1	8	6	11	3	10	9	11	15	20	26	31	12
Series2	3.86%	3.45%	5.56%	1.49%	3.68%	3.63%	4.95%	6.58%	7.72%	8.18%	10.03%	5.88%

Theatre activity – session count

2018/2019 YTD Session count		
Elective	Main block used	DTC Used
Apr-18	310	46
May-18	320	47
Jun-18	305	47
Jul-18	323	48
Aug-18	295	56
Sep-18	283	42
Oct-18	336	57
Nov-18	348	61
Dec-18	286	55
Jan-19	344	78
Feb-19	323	67
Mar-19	309	28



A system to record theatre session cancellation reasons has commenced through the 6-4-2 meeting and will be included in future reporting.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**88-19**	
Report title:	**Finance Report M11 February 2019**				
Sponsor:	Michelle Miles, Director of Finance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	Finance Report M11.				
Executive summary					
Purpose of report:	The Trust delivered a deficit of £653k after technical adjustments in month; £6k ahead of forecast. The YTD deficit has increased to £5,488k; a favourable variance of £61k against forecast. Income was largely in balance and pay underspends of £31k have been offset by net non-pay expenditure overspends of £25k (Non pay overspend £91k less financing underspend of £67k). The Trust is still forecasting to achieved the revised plan, however there are some risks especially in relation to activity and impact on clinical income in March. This is being seen in the first two weeks of March through the four eyes dashboard.				
Summary of key issues	The board is asked to **note** the contents of this report.				
Recommendation:					
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 BAF has been updated to reflect the Controls / Assurance set out in this paper				
Corporate risk register:	The risk register has been updated to reflect the gaps in controls/ assurance set out in this paper Corporate Risk rating of 25				
Regulation:	The Finance Use of Resources rating is 3.				
Legal:					
Resources:					
Assurance route					
Previously considered by:	Finance and Performance Committee 25.03.2018 EMT 25.03.2018				
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
(M11) February 2019

Executive Director: Michelle Miles

Contents

Queen Victoria Hospital
NHS Foundation Trust

3. Finance Performance - Forecast
4. 2019/20 Summary Trend Position
5. Summary 18/19 Forecast
6. Activity Performance by POD
7. Financial Position by Business Unit
8. CIP – service line performance
9. Balance Sheet
10. Capital
11. Appendix A – 2018/19 Control Total Performance

M11 Financial Performance via Forecast

Queen Victoria Hospital NHS
NHS Foundation Trust

Forecast Performance		Annual	In Month £'000			Year to Date £'000		
Income and Expenditure		Forecast	Forecast	Actual	Favourable /(Adverse)	Forecast	Actual	Favourable /(Adverse)
Income	Patient Activity Income	63,399	5,196	5,120	(76)	58,057	58,520	463
	Other Income	5,827	363	438	75	5,413	5,020	(393)
Total Income		**69,226**	**5,559**	**5,558**	**(1)**	**63,470**	**63,541**	**70**
Pay	Substantive	(43,028)	(3,568)	(3,660)	(92)	(39,391)	(39,519)	(128)
	Bank	(2,379)	(211)	(117)	95	(2,167)	(2,022)	145
	Agency	(3,221)	(279)	(250)	28	(2,910)	(2,788)	122
Total Pay		**(48,627)**	**(4,058)**	**(4,027)**	**31**	**(44,468)**	**(44,330)**	**139**
Non Pay	Clinical Services & Supplies	(12,928)	(1,028)	(1,179)	(151)	(11,842)	(12,070)	(228)
	Drugs	(1,588)	(130)	(116)	14	(1,458)	(1,436)	22
	Consultancy	(218)	(21)	(49)	(28)	(197)	(138)	60
	Other non pay	(7,193)	(558)	(483)	75	(6,636)	(6,769)	(133)
Total Non Pay		**(21,928)**	**(1,737)**	**(1,828)**	**(91)**	**(20,133)**	**(20,412)**	**(279)**
Financing		(4,616)	(438)	(371)	67	(4,179)	(4,047)	131
Total Expenditure		**(75,171)**	**(6,233)**	**(6,226)**	**7**	**(68,780)**	**(68,789)**	**(9)**
Surplus / (Deficit)		**(5,945)**	**(674)**	**(668)**	**6**	**(5,310)**	**(5,249)**	**61**
Adjust for Donated Income		400			-	400	400	-
Adjust for Donated Depn.		(227)	(16)	(16)	0	(201)	(201)	-
Adjust for Land Sale			-	-	-	-	-	-
NHSI Control Total Excluding STF and sale of land		**(6,118)**	**(658)**	**(653)**	**6**	**(5,509)**	**(5,448)**	**61**

YTD forecast performance

The Trust delivered a deficit of £5448k YTD; £61k better than forecast.

The income position is in better than forecast . Clinical income over-recovered by £463k and other income under recovered by £393k. This is largely due to the reclassification of Agenda for change Income from other income to Patient activity income.

The pay position is a £139k improvement on forecast due to a decreases within agency and bank staff due to additional substantive recruitment.

The non pay position is £279k more than forecast largely within clinical supplies due to additional costs within clinical areas and within Other Non Pay due to additional costs within corporate areas which are a continuation of the increased costs within Estates & Facilities for security, rates and provisions and IM&T budgets. . Financing is £131k less than forecast due to delay in capital expenditure programme.

Forecast overview

The Trust submitted a revised forecast of a deficit of £5.945m before technical adjustments for donated assets and depreciation to NHSI in January - part of the previous month's submission. The technical adjustments for donated assets income and depreciation increases the deficit to £6.159m

The Trust delivered a deficit of £653k after technical adjustments in month; £6k ahead of forecast. The YTD deficit has increased to £5,488k; a favourable variance of £61k against forecast.

Income was largely in balance and pays underspends of £31k have been offset by net non pay expenditure overspends of £25k (Non pay overspend £91k less financing underspend of £67k.

The Trust is expected to meet forecast at year end. The Trust is expected to meet forecast at year end. However there are some risks especially in relation to activity and the impact on expected clinical income in March.

In month Forecast performance

The Trust delivered a deficit of £653k in month; £6k better than forecast.

The income position is in line with forecast . Clinical income under recovered by £76k and other income over recovered by £75k.

The pay position is a £31k improvement on forecast due to a decreases within agency and bank staff due to additional substantive recruitment.

The non pay position is £91k more than forecast largely within clinical supplies due to additional costs within clinical areas. Financing is £55k less than forecast due to delay in capital expenditure.

Summary Trend position - Income and Expenditure Trend

Queen Victoria Hospital NHS Foundation Trust

Board Line	Actual M10 17/18	Actual M11 17/18	Actual M12 17/18	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Actual M8	Actual M9	Actual M10	Actual M11	Forecast M12	Forecast 18/19 In Month	Actuals 18/19 In Month
Patient Activity Income	5,389	4,811	5,051	5,006	5,329	5,620	5,577	5,491	5,114	5,121	5,318	5,031	5,792	5,120	5,342	5,145	5,120
Other Income	429	496	898	361	337	523	453	447	823	476	641	523	(3)	438	414	414	438
Total Income	**5,818**	**5,307**	**5,949**	**5,367**	**5,666**	**6,143**	**6,030**	**5,938**	**5,938**	**5,598**	**5,960**	**5,554**	**5,789**	**5,558**	**5,756**	**5,559**	**5,558**
Substantive	(3,468)	(3,415)	(3,497)	(3,553)	(3,654)	(3,536)	(3,660)	(3,685)	(3,188)	(3,570)	(3,756)	(3,661)	(3,596)	(3,660)	(3,637)	(3,568)	(3,660)
Bank	(122)	(132)	(139)	(326)	(140)	(148)	(221)	(155)	(206)	(171)	(217)	(160)	(161)	(117)	(211)	(211)	(117)
Agency	(205)	(251)	(289)	(276)	(295)	(305)	(259)	(294)	(234)	(294)	(252)	(144)	(185)	(250)	(311)	(279)	(250)
Total Pay	**(3,794)**	**(3,798)**	**(3,925)**	**(4,155)**	**(4,090)**	**(3,989)**	**(4,140)**	**(4,134)**	**(3,628)**	**(4,035)**	**(4,224)**	**(3,965)**	**(3,942)**	**(4,027)**	**(4,159)**	**(4,058)**	**(4,027)**
Clinical Services & Supplies	(1,054)	(1,025)	(301)	(1,076)	(944)	(1,193)	(1,038)	(1,031)	(752)	(1,103)	(1,251)	(1,299)	(1,204)	(1,179)	(1,086)	(1,028)	(1,179)
Drugs	(118)	(105)	(126)	(116)	(137)	(143)	(150)	(128)	(103)	(135)	(163)	(122)	(122)	(116)	(130)	(130)	(116)
Consultancy	(17)	-	(83)	(8)	(37)	(22)	(28)	(8)	-	(3)	(16)	(1)	34	(49)	(21)	(21)	(49)
Other non pay	(562)	(595)	(484)	(607)	(592)	(605)	(650)	(724)	(330)	(618)	(759)	(636)	(765)	(483)	(557)	(558)	(483)
Total Non Pay	**(1,750)**	**(1,726)**	**(993)**	**(1,807)**	**(1,709)**	**(1,963)**	**(1,866)**	**(1,891)**	**(1,185)**	**(1,859)**	**(2,188)**	**(2,059)**	**(2,057)**	**(1,828)**	**(1,794)**	**(1,737)**	**(1,828)**
Financing	(345)	(345)	(421)	(373)	(374)	(381)	(343)	(345)	(358)	(380)	(374)	(377)	(372)	(371)	(438)	(438)	(371)
Total Expenditure	**(5,890)**	**(5,869)**	**(5,340)**	**(6,336)**	**(6,172)**	**(6,334)**	**(6,349)**	**(6,371)**	**(5,170)**	**(6,274)**	**(6,786)**	**(6,400)**	**(6,371)**	**(6,226)**	**(6,392)**	**(6,233)**	**(6,226)**
Surplus / (Deficit)	**(72)**	**(561)**	**609**	**(969)**	**(506)**	**(191)**	**(318)**	**(433)**	**768**	**(676)**	**(826)**	**(846)**	**(582)**	**(668)**	**(636)**	**(674)**	**(668)**
Donated Income				-	-	-	-	-	400						-		
Donated Depreciation	(19)	(19)	124	(20)	(20)	(22)	(17)	(20)	(20)	(17)	(17)	(17)	(16)	(16)	(16)	(16)	(16)
Land Sale																	
NHSI Contol Total Excluding STF	**(52)**	**(542)**	**485**	**(950)**	**(486)**	**(169)**	**(301)**	**(413)**	**387**	**(659)**	**(809)**	**(829)**	**(569)**	**(653)**	**(620)**	**(658)**	**(653)**

Summary

- The forecast for month M12 is based on the forecast of £5,945 before technical adjustments. The Trust has to generate a deficit of £696k before technical adjustments to meet forecast for the year (M12 forecast £636k + £61k underspend YTD to forecast).
- Income less than previous months activity due to the reduction of working days within the month. There are emerging issues re activity capacity in month 12 which is concerning and may impact forecast position. There has been a reclassification of AFC income to Patient Activity Income from Other Income, which has been back dated for prior periods.
- Pay has increased compared to the prior period, Substantive has slightly reduced, agency has increased in month. Temporary staffing is less than forecast.
- Non pay is similar to previous period and remains higher than trend and forecast. Clinical stocktake has identified that stock levels have remained relatively high matching those at the beginning of year which have had expected to reduce. Brexit uncertainty has had an impact.

Summary - 2018/19 Forecast

Queen Victoria Hospital NHS Foundation Trust

	Reporting category	201819 Annual Budget (£k)	2018/19 Annual Forecast (£k)	2018/19 Annual Variance (£k)
INCOME	Patient Activity Income	67,086	63,399	(3,687)
	Other Income	4,739	5,770	1,031
INCOME Total		**71,825**	**69,169**	**(2,656)**
PAY EXPENDITURE	Agency	(273)	(3,221)	(2,948)
	Bank	(483)	(2,379)	(1,896)
	Substantive	(45,391)	(43,028)	2,363
PAY EXPENDITURE Total		**(46,146)**	**(48,627)**	**(2,481)**
NON PAY EXPENDITURE	Drugs	(1,553)	(1,589)	(36)
	Clinical Services & Supplies	(12,870)	(12,846)	24
	Consultancy	(79)	(218)	(139)
	Other non pay	(5,562)	(7,216)	(1,653)
	Depreciation and amortisation	(3,178)	(3,129)	49
	Non Operating Income	12	35	24
	Non Operational Expenditure	(1,548)	(1,525)	22
NON PAY EXPENDITURE Total		**(24,779)**	**(26,487)**	**(1,708)**
Grand Total		**900**	**(5,945)**	**(6,846)**

Scenario Analysis

	Best case (£k)	Most likely (£k)	Worse case (£k)
Baseline forecast before interventions	(6,324)	(6,324)	(6,324)
Interventions			
Four eyes additional Theatre Productivity	340	272	
CT scanner Business case	13	9	
CIP schemes over and above run rate	149	99	
Net change in activity due to winter			(550)
Total forecast	**(5,823)**	**(5,945)**	**(6,874)**
Plan	900	900	900
Variance	(6,723)	(6,845)	(7,775)

Summary

- The revised forecast shows the Trust making a deficit of **£5.9m**; an adverse variance to plan of £6.8m before PSF, the impact of the land sale and donated depreciation / income.
- This represents the most likely case. The best case is a deficit of £5.8m and worst case a deficit of £6.9m
- This forecast would report an estimated NHSI Use of resources score of 4 – the lowest possible.
- The forecast is based on the YTD Mth 09 position.
- The forecast has been reviewed and approved by the Board and disseminated to NHSI.

Key Interventions included within the forecast

- Four eyes, cost and income likely to be achieve in this financial year, best case increases the current achievement of a 16% opportunity to c10%
- Additional CIP which reduces run rate to the end of the financial year, over and above the current run rate
- CT Scanner and the potential increase in income
- Clinical Income due to variation in winter period based on actual activity reduction in 2017/18

Activity Performance by POD – M11 2018/19

Queen Victoria Hospital NHS
NHS Foundation Trust

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	852	939	87	61	68	6	10,163	11,164	1,001	732	804	72
Elective (Daycase)	Spells	1,276	1,175	(101)	1,396	1,213	(183)	12,258	11,392	(866)	13,406	12,373	(1,033)
Elective	Spells	384	308	(76)	895	701	(193)	3,697	3,425	(272)	8,595	8,560	(35)
Non Elective	Spells	449	361	(88)	1,062	1,059	(3)	5,350	4,623	(727)	12,662	11,182	(1,480)
XS bed days	Days	52	75	23	14	20	6	609	753	144	169	202	33
Critical Care	Days	70	68	(2)	72	57	(15)	835	972	137	863	1,112	249
Outpatients - First Attendance	Attendances	3,542	3,356	(186)	491	450	(41)	41,017	41,577	560	5,686	5,561	(125)
Outpatients - Follow up	Attendances	10,265	9,654	(611)	742	710	(31)	118,858	111,839	(7,019)	8,587	8,233	(353)
Outpatient - procedures	Attendances	2,386	1,908	(478)	315	244	(71)	27,652	27,509	(143)	3,652	3,634	(18)
Other	Other	3,546	2,932	(614)	536	571	35	41,114	42,672	1,558	6,220	6,537	317
Prior Period Adjustments and WIP					51	26	(25)				463	322	(141)
					5,635	**5,120**	**(516)**				**61,035**	**58,520**	**(2,515)**

Summary

Minor injuries attendances are 87 and £6k above plan in month. YTD activity is 1,001 attendances and £72k above plan.

Daycase activity in month is 101 spells and £183k below plan with under-performance in plastics (hands & breast) £173k, Sleep £15k and Corneo Plastics £8k. With Maxillofacial over performing by £13k. YTD activity is 866 spells and £1,033k under plan within Maxillofacial £319k, Plastics £483k, Corneo Plastics £169k and Sleep services £61k. Activity in month is higher than average above the average for the year by 153 and 251 more spells than February 2018, with the main increases being within Eyes & Maxillofacial.

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	74	53	(21)	885	1,087	202
Clinical Support	531	555	25	6,172	6,469	297
Eyes	613	578	(35)	6,326	6,371	45
Oral	1,238	1,107	(130)	13,305	12,437	(868)
Plastics	2,714	2,418	(296)	29,395	27,287	(2,108)
Sleep	411	369	(42)	4,439	4,434	(4)
Other incuding WIP/ coding	55	38	(17)	513	437	(77)
Grand Total	**5,635**	**5,120**	**(516)**	**61,035**	**58,520**	**(2,515)**

Elective activity in the month is 76 spells below plan and £193k. The activity is under performing in Sleep studies 48 spells & £48k below plan, Oral 19 spells & £101k, Plastics 6 spells & £32k and Corneo Plastics 3 spells & £12k. The YTD activity is 272 spells below plan and £35k below plan. Over performance within Plastics 6 spells £190k and Eyes 44 spells and £103k. Oral below plan on activity 112 spells, by £185k, and underperformance in Sleep 210 spells, £143k. In month is slightly below trend by 4 spells, however 12 more spells than February 2018.

Non-elective activity has under performed by 88 spells and under performed by £3k in month which is mainly within Plastics, 78 spells and £11k, being of set by Corneo Plastics over performance of 2 spells and £8k. The YTD position reports an under-performance of 727 spells and £1,480k underperformance due to under performance within plastics services lines £1,587k partially offset by overperformance within eyes (corneoplastics) £141k. Trend for Non Elective continues to fall, however a slight increase from January by 8 spells, compared to last year 39 spells lower than February 2018.

Critical care days have under -performed by 2 days in month and under performed by £15k. The YTD position is above plan by 137 days and £249k YTD. Trend is decreasing within critical care bed days, with the last 3 months being below trend.

Outpatient attendances (FA/FUs) are below plan for attendances by 797 and £72k below plan in month and 6,459 attendances and £478k below plan YTD. Outpatient procedures are £71k below plan in month and £18k below plan YTD. Plastics are the main area of under performance of £79k, Oral £38k and Corneo Plastics services £19k below plan. YTD Plastics is the main area of underperformance £37k and Oral £187k. 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 has over performed in month by £35k mainly due to Clinical Support £29k, mainly within Radiology £33k. YTD over performance of £317k due to Radiology direct access and unbundled outpatients diagnostics, £263k and sleep devices £184k, being offset by Head & Neck specialist commissioning top up of £171k.

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.

Financial Position by Business Unit – M11 2018/19

Queen Victoria Hospital NHS
NHS Foundation Trust

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	(323)	(2,153)	(9)	(170)	(122)	(904)	3	(49)	24,638	2,104	1,653	(451)	65%	22,345	19,069	(3,275)	85%
1.2 Oral	(49)	(805)	8	75	(52)	(373)	(121)	(665)	8,061	708	493	(215)	47%	7,277	5,509	(1,768)	53%
1.3 Eyes	(32)	56	11	66	(15)	(187)	2	(125)	4,488	410	377	(33)	64%	4,041	3,851	(190)	72%
1.4 Sleep	(76)	(155)	(0)	3	13	60	(32)	(242)	2,352	200	106	(95)	44%	2,129	1,795	(334)	51%
1.5 Clinical Support	122	451	3	(40)	13	364	115	119	(2,174)	(203)	49	253		(2,001)	(1,108)	893	
1.6 Perioperative Care	0	1	5	9	(73)	(799)	(211)	(408)	(11,703)	(941)	(1,219)	(278)		(10,762)	(11,959)	(1,197)	
1.7 Operational Nursing	54	250	(3)	(24)	(13)	(383)	(19)	(190)	(6,091)	(512)	(494)	18		(5,592)	(5,941)	(349)	
Operations Total	**(303)**	**(2,354)**	**15**	**(82)**	**(249)**	**(2,222)**	**(264)**	**(1,562)**	**19,572**	**1,767**	**965**	**(802)**		**17,436**	**11,215**	**(6,221)**	
Nursing & Clinical Infrastructure																	
2.1 Clinical Infrastructure	-	-	-	36	(12)	(96)	4	16	(1,134)	(94)	(102)	(8)		(1,041)	(1,085)	(44)	
2.5 Director Of Nursing	-	-	(7)	41	(23)	(238)	47	(86)	(2,800)	(231)	(214)	17		(2,569)	(2,852)	(282)	
Nursing & Clinical Infrastructure	**-**	**-**	**(7)**	**77**	**(35)**	**(333)**	**51**	**(70)**	**(3,935)**	**(325)**	**(316)**	**9**		**(3,610)**	**(3,936)**	**(326)**	
Corporate Departments																	
3.1 Non Clinical Infrastructure	(3)	(30)	9	51	14	(13)	(81)	(346)	(4,352)	(358)	(418)	(60)		(3,995)	(4,334)	(339)	
3.2 Commerce & Finance	-	-	(1)	24	(39)	(89)	(13)	(464)	(2,881)	(242)	(296)	(53)		(2,638)	(3,168)	(529)	
3.4 Finance Other	(210)	(130)	21	309	36	895	266	548	(713)	(456)	(342)	114		(4,201)	(2,579)	1,622	
4.1 Human Resources	-	-	(8)	118	(10)	(11)	(2)	(5)	(964)	(79)	(99)	(20)		(886)	(784)	101	
5.4 Corporate	-	-	44	72	(61)	(15)	3	(43)	(1,826)	(150)	(163)	(13)		(1,676)	(1,663)	14	
Corporate Total	**(212)**	**(160)**	**66**	**573**	**(60)**	**765**	**173**	**(310)**	**(10,736)**	**(1,285)**	**(1,318)**	**(32)**		**(13,396)**	**(12,527)**	**869**	
Surplus / (Deficit)	**(516)**	**(2,514)**	**74**	**569**	**(344)**	**(1,790)**	**(39)**	**(1,943)**	**4,900**	**156**	**(668)**	**(825)**		**430**	**(5,249)**	**(5,679)**	

Summary

Patient Activity Income: The main areas of under performance in month are, Plastics (Elective, Daycases & Non Elective), Oral (mainly elective & Daycases), Clinical services (Prosthetics excluded devices) and Critical care. YTD underperformance of £2,514k is mainly within Plastics (mainly Non Elective & outpatients), Oral services (Daycases, Outpatients & H&N Top up) and Sleep services (Elective, Daycases & Outpatients). This is being offset by Operational Nursing (critical care bed days which have been much higher in prior periods), Clinical Support (MIU/ direct access activities), Eyes (emergency and PBR exclusion activities).

Other income: In month is above plan by £74k, above plan YTD £569k. Plastics & Oral in month is due to additional funding for RTT for workforce support. Eyes is mainly due to deferral income for the eye bank. Director of Nursing income has decreased in month due to income incorrectly invoiced in prior periods. Corporate in month is due to additional income for Training (PGME).

Pay: In month is over spent by £344k in month; over spent by £1,790k YTD. The main drivers of overspend are within plastics and perioperative care. Plastic service is below plan by £122k in month mainly due to additional medical costs, which is being partially funded by the CCG's and Unidentified CIP. YTD is adverse by £904k which is mainly due to medical pay due to agency usage at the beginning of the year, additional medical payments and the allocation of unidentified CIPs. Perioperative is below by £73k in month and above plan £799k YTD which is due to high agency and bank usage to cover vacancies and additional payments for weekend work. The Trust is above the NHSI agency cap by £1.3m YTD. Agenda for change back pay has seen an increase of £491k, which is offset within income, however the incremental drift due to the higher increases is a cost pressure to the Trust, further work will be undertaken to understand this.

Non Pay: In month is over spent by £39k; over spent YTD £1,943k. There was unidentified saving of £197k in month and £1,471k YTD shown within the position. Oral is mainly due to the contract with East Sussex Hospitals and outsourcing activity to McIndoe. Depreciation costs within Finance other are less than anticipated in month £16k and YTD £225k.

Cost Improvement Plan (CIP) – M11 2018/19

Queen Victoria Hospital NHS Foundation Trust

Business Unit	Lead	CIPP Target £	Estimated Financial Delivery based on RAG rating	18/19 Gap	Estimated Financial Delivery based on RAG rating as reported at Month 9	Change (+ve means identification of further CIPPs compared to reported at Month 9)	Sum of NHSI Planned Savings YTD £ by BU	Sum of YTD Actual Savings Total £	Sum of YTD Over / (Under) Achievement £	Sum of NHSI Planned Savings TOTAL £ by BU	Sum of Forecast Savings Total £	Shortfall £
1.1 Plastics	Paul Gable	(461,621)	(118,436)	(343,185)	(79,936)	38,500	(406,691)	(72,451)	(334,239)	(461,621)	(88,000)	(373,621)
1.2 Oral	Georgina Baidya	(365,162)	(10,000)	(355,162)	(10,000)	0	(319,295)	(14,444)	(304,851)	(365,162)	(20,151)	(345,011)
1.3 Eyes	Georgina Baidya	(170,687)	(76,832)	(93,855)	(76,832)	0	(149,044)	(89,760)	(59,284)	(170,687)	(82,218)	(88,469)
1.4 Sleep	Sue Aston	(48,272)	(75,230)	26,958	(75,230)	0	(41,385)	(76,313)	34,927	(42,267)	(83,196)	40,929
1.5 Clinical Support Services	Paul Gable	(429,084)	(287,680)	(141,404)	(285,452)	2,228	(381,229)	(208,293)	(172,936)	(429,084)	(283,313)	(145,771)
1.6 Perioperative Care	Sue Aston	(646,490)	(82,235)	(564,255)	(82,235)	0	(572,095)	(47,626)	(524,469)	(646,490)	(41,126)	(605,364)
1.7 Operational Nursing	Nicky Reeves	(182,391)	(1,500)	(180,891)	(1,500)	0	(159,482)	(4,583)	(154,898)	(182,391)	(5,003)	(177,388)
2.1 Performance & Access	Phil Kennedy	(50,977)	(23,752)	(27,225)	(23,752)	0	(44,948)	(30,687)	(14,261)	(50,977)	(34,441)	(16,536)
2.5 Director of Nursing	Nicky Reeves	(172,735)	(96,003)	(76,733)	(96,403)	(400)	(160,032)	(84,169)	(75,863)	(178,740)	(99,002)	(79,738)
3.1 Non Clinical Infrastructure	Steve Davies	(240,528)	(174,113)	(66,415)	(174,113)	0	(209,243)	(46,458)	(162,785)	(240,528)	(181,100)	(59,428)
3.2 Commerce & Finance	Jason McIntyre	(136,847)	(207,320)	70,473	(207,320)	0	(131,667)	(162,996)	31,329	(135,847)	(161,130)	25,283
4.1 Human Resources	Dave Hurrell	(55,100)	0	(55,100)	0	0	(50,443)	(62,069)	11,626	(55,100)	(56,735)	1,635
5.4 Corporate	Clare Pirie	(89,106)	0	(89,106)	0	0	(79,744)	(17,016)	(72,009)	(89,106)	0	(89,106)
Targets in Op Plan				0		0	0	0	0	0	0	0
Grand Total		**(3,049,000)**	**(1,153,101)**	**(1,895,899)**	**(1,112,772)**	**40,328**	**(2,705,296)**	**(916,865)**	**(1,797,713)**	**(3,048,000)**	**(1,135,415)**	**(1,912,585)**

Summary

- At M11 the Trust YTD delivered £917k against plan; an under delivery of £1,798k. This included unidentified savings that have been factored into the position.
- The Trust is forecasting saving of £1,135k for the year. This includes £125k of non recurrent saving. The above savings includes an additional £225k of savings which will have an impact in 2019/20.

Balance Sheet – M11 2018/19

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet as at the end of February 2019	2017/18 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	47,588	47,764	47,186
Other Receivables	-	-	-
Sub Total Non-Current Assets	47,588	47,764	47,186
Current Assets			
Inventories	1,178	1,186	1,177
Trade and Other Receivables	8,217	9,247	9,400
Cash and Cash Equivalents	8,914	4,460	4,319
Current Liabilities	(8,933)	(11,255)	(10,078)
Sub Total Net Current Assets	9,376	3,638	4,819
Total Assets less Current Liabilities	56,965	51,402	52,005
Non-Current Liabilities			
Provisions for Liabilities and Charges	(625)	(625)	(625)
Non-Current Liabilities >1 Year	(5,823)	(5,045)	(5,045)
Total Assets Employed	**50,517**	**45,732**	**46,335**
Tax Payers' Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	26,100	21,315	21,918
Revaluation Reserve	12,180	12,180	12,180
Total Tax Payers' Equity	**50,517**	**45,732**	**46,335**

NB Analysis is subject to rounding differences

Summary

- The capital asset net value has increases in month by £578k due to increased progress in IT and Estate projects.
- Net current assets have decreased in month by £1.2m reflecting the operating loss and increased capital spend.
- Inventories are being monitored on a regular basis and a stock-take will be made at year end.
- Trade and other receivables have decreased by £0.2m.
- Cash has increased by £140k this period.
- Current liabilities have increased by £1.2m being invoices received and capital projects.
- Non current liabilities - no change.

Issues

- Sufficient cash balances are not currently being generated by the Trust to provide liquidity, service the capital plan or to meet future loan principal repayment obligations.

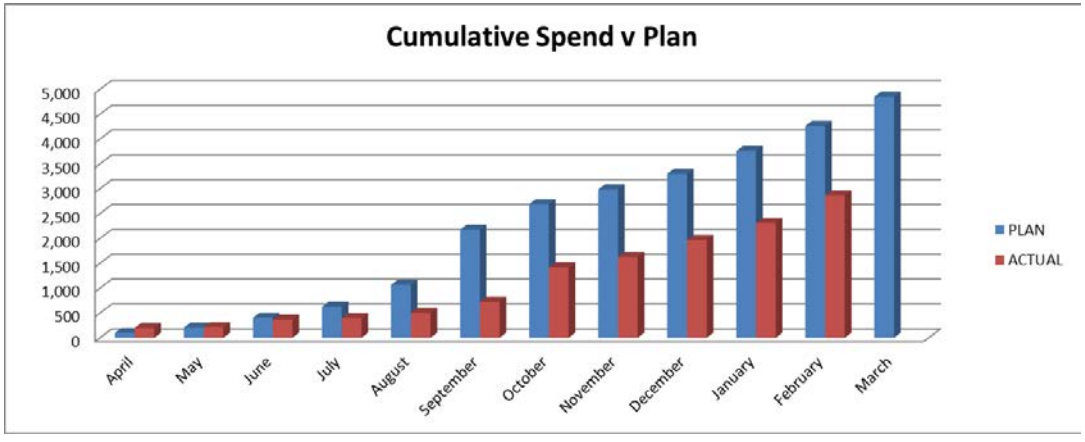
Actions

- Further details of actions taken to ensure robust cash management processes are outlined on the debtor and cash slides.

Capital – M11 2018/19

Queen Victoria Hospital NHS
NHS Foundation Trust

Month 11 - February 2019	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	33	183	100	116
Backlog maintenance - Health & Safety	100	105	-	105	76	24
Backlog maintenance - Fire Safety	145	145	32	113	94	51
Backlog maintenance - Internal Accommodation	210	234	28	206	235	(25)
Backlog maintenance - External Works	180	180	79	101	79	101
STF funding allocated to capital	1,000	700	156	544	262	738
Other projects	413	378	666	(288)	783	(370)
Estates projects	**2,264**	**1,958**	**995**	**963**	**1,630**	**634**
Medical Equipment	**1,033**	**992**	**782**	**210**	**934**	**99**
Information Management & Technology (IM&T)						
Ordercomms	120	120	187	(67)	187	(67)
Infrastructure strategy - wireless extension	60	60	68	(8)	68	(8)
Infrastructure strategy - hardware	170	141	-	141	-	170
Infrastructure strategy - end user reconfiguration	150	125	63	62	303	(153)
Infrastructure strategy - desktop/mobile	100	83	105	(22)	371	(271)
Health & Social Care Network	150	150	89	61	98	52
E-Observations	108	90	49	41	61	47
EDM	108	95	178	(83)	198	(90)
Other projects	474	448	348	100	465	9
Information Management & Technology (IM&T)	**1,440**	**1,313**	**1,086**	**226**	**1,750**	**(310)**
Contingency	**113**	**-**	**-**	**-**	**-**	113
Total	**4,850**	**4,263**	**2,864**	**1,399**	**4,314**	**536**



Summary

- The original Capital plan for 2018/19 was £3,850k including £400k for the donated CT scanner. Earlier in the year £1,000k was added following the decision to invest part of the trust's STF funding in capital projects (see below). A successful bid for £355k (exact figure to be confirmed) has been made to the Sussex & East Surrey STP for additional funding for the electronic observations project; this is now expected in 2019/20.
- 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 STF funding will be used to improve the estate, mainly in the Burns/Critical Care area but also to provide enhanced facilities for staff. £800k has been allocated to the Burns/Critical Care project, but this will require planning permission and detailed development work which will cause the timescale to stretch into 2019/20.
- Apart from the additional STF funding, the largest element of the Estates programme is backlog maintenance. The Trust is in year 3 of a 5 year backlog maintenance programme. Most of the planned work is expected to be completed by the end of the financial year. New contractors have been appointed following the liquidation of a contractor undertaking three projects, but there will inevitably be some slippage into 2019/20.
- The IT programme is largely based on the IM&T Strategy. The implementation of Ordercomms, the electronic ordering of diagnostic tests and images, is now complete. The EDM project is currently in remediation and a recovery plan has been developed.
- YTD expenditure is 33% below plan. Forecast full year expenditure is now £536k below plan as a result of the extended timeframe for spending most for the STF funding, partly offset by increases elsewhere in the programme. Progress is being monitored by the Capital Planning Group.

Appendix 2 Summary Position against Plan – YTD M11 2018/19

Queen Victoria Hospital NHS
NHS Foundation Trust

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	67,086	5,635	5,120	(516)	61,035	58,520	(2,514)
	Other Income	8,816	364	438	74	4,452	5,020	569
Total Income		**75,902**	**6,000**	**5,558**	**(442)**	**65,486**	**63,541**	**(1,946)**
Pay	Substantive	(45,468)	(3,621)	(3,660)	(40)	(41,847)	(39,519)	2,328
	Bank	(483)	(40)	(117)	(77)	(442)	(2,022)	(1,580)
	Agency	(273)	(23)	(250)	(228)	(250)	(2,788)	(2,539)
Total Pay		**(46,223)**	**(3,684)**	**(4,027)**	**(344)**	**(42,539)**	**(44,330)**	**(1,790)**
Non Pay	Clinical Services & Supplies	(12,870)	(1,231)	(1,179)	52	(11,536)	(12,070)	(534)
	Drugs	(1,553)	(129)	(116)	13	(1,423)	(1,436)	(13)
	Consultancy	(79)	(7)	(49)	(43)	(73)	(138)	(65)
	Other non pay	(5,562)	(400)	(483)	(84)	(5,163)	(6,769)	(1,606)
Total Non Pay		**(20,064)**	**(1,767)**	**(1,828)**	**(61)**	**(18,195)**	**(20,412)**	**(2,217)**
Financing		(4,714)	(393)	(371)	22	(4,322)	(4,047)	274
Total Expenditure		**(71,002)**	**(5,843)**	**(6,226)**	**(383)**	**(65,056)**	**(68,789)**	**(3,733)**
Surplus / (Deficit)		**4,900**	**156**	**(668)**	**(825)**	**430**	**(5,249)**	**(5,679)**
Adjust for Donated Income		500	-	-	-	500	400	(100)
Adjust for Donated Depn.		(245)	(20)	(16)	5	(225)	(201)	24
Adjust for Land Sale		4,000	-	-	-	-	-	-
NHSI Control Total Excluding STF and sale of land		**645**	**177**	**(653)**	**(829)**	**155**	**(5,448)**	**(5,603)**

YTD Performance

- The Trust is £5,603 adverse to plan YTD. Income is below plan by £1,946k YTD and expenditure is overspent by £4,007k partially offset by £274k of technical adjustments. Non recurrent income relates mainly to RTT income and donated income. The non recurrent expenditure relates to consultancy expenditure, bank expenditure and R&D expenditure.
- Income has under recovered by £1,506k YTD recurrently, which is due to patient activity income under recovery of £2,514k partially offset by other income over recovery of £569k.
  - Patient activity income: Day case is under plan by £1,033k, non elective by £1,506k and outpatients by £497k. This is partially offset over performing against plan by MIU £72k, Critical Care £249k and direct access within Radiology £286k..
  - The main areas of under performance are Plastics (adverse £2,108k mainly driven by non elective and outpatients first ,F/up and procedures) and Oral services £868k. Eyes services is favourable YTD by £45k, Operational Nursing (Critical care) by £249k and Clinical Support by £297k.
  - Other income has over performed largely due to additional income from CCG's for RTT £134k, additional income from Research and LDA funding.
- The YTD pay position is £1,790k adverse YTD. This includes the AFC award pay pressure of c£634k (partially offset by income of £575k) and £1,423k due to unidentified savings and slippage on schemes. Medical staffing (Plastics and Oral) and Nursing overspends (Theatres, ITU and Canadian wing) have been offset by underspends within Clinical support (Therapies, Histopathology and Radiography).
- Non pay is over spent by £2,217k YTD £534k within clinical supplies partially offset by pass-through income within patient activity £186k (Sleep). Within other non pay £1,606k , mainly due to unidentified CIP £1,540k and £255k costs in relation to theatres productivity initiative. This has been partially offset by depreciation charges underspends within financing due to delay in the capital programme of £274k.

Summary - Plan Performance

- The Trust delivered a deficit of £628k in month; £804k below plan. The YTD deficit has increased to £5,448k; an adverse variance of £5,603k against plan.
- The Trust has submitted a reforecast position to NHS of a deficit of £5.95m before PSF, the impact of the land sale and donated depreciation / income.

In Month Performance

- The Trust is £804k adverse to plan in month. Income is below plan by £442k and expenditure is overspent by £405k partially offset by £22k of technical adjustments. Non recurrent income in month relates to RTT income.
- Patient activity income: The Trust generated a higher level of patient treatment income as same time last year of £356k, with the adverse weather at the end of February last year being the main factor.
- Day case spell activity is under plan by £183k, Elective activity by £193k, Non elective activity by £3k, Critical care bed days by £14k, Outpatient attendances by £144k. The main areas of under performance are Plastics £296k below plan Oral services £130k below plan and Sleep services by £42k below plan. Offsetting the under performance is clinical support by £25k.
- Other Income is above plan by £74k, due primarily to an increase of PGME income £40k, additional income within Research £46k mainly for CRN funding and some additional commercial income. Additional non recurrent income from CCG's to support RTT of c£20k within Plastics & Oral services.
- Pay is £344k adverse in month. This is mainly due to unidentified savings of £187k, and over spends within medical staffing of £147k (Plastics and Eyes services) due to additional sessions. An increase in spend from the new pay awards for AFC of c£60k which has been partially offset by additional income. Run rate has increased in temporary staffing, spend has increased from previous period by £21k. The Trust has incurred £250k of agency expenditure in month; £116k above ceiling.
- Non Pay is £61k adverse in month. The main driver is unidentified CIP £206kk. Clinical Services & Supplies has reduced in spend from previous month by £25k, with less days within the month. Stock levels have remained at similar levels of previous stock takes, with the year end stock take taking place weekend of 23rd March.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**89-19**	
Report title:	Business Planning 2019/20				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Author:	Michelle Miles – Director of Finance and Performance				
Appendices:	Business Planning 2019/20				
Executive summary					
Purpose of report:	To update the board on the submitted Business Plan				
Summary of key issues	The Trust has submitted it Operating Plan in line with NHS Improvement timelines. The Operating Plan comprises of the Trust's proposed activity, workforce and financial plans for the coming year. All elements are approved by the Trust's Board. Due to the deteriorating financial positon the Trust is unable to sign up to its control total.				
Recommendation:	The board is asked to ratify the plan				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
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:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital NHS
NHS Foundation Trust

Business Planning 2019/20 Ratification

Lead – Director of Finance & Performance

National Context – timeline - Update

Queen Victoria Hospital NHS
NHS Foundation Trust

December/ January

- Planning guidance released 21 December with further information provided 10th January 2019
- Control totals issued 15th January
- Re-Forecast submitted 15th January
- Draft Activity Plan submitted 16th January

February

- Submission of draft operational plans due 12th February 2018 - **£8.6m deficit**

March / April 2019

- Operating plans agreed by board by end of March 2019 and final operating plans submitted 4th April 2019. Submitted £8.6m deficit.
- March Finance and Performance Committee invited all board members and approved the plan prior to submission for Board Level approval.

- No changes to the breakdown of the financial positon to update to the board to report which has led to the Trust being unable to sign up to its control total.

Agreed Approach to Business Planning

Queen Victoria Hospital NHS
NHS Foundation Trust

Approach to Income

- Based on activity achieved in Months 1-6 of 2018/19, increased by demographic growth, seasonality and additional activity to deliver the 'RTT' backlog.

- Plan will be a significant increase on current activity delivery. Final agreement with activity levels yet to be agreed with the commissioners.

Approach to Pay & Non Pay

- Based on current budget as a baseline
- Reviews undertaken in performance meetings on current overspend, current underspends and if these will be recurrent into the new financial year
- Underspending recurrent budgets to be removed in the new financial year
- Overspends to be logged as a cost pressure in the new financial year
- Unachieved CIP's reviewed and listed as a cost pressure in the new financial year
- CIP ideas reviewed for 19/20
- Cost pressures reviewed for 19/20
- Service developments reviewed for 19/20

Control Total Options

Queen Victoria Hospital NHS
NHS Foundation Trust

Factors	A - Accept the control total and deliver all conditions	B -Accept the control total and fail to deliver all conditions	Reject control total
Regulator expectation	Demonstrate willingness to play a part in supporting the sector to return to financial balance. Politically favourable.	Comply with NHSI's request, regulator intervention	Suggests lack of willingness to support the sector wide economic challenge. Politically unfavourable.
Provider Sustainability fund(PSF) & Fines	Eligible to fund(£0.68m), subject to delivery of required conditions. Liable for 52 week breech fines C375k	Performance against conditions will trigger periodic payments of the fund. Liable for 52 week breech fines c£375k	Ineligible to access fund (£0.68m) and lose the opportunity to increase cash balance. Liable for 52 week breech fines, 18 week RTT and cancer targets to a capped rate of 2.5% of the contract value c£1.2m
Sanction - financial sanctions set out in Schedules 4A and 4B of the particulars of the Contract	Would not be subject to standard contract sanctions covered by Schedules 4A and 4B	Would not be subject to standard contract sanctions covered by Schedules 4A and 4B	Would be subject to standard contract sanctions covered by Schedules 4A and 4B
Ability to deliver control total	The Trust is unable to deliver control total given current gap in 2018/19 and forecast gap in 2019/20	The Trust is unable to deliver control total given current gap in 2018/19 and forecast gap in 2019/20	The Trust is unable to deliver control total given current gap in 2018/19 and forecast gap in 2019/20

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 17 April 2019

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

Risk Appetite The Trust has a **moderate appetite** for risks that impact on Organisational Excellence . The engagement and motivation of the workforce, supported by evidence based research, will impact on patient experience

Rationale for risk current score
- National workforce shortages in key nursing areas particularly theatres, CCU
- Generational changes in workforce shows high turnover in newly qualified Band 5 nurses in first year of employment
- 2-3 years to train registered practitioners to join the workforce
- Around 40,000 nursing vacancies in England
- managers skill set in triangulating workforce skills mix against activity and financial planning
- Unknown impact of STP case for change/clinical strategy
- Staff survey results and SFFT show staff engagement is lower than previous years
- Impact on adequate substantive staffing resource in theatres to support productivity/meet RTT
- Agenda for Change 2018 reform impact as yet untested
- Addressing the reasons for retention is challenging as pressures on managers/leaders can lead to a reluctance to adopt new ways of working and support significant change
- Overseas nurses will take some months to arrive and have a positive impact

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

Future risks
- An ageing workforce highlighting a significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- Consultant contract negotiations may resume in 2019 unknown financial impact

Future Opportunities
- Closer partnership working with STP and through LWAB particularly for whole system leadership and talent management initiatives

Controls / assurance
- Developing more robust workforce controls as part of business planning
- Leading the Way, leadership development programme funded for a further year 2019/20
- All works streams being captured in one People and OD Strategy 2019
- 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, Activity Manager underway
- Engagement and Retention plan actions ongoing
- Overseas recruitment now continues. Next arrivals expected in Q1
- The Trust commissioned an external Well Led review and regularly updates the resulting action plan
- Chosen as a pilot site for the Best Place to Work initiative
- Work underway to finalise ESR hierarchy
- Some positive gains from the 2018 NHS Staff survey results and SFFT

Gaps in controls / assurance
- Management competency in workforce planning
- Continuing resources to support the development of staff – optimal use of apprenticeship levy budget
- Continuing attraction and retention problems in theatres , critical care and paediatrics and C Wing
- Theatre recruitment and retention workstream launched (Four Eyes)
- Capacity of workforce team to support the required initiatives to address recruitment and retention challenges including pay and agency controls
- Reconciliation required between ledger and ESR to enable full establishment control

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**91-19**	
Report title:	**Workforce Report – April report - March Data**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	David Hurrell, Deputy Director of Workforce				
Appendices:	Workforce Report				
Executive summary					
Purpose of report:	The Workforce and OD report for April 2019 (March 2019 data) provides the Board of Directors with a breakdown of key workforce indicators and information linked to performance. It includes further details on the progress of the overseas nursing campaign.				
Summary of key issues	Ongoing challenges related to turnover and use of temporary staffing				
Recommendation:	The Board are asked to note the report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
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:	KSO5. Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care				
Corporate risk register:	Recruitment and Retention of staff				
Regulation:	Well Led				
Legal:	n/a				
Resources:	Managed by HR/OD with support from finance and operations				
Assurance route					
Previously considered by:	Finance and Performance Committee – 23 April 2019 Executive Management Team – 24 April 2019				
	Date:		Decision:	Information	
Previously considered by:					
	Date:		Decision:		
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – April 2019

Reporting Period - March 2019

1.1 Current Month Picture

KPI	Narrative
Vacancies Section 2	'Staff in Post' numbers increased by 5.65wte in month to finish at a position of 874.06wte; this is the highest staff in post numbers on record at QVH. March saw 15.35wte new starters, including 5.61wte qualified nurses and operating department practitioners (ODP), and 2wte healthcare assistants. Vacancy levels decreased across the Trust by 0.57%, to an overall vacancy percentage figure of 11.79%, which is ahead of the desired trajectory and brings this from red to amber-rated for the first time since September 2016. This was prompted by reduced vacancies in all areas with the exception of Clinical Support and Performance & Access business units.
Turnover Section 3	The monthly turnover position of 1.61% has increased the annualised rolling turnover position by 0.21%, to an in-month position of 17.67%. This is an improvement on the planned trajectory of 17.87%. There were a total of 12.74wte leavers in month, which included 1wte qualified nurse / ODP within Perioperative Care. The biggest reduction was seen in Corporate Services (4wte). The Trust stability score reduced by 0.78% to 98.58%, reflecting 5wte leavers with less than 1 years service. This is well within tolerance levels, however 8.5wte had less than 2 years service, which is unusual; this will be monitored over the next reporting periods to identify whether this continues.
Temporary Staffing Section 4	There was a small increase in temporary staffing in month, up from February's position of 102.88wte to a combined in month position of 107.47wte. Total agency usage decreased again in month by 2.54wte, driven in large by a 2.58wte reduction in qualified nursing. A small increase in non-clinical agency (+0.89wte to 29.96wte total) was off-set by reductions in unqualified nursing agency (-0.35wte to 8.05wte total) and other AHPs/ST&Ts (-0.5wte to 2.58wte total). Continuous bank recruitment efforts have supported further increases to bank usage of +7.13wte, driven by increases for Qualified Nursing (+5.01wte to 30.11wte) and non-clinical (+2.72wte to 29.96wte total).
Sickness Section 5	Confirmed sickness levels for February show an in month absence rate of 3.55%, an increase from January's position of 3.24%. Analysis at a departmental level shows the high trend in the Sleep Disorder Centre starting to reduce. High levels remain also within Perioperative Service (5.19% for February) and Operational Nursing (4.63%). Coughs, cold and flu was the most common reason for absence (18.9%), with gastrointestinal reasons remaining high at 15.3% of absences. A comparison from January December data shows an increase in gastrointestinal absence occurrences (44 to 46) and only a minor reduction number of total days lost (167 to 161 days). An overview of gastrointestinal episodes has been provided to the infection control team in case trends could be identified.
Appraisals Section 6	Appraisal compliance figure increased marginally from 84.91% to 86.81%. Oral Services had the biggest shift, increasing 24.86% to 89.33% in month. Increases were also seen in Plastics (+7.32% to 78.75%), Clinical Support (+2.96% to 98.38%), Director of Nursing (+2.96% to 92.68%) and Perioperative Care (+0.58% to 84.02%). Reductions were seen in all other business units, with the biggest reduction in Performance & Access (-7.42% to 75.56% total). An improvement in medical appraisal has been seen (79.73% to 85.16%), with the most outstanding within Anaesthetics (n=8), Oral Services (n=7) and Plastics (n=6).
MAST Section 6	Mandatory and Statutory Training compliance figures decreased marginally, from 92.03% to 91.96%. Clinical Support, Performance & Access and Director of Nursing's office are above the Trust 95% target, with Operational Nursing only marginally off with 94.46%. Small decreases were seen in compliance within Sleep Disorder Centre (-2.62%), Oral Services (-1.26%), Corporate Services (-0.94%) and Eyes (-0.79%). All topics are above 80% with the exception of Information Governance compliance falling, now at 78.39%.

KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19			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	Compared to Previous Month
Establishment WTE *Note 1				955.65	955.65	955.65	955.65	955.65	990.87	990.87	990.87	990.87	990.87	990.87	**990.87**	**990.87**	◄►
Staff In Post WTE				845.26	831.41	827.24	829.77	835.19	848.43	845.94	860.66	868.62	863.91	867.20	**868.41**	**874.06**	▲
Vacancies WTE				110.39	124.24	128.41	125.88	120.46	142.44	144.93	130.21	122.25	126.96	123.67	**122.46**	**116.81**	▼
Vacancies %	>12%	8%<>12%	<8%	11.55%	13.00%	13.44%	13.17%	12.61%	14.38%	14.63%	13.14%	12.34%	12.81%	12.48%	**12.36%**	**11.79%**	▼
Agency WTE				42.51	45.58	50.61	42.85	46.85	46.11	45.33	47.07	44.12	37.43	39.95	**39.31**	**36.77**	▼
Bank WTE *Note 2				65.26	52.24	59.82	64.34	63.37	59.28	58.49	61.13	65.64	51.69	61.66	**63.57**	**70.70**	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	19.57%	20.38%	20.43%	19.20%	18.17%	18.42%	19.88%	20.29%	19.52%	19.23%	18.73%	**17.46%**	**17.67%**	▲
Monthly Turnover				1.91%	2.24%	1.00%	0.68%	1.10%	1.58%	2.94%	1.56%	0.75%	1.48%	1.43%	**0.64%**	**1.61%**	▲
Stability %	<70%	70%<>85%	>=85%	98.78%	98.18%	99.18%	99.28%	98.66%	98.48%	97.80%	98.86%	99.56%	98.28%	98.87%	**99.36%**	**98.58%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	3.73%	2.74%	3.04%	3.52%	3.29%	3.23%	2.42%	3.02%	3.16%	*2.97%*	*3.24%*	3.55%	*TBC*	▲
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	81.89%	81.64%	82.20%	80.40%	79.55%	78.71%	76.89%	81.18%	83.76%	85.94%	84.64%	**84.91%**	**86.81%**	▲
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 3	<80%	80%<>95%	>=95%	89.59%	90.12%	89.07%	89.56%	89.70%	88.54%	87.70%	87.75%	88.31%	89.79%	90.68%	**92.03%**	**91.96%**	▼

	Measure	2017-18 Quarter 4: Of 306 responses: 90% : 5.23%	2018-19 Quarter 1: Of 205 responses: 89.27% : 0.49%	2018-19 Quarter 2: Of 151 responses: 91.39% : 2.64%	2018-19 National Survey Of 491 responses: 91% : 2%	2018-19 Quarter 4: Of 182 responses: 96.15% : 1.09%	Qtr 1 & Qtr 1 ▲Responses ▲ Likely ▼Unlikely
Friends & Family Test - Treatment Quarterly staff survey to indicate likelihood of recommending QVH to friends & family to receive care or treatment	Extremely likely / likely %: Extremely unlikely / unlikely%						
Friends & Family Test - Work Quarterly staff survey to indicate likelihood of recommending QVH to friends & family as a place of work	Extremely likely / likely %: Extremely unlikely / unlikely%	2017-18 Quarter 4: Of 306 responses: 57.19% : 26.47%	2018-19 Quarter 1: Of 205 responses: 51.22% : 20.48%** *(**data inaccuracy up to 8% due to survey error)*	2018-19 Quarter 2: Of 151 responses: 61.59% : 24.50%	2018-19 National Survey Of 491 responses: 62% : 15%	2018-19 Quarter 4: Of 182 responses: 73.62% : 13.73%	Qtr 2 & Qtr 2 ▲Responses ▲ Likely ▼Unlikely

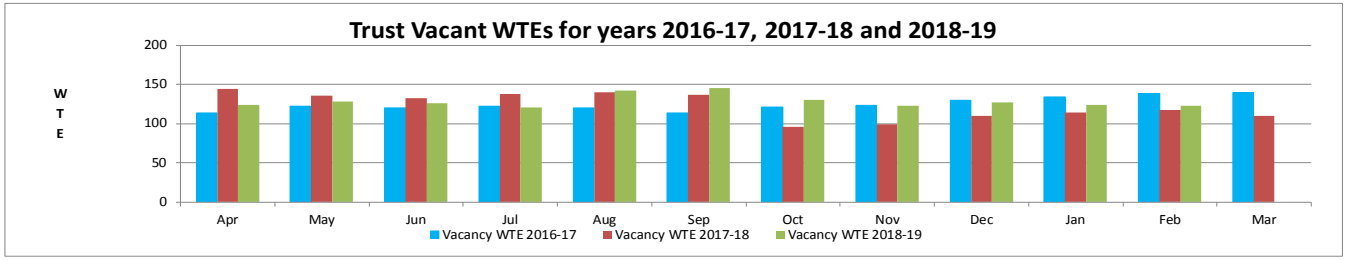
*Note 1 - 2018/19 Establishment updated in Aug 18. Establishment updated in August 2017 with nursing update in October 2017
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups.
*Note 3 - New RAG ratings for 2017/18 for Appraisals and for Statutory & Mandatory Training plus 2 new Board Reportable competences introduced - Fire Safety and Safeguarding Adults Level 2.

2. Vacancies and Recruitment

VACANCY PERCENTAGES	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate	10.38%	9.82%	9.65%	▼
Eyes	0.24%	13.64%	13.64%	◄►
Sleep	20.67%	17.78%	17.16%	▼
Plastics	0.58%	1.78%	0.61%	▼
Oral	6.54%	5.52%	5.01%	▼
Periop	20.99%	20.96%	19.91%	▼
Clinical Support	6.37%	5.94%	7.09%	▲
Clinical Infrastructure	7.30%	5.39%	10.16%	▲
Director of Nursing	5.91%	1.47%	0.93%	▼
Operational Nursing	20.70%	20.05%	17.27%	▼
QVH Trust Total	12.48%	12.36%	11.79%	▼

NON-MEDICAL RECRUITMENT(WTE)	Posts advertised this month	Recruits in Pipeline
Corporate	8.38	11.14
Eyes	1.00	3.20
Sleep	2.60	0.01
Plastics	1.60	0.00
Oral	0.00	0.00
Periop	4.01	11.52
Clinical Support	6.69	9.40
Clinical Infrastructure	2.00	1.00
Director of Nursing	0.00	0.00
Operational Nursing	15.71	7.94
QVH Trust Total	41.99	44.21
of which Qual Nurses / Theatre Practs (external)	18.23	*13.27*
of which HCA's & Student/Asst Practs (external)	0.00	*4.08*

MEDICAL RECRUITMENT (WTE)	Posts advertised this month		Recruits in Pipeline
Clinical Support	1.01		3.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.01*		*3.00*
of which are SAS doctors	*0.10*		*0.00*
of which are Consultants (including locums)	*1.00*		*0.00*
Plastics	15.00		4.00
of which are Deanery Trainees, Trust Registrars or Fellows	*14.00*		*4.00*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*1.00*		*0.00*
Eyes	2.00		4.00
of which are Deanery Trainees, Trust Registrars or Fellows	*2.00*		*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	1.00	#	5.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*		*5.00*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*1.00*		*0.00*
Periop	2.00		3.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*		*0.00*
of which are SAS doctors	*0.00*		*1.00*
of which are Consultants (including locums)	*2.00*		*2.00*
QVH Trust Total	21.01		19.00
of which are Deanery Trainees, Trust Registrars or Fellows	*16.01*		*16.00*
of which are SAS doctors	*0.10*		*1.00*
of which are Consultants (including locums)	*5.00*		*2.00*



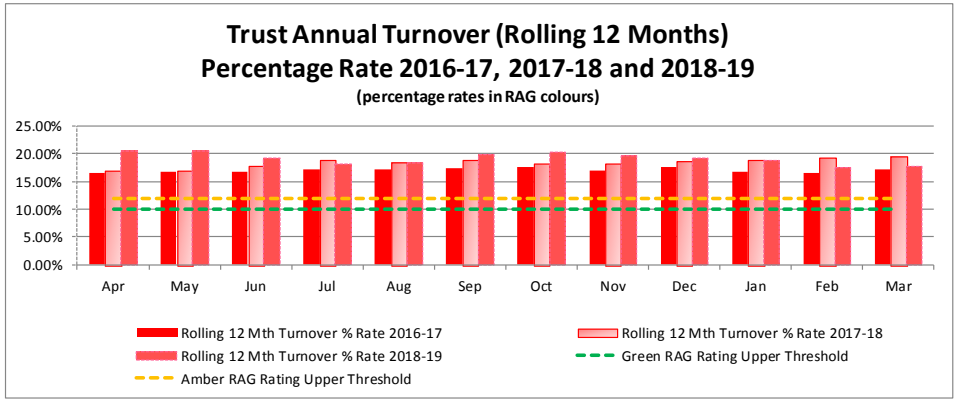
International Recruitment	Offered and Accepted (WTE)	Expected to start in the next month	Expected to start within 2-3 months	Expected to start within 4-6 months	Started
Critical Care	13	0	2	2	0
Other Nurse	14	0	3	2	0
Theatres / Recovery	28	1	4	5	1
Total	55	1	9	9	1

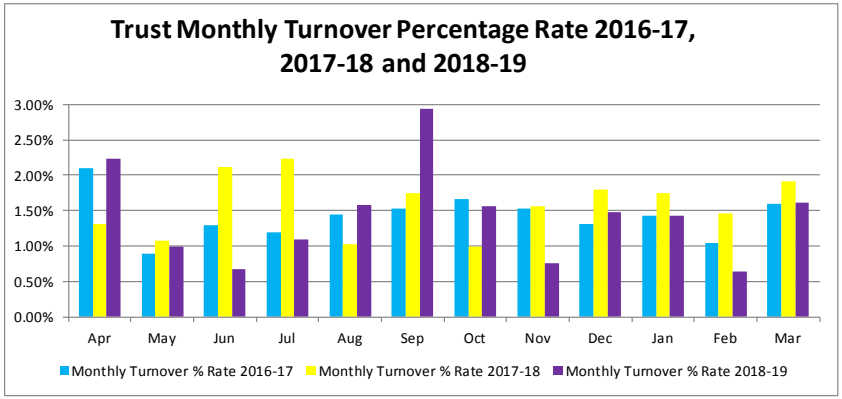
***Please note 50% of offered are expected to be unsuccessful during the international recruitment process or withdraw.**

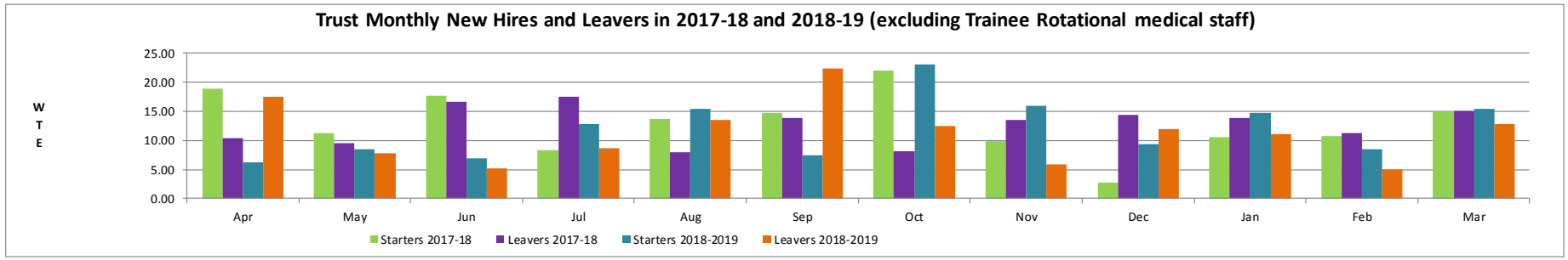
3. Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate %	17.59%	16.29%	17.88%	▲
Eyes %	29.63%	34.76%	38.31%	▲
Sleep %	23.98%	24.09%	27.64%	▲
Plastics %	19.13%	20.94%	22.48%	▲
Oral %	21.26%	19.11%	19.48%	▲
Peri Op %	15.60%	13.16%	12.31%	▼
Clinical Support %	15.12%	13.44%	14.42%	▲
Clinical Infrastructure %	24.46%	18.08%	20.69%	▲
Director of Nursing %	12.54%	12.35%	12.17%	▼
Operational Nursing %	21.92%	20.91%	17.88%	▼
QVH Trust Total %	18.73%	17.46%	17.67%	▲

MONTHLY TURNOVER excl. Trainee Doctors	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate %	1.12%	0.63%	2.51%	▲
Eyes %	6.09%	5.46%	7.32%	▲
Sleep %	3.41%	0.00%	3.24%	▲
Plastics %	4.00%	1.77%	1.28%	▼
Oral %	0.00%	0.00%	0.00%	◄►
Peri Op %	1.41%	0.71%	0.70%	▼
Clinical Support %	1.46%	0.00%	1.83%	▲
Clinical Infrastructure %	0.00%	0.00%	5.37%	▲
Director of Nursing %	3.32%	0.00%	0.00%	◄►
Operational Nursing %	0.00%	0.45%	0.00%	▼
QVH Trust Total %	1.43%	0.64%	1.61%	▲







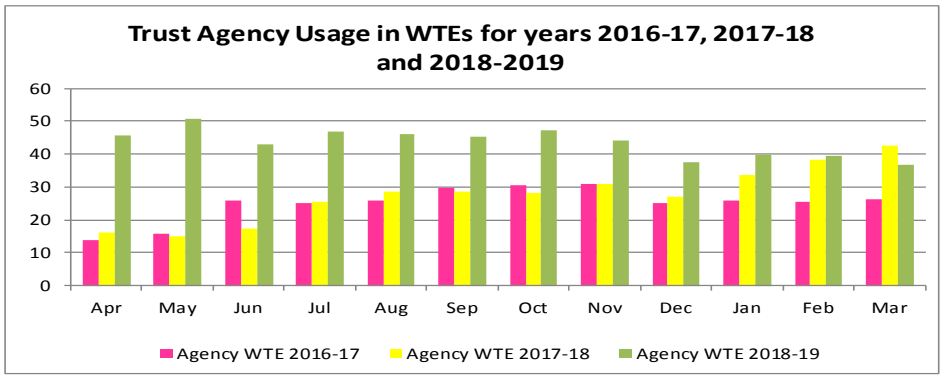
4. Temporary Workforce

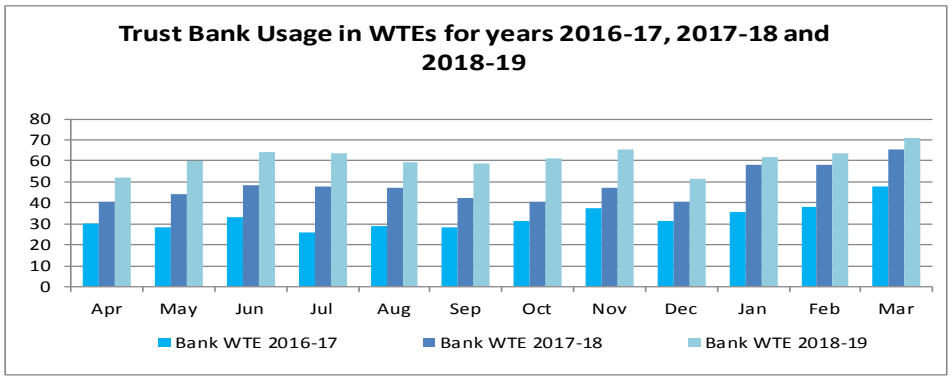
Agency				
BUSINESS UNIT (WTE)	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate	8.08	8.41	9.23	▲
Eyes	0.00	0.00	0.00	◄►
Sleep	0.47	0.18	0.00	▼
Plastics	1.93	0.80	0.87	▲
Oral	0.00	0.00	0.00	◄►
Periop	18.90	17.84	13.31	▼
Clinical Support	3.38	2.77	2.50	▼
Clinical Infrastructure	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	7.19	9.31	10.85	▲
QVH Trust Total	39.95	39.31	36.77	▼

Bank				
BUSINESS UNIT (WTE)	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate	8.73	9.36	10.10	▲
Eyes	1.33	1.05	1.72	▲
Sleep	2.49	3.35	2.86	▼
Plastics	3.33	2.29	1.80	▼
Oral	1.62	1.46	1.74	▲
Periop	16.17	17.15	18.69	▲
Clinical Support	6.27	5.39	7.19	▲
Clinical Infrastructure	4.73	3.93	4.01	▲
Director of Nursing	0.54	0.92	0.90	▼
Operational Nursing	16.46	18.66	21.67	▲
QVH Trust Total	61.66	63.57	70.70	▲

Agency				
STAFF GROUP (WTE)	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Qualified Nursing	26.10	26.79	24.21	▼
HCAs	0.00	0.35	0.00	▼
Medical and Dental	1.05	0.00	0.00	◄►
Other AHP's & ST&T	3.84	2.95	2.45	▼
Non-Clinical	8.96	9.21	10.10	▲
QVH Trust Total	39.95	39.31	36.77	▼

Bank				
STAFF GROUP (WTE)	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Qualified Nursing	23.59	25.10	30.11	▲
HCAs	7.80	8.75	8.05	▼
Medical and Dental	0.14	0.00	0.00	◄►
Other AHP's & ST&T	2.33	2.47	2.58	▲
Non-Clinical	27.80	27.24	29.96	▲
QVH Trust Total	61.66	63.57	70.70	▲



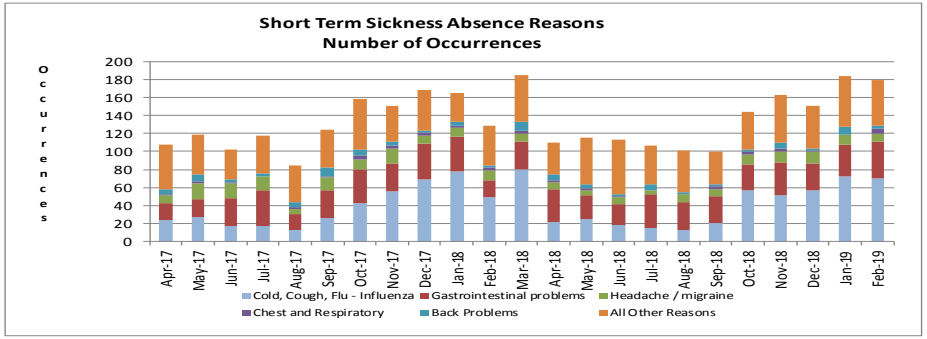


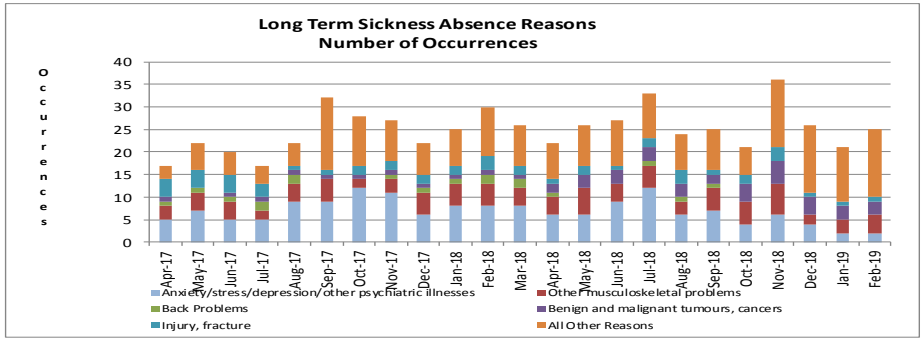
5. Sickness Absence

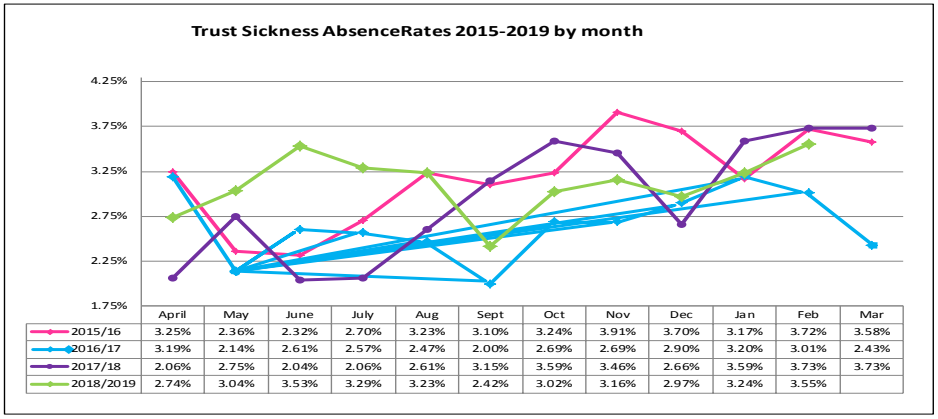
SHORT TERM SICKNESS	Dec-18	Jan-19	Feb-19	Compared to Previous Month
Corporate	1.27%	1.52%	0.73%	▼
Clinical Support	1.03%	1.37%	1.59%	▲
Plastics	1.01%	0.99%	1.92%	▲
Eyes	1.85%	3.14%	0.98%	▼
Sleep	0.13%	0.43%	1.35%	▲
Oral	0.63%	0.37%	2.21%	▲
Periop	2.32%	2.92%	2.32%	▼
Clinical Infrastructure	2.04%	2.88%	1.88%	▼
Director of Nursing	0.23%	0.32%	3.74%	▲
Operational Nursing	1.82%	3.18%	2.57%	▼
QVH Trust Total	1.43%	1.93%	1.86%	▼

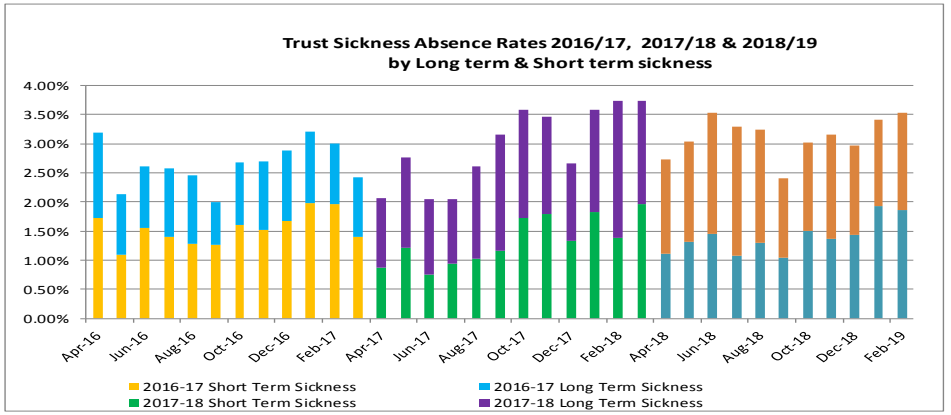
LONG TERM SICKNESS	Dec-18	Jan-19	Feb-19	Compared to Previous Month
Corporate	0.63%	0.70%	1.25%	▲
Clinical Support	1.69%	1.47%	1.47%	◄►
Plastics	2.68%	2.49%	1.94%	▼
Eyes	0.00%	0.00%	1.92%	▲
Sleep	3.96%	5.97%	3.96%	▼
Oral	0.47%	0.00%	0.00%	◄►
Periop	2.38%	2.60%	2.87%	▲
Clinical Infrastructure	1.90%	0.00%	0.00%	◄►
Director of Nursing	0.00%	0.00%	0.00%	◄►
Operational Nursing	1.49%	1.55%	2.06%	▲
QVH Trust Total	1.54%	1.49%	1.68%	▲

ALL SICKNESS (with RAG)	Dec-18	Jan-19	Feb-19	Compared to Previous Month
QVH Trust Total	2.97%	3.42%	3.55%	▲



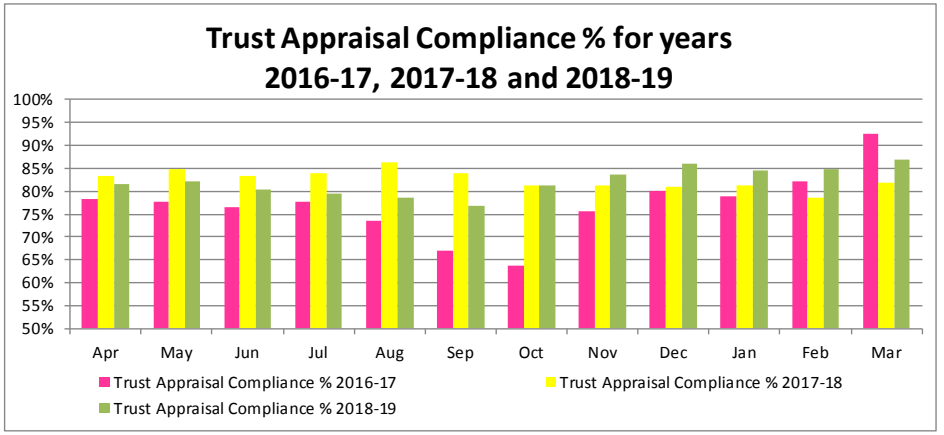




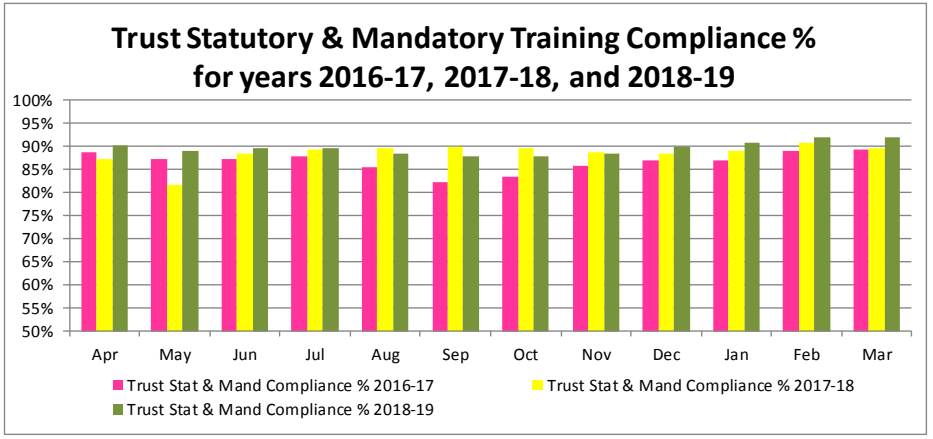


6. Training, Education and Development

APPRAISALS	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate	85.03%	86.86%	86.13%	▼
Eyes	82.86%	81.25%	80.00%	▼
Sleep	100.00%	93.55%	90.32%	▼
Plastics	67.07%	71.43%	78.75%	▲
Oral	69.33%	64.47%	89.33%	▲
Peri Op	82.66%	83.44%	84.02%	▲
Clinical Support	90.32%	87.42%	90.38%	▲
Performance and Access	81.40%	82.98%	75.56%	▼
Director of Nursing	91.89%	89.74%	92.68%	▲
Operational Nursing	93.06%	95.43%	91.57%	▼
QVH Trust Total	84.64%	84.91%	86.81%	▲



MANDATORY AND STATUTORY TRAINING	Jan-19	Feb-19	Mar-19	Compared to Previous Month
Corporate	92.66%	93.54%	92.60%	▼
Eyes	94.32%	93.87%	93.08%	▼
Sleep	91.11%	93.77%	91.15%	▼
Plastics	78.97%	84.52%	84.68%	▲
Oral	87.99%	91.68%	90.42%	▼
Peri Op	85.64%	86.54%	87.30%	▲
Clinical Support	94.35%	95.48%	96.48%	▲
Performance and Access	94.96%	94.02%	95.75%	▲
Director of Nursing	94.32%	94.74%	95.89%	▲
Operational Nursing	95.52%	94.99%	94.46%	▼
QVH Trust Total	90.68%	92.03%	91.96%	▼



7. Medical and Dental Workforce

Medical Workforce

- **Local Clinical Excellence Awards:** The Employer Based Awards Committee met this month to allocate the sixteen awards that were available. The Committee agreed the allocation which has to be approved by the Nomination and Remuneration Committee before the awards can be announced later this month.
- **Locum Agencies**: one agency Locum Consultant and one Registrar in Plastic Surgery and one Fellow in Corneo Plastic Surgery this month
- **Permanent Recruitment**: Currently recruiting for a Consultant Ear, Nose and Throat Surgeon with a specialist interest in Head and Neck Surgery, which is a joint post Medway Hospital, and for two Consultants in Anaesthetics
- **Doctors in Training**: 13 new doctors started in Oral and Maxillofacial Surgery, Plastic Surgery, Radiology and Corneo Plastic Surgery during April
- **Job Planning:** Round Two of job planning is continuing and delayed until the end of April 2019 due to a robust review of Plastic Surgery job plans.
- **Medical appraisal rates** for March 19:

Org L4	Assignment Count	Required	Achieved	Compliance %
276 Clinical Support (Div)	9	9	8	88.89%
276 Eye (Div)	9	9	8	88.89%
276 Oral (Div)	44	44	37	84.09%
276 Perioperative Care (Div)	35	35	27	77.14%
276 Plastics (Div)	56	56	50	89.29%
276 Sleep (Div)	2	2	2	100.00%
Total	**155**	**155**	**132**	**85.16%**

Medical Education

Monthly update

- The LAB meeting for educational governance took place on 28 March.
- A regional training day for Core Surgery trainees took place on 14 March, with excellent feedback.
- The ever-popular Trauma and Burns course ran on 27 March.
- The junior doctors forum took place on Monday 18 March and was well attended.

Upcoming developments

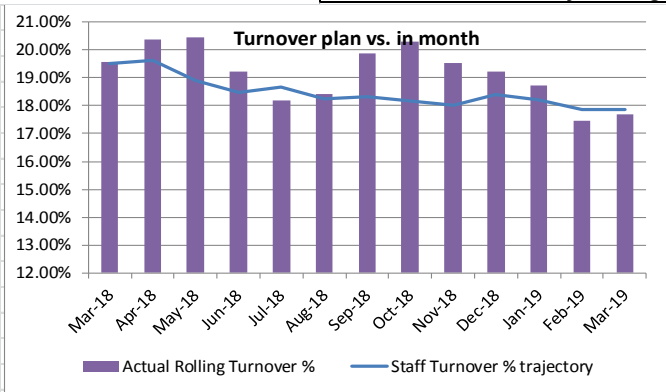
- Preparations are underway for the April rotation, when new OMFS and higher plastic surgery trainees will be joining the Trust.
- Mr Mike Williams will be presenting at an evening lecture on Weds 24 April, discussing “World War I: The birth of maxillofacial surgery”. All staff are welcome to attend.

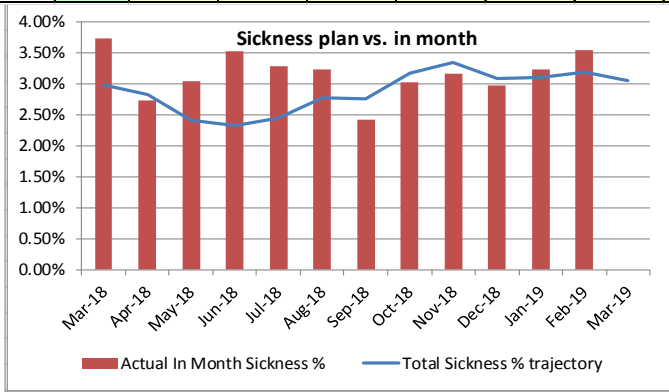
Statutory and mandatory training compliance

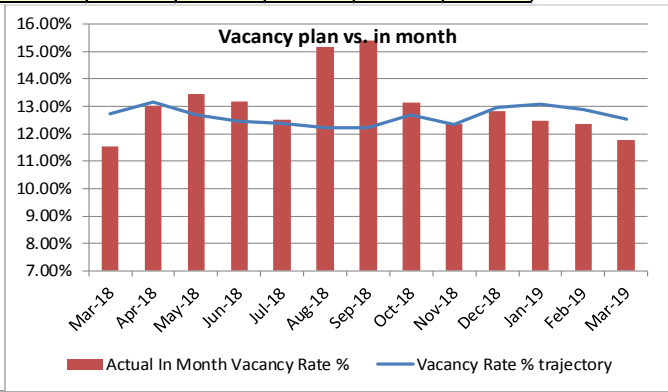
- Work continues to improve compliance rates. Permanent/fixed term medical and dental employees are currently showing 87.7% compliant, which is another small improvement on the previous month. Medical and dental bank workers are showing as 58.7% compliant, which is an improvement of over 13% on the previous month, and demonstrates that the efforts taken to improve the compliance are working.

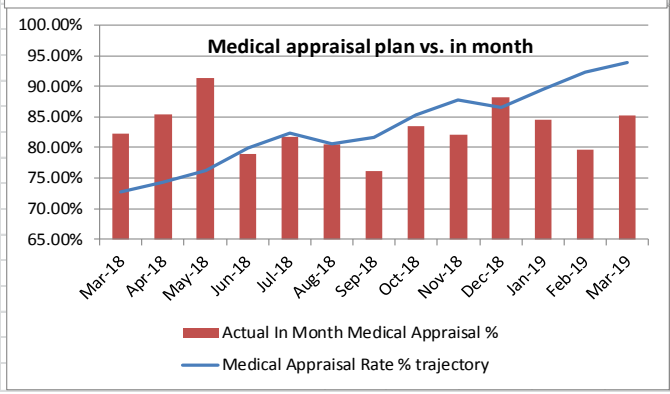
8. Trajectories

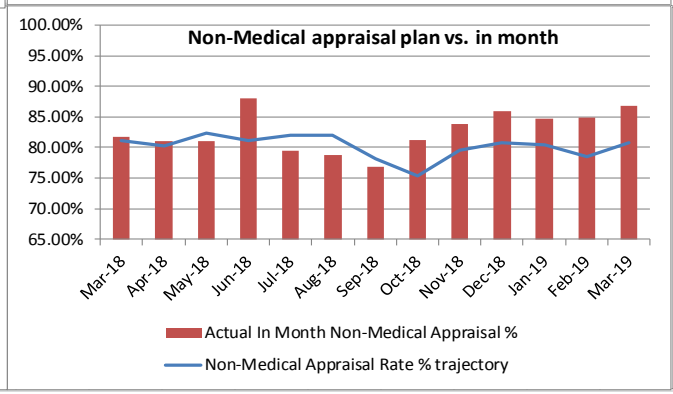
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Staff Turnover % trajectory	19.51%	19.62%	18.91%	18.46%	18.67%	18.24%	18.32%	18.18%	18.00%	18.41%	18.20%	17.84%	17.87%
Actual Rolling Turnover %	19.57%	20.38%	20.43%	19.20%	18.17%	18.42%	19.88%	20.29%	19.52%	19.23%	18.73%	17.46%	17.67%
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%	3.04%	3.53%	3.29%	3.23%	2.42%	3.02%	3.16%	2.97%	3.24%	3.55%	
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%	13.17%	12.53%	15.15%	15.40%	13.14%	12.34%	12.81%	12.48%	12.36%	11.79%
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%	80.96%	80.96%	88.08%	79.55%	78.71%	76.89%	81.18%	83.76%	85.94%	84.64%	84.91%	86.81%
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%	93.82%
Actual In Month Medical Appraisal %	82.35%	85.42%	91.28%	78.93%	81.75%	80.52%	76.16%	83.54%	82.17%	88.13%	84.62%	79.73%	85.16%
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%	89.56%	89.70%	88.54%	87.70%	87.75%	88.31%	89.79%	90.68%	92.03%	91.96%

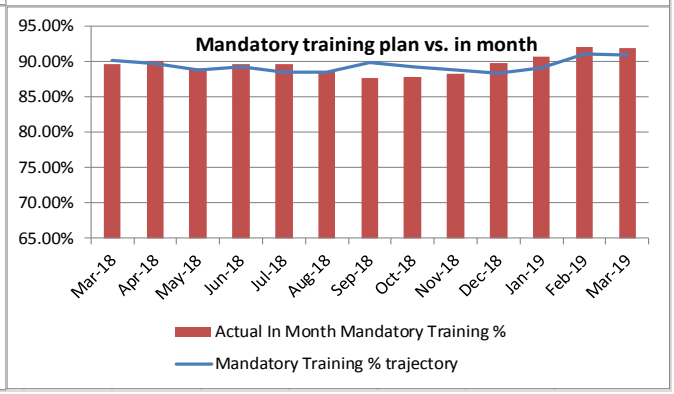












9. Organisational Development

Monthly update

- Locality data on the NHS 2018 Staff Survey reports were completed and issued to the Executive Management Team. These will be distributed to the relevant locality areas.
- Leading the Way workshops have been organised for 2019/20 and are available for staff to view on Qnet.
- Training is now being delivered on the new appraisal and pay progression policy to all managers and has been published on Qnet and promoted on Connect
- Work Experience Policy/process has been agreed has been handed over to the Business Units to manage locally

Upcoming developments

- Best Place to Work initative is under way and we have met the provider to agree next steps. Launch date to be agreed next week with the EMT.
- Working with the training leads to introduce combined training days for clinical and non-clinical staff.

Statutory and mandatory training compliance

- Mandatory & Statutory Training compliance as seen a slight decrease this month. 2 areas are currently reporting as RED and compliance needs to be improved in these areas (Information Governance is at 72.47% - a decrease from last month 74.56%). Infection Prevention and Control L11yrly has increased to 78.38% from last month 77.78%
- Appraisals have increased this month.
- Work continues to improve compliance rates.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**92-19**	
Report title:	**Self-certification 2019**				
Sponsor:	Clare Pirie, Director of communications and corporate affairs				
Author:	Hilary Saunders, Deputy company secretary				
Appendices:	None				
Executive summary					
Purpose of report:	The Board is required to self-certify that it is assured that it has complied with the NHS Provider Licence and NHS Acts, and has had regard to the NHS Constitution.				
Summary of key issues	The Board is asked to **CONFIRM** that:: • It has complied with the NHS provider licence condition • It has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • It has complied with required governance arrangements (Condition FT4(8)) • It has a reasonable expectation that required resources will be available to deliver the designated Commissioner Requested Services (Condition CoS7(3) over the next financial year but specific factors may cast may doubt on this				
Recommendation:	The Board is asked to approve the Trust's self-certification statement				
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:	None				
Corporate risk register:	None				
Regulation:	• NHS Provider Licence • NHS Acts • NHS Constitution.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
Next steps:	Publication of self-certification statement to QVH website • G6/CoS7 before 31 May 2019 • FT4 before 30 June 2019				

Report to:	Board of Directors
Meeting date:	2 May 2019
Reference number:	92-19
Report from:	Clare Pirie, Director of Communications and Corporate Affairs
Author:	Hilary Saunders, Deputy Company secretary
Appendices:	N/A
Report date:	24 April 2019

Self-Certification 2019

1. Introduction

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

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

2. What is required

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

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

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

3. QVH self-certification

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

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

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

This will be set out in section 3.7 of the annual report (as part of the annual governance statement).

3.1.2 Condition FT4 requires that NHS foundation trusts certify compliance with required governance standards and objectives. This will be set out in section 2.2 of the annual report (under performance analysis).

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

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

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

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

Trauma and Head

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

Women and Children

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

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

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

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

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

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

3.5 Providers must review whether their governors have received enough training and guidance to carry out their roles. There is no set requirement for this, it is left to the discretion of the trust how this is delivered. In July 2018, arrangements were made for newly appointed governors to join the Trust's two-day induction. In the same month, they were also invited to attend a half day induction programme specifically focusing on their role as governor. In November 2018, the Trust ran a workshop aimed at helping governors understand the role of the NED which helped them to understand how they should carry out their main responsibilities of holding the non-executive directors individually and collectively to account for the performance of the Board of Directors.

As part of contributing to the development of the Trust's forward plans, Council also received a presentation by the Chief Executive on the Trust's strategy which outlined the financial, performance and workforce challenges the Trust was facing and also an update on the trend towards the consolidation of provider organisations through new alliances and groups

The Trust is assured that the training in place supports Council in meeting its duties and that the induction programme, the lead governor system, *Governors' Monthly Update* publication and the AGM/AMM all contribute to this.

4. Recommendation

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

4.1 It has complied with the NHS provider licence condition

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

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

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**93-19**	
Report title:	**Brighton and Sussex University Hospitals NHS Trust, Western Sussex Hospitals NHS Foundation Trust and Queen Victoria Hospital NHS Foundation Trust Collaboration**				
Sponsor:	Steve Jenkin, Chief Executive				
Author:	Clare Pirie, Director of communications and corporate affairs				
Appendices:	A QVH/WSHT/BSUH joint executive programme ToRs B QVH/WSHT/BSUH joint programme steering group ToRs				
Executive summary					
Purpose of report:	Following small revisions to the ToRs agreed by the Board at its meeting on 7 March, the Board is asked to approve the final version which will support the programme of work associated with the partnership between BSUH, WSHT and QVH				
Summary of key issues	• A change to the Joint Executive Programme Board ToRs which adds Finance and HR director representation to the membership • A change to the Joint Programme Steering Group which adds HR representation to the membership				
Recommendation:	The Board is asked to **approve** the Terms of Reference for the Joint Programme Executive Board and the Joint Programme Steering Group.				
Action required	**Approval**				
Link to key strategic objectives (KSOs):	**KSO1:** This work is planned with a view to better meeting the needs of the regional population	**KSO2:** QVH retains a world-class expertise in the clinical services involved.	**KSO3:** This work is planned to improve the sustainability of service provision	**KSO4:** Partnership working is key current services and to the future of QVH	**KSO5:** The QVH workforce need to be kept well-informed and engaged with this process
Implications					
Board assurance framework:					
Corporate risk register:	Link to risks 1139 patients with complex open lower limb fractures; 968 Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds				
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:					
Next steps:	These Terms of reference have been approved by the boards of BSUH and WSHT.				

Queen Victoria Hospital NHS Foundation Trust
and
Brighton and Sussex University Hospitals NHS Trust
and
Western Sussex Hospitals NHS Foundation Trust

Joint Executive Programme Board

Terms of Reference

Title:	**Joint Executive Programme Board**
Date approved and approving body:	Approved by the Board of Queen Victoria Hospital NHS Foundation Trust (QVH) on 7th March/2nd May 2019, by the Board of Brighton and Sussex University Hospitals NHS Trust (BSUH) on March 27th 2019 and by the Board of Western Sussex Foundation NHS Trust (WSHT) on March 28th 2019
Constitution and establishment:	The Joint Executive Programme Board (JEPB) has been constituted under the authority of the Boards of QVH, BSUH and WSHT (the partner organisations) in line with the Memorandum of Understanding which sets out the aims and objectives of the strategic partnership between the three organisations and reflects the current management arrangement between WSHT and BSUH.
Accountability:	The JEPB is accountable to the Boards of the three constituting organisations
Purpose:	To ensure that the clinical, operational and financial benefits of a strengthened strategic partnership between the three partner organisations are delivered by overseeing a programme of work that both defines and makes recommendations on : i. The scope of the future collaboration (clinical/non-clinical and organisational) ii. The timetable and process for delivering change iii. The transaction vehicle(s) required to facilitate collaboration and change and oversees the implementation of specific priority opportunities for increased collaboration and service improvement.
Membership:	• Steve Jenkin – Chief Executive, QVH (Co- Chair) • Marianne Griffiths – Chief Executive, BSUH/WSHT (Co-Chair) • George Findlay – Deputy Chief Executive/Chief Medical Officer, BSUH/WSHT • Ed Pickles – Medical Director, QVH • Rob Haigh – Medical Director, BSUH • Helen Weatherill – HR Director BSUH • Geraldine Opreshko – Director of Workforce and Organisational Development QVH • Clare Stafford – Finance Director BSUH • Michelle Miles – Finance Director QVH • Abigail Jago – Director of Operations, QVH • Jayne Black – Chief Operating Officer, BSUH • Oliver Philips – Director of Strategy and Planning, BSUH/WSHT • Ian Francis – Director Of Strategy, QVH • Amanda Harrison – Programme Director The Co-chairs may agree additional attendees as required in line with the duties of the Board.
Communication:	A notice of each meeting, including an agenda and supporting papers, will be

	available for each member of the JEPB one week prior to the date of the meeting. Additional agenda items should be submitted to the Chair at least three days prior to the date of the meeting. As a principle, the late submission of papers will be discouraged, in order to support group members having adequate time to review.
Quorum:	A quorum shall consist of at least one third of the membership with all organisations being represented by at least one member. Deputies will count towards the quorum.
Frequency of meetings:	Routine meetings of the group will be held as a minimum quarterly Extraordinary meetings may also be scheduled to expedite action in respect of any urgent issues arising in the interim period.
Agenda and notes/action points:	The Group shall be supported by the Programme Director with administration support by BSUH. In this respect, support will include: • The agreement of the agenda with the Chair, collation of relevant papers, taking and disseminating the minutes, and keeping a record of matters arising and issues to be carried forward. • Ensuring reports are received from the Programme Steering Group and Workstream Groups in a timely manner. • Ensuring the group's Terms of Reference are reviewed on an annual basis.
Attendance at meetings:	Members are expected to attend all meetings of the JEPB. With agreement of the Chair members unable to attend may send a deputy who is briefed and who will count towards the quorum. One representative from each organisation must be in attendance at the meeting of the JEPB.
Duties:	1. To consider the opportunities for future strategic, clinical and non-clinical collaboration between the three constituent organisations and across the broader health economy when required, and make recommendations on the priorities for implementation. 2. To identify the benefits delivered by each opportunity at a patient, system and organisation level; including improvements in sustainability, clinical outcomes and financial and operational performance 3. To identify the risks associated with each opportunity including at a patient, system and organisation level and ensure that acceptable mitigations are in place to manage these during implementation and ongoing delivery 4. To identify priority projects and agree the scope, objectives and priorities of the overall programme of work and the objectives, success measures and timeline for the individual workstreams; making recommendations to the respective Boards for agreement 5. To oversee the implementation of the agreed programme of work, identifying risks to implementation, ensuring that effective actions are identified and taken to address these risks and that the impact of these actions on implementation are monitored. 6. To support internal and external communication about the overall programme and ensure communications plans are developed and delivered in support of specific projects

	7. To agree option appraisal criteria for assessing the options for achieving workstream objectives in order that preferred options can be recommended to the individual organisation's Boards for approval 8. To agree any business case or development proposal arising from the programme in order that these can be recommended to individual organisation's Boards for approval. 9. To receive reports from the Joint Programme Steering Group in order to monitor the implementation of the programme of work. 10. To agree actions to address any risks and issues that are escalated to them 11. To ensure overall programme governance is linked to individual organisational governance arrangements 12. To escalate any concerns, together with recommendations for action, to the Boards of the partner organisations and act as a point of reporting, communication and dissemination of information to the respective organisations. 13. To approve the Terms of Reference and membership of any sub-group, and oversee the work of those sub-groups, receiving exception reports and acting to facilitate the work of the sub-groups.
Sub-groups:	The JEPB will oversee the work of a Joint Programme Steering Group and the working groups established to lead specific collaboration projects. The JEPB has the power to establish any sub-groups required to ensure the successful delivery of its duties.
Reporting responsibilities:	A summary report of the matters considered by the JEPB should be submitted to each partner organisation for consideration through their internal governance systems. The JEPB is not a decision making group. Decisions required must be made through the governance arrangements of the member organisations.
Review:	Terms of Reference are due for review in January 2020.

Queen Victoria Hospital NHS Foundation Trust
and
Brighton and Sussex University Hospitals NHS Trust
and
Western Sussex Hospitals NHS Foundation Trust

Joint Programme Steering Group

Terms of Reference

Title:	**Joint Programme Steering Group**
Date approved and approving body:	Approved by the Joint Executive Programme Board on March 1st 2019
Constitution and establishment:	The Joint Programme Steering Group (JPSG) has been constituted under the authority of the Joint Executive Programme Board in line with the Memorandum of Understanding which sets out the aims and objectives of the strategic partnership between the three organisations and reflects the current management arrangement between WSHT and BSUH.
Accountability:	The JPSG is accountable to the JEPB
Purpose:	To oversee the implementation of the specific priority opportunities for increased collaboration identified by the JEPB and agreed by the Boards of the three partner organisations.
Membership:	• Programme Director – Amanda Harrison (Chair) • Oliver Phillips – Director of Strategy and Planning, BSUH/WSHT • Ian Francis – Director of Strategy, QVH • Helen Weatherill – HR Director BSUH • Geraldine Opreshko – Director of Workforce and Organisational Development QVH • Ali McKinley – Head of Business Development BSUH • Peter Lane – Divisional Director of Ops, Specialist Services, Plastics, BSUH • Dominic Clarke – Divisional Director of Ops, Surgery, OFMS, BSUH • Carly Knell – Divisional Director of Ops, Children and Women's, BSUH • Paul Gable – Service Lead Burns/Plastics, QVH • Georgina Baidya – Service Lead OFMS, QVH • Nora Nugent – Clinical Lead Burns, QVH • Paul Drake – Clinical Lead Orthoplastics, QVH • Martin Jones – Clinical Lead Plastics, QVH • Ken Sneddon – Clinical Lead OMFS, QVH • Brian Bisase – Clinical Lead OMFS/Head and Neck, QVH • Ryan Watkins – Chief for Children and Women, Paed Burns, BSUH • Marco Maccario – Chief for Specialist Services, Plastics, BSUH • Lisa Leonard – Chief for Surgery, OFMS, BSUH. • Jason McIntyre – Finance Lead, QVH • Adam Shields – Finance Lead, BSUH • Emer Keating – Project Manager Paediatric Burns, QVH The Chair may agree additional attendees/invitees as required in line with the duties of the Steering Group.
Communication:	A notice of each meeting, including an agenda and supporting papers, will be available for each member of the JPSG one week prior to the date of the meeting. Additional agenda items should be submitted to the Chair at least three days prior to the date of the meeting. As a principle, the late submission

	of papers will be discouraged, in order to support group members having adequate time to review.
Deputies	With the Chair's agreement members may nominate deputies or other members to represent them at a meeting.
Quorum:	A quorum shall consist of at least one third of the membership with all organisations being represented by at least one member. Deputies will count towards the quorum.
Frequency of meetings:	Routine meetings of the group will be held as a minimum six weekly. Extraordinary meetings may also be scheduled to expedite action in respect of any urgent issues arising in the interim period.
Agenda and notes/action points:	The Group shall be supported with administration support by BSUH. In this respect, support will include: • The agreement of the agenda with the Chair, collation of relevant papers, taking and disseminating the minutes, and keeping a record of matters arising and issues to be carried forward. • Ensuring reports are received from the Programme Steering Group and Workstream Groups in a timely manner. • Ensuring the group's Terms of Reference are reviewed on an annual basis.
Attendance at meetings:	Members are expected to attend all meetings of the JPSG. With agreement of the Chair members unable to attend may send a deputy who is briefed and who will count towards the quorum. One representative from each organisation must be in attendance at the meeting of the JPSG.
Duties:	1. To manage the overall programme of work and ensure the programme workstreams are on track to meet their objectives within the required timeframes 2. To establish and maintain individual project governance and reporting to ensure successful delivery of the overall programme 3. To ensure the process of option development and assessment is robust 4. To develop options appraisal criteria and manage the options appraisal process 5. To identify and address risks and issues with the overall programme delivery and individual workstreams, escalating these as required 6. To ensure short and long term impact on clinical, operational and financial performance and sustainability are incorporated into the work of the workstreams 7. To oversee the development of associated business cases or development proposals arising from the programme 8. To ensure comprehensive implementation plans are developed and that the risks and issues associated with implementation are identified and addressed, escalating these as required 9. To oversee the implementation of agreed collaborative working including service developments and improvements. 10. To monitor and evaluate the benefits realised by collaborative working. 11. To escalate any concerns, together with recommendations for action, to the JPEB 12. To act as a point of reporting, communication and dissemination of information to the relevant operational teams within their respective organisations. 13. To receive reports from the Workstream Groups in order to monitor the implementation of the programme of work.. 14. To approve the Terms of Reference and membership of any sub-group, and oversee the work of those sub-groups, receiving exception reports and acting to facilitate the work of the groups.

Sub-groups:	The JPSG will oversee the work of the workstream groups established to lead specific collaboration projects.
Reporting responsibilities:	A summary report of the matters considered by the JPSG should be submitted to the JEPB for consideration The JPSG is not a decision making group. Decisions required must be referred to the JPEB and made through the governance arrangements of the member organisations..
Review:	Terms of Reference are due for review in November 2019.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**02 May 2019**		**Agenda reference:**	**95-19**	
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 March 2019				
Summary of key issues	The Committee received updated assurance on KSO3. It also received an update from KPMG on the 2018/19 audit and reports and updates from Internal Audit.				
Recommendation:	The Board is asked to **NOTE** the contents of this report.				
Action required *[highlight **one** only]*	Approval	Information	Discussion	Assurance	Review
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:	2 May 2019
Reference number:	95-19
Report from:	Kevin Gould, Chair
Author:	Kevin Gould, Chair
Report date:	23 April 2019

Audit Committee report
Meeting held on 20 March 2019

1. The Committee received an assurance update on KSO3 from the Director of operations. This was a follow-up to the report received in September at which time a number of gaps in assurance were noted. The committee was assured by the progress that has been made in control and data quality, although noted the ongoing risks to delivering standards.

2. The Committee reviewed and approved its workplan for 2019/20.

3. KPMG provided its update and progress report for the 2018/19 audit. Completion of the audit will be more challenging this year due to the deterioration in the Trust's financial position and new accounting standards. Additional time on-site is planned to ensure this is done within the required timeframes. The trust and KPMG will need to make more detailed disclosures relating to Going Concern due to the financial situation.

4. Mazars advised that three internal audit reports had been issued since the last meeting. Two, Information Technology Strategy and Payroll were rated Satisfactory. A report on Recruitment & Retention was rated "Limited Assurance" with one high priority finding. The Committee agreed in future to ask an appropriate senior manager to attend when reports rated less than satisfactory were received to provide assurance that appropriate actions were being taken. The Committee again expressed concern about the amount of work still to be completed given only 64% of the work had been executed and 8 reports remain to be completed.

5. The Committee received a report on the progress of Counter Fraud activity.

6. The Committee received draft annual reports for Internal Audit and Counter Fraud.

7. Since this meeting, the Committee has received presentations from potential providers for Internal Audit and Counter Fraud. An update will be provided verbally.

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