Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 4 July 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: 4 July 2019

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	John Thornton
Non-Executive Directors	-	Kevin Gould
	-	Gary Needle
	-	Karen Norman
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 *(apologies)*
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary (minutes)	-	Hilary Saunders
Deputy Director of Workforce	-	Dave Hurrell

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

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

Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 4 July 2019
10:00 – 13:00
Education Centre, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
97-19	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
98-19	**Patient story** *Jo Thomas, Director of nursing*	*assurance*	-
99-19	**Draft minutes of the meeting held in public on 02 May 2019** *Beryl Hobson, Chair*	*approval*	1
100-19	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	9
101-19	**Chair's report** *Beryl Hobson, Chair*	*assurance*	10
102-19	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	13
Key strategic objective 5: organisational excellence			
103-19	**Board assurance framework** *Dave Hurrell, Deputy director of workforce and OD*	*assurance*	22
104-19	**Workforce monthly report** *Dave Hurrell, Deputy director of workforce and OD*	*assurance*	23
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
105-19	**Board Assurance Framework** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*assurance*	39
106-19	**CQC inspection report** *Jo Thomas, Director of nursing*	*assurance*	41
107-19	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	-
108-19	**Corporate risk register (CRR)** *Jo Thomas, Director of nursing*	*review*	91

109-19	**Quality and safety report** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*assurance*	102
110-19	**National inpatient survey results** *Jo Thomas, Director of nursing*	*assurance*	136
111-19	**Paediatric burns update** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*information*	-
112-19	**Clinical strategy priorities update** *Ed Pickles, Medical director*	*assurance*	-
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
113-19	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	158
114-19	**Financial, operational and workforce performance assurance** *John Thornton, Committee chair*	*assurance*	160
115-19	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	163
116-19	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	191
Governance			
117-19	**Review of committee chairs and membership** *Beryl Hobson, Chair*	*approval*	207
118-19	**Appointment of Senior Independent Director** *Beryl Hobson, Chair*	*approval*	210
119-19	**Annual approval of Standing financial instructions** *Michelle Miles, Director of finance*	*approval*	212
120-19	**Annual approval of Standing orders and Reservation of powers/scheme of delegation** *Michelle Miles, Director of finance and* *Clare Pirie, Director of communications and corporate affairs*	*approval*	252
121-19	**Audit committee assurance** *Kevin Gould, Non-executive director and committee chair*	*assurance*	326
Any other business (by application to the Chair)			
122-19	*Beryl Hobson, Chair*	*discussion*	-

Questions from members of the public			
123-19	*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**: 05 September 2019 at 10:00	**Council of governors** **Public**: 29 July 2019 at 15:00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 2 May 2019, 10:00 – 13:00, Education Centre, QVH site**	
Present:	Beryl Hobson, (BH)	Trust chair (voting)
	Kevin Gould (KG)	Non-executive director (voting)
	Steve Jenkin (SJ)	Chief executive (voting)
	Abigail Jago (AJ)	Director of operations (non-voting)
	Michelle Miles (MM)	Director of finance (voting)
	Gary Needle (GN)	Non-executive director (voting)
	Karen Norman (KN)	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 73-19)**
Public gallery:	One member of staff and three public governors	

Welcome

72-19 **Welcome, apologies and declarations of interest**

The Chair opened the meeting and welcomed KN to her first meeting as non-executive director. She also welcomed members of staff and council who were in the public gallery.

There were no new declarations of interest.

Standing items

73-19 **Patient story**

The Patient experience manager joined the meeting with a patient who had been invited to tell her story following her recent Moh's surgery. She explained that whilst during her pre-assessment she had been given sufficient information regarding the Moh's procedure, at no time was the impact of the subsequent reconstruction explained to her. Given her personal commitments at the time, this had impacted detrimentally on her recovery period. She explained that had she realised the implications, she would have deferred treatment but due to the nature of the procedure, had no option but to proceed with the reconstruction.

The patient had met with the Patient experience manager and suggested that future Moh's consultations should be done jointly with a plastic surgeon. She had also supported the Trust in developing an updated patient leaflet tailored specifically to this type of procedure.

The Chair apologised to the patient on behalf of the Board, and thanked her for her support in ensuring lessons would be learned. It was agreed that this story would be shared at the next Joint Hospital Clinical Governance meeting as a reminder to medical staff not to underestimate patient recovery time. **[Action: EP]**

There were no more questions and the Board thanked the patient for attending.

74-19 **Draft minutes of the meeting session held in public on 07 March 2019**

The minutes of the meeting held in public on 7 March were **APPROVED** as a correct record.

75-19	**Matters arising and actions pending** The board received and approved the current record of matters arising and actions pending.
76-19	**Chair's report** BH presented her report which updated the Board of activities since their last public meeting. She was gratified by the high number of new starters attending a recent staff induction, amongst them theatre and critical care staff. There were no further comments and the Board **NOTED** the contents of the report.
77-19	**Chief executive's report** SJ opened with the overall BAF, noting that whilst this was the latest version, the dates on the document still reflected the previous report. Key risks remained workforce; underperformance against income, cost improvement and the underlying financial deficit, and the 52 week breach position. Highlights of his report included: • That good progress had been made in respect of performance targets; • Whilst the financial position remains subject to audit, the Trust is reporting a year-end deficit of £6.1m which will challenge our long term financial sustainability; • Following the factual accuracy review, it was anticipated that the CQC will publish their final report on, or around, 20 May; • Ecology surveys required to start the planning application for the proposed land sale will be underway shortly; a site agent will be commissioned to work alongside the Trust to provide specialist support on marketing the land. MM advised that she was liaising with the appropriate personnel at NHS Improvement (NHSI) with regard to the land sale, who had indicated they were in full support of the process • The improved Staff Friends and Family Test for the last quarter saw an increase both in measures for QVH as a place to receive care and also as a place to work. • A summary of the Q3 NHSI finance and operational performance figures for the provider sector. • A summary of QVH media activity in February and March. The Board discussed the update, highlighting in particular: • That the majority of dashboard indicators reflected improved performance. • Workforce pressures remained a significant challenge nationally, and not just for the Trust. GO briefly updated the board on work undertaken as part of the regional and national overview of NHS workforce and agreed to provide an update at a future seminar once more details were available. **[Action: GO]** • That the Patient First initiative, (the improvement methodology and strategic approach used by Western Sussex Hospitals and Brighton) would be considered further by the Hospital Management Team in June; updates would be provided to the Board as in due course. **[Action: CP]** • The revised STP structure, with Bob Alexander appointed to the role of independent chair of the STP/ICS footprint and Adam Doyle, CEO of the CCG Alliance to be Senior Responsible Officer. • Recent estates and facilities improvements throughout the QVH site which were highly commended. There were no further comments and the Board **NOTED** the contents of the latest report.
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services	
78-19	**Board assurance framework** The Board reviewed the current BAFs for KSO1and KSO2, noting an increase in PALS contacts regarding appointments and waiting times and also the difficulties in recruiting histopathology medical staff.

79-19	**Quality and governance assurance** KG presented a report which had been prepared by Ginny Colwell as Chair of Quality and governance committee (Q&GC) before she departed last month. The Board considered the report, seeking clarification in respect of the following: • Whilst overall results of the latest national inpatient survey had been excellent, issues with food quality remained; the Board was advised that a new Head of facilities was due to join the Trust shortly and would focus on this. In the meantime, CP reported that agreement had been reached for outsourcing of the Hurricane Café and this would increase the variety of food on offer. • Concern was raised that the CQUIN around reduction of antibiotic usage was not likely to be achieved. EP explained that whilst much work had been undertaken, further action was still required; however, he was assured overall that the Trust was going in the right direction. In the meantime, the Trust would continue to meet with commissioners regarding evidence and the steps being taken to achieve this target. There were no further comments and the Board **NOTED** the contents of the update.
80-19	**Corporate risk register** JMT presented the latest corporate risk register which had been reviewed recently by the Quality and governance committee (Q&GC) and the Clinical governance group (CGG). One additional risk had been added; this was the Trust's inability to meet legislative requirements of the Falsified Medicines Directive, introduced in February 2019. JMT advised that this had been discussed at the clinical support service meeting. It was a national issue, with all trusts currently non-compliant as required software was not currently available; work was underway externally to develop a programme but this was unlikely to be before December 2019. The Board sought and received clarification that risk item 877 (rated at 16), was a different risk to that shown on the KSO4 BAF and that there was no direct correlation. Once again, the Board commended the quality of the corporate risk register . There were no further comments and the Board **NOTED** the contents of the update.
81-19	**Quality and safety report** JMT presented the KSO1 section of the quality and safety report, asking the Board to note in particular: • The progress made on clinical harm reviews relating to the 52-week wait position. • Actions taken in respect of Brexit. • Recent success in developing and retaining the health care assistant workforce as a result of the introduction of the new national care certificate programme. As part of the KSO2 update, EP highlighted: • The continuing discussions between Western, Brighton and QVH regarding clinical pathways; progress had been slower than hoped for, with some proposals presenting financial challenges. • The 'Getting it Right First Time' (GIRFT) programme had included recent 'deep dive' reviews at QVH into perioperative care, breast surgery and hospital dentistry. Whilst the summary report will be presented to Q&GC, the subsequent action plan will be monitored through the Hospital Management Team meeting. It was gratifying that early report findings appeared to reflect well on outcomes for QVH patients. The Board sought and received assurance that the new annual leave allocation and booking system would address problems created last year, when a high level of staff absence had impacted on Trust activity levels. In addition, the job planning process was now an annual requirement and would provide better transparency and further assurance.

	There were no further comments and the Board **NOTED** the contents of the update.
82-19	**Paediatric burns business case** EP presented a business case considering the options for improving burn care services for children within Kent, Surrey and Sussex; this paid particular attention to the preferred option of shared inpatient and outpatient services with the Royal Alexandra Children's Hospital (RACH) in Brighton. The highlights of his presentation are as follows: • The Trust had been operating under derogation for its paediatric burns service for several years. The continuing fall in numbers (around 40 patients in 2018/19, with 15% being transferred out) was severely impacting sustainability of service. • In 2013 national Burns Care Standards specified that burns units should be co-located with a number of other clinical services, not available on the QVH site. • At that time, the London and South East Burns Network (LSEBN) had agreed QVH could continue to provide these services on an interim basis, with derogation against a number of standards. In the meantime, NHS England (NHSE) had asked QVH to develop an alternative service model working with partners to ensure future compliance with Burns Care Standards. The resultant 2016 Strategic Outline Base proposed that QVH develop an acute inpatient paediatric burn service (with outpatient provision for the local population) in collaboration with RACH. Whilst commissioners felt at the time that this was not financially viable, this business case had provided the opportunity to re-examine the options. • Further analysis, together with a full risk assessment, had concluded that the previously preferred option of developing a service with the RACH was not viable. • Option three, (ie divestment of paediatric services to other partners in the network) was now the most likely solution; noting the impact this could have on burns and children's services more broadly. • In conclusion EP recommended that the next step was to further engage with commissioners and the LSEBN to seek support for provision of additional mitigations or to identify if any other options might be implemented with reduced levels of risk compared to the original preferred option (5b). The Board considered the report, seeking clarification of the following • Although the Trust continued to be accountable for risks associated with working under derogation, EP and JMT described at length the extensive controls and mitigations in place to address the insufficiencies in the current service model; these included adjusting clinical criteria for admission to the service to mitigate clinical risk. • EP had already met with LSEBN and specialist commissioners who were fully cognisant of the current position. • Once the 3Ts project had further progressed, BSUH may have space for the adult inpatient burns service, but this would not be until 2021. • Whilst this was a well-documented issue, with regulators, specialist commissioners, the CQC and LSEBN fully cognisant of the position, QVH had a duty to maintain the impetus until a satisfactory resolution had been achieved. • The business case would be circulated to all stakeholders, including specialist commissioners; a view on whether or not the corporate risk rating should be amended would be taken dependent upon the overall response. In the meantime, this would remain a standing agenda item. The Board commended the quality of the report and asked thanks to be extended to Emer Keating, Darzi fellow and report author. There were no further comments gave approval to the executive management team to proceed with next steps working towards the possibility of option 3 (divestment of paediatric services to other partners in the network).
83-19	**6-monthly nursing workforce review** JMT reminded Board of the national requirement to ensure evidence of safe staffing and to review nursing establishments on a 6-monthly basis. Today's report had been reviewed recently by Q&GC.

	The Board considered the contents of the report, seeking additional clarification as follows: • No clear correlation could be made between increased rates of sickness and reduced staffing. QVH had a small workforce and changes expressed in percentages could show a significant difference. There had also been high levels of gastroenteritis throughout the Trust; as clinical staff were required to leave a clear period of 48 hours before returning to work, this had also impacted on length of absence. • Staff vacancies in critical care remained but the Trust was using bank and agency staff to cover any shortfall, with the majority of shifts covered by our own bank staff. In the meantime, both overseas and domestic recruitment programmes continued. • The Board considered the high number of nursing and theatre practitioner staff eligible to retire in the next two years. Whilst the domestic recruitment programme had seen the arrival of younger members of staff which would offset this risk, it was particularly important to focus on retention of this cohort. There were no further comments and the Board **NOTED** the contents of the latest report.
84-19	**7-day hospital services board assurance framework** EP presented the Trust's 7-day hospital services self-assessment asking the Board to note that this was a mandatory process, which replaced the national reporting of 7-day service standards compliance. The Board was asked to note full compliance with priority standards; however, QVH was an outlier and it had been agreed with regulators that achievement was dependant on partnership working with other trusts and development of local standards for timely consultant review. EP described in detail the consultation process undertaken with NHSI before reaching agreement. The Board reviewed the self-assessment seeking clarification as follows: • Nationally, the 7-day services agenda now focused more on safety rather than merely operational effectiveness; EP noted that a formal relationship with another trust was the best way of improving safety. • Weekend pharmacy services were managed through a telephone pharmacy service with site practitioner support. • There were 66% fewer inpatients in hospital at weekends and it was important to get the right balance of resources under such circumstances. • This was a bi-annual submission. There were no further questions and the Board **NOTED** the contents of the update.
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
85-19	**Board assurance framework(BAF)** The Board reviewed the current BAFs for KSOs 3 and 4. AJ reported that overall scores remained the same for KSO3, noting that initial recruitment for a breast locum had been unsuccessful. MM advised that the current KSO4 risk rating of 25 remained. A review of gaps in controls and assurances had been undertaken, and now included several new additions. In particular MM highlighted completion of the reconciliation process between ESR and the ledger; data would be reviewed on a monthly basis from now on. There were no further comments and the Board **NOTED** the contents of the update.
86-19	**Financial, operational and workforce performance assurance** As Chair of the Finance and performance committee (F&PC), JT presented a report following its most recent meeting. In response to questions about the limited assurance on plans to improve capacity in

	order to drive activity levels, AJ and MM provided detailed assurance of how this was being managed, reminding the Board that activity levels were reviewed on a weekly basis. There were no further comments and the Board **NOTED** the contents of the update.
87-19	**Operational performance** AJ presented the latest operational performance report highlighting the following: • Delivery of waiting time standards including diagnostics, MIU, referral to treatment time (RTT) in-month targets, and 62-day and 2-week wait cancer targets. • The eRS/DeRS optimisation programme. Potential for an e-vetting process was being scoped but was dependant on capacity within the procurement. It was noted that the outpatient improvement programme was extra work on top of 'business as usual' and the organisation should be mindful of additional stress this could create for already stretched resources. The Board discussed the report highlighting in particular: • The huge improvement in delivery of RTT performance, with good clinical engagement. The Chair agreed to write to those staff on behalf of the Board to thank them for their engagement and support. **[Action: BH]** • The improved performance against cancer standards. • The increase in on the day cancellations. This had been partly as a result of clinicians' sickness absence and infrastructure issues within Rowntree theatres, (now being addressed through the Trust's capital programme). However, the drive to improve rates of cancellations on the day would continue. The Board concluded by commending the quality of reporting. There were no further comments and the Board **NOTED** the contents of the update.
88-19	**Financial performance** In addition to the MO11 report contained within the board pack, MM had circulated separately a copy of the draft unaudited MO12 position, noting that this was in line with the reforecast submitted to NHSI. She reminded the Board of the reasons for the slippage on the capital plan, but this had been offset by bringing forward IT projects from the next financial year. The Board sought and received assurance of the mitigations in place to ensure robust management of cash deficits. It also received confirmation that the Trust would incur additional charges as a result of being in deficit. As it was a requirement to repay any monies borrowed, a repayment scheme would be established once the Trust returned to break-even position. There were no further comments and the Board **NOTED** the contents of both updates.
89-19	**Ratification of 2019/20 business planning process** For the record, it was noted that the Board had convened in April to approve the 2019/20 business plan.
Key strategic objective 5: organisational excellence	
90-19	**Board assurance framework** As noted by JT in his earlier report, given the generally positive movements within workforce there had been a recent discussion at F&PC to consider if the current BAF risk rating was now too high; however it had been agreed that at this stage, it was still too soon to make any change. There were no comments and the Board **NOTED** the contents of the update.
91-19	**Workforce monthly report**

	GO presented the latest workforce report highlighting the following: • The overall vacancy rate currently stood at 11.79%, the lowest since September 2016. • Turnover had increased slightly in month, impacting negatively on the annualised turnover rate. A higher than usual number of these staff had been at the Trust for less than two years and the situation would be monitored to see if this trend continued. However, it was also noted that since QVH had engaged with the NHSI retention programme overall turnover rates had reduced by 3%. • There had been a slight increase in use of temporary staffing. This was partly due to covering annual leave and also the current level of vacancies in theatres and critical care. Whilst the overseas recruitment drive continued, it was taking longer than originally planned to bring in these new members of staff. • There had been a strong response to the recent medical recruitment campaign for new consultant anaesthetists. • Mandatory and statutory training (MAST) compliance figures had fallen slightly. From September onwards training would be delivered in half or full day sessions to better support operational planning. • A reminder of the ways in which Health Roster supported enhanced planning of annual leave and operational activity. However, waiting list issues had had a detrimental impact on the way in which both could be managed during the final quarter of 2018/19. • It was unlikely that the target of 20 nurses starting at the Trust by June 2019 (originally agreed as part of the international recruitment programme) would be achieved. However, GO confirmed that QVH was contracting directly with another local trust to recruit an additional five theatre nurses. There were no further comments and the Board **NOTED** the contents of the update.
Governance	
92-19	**QVH self-certification of NHS Provider licence conditions** CP reminded the board of the annual sign off requirement evidencing compliance with the NHS Provider Licence and NHS Acts, and with regard to the NHS Constitution. Whilst it was up to providers as to how they undertake this, any process should demonstrate that the board understands clearly whether or not the provider can confirm compliance. The board considered a paper evidencing compliance in each category. It was noted that that MM recommended had recommended the Board confirm option b, (ie. required resources will be available over the next financial year but specific factors may cast may doubt on this); the reason being that the QVH burns service does not meet the national specification and therefore is in derogation. The Board also considered whether, as an organisation in deficit, it should also include additional narrative with regard to resources. CP agreed to check whether decision making around self-declaration of NHS provider licence conditions should reference deficit.**[Action: CP]** Subject to this clarification, the Board confirmed that: • It had complied with the NHS provider licence condition • It had taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • It had complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, it had a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)
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**

	The Board noted that two small changes had been made to the terms of reference since their last review. These included • 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 The Board commented that it was unusual to include names as well as titles on terms of reference; however, given the complexity of managing these groups across three separate organisations, this was a pragmatic approach. The Board suggested that ToRs wouldn't require further approval should any individual name change in the future. There were no further comments and the Board **APPROVED** the Terms of Reference for the Joint Programme Executive Board and the Joint Programme Steering Group.
94-19	**Annual declarations of interest** The Board **NOTED** that the annual declaration of interest process for 2019/20 was complete and the updated register was included in the board papers.
95-19	**Audit committee** The Board **NOTED** the contents of the latest update from the Chair of Audit.
Any other business	
96-19	There was none.
Questions from members of the public	
97-19	A governor asked a question about QVH use of antibiotics and the risk of drug resistant infections. EP responded that this was an area of ongoing work, particularly improvements around the use of prophylactic antibiotics used for some surgery.

Chair …… Date …….

Matters arising and actions pending from previous meetings of the Board of Directors									
ITEM	MEETING Month	REF.	TOPIC	CATEGORY	AGREED ACTION	OWNER	DUE	UPDATE	STATUS
1	June 2019 (seminar)	NA	Trust requirements for Staff MAST	NA	Board to formally ratify decision taken at June seminar regarding revised Statutory and Mandatory training requirements	JMT	Jul-19	To be considered as part of matters arising	Pending
2	May 2019	73-19	Patient story	Standing items	At next JHGM, the medical director will apprise staff of the recent patient story with a reminder not to underestimate the impact of recovery time.	EP	May-19	On JHGM agenda for 8th July 2019 (next available meeting from May board)	Pending
3	May 2019	77-19	CEO report	Standing items	Board to receive update on current national and regional NHS Workforce Plans at a future seminar.	GO	Jun-19	Update provided at June BoD seminar	Closed
4	May 2019	77-19	CEO report	Standing items	Following June HMT meeting, Board will receive regular updates on implementation of Patient First initiative	CP	Jul-19	The exec team will be looking at this further and HMT will continue to own and work through. The Board will be kept informed of any significant developments. Update will included on December seminar programme	Closed
5	May 2019	87-19	Operational performance	KSO3	Members of staff who had supported improvements in delivery of RTT performance to receive letters of thanks	AJ	Jul-19		Closed
6	May 2019	92-19	Self certification	Governance	CP to check whether decision making around self-declaration of NHS provider licence conditions should reference deficit.	CP	May-19	**Update 03 05 2019** The declaration around commissioner designated services will remain unchanged (ie the required resources will be available over the next financial year but specific factors may cast doubt on this). The narrative has been updated to reflect the deficit situation burns derogation; will also be included.	Closed
7	March 2019	48-19	Operational report	KSO3	F&PC to receive update on reasons for the trend in increase of cancellations	AJ	May-19	Now included in weekly F&P report	Closed
8	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	Jul-19	Following discussion at EMT, and with endorsement of CEO, it has been agreed that Workforce changes are not part of the OP programme and so will not be reflected in a KPI.	Closed
9	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.	Closed
10	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	Jul-19	CRR 1059 and 968 will be updated with details of pathway changes.	Pending
11	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	DoN provided the Board with detailed assurance as to why QVH could not be considered an outlier	Closed
12	March 2019	56-19	Quality and safety	KSO2	Board to receive update on clinical strategy priorities	EP	~~July 2019~~ Sept 2019	Verbal update will be provided at July Board. Written report to be submitted in September 2019.	Pending
13	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	As above; planned for public BOD business meeting September 2019.	Pending

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**101-19**	
Report title:	**Chair's Report**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	None				
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	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:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	4 July 2019
Agenda item reference no:	101-19
Report from:	Beryl Hobson, Chair
Date of report:	25 June 2019

Chairs Report

Overview

1. Whilst I am sure that our CQC report will be mentioned many times in these board papers and during the meeting itself, I could not start this report without saying what a great achievement this was. The outcome of Good with Outstanding Care is a positive reflection of everyone involved in QVH – whatever our role, we all play an important part in providing outstanding care for our patients. So a big thank you to everyone at QVH. Clearly we should not rest on our laurels and should look at every aspect of our work to see if we can push this up to Outstanding across the board. However let's also celebrate everything that makes us good and outstanding.

2. This outstanding quality of care has also been reflected in the results of CQC's national inpatient survey, where we managed to improve on excellent results in previous surveys.

3. I wrote in my last report that significant board time has been spent discussing our financial and operational position. The operational position is showing improvement and at the last board meeting we congratulated the plastics team for a significant improvement in their waiting times, which is due to a great team effort. Our financial situation this year continues to be of concern, and we are asking every team and every individual to consider how we can reduce our costs. As we can no longer depend on increases in activity to produce a financial surplus we must escalate our focus on cost reduction combined with improved efficiency and productivity.

4. I am delighted to report that the governors have appointed Paul Dillon-Robinson as a non-executive director of QVH (the governors will be confirming this at their meeting later in July). Paul will commence his role on 1 October, following the departure of John Thornton. Paul is a chartered accountant, has been head of internal audit in various public sector organisation for over 25 years, and his final executive role was as director of internal audit at the House of Commons. He is an independent consultant and a non-executive director for a couple of organisations. On behalf of the board and council of governors I extend a warm welcome to Paul.

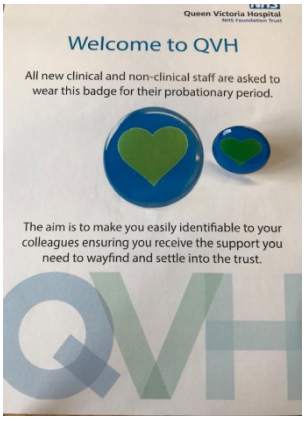
5. Following this board meeting, the board's nominations and remuneration committee will be meeting to receive a recommendation from the CEO regarding the appointment of a new medical director to replace Ed Pickles at the end of his term later this year. Whilst it would be premature to announce the candidate's name at this stage, I hope to be able to confirm a successful appointment in my next report.

Chair's activities

6. I was unable to attend the Sustainability and Transformation Programme (STP) Oversight Group in June but Kevin Gould attended on my behalf. The meeting provided an update on the development of the Health and Care Strategy and the STP Priorities programme. Reflecting on the meeting Kevin commented that Steve Jenkin's involvement in the STP Executive ensures that our board is as up to date as possible on matters relating to the STP.

7. Since the last board meeting, I have attended a number of meetings and walk rounds including:
    a. Trust induction – along with all our new people, it was good to meet four of the nurses who have been recruited from outside the UK.
    I also picked up the attached at induction, and enclose a copy so all board members are aware if they see someone wearing the green heart badge.
    b. Visits to:
        - Prosthetics
        - I.T.
        - Estates
        - QVH Macmillan information centre
        - Maxfac secretaries
        - Histopathology (Open Day)
        - C-Wing

    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.



8. Steve Jenkin and I met with the Mayor of East Grinstead, Cllr Danny Favor (who is charge nurse in our Corneoplastics team) and the Town Clerk, Julie Holden, and updated them on developments at the hospital.

9. In my role, I chair the interviews for medical consultant appointments. Since the last board meeting, I have been involved in the appointment of an ENT consultant (joint appointment with Medway). On my behalf, Gary Needle chaired the appointment panel for several consultant anaesthetists.

10. In our June board seminar programme we had an update on QVH partnership working; discussed the financial recovery plan; reviewed the Trust mandatory and statutory training targets; discussed the CQC inspection report and action planning process and were given a very helpful presentation of the national and regional NHS workforce plans.

Governor activity

11. The Council of Governors has recently held elections for the various committee roles in which they are involved. The role of lead governor was created to facilitate communication and decision making at a strategic level, ensuring integrated and effective governance. As set out in the constitution, the post holder is recommended by the Chair for approval by the council of governors. This year I am recommending Peter Shore to replace John Belsey. Peter has been the governor attending finance and performance committee and is on the governors' appointments committee (in which role he has been involved in NED appointments).

12. On behalf of the Board I would like to thank John Belsey who has been the lead governor for the last two years. John did not put his name forward this year due to his many other extensive commitments. I have met regularly with John and have welcomed his wise counsel and support. Whilst he will remain as a governor, I wish him well with his roles.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**102-19**	
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				
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 • CQC report & inpatient survey • NHS Improvement published Q4 finance and operational performance				
Recommendation:	For the Board to **NOTE** the report				
Action required	Approval	**Information**	Discussion	Assurance	Review Y
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	17/06/19	Decision:	Review BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
JULY 2019

TRUST ISSUES

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 26th and 27th February 2019. The report of their inspection was published on 23 May and QVH retained its overall Good rating and maintained Outstanding for the caring domain.

NHS inpatient survey 2018

The 2018 survey of adult inpatients (sixteenth iteration of the survey) involved 144 acute and specialist NHS trusts. 76,668 people responded to the survey, yielding an adjusted response rate of 45%. CQC published the survey findings on 20 June 2019 (fuller report contained later in papers).

Each trust has been assigned one of five bands: 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected'. Eight acute specialist trusts have been categorised within the highest band, identified as 'much better than expected' with results that indicate patient experience was substantially better than elsewhere. Six of those trusts including QVH were also rated 'much better' in both the 2016 and 2017 surveys. The table below shows the top eight trusts:

Trusts achieving 'much better than expected' results

Eight acute trusts were classed as 'much better than expected' in 2018. Seven of these had the same banding in 2017 and six had the same banding in 2016, demonstrating consistently high levels of positive patient experience. All of these trusts are classed as specialist trusts.

	Historic results	Overall results				Core service		Overall CQC rating
	2017	2018	Most Negative (%)	Middle (%)[c]	Most Positive (%)	Medical care	Surgery	
Trust average			16	18	66			
The Christie NHS Foundation Trust	MB	MB	9	12	79	MB	MB	O
The Clatterbridge Cancer Centre NHS Foundation Trust	MB	MB	11	13	76	MB	N/A	G
Liverpool Heart and Chest Hospital NHS Foundation Trust	MB	MB	10	12	78	MB	MB	O
Queen Victoria Hospital NHS Foundation Trust	MB	MB	9	11	81	MB	MB	G
Royal Brompton & Harefield NHS Foundation Trust	B	MB	11	14	75	MB	B	G
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	MB	MB	8	11	81	MB	MB	G
The Royal Marsden NHS Foundation Trust	MB	MB	8	12	80	MB	MB	O
The Royal Orthopaedic Hospital NHS Foundation Trust	MB	MB	10	15	75	N/A	B	G

Key: Trust performance — About the same (S) | Better (B) | Much better (MB)
CQC rating — Inadequate (I) | Requires Improvement (RI) | Good (G) | Outstanding (O)

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

League of Friends

The 70th Annual General Meeting of the League of Friends of QVH was attended by both Chair and CEO on 25 June 2019. The League of Friends is a tremendous supporter of the hospital and last year committed expenditure of over £475,000. The major purchase was of a CT scanner, installed in December 2018; those present heard that QVH has now scanned its first thousand patients. Both the Chair and CEO thanked the League of Friends for their ongoing support.

Histopathology Open Day

Biomedical Science Day on 20 June 2019 was celebrated by our Histopathology Department by holding an Open Day for staff and volunteers to understand the impressive work they carry out for

patients on behalf of QVH. Thank you to laboratory services manager Fiona Lawson and the team for organising such an interesting and educational visit.

Volunteers' Coffee Morning
In celebration of National Volunteers Week, head of fundraising Camilla Slattery organised a coffee-morning courtesy of the Crowne Plaza Hotel in Felbridge on 7 June 2019. Both the CEO and Director of Nursing attended the event taking time to speak and thank all our volunteers for their work in supporting the hospital.

Visit from CEO of CCG Alliance
The CEO for Sussex and E Surrey Clinical Commissioning Group (CCGs) Alliance Adam Doyle spent a half day visiting some of our services on 30 May. Thanks to the following areas for generously giving of their time. Adam later commented on Twitter:

What a great morning I've had @qvh with @steve_jenkin. We talked about their recent CQC inspection 👍 and I had the privilege to see the following services: sleep, theatres, prosthetics, psychological therapies, minor injuries - I spoke to some fantastic staff #proud @SES_STP

Patient First
Pete Landstrom, Chief Delivery and Strategy Officer for Western Sussex Hospitals Foundation Trust (WSHFT) and Brighton and Sussex University Hospital Trust (BSUH) ran a workshop on Patient First for our Hospital Management Team on 17 June 2019. Patient First is the long-term approach WSHFT has developed aimed at transforming hospital services for the better. QVH is keen to adopt a similar approach to ensure continuous improvement of its services.

Integrated Performance Dashboard Summary
Our Integrated Performance Dashboard summary (Appendix 1) highlights 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.

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

The entire BAF was reviewed at the executive management team meeting on 17 June 2019 alongside the corporate risk register. KSO 1 and 2 were also reviewed at the Quality and Governance Committee on 20 June 2019. KSO 3, 4 and 5 were reviewed on 24 June 2019 at the Finance and Performance Committee. The key risk 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.

Media
Appendix 2 shows a summary of QVH media activity during April and May 2019.

SECTOR ISSUES
Sussex and E Surrey Sustainability Transformation Partnership (STP)
Following an initial meeting on 1 May 2019, the four acute providers across Sussex have agreed to establish a Sussex Acute Collaborative Network (SACN) reporting their respective Boards and to the Sussex Sustainability and Transformation Partnership (STP) via the STP Executive Group. WSHFT, BSUH, QVH and East Sussex Healthcare Trust are seeking to enable greater collaborative working between the trusts in Sussex with the aim of developing and delivering sustainable models for local services and specialist care delivered in centres of excellence.

NATIONAL ISSUES

NHS Improvement (NHSI) published the Q4 finance and operational performance figures for the provider sector on 13 June. These figures cover the period 1 January to 31 March 2019. Key headlines include:

- Provider sector deficit was £571m at year end, £177m worse than the planned deficit of £394m. However, the NHS as a whole is in balance due to surpluses on the commissioner side.
- The underlying deficit – which removes non-recurrent measures including the provider sustainability fund is £5bn. This is a deterioration of £700m in the year.
- The number of staff vacancies stood at 96,348 whole time equivalents, or 8.1% of the total workforce. Nursing vacancies are up by nearly 4,000 in the year.
- 107 of the 230 trusts finished the year in deficit, 5 more than the corresponding time a year ago.
- Quarterly performance against the 18 week referral to treatment (RTT) standard was 86.7%, down from 87.3% in Q4 2017/18.
- The number of patients waiting longer than 52 weeks is improving significantly. In Q4, there were 1,154 patients waiting over a year for treatment, a reduction of 63% on the same time last year.
- The national target of 85% for the 62 day standard for urgent referrals for cancer has deteriorated to 77.4%.
- The waiting list for diagnostic tests is getting longer, up 2.4% to 1 million. 2.53% of patients waited longer than six week for a diagnostic test.

Source: NHS Providers

Review of child cancer standards

NHS England has asked Sir Mike Richards, former national cancer director and chief inspector of hospitals, to carry out an independent review of child cancer standards. This follows allegations that clinicians had faced pressure to soften standards on the co-location of intensive care with paedatric cancer services, and that previous reports suggesting fragmented services across London were providing poor quality care had not been acted on. Concerns raised include the level of paediatric transfers for intensive care out of the specialist cancer service provided by the Royal Marsden Foundation Trust's Sutton hospital.

Although safety, clinical outcomes and patient feedback in paediatric services provided by QVH remain of a very high standard, the Board of QVH has always kept a close watch on the national direction of travel around children's services and we will ensure if there is any relevant learning from this review it is carefully considered.

Source: Health Service Journal

Steve Jenkin
Chief Executive

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 17/06/19 alongside the corporate risk register. KSO 1 and 2 were also reviewed at the Quality and Governance Committee, 20/06/19. KSO 3, 4 and 5 were reviewed 24/06/19 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 . Additional assurance continues to be sought internally and the evidence of this is referenced in the respective director reports to the July trust board .

	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	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	25	25	16
KSO 5	20	20	20	20	15

Integrated Dashboard Summary
Key indictators at a glance - July 2019

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	0
No of off-site deaths (within 30 days)	2
Contacts	19769
Complaints	2
Closed <30 days	5
FFT	
In-patient	98%
Day surgery	95%
MIU	95%
Trauma	95%
O/Ps	96%

KSO3 Operational Excellence	
MIU <4hrs	100.00%
RTT 18 weeks	81.11%
Cancer 2ww	86.20%
Cancer 62 day	89.00%
Diagnsotics <6weeks	99.50%
52ww	42
(patient choice)	17
Referrals via eRS	99.00%

KSO4 Financial Sustainability	
Financial plan YTD	(£2136k)
Variance to plan YTD	(£498k)
Patient activity income YTD	(£879k)
CIP delivery YTD	£86k
Agency spend % of pay bill in month	4.17%

KSO5 Organisational Excellence	
Vacancy rate	10.66%
Turnover rate	15.67%
Sickness rate	3.12%
Appraisal rate	85.53%
MAST	92.23%
Q4 Staff FFT (work at QVH)	73.62%
Q4 Staff FFT (care at QVH)	96.15%

Activity - M2	Plan	Actual	2018/19
MIU attendances	994	**1,126**	1,005
Elective (day case)	1,021	**1,086**	918
Elective	323	**349**	331
Non-elective	450	**444**	443
Critical care	96	**74**	51
O/P first attendance	3,700	**4,206**	4,197
O/P follow up	9,739	**10,826**	11,007
O/P procedures	2,388	**1,698**	1,255
Other	3,907	**2,747**	3,873

Key	Improved Performance	Deteriorating Performance	Remains the same

Current summary: sustained improvements in workforce, however, financial challenges around income and CIP. Significant numbers of patient choice impacting upon 52ww position although RTT position is improving in line with trajectory agreed with commissioners.

QVH Media Update – April and May 2019

Call the Midwife star to take on Sussex charity challenge


Call the Midwife star set for QVH charity challenge

We achieved extensive coverage of our press release informing the media that charity ambassador, Jack Ashton, would be taking part in the Mud Monsters Run this June in aid of QVH Charity.

Publications to run the story included the **East Grinstead Gazette**, the **Crawley and Horley Observer**, the **West Sussex County Times**, and the **Brighton and Hove Independent**. Jack Ashton was also interviewed on local radio station **Meridian FM**.


Call the Midwife star to take on Sussex charity challenge

Call the Midwife actor Jack Ashton will be swapping his church robes for running gear as takes on a muddy challenge for charity this summer.

Jack, best known for playing Reverend Tom Herseward in the popular BBC drama series, will be taking on the slightly different role this summer as he heads up the Queen Victoria Hospital team in the East Grinstead Mud Monsters run.


Swing Concert Hits The Right Note And Raises Vital Funds For Local Charity

When swing was king

RH Uncovered covered a sell-out concert at the Chequer Mead Theatre in East Grinstead which raised more than £2,700 for QVH Charity. The magazine also promoted the article on its Facebook page.

Give a gift, not chocolate this Easter


Give a gift instead of chocolate urges hospital

RH Uncovered ran an article based on a press release we issued to encourage people to consider making a donation to QVH Charity this year, instead of buying chocolate eggs for our young patients.

The story was also covered by the **East Grinstead Gazette** (see left), **More Radio**, and QVH head of fundraising, Camilla Slattery, was interviewed on the breakfast show on **BBC Sussex** and **BBC Surrey**.


RH Uncovered

Give a gift, not chocolate this Easter

This Easter Queen Victoria Hospital NHS Foundation Trust are asking their supporters to join them in thinking about the health implications of excessive quantities of sugary snacks which are given to some of their patients at this time of year.

Queen Victoria Hospital is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the south of England. ... See More

Gender pay gap

The Guardian published an article raising concerns about the Trust's gender pay gap. It said: "The Queen Victoria Hospital NHS foundation trust in West Sussex reported the highest pay gap of almost 40%, despite women making up more than half of the highest earners and 83% or more of all other pay levels at that trust. A trust spokeswoman said the gap was due to 54 of their highest-earning consultants being male, compared with only 18 female consultants. This will change as we appoint more female consultants and as our current female doctors progress into more senior roles." This story (and QVH) also received a mention in **Cosmopolitan** magazine.

Guinea Pig club member tribute

The JC published a lovely article about Jack Toper, a Jewish Second World War veteran and member of the Guinea Pig club, who has died, aged 97. Mr Toper had more than 30 operations at QVH under the care of Sir Archibald McIndoe.


Jack Toper, RAF veteran and member of the Guinea Pig club, dies at 97

Mr Toper became a key member of a group founded for fellow servicemen who suffered disfiguring injuries in combat

Boy severely injured in playground accident
Several news providers covered a story about a 16-year-old boy who was left with serious injuries after falling on to play equipment at a park in Sheerness. The boy was brought to QVH for emergency surgery. Among those to publish this story were the **Daily Mail**, the **Mirror**, the **Daily Star** (pictured right), the **Metro**, **Kent Live** and **Kent Online**.


Boy 'SCALPED' on 'death trap' children's slide in Brit playground


People

Dedication, commitment and experience

Dedication, commitment and experience
QVH consultant orthodontist Dr Lindsay Winchester is the subject of a five-page spread in **Orthodontic Practice Magazine**, a monthly online publication. The article takes the form of a 'fact file' and full length interview with Lindsay about her background, her career and work at QVH, and her life outside work. The full article can be found at www.orthodontic-practice.co.uk

QVH nurse becomes first Filipino town mayor in the UK
There was coverage in local, national and international media, of Danny Favor becoming the UK's first Filipino-born town mayor. Danny, who is an ophthalmic clinical nurse specialist at QVH, has chosen QVH Charity as one of his three mayoral charities for the year. The story was featured in the **East Grinstead Gazette** (right), **Manila Bulletin**, **ABS-CBN**, the **Philippine Star**, and the **Balik Bayan Asian Journal**, among others.


First Filipino elected as town mayor in the UK


'Good' rating for hospital

The Queen Victoria Hospital trust (QVH) has been rated good overall by the health watchdog.

Care Quality Commission (CQC) inspectors visited the trust in January and February to assess the quality of three core services - burns and plastics, outpatients, and critical care.

The trust's hospital in East Grinstead in West Sussex specialises in reconstructive surgery and burns care.

The CQC rated the trust as outstanding for caring and good for being safe, effective and responsive to people's needs, and for being well-led.

Dr Nigel Acheson, CQC's deputy chief inspector of hospitals for the south, said: "Staff continued to treat patients and their families with dignity and respect, their needs were met in a caring and compassionate manner.

"We also saw that areas concern we had identified at the previous inspection, such as the lack of residential medical cover for out of hours services, had been addressed."

Steve Jenkin, QVH's chief executive, said: "This report reinforces what I regularly hear directly from our patients - our staff work really hard to make every patient feel cared for with compassion and respect."

QVH rated 'good' by Care Quality Commission
The CQC's 'good with outstanding care' rating for QVH has so far been published by the **BBC News website** and **Susy Radio**. This news was also shared on the **BBC Sussex** and **BBC South East** Twitter accounts.


BBC South East
@bbcsoutheast
Follow
The Queen Victoria Hospital trust has been rated good overall by the health watchdog.
BBC NEWS
BBC Live: South East
All the latest news, sport and travel from across Sussex, Kent and Surrey.
bbc.co.uk

McIndoe talk at Cuckfield women's institute
QVH gets a mention in an article by the **Mid Sussex Times** about a talk at Cuckfield WI about Sir Archibald McIndoe by Alex Sewell from East Grinstead museum. One Sir Archibald's daughters, Adonia, attended the evening.


The ladies of a Cuckfield group were treated to a special talk by a member of a nearby museum.

Cuckfield WI were pleased to welcome Alex Sewell from the East Grinstead Museum, who presented a talk on Sir Archibald McIndoe.

"Girl's horror injury on outdoor gym"
QVH also gets a mention in a story by **Kent Online** about a girl who suffered serious injuries to her finger after catching on a piece of fitness equipment in a park. The girl was brought to QVH for surgery.


Girl nearly loses finger on sharp bolt on static running machine in Minster play park

"Pensioner given painkillers to treat cancer"
The Mail Online has published a story about a man who was prescribed painkillers by his GP to treat a condition that turned out to be cancer. The man, from Gillingham in Kent, was eventually referred to QVH and is due to be seen by plastics surgeons in due course.

QVH on social media

By far our most successful posts on social media during this period were focused on our CQC rating. This 60" video thanking staff for all their hard work has had a total of more than 3,600 views, reached more than 6,000 people and has been shared more than 40 times. Meanwhile, a Facebook post announcing the result of our inspection has reached more than 11,000 people and received nearly 400 engagements.

If you use social media you can follow us on Facebook and Twitter

Press releases

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

- Give a gift, not chocolate this Easter
- Swing concert hits the right note and raises vital funds for local charity
- QVH celebrates international clinical trials day
- Care Quality Commission finds 'outstanding' care at QVH

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

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 12 June 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

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

Rationale for risk current score
- National workforce shortages in key nursing areas particularly theatres, CCU
- Generational changes in workforce, high turnover in newly qualified Band 5 nurses in first year of employment
- 2-3 years to train registered practitioners to join the workforce
- Over 40,000 nursing vacancies in England, circa 1,700 in SES STP
- managers skill set in triangulating workforce skills mix against activity and financial planning
- SES STP case for change published and supported by a workforce strategy
- NHS Interim People Plan published
- Staff survey results and SFFT staff engagement show some improvement, needs to be sustained.
- Impact on adequate substantive staffing resource in theatres to support productivity/meet RTT
- 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 arriving but will take some months to have a positive impact

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 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, improvements in some KPI's
- Overseas recruitment continues with nurses now arriving
- 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 which launched on 3 June
- Work underway to finalise ESR hierarchy with ledger
- 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 C Wing
- 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:	**04/07/2019**		**Agenda reference:**	**104-19**	
Report title:	**Workforce Report (June report, May Data)**				
Sponsor:	Geraldine Opreshko, Director of Workforce and OD				
Author:	David Hurrell, Deputy Director of Workforce				
Appendices:	A People and Organisational Development Strategy 2019 – highlight report				
Executive summary					
Purpose of report:	• The Workforce and OD report for June 2019 (May data) provides the Trust Board with a breakdown of key workforce indicators and information linked to performance. • The Board ratified the first QVH People and OD strategy 2019 at the January Board meeting. It was agreed that on a quarterly basis a report would be presented to highlight progress against the goals which also incorporates themes and feedback from the staff survey and staff friends and family test. This is attached as an appendix to the main report				
Summary of key issues	Some key improvements in workforce metrics Small improvements are being seen across all key areas, reflected in more recent staff engagement scores				
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:	The challenges are reflected in KSO 5 Organisational Excellence				
Corporate risk register:	A number of risks on the Corporate risk register are specific to workforce challenges and in particular the level of vacancies and use of temporary staffing				
Regulation:	Workforce challenges will be implicit in all 5 domains of the CQC and in particular – Are they well Led?				
Legal:	No implications				
Resources:	The Workforce and OD team are trying to keep pace with demand and the need to support managers within existing resources				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	24/06/19	Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – June 2019

Reporting Period - May 2019

Current Month Picture

KPI	Narrative
Vacancies Sections 1 & 2	'Staff in Post' numbers decreased marginally by 1.58wte in month to finish at a position of 885.27wte. May saw 6.98wte (9 headcount) starters, including 2wte medical staff, 4.19wte admin & clerical staff and 0.79wte estates & ancillary. Vacancy levels increased marginally (0.16%) to an overall vacancy percentage figure of 10.66%, well ahead of the desired trajectory. The budgeted establishment remains the same as 2018/19 financial year currently, and will be updated in time for the next report. It is anticipated that there will be an increase, which will impact on reported vacancy levels.
Turnover Section 3	The monthly turnover position of 1.1% is a return to average levels, the annualised rolling turnover position continuing to reduce to an in-month position of 15.67%. This continues an improvement against trajectory and below levels seen since April 2016. There were 8.8wte leavers in month (10 headcount), including 1 qualified and 1 unqualified clinical staff within Perioperative Services. This month's Workforce report includes a move to an annualised stability index figure (previously monthly) as a more meaningful measure. The annualised stability index shows an improving trend since October 2018, from 80.36% to current position of 84.04%.
Temporary Staffing Section 4	There was a small increase in temporary staffing in month (101.76wte total), caused by increased bank usage (+3.44wte) in qualified nursing and non-clinical areas. Agency usage remained stable (34.47wte in month), with a small increase in qualified nursing (+1.35wte) and a small reduction in non-clinical bank (-1.95wte) as a result of a successful bank administration recruitment campaign.
Sickness Section 5	Confirmed sickness levels for April show an in month absence rate of 3.12%, a continued decrease from February's position of 3.55% and March 3.3%. This was driven by a significant reduction in 'gastrointestinal' reasons for absence, reducing from 171 days absence to 93 days absence in April. Days lost to 'other musculoskeletal problems' remains the top cited reason for absence (15 staff affected, losing 154 working days totalling 15.7% of all absences), but the second most cited reason has changed to 'benign and malignant tumours, cancers' (affecting 4 staff, losing 117 working days and totalling 11.9% of all absences). The Trust's revised Managing Attendance Policy places emphasis on 'support conversations' for long-term sickness cases like this, and the HR Advisory team link staff with the on-site MacMillan centre for support and guidance during these difficult circumstances.
Appraisals Section 6	Appraisal compliance figure reduced from 86.69 to 85.53% (-1.16%). Significant improvements were seen in Plastics (+6.8%) and Performance & Access (+7.8%) directorates. However, significant decreases in Corporate services (-5.2%), Sleep (5.9%) and Operational Nursing (-4.1%) undermined these improvements. In terms of staffing categories, appraisal rates for medical staff are now the lowest at 80.77%, followed by non-clinical staff at 81.97%, with other clinical staff at 89.39%. Improvements were seen in Plastics (+2.26%), Perioperative Services (+0.95%) and Operational Nursing (+1.91%) areas.
MAST Section 6	Mandatory and Statutory Training compliance figures increased marginally, from 91.98% to 92.23%. Clinical Support, Performance & Access and Director of Nursing's office continue to be above the Trust 95% target. Next month the Trust compliance target will change to 90%; this month's data would suggest that Plastics (currently at 85.02%) and Perioperative Services (currently at 87.47%) would be the only outliers for this revised compliance target. Information Governance compliance has improved marginally (82.26%) so that all subjects are above 80%. Emergency planning, infection control (level 1), moving and handling (level 1) and Safeguarding Adults (levels 1 & 2) are all above 95%.

KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19 & 2019/20			May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Compared to Previous Month
Establishment WTE ***Note 1***				955.65	955.65	955.65	990.87	990.87	990.87	990.87	990.87	990.87	990.87	990.87	990.87	990.87	◄►
Staff In Post WTE				827.24	829.77	835.19	848.43	845.94	860.66	868.62	863.91	867.20	868.41	874.06	886.85	885.27	▼
Vacancies WTE				128.41	125.88	120.46	142.44	144.93	130.21	122.25	126.96	123.67	122.46	116.81	104.02	105.60	▲
Vacancies %	>12%	8%<>12%	<8%	13.44%	13.17%	12.61%	14.38%	14.63%	13.14%	12.34%	12.81%	12.48%	12.36%	11.79%	10.50%	10.66%	▲
Agency WTE				50.61	42.85	46.85	46.11	45.33	47.07	44.12	37.43	39.95	39.31	36.77	34.44	34.47	▲
Bank WTE ***Note 2***				59.82	64.34	63.37	59.28	58.49	61.13	65.64	51.69	61.66	63.57	70.70	63.85	67.29	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	20.43%	19.20%	18.17%	18.42%	19.88%	20.29%	19.52%	19.23%	18.73%	17.46%	17.67%	15.74%	15.67%	▼
Monthly Turnover				1.00%	0.68%	1.10%	1.58%	2.94%	1.56%	0.75%	1.48%	1.43%	0.64%	1.61%	0.66%	1.10%	▲
12 Month Rolling Stability % ***Note 3**	<70%	70%<>85%	>=85%	81.95%	82.21%	82.34%	82.07%	81.00%	80.36%	80.69%	81.17%	81.46%	81.86%	82.86%	83.76%	84.04%	▲
Sickness Absence %	>=4%	4%<>3%	<3%	3.04%	3.52%	3.29%	3.23%	2.42%	3.02%	3.16%	2.97%	3.24%	3.55%	3.30%	3.12%	*TBC*	▼
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	82.20%	80.40%	79.55%	78.71%	76.89%	81.18%	83.76%	85.94%	84.64%	84.91%	86.81%	86.69%	85.53%	▼
Statutory & Mandatory Training (Permanent & Fixed Term staff) ***Note 4***	<80%	80%<>95%	>=95%	89.07%	89.56%	89.70%	88.54%	87.70%	87.75%	88.31%	89.79%	90.68%	92.03%	91.96%	91.98%	92.23%	▲

		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	**Measure** 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	**Measure** 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

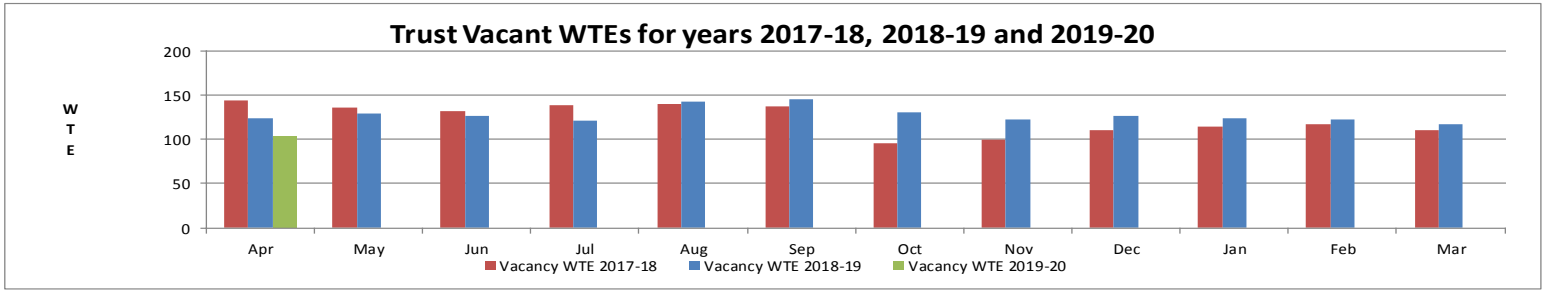
*Note 1 - 2018/19 Establishment updated in Aug 18.
*Note 2 - Bank WTE does not include extra hours worked by medical staff within establishment or overtime worked by all staff groups.
*Note 3 - 12 month rolling stability index added as an additional measure. This shows % of employees that have remained in employment for the 12 month period.
*Note 4 - 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.

1. Vacancies and Recruitment

VACANCY PERCENTAGES	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate	9.65%	7.18%	6.14%	▼
Eyes	13.64%	14.97%	12.02%	▼
Sleep	17.16%	19.83%	20.86%	▲
Plastics	0.61%	-0.25%	-0.98%	▼
Oral	5.01%	5.25%	5.58%	▲
Periop	19.91%	17.61%	18.76%	▲
Clinical Support	7.09%	5.82%	7.09%	▲
Clinical Infrastructure	10.16%	10.16%	10.16%	◄►
Director of Nursing	0.93%	1.56%	2.43%	▲
Operational Nursing	17.27%	15.61%	15.72%	▲
QVH Trust Total	11.79%	10.50%	10.66%	▲

NON-MEDICAL RECRUITMENT(WTE)	Posts advertised this month	Recruits in Pipeline
Corporate	2.00	6.09
Eyes	1.00	2.30
Sleep	0.00	0.00
Plastics	0.00	0.00
Oral	0.00	0.00
Periop	2.00	4.11
Clinical Support	2.60	9.80
Clinical Infrastructure	2.00	5.00
Director of Nursing	0.00	0.00
Operational Nursing	11.62	13.16
QVH Trust Total	21.22	40.46
of which Qual Nurses / Theatre Practs (external)	11.62	*11.92*
of which HCA's & Student/Asst Practs (external)	2.00	*0.60*

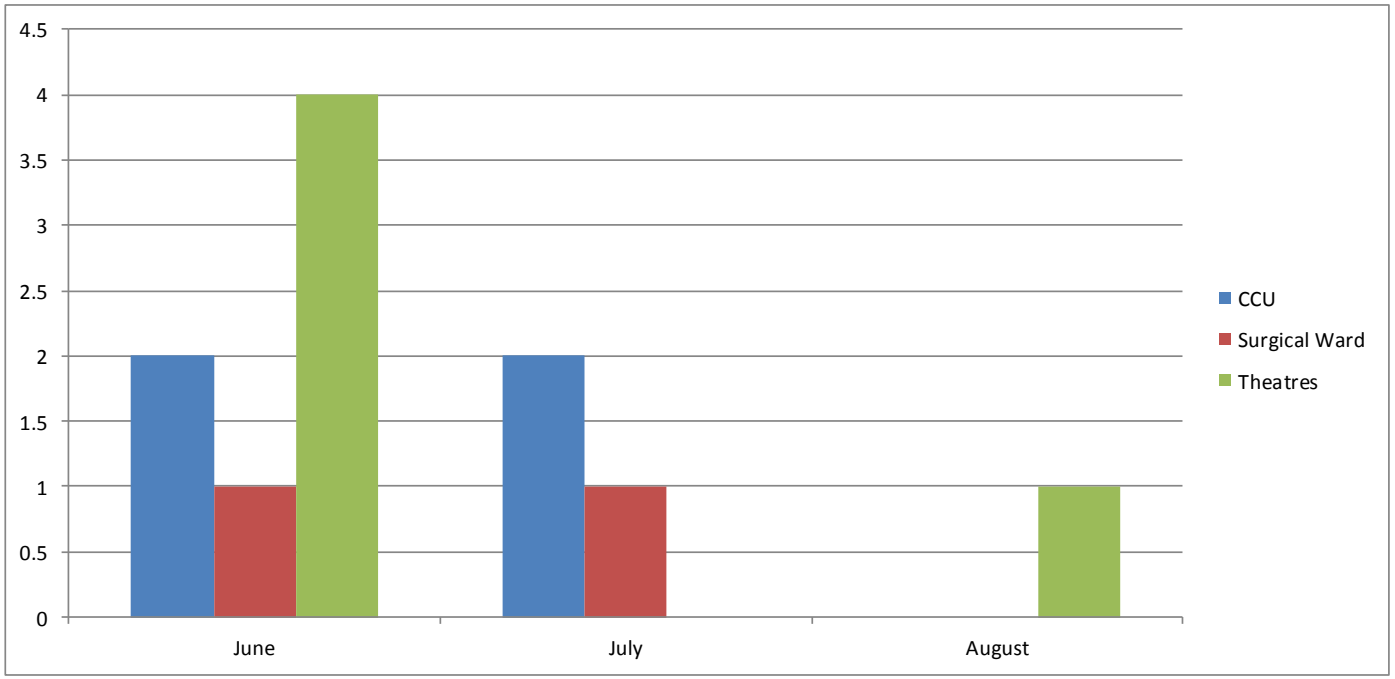
MEDICAL RECRUITMENT (WTE)	Posts advertised this month	Recruits in Pipeline
Clinical Support	0.10	1.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.01*	*1.00*
of which are SAS doctors	*0.10*	*0.00*
of which are Consultants (including locums)	*0.00*	*0.00*
Plastics	0.00	12.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*11.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*1.00*
Eyes	0.00	6.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*6.00*
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	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*1.00*	*1.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*1.00*
Periop	0.00	2.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*	*1.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*1.00*
QVH Trust Total	1.10	23.00
of which are Deanery Trainees, Trust Registrars or Fellows	*1.10*	*20.00*
of which are SAS doctors	*0.00*	*0.00*
of which are Consultants (including locums)	*0.00*	*3.00*



2. International Recruitment

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	7	2	2	0	0
Other Nurse	10	1	1	0	3
Theatres / Recovery	12	4	1	0	3
Total	29	7	5	0	6

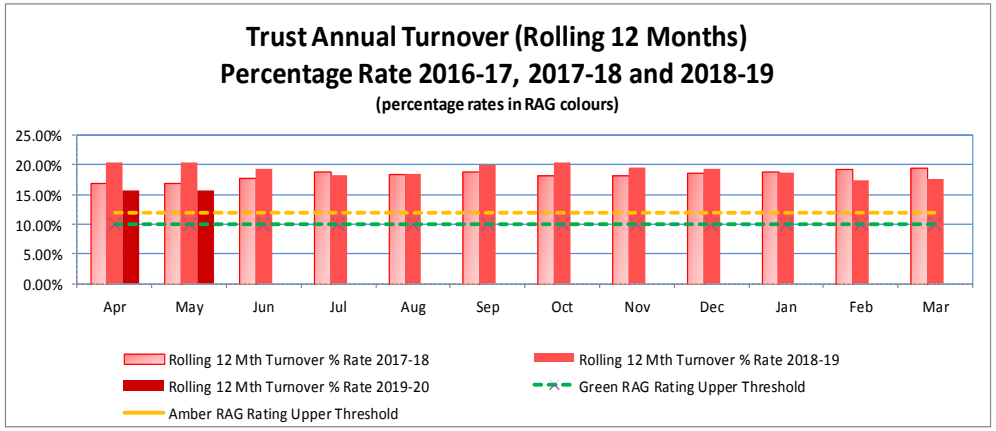
***Please note 50% of offered are expected to be unsuccessful during the international recruitment process or withdraw.**

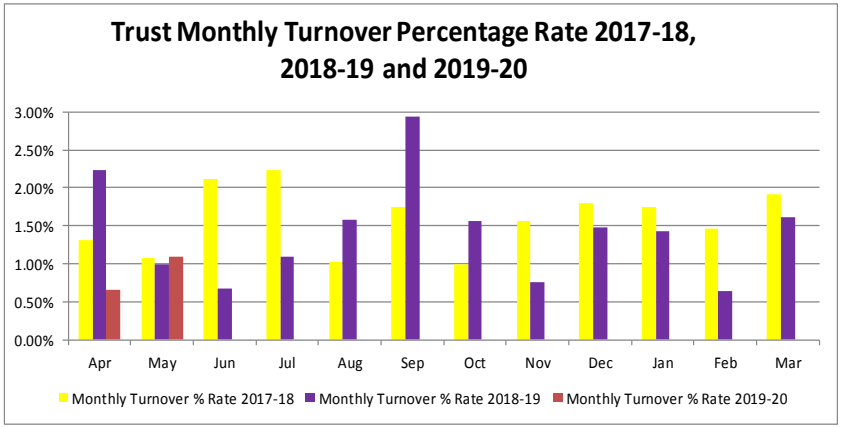


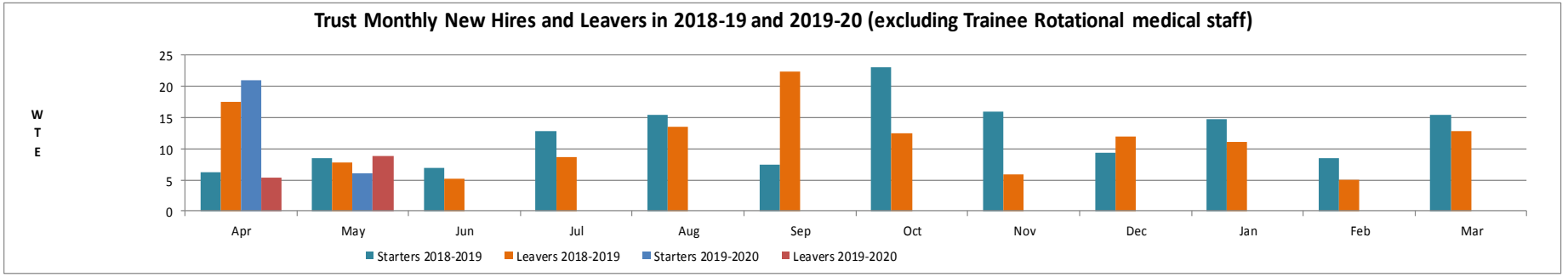
3. Turnover, New Hires and Leavers

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate %	17.88%	15.21%	15.29%	▲
Eyes %	38.31%	33.01%	34.95%	▲
Sleep %	27.64%	21.47%	21.37%	▼
Plastics %	22.48%	20.30%	17.35%	▼
Oral %	19.48%	15.04%	11.44%	▼
Peri Op %	12.31%	11.35%	12.43%	▲
Clinical Support %	14.42%	12.98%	14.25%	▲
Clinical Infrastructure %	20.69%	20.52%	18.07%	▼
Director of Nursing %	12.17%	8.66%	10.58%	▲
Operational Nursing %	17.88%	17.57%	16.85%	▼
QVH Trust Total %	17.67%	15.74%	15.67%	▼

MONTHLY TURNOVER excl. Trainee Doctors	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate %	2.51%	0.61%	1.80%	▲
Eyes %	7.32%	1.63%	5.54%	▲
Sleep %	3.24%	0.00%	0.00%	◄►
Plastics %	1.28%	0.00%	0.00%	◄►
Oral %	0.00%	0.00%	0.00%	◄►
Peri Op %	0.70%	1.03%	1.37%	▲
Clinical Support %	1.83%	0.24%	1.30%	▲
Clinical Infrastructure %	5.37%	0.00%	0.00%	◄►
Director of Nursing %	0.00%	0.00%	1.94%	▲
Operational Nursing %	0.00%	1.37%	0.00%	▼
QVH Trust Total %	1.61%	0.66%	1.10%	▲







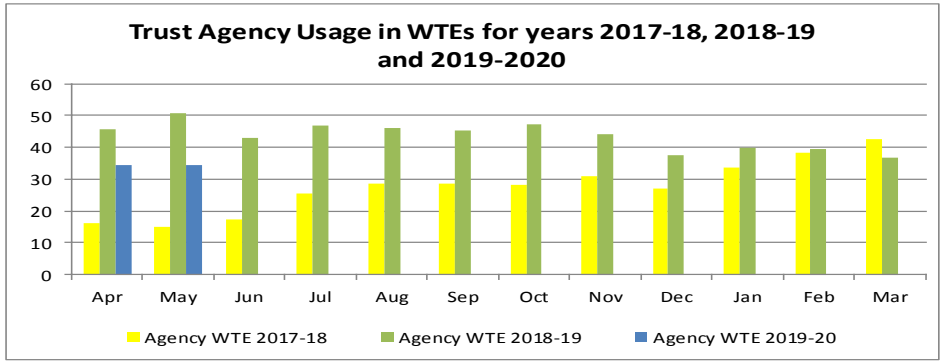
4. Temporary Workforce

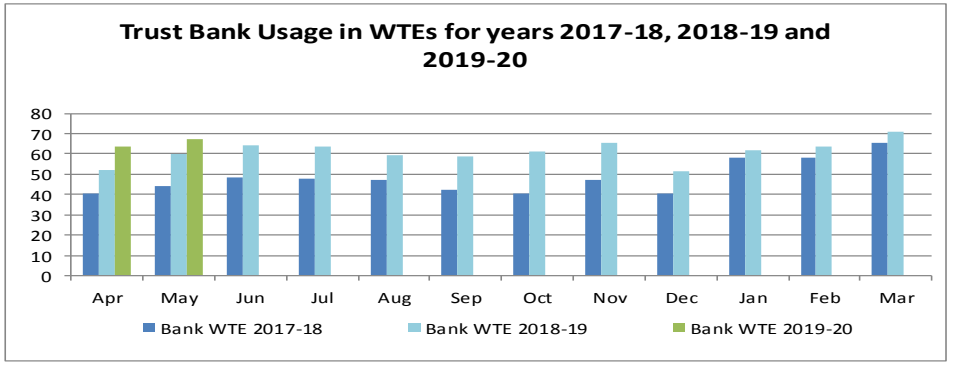
Agency				
BUSINESS UNIT (WTE)	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate	9.23	9.69	7.78	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.00	◄►
Plastics	0.87	1.51	1.48	▼
Oral	0.00	0.00	0.00	◄►
Periop	13.31	13.40	14.40	▲
Clinical Support	2.50	2.61	3.46	▲
Clinical Infrastructure	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	10.85	7.23	7.35	▲
QVH Trust Total	36.77	34.44	34.47	▲

Bank				
BUSINESS UNIT (WTE)	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate	10.10	11.21	10.12	▼
Eyes	1.72	1.06	1.97	▲
Sleep	2.86	3.27	4.00	▲
Plastics	1.80	1.87	2.14	▲
Oral	1.74	1.10	1.64	▲
Periop	18.69	16.90	19.17	▲
Clinical Support	7.19	5.97	6.17	▲
Clinical Infrastructure	4.01	4.19	3.30	▼
Director of Nursing	0.90	0.58	0.32	▼
Operational Nursing	21.67	17.70	18.46	▲
QVH Trust Total	70.70	63.85	67.29	▲

Agency				
STAFF GROUP (WTE)	Mar-19	Apr-19	May-19	Compared to Previous Month
Qualified Nursing	24.21	20.63	21.75	▲
HCAs	0.00	0.00	0.00	◄►
Medical and Dental	0.00	0.78	0.79	▲
Other AHP's & ST&T	2.45	2.61	3.46	▲
Non-Clinical	10.10	10.42	8.47	▼
QVH Trust Total	36.77	34.44	34.47	▲

Bank				
STAFF GROUP (WTE)	Mar-19	Apr-19	May-19	Compared to Previous Month
Qualified Nursing	30.11	23.77	25.12	▲
HCAs	8.05	8.70	8.55	▼
Medical and Dental	0.00	1.37	1.17	▼
Other AHP's & ST&T	2.58	3.01	2.36	▼
Non-Clinical	29.96	27.00	30.08	▲
QVH Trust Total	70.70	63.85	67.29	▲



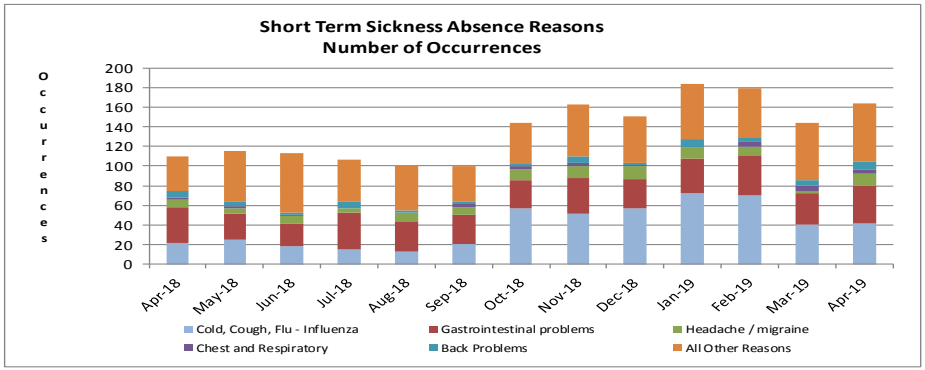


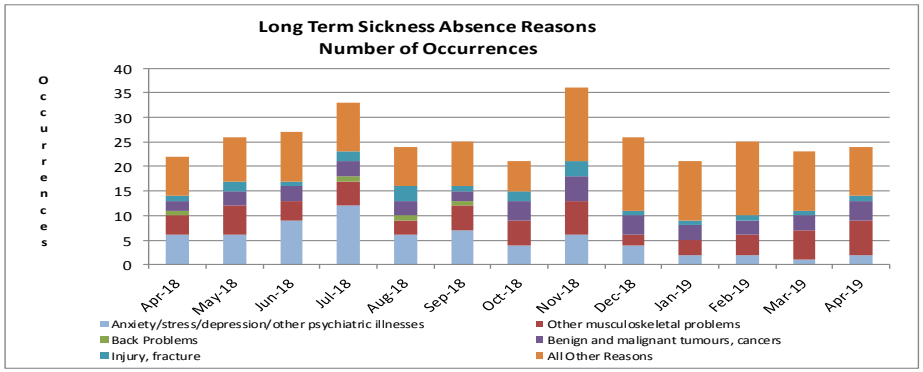
5. Sickness Absence

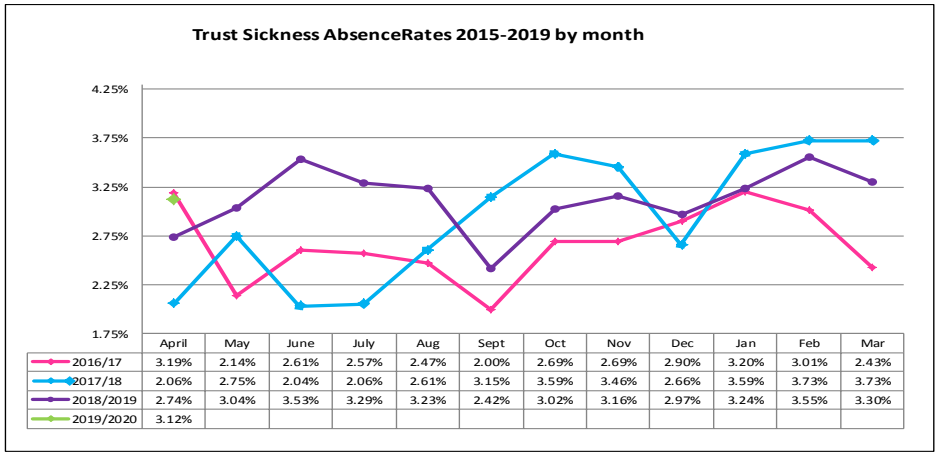
SHORT TERM SICKNESS	Feb-19	Mar-19	Apr-19	Compared to Previous Month
Corporate	0.73%	0.81%	0.92%	▲
Clinical Support	1.59%	1.83%	1.45%	▼
Plastics	1.92%	1.10%	0.49%	▼
Eyes	0.98%	2.23%	0.24%	▼
Sleep	1.35%	1.81%	1.11%	▼
Oral	2.21%	0.44%	0.24%	▼
Periop	2.32%	2.56%	2.22%	▼
Clinical Infrastructure	1.88%	1.67%	0.93%	▼
Director of Nursing	3.74%	0.79%	0.91%	▲
Operational Nursing	2.57%	1.55%	2.57%	▲
QVH Trust Total	1.86%	1.52%	1.42%	▼

LONG TERM SICKNESS	Feb-19	Mar-19	Apr-19	Compared to Previous Month
Corporate	1.25%	1.18%	0.61%	▼
Clinical Support	1.47%	1.09%	1.39%	▲
Plastics	1.94%	2.78%	2.03%	▼
Eyes	1.92%	1.34%	0.00%	▼
Sleep	3.96%	4.88%	7.07%	▲
Oral	0.00%	0.00%	0.00%	◄►
Periop	2.87%	2.92%	3.18%	▲
Clinical Infrastructure	0.00%	1.26%	0.80%	▼
Director of Nursing	0.00%	0.00%	0.00%	◄►
Operational Nursing	2.06%	2.12%	2.16%	▲
QVH Trust Total	1.68%	1.78%	1.71%	▼

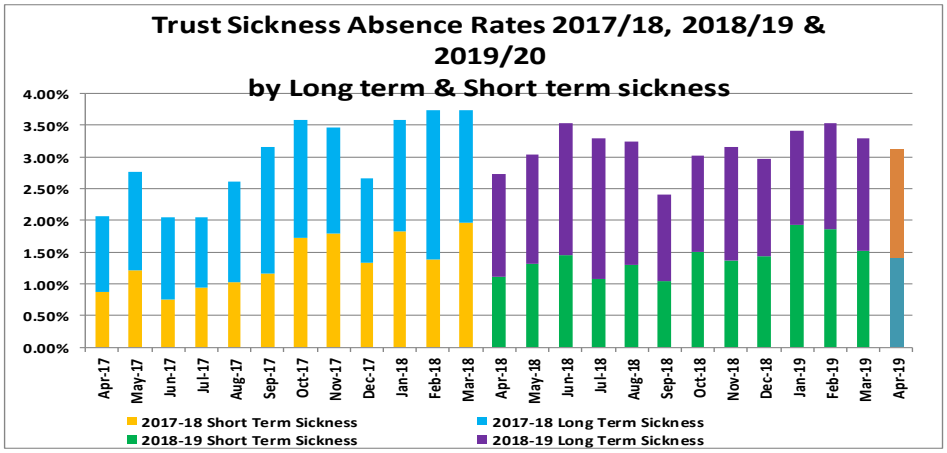
ALL SICKNESS (with RAG)	Feb-19	Mar-19	Apr-19	Compared to Previous Month
QVH Trust Total	3.55%	3.30%	3.12%	▼





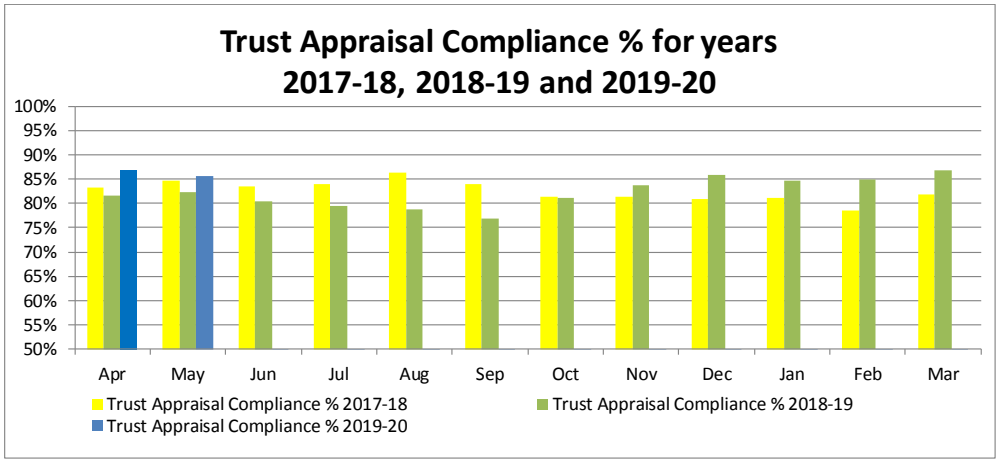


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	3.19%	2.14%	2.61%	2.57%	2.47%	2.00%	2.69%	2.69%	2.90%	3.20%	3.01%	2.43%
2017/18	2.06%	2.75%	2.04%	2.06%	2.61%	3.15%	3.59%	3.46%	2.66%	3.59%	3.73%	3.73%
2018/2019	2.74%	3.04%	3.53%	3.29%	3.23%	2.42%	3.02%	3.16%	2.97%	3.24%	3.55%	3.30%
2019/2020	3.12%											

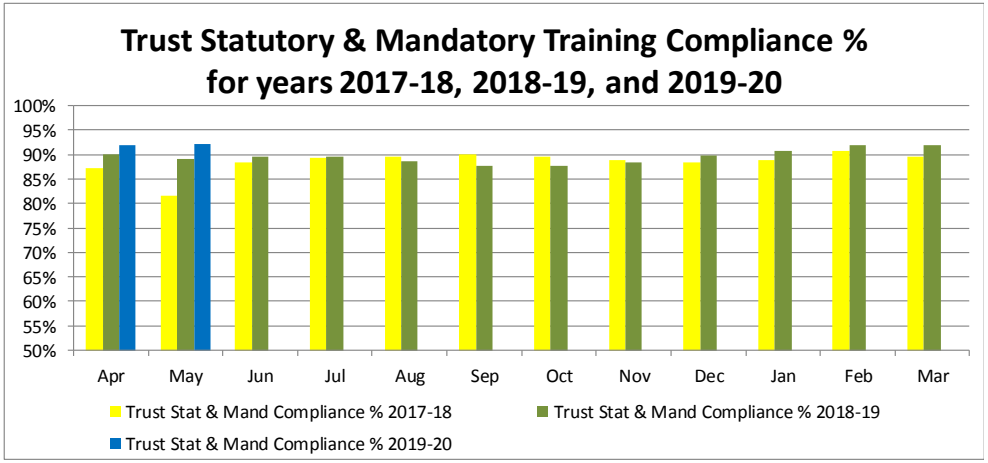


6. Training, Education and Development

APPRAISALS	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate	86.13%	84.36%	79.12%	▼
Eyes	80.00%	76.67%	76.67%	◄►
Sleep	90.32%	87.10%	81.25%	▼
Plastics	78.75%	81.01%	87.80%	▲
Oral	89.33%	87.84%	86.84%	▼
Peri Op	84.02%	84.97%	82.95%	▼
Clinical Support	90.38%	89.94%	90.57%	▲
Performance and Access	75.56%	74.42%	82.22%	▲
Director of Nursing	92.68%	90.00%	94.87%	▲
Operational Nursing	91.57%	93.48%	89.36%	▼
QVH Trust Total	86.81%	86.69%	85.53%	▼



MANDATORY AND STATUTORY TRAINING	Mar-19	Apr-19	May-19	Compared to Previous Month
Corporate	92.60%	94.38%	94.59%	▲
Eyes	93.08%	87.46%	90.03%	▲
Sleep	91.15%	92.97%	92.68%	▼
Plastics	84.68%	85.07%	85.02%	▼
Oral	90.42%	90.88%	90.62%	▼
Peri Op	87.30%	87.81%	87.47%	▼
Clinical Support	96.48%	95.74%	95.61%	▼
Performance and Access	95.75%	96.54%	97.39%	▲
Director of Nursing	95.89%	95.77%	95.12%	▼
Operational Nursing	94.46%	93.52%	94.93%	▲
QVH Trust Total	91.96%	91.98%	92.23%	▲



7. Medical and Dental Workforce

Medical Workforce

- **Appraisal and revalidation:** three doctors revalidated in May, with three doctors due in June. Medical appraisal compliance dropped, with a breakdown by directorate below:

Org L4	Assignment Count	Required	Achieved	Compliance %
276 Clinical Support (Div)	9	9	9	100.00%
276 Eye (Div)	10	10	9	90.00%
276 Oral (Div)	44	44	34	77.27%
276 Perioperative Care (Div)	34	34	23	67.65%
276 Plastics (Div)	57	57	50	87.72%
276 Sleep (Div)	2	2	1	50.00%

- **Agency usage**: remains low, and relates to a Locum Consultant in Plastic Surgery and a Corneo Fellow in month
- **Recruitment:** the recruitment team have commenced the required pre-employment checks for the August intake of doctors, with 25 new doctors and no gaps currently anticipated. Unusually the deanery have provided QVH with more Trainee Anaesthetists that the existing rota caters for; this will be a small Trust cost-pressure but will increase resilience for any unplanned changes or absence
- **ESR:** from 1 May 2019 extra duty claim forms for medical and dental staff are being processed electronically, allowing for higher transparency and efficiency
- **Job Planning:** Round Two of job planning continues to be delayed beyond the March 2019 deadline, with no directorate yet completed

Medical Education

Monthly update

- The BMA are holding a referendum with their junior doctor members around proposed changes to the 2016 terms and conditions, centering on increased enhancments and revised rostering rules to improve work-life balance. Government and the treasury will consider the proposals following this, which will then enable consideration of the additional funding required by Trusts to support the change which is planned from 1 August 2019
- The Trust hosted a very well received pan Thames training day for plastic surgery registrars on 22 May and an equally successful all day teaching session for OMFS trainees on 30 May
- The Trust will be consulting with the Junior Doctors Forum on the best way to spend a £30k allocation to improve their working conditions

Upcoming developments

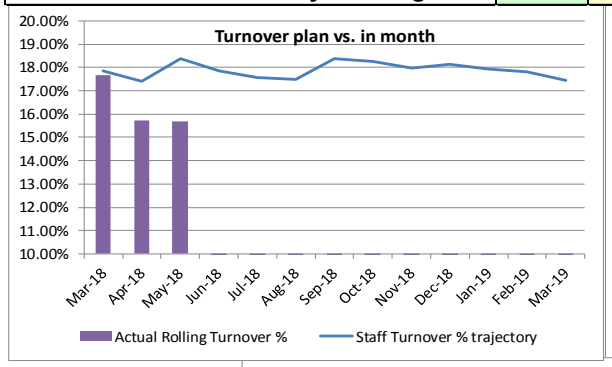
- We are awaiting the results of the GMC survey of doctors in training, due out on 1 July

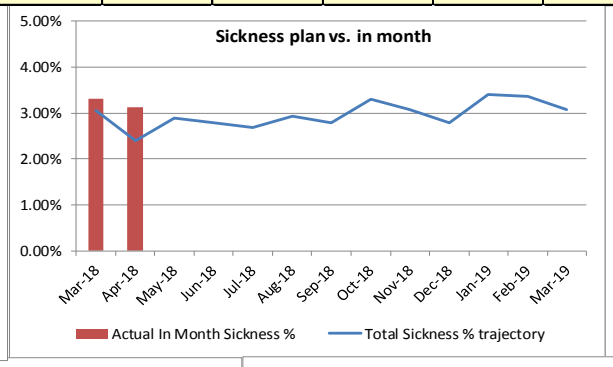
Statutory and mandatory training compliance

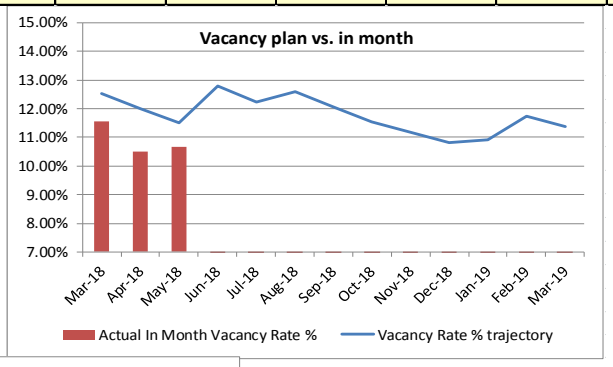
- Substantive medical and dental compliance rates remain static at 87.97%; bank worker compliance continues to improve at 64.13% in month

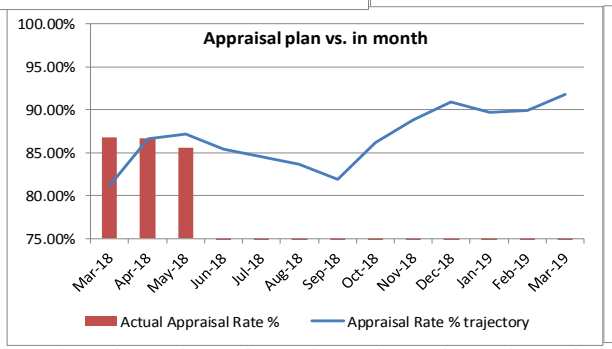
8. Trajectories

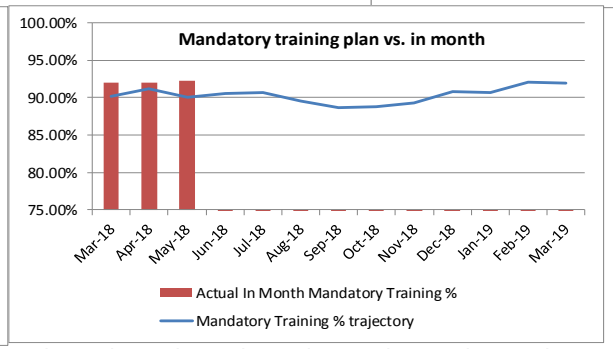
	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Staff Turnover % trajectory	17.87%	17.42%	18.39%	17.86%	17.58%	17.50%	18.40%	18.26%	17.97%	18.13%	17.93%	17.80%	17.46%
Actual Rolling Turnover %	17.67%	15.74%	15.67%										
Total Sickness % trajectory	3.05%	2.40%	2.90%	2.79%	2.68%	2.92%	2.79%	3.31%	3.08%	2.78%	3.40%	3.37%	3.08%
Actual In Month Sickness %	3.30%	3.12%											
Vacancy Rate % trajectory	12.54%	12.02%	11.52%	12.81%	12.24%	12.58%	12.08%	11.53%	11.19%	10.82%	10.93%	11.73%	11.39%
Actual In Month Vacancy Rate %	11.55%	10.50%	10.66%										
Appraisal Rate % trajectory	81.16%	86.64%	87.20%	85.40%	84.55%	83.71%	81.89%	86.18%	88.76%	90.94%	89.64%	89.91%	91.81%
Actual Appraisal Rate %	86.81%	86.69%	85.53%										
Mandatory Training % trajectory	90.23%	91.12%	90.07%	90.56%	90.70%	89.54%	88.70%	88.75%	89.31%	90.79%	90.68%	92.03%	91.96%
Actual In Month Mandatory Training %	91.96%	91.98%	92.23%										











9. Organisational Development

QVH Monthly update

- OD & L have developed a series of bespoke sessions from the NHS 2018 Staff Survey results to support these areas in developing meaningful action plans to improve staff engagement. This was trialled with the Workforce & OD team and has since been rolled out to Performance and Access, Clinical Support, Eyes, Oral, Sleep, and Perioperative Services
- Leading the Way workships continue to be promoted across the organisation from Best Practice Workshops (finance, appraisals and HR) to specialist themed sessions
- Best Place to Work initative launched on 4th June 2019. Closing date will be Friday 21st June 2019. To date over 300 people at QVH have got involved, with more than 370 ideas and comments

Upcoming developments

- We are currently working with the STP to introduce a system-led coaching for leaders based programme
- OD & L are developing further career pathways for sleep technicians and administration

Interim People Plan (National)

NHS England & Improvement published the Interim People Plan on 3 June 2019, outlining the immediate priorities of the new Chief People Officer while the Long Term Plan is developed. It's key themes strengthen the Trust's own People and Organisational Development Strategy, and are outlined below:

1. **Make the NHS the best place to work**: We must make the NHS an employer of excellence – valuing, supporting, developing and investing in our people.
2. **Improve our leadership culture:** Positive, compassionate and improvement focused leadership creates the culture that delivers better care. We need to improve our leadership culture nationally and locally.
3. **Prioritise urgent action on nursing shortages**: There are shortages across a wide range of NHS staff groups, However, the most urgent challenge is the current shortage of nurses. We need to act now to address this.
4. **Develop a workforce to deliver 21st century care**: We will need to grow our overall workforce, but growth alone will not be enough. We need a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care.
5. **Develop a new operating model for workforce**: We need to continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally, with more people planning activities undertaken by local integrated care systems (ICSs).
6. **Take immediate action in 2019/20 while we develop a full five-year plan**: We can and must take action immediately, which is why we have set out a focused set of actions for the year ahead while we continue our collaborative work to develop a costed five-year People Plan later this year.

There will be a considerable focus on Workforce & Organisational Development nationally, regionally and across the STP, expedited by the need for QVH to become a part of an Integrated Care System by April 2021.

Quarterly report on the People and OD Strategy 2019

Incorporating staff survey and SFFT findings

Our goals:

Goal 1: Engagement and Communication

We want our workforce to:

- feel proud to work for Queen Victoria Hospital as an employer of choice
- be engaged in shaping the services we provide
- be proactive in cascading information from team brief, up as well as down
- promote and embed an open and transparent culture where we listen and act on staff concerns and suggestions

Goal 2: Attraction and Retention

We will:

- regularly benchmark, review and promote what we can offer as an employer to ensure we are competitive in local markets
- use innovative and diverse methods to publicise the Trust and attract new talent
- ensure our recruitment and on-boarding process is as efficient as possible
- analyse workforce data from stay/exit interviews and staff surveys to respond to arising themes
- support business units with proactive plans to address staff shortages and improve their experience of working at QVH
- support workforce mobility across the STP

Goal 3: Health and Well-being

We will:

- ensure we promote and provide access to the support and services available in the workplace
- support managers to ensure they understand and act on their duty of care to staff
- support staff to take responsibility for their own health
- encourage a flexible working culture that meets both the needs of the individual and the Trust to enable a healthy work life balance
- work collaboratively with others to identify, share and implement good practice
- continue to widely promote access to the services available as well as the calendar of events

Goal 4: Learning and Education

We will:

- create a culture of learning and continuous feedback in the workplace
- utilise the apprenticeship levy to support growing our own talent particularly in key workforce shortage areas
- work in partnership with others across our health and social care system to maximise return on education investment
- establish clear career pathways to support the progression and development of staff
- encourage staff to take ownership of their professional and personal development supported by flexible learning and educational pathways
- ensure all staff have a meaningful appraisal and set of objectives aligned to Trust strategic direction

Goal 5: Talent and Leadership

We will:

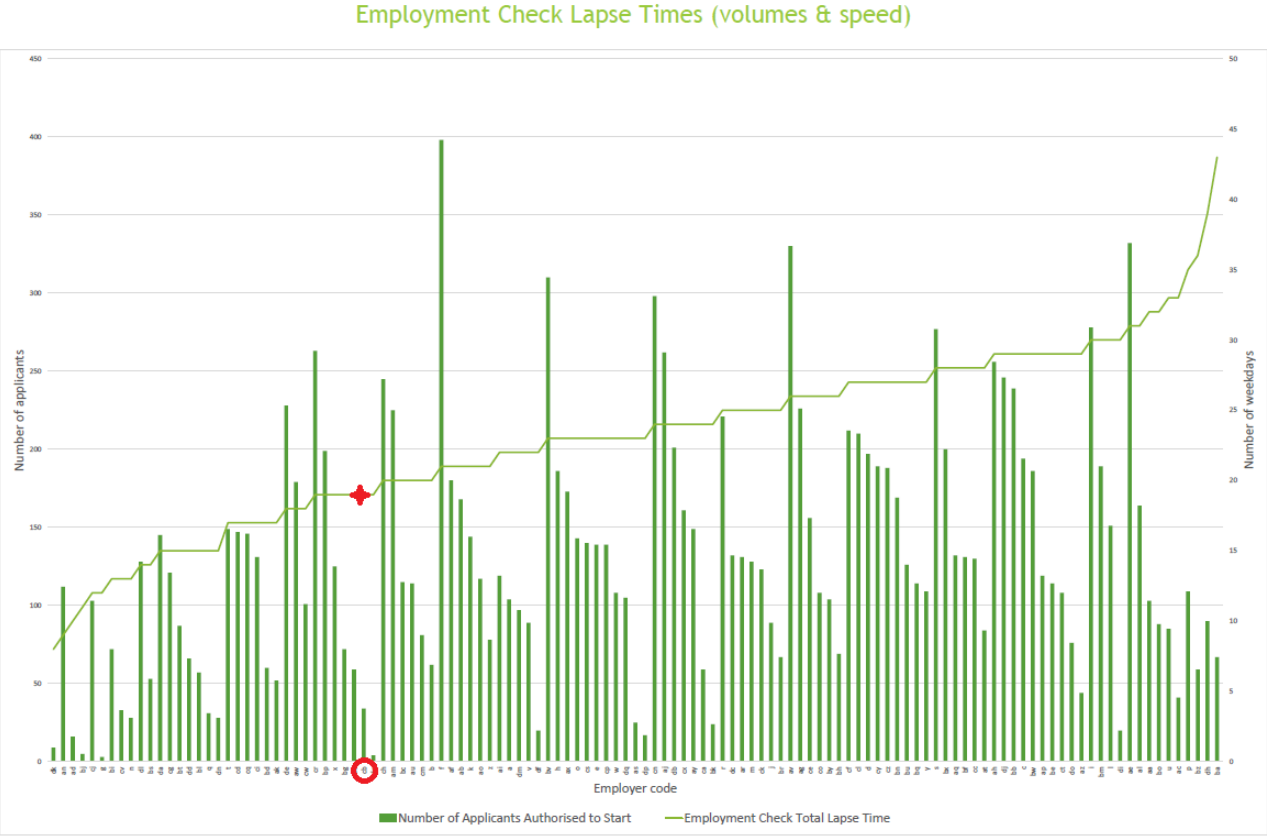
- work collaboratively across the STP system to keep talent in our health and care system
- develop a framework for talent mapping
- support staff to be the best they possibly can be in their current roles
- have a long-term collegiate approach to management and leadership development

Goal 1: Engagement and Communication

- Staff Friends and Family Test: comparing quarter 4 of 2017/18 to quarter 4 of 2018/19, staff recommending QVH as a place to receive treatment has improved from 90% to 96% and staff recommending QVH as a place to work has improved from 57% to 74%
- Connect: the Communications team have responded to staff feedback by making Connect shorter and reducing duplication of content over multiple weeks. Managers have been reminded to make clear to staff that they have a responsibility to read Connect to ensure they are up to date with key information
- Team Brief: feedback from staff who receive team brief messages is positive on the content and format, including provision of feedback back to the executive team; more work is being done to ensure clarity on who is briefing what groups of staff
- Social media: we know that many of our followers on Facebook and Twitter are QVH staff; this is a growing way of sharing news and getting positive engagement around individual/team achievements
- QVH Charity fundraising: staff teams are increasingly engaging with the charity through events like the mud run and the quiz. This brings benefits well beyond the funds raised, giving staff an opportunity to enjoy social time with colleagues, creating a shared narrative around the hospital's work and a sense of achievement
- QVH is collaborating with Clever Together to enable staff to contribute comments, challenges and ideas to help create a culture of learning and continuous feedback in the workplace through an online platform during June

Goal 2: Attraction and Retention

- Recruitment and retention premia, remuneration for bank rates and job gradings benchmarked within our STP and Kent & Medway STP in May 2019. QVH remains competitive in all areas and +33% above average for nursing bank pay rates
- The Trust is trialling more sophisticated use of social media such as LinkedIn to attract new talent, with positive outcomes seen in attracting 68 applications for a recent Plastics Junior Clinical Fellow role, the highest on record
- The Q1 TRAC benchmarking exercise has shown that QVH is better than average for both time to shortlist (n= 5 days compared to mean average 8 days) and time to complete pre-employment checks (n = 19 days compared to mean average n = 23 days)



- A new stay/exit interview questionnaire commenced this quarter; results will be triangulated with staff survey and Best Place to Work data in time for the next quarterly update
- The QVH Director of Workforce & OD is the chair of the STP Leadership & Talent Management group with key deliverables outlined in the area of supporting workforce mobility across the STP. The QVH Head of Workforce Services is also in the Collaborative Resourcing Group, who are applying pressure to reduce nurse agency rates regionally and reliance on agencies who operate above capped rates

Goal 3: Health and Well-being

- Health & Wellbeing CQUIN – QVH has been awarded the full allocation of £51k funding for the 2018/19 CQUIN due to our detailed health & wellbeing plan and range of initiatives. Although there is no CQUIN allocation for 2019/20, the HR Advisory team continue to invest the same amount of attention to this important area
- The Employee Assistance Programme is publicised in all main correspondence with the HR Advisory team, Occupational Health and on the staff intranet pages. In the last year the service supported in 54 cases as a result of 25 members of staff making contact with Care first for the first time. This usage represents a 5.4% annual usage against headcount, demonstrating a good level of awareness within the organisation
- Staff are continuing to make good use of rapid access to physiotherapy services, with 41 referrals and a mean average waiting time of only 8 working days from referral to treatment in the last quarter
- 18 staff are being trained on basic mediation skills training to support staff in the workplace, foster good working relations and as an informal route to resolving workplace disputes that are a frequent cause of workplace stress

Goal 4: Learning and Education

- The OD & Learning team are utilising the Apprenticeship levy to support staff develop talent particularly in workforce shortage areas. QVH currently offers offer 10 different apprenticeships including nursing associate and assistant practitioner. Both these roles support registered staff in workforce shortage clinical areas. QVH are currently procuring for operating department apprenticeships to support retention and talent development for a staff group that is nationally in short supply
- We are working with our colleagues in the STP to identify opportunities to maximise return on education investment. Presently they are developing a joint approach for a coaching strategy across the region
- OD & Learning have introduced a career pathway for Health Care Assistants to enable their development as Nursing Associates, operating department practitioners and qualified nurses, and are developing further career pathways for sleep technicians and administration
- Combined Mandatory Training Days for clinical and non-clinical staff are being arranged to support flexible learning; these will be in place for September 2019
- The Funding panel is continuing to support development of staff across all areas of the Trust to enable the Trust to meet its strategic goals

Goal 5: Talent and Leadership

- The STP leads for organisational development meet on a quarterly basis to identify ways to keep talent in our heath and care system. This group is in the early stages of scoping out a framework for identifying talent across the region which will maximise resources and ensure talent is developed and utilised
- The appraisal policy and process has been updated to reflect the new NHS Terms and Conditions of Service (2018) pay progression and pay step review. Appraisal documentation has also been updated to allow individuals to link their roles to wider strategic picture and QVH's key Strategic Objectives. Training is now provided on an ongoing basis and all documentation is available for all staff on Qnet. Not only will this encourage staff to take ownership of their professional and personal development but help them to look at their educational pathways
- For 2019/20, QVH has a published timetable of management and leadership development opportunities via the Leading the Way Programme which will enable people to develop their skills and knowledge within this area. Along with these workshops, staff can also choose to gain a formally recognised qualification in management and leadership if they so desire

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed: 24rd June 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. ~~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.~~ 2.In a complex and changing health system commissioner or provider led changes in patient pathways, service specifications and location of services may have an unintended negative impact on patient experience.

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
- Sustained excellent performance in CQC 2018 inpatient survey, one of eight trust who were much better than national average
- Patient safety incidents triangulated with complaints and outcomes monthly no early warning triggers
- International recruitment- 5 staff commenced and further 13 staff with start dates in the trust in July and August.
- 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
- Sustained CQC rating of good overall and outstanding for care

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 improved toilet facilities for patients and public
- 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. International recruits now arriving
- Burns and Paediatric services not currently meeting all national guidance. CCG and Regulators fully aware of this, mitigation in place.
- 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, 1143

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 10h June 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 and specialised commissioning future intentions.
- 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
- QVH led specialised commissioning

Controls and assurances:

- Clinical governance leads and reporting structure
- Clinical indicators ,NICE reviews and implementation
- 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), particularly those provided by other trusts (RR845)
- Plan for sustainable ITU on QVH site (CRR1059)
- Achieving sustainable research investment
- Balance service delivery with medical training cost (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:	**04/07/2019**		**Agenda reference:**	**106-19**	
Report title:	Care Quality Commission inspection report for QVH				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Jo Thomas, Director of Nursing				
Appendices:	CCQ inspection report 23 May 2019				
Executive summary					
Purpose of report:	The purpose of this report is to apprise the Board of the outcome of its Care Quality Commission (CQC) inspection from the 29th January 2019 - 27th February 2019. The inspection report published 23 May 2019 saw the Trust retain 'Good' overall with 'Outstanding' patient care. The inspection report and appended evidence detail the judgements made on the safety, care, effectiveness, responsiveness and well led elements of the services and care provided at QVH.				
Summary of key issues	CQC's published report listed 14 minor recommendations for QVH which were added to the action plan, with a further five minor actions which were identified from review of the CQC evidence appendix report. The action plan has been compiled following this inspection and will be monitored on a monthly basis by the Clinical Governance Group. Implementation evidence will be stored and presented to the CQC for assurance.				
Recommendation:	To Board is asked to **note** the CQC Inspection findings and action plan.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	The CQC Action Plan contributes directly to the delivery of all Trust KSOs				
Corporate risk register:	No new impact or risks to be added were identified.				
Regulation:	The CQC Action Plan 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 CQC Action Plan upholds the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The CQC Action Plan was produced using existing resources.				
Assurance route					
Previously considered by:	Links to reports shared trust wide, EMT, HMT and board seminar during May and June.				
	Dates:	various	Decision:	NA	
Next steps:	This action plan will be monitored on a monthly basis by the Clinical Governance Group. Implementation evidence will be stored and presented to the CQC for assurance.				

Summary of the CQC announced inspection 29 January to 27 February 2019

The Trust had its Care Quality Commission (CQC) inspection from the 29th January 2019 - 27th February 2019 and the inspection report published 23 May 2019 saw the trust retain 'Good' overall with 'Outstanding' patient care. Inspectors noted that staff were highly motivated and inspired to offer care that was exceptionally kind and promoted people's dignity; relationships between patients and staff were strong, caring, respectful and supportive.

QVH staff work hard to promote and maintain this standard of care and our staff are rightly proud of the way they genuinely go above and beyond for patients.

The current ratings for the trust are displayed in the table below. The significant improvement in critical care with all core elements now rated as good. Outpatients effectiveness domain was not rated, feedback was sought from the CQC regarding this and the reason given was lack of benchmarks for outpatients.

Ratings for Queen Victoria Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019	Good May 2019	Good May 2019
Critical care	Good ↑ May 2019	Good ↑ May 2019	Good May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019
Services for children and young people	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Outpatients	Good →← May 2019	Not rated	Outstanding ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Minor injuries unit	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall*	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The full inspection report and evidence appendix can be found at:
https://www.cqc.org.uk/location/RPC04

The report has been widely disseminated throughout the Trust and at the Q&GC. A summary of the action plan is included below this will be managed and monitored monthly at the Clinical Governance Group. A meeting is planned with the CQC in July to discuss and seek guidance on how the Trust can move from 'good' to 'outstanding' overall.

Action	Action	Area	Completed
A1	Review agency staffing matrix used on used within critical care	Critical care	Yes
A2	Consider submitting data to the National Intensive Care National Audit and Research Centre audit	Critical care	In progress
A3	Ensure complaints are responded to within the timeframe set out in their policy.	Trust wide	In progress
A4	Review intensive care consultant cover within critical care in line with the Guidelines for the Provision of Intensive Care Services 2015	Critical care	In progress
A5	Review Trust admission criteria to ensure patients treated can have their needs safely supported	Trust wide	In progress
A6	Review storage arrangements for all COSHH (Control of Substances Hazardous to health) products with clinical and facilities teams	Trust wide	In progress
A7	Review toilet facilities in the Rowntree Theatre Unit to ensure they meet the needs of wheelchair users	Estates	In progress
A8	Ensure that hearing loops are added to all outpatient departments.	Outpatients	In progress
A9	Ensure that resuscitation equipment is checked in line with trust policy	Trust wide	Yes
A10	Review mandatory training targets and ensure compliance with these target	Trust wide	In progress
A11	Formulate plan for improving MCA training compliance	Trust wide	In progress
A12	Develop and document their strategic direction and corresponding financial strategy	Trust wide	In progress
A13	Ensure systems and processes are in place to identify, govern and implement all Cost Improvement Programmes.	Trust wide	In progress
A14	Implement a process for undertaking post implementation reviews of larger business cases.	Trust wide	In progress
A15	Review procedures and policies relating to formal disciplinary to ensure fair and equal application	Trust wide	In progress
A16	Review processes and systems in place to ensure data quality across services including at all hub sites.	Trust wide	In progress
A17	Explore opportunities to embed a structured continuous improvement programme to support both operational and financial performance	Well led	In progress
A18	Whole executive team to attend Finance and performance committee.	Well led	Yes
A19	Formulate strategy for achieving improved financial performance and referral to treatment times, whist delivering good quality sustainable care under these pressures	Well led	In progress

Recommendation:

The Board is asked to note the outcome of the CQC inspection and subsequent action plan.

Queen Victoria Hospital NHS Foundation Trust

Inspection report

Holtye Road
East Grinstead
West Sussex
RH19 3EB
Tel: 01342414000
www.qvh.nhs.uk

Date of inspection visit: 29 Jan to 27 Feb
Date of publication: 23/05/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Queen Victoria Hospital NHS Foundation Trust is a leading specialist centre for reconstructive surgery and rehabilitation, helping people who have been damaged or disfigured through accidents or disease. Queen Victoria Hospital NHS Foundation Trust provides a specialist burns and plastic surgery service to both adults and children. Patients are admitted from the south east of England including south and east London. The trust also provides 'hub and spoke' specialist services at other hospitals in the south east of England, bringing Queen Victoria Hospital NHS Foundation Trust staff with specialist skills to remote hospital locations. The hospital provides a minor injuries unit and community services for people living in and around East Grinstead and is situated on the outskirts of the town.

Queen Victoria Hospital NHS Foundation Trust holds contracts with 21 Clinical Commissioning Groups (CCGs); the co-ordinating commissioner is Horsham and Mid-Sussex CCG with associates including West Kent, High Weald Lewes Havens and Coastal West Sussex CCGs. The trust also holds a contract with NHS England for the provision of specialised head and neck surgery, ophthalmic (eyes), burns services and other specialist dental services.

The trust was last inspected in 2016 and was rated as good overall.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

What this trust does

Queen Victoria Hospital NHS Foundation Trust is a leading specialist centre for reconstructive surgery and rehabilitation, helping people who have been damaged or disfigured through accidents or disease. Queen Victoria Hospital NHS Foundation Trust provides a specialist burns and plastic surgery service to both adults and children. Patients are admitted from the south east of England including south and east London. The trust also provides 'hub and spoke' specialist services at other hospitals in the south east of England, bringing Queen Victoria Hospital NHS Foundation Trust staff with specialist skills to remote hospital locations. The hospital provides a minor injuries unit and community services for people living in and around East Grinstead and is situated on the outskirts of the town.

Queen Victoria Hospital NHS Foundation Trust has 65 beds (including nine paediatric beds, and five critical care beds) thirteen operating theatres and employs over 900 staff. The hospital works in partnership with major trauma centres in south London and Brighton.

Queen Victoria Hospital NHS Foundation Trust was one of the first foundation trusts and has 7,600 public members across Sussex, Kent and Surrey.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. We use a risk-based approach to determine which core services to inspect. This inspection was unannounced, and we inspected three core services on 29 and 30 January 2019.The core services we inspected were burns and plastics, outpatients and critical care. We returned to review the leadership of the trust on 26 and 27 February 2019.

As part of the inspection, we reviewed information supplied by the trust and other national data and information that is available to us. We also considered any comments or concerns made directly to the Commission by members of the public or staff.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

We did not inspect all core services during this inspection, we inspected surgery (burns and plastics), outpatients and critical care. Overall, we rated the trust as good for safe, effective, responsive, well-led and outstanding in caring. All three core services we inspected were rated as good overall.

We rated safe, effective, responsive and well-led as good, and caring as outstanding. We rated all three of services as good. In rating the trust, we took into account the current ratings of the two services not inspected this time.

We rated the trust overall as good.

- The trust had responded to concerns raised in our last inspection in critical care and improvements had been made. These included, for example, dedicated medical cover out of hours.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- The service followed best practice when prescribing, administering, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- There was a strong, visible person-centred culture and the service truly respected and valued patients as individuals. Staff were highly motivated and inspired to offer care that was exceptionally kind and promoted people's dignity.

Summary of findings

- Feedback from patients, those close to them and stakeholders was continually positive about the way staff treated people. The trust performed 'much better than expected' compared with other trusts in CQC's 2017 Adult Inpatient Survey. NHS Friends and Family Test data displayed on the wards showed almost all patients would recommend the service to family and friends. There were consistently high recommendation rates, which reached 100% in nine out of 12 months in 2018 on the Burns Unit, and eight out of 12 months on Margaret Duncombe Ward.
- Staff saw patients emotional and social needs as being as important as their physical needs. Staff provided emotional support to patients and those close to them to minimise their distress and help them in their recovery from traumatic events or major surgery.
- Patient safety and the patient experience were the focus of the trust's strategy and service delivery.
- Staff were fully committed to working in partnership with people and making this a reality for each patient. The service always reflected patients' individual preferences and needs in the delivery of care.
- Advice and guidance for non-urgent GPs referrals were in place, this allowed GPs access to consultant advice prior to referring patients into specialist clinics.
- Safety huddles were held every morning in each outpatient department. All staff working in the outpatient clinics met at the same time every day to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.
- The trust's leadership team had the skills, knowledge, experience and integrity that they needed to lead the trust. Executives were given the support they needed. Where an individual board member was lacking in experience, they were supported to gain relevant expertise.
- The trust's existing strategy and projected 'strategic direction' were aligned to local plans in the wider health and social care economy and were planned to meet the needs of the relevant population. The trust worked closely with other trusts, clinical commissioning groups and sustainability and transformation partnerships to identify and meet regional patient's needs.
- The trust monitored their progress against delivery of the strategy and local plans. The strategic objectives, were outlined in the unique and exemplar Board Assurance Framework (BAF). The trusts BAF brought together the strategic objectives and used them to evaluate board work and risk. This ensured objectives were reviewed and acted against, in terms of current risks and long-term strategy.
- The different levels of governance and management functioned effectively to provide assurance. The board had a structure of committees which were chaired by non-executive members and reported directly to the board. Each committee reviewed evidence to gain information and assurances and escalated to the board in line with their terms of reference.
- The trust had arrangements for identifying, recording and managing risks, issues and had identified actions to reduce the impact of them. The trust used a risk register system to manage risks of all levels. Core service level risks were held on a departmental risk register. Risks that were strategic or affected multiple core services were held on the trust risk register. The board reviewed and managed the trust risk register.
- The trust had positive and collaborative relationships with external partners. It worked closely with other trusts in the region, clinical commissioning groups and the regional sustainability and transformation partnership to build a shared understanding of systemic challenges and identify and meet patient's needs.
- The two highest rated risks on the risk register were both rated 20. One was referral to treatment time delivery and performance and one was financial performance.

Summary of findings

- The trust had a referral to treatment time recovery action plan to eliminate 52 week waits across the three affected areas of the trust, and reach performance compliance by September 2019. The trust was on trajectory to meet this target.
- The trust was beginning its journey to address financial performance. The board recognised that system-wide working and collaboration could be key to its financial sustainability and that they needed to utilise support within the system and determine their position and the corresponding financial strategy aligning to this.
- The trust used secure electronic systems with security safeguards. It had a clear technology infrastructure plan for the hospital hub (main) site and had implemented current cyber security systems.
- The trust had a focus on learning. They supported research internally and as part of external research projects. Learning from and participation in internal and external reviews was used to lead improvement and innovation. The trust was able to identify numerous research-based initiatives it had adopted over the past 12 months to improve patient care.

However:

- Mandatory training rates including safeguarding and Mental Capacity Act 2005 modules for all staff groups did not always meet the trust target of 95%. However, at the time of inspection compliance had improved. For example, the critical care unit had an aggregated compliance rate of 90%.
- The service's admissions policy for surgical and critical care patients relied heavily on the individual judgement of the on-call consultant as to whether a patient met the criteria for admission to the hospital. For example, there was no specific criteria for burns patients around the total body surface area affected by the burns. There were also no specific criteria for significant co-morbidities. However, the service had service-level agreements with a nearby large NHS acute teaching hospital trust for the provision of services such as general surgeons and geriatricians (specialist elderly medicine consultants) to support patients with existing co-morbidities.
- There were high numbers of registered nurse vacancies predominantly in theatres and critical care and heavy reliance on temporary staff. However, the trust had systems and processes to mitigate the risk, for example, a limit to how many agency staff could be allocated to each theatre. These services used regular agency staff to provide consistency and continuity.
- Nursing agency usage was higher than was recommended for a critical care unit. The Guidelines for the Provision of Intensive Care Services, 2015 recommended level was a maximum of 20% agency staff usage. There was a departmental policy of not having more than 50% agency on any one shift. This was an improvement which had been discussed and approved by senior clinical leads and the managers within the trust. Senior staff explained that due to the number of nurses, this would mean not more than two agency nurses per shift.
- The critical care unit was not fully meeting the Guidelines for the Provision of Intensive Care Services 2015 but there had been an improvement since the last inspection. At the time of our last inspection critical care had no intensive care consultants but now had intensive care consultant cover Monday to Friday. However, the unit still lacked this cover out of hours and at weekends.
- The trust had struggled to meet both the 18-week referral to treatment and cancer targets. Five specialties were below the England average for non-admitted pathways for referral to treatment times. The trust was acting to address this and was on a trajectory to meet the targets by April 2020.
- The trust was not meeting its targets for cancellations of outpatient appointments in the seven days prior to the appointment. These rates varied within the reporting period, but neither the plastic surgery department, sleep disorder unit and ophthalmology met their target during the reporting period. On the day cancellations by the hospital had stayed the same for a period but also failed to reach their target.

Summary of findings

- The hospital did not meet the British Burn Association National Burn Care Standards. This was because, as a specialist trust, the hospital did not provide the usual range of hospital services such as general surgery, mental health liaison and paediatric medicine. To reduce these risks, the trust had service level agreements with a nearby acute NHS trust to provide these services in a timely way, 24 hours a day, seven days a week.
- The trust was not expected to meet its financial plan in this year and the trust was projected to have a deficit of £5.9 million in 2018 to 2019. The trust was not used to operating within such a financially challenging environment. They were in the process of developing systems to manage the trust under these pressures.

Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- Risk to patients was identified and monitored. The critical care outreach team was available 24 hours a day to support patients on the unit or on the wards. The unit used a safety checklist for invasive procedures produced by the Intensive Care Society. The unit had a policy for insertion of central lines and guidance for the use of arterial lines.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. We saw staff had enough time to look after patients safely.
- Records we reviewed demonstrated that the National Early Warning Scoring (NEWS) system was being used consistently and correctly.
- Safety huddles were held every morning in each outpatient department. All staff working in the outpatient clinics met at the same time every day to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff felt supported when doing so.
- Staff managed medicines consistently and safely. Medicines were stored correctly and disposed of safely. Staff kept accurate records of medicines.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Records we reviewed had clear documentation and a high standard of record keeping in line with national guidelines.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and equipment and looked after them well. Equipment received annual servicing and electrical safety testing to ensure it was safe and fit for purpose. The hospital had emergency equipment in clinical areas to allow staff to respond promptly to medical emergencies such as cardiac arrest and sepsis.

However:

- Mandatory training rates including safeguarding and Mental Capacity Act 2005 modules for all staff groups did not always meet the trust target of 95%. However, at the time of inspection compliance had improved. For example, the critical care unit had an aggregated compliance rate of 90%.
- The service's admissions policy for surgical and critical care patients relied heavily on the individual judgement of the on-call consultant as to whether a patient met the criteria for admission to the hospital. For example, there was no specific criteria for burns patients around the total body surface area affected by the burns. There were also no specific criteria for significant co-morbidities. However, the service had service-level agreements with a nearby large NHS acute teaching hospital trust for the provision of services such as general surgeons and geriatricians (specialist elderly medicine consultants) to support patients with existing co-morbidities.

Summary of findings

- Although nursing staffing levels were safe within critical care, the service was using up to 50% agency staff on any one shift and the Guidelines for the Provision of Intensive Care Services 2015, recommends a maximum of 20% usage of agency staff on any one shift.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- The trust ensured staff were competent for their roles. Staff had the right qualifications and skills to carry out their roles effectively and in line with best practice. Staff received supervision and appraisals. Staff had access to learning and development opportunities.
- There was a multidisciplinary approach to patient care. Doctors, nurses and other healthcare professionals supported each other to deliver effective care and treatment.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Records we reviewed demonstrated staff obtained and recorded patient consent in line with legislation and national guidance.
- Staff had a scheduled approach to assessing and monitoring patients. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Health promotion was provided to patients and staff. Leaflets were available on conditions such as deep vein thrombosis. Smoking cessation and alcohol consumption advice was given at pre-assessment.

However:

- The service did not meet the British Burn Association National Burn Care Standard C.05: Additional Clinical Services. This was because, as a specialist trust, the hospital did not provide the usual range of district general hospital services such as general surgery, mental health liaison and paediatric medicine. To reduce these risks, the trust had service level agreements with a nearby acute NHS teaching hospital trust to provide these services in a timely way, 24 hours a day, seven days a week as needed.
- The service did not fully participate with audits nationally. The service did not participate in the Intensive Care National Audit Research Centre audit program. However, they did participate in audit through the Southeast Critical Care Network.

Are services caring?

- Patients were given timely support and information to cope emotionally with their care, treatment, condition in order to minimise their distress. We observed emotional support being given to a distressed patient.
- Psychological and physical care was delivered in parity. We saw mindfulness-based cognitive therapy courses were available to help patients manage emotions following traumatic injuries, burns, facial conditions or cancer surgery. Mindfulness courses were popular with patients and well-attended.
- The hospital provided a variety of equipment to support patients living with dementia for example bright coloured, dementia-friendly crockery.

Summary of findings

- Staff involved patients and those close to them in decisions about their care and treatment. Patients and visitors told us they felt well informed and included in the decision processes
- Staff communicated well with patients, so they understood their care, treatment and condition. During our inspection, we heard many examples of staff going 'the extra mile' to provide compassionate care that exceeded expectations.
- Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Staff described how they were always able to give patients the time they needed, and managers supported and encouraged them in this. They felt this was part of the person-centred culture of the trust.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. However, complaints were not always dealt with within the timeframe in the trust policy. There was openness and transparency in how complaints were dealt with.
- The trust planned and provided services in a way that met the needs of local people, as well as patients from further away that required specialist services. The facilities and premises were suitable for the services being delivered. The trust operated 'hub and spoke' clinics for some specialties and held satellite clinics in locations across the south east region. This allowed patients who lived far away from the trust to benefit from the service's specialist skills and expertise closer to their home.
- The trust worked with partner services to provide holistic care. For example, the trust had a good working relationship with a local trust to provide support for patients with a mental health condition. We saw input from mental health professionals within the patient records we reviewed.
- The trust took account of patients' individual needs. The trust had several options available to support people with communication difficulties.
- The trust had a variety of innovative methods of supporting patients living with dementia.
- Advice and guidance for non-urgent GPs referrals were in place, this allowed GPs access to consultant advice prior to referring patients into specialist clinics.

However:

- In two surgical specialties, plastics and oral surgery, people could not always access the service when they needed it. The trust experienced a decline in referral to treatment performance in 2018. In partnership with NHS Improvement's intensive support team, the trust reviewed their waiting list systems and processes an implemented initiatives to reduce the waiting lists. These included Saturday clinics, use of a locum breast consultant, outsourcing of some operating lists, and improving theatre efficiency and utilisation. As a result, the trust was on its trajectory to meet its target for wait times by April 2020.
- There were no wheelchair-accessible toilets in the Rowntree Theatre Unit, where patients attended for procedures such as minor skin excisions under local anaesthetic. This meant staff would need to transfer wheelchair-users to an accessible toilet elsewhere in the hospital.
- There was no hearing loop in some of the outpatient departments. Hearing loops are audio systems that help people with a hearing impairment hear more clearly.

Summary of findings

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. They were knowledgeable about the issues and priorities for the quality and sustainability of the service, understood the challenges and how to address them. All staff we met spoke positively about the leadership, both at local and executive level. They described leaders as being visible and approachable and supporting them to deliver the best possible patient experience.
- Staff understood candour, openness, honesty, and transparency. The trust's values were embedded and promoted by all staff. Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on the shared values. Any behaviour which was inconsistent with the values was dealt with swiftly and effectively, regardless of seniority.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations effectively. The trust had several forums and groups that promoted staff engagement, both face-to-face and through newsletters and social media. The chief executive held regular staff forums, including breakfast meetings in the theatre department, which staff valued. The trust promoted staff wellbeing through mindfulness sessions and groups to support them with emotional eating and stopping smoking.
- The service was committed to improving by learning from when things went well and when they went wrong, promoting training, research and innovation. We saw examples of projects and changes to drive continuous improvement.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Staff we spoke with understood the risks to the service, and we saw the service acted to reduce risks.
- Senior staff regularly reviewed risk registers and updated them with actions taken to reduce risks and any changes in risk ratings. The service monitored a range of performance and outcome measures each month. They acted to address performance that fell below targets, such as referral to treatment times.
- The trust was managing substantial risks in relation to financial challenges and referral to treatment times.
- The trust collected, analysed, managed and used information well. Relevant information was displayed on notice boards within clinical areas. This included performance data such as safety thermometer data, staffing data and NHS Friends and Family recommendation rates.

However:

- The board's financial position changed in 2018; it had previously met its financial plans but was expected to have a deficit in 2018/19. The trust was operating under new financial pressures and it did not have past experience of managing the related challenges. The board was still establishing how it will move forward under these pressures.
- The trust did not have an agreed and structured continuous improvement programme which could support both operational and financial performance improvement, although we understood the trust was in discussion with other trusts to learn from their experiences.
- We found that the board committee which scrutinised finance and performance was not attended by the whole executive team, although the entire board received the board papers and Director of Nursing and Medical Director were able to attend the meetings.

Summary of findings

- The trust had not met multiple referral to treatment performance targets across core services in 2018. There were internal and external reasons for the reduced compliance including; regional increase in demand, significant vacancy levels across departments and the identification of patients who had erroneously been left on a waiting list previously. The trust was working internally and with external organisations including NHS Improvement and commissioners to manage and balance the backlog, increasing demand and capacity. The trust had implemented initiatives and progressed to improve patients' waiting times. They were on trajectory to meet their targets by 2019 for 52 week breaches and March 2020 for open pathways.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in leadership, burns and plastics, critical care, sleep disorder clinic, corneoplastics, facial paralysis care and making or fitting prosthetic devices.

Areas for improvement

We found 14 areas the trust may wish to consider to improve service quality.

Action we have taken

We did not issue requirement notices nor take enforcement action against the provider.

What happens next

We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- Psychological and physical care was delivered in parity. A variety of therapy courses were provided to support psychological support in conjunction with physical health needs. Rehabilitation and independent living programmes were available for patients to make the transition home easier. Staff went the extra mile to support patients return to pre-injury or pre-disease health.
- Individual needs of patients were paramount and there was a range of innovations available to support patients' needs. Volunteers made heart-shaped cushions to support patients following breast reconstruction surgery and help them feel comfortable. They also made fabric bags to cover patient's drains following surgery to treat breast cancer.
- There was a variety of different equipment available to support patients living with dementia.
- The trust had a significant focus on research and development. They had been involved in developing a variety of innovations and improvements. Some of these included screening tests in the world of facial paralysis care, making or fitting prosthetic devices, sight saving procedures and accreditation as a sleep centre in the UK, in conjunction with the European Sleep Research Society.

Summary of findings

- The strategic objectives were outlined in the Board Assurance Framework (BAF). The trust's BAF was an unique document that brought together the strategic objectives and used them to evaluate board work and manage risk. This ensured objectives were reviewed and acted against, in terms of current risks and long-term strategy.

Areas for improvement

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

- The trust should consider reducing the amount of agency staff used on each shift within critical care.
- The trust should consider how to fully meet the Guidelines for the Provision of Intensive Care Services 2015 in relation to intensive care consultant cover within critical care.
- The trust should consider revising their admission criteria to ensure patients treated can have their needs safely supported.
- The trust should continue working to improve referral to treatment times for surgical patients.
- The trust should review the toilet facilities in the Rowntree Theatre Unit and consider whether the current facilities meet the needs of all patients attending the unit.
- The trust should ensure that resuscitation equipment is checked in line with trust policy.
- The trust should ensure complaints are responded to within the timeframe set out in their policy.
- The trust should review its mandatory training targets and ensure compliance with these targets.
- The trust should develop and document their strategic direction and corresponding financial strategy.
- The trust should ensure it has robust systems and processes to identify, govern and implement its cost improvement programme.
- The trust should ensure that it has the right resources and capacity across its leadership teams and finance and performance committee to develop a new financial strategy and operate under new financial pressures.
- The trust should consider implementing a structured process for undertaking post implementation reviews of larger business cases.
- The trust should ensure process and policies, particularly those relevant to the formal disciplinary process, are applied equally no matter a staff members race or other characteristic protected under the Equality Act.
- The trust should ensure data quality across services including at all hub sites.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Summary of findings

- The trust's leadership team had the skills, knowledge, experience and integrity that they needed to lead the trust. Where an individual board member was lacking in experience, they were supported to gain relevant expertise.
- The trust board included four executive directors, five non-executive directors and three non-voting directors. Board members had a variety of different backgrounds, skills and expertise which provided the balance of knowledge and experience necessary to run all elements of the board.
- The trust performed reviews during the application process and annually to ensure that all people who had director level responsibility for the quality and safety of care were fit and proper to carry out this role.
- The trust had an appraisal process to identify and support individual's development needs.
- Board members were visible and approachable. They were on the single site throughout their workday, visible in clinical areas when they were on call and more generally when they were needed on the site for clinical care or escalation. Additionally, they held responsibility for different directorates and engaged with staff at all levels within that area through attendance at meetings and presence on site.
- The trust had clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The trust had performed internal reviews and commissioned an external review to identify development areas. Board members provided examples of how these reviews had formed the current board development program.
- The board considered sustainable, compassionate, inclusive and effective leadership when board members changed, ensuring there was a succession plan to direct these changes. For instance, two of the board's non-executive directors would come to the end of their terms in 2019. To prepare for this change, the board performed a skills audit to identify skills and experience the board had and what it needed for the future. The audit identified the skills which the board needed and the types of previous roles an applicant might have had to develop these roles.
- The trust had a clear vision and strategy as set out in the organisation's 2020 Queen Victoria Hospital Strategic plan. It included a set of vision and values which put quality and the patient at the centre of the trust's vision. The trust had a direction of travel reflecting more recent challenges and strategic changes, which was not yet in written form.
- The trust's existing strategy and projected 'strategic direction' were aligned to local plans in the wider health and social care economy and were planned to meet the needs of the relevant population. The trust worked closely with other trusts, clinical commissioning groups and sustainability and transformation partnerships to identify and meet regional patient's needs.
- The trust monitored their progress against delivery of the strategy and local plans. The strategic objectives were outlined in the unique and exemplar board assurance framework (BAF). The trust's BAF brought together the strategic objectives and used them to evaluate board work and risk. This ensured objectives were reviewed and acted against, in terms of current risks and long-term strategy.
- The trust used the BAF to organise it's work so the all projects were expressed in terms of the trust's key objectives. These objectives formed the basis for the board's work. This ensured that the board's time and energy was used to meet the objectives.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff reported they felt supported, respected and valued and the trust culture was improving. During the core service inspection staff reported a respectful and supportive culture. They said leaders were visible and approachable and the management supported an open and honest culture.
- The culture was centred on the needs and experience of people who use services. Patients we spoke to during the core service inspection reported that the trust's culture put patient's needs at the centre of services. This was supported by responses to the Friends and Family Test.

Summary of findings

- The culture encouraged openness and honesty at all levels within the organisation. The trust had processes so staff could feel safe raising concerns and concerns would be addressed. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and we saw that when concerns were raised they were investigated, learning was identified and action was taken as a result of these concerns.
- The trust addressed behaviour and performance that was inconsistent with the vision and values, regardless of seniority of those involved. All staff were required to uphold the vision and values. We saw an examples of staff members raising concerns about a senior member of staff's treatment of junior members.
- There were mechanisms for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. The board recognised the importance of development and internal promotion opportunities, it also recognised the limitations created by the nature of being a small, specialised trust.
- Staff reported receiving appraisals and being supported in their development. The staff survey verified this, reflecting the trust level of compliance with appraisals had improved significantly since 2017.
- Board papers and interviews reflected that the board and senior staff members understood that there was work to be done to ensure that the trust provide the same experience for all employees no matter their race or other protected characteristics.
- We saw that there were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. Staff at all levels reported that they worked closely and that there was a 'family' feeling between staff at the trust.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. Board members understood roles and responsibilities and there were clear terms of reference for all committees.
- The board had a structure to ensure accountability for board decisions. As a foundation trust, the trust had a board of directors and a council of governors. The board of directors acted as a unitary board. All members of the board provided scrutiny and input across all areas of financial, operational and quality performance.
- We observed board members throughout the inspection and at board and committee meetings. We saw colleagues were supportive and challenging, which was in line with what board members reported. Board members provided good examples of debate and challenge from non-executive directors and between executive directors.
- The different levels of governance and management functioned effectively. The board had two permanent statutory committees and three formal (but non-statutory) committees. All five committees were chaired by non-executive members and reported directly to the board. Each committee fed information into the board in line with their terms of reference.
- The board had oversight of each business unit's risk and performance. Each business unit had a head and managed risk and governance at a business unit level. Business unit heads fed into the clinical and governance committee which reported to the board every other month.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected**.** The trust had a risk culture which focused on identification and management of risks using comprehensive assurance systems. Staff at all levels recognised their responsibility for risk and incident reporting.

Summary of findings

- The trust had arrangements for identifying, recording and managing risks, issues and had identified actions to reduce the impact of them. The trust used a risk register system to manage risks of all levels. Risks were recorded on registers which were used to ensure oversight and management of the risks. Core service level risks were held on a departmental risk register. Risks that were strategic or affected multiple core services were held on the trust risk register. The board reviewed the trust risk register.
- One of the two highest rating risks was referral to treatment time delivery and performance. In August 2018, the trust agreed a referral to treatment time recovery action plan, to eliminate 52 week waits across the three affected areas of the trust and reach performance compliance by September 2019. The referral to treatment time plan addressed elements of improvement including: 'systems and processes, trajectories and performance reporting, capacity and pathways and sustainability'.
- The trust was managing risks associated with the referral to treatment time issues. We attended a weekly meeting which confirmed all departmental leads were aware of every patient on their waiting list, the challenges they faced and were supported by the director of operations to overcome these challenges. The director of operations offered an appropriate amount of challenge and support to department leads in delivering performance.
- The other highest rating risk was financial sustainability. The trust recognised that system-wide working and collaboration could be key to its financial sustainability and that they needed to utilise support within the system and determine their position and the corresponding financial strategy aligning to this.
- The trust was in the process of developing internal strategies, programs and structures to manage the trust in light of the financial challenges it had not faced previously.
- Potential risks were taken into account when planning services. The trust was a small, specialist trust remotely situated between other, larger acute trusts in the region. It recognised that many of the risks to the trust were intertwined with its size and specialist nature. The trust was forward looking and recognised that system-wide working and collaboration could be the way to address many of the risks that faced the trust.
- The trust had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The trust had an audit program that included audits at divisional, and provider level. The trust submitted information from some audits for benchmarking against other, similar, providers. Divisional clinical audit results were fed into the quality and safety committee which reported to the board.
- The trust had a wider information technology strategy which it was implementing to create a holistic information technology system across the trust. The strategy was signed off by the board and chief information officer.
- It used secure electronic systems with security safeguards. The trust had a clear infrastructure plan for the hospital hub (main) site. The trust had implemented current cyber security systems. This included systems, cybersecurity and commitment from the sustainability and transformation partnership to help the trust to obtain and electronic observation system that would allow secure mobile access. The program included telephony systems and secure messaging.
- The trust engaged well with patients and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. People who use services, those close to them and their representatives were engaged and involved in decision-making to shape services and culture. The trust reached out to the public through a variety of mediums and benefited from transactional feedback, it had recently drafted a strategy for collecting and using community feedback to inform change.
- The trust reached out to staff members using a variety of media, but staff members did not always feel engaged. Staff were somewhat engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.

Summary of findings

- There were positive and collaborative relationships with external partners to build a shared understanding of challenges and needs within the system and to deliver services to meet those needs. The trust worked closely with other trusts in the region, clinical commissioning groups and the regional sustainability and transformation partnership to identify and meet regional patient's needs.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
- Leaders and staff aimed for continuous learning, improvement and innovation including participating in appropriate research projects and recognised accreditation schemes. Current research studies at the trust were either initiated 'in house' by their own clinicians or part of multi-centre studies which the trust was invited to join. The trust had effective governance processes for research and patient involvement.
- In 2017 to 2018 the trust had initiated four of its own fully grant-funded studies. Additionally, they collaborated with another regional trust on research initiatives in burns and infection control and a trust in another region of the country, with a commercial partner, to develop a new device to assist with the rehabilitation of facial palsy patients.
- Learning from and participation in internal and external reviews was used to lead improvement and innovation. The trust was able to identify numerous innovative, research-based initiatives it had adopted over the past 12 months, particularly in the areas of burns and plastics and outpatients.
- The trust managed concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. There was openness and transparency in how complaints were dealt with.

However:

- The trust saw a financial deterioration in 2018 to 2019 and was not expected to meet its financial plan in this year. The trust originally submitted a forecast that it would have a £6.8 million surplus. However, it had submitted a revised forecast which showed a deficit of £5.9 million in 2018 to 2019.
- The trust did not have an agreed and structured continuous improvement programme to support both operational and financial performance improvement. Although they were exploring opportunities with other organisations.
- Oversight of the finance and performance of the trust was through the finance and performance committee, which was not attended by the whole executive team. This meant that the committee could not hold the whole executive team to account for the financial performance of the trust.
- The trust had identified a strategic direction to address recent concerns including financial and referral to treatment time challenges. However, it did not have a written strategy for achieving the priorities and delivering good quality sustainable care under these pressures.
- The trust was not used to operating within a financially stressed environment. It had not yet ensured that it had effective systems to manage the trust under these pressures.
- The trust did not have a system to ensure it understood the impact of business case investments or use this information to inform future investments or business case applications. There was no structured approach to reviewing the outcome of business case investments.
- Across the trust mandatory training rates did not meet the trust target of 95%.
- Workforce Race Equality Standard data showed that the experience of BME employees was not always the same as of non-BME employees although this data is derived from a small percentage of BME staff at the trust. It noted BME employees were significantly more likely than their white counterparts to enter the formal disciplinary process. The trust was taking action to address this inequity by reviewing how it applied disciplinary processes across all employees.

Summary of findings

- The organisation did not have targeted methods to engage with or include staff with a protected equality characteristic under the Equality Act. The trust generally reached out to the entire staff body in an open manner but did not direct messages or communications to particular staff groups.
- The trust had not met multiple referral to treatment performance targets across core services in 2018. The trust had implemented initiatives and progressed to improve patients' waiting times. They were on trajectory to meet their targets by 2019 for 52 week breaches and March 2020 for open pathways.
- All information technology systems were not integrated and did not provide a holistic understanding of performance or patients throughout their pathway. This created a risk and was an aggravating factor that led to challenges including certain patients being left off waiting lists.
- The trust did not always collect, analyse, manage and use information well to support all its activities. The trust used several different key systems to manage information within the trust. These included systems to manage administrative systems, radiology, patient care notes and electronic documents management.
- The trust did not have complete visibility of data relating to all spoke sites. The trust was working diligently to address this issue, but some challenges continued regarding data held at and by other sites.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ➔➔ May 2019	Good ➔➔ May 2019	Outstanding ➔➔ May 2019	Good ➔➔ May 2019	Good ➔➔ May 2019	Good ➔➔ May 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Queen Victoria Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019	Good May 2019	Good May 2019
Critical care	Good ↑ May 2019	Good ↑ May 2019	Good May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019
Services for children and young people	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Outpatients	Good →← May 2019	Not rated	Outstanding ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Minor injuries unit	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall*	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Queen Victoria Hospital (East Grinstead)

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East Grinstead
West Sussex
RH19 3DZ
Tel: 01342414362
www.qvh.nhs.uk

Key facts and figures

Queen Victoria Hospital NHS Foundation Trust is a leading specialist centre for reconstructive surgery and rehabilitation, helping people who have been damaged or disfigured through accidents or disease. Queen Victoria Hospital NHS Foundation Trust provides a specialist burns and plastic surgery service to both adults and children. Patients are admitted from the south east of England including south and east London. The trust also provides 'hub and spoke' specialist services at other hospitals in the south east of England, bringing Queen Victoria Hospital NHS Foundation Trust staff with specialist skills to remote hospital locations. The hospital provides a minor injuries unit and community services for people living in and around East Grinstead and is situated on the outskirts of the town.

Queen Victoria Hospital NHS Foundation Trust has 65 beds (including nine paediatric beds, and five critical care beds) 13 operating theatres and employs over 900 staff. The hospital works in partnership with major trauma centres in south London and Brighton.

Queen Victoria Hospital NHS Foundation Trust was one of the first foundation trusts and has 7,600 public members across Sussex, Kent and Surrey.

At our last inspection we rated the hospital overall as 'good.'

Summary of services at The Queen Victoria Hospital (East Grinstead)

Good →←

Our rating of services stayed the same. We rated it them as good because:

- There were arrangements to keep service users safe from abuse which were in line with relevant legislation. The majority of staff had received training, were able to identify who might be at risk of potential harm and knew how to seek support or advice.
- The hospital was providing safe care. There were sufficient staff to meet the needs of patients although some services were heavily reliant on a temporary workforce. Recent recruitment campaigns both locally and overseas had been successful.

Summary of findings

- The critical care unit had improved it's out of hours medical cover since our last inspection. At the time of our last inspection one doctor out of hours was needed in multiple places at once including in theatre and attending to unwell patients. This inspection there had been a change in policy to ensure surgery had finished before the other medical staff would leave the hospital.
- Services were delivered by staff that were competent, trained and supported by their managers, to provide safe and effective care. The trust provided regular training and development opportunities for staff. The trust invested in research, for example, there was specialist research nurses in burns and plastics.
- Staff kept themselves, equipment and the premises clean. Staff demonstrated good hand hygiene practice and safe disposal of sharps and waste. Staff complied with national and trust processes to control and prevent the spread of infection.
- Medicines were stored, prescribed and given correctly and medicines fridge temperatures checked.
- Patients were given enough food and drink to meet their needs. The hospital had recently extended the range of teas available to include ginger and peppermint teas to hydrate patients suffering from post-operative nausea or gas. Pain levels were assessed, and patients received adequate pain relief.
- Staff understood and complied with the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act, 2005.
- Staff provided compassionate and respectful care. Staff provided emotional support to patients and relatives and involved patients and those close to them in decisions about their care and treatment. During our inspection, we heard many examples of staff going 'the extra mile' to provide compassionate care that exceeded expectations.
- The hospital provided care and treatment in accordance with evidence-based guidance. Staff were aware of clinical guidance for patients with specific needs or diseases.
- There was an audit program that covered many areas of practice in the critical care unit. The unit looked for areas to improve. There was a positive culture to learning from things when they went wrong or went well.
- The hospital made improvements following learning from complaints and patient feedback. We saw managers fed back complaint learning to staff in staff newsletters. However, the trust did not always respond to complaints within the timeframe set out in the trust's policy.

However:

- The hospital did not meet the British Burn Association National Burn Care Standards. This was because, as a specialist trust, the hospital did not provide the usual range of hospital services such as general surgery, mental health liaison and paediatric medicine. To reduce these risks, the trust had service level agreements with a nearby acute NHS trust to provide these services in a timely way, 24 hours a day, seven days a week.
- The critical care unit was not fully meeting the Guidelines for the Provision of Intensive Care Services 2015 but there had been an improvement since the last inspection. At the time of our last inspection critical care had no intensive care consultants but now had intensive care consultant cover Monday to Friday. However, the unit still lacked this cover out of hours and at weekends.
- Nursing agency usage was higher than was recommended for a critical care unit. The unit had a target of a maximum 50% usage, but the recommended level was a maximum of 20%.
- There were significant numbers of registered nurse vacancies predominantly in theatres and critical care and heavy reliance on temporary staff. However, the trust had systems and processes to mitigate the risk, for example a limit to how many agency staff could be allocated to each theatre. These services used regular agency staff to provide consistency and continuity.

Summary of findings

- The trust's admissions policy for surgical patients and critical care patients relied heavily on the individual judgement of the on-call consultant as to whether a patient met the criteria for admission to the hospital. For example, there was no specific criteria for burns patients around the total body surface area affected by the burns. There were also no specific criteria for significant co-morbidities. Comorbidity describes two or more disorders or illnesses occurring in the same person.
- Mandatory training rates including safeguarding and Mental Capacity Act modules for all staff groups did not always meet the trust target of 95%. However, at the time of inspection compliance had improved.
- The trust had struggled to meet both the 18-week referral to treatment and cancer targets. Five specialties were below the England average for non-admitted pathways for referral to treatment times.
- Plastic surgery department, sleep disorder unit and ophthalmology appointment cancellations by the hospital within seven days varied in the reporting period, none met their target. On the day cancellations by the hospital had stayed the same for a period but failed to reach their target.
- Resuscitation equipment within the plastic and burns department and maxillofacial department had some daily and weekly checks missing which was not in line with the trust's policy.

Surgery

Good

Key facts and figures

The surgical services Queen Victoria Hospital provides include burns care (unit level care) to Kent, Surrey and Sussex, elective and trauma care in plastic and reconstructive surgery, predominately in breast reconstruction, skin cancer and complex hand surgery. Hand surgery accounts for approximately one quarter of all elective plastic surgical operations at the trust. It also comprises approximately 80% of the trauma workload at the hospital. In 2017, the burns service accepted 1,182 adult new referrals. Of these, 96 required inpatient care. The service also accepted 907 paediatric burns referrals, 20 of whom required inpatient care on the children's ward, Peanut Ward.

The trust provides a nationally recognised facial palsy service and are one of the biggest oral and maxillofacial surgery units in the country, providing surgery for all ear, nose, throat and maxillofacial cancers, (except for thyroid cancer). It is the designated cancer surgery centre for West Kent and Medway. The service also supports head and neck multidisciplinary teams at Guildford and Brighton. The trust provides complex eye surgery, including corneo-plastic (corneal transplants) and oculoplastic (surgery to the eye socket, eyelids or tear ducts). This is supported by an on-site eye bank, supplying harvested corneal tissue. Surgery for all these specialties is provided 24 hours a day, seven days a week for both adults and children age three and over. The trust accepts trauma referrals from all of Kent, Sussex and Surrey. The trust provides services on a 'hub and spoke' model to networked trusts, including support to the major trauma centre at a nearby NHS acute teaching hospital.

The hospital has 13 operating theatres. The recovery area has 12 bays, including two specific bays at one end of the recovery area used for the post-operative recovery of children. Canadian Wing comprises of a male ward (Ross Tilley Ward) and female ward (Margaret Duncombe Ward). Adult inpatients stay on Canadian Wing following plastic and reconstructive surgery. The hospital has a total of 65 inpatient beds, including six on the Burns Unit.

Our inspection was unannounced (staff did not know we were coming) over two days. During our visit, we spoke with 31 members of staff, including consultants, nurses, operating department practitioners, service managers, secretaries and psychological therapists. We spoke with four patients and reviewed seven sets of patient records. We reviewed a variety of documents, including staffing rotas, meeting minutes, clinical policies and performance data.

Summary of this service

We inspected burns services and plastic surgery services during this inspection but not surgery overall.

Our rating of this service stayed the same. We rated it as good because:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- **The service had suitable premises and equipment and looked after them well.** We saw records of daily checks of critical equipment, such as oxygen, suction, call bells and hoists. Equipment received annual servicing and electrical safety testing to ensure it was safe and fit for purpose.
- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.

Surgery

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- **The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.
- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- **The service used safety monitoring results well.** Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- **The service provided mandatory training in key skills to all staff.** Although not all staff held up-to-date mandatory training, data available at the time of our visit showed mandatory training rates now met the trust target of 95% in some areas.
- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- **Staff gave patients enough food and drink to meet their needs and improve their health.** They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- **Staff assessed and monitored patients regularly to see if they were in pain**. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- **The service made sure staff were competent for their roles.** Managers appraised staff performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care.
- **The service provided consultant cover 24 hours a day, seven days a week, for any patients needing consultant review.** Records we reviewed demonstrated daily medical review of patients.
- **The service promoted healthy living with its patients.** Staff referred patients for stop smoking services and support to reduce alcohol consumption where relevant.
- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- **There was a strong, visible person-centred culture and the service truly respected and valued patients as individuals.** Staff were highly motivated and inspired to offer care that was exceptionally kind and promoted people's dignity.

Surgery

- **Feedback from patients, those close to them and stakeholders was continually positive about the way staff treated people**. The trust performed 'much better than expected' compared with other trusts in CQC's 2017 Adult Inpatient Survey. NHS Friends and Family Test data displayed on the wards showed almost all patients would recommend the service to family and friends. There were consistently high recommendation rates, which reached 100% in nine out of 12 months in 2018 on the Burns Unit, and eight out of 12 months on Margaret Duncombe Ward.
- **Staff saw patients emotional and social needs as being as important as their physical needs.** Staff provided emotional support to patients and those close to them to minimise their distress and help them in their recovery from traumatic events or major surgery.
- **Staff were fully committed to working in partnership with people and making this a reality for each patient.** The service always reflected patients' individual preferences and needs in the delivery of care.
- **The trust planned and provided services in a way that met the needs of local people, as well as patients from further away that required specialist services.** The facilities and premises were suitable for the services being delivered.
- **The service took account of patients' individual needs.** Staff acted to meet the needs of different patient groups so they could access the service on an equal basis to others.
- **The service treated concerns and complaints seriously and investigated them. They learned lessons from the results and shared these with all staff.** We saw examples of improvements following learning from complaints and patient feedback.
- **Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.** They were knowledgeable about the issues and priorities for the quality and sustainability of the service, understood the challenges and how to address them.
- **The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups.** Staff we spoke with at different levels knew the strategic objectives for the service and how they contributed to them.
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** All staff we spoke with were highly positive about the caring culture of the trust.
- **The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**
- **The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** Staff we spoke with understood the risks to the service, and we saw the service acted to reduce risks.
- **The trust collected, analysed, managed and used information well.**
- **The trust engaged well with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations effectively.**
- **The trust engaged well with patients, staff, the public and local organisations to plan and manage services.** They collaborated with partner organisations effectively.
- **The service was committed to improving by learning from when things went well and when they went wrong, promoting training, research and innovation.** We saw examples of projects and changes to drive continuous improvement.

Surgery

However:

- **For some surgical specialties, people could not always access the service when they needed it.** The trust experienced a decline in referral to treatment performance in 2018. Between September 2017 and August 2018, referral times were better than the England average for the ophthalmology and ear, nose and throat specialties. They were worse than the England average for the plastic surgery and oral surgery specialties.
- We saw chemicals subject to Control of Substances Hazardous to Health (COSHH) regulations, such as floor cleaner, toilet cleaner and a biohazard spill kit stored in unlocked sluice rooms on Canadian Wing on the second day of our visit. We highlighted this issue to a matron, who took immediate action to lock the chemicals away to prevent unauthorised access.
- The service did not meet the British Burn Association National Burn Care Standard C.05: Additional Clinical Services. This was because, as a specialist trust, the hospital did not provide the usual range of district general hospital services such as general surgery, mental health liaison and paediatric medicine. To reduce these risks, the trust had service level agreements with a nearby acute NHS teaching hospital trust to provide these services in a timely way, 24 hours a day, seven days a week as needed.
- The service's admissions policy for surgical patients relied heavily on the individual judgement of the on-call consultant as to whether a patient met the criteria for admission to the hospital. For example, there was no specific criteria for burns patients around the total body surface area affected by the burns. There were also no specific criteria for significant co-morbidities.
- Mandatory training rates for medical and dental staff were 81%, which did not meet the trust target of 95%.

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good because:

- **The service provided mandatory training in key skills to all staff.** Although not all staff held up-to-date mandatory training, data available at the time of our visit showed mandatory training rates for nursing staff now met the trust target of 95% in some areas. Trust data from 31 December 2018 showed mandatory completion rates for nursing and theatre staff ranged from 90% to 96%. Medical and dental staff overall mandatory training completion rates were 81%. Completion rates for individual modules ranged from 47% (information governance) to 91% (health, safety and welfare).
- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- **The service controlled infection risk well.** Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- **The service had suitable premises and equipment and looked after them well.** We saw records of daily checks of critical equipment, such as oxygen, suction, call bells and hoists. Equipment received annual servicing and electrical safety testing to ensure it was safe and fit for purpose. The service had emergency equipment in clinical areas to allow staff to respond promptly to medical emergencies such as cardiac arrest and sepsis.
- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary. The service assessed a comprehensive range of risks to patients, including anaesthetic risks, falls,

risks of venous thromboembolism (VTE, or blood clots in veins) and mental health. We observed theatre staff following the World Health Organisation (WHO) Surgical Safety Checklist to ensure the right patient received the right operation. Observational and quantitative audits provided assurances staff completed the checklist thoroughly to keep patients safe.

- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care. Records we reviewed had clear documentation and a high standard of record keeping in line with General Medical Council and Nursing and Midwifery Council guidance. Records included care plans that identified all patients' care needs.
- **The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time. The service stored medicines, including controlled drugs, securely in line with national standards for medicines management. This was an improvement from our previous inspection in 2015, when we found controlled drugs were not always stored securely in theatres. The service stored refrigerated medicines within the manufacturer's recommended temperature range to maintain their function and safety
- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- **The service used safety monitoring results well.** Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

However:

- We saw chemicals subject to COSHH regulations, such as floor cleaner, toilet cleaner and a biohazard spill kit stored in unlocked sluice rooms on Canadian Wing on the second day of our visit. We highlighted this issue to a matron, who took immediate action to lock the chemicals away to prevent unauthorised access.
- Mandatory training rates for medical and dental staff did not meet the trust target of 95%.
- The service's admissions policy for surgical patients relied heavily on the individual judgement of the on-call consultant as to whether a patient met the criteria for admission to the hospital. For example, there was no specific criteria for burns patients around the total body surface area affected by the burns. There were also no specific criteria for significant co-morbidities. However, the service had service-level agreements with a nearby large NHS acute teaching hospital trust for the provision of services such as general surgeons and geriatricians (specialist elderly medicine consultants) to support patients with existing co-morbidities.

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good because:

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance. Audits provided assurances around compliance with

policies, national guidance and best practice, as well as identifying areas for continuous improvement. The service participated in burns research projects and had a dedicated burns research nurse, in line with National Burns Care Standard B.05. We reviewed recent peer-reviewed publications, and saw the service's research helped to optimise care for their own patients and to promote advancements in the field of burns care.

- **Staff gave patients enough food and drink to meet their needs and improve their health.** They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences. The Burns Unit multidisciplinary team included a burns dietitian, who reviewed patients five days a week in line with National Burns Care Standard B.27.A.
- **Staff assessed and monitored patients regularly to see if they were in pain**. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. All patients we spoke with told us staff managed their pain well. Pain audits, such as a recent dental abscess pain management audit, provided assurances around pain management.
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services, national guidance or published literature to learn from them. Excision rates for melanoma (a type of skin cancer that develops from pigment-containing cells such as moles) were 94.6% in the period April 2017 to March 2018. This was better than the 75% the trust benchmarked against, which came from National Institute for Health and Care Excellence (NICE) guidance. Patients using the burns service also had good outcomes. Data published in the trust's 2017-18 quality report showed the trust's average healing times for burns in 2017 were 11 days for children under 16 years, 13 days for 16 to 65-year olds, and 18 days for adults over 65 years. Burns healing in less than 21 days are less likely to be associated with poor long-term scars. The quality report showed healing times had improved from the previous year, when average healing times were 17 days for 16 to 65-year olds, and 28 days for over 65-year olds.
- **The service made sure staff were competent for their roles.** Managers appraised staff performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Appraisal records we reviewed showed documentation of meaningful appraisal, with set objectives for the staff member and team. The service provided ongoing training and continuous professional development to help staff provide the best care they could to their patients. Staff working in the Burns Unit attended Emergency Management of the Severe Burn (EMSB) courses, and a matron was a qualified coordinator for this course. This was in line with the British Burn Association National Burn Care Standard B.23: Education and Training- EMSB.
- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care. All staff we spoke with reported effective multidisciplinary relationships with colleagues from different groups. Patient records we reviewed demonstrated input from a range of professionals into patient care, including consultants, nurses, mental health, dietitians, physiotherapy and occupational therapy staff. The trust had telemedicine facilities to enable staff to join regional specialist multidisciplinary team meetings, such as for breast and melanoma. In theatres, staff attended monthly multidisciplinary simulation training to help them respond effectively as a team to emergency situations such as major haemorrhage (significant blood loss).
- **The service provided consultant cover 24 hours a day, seven days a week, for any patients needing consultant review.** Records we reviewed demonstrated daily medical review of patients.
- **The service promoted healthy living with its patients.** Staff referred patients for stop smoking services and support to reduce alcohol consumption where relevant. On the wards, we saw a range of health promotion posters and leaflets available for patients. Patient notes we reviewed demonstrated staff encouraged patients to adopt healthy living habits, such as reducing screen time and caffeine at night to help them sleep better.

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Records we reviewed demonstrated staff obtained and recorded patient consent in line with legislation and national guidance.

However:

- The service did not meet the British Burn Association National Burn Care Standard C.05: Additional Clinical Services. This was because, as a specialist trust, the hospital did not provide the usual range of district general hospital services such as general surgery, mental health liaison and paediatric medicine. To reduce these risks, the trust had service level agreements with a nearby acute NHS teaching hospital trust to provide these services in a timely way, 24 hours a day, seven days a week as needed.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- **There was a strong, visible person-centred culture and the service truly respected and valued patients as individuals.** Staff were highly motivated and inspired to offer care that was exceptionally kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. During our inspection, we heard many examples of staff going 'the extra mile' to provide compassionate care that exceeded expectations.
- **Feedback from patients, those close to them and stakeholders was continually positive about the way staff treated people**. The trust performed 'much better than expected' compared with other trusts in CQC's 2017 Adult Inpatient Survey. NHS Friends and Family Test data displayed on the wards showed almost all patients would recommend the service to family and friends. There were consistently high recommendation rates, which reached 100% in nine out of 12 months in 2018 on the Burns Unit, and eight out of 12 months on Margaret Duncombe Ward.
- **Staff saw patients emotional and social needs as being as important as their physical needs.** Staff provided emotional support to patients and those close to them to minimise their distress and help them in their recovery from traumatic events or major surgery. Specialist psychological therapists worked within the multidisciplinary team. They supported patients and relatives to manage their fears, anxieties and feelings. The service provided various support groups and mindfulness courses to help patients cope emotionally and access peer support from others in a similar situation.
- **Staff were fully committed to working in partnership with people and making this a reality for each patient.** The service always reflected patients' individual preferences and needs in the delivery of care. Staff used determination and creativity to overcome obstacles to help patients realise their potential. One example of this was physiotherapists going out running with patients if this was part of their usual routine to help them feel 'normal' during their hospital stay. Staff recognised people needed to have access to, and links with, their support networks in their community and they supported people to do this. This included helping arrange charity funding for accommodation for patients' relatives so they could stay nearby and spend more time visiting their loved one in hospital. Staff took time to get to know patients and provide 'home comforts' to them, such as by making their tea the way they liked it and playing their favourite music.

Surgery

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- **The trust planned and provided services in a way that met the needs of local people, as well as patients from further away that required specialist services.** The facilities and premises were suitable for the services being delivered. The trust operated 'hub and spoke' clinics for some specialties, and held satellite clinics in locations across the southeast region. This allowed patients who lived far away from the trust to benefit from the service's specialist skills and expertise closer to their home.
- **The service took account of patients' individual needs.** Staff acted to meet the needs of different patient groups so they could access the service on an equal basis to others. This included the needs of patients living with dementia, patients with learning disabilities, bariatric patients (those with a high body mass index) and patients unable to speak English. Staff 'went the extra mile' to meet the individual needs of patients and their loved ones. They helped relatives apply for charitable funding for accommodation nearby so they could spend more time visiting their loved ones. They allowed patients with learning disabilities to come into the ward the day before their operation so they could get to know the environment and the staff who would be caring for them. The service allowed carers of patients living with dementia or learning disabilities to stay overnight on the ward to provide comfort and support to the patient. The service had a dedicated burns flat to help patients make the adjustment from the burns unit to independent living.
- **The service treated concerns and complaints seriously and investigated them. They learned lessons from the results and shared these with all staff.** We saw examples of improvements following learning from complaints and patient feedback. Complaint responses we reviewed showed evidence of investigation, explanation, learning and apology.

However:

- **For some surgical specialties, people could not always access the service when they needed it.** The trust experienced a decline in referral to treatment performance in 2018. Between September 2017 and August 2018, referral times were better than the England average for the ophthalmology and ear, nose and throat specialties. They were worse than the England average for the plastic surgery and oral surgery specialties. In partnership with NHS Improvement's intensive support team, the trust reviewed their waiting list systems and processes. We saw initiatives and progress to improve patients' waiting times for operations. These included Saturday clinics, use of a locum breast consultant and the outsourcing of some operating lists to a local independent hospital. There was further work to reduce waiting lists by improving theatre efficiency and utilisation. In August 2018, the trust agreed a referral to treatment recovery action plan to reach performance compliance by September 2019. The department's performance against the plan reflected that from August 2018 to January 2019 (the most recent information available at the time of our visit), plastics remained on its trajectory against the plan.
- There were no wheelchair-accessible toilets in the Rowntree Theatre Unit, where patients attended for procedures such as minor skin excisions under local anaesthetic. This meant staff would need to transfer wheelchair-users to an accessible toilet elsewhere in the hospital.

Is the service well-led?

Good 

Surgery

Our rating of well-led stayed the same. We rated it as good because:

- **Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.** They were knowledgeable about the issues and priorities for the quality and sustainability of the service, understood the challenges and how to address them. All staff we met spoke positively about the leadership, both at local and executive level. They described leaders as being visible and approachable and supporting them to deliver the best possible patient experience.
- **The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups.** Staff we spoke with at different levels knew the strategic objectives for the service and how they contributed to them. The trust values were humanity, continuous improvement of care and pride, under-pinned by quality. Staff we spoke with described how they brought the values to life through their day-to-day work, such as the pride they took in the care they gave to patients.
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** All staff we spoke with were highly positive about the caring culture of the trust. Staff described the trust as a "fantastic place to work".
- **The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.** Governance meeting minutes we reviewed demonstrated staff reviewed governance and risk items including incidents, complaints, audit performance and learning to drive continuous improvement.
- **The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** Staff we spoke with understood the risks to the service, and we saw the service acted to reduce risks. Senior staff regularly reviewed risk registers and updated them with actions taken to reduce risks and any changes in risk ratings. The service monitored a range of performance and outcome measures each month. They acted to address performance that fell below targets, such as referral to treatment times.
- **The trust collected, analysed, managed and used information well.** Relevant information was displayed on notice boards within clinical areas. This included performance data such as safety thermometer data, staffing data and NHS Friends and Family recommendation rates. Staff spoke positively around recent improvements to IT systems, which included improvements in accessing laboratory results electronically. The service had processes for reviewing, managing and implementation of national patient safety alerts.
- **The trust engaged well with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations effectively.** The trust had several forums and groups that promoted staff engagement, both face-to-face and through newsletters and social media. The chief executive held regular staff forums, including breakfast meetings in the theatre department, which staff valued. The trust promoted staff wellbeing through mindfulness sessions and groups to support them with emotional eating and stopping smoking.
- **The service was committed to improving by learning from when things went well and when they went wrong, promoting training, research and innovation.** We saw examples of projects and changes to drive continuous improvement. A theatre safety improvement project had helped improve theatre safety culture, resulting in a reduction in the number of never events.

Outstanding practice

We found examples of outstanding practice in this service:

- We identified the dedicated burns rehabilitation flat as an area of outstanding practice for helping patients make the transition back to independent living following a burn injury.

Surgery

- We identified the person-centred culture and determination of staff to go “above and beyond” for their patients as an area of outstanding practice.
- We identified the trust’s support for staff wellbeing, with the provision of mindfulness sessions and a dedicated, psychological therapist-led support group for emotional eating, as an area of outstanding practice.

Areas for improvement

We found areas for improvement in this service.

- The trust should consider revising their burns admission criteria to ensure the service is consistent in only accepting patients with co-morbidities and total body surface area affected by burns that they can safety support on the Queen Victoria Hospital site.
- The trust should ensure products subject to Control of Substances Hazardous to Health (COSHH) regulations are stored securely at all times. The trust should consider carrying out audits or checks to gain ongoing assurances around the storage of COSHH products.
- The trust should continue working to improve referral to treatment times for surgical patients.
- The trust should work to improve mandatory training rates for medical and dental staff to meet the trust target of 95%.
- The trust should review the toilet facilities in the Rowntree Theatre Unit and consider whether the current facilities meet the needs of all patients attending the unit.

Critical care

Good 

Key facts and figures

The intensive, high dependency and step-down areas had been joined into one critical care unit (CCU), caring for level 1-3 patients and there was a maximum of five patient beds, admitting 20 to 30 patients per month. Over the past 12 months this unit had cared for 228 patients.

Level 1 patients are those at risk of their condition deteriorating, or recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.

Level 2 patients are those needing more detailed observation or intervention including support for a single body organ not working or post-operative care and those 'stepping down' from higher levels of care.

Level 3 patients are those that need a machine to breathe for them alone or monitoring and support for two or more organs not working. This level includes all complex patients requiring support for multi-organ failure.

This critical care unit had a two-bed bay and three individual rooms to care for up to five patients. The unit at the entrance had a large office and nurses' station to welcome patients and visitors. The critical care unit at the time of our last inspection had a shared management structure with the burns unit and the emergency care department. The unit at this inspection had been separated clinically and managerially from the burns unit and medical management was delivered by anaesthetic doctors and critical care consultants. The unit only cared for patients over 18 years old. The hospital's patients were admitted after referrals from other hospitals. The unit mostly cared for elective patients for maxillofacial post-operative care, but the unit did also care for emergency burns patients.

The trust had appointed three accredited intensivists since the last inspection to support anaesthetic consultants. On-site resident anaesthetic, plastic and maxillofacial consultant cover out of hours had increased since our last inspection. At the time of our last inspection there was one doctor that had to cover out of hours and was needed in multiple places at once including to work in theatre and to attend to unwell patients. This inspection there had been a change in policy to ensure that if the one doctor at night was needed in theatre then there would be another doctor that would be called in to cover the hospital.

We inspected the department over two days. During this inspection, we spoke with two patients, two relatives, 21 members of staff and reviewed six sets of patient records and seven medication charts. We also reviewed information from a range of sources, including information provided by the trust before, during and after the site visit.

Summary of this service

Our rating of this service improved. This was because the service had improved the medical cover and the governance structure. We rated it as good because:

- **The unit had a governance structure focused on critical care.** This monitored incident trends, unit performance, risks and managed improvement. This was an improvement from our last inspection.
- **The unit was visibly clean and infection control was a priority.** All staff complied with infection control policy. Cleaning records were clear and showed compliance with national standards.
- **Openness and transparency about safety was encouraged.** Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff felt supported when doing so.

Critical care

- **Staff managed medicines consistently and safely.** Medicines were stored correctly and disposed of safely. Staff kept accurate records of medicines. Medication charts were completed in line with national guidance with allergies clearly recorded and no missed doses. Microbiological samples were taken before administering antibiotic treatment.
- **People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.** This was monitored to ensure consistency of practice.
- **Feedback from patients we spoke with was always positive and praised staff's care and availability.** People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Patients relatives felt they were involved in the care process.
- **There was an audit program that covered many areas of practice in the critical care unit.** The unit looked for areas to improve. There was a positive culture to learning from things when they went wrong or went well. This included feedback from patients.
- **There was a new proactive leadership team which had the respect of their staff.** This team had created a positive culture but as they were new to the unit this was not yet embedded.
- The unit had managed to recruit more permanent and bank staff since our last inspection.
- **The unit had improved it's out of hours medical cover since our last inspection.** At the time of our last inspection there was one doctor that had to cover out of hours and was needed in multiple places at once including to work in theatre and to attend to unwell patients. This inspection there had been a change in policy to ensure that if the one doctor at night was needed in theatre then there would be another doctor that would be called in to cover the hospital.

However:

- Mandatory training figures submitted showed some of the trust targets were not being achieved, however the trust set a high target of 95% and these figures had improved when we visited the site on inspection.
- There was a departmental policy of not having more than 50% agency on any one shift which had been discussed and approved by senior clinical leads and the managers within the trust. This was a positive step, but was not in line with the 20% usage limit from the Guidelines for the Provision of Intensive Care Services, 2015.
- The unit was not fully meeting the Guidelines for the Provision of Intensive Care Services 2015 but had improved from the last inspection. The unit at our last inspection had no intensive care consultants but now had intensive care consultant cover Monday to Friday but still lacked this cover out of hours and at weekends.
- The unit did not take part in the Intensive Care National Audit and Research Centre which was a national audit program designed for critical care units. However, the unit did take part in the South East Coast Critical Care Network.

Is the service safe?

Good ↑

Our rating of safe improved. Medical staffing had improved at the unit since our last inspection. The unit had a positive culture of protecting patients through learning from incident reports and thorough risk assessment. We rated it as good because:

- **Cleaning, infection control and hygiene was understood by staff.** The unit was visibly clean and had processes in place to keep the unit clean. We also saw staff adhering to the bare below the elbow policy as well as using personal protective equipment correctly. The unit had hand hygiene audits that showed high rates of compliance.

Critical care

- **Equipment and the environment in the unit was suitable and kept people safe.** Most equipment was serviced yearly in accordance with the manufacturer's guidance. We saw that substances subject to Control of Substances Hazardous to Health regulations were stored securely. The resuscitation trolley for the critical care unit had a tamper evident seal, a log showing daily checks had been completed. The unit had clear segregation of clinical and non-clinical waste.
- **Risk to patients was identified and monitored.** The critical care outreach team was available 24 hours a day to support patients on the unit or on the wards. All patients were continually assessed with the revised National Early Warning System (NEWS2) in line with national guidance. NEWS2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, such as blood pressure and heart rate which were already recorded in routine practice. This scoring system was then used to identify deteriorating patients. We saw this in use in the critical care unit for three patients and was being recorded in line with national guidance. The clinical lead told us that they were now using the safety checklist for invasive procedures produced by the Intensive Care Society which are in line with national guidance.
- **Staffing levels and skill mix were planned, implemented and reviewed to keep people safe.** We saw staff had enough time to look after patients safely.
- **Staff had access to information they needed to assess, plan and deliver care, treatment and support to people in a timely way.** Records were accurate and kept up to date. Staff told us that they could always access information that they needed to care for patients. The critical care unit used a daily multidisciplinary record. This was used by medical staff, nursing staff and allied healthcare professionals. We reviewed six patient records and saw they were completed legibly in line with trust policy.
- **Staff managed medicines consistently and safely.** Medicines were stored correctly and disposed of safely. Staff kept accurate records of medicines. The seven medication charts we review were completed in line with national guidance. Controlled medicines were stored securely, and all cupboards clearly labelled. Records showed that nursing staff had completed all checks for controlled medicines in line with trust policy.
- **Managers encouraged openness and transparency about safety.** Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff felt supported when doing this. The matron of the critical care unit investigated incidents and we saw in the meeting minutes these were reviewed at the monthly meeting. We saw an incident report about a patient fall that had been investigated. We also saw that the learning had been shared via email and a notice board in the critical care office.
- The Patient Safety Thermometer data was displayed at the entrance to the unit for staff, visitors and patients to see.
- **Safeguarding of people at risk was understood by staff and management as a priority.** Staff could describe what they would do to protect patients from abuse. However, the trust was not meeting all its targets for training in safeguarding.

However:

- Mandatory training targets were not being met when the unit submitted their information. The trust set a high target of 95% completion and was only meeting one of these targets for nursing staff and no modules met this target for medical staff. However, nursing staff had seven modules between 80% to 96% and the remaining four modules were between 64% and 79%. Medical staffing had five modules between 80% to 90% and the remaining five modules were between 65% and 79%. There had been an improvement in the completion rates when we visited the unit.
- Although nursing staffing was in line with safe staffing levels, the service was using up to 50% agency staff on any one shift and the Guidelines for the Provision of Intensive Care Services 2015, recommends a maximum of 20% usage of

agency staff on any one shift. The service had regular agency staff that they used. Agency staff had an induction to the unit which included showing them how to access the unit's policies. The unit had managed over the year of 2018 to have at maximum an unfilled shift rate for registered nursing staff of 7% in one month with the other months being 4% or less of unfilled shifts.

Is the service effective?

Good ↑

Our rating of effective improved. The service had improved their pain management since the last time we inspected. The service had prompt cards based on the national guidance to act as a reminder for staff. We rated it as good because:

- **People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.** This was monitored to ensure consistency of practice. The critical care units had policies, protocols and care bundles that were in date and based on guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society. We saw the unit used a delirium scale in line with national guidance.
- **The service provided patients with enough food and drink.** The service put a priority on having high levels of nutritional support for patient. The unit had dietitian cover five days a week. The dietitian was present on the multidisciplinary ward round. The unit used the Malnutrition Universal Screening Tool to identify patients that needed extra help with nutrition. The unit had adapted this tool to identify more burns patients.
- **There was suitable process to monitor pain and given relief as needed.** We spoke to a patient and relatives; both agreed pain relief was given as needed. Care plans for dressing changes included a review of pain and the effectiveness of pain relief given.
- **The service monitored patient outcomes and had local audit programs.** The service did not participate in the Intensive Care National Audit Research Centre audit program. However, they did participate in the Southeast Critical Care Network.
- **The service made sure staff were competent for their roles.** Managers appraised most staff member's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Appraisal rate for nursing staff had improved to 86% in the last report it was 84%.
- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care. There was a multidisciplinary ward round that included the critical care consultant, a doctor from the surgical team, nurse in charge of critical care, dietician, physiotherapist, occupational therapist and the speech and language therapist.
- **Health promotion was provided to patients and staff.** Leaflets were available on conditions such as deep vein thrombosis. The service had support for those with alcohol dependency. Patients that required help to lose weight were identified and offered signposting to support available in the community by the dietician.
- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act (MCA) 2005.** They knew how to support patients experiencing a mental health condition and those who lacked the capacity to make decisions about their care. All staff described when they would use of the Mental Capacity Act and how to find the guidance on the unit's computer.

Critical care

Is the service caring?

Good ➔➔

We previously inspected, but had insufficient evidence to rate, caring. On this inspection, we rated it as good, because:

- **Feedback from patients we spoke with was always positive and praised staff's care and availability.** People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Patients' relatives felt they were involved in the care process.
- **Staff cared for patients with compassion.** We spoke to two patients, two visitors and saw eight compliment cards. Feedback from patients confirmed staff treated them well and with kindness. A compliment card we saw talked about the amazing care and this said, "fantastic team from consultants right down to domestic staff."
- **Staff provided emotional support to patients to minimise their distress.** We observed emotional support being given to a distressed patient. We also saw a compliment card that talked about the emotional support they were given for their emotional state. We saw one patient being offered colouring equipment to help their anxiety.
- **Staff involved patients and those close to them in decisions about their care and treatment.** Patients and visitors told us they felt well informed and included in the decision processes.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- **The trust planned and provided services in a way that met the needs of local people.** The unit worked with partner services to provide care. The unit had a specialist mental health nurse that assessed patients when the unit made a referral. The service was designed to have extra capacity in critical care to accept any emergency burns admission. This capacity could be used for other deteriorating patients.
- **The service took account of patients' individual needs.** The service had several options available to support people with communication difficulties. As the unit had many maxillofacial patients that would be awake but unable to talk, written communication was more significant to this unit. The service had small whiteboards that were given to patients to allow them to communicate by writing instead of talking. Patients with a risk of self-harm were risk assessed and when needed given constant supervision by a mental health nurse. They would provide assessment, guidance and support when needed.
- **People had access to the service when they needed it.** Waiting times for treatment and arrangements to admit, treat and discharge patients were in line with good practice. The unit had minimal delayed discharges, only six in four months. The unit also had only had ten operations that were delayed due to bed pressures. Bed pressures could be that the unit either did not have enough bed spaces or that the unit did not have enough staff to open more bed spaces.
- **The service treated concerns seriously, investigated them and learned lessons from the results, which were shared with all staff.** The service had no formal complaints from July 2017 to January 2019. The service had one informal complaint about food temperature that they had investigated, and learning had been shared. The service

sought patient feedback via a display that asked patients and visitors about comments or complaints which included paper complaint forms with a box for them to be posted into. The unit also asked patients to tell them comments about the service which were then displayed on a “you said” board along with a “we did” board that described what the service had done as a result of the comments from patients.

Is the service well-led?

Good ↑

Our rating of well-led improved. The unit had implemented an individual governances and leadership structure for the unit since the last time we inspected. There was a new proactive leadership team which had the respect of their staff. This team had created a positive culture but as they were new to the unit this was not yet imbedded. We rated it as good because:

- **The unit had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.** We saw leaders were visible and approachable. Staff told us they reported concerns to their leaders and felt supported by their leaders to do this. We saw successful strategies were in place to ensure and sustain delivery and development of the desired culture. The unit’s leadership team had recently been appointed.
- **The unit had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and key groups representing the local community.** Staff told us they were involved in creating the unit’s strategy and vision. There was a clear vision and set of values, with quality and sustainability as top priorities. Staff we spoke to understood the principles of these values and vision. The unit had a plan for the next five years to expand the service.
- **Managers promoted a positive culture that supported and valued staff.** This created a sense of common purpose based on shared values. All staff reported there was a warm and welcoming feeling to the unit’s team. Nursing staff, medical staff and support staff told us that all disciplines were included and valued. Leadership had organised a social group that included all members of staff and adapted to the needs of individuals within the team.
- **The unit used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.** The last time we inspected this service they did not have their own governance meetings. On this inspection the critical care service had monthly governance meetings. We saw in meeting minutes that critical care audits and mortality reviews were discussed at these meetings.
- **The unit had effective systems for identifying risks, planning to eliminate or reduce them.** The critical care unit had its own risk register and discussed this at their monthly governance meetings. There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. The unit’s pharmacist is responsible for the unit’s antimicrobial stewardship and is supported by a microbiologist one day a week.
- **The trust collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.** Performance issues were discussed at the monthly governance meetings. We saw the unit had a monthly newsletter that shared information with unit staff. This included information on training courses available and action that had been taken about the staffing shortage.
- **The unit engaged well with patients, staff and local organisations to plan and manage services, and collaborated with partner organisations effectively.** There was a service level agreement with another NHS trust to provide a range of support to the critical care unit. Staff told us about a wellness training course that was available to help train staff to cope with stress.

Critical care

- **The unit was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.** The leadership team for the unit had produced a list of improvements that were identified from our last report on the service and they had taken actions on these. This included simplifying their fluid charts to increase completion rates.

Outstanding practice

We found examples of outstanding practice in this service:

- The service had a positive culture that clearly supported staff and patients. The staff talked about the family atmosphere. The new leadership team had a positive impact on service improvements and were visible and available on the unit to provide support.
- The multi-disciplinary team worked together to support patients and ensured this continued after discharge from the unit back to a ward. We were told that everyone was included, and this was supported by all levels of staff. Patients, consultants, nurses, therapist and cleaners all reported feeling part of one team.
- The service had processes to identify and protect patients with mental health conditions. The service had an agreement in place with another NHS trust to provide them with registered mental health nurses when needed.

Areas for improvement

We found areas for improvement in this service:

- The service should continue to improve mandatory training completion, so they meet their targets and ensure all staff are always receiving training.
- The service should reduce their reliance and usage of agency nursing staff to meet with the Guidelines for the Provision of Intensive Care Services 2015, which recommends a maximum of 20% usage of agency staff on any one shift.
- The service should ensure medical staffing meets with the Guidelines for the Provision of Intensive Care Services 2015 by having intensive care consultant cover seven days a week.
- The service should participate in national audits to monitor and improve patient care.

Outpatients

Good 

Key facts and figures

The Queen Victoria Hospital is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the South of England.

The outpatient department supports the trust's surgical specialties of maxillofacial (mouth and face), plastic, burns and ophthalmic (eye) surgery for adults and children. They also have an outpatient department serving the sleep disorder centre, seeing a full range of respiratory and neurological sleep disorders.

Queen Victoria Hospital NHS Foundation Trust runs regular clinics in other specialties, including cardiology, rheumatology (disorders of joints muscles and ligaments), dermatology (disorders of the skin), ear nose & throat, urology (urinary disorders), care of the elderly and general paediatrics, staffed by consultants from other local teaching hospitals and district general hospital trusts.

Occupational therapy, physiotherapy, psychological therapy and rehabilitation teams run outpatient appointments that serve both regional surgery services and the needs of the local population.

The trust also holds a local GP rapid access clinic, alongside the minor injuries unit.

The trust outpatient department had 184,975 appointments from August 2017 to July 2018.

As part of our unannounced inspection we visited, ophthalmology and corneo-plastics outpatients; hand therapies department; burns and plastics; the sleep disorder unit; and maxillofacial clinics.

During our inspection we spoke with nine patients and two carers. We spoke with 19 members of staff including nurses, health care assistants, consultants, therapists, divisional leads and managers. We reviewed five patient records and one complaint record. We reviewed performance information about the department and the trust.

The service provided both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics were held Monday to Friday from 9am to 5pm with some additional clinics on a Saturday.

The last inspection rated the service as good overall. On this inspection we rated this service as good.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- **Staff understood how to protect patients from abuse.** Most of the staff had training in recognising the signs of abuse and how to apply their knowledge.
- **The service controlled infection risk well.** We observed staff following national guidance on infection control and prevention. For example, we observed staff decontaminating their hands immediately before and after every episode of direct contact or care.
- **Staff completed and updated risk assessments for each patient.** Safety huddles were held every morning in each outpatient department. All staff working in the outpatient clinics met at the same time every day to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.
- **The service had suitable premises and equipment and looked after them well.** The design, maintenance and use of facilities and equipment kept people safe. Equipment was maintained and monitored to ensure it was fit for use.

Outpatients

- **Staff kept detailed records of patients' care and treatment.** People's individual care records, **including** clinical data was written, stored and managed in a way that kept people safe.
- **The service followed best practice when prescribing, giving, recording and storing medicines.** Medicines in outpatients were managed safely and stored in a lockable cupboard.
- **The department provided care and treatment based on national guidance.** Speciality clinics operating within the outpatient department followed relevant national guidance and participated in national and local audits.
- **The service made sure staff were competent for their roles.** The trust figures showed below target figures, however; compliance for appraisal rates exceeded the trust target in the departments we visited.
- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- **Staff cared for patients with compassion.** People were treated with compassion, kindness, dignity and respect, when receiving care. Staff communicated with people in a way that supported them to understand their care and treatment.
- The **department** was clearly signposted and we observed staff helping to direct patients to where they needed to go. We observed staff interacting with patients in a way that was supportive and helpful.
- **Advice** and guidance for non-urgent GPs referrals were in place, this allowed GPs access to consultant advice prior to referring patients into specialist clinics.
- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.** There was evidence of learning and improvement from complaints, but response times were not in line with the trust policy.
- **Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.** There was a trust wide vision for 'delivering excellence' and a strategy detailing 'outstanding patient experience, world class clinical service, operational excellence, financial sustainability and organisational excellence'. All departments we visited were aware of the vision and were committed to achieving it.
- The **trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.** Data security standards were being implemented by the trust which underpinned its cyber security strategy in 2017/18. They achieved the Cyber Essentials accreditation in February 2018 and Cyber Essentials Plus in March 2018.
- The Compliance in Practice inspection process as a quality improvement initiative was being used by the trust.
- The trust had an onsite psychological therapies team who supported patients and staff who were experiencing mental health or emotional difficulties.Access to the team was reported to be timely and efficient.
- The sleep disorder centre was one of the six largest centres in the UK, it admitted up to 42 patients for inpatient studies in a week, there were 15 outpatient clinics per week, and day case admissions for therapy each weekday.

However:

- Resuscitation equipment within the plastic and burns department and maxillofacial department was subject to daily and weekly checks but there were some gaps in the recording of these.
- Complaint response time was not in line with the trust policy of 30 days.

Outpatients

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so**. Most staff had training in recognising the signs of abuse and how to apply their knowledge.
- **The service controlled infection risk well.** Standards of cleanliness across the department were maintained, with systems to prevent healthcare associated infections. Staff kept the environment, premises visibly clean. Staff followed national guidance on infection control. We observed staff decontaminating their hands immediately before and after every episode of direct contact or care.
- **The service had suitable premises and equipment and looked after them well.** To monitor cleaning standards the domestic supervisor completed between 12 and15 cleanliness audits weekly. If areas were not to a satisfactory standard immediate action was taken.
- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.** Safety huddles were held every morning in each outpatient department. All staff working in the outpatient clinics met at the same time every day to discuss current safety issues relating to the premises, patient care and other relevant issues that could impact on patient safety.
- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care**. People's individual care records, including clinical data was written, stored and managed in a way that kept people safe.
- **The service followed best practice when prescribing, giving, recording and storing medicines.** Medicines' in outpatients were managed safely. Medicines were kept in a locked cupboard in a treatment room which was locked when not in use.
- **The service managed patient safety incidents well.** Lessons were learned and improvements made when things went wrong. Staff understood their responsibilities to raise concerns, record safety incidents and report them internally and externally.

However:

- Resuscitation equipment within the plastic and burns department and maxillofacial department were not checked daily and weekly in line with the policy.

Is the service effective?

We inspected, but did not rate:

- The **service provided care and treatment based on national guidance and evidence of its effectiveness.** The department provided care and treatment based on national guidance. Speciality clinics operating within the outpatient department followed relevant national guidance and participated in national and local audits.
- The **service made sure staff were competent for their roles.** Staff that were new to the department had an appropriate induction and appraisal completion rates within outpatient department was high. All staff were supported to develop in their chosen speciality and received many opportunities to learn in the clinical environment. We saw examples of learning logs, competencies were assessed in line with best practice and national guidelines.

Outpatients

- **Staff gave patients enough food and drink.** To meet their needs whilst in the outpatient department.
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** Outpatient services had processes to record patient outcomes after each clinic appointment. The service used an outcome form which medical and clinical staff completed at the end of each appointment.
- Therapy services used a range of validated measures for before and after treatment to monitor the effectiveness of the therapy services.
- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** Staff we spoke with understood their roles and responsibilities regarding the Mental Capacity Act 2005 and received training, however the trust target was not met.
- The sleep disorder units clinical lead was an elected member of the Committee of the British Sleep Society and was actively engaged in developing an accreditation process for sleep centres in the UK, in conjunction with the European Sleep Research Society.
- The trust developed innovations and improvements to screening tests in the world of facial paralysis care.
- The trust was the main centre for reinnervating the cornea in the United Kingdom and Europe. Corneal neurotisation was a revolutionary sight-saving procedure which restores sensation to the cornea by using nerve grafts.
- Electrochemotherapy treatment had been available at the trust since summer 2017 for head and neck, skin and breast cancer patients. National Institute for Health and Care Excellence (NICE) approved this treatment, it is combined with a low dose chemotherapy drug and an electrical pulse applied directly to the cancer cells. The treatment allowed more of the cancer drug to enter the cells with a dramatic increase of its effectiveness.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- **Staff cared for patients with compassion.** People were continuously treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service and those who were close to them was positive about the way staff treated people.
- Patients told us staff were continually positive about the way they treat people and expressed that staff go the extra mile to support their needs. For example, one patient was unexpectedly admitted to the ward, staff ensured their relative was kept informed, they were offered food and drink then staff arranged transport home for the relative as they were unable to do this themselves.
- Staff interacted with patients and those close to them in a respectful and considerate manner. Patients throughout all outpatient areas consistently reported that staff were kind and respectful and that the service offered was exceptional.
- **Staff provided emotional support to patients to minimise their distress.** Patients were always given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Staff communicated well with patients so they understood their care, treatment and condition.
- We were continually told by patients they were active partners in their care, staff were committed to working in partnership with them and those close to them which made them feel really cared for and their individual preferences were always considered and discussed in the delivery of their care.

Outpatients

- Staff demonstrated the need to respond in a compassionate, timely and appropriate way to people's experience of physical pain, discomfort or emotional distress. Patients told us that their emotional health was considered by staff as important as their physical health. Staff we spoke with demonstrated an exceptional understanding of the need to assess and support patients from a psychological and social perspective as well as a physical one.
- Psychological therapy services were available on site which all staff we spoke to knew how to refer patients. Staff told us they could also access this service should they require psychological support.
- **Staff involved patients and those close to them in decisions about their care and treatment.** Patients' we spoke with told us they felt involved in their treatment and care. They told us that clinical staff were open in their approach and that information was readily available, both verbally and in written formats to help them understand their condition and treatment plans, 'nothing was too much trouble'.
- Patients consistently told us, they always felt fully involved in their care and felt fully informed about their diagnosis and managing risks. Staff supported carers and loved ones to assist the patient with appropriate care to support and enable independence.
- Patients relatives told us they were 'overwhelmed' with the 'kindness and inclusion' they felt being involved with the treatment for their relative received. We were told: 'At all times I felt I could ask any question and it was not too much trouble.'
- Staff said there was an open-door policy for carers and encouraged their participation in the care and support of their loved ones.
- Patients were asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. Test results for outpatients was 95% which was better than the England average of 94%.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

- **The trust planned and provided services in a way that met the needs of local people.** Staff told us patients living with dementia had access to the butterfly scheme. A sticker was put on the patients notes to alert the staff that the patient may require support. Outpatient department staff had received training for this.
- **The service took account of patients' individual needs.** Booklets were devised and improved for patients who were visually impaired by staff in the corneo-plastics department. It was printed in larger text and fully detailed all procedures that took place, there was the option to have even larger print if required. The team also developed a patient helpline within clinic hours from Monday to Friday, from 9am to 5pm to assist with patient queries. Out of hours, the helpline was supported by the inpatient ward area to assist with patient queries. If it was urgent then patients would be seen that day.
- Bariatric (patients with a high body mass index) equipment was available; beds, chairs and sofas. Staff told us they could access equipment from other departments as well if needed. Wheelchairs were available in the main corridor, near the entrance from the visitor car park. If none were available, a member of staff would assist in obtaining one.
- The learning disability nurse was accessible to all staff within the trust. Staff would contact the nurse for advice and input when required.
- The department was clearly signposted and we observed staff helping to direct patients to where they needed to go. We observed staff interacting with patients in a way that was supportive and helpful.

Outpatients

- There were notice boards in clinic waiting areas advising who the relevant nurse and healthcare assistant attached to that clinic was. Staff also monitored the wait times and informed the patients if the clinic was running late.
- Four specialties were better than the England average waiting time for non-admitted pathways (waiting to start treatment which does not involve admission to hospital). Five specialties were better than the England average waiting time for incomplete pathways (patients who have been referred but treatment had not yet started).
- The 'did not attend' rate was similar to the England average. Waiting times are recoded centrally so patients can compare hospitals across the country.
- From 1 October 2018 all outpatient referrals nationally were to be received via the NHS e-Referral System. Senior staff told us they had worked with clinical commissioning groups to improve the uptake of e-referrals, the trust reported it was working well.
- Advice and guidance services for non-urgent GP referrals were in place, this allowed GPs access to consultant advice prior to referring patients into specialist burns care, general plastic surgery, head and neck surgery, maxillofacial surgery, corneo-plastic surgery and community services.
- An agreed plan with support from external agencies to eliminate 52 week waits and reach performance compliance was agreed and was on track to be achieved, we have reviewed the trajectory which supported this. The referral to treatment plan was implemented in August 2018 which included extra theatre lists, virtual clinics and recruitment incentives.
- The trust told us they had weekly patient tracking list meetings and reviewed every patient on the list. They had accommodated extra clinics and developed spoke clinics in surrounding areas and were meeting weekly with commissioners.
- We saw the trust had a comprehensive recovery plan, was completing actions on the recovery plan and was on trajectory for meeting its waiting time targets.
- The trust had undertaken harm reviews of patients who had not received treatment within national guidelines. These reviews had shown no patient had experienced physical harm.
- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.** Between July 2017 and June 2018 there were 20 complaints about outpatients at Queen Victoria hospital. All complaints were responded to and outcomes shared with staff when relevant.

However:

- **The service was not meeting all of its 18-week referral to treatment and the cancer targets. The trust had systems and an action plan to rectify the backlog of referrals.** The trust had sought advice and support from external agencies to ensure the plan was achievable and sustainable. The trust had undertaken harm reviews of patients who had not received treatment within national guidelines. These reviews had shown no patient had experienced physical harm although the trust acknowledged that patients may have experienced emotional distress. The trust was meeting their trajectory to address the waiting times.
- Five specialties were below the England average for non-admitted pathways (no admission to hospital/day cases) for referral to treatment times.
- Plastic surgery department, sleep disorder unit and ophthalmology appointment cancellations by the hospital within seven days varied in the reporting period, none met their target. On the day cancellations by the hospital had stayed the same for a period, but failed to reach their target.
- The trust took an average of 39 working days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be completed in 30 working days.

Outpatients

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good because:

- **Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.** The outpatient services had the leadership capacity and capability to deliver high-quality, sustainable care. Leaders had the skills, knowledge, experience and integrity needed and there were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.
- Staff told us the chief executive talked openly and the leadership team were visible and approachable.
- **The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.** There was a trust wide vision for 'delivering excellence and a strategy detailing 'outstanding patient experience, world class clinical service, operational excellence, financial sustainability and organisational excellence. Staff were aware and committed to achieving it.
- **Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** Staff told us there was an open and honest culture and were aware how to raise concerns in the workplace but staff we spoke with reported there were not any.
- **The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.** Information governance toolkit assessments were completed, overall score for 2017/18 for the trust was 79% and was graded as satisfactory.
- **The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.** The trust had systems and processes to engage with patients, staff, the public and local organisations to plan and manage services. Patients had been involved in service improvement activities within the department.
- **The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.** The trust began implementing data security standards that underpinned its cyber security strategy in 2017/18. They achieved the Cyber Essentials Accreditation in February 2018 and Cyber Essentials Plus in March 2018.
- **The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.** Maxillofacial was currently the lead for many evidenced based research projects and the lead site for the national portfolio artificial eye study. The study was collecting nationwide data on artificial eye patients via a questionnaire covering patient's cleaning regimes, the presence of any deposit/discharge for ocular prostheses, overall experience of ocular rehabilitation treatment and quality of life after eye loss.
- **The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** The trust reported to have used the Compliance in Practice inspection process as a quality improvement initiative. Newly devised action plans were completed by department leads following each 'inspection' to remedy any areas of poor performance or inconsistencies identified.

Outpatients

Outstanding practice

We found areas of outstanding practice in this service.

- Information booklets were devised for new patients by staff in the corneo-plastics department. It was printed in larger print and fully detailed all procedures that took place, there was the option to have even larger print if required. The team also developed a patient helpline within clinic hours from Monday to Friday, from 9am to 5pm to assist with patient queries. Out of hours, the helpline was supported by the inpatient ward area to assist with patient queries. If it was urgent then patients would be seen that day.
- The trust developed innovations and improvements to screening tests in the world of facial paralysis care.
- The principal maxillofacial prosthetist, which is a person skilled in making or fitting prosthetic devices, had set up a national study to examine the quality of care delivered to those patients who use prosthetic eyes. External funding was obtained for this study. It had been adopted onto the national portfolio. So far 472 patients have joined nationally. In recognition of this, the principal maxillofacial prosthetist received the 'Rising Star' award from the Comprehensive Research Network in February 2018.
- Improving learning opportunities had been a focus for the trust. Nurse associates were now in post and reported it to be a supportive and positive learning experience.
- The trust was the main centre for reinnervating the cornea in the United Kingdom and Europe. Corneal neurotisation was a revolutionary sight-saving procedure which restores sensation to the cornea by using nerve grafts.
- The sleep disorder units clinical lead was an elected member of the Committee of the British Sleep Society and was actively engaged in developing an accreditation process for sleep centres in the UK, in conjunction with the European Sleep Research Society.

Areas for improvement

We found areas for improvement the trust should do;

- The trust should ensure they identify issues preventing the regular checks of emergency equipment and act to address this.
- The trust should ensure they continue to improve the waiting list times to meet the 18-week target.
- The trust should ensure they improve Mental Capacity Act training compliance to meet trust target.
- The trust should ensure they identify factors which affect the response time to complaints and improve the process.

Our inspection team

Catherine Campbell, head of hospitals inspection south east, chaired this inspection and Sarah Ivory-Donnelly, inspection manager led it. An executive reviewer, Garry Marsh, Executive Director of Patient Services and Directors of Infection Prevention and Control, supported our inspection of well-led for the trust overall.

The team included two further inspection managers, eight inspectors, one assistant inspector and eight specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**108-19**	
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 Board is requested to note the Corporate Risk Register information and the progress from the previous report. There were two key changes to the CRR this period: ➢ One new risk added ➢ One risk decreased in score from 12 to 9				
Recommendation:	The Board is asked to note the Corporate Risk Register information and the progress from the previous report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	The entire BAF has been reviewed by EMT together with the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	The Corporate Risk Register is considered monthly by the Executive Management Team				
	Date:	10.6.19	Decision:	Reviewed and updated	
Previously considered by:	The Corporate Risk Register is reviewed by the Quality and governance committee				
	Date:	19.6.19	Decision:	Noted	
Next steps:	NA				

Corporate Risk Register Report
April and May 2019 Data

Key updates:

Corporate Risks added between 01/04/2019 and 31/05/2019: 1

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1143	Reduced numbers of Corneo Fellows: Unfilled corneo fellow positions leading to increasing patient waiting time and cancelled appointments	R/V with Exec Lead and BU Manager

Corporate Risks rescored this period: 1

Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
1126	Recruitment and workforce team constraints and limitations	4x3=12	**3x3=9**	Recruitment manager post agreed on a permanent basis.	R/V by Risk owner

No Corporate Risks were 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 83 risks currently on the Trust Risk Register as at 10th June 2019, of which 15 are Corporate, with the following modifications occurring during this reporting period (April / May):

- 1 new risks added: corporate
- 12 risks closed: all local
- 1 Risk scores decreased to 9 and Risk added to local 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, 1133**	**0**
Likely	**0**	**0**	**6** **ID: 1040, 1094, 1116, 1117, 1122, 1139**	**3** **ID: 1035, 1136 1077,**	**0**
Certain	**0**	**0**	**1** **ID1143**	**1** **ID: 1125,**	**1** **ID: 877**

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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
1143	15/04/2019	Reduced numbers of Corneo Fellows	Unfilled fellow positions leading to increasing patient waiting time and cancelled appointments	1 locum for general work; specialty-specific locum fellows not available on short contracts□ X3 adverts to fill positions - unsuccessful□ In process of recruiting additional locum to cover gaps	Abigail Jago	Georgina Baidya	Patient Safety	15	6			KS05
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		May update: discussions with BSUH ongoing □ 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
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	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□ Loss of long established staff	1. Pharmacy clerk on bank and working part-time. □ 2. Two locum pharmacists covering band 7 and band 8a posts □ 3. Some part-time staff willing to work additional hours at plain rate.□ 4. Locum technician helping to cover pharmacist sickness with audits and back log of work.□ 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	Staff member of reduced hours following long term sickness. Being monitored. Some hours covered by locum technician Recruitment underway for all posts - 1 out to advert, 1 JD being reviewed prior, 1 due to start July 19 Planing for maternity leave - 1 post covered. other post covered by badn 7 locum, advertised second time	19/5/19 Recruitment still underway for all posts but at varying stages. 2 further resignations. Pharmacy clerk already left as on 1 month notice. High number of new and locum staff requiring greater supervision. Apprenticeship for band 2 assistants requires 10% off the job training. □ □ 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
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		5/4/19: R/V with Exec Lead - capacity planning complete; activity to deliver 2019/20 plan has been signed off with Commissioners and on track with revised trajectory□ 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
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		May update: PoaP submitted to EMT - further information requested□ 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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
1117	26/06/2018	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		May 2019 Currently working with JAC to upgrade Pharmacy IT system. FMD software still in testing so a further will upgrade will be needed at at later date once working fully.□ March 2019: Reviewed at the Clinical Support Services Governance meeting (19/03/2019) - □ Software currently not available, this is an issue for all Trusts nationally: work underway externally to devise programme, will not be before December 2019□ 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)□ □ □ Potential candidate: Awaiting GMC Number: 16/4/19: SA	Dr Edward Pickles	Sue Aston	Patient Safety	12	4		15th May: Sleep Operational meeting 13th May: Discussion regarding delay in recruiting current applicant - delay in obtaining GMC number. Plan to re-advertise, discussion regarding requirement for the service- Respiratory Consultant to be confirmed. Revised POAP for Locum to be submitted today. Shifts are being covered with substantive and regular experienced Sleep Consultant locums are employed to ensure service delivery and standards are being met. RTT/activity maintained above 92%.□ 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:	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
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.	15/05/2019 - Vacancy rate has improved to 4.55 WTE. 2 international nurses due at end of May which will reduce our vacancy to 2.55.□ 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.□	KSO1 KSO2
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.□ 8. SA: Action to improve recruitment time frame to reduce avoidable delays	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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
1059	22/06/2017	Remote site: Lack of co-location with support services for specific services	Lack of co-location with clinical specialities & facilities which may be required to manage complications of procdures undertaken at QVH	SLA with BSUH re: CT scanning, acute medical care, paediatric care and advice□ Guidelines re: pre-assessment & admission criteria, to QVH□ Skilled and competent medical and nursing staff with mandatory training focused on QVH specific risks□ Clinical governance oversight of scope of practice at QVH	Dr Edward Pickles	Dr Edward Pickles	Patient Safety	12	10	Actions to date PEG service review	May 2019 update: CT scanning services working well; exploring out of hours provision going forward. MoU discussion with BSUH continue□ 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	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	KSO1 KSO2 KSO3

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
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	Jo Thomas	Nicola Reeves	Patient Safety	16	9	Actions update	May update: staff nurse vacancy rates: Senior S/N 26% S/N vacancy rate now 38% and x1 WTE international RN joining team April update: Senior staff nurse and staff nurse vacancy rates: Senior Staff nurse = 36%: 1 WTE started 1st April and a 0.61 WTE will be starting on 29th April Staff nurse = 51%: 1 WTE started on 18th March March update: staff member commencing ITU course Sept February 18th:vacancy rate 34% - registered and unregistered. Additional substantive staff due to start in April 2019. January 2019: • Increase in staffing moving from agency to bank	KSO1 KSO2
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	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.	May update: presented to Board - discussions with Burns Network and Commissioners held March 11th update: Paeds BC discussed at private board - formal decision awaited from BSUH 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 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	KSO2 KSO3 KSO5

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
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	May 2019 2019/20 Operating plan resubmitted £7.4m - approved by Board. Key changes - NHSI agreed to rescind £0.8m of fines;Additional £0.6m of cip challenge included; further cost pressures £0.2m pril 2019 2019/20 Final Operating Plan plan submitted £8.6m deficit. larch 2019 NHSI review of Draft operating plan £8.6m deficit with Trust senior executives. ebruary 2019 2019/20 Draft Operating plan submitted £8.6m deficit. anuary 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 /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:	**19/06/2019**		**Agenda reference:**	**109-19**	
Report title:	Quality & safety report				
Sponsor:	Jo Thomas, Director of Nursing and Quality Ed Pickles, Medical Director				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	1. Nursing 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 Board's attention should be drawn to the following key areas detailed in the reports: • The Trust's overall CQC inspection rating of 'Good' and 'Outstanding' for care • CQC actions for improvement to be taken forward • South East Critical Care Network's (SECCN) visit to Critical Care and the improvements seen since their last visit				
Recommendation:	The Board is asked to **NOTE** 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 KSOs 1 and 2; elements of KSOs 3 and 5 also impact on this.				
Corporate risk register:	CRR is reviewed as part of the report compilation; 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:	Nil				
Assurance route					
Previously considered by:	Quality and governance committee				
	Date:	21/06/19	Decision:	Noted	
Next steps:	NA				

Executive Summary - Quality and Safety Report, July 2019

Domain	Highlights
Director of Nursing and Quality	The Trust had its Care Quality Commission (CQC) inspection from the 29th January 2019 - 27th February 2019 and the inspection report published 23 May 2019 saw the trust retain 'Good' overall with 'Outstanding' patient care. Inspectors noted that staff were highly motivated and inspired to offer care that was exceptionally kind and promoted people's dignity; relationships between patients and staff were strong, caring, respectful and supportive. QVH works hard to promote and maintain this standard of care and our staff are rightly proud of the way they genuinely go above and beyond for patients. The Trust was appreciative of the feedback on managers promoting a positive culture that supports and values staff, creating a sense of common purpose based on shared values. Our staff make QVH a very special place to work with high quality services, innovation and partnership working. Our staff are passionate about their work and further improving our services for patients. The Trust also received in May the South East Critical Care Network (SECCN) report from the 17 April review meeting. The visit consisted of face to face meetings with critical care leads and staff and a detailed gap analysis using the SECCN service specification tool. The summary of this visit concluded; 'The progressive and outward looking attitude to critical care, with acknowledgement of immediate and future challenges, but with an evident resolve to identify and create opportunity. SECCN noted the range of mitigations in place to care for the case mix and make appropriate clinical decisions as to whether a patient can be safely managed at the trust or not.' It is pleasing to see the recognition in both these independent reports of the clinical leadership and quality improvements in the critical service.

Medical Director	Discussions around networked care between BSUH, QVH, WSHT and ESHT continue. The job plans for three new posts for networked Oral and Maxillofacial Surgery have been finalised, providing an on-call rota to the Major Trauma Centre (MTC) at Royal Sussex County Hospital, and orthognathic, head and neck cancer and trauma surgery to the Sussex area. The discussions regarding improved plastic surgery for trauma support to the MTC have progressed and a new proposal is in development. This may require significant investment from both trusts. The immediate risk regarding lower limb orthoplastic surgery remains unchanged. (CRR 1139), and a small number of cases are being referred from BSUH to other orthoplastic centres. We plan to commence a diversion of KSS paediatric burn and scald referrals, which require inpatient care, to burn centres at Chelsea and Westminster and Chelmsford from 1st August 2019. This has network and commissioner support. The formation of the Sussex Acute Collaboration Network will develop further work streams around dermatology and head and neck (including ENT). Draft terms of reference and governance structure have been developed and will be finalised at the next meeting on the 3rd July. The STP clinical and professional cabinet continue to develop the vision and clinical strategy. A new 'Prevention Board' is being created to address the prevention priority bourne of the Case for Change.

Executive Summary - Care Quality Commission (CQC) inspection

QVH had its Care Quality Commission (CQC) inspection from the 29th January 2019 - 27th February 2019 and the Trust achieved 'Good' overall with 'Outstanding' patient care. Of particular note was the improvement of critical care to 'Good' for all five domains and 18 citations of outstanding practice across all services inspected.

Ratings for Queen Victoria Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019	Good May 2019	Good May 2019
Critical care	Good ↑ May 2019	Good ↑ May 2019	Good May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019
Services for children and young people	Good Apr 2016	Good Apr 2016	Outstanding Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Outpatients	Good →← May 2019	Not rated	Outstanding ↑ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Minor injuries unit	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
Overall*	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Report by Exception - Key Messages

Domain	Issue raised	Action taken
Safe: clinical harm reviews	Clinical Harm Review meetings: Trust continues to reduce 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 Face (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 440 reviews have been undertaken. There have been 26 patients under surveillance in plastics and 14 in MaxFax all no harm identified. There is one case in plastics currently under surveillance with surgery planned for the end of June. Monthly CHR assurance meetings are to be arranged from April between the Head of Risk and Patient Safety and the Clinical Commissioning Group.
Safe: Datix	**What we expect**- fit for purpose system for staff reporting: upgraded to Version 14 in January 2019	The Risk and Patient Safety Team added improved functions, including: -Data cleansed categories and sub categories to enable improved report statistics - Added mandatory field to capture reason for delayed reporting (identified as recommendation from Internal Audit) - Included bespoke fields for some specialties, including reason for unexpected admission to CCU = 'Clinical' or 'logistical' - Improved page at log-in for staff to have full sight of all their outstanding Datix' Work will continue with staff being supported to complete timely, meaningful investigations with appropriate learning identified.

Responsive: patient leaflets	**What we expect** – Patient information to be available in an evidence based, up to date, easy to understand format.	The Trust undertook a review of all patient leaflets to ensure all leaflets which has surpassed their review were taken out of circulation and new streamlined processes implemented to ensure that clinical staff are able to review and gain approval for all leaflets approaching review in a more timely manner. A draft format of standardised leaflet format approved by the Patient Experience Group and will be presented to the Clinical Governance Group in July 2019 for approval. This new format will include more accessible guidelines and submission form which seeks to reduce the timeframe for leaflet approval. All leaflets will now have risks quantified and content guidance to ensure standardisation across the Trust. The approving Patient Information Group is currently a virtual group which will be re-established into a face-to-face meeting to aid approval timescales and the resolution of queries. A patient representative will also become a member of the Group.

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			Quarter 1 2019/20		12 month total/ rolling average
		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Infection Control														
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	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%	97%	98%	97%	98%	99%	96%	96%	97%	97%	94%	95%	97%
MRSA screening - trauma	>95%	97%	96%	95%	96%	95%	96%	95%	96%	96%	96%	98%	94%	96%
Incidents														
Never Events	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Serious Incidents	0	0	0	1	0	0	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	5	5	5	4	8	3	2	1	1	4	0	1	36
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	0	0	1	0	0	0	0	0	0	0	0	1
WHO quantitative compliance		98%	98%	98%	99%	99%	98%	99%	98%	99%	99%	99%	99%	99%
Non-clinical cancellations on the day		18	9	6	7	22	14	18	22	22	11	19	17	185
Needlestick injuries						4	2	1	1	3	3	2	0	16
Pressure ulcers (all grades)						1	0	0	1	0	0	1	0	3
Paediatric transfers out (<18 years)			0	0	0	0	2	0	1	0	1	2	0	3
Medication errors														
Total number of incidents involving drug / prescribing errors		7	8	8	7	16	13	9	7	16	10	7	8	116
No & Low harm incidents involving drug / prescribing errors		7	8	8	7	16	13	9	7	16	10	7	8	116
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		0.6	1.2	1.2	0.6	2.2	2.2	0	0.5	1.1	1.2	0.6	0.5	1.0
Harm free care rate (QVH)	>95%	97%	98%	100%	93%	100%	100%	100%	96%	97%	100%	97%	100%	98.2%
Harm free care rate (NATIONAL benchmark) - one month delay	>95%	94.1%	94.1%	93.9%	94.3%	94.1%	94.3%	94.3%	93.8%	93.8%	93.9%	93.8%	93.8%	94%
Pressure Ulcers														
Hospital acquired - category 2 or above	15	0	1	0	0	0	1	0	1	0	0	0	0	3
VTE initial assessment (Safety Thermometer)	>95%	97.1%	88.1%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	93.0%	100.0%	97.9%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	>95%	100%	95%	98%	100%	97%	100%	100%	100%	89%	100%	100%	92%	98.0%
Patient Falls resulting in no or low harm (inpatients)		4	2	3	3	4	5	2	3	3	2	0	2	33
Patient Falls resulting in moderate or severe harm or death (inpatients)		0	0	0	0	0	0	0	0	0	0	0	0	0
Patient falls per 1000 bed days		3.31	1.61	2.6	2.62	3.05	3.79	2.11	3.03	2.97	1.82	0	1.69	2.60

Safe - South East Critical Care Network (SECCN) Report

The South East Critical Care Network (SECCN) visited the Trust's Critical Care Unit on 17th April 2019. This meeting focussed on progress made since their last visit as well as current challenges faced by the unit and possible avenues for SECCN support.

A progressive and outward looking attitude to Critical Care, with acknowledgement of immediate and future challenges, but with an evident resolve to identify and create opportunity.

The Critical Care medical workforce has been strengthened by the addition of a Faculty of Intensive Care Medicine (FICM) accredited Intensivist and the nursing workforce bolstered by a proactive recruitment and retention strategy. Links with neighbouring trusts could be strengthened and QVH are actively seeking to do so. An improved governance structure is being set up with increased MDT engagement in M & M review.

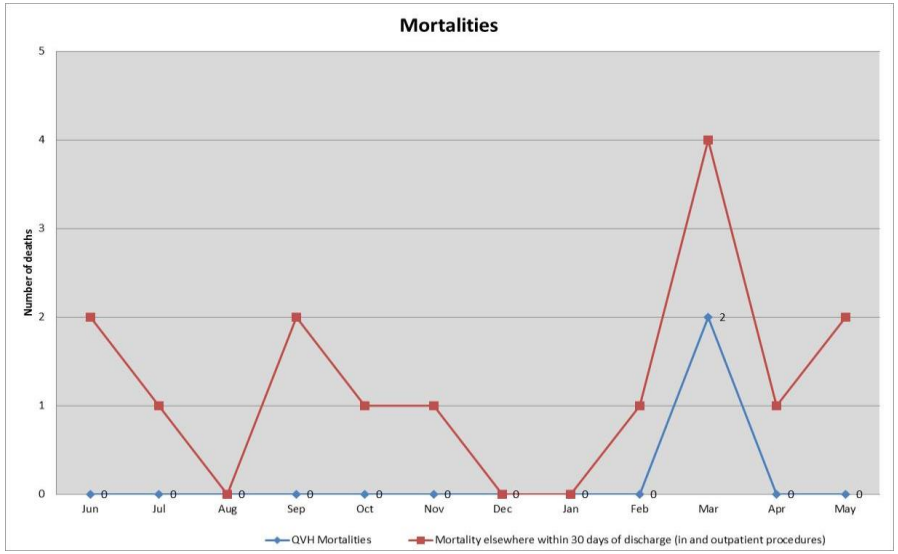
QVH Critical Care has assessed compliance against standards in both SECCN service specification tool and GPICS. Based on the assessment, a comprehensive plan of action for standards open to improvement through Critical Care or Trust measures would be extremely beneficial. Standards that are not met and are not likely to be met without wider commissioning and strategic engagement need to be identified and due ownership of the necessary actions agreed.

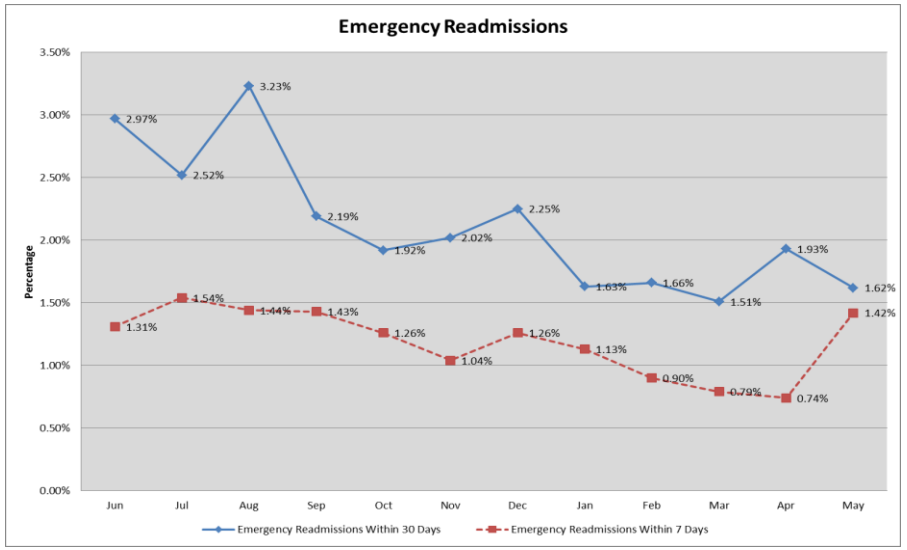
The inability of QVH to provide dedicated Intensivist cover for Critical Care is determined by the small unit size. It is hard to see how a large pool of intensivists could maintain a meaningful level of exposure to Critical Care that could justify ICM accreditation and the recruitment of Anaesthetists with experience of ICM is sensible. Nonetheless, the ability to care safely for a very sick patient is a fundamental principle of Critical Care and it is important that QVH can demonstrate this. Equally important is assurance that safe management is reproducible whatever day of the week or staff in attendance. Robust protocol must stipulate clinical procedure, a formalised communication strategy that does not depend on good will and uncertain availability and a clear process of escalation. SECCN found no evidence to suggest poor performance or patient outcome and QVH must take active steps to safeguard this.

Repeating SECCN advice from the previous assurance visit, the inability to meet a portfolio of national standards does not prohibit the delivery of critical care but does necessitate discussion with commissioners about expectations of care delivery and future commissioning intentions and it is recognised that any Trust discussion concerning future Critical Care services has to include commissioning colleagues.

To take this work forwards the trust has writing to NHS England Specialist commissioner sharing the report and requesting to set a term of reference for review of commissioning intentions for critical care within the Trust.

Effective - Performance Indicators





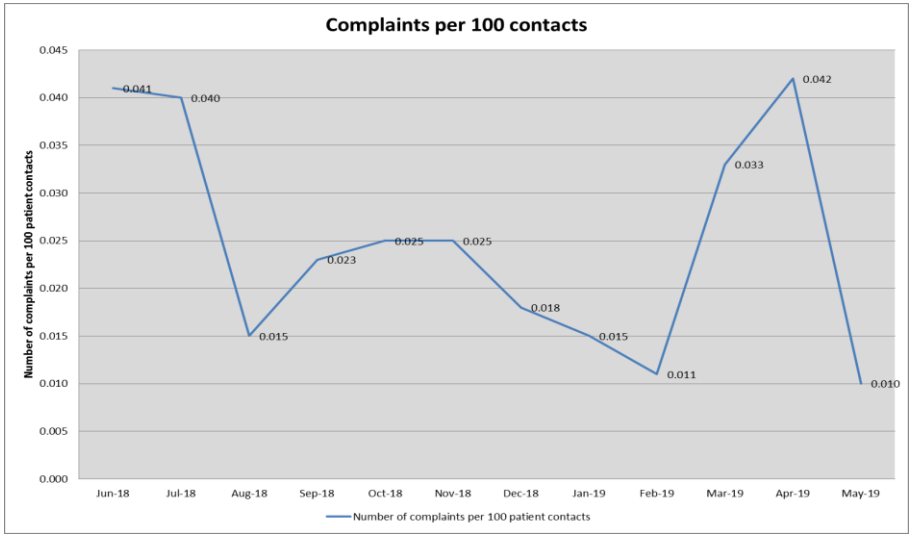
	Quarter 2 2018/19		Quarter 3			Quarter 4			Quarter 1 2019/20	
	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Number of deaths on QVH site	0	0	0	0	1	0	1	2	0	0
Number of deaths off- site within 30 days of IP or OP procedure	0	2	0	2	2	0	0	2	1	2
No of completed preliminary reviews	0	2	0	2	1	0	1	2	0*	0*
No of deaths subject to a Structured Judgement Review	0	1	0	0	1	0	0	1	0	0
No of deaths in patients with co-existing learning difficulties	0	0	0	0	0	0	0	0	0	0

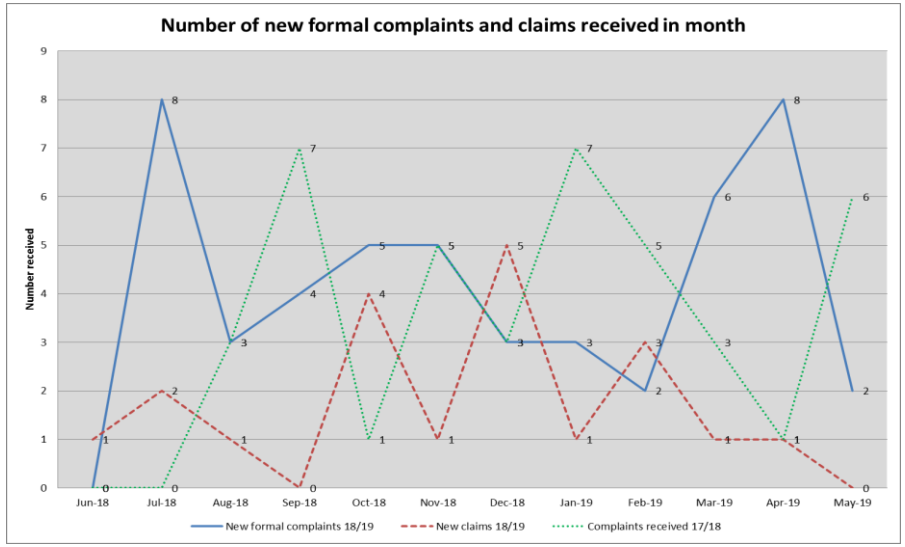
* to be completed

Learning from deaths

QVH reviewed the recommendations made in the third annual report of the English Learning Disabilities Mortality Review (LeDeR) Report which was published in April 2019. All learning disability inpatient deaths will be highlighted to both the Medical Director and Trust Lead for LeDeR to ensure appropriate escalation is followed to enable a full review of the death to be undertaken by an appropriately trained external reviewer. The review and learning will be shared at CGG and wider forums to ensure trust learning is disseminated.

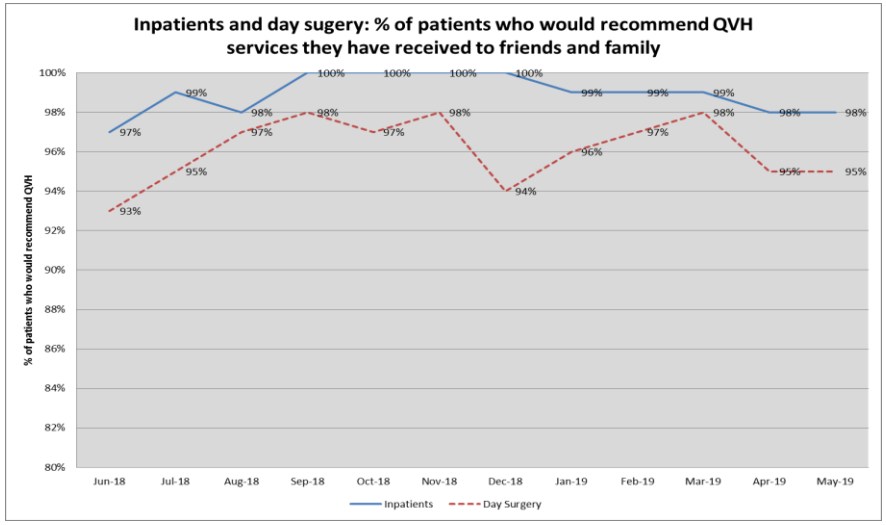
Caring - Current Compliance - Complaints and Claims

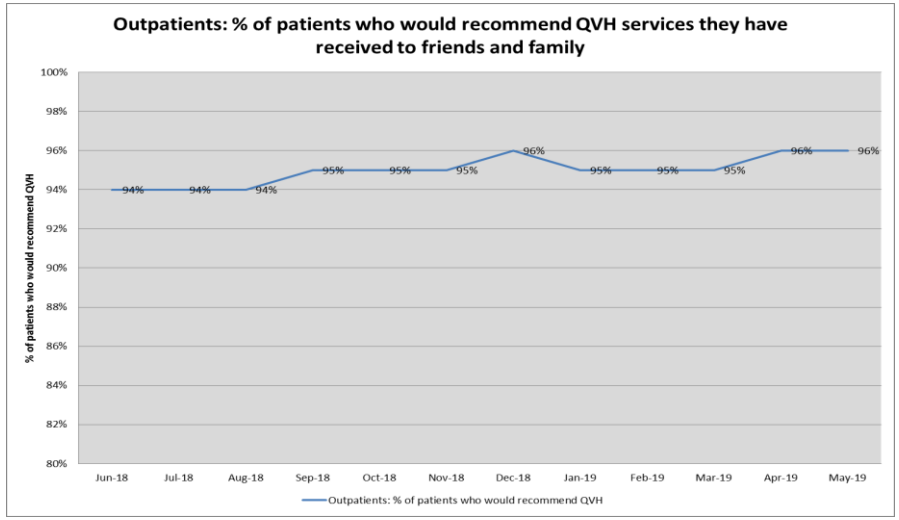


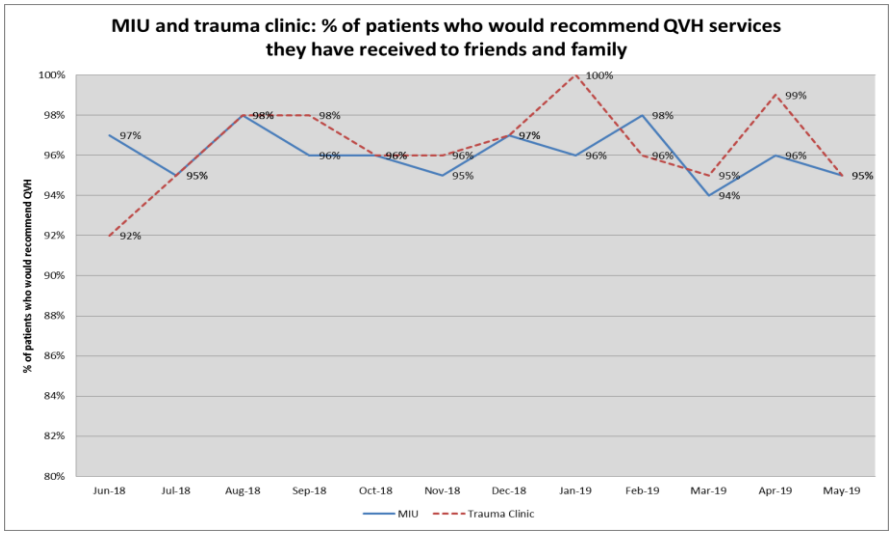


	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Contacts (IP+OP+MIU, all sites)	19342	20035	19406	17496	20263	20100	16374	20479	18100	18444	18993	19769
Complaints	8	8	3	4	5	5	3	3	2	6	8	2
Complaints per 100 contacts	0.041	0.040	0.015	0.023	0.025	0.025	0.018	0.015	0.011	0.033	0.042	0.010
Number of complaints referred to the Ombudsman for 2nd stage review	0	0	1	0	0	0	0	0	0	0	0	0
Number of complaints re-opened	0	1	0	0	0	0	0	0	1	0	0	0

Caring - Current Compliance - FFT







Nursing Workforce - Current Compliance

Domain	Compliance	Actions
Ross Tilley	During April and May there were 7/122 occasions where staffing numbers did not meet planned levels (3/118 in February and March). All escalated to site practitioner as per trust protocol.	Staffing according to bed occupancy and acuity with additional staff deployed from other areas due to agency non attendance and short notice sickness. 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 April and May there were 8/122 occasions where staffing numbers did not meet planned levels (6/118 in February and March). All escalated to the site practitioner as per trust protocol.	Staffing according to bed occupancy and acuity with additional staff deployed on high acuity days and resources redeployed from other areas or on 1 occasion 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 April and May there were 3/122 occasions where staffing numbers did not meet planned levels 3/118 in February and March). 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 April and May there was 9/122 occasion where staffing numbers did not meet planned levels (8/118 in February and March). All escalated to site practitioner as per trust protocol.	The ward was closed at 19:30 on three nights in April . There were 15 inpatients over 13 nights One child transferred to BSUH due to clinical need. The ward closed at 19:30 on four nights in May. There were 20 inpatients over fourteen nights. 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 April and May there was 2/122 occasions where staffing numbers did not meet planned levels(1/118 in February and Marc). 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 staff redeployed to other areas where occupancy /safety allowed to support short notice sickness. There were 5/60 shifts in April that had 50% agency cover, 15/60 shifts has 20-33% agency cover and 40/60 shifts with no agency cover required. In May there were 6/62 shifts that had 50% agency cover, 13/62 shifts with 20-33% agency cover and 43/62 shifts with no agency cover required. There were no Datix safety incidents relating to the one shift below template ward FFT scores and complaints information.
Site Practitioner Team	During April and May there were 9/122 occasions where staffing numbers did not meet planned levels (9/118 in February and March).	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.

Data extracted from the workforce score card in appendix 1

Qualified Nursing Workforce - Performance Indicators

QUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19 & 2019-20	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)		253.28	253.28	253.28	253.28	246.76	246.76	246.76	246.76	246.76	246.76	246.76	**246.76**	**246.76**	◄►
Nursing Headroom		*18.22*	*18.22*	*18.22*	*18.22*	*N/A*	*N/A*	*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	246.76	246.76	246.76	246.76	246.76	246.76	246.76	**246.76**	**246.76**	◄►
Staff In Post WTE		188.22	187.74	187.82	186.19	183.31	184.96	186.27	186.72	185.92	185.96	189.72	**196.69**	**196.00**	▼
Vacancies WTE		49.45	49.93	49.85	51.48	63.45	61.80	60.49	60.04	60.84	60.80	57.04	**50.07**	**50.76**	▲
Vacancies %	>18% / 12%<>18% / <12%	21.04%	21.24%	21.21%	21.90%	25.71%	25.04%	24.51%	24.33%	24.66%	24.64%	23.12%	**20.29%**	**20.57%**	▲
STARTERS WTE (Excluding rotational doctors)		0.00	0.00	1.00	3.68	0.51	3.64	3.23	3.81	1.41	0.60	5.61	**6.43**	**0.00**	▼
LEAVERS WTE (Excluding rotational doctors)		1.40	0.81	1.97	6.00	7.60	2.80	1.43	3.93	1.00	0.64	1.00	**1.36**	**1.00**	▼
Starters & Leavers balance		-1.40	-0.81	-0.97	-2.32	-7.09	0.84	1.80	-0.12	0.41	-0.04	4.61	**5.07**	**-1.00**	
Agency WTE		34.20	31.53	35.09	36.29	36.06	35.35	32.92	23.88	26.10	26.79	24.21	**20.63**	**21.75**	▲
Bank WTE		19.64	21.09	17.23	18.77	17.73	20.74	23.92	19.02	23.59	25.10	30.11	**23.77**	**25.12**	▲
Trust rolling Annual Turnover %	>=12% / 10%<>12% / <10%	16.76%	16.35%	17.06%	19.77%	21.72%	21.83%	21.16%	19.73%	19.01%	17.87%	16.51%	**15.69%**	**15.40%**	▼
Monthly Turnover		0.74%	0.43%	1.05%	3.20%	3.42%	1.57%	0.52%	2.00%	0.57%	0.37%	0.56%	**0.73%**	**0.54%**	▼
Sickness Absence %	>=4% / 4%<>3% / <3%	5.97%	*6.12%*	6.50%	*4.26%*	3.33%	3.11%	*3.60%*	3.21%	4.20%	3.74%	2.80%	3.96%	***4.50%***	**May Indicative Figure**

Unqualified Nursing Workforce - Performance Indicators

Unqualified Nursing

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19 & 2019-20			May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				107.92	107.92	107.92	107.92	100.79	100.79	100.79	100.79	100.79	100.79	100.79	**100.79**	**100.79**	◄►
Nursing Headroom				8.33	8.33	8.33	8.33	N/A	N/A	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	100.79	100.79	100.79	100.79	100.79	100.79	100.79	**100.79**	**100.79**	◄►
Staff In Post WTE				82.51	83.51	84.94	86.30	82.52	83.91	85.38	84.55	81.07	82.65	87.93	**89.70**	**87.43**	▼
Vacancies WTE				17.08	16.08	14.65	13.29	18.27	16.88	15.41	16.24	19.72	18.14	12.86	**11.09**	**13.36**	▲
Vacancies %	>18%	12%<>18%	<12%	17.15%	16.15%	14.71%	13.34%	18.13%	16.75%	15.29%	16.11%	19.57%	18.00%	12.76%	**11.00%**	**13.26%**	▲
STARTERS WTE (Excluding rotational doctors)				2.00	2.00	2.00	1.00	0.61	2.00	3.47	2.00	0.00	3.84	2.00	**4.51**	**0.00**	▼
LEAVERS WTE (Excluding rotational doctors)				0.00	0.00	0.00	0.00	1.57	1.00	1.00	2.49	1.00	1.00	0.00	**1.72**	**1.00**	▼
Starters & Leavers balance				2.00	2.00	2.00	1.00	-0.96	1.00	2.47	-0.49	-1.00	2.84	2.00	**2.79**	**-1.00**	
Agency WTE				3.57	1.76	0.00	1.62	2.19	2.19	2.40	0.94	0.00	0.35	0.00	**0.00**	**0.00**	◄►
Bank WTE ***Note 2***				6.51	7.96	10.07	8.13	7.76	7.95	7.29	5.92	7.80	8.75	8.05	**8.70**	**8.55**	▼
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	27.14%	25.08%	21.08%	20.26%	16.74%	14.51%	15.23%	16.16%	14.97%	12.08%	9.85%	**12.29%**	**13.78%**	▲
Monthly Turnover				0.00%	0.00%	0.00%	0.00%	2.02%	1.28%	1.26%	1.97%	1.34%	1.44%	0.00%	**2.41%**	**1.44%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	1.23%	2.43%	2.00%	4.33%	3.97%	8.87%	6.14%	4.08%	4.49%	6.85%	7.78%	5.93%	***4.50%***	***May Indicative Figure***

Medical Workforce - Performance Indicators

Metrics	2017/18 total / average	Target	Quarter 1 2018/19	Quarter 2			Quarter 3			Quarter 4			Quarter 1 2019/20		Year to date actual/ average
			June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	
Medical Workforce															
Turnover rate in month, excluding trainees	21.63% 12Mth rolling	<1%	0%	1.31%	1.60%	2.42%	0%	0%	1.16%	3.44%	0.96%	3.97%	0%	1.15%	15.94% 12 mth Rolling
Turnover in month including trainees 9%	45.43% 12Mth rolling		0.71%	10.76%	3.15%	2.10%	1.35%	0.68%	2.79%	2.77%	8.85%	2.46%	6.81%	2.53%	45.59% 12 mth rolling
Management cases monthly		**0**	3	3	1	1	1	1	1	0	0	0	0	0	11
Sickness rate monthly on total medical/dental headcount	1.43%		0.88%	0.86%	2.05%	1.18%	0.94%	1.19	1.09	1.19%	1.59%	1.99%	2.25%	Available July 19	2.25%
Appraisal rate monthly (exclude deanery trainees)	88.96% Mar 18		90.38%	87.90	82.83%	79.38%	83.54	89.09	88.13%	84.62%	79.73%	85.16%	82.67	80.77%	80.77%
Mandatory training monthly		**95%**	83%	84%	81%	77%	78.7%	83%	84%	84%	87%	87%	88%	87%	83%
Exception Reporting – Education and Training			0	0	0	0	0	0	0	1	0	0	4	1	6
Exception Reporting – Hours			0	1	0	0	0	0	0	0	0	1	0	0	2

Medical & Dental Staffing

There are currently 100 doctors for whom the QVH is their designated body. The current appraisal rate has fallen to 81%. This is being addressed. All doctors are revalidated with a licence to practice. Four positive recommendations for revalidation have been submitted in the previous two months, following a panel discussion at the Appraisal and Revalidation Group. Two revalidation recommendations were deferred due to insufficient supporting information.

A total of 16 Clinical Excellence Awards (CEA) awards were made to 13 successful applicants at the CEA panel on the 15th April, in line with new national contractual arrangements. These 2018/19 awards will be for a period of 3 years. The national interim scheme is planned for 3 years.

	The results of the 2019 GMC National Training Survey are expected on the 1st July. Along with all training hospitals, the trust has been awarded £30K from HEE to improve facilities for Junior Doctors. Medical Education are currently surveying doctors on how the money might be most beneficially spent, and it will be monitored through the Junior Doctors' Forum. The use of Exception Reporting may finally be increasing, with 7 reports submitted in June. These mostly relate to missed educational opportunities (most commonly trainees being moved from training lists in operating theatres to cover service requirements in outpatients).
Education	We now have no HEE trainees attending spoke sites without immediate on-site consultant supervision, and have been able to respond positively to HEE's requests for updates to their action plan following the inspection in September 2018. The roll out of multidisciplinary training continues, with in-situ training now planned for Canadian Wing. The trust will need to consider how best to relieve faculty and attendees from clinical responsibilities to attend training, and best utilise significant charitable investment in simulation equipment. QVH has very successfully hosted training days for Pan-Thames plastics registrars and HEE KSS OMFS trainees in May. The BMA is currently balloting junior doctors on their revised contract, after negotiations with NHS Employers.

NURSING METRICS - 12 MONTH ROLLING

BURNS WARD

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No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19 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	May	Rolling Year to Date Actual	Trend	Comments
SAFE																			
1	**Incidents**	Total reported - All incidents	106	_	12	17	6	8	12	9	8	6	6	3	6	10	103		
2		Total reported - Patient safety	53	_	7	4	2	4	8	6	3	5	3	2	5	7	56		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	7	0	1	0	1	0	1	0	1	1	1	0	0	0	6		
6		Falls - With harm	3	0	1	0	0	0	1	0	0	0	1	0	0	0	3		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1		
9	**MRSA Screening**	Elective patients	99.0%	95%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
10		Trauma patients	99.0%	95%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	99%		
11		Reported cases	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
13	**Hand Hygiene**	Hand hygiene	98%	95%	100%	N/S	80%	100%	100%	100%	100%	100%	100%	100%	95%	100%	98%		
14		Bare below the elbows	100%	95%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
15	**Drug Assessments**	% staff compliant	92%	100%	100%	100%	93%	100%	85%	92%	90%	80%	90%	100%	100%	100%	94%		
16	**Medication Audit**	Missed dose			eported 1/4	Reported 1/4ly			Reported 1/4ly			eported 1/4ly					0		
17		Omitted dose			eported 1/4	Reported 1/4ly			Reported 1/4ly			eported 1/4ly					0		
18		Total doses			eported 1/4	Reported 1/4ly			Reported 1/4ly			eported 1/4ly					0		
19	**Medication Errors**	Reported errors	8	0	1	0	0	1	1	2	1	1	0	0	0	2	9		Same patient. ID21897 (22/05/2019) Prescription for 2g OD of Metformin but patient received 2G BD. ID21910 (23/05/2019) Pharmacist asked Dr to prescribe patients regular insulin. Dr did not prescribe as Pt was NBM. Pt started eating again - Blood glucose detected as "high"
20	**Safety Thermometer**	Harm Free Care %	97.0%	95%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%		94%		
21		New Harm Free %	99%	95%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		98%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	96%	95%	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%		
24		Monthly screening % (Informatics)	99%	95%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%		99%		
25	**Shift meets requirement** Day %	RN	97.0%	95%	96%	97%	96%	97%	99%	101%	99%	98%	96%	91%	95%	100%	97%		
26		HCA	94.0%	95%	64%	97%	93%	97%	84%	94%	95%	100%	100%	103%	100%	95%	94%		
27	**Shift meets requirement** Night %	RN	98.0%	95%	100%	97%	97%	97%	100%	100%	97%	100%	96%	98%	100%	95%	98%		
28		HCA	105.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
EFFECTIVE																			
29	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	99%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
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			eported 1/4ly					#DIV/0!		
CARING																			
32	**Friends & Family Test**	Patient numbers (eligible to respond)	433	_	74	52	16	17	23	20	24	30	24	19	13	29	341		
33		% return rate	60%	40%	7%	31%	100%	100%	62%	100%	100%	60%	75%	47%	100%	90%	73%		
34		% recommendation (v likely/likely)	98.0%	90%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	10000%	925%		
35		% unlikely/extremely unlikely	0%	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	0		
WELL-LED																			
37	**Vacancy** Establishment=	Full Team WTE	31.2									32.46	29.99	29.99	29.99	29.99	30		
38		Vacancy WTE	8.1	10%	6.72	6.48	7.77	7.51	9.02	8.12	9.02	9.3	9.86	9.25	8.34	8.34	8		
39		Vacancy (hrs)	1311.1	10%	1092	1053	1263	1220	1465.8	1319.5	1465.8	1511.25	1602.3	1503.12	1355.3	1355.3	1351		
40	**Temporary Staffing** excluding RMN	Agency Use	301.8	10%	107.5	266.25	280	345	302.25	346.75	382.25	406.75	324.75	200.5	179	162	275		
41		Bank Use-all staff	465.98	10%	418	587.75	343.8	274.5	332	373.75	418.25	592.5	746.15	923	613.75	530.35	513		
		Bank Use-non-clinical														60.26			
43	**Sickness-all staff**	Hours	79.65		103.5	79.25	90	41.5	94.75	154	36.5	170	5	22.25	23	93.5	76		
44		%	1.6%	3%	2.1%	1.6%	1.9%	0.9%	1.9%	3.2%	0.7%	3.5%	0.1%	0.5%	0.5%	1.9%	2%		
45	**Sickness non clinical**	Hours													0	7.5			
46		%													0.0%	0.2%			
47	**Maternity**	Hours										0	0	0	0	0	0		
48	**Budget Position**	YTD Position	-86992	>0	-39429	-44803	-40236	-10887	-704	-10195	354	-49955	5311	105659					
49	**Statutory & Mandatory**	Mandatory training	93.0%	95%	89%	91%	92%	93%	96%	97%	94%	94%	95%	94%	93%	95%	94%		
50		Appraisal	89.0%	95%	93%	92%	84%	88%	92%	79%	92%	88%	100%	96%	96%	92%	91%		Head of Nursing working with Matron to ensure compliance improves
51	**Uniform Audit**	Compliance with uniform policy %	98%	95%					100%	100%	100%	100%	100%	90%	95%	90%	97%		Awaiting further detail from IPACT to understand reasons for this

NURSING METRICS - 12 MONTH ROLLING

CORNEOPLASTIC OPD

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QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20		Rolling Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	71	_	3	11	6	7	5	11	2	5	2	5	8	3	68		
2		Total reported - Patient safety	30	_	0	7	1	3	2	2	1	3	2	2	5	2	30		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	2	0	0	0	0	0	1	1	0	0	0	0	0	0	2		
6		Falls - With harm	1	0	0	0	0	0	0	1	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	0		
8	**Inoculation Injury**	Reported incidents	0	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	0		
10	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
11	**Hand Hygiene**	Hand hygiene	99%	95%	100%	93%	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	99%		
12		Bare below the elbows	100%	95%	100%	100%	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%		
13	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
14		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
15		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
16	**Medication Errors**	Reported errors	16	0	0	4	0	1	0	1	1	1	1	1	1	1	12		ID21764 (19 Mar 2019 - reported 1 May 2019): Patient presented prescription with another patients name on it. Prescription was for presenting patient not the named patient on the prescription. Correct medication dispenced.
EFFECTIVE																			
17	**Compliance in Practice** (CiP)	Inspection score	91%	80%	90.7%	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0%		
CARING																			
18	**Friends & Family Test**	Patient numbers (eligible to respond)	24297	_	2020	2288	2044	1846	2292	2262	1830	2218	1541	1784	1855	2144	24124		
19		% return rate	21.0%	20%	20%	24%	21%	20%	19%	19%	26%	21%	19%	22%	13%	5%	19%		Changes to trust data capture due to IG concern in April and May
20		% recommendation (v likely/likely)	93.0%	90%	93%	91%	92%	95%	93%	95%	95%	93%	92%	96%	95%	93%	94%		
21		% unlikely/extremely unlikely	3.0%	0%	2%	4%	3%	1%	3%	1%	2%	3%	3%	3%	2%	4%	3%		

RESPONSIVE																			
22	**Complaints**	No. recorded	6	0	1	2	0	0	1	1	0	0	0	0	0	0	5		
WELL-LED																			
23	**Vacancy** Establishment=	Full Team WTE	18.1									18.06	18.06	18.06	18.06	18.06	18		
24		Vacancy WTE	2.8	10%	2.48	2.48	2.48	2.24	3.23	3.69	3.69	2.5	2.5	2.5	2.5	2.5	3		
25		Vacancy (hrs)	456.4	10%	403	403	403	364	524.88	599.62	599.6	406.25	406.3	406.25	406.3	406.3	444		
26	**Temporary Staffing** excluding RMN	Agency Use	0	10%	0	0	0	0	0	0	0	0	0	0	0	0	0		
27		Bank Use-All staff	216	10%	170.5	168	168.5	226	222	275	182	312	281.25	288.25	245	320.5	235		
		Bank Use non-clinical														0			
29	**Sickness-all staff**	Hours	67.38		47.5	0	96.5	10	205	163.5	46.5	85	40	97.5	124	69.5	82.6		
30		%	2.2%	3%	1.5%	0.0%	3.1%	0.3%	6.6%	5.2%	1.5%	2.9%	1.4%	3.3%	4.2%	2.4%	2.7%		Sickness absence all currently managed through Trust policy
31	**Sickness-non-clinical**	Hours													0	0			
32		%													0.0%	0.0%			
33	**Maternity**	Hours			0	0	0	0	0	0	0	0	0	0	0	0	0		
34	**Budget Position**	YTD Position	521464	>0	49650	65400	76928	93558	30102	30917	44629	50376	25393	50721					
35	**Statutory & Mandatory**	Mandatory training	96%	95%	92%	91%	94.6%	94%	97%	96%	97%	99%	100%	99%	94%	97%	96%		
36		Appraisal	97%	95%	90%	95%	100%	95%	100%	100%	100%	89%	100%	95%	100%	100%	97%		
37	**Uniform Audit**	Compliance with uniform policy %	82%	95%					N/S	95%	85%	45%	85%	100%	100%	100%	87%		

NURSING METRICS - 12 MONTH ROLLING

CRITICAL CARE UNIT

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No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19 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	May	Rolling Year to Date Actual	Trend	Comments
SAFE																			
1	**Incidents**	Total reported - All incidents	181	_	16	8	18	25	17	15	7	15	16	17	11	11	176		please say which were unplanned visits to CCU to give context
2		Total reported - Patient safety	145	_	11	8	17	23	13	12	7	10	16	12	9	10	148		
3		Formal internal investigation	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	5	0	1	0	0	1	0	2	0	0	0	0	0	0	4		
6		Falls - With harm	1	0	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	0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1		
9	**MRSA Screening**	Elective patients	100%	95%	n/a	n/a	n/a	100%	100%	n/a	n/a	100%	n/a	n/a	n/a	100%	100%		
10		Trauma patients	99.0%	95%	100%	100%	100%	100%	100%	100%	100%	n/a	89%	100%	100%	100%	99%		
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
13	**Hand Hygiene**	Hand hygiene	97.0%	95%	90%	93%	100%	N/S	100%	100%	100%	92%	87%	100%	100%	100%	97%		
14		Bare below the elbows	97.0%	95%	100%	93%	100%	N/S	100%	89%	100%	100%	89%	100%	100%	100%	96%		
15	**Drug Assessments**	% staff compliant	98.0%	100%	88%	93%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%	98%		
16	**Medication Audit**	Missed dose			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
17		Omitted dose			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
18		Total doses			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
19	**Medication Errors**	Reported errors	6	0	0	0	0	1	0	0	0	0	1	2	0	3	7		ID21871 (17/05/2019): Local anaesthetic infusion had not been prescribed. ID21909 (22/05/2019): Patient allergic to opiates had been given diamorphine 7mg in theatre. ID21942 (31/05/2019): Teicoplanin infusion started at midnight. Noticed at 06:30 that infusion had not gone through. Cannulas flushed and infusion restarted - temporary staffing related, issue raised with appropriate staff, first error with this bank staff member, reflective account provided, discussed with staff member.
20	**Safety Thermometer**	Harm Free Care %	96.0%	95%	100%	100%	100%	100%	100%	100%	100%	50%	100%	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%	88%	100%			99%		
25	**Shift meets requirement** Day %	RN	96.0%	95%	99%	90%	99%	98%	94%	100%	90%	100%	99%	100%	98%	98%	97%		
26		HCA	98.0%	95%	91%	96%	100%	96%	96%	105%	96%	100%	91%	100%	96%	100%	97%		
27	**Shift meets requirement** Night %	RN	94.0%	95%	96%	88%	95%	88%	89%	93%	87%	100%	100%	100%	99%	100%	95%		
28		HCA	115.0%	95%	50%	50%	100%	100%	113%	100%	88%	91%	87%	100%	100%	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%	0%	n/a	n/a	n/a	n/a	100%	100%	100%	100%	na	na	na	80%		
31	**Compliance in Practice** (CiP)	Inspection score		80%	ported 1/	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	0		
WELL-LED																			
33	**Vacancy** Establishment=	Full Team WTE	28							29.25		27.57	27.57	27.57	27.57	27.57	28		
34		Vacancy WTE	10.5	10%	11.01	10.48	10.98	11.02	11.92	11.73	10.73	9.44	9.44	9.44	7.1	6.19	10		Ward Establishment = 29.37 WTE
35		Vacancy (hrs)	1699	10%	1789	1703	1784	1791	1937	1906	1743	1534	1534	1534	1153.8	1005.9	1618		
36	**Temporary Staffing** excluding RMN	Agency Use	751.7	10%	976.5	918	965	940.5	884.5	828	218	347.5	437	520.5	259.5	237.5	628		
37		Bank Use-all staff	414.4	10%	172	171	271	327.5	432.25	691.05	667.25	591.75	499.5	677.75	510.5	549.75	463		
		Bank Use-non-clinical														0			
39	**Sickness-all staff**	Hours	301.4			360.5	221	187.5	423.5	357	362.5	416.5	400.5	366	314	438	350		
40		%	6.5%	3%	5.0%	7.7%	4.6%	3.9%	8.9%	7.5%	7.6%	9.3%	8.9%	8.2%	7.0%	9.8%	7%		Long term sickness staff remains, with some short term sickness for various reasons. No trends identified. All managed within Trust AttendancePolicy
41	**Sickness non clinical**	Hours													0	0			
42		%													0.0%	0.0%			
43	**Maternity**	Hours												0	0	0	0		
44	**Budget Position**	YTD Position	-217834	>0	-33259	-108905	51653	56696	11881	-2451	-118838	30575	16517	-78903			-62872		
45	**Statutory & Mandatory**	Mandatory training	89%	95%	86%	87%	86%	88%	87%	84%	90%	96%	96%	94%	93%	94%	90%		Head of Nursing working closely with Matron to address this within the team
46		Appraisal	83.0%	95%	81%	90%	85%	84%	89%	80%	89%	90%	81%	75%	87%	84%	85%		Ward Matron working with staff to imporve, appraisal dates booked
47	**Uniform Audit**	Compliance with uniform policy %	76%	95%					93%	64%	91%	92%	50%	69%	71%	64%	74%		This relates to all clinical staff wearing lanyards in the clinical area. This has now been addressed, staff are aware to challenge non-complinace and escalate as appropriate

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	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/2020		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	155	_	14	12	16	12	15	18	10	20	12	19	21	15	184		
2		Total reported - Patient safety	42	_	1	3	4	2	7	5	5	2	6	5	10	6	56		
3		Formal internal investigation	2	0	0	0	0	0	0	1	0	0	0	1	0	0	2		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	1	0	0	1	0	0	0	0	0	0	0	0	0	1	2		ID21782 (03/05/2019): Patient stumbled and fell backwards in waiting area 2. 2 skin tears to right elbow but no other injuries reported
6		Falls - With harm	1	0	0	1	0	0	0	0	0	0	0	0	0	1	2		ID21782-As Above: Minor Harm. Dressing applied. Patient sent to MIU for full check. All appropriate action taken at time of incident
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1		
8	**Inoculation Injury**	Reported incidents	3	0	0	0	0	1	0	0	1	1	0	0	0	0	3		
9	**MRSA**	Reported cases	0	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	0		
11	**Hand Hygiene**	Hand hygiene	89.0%	95%	N/S	80%	100%	100%	90%	80%	60%	N/S	100%	100%	90%	100%	90%		Matron aware and encourage to escalate staff within department that are non-compliant and complete DATIX to rasie awareness of issues
12		Bare below the elbows	100.0%	95%	N/S	100%	100%	100%	100%	100%	100%	N/S	100%	100%	100%	100%	100%		
13	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
14		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
15		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
16	**Medication Errors**	Reported errors	2	0	0	0	0	0	1	0	0	0	1	0	0	0	2		
EFFECTIVE																			
17	**Compliance in Practice** (CiP)	Inspection score	90%	80%	90.3%	Reported 1/4ly			90.4%			ported 1/4ly					90%		
CARING																			
18	**Friends & Family Test**	Patient numbers (eligible to respond)	136854	_	12866	12975	12813	11732	11983	13846	11143	14050	10465	12252	12085	13435	149645		
19		% return rate	17.0%	20%	16%	16%	16%	17%	18%	16%	17%	18%	16%	17%	12%	8%	16%		Changes to trust data capture due to IG concern in April and May
20		% recommendation (v likely/likely)	95.0%	90%	94%	94%	94%	96%	95%	95%	96%	95%	95%	95%	96%	96%	95%		
21		% unlikely/extremely unlikely	2.0%	0%	2%	2%	3%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%		

RESPONSIVE																			
22	**Complaints**	No. recorded	2	0	1	0	1	0	0	0	0	0	0	0	0	0	2		
WELL-LED																			
23	**Vacancy** Establishment=	Full Team WTE	15.4									15.37	15.37	15.37	15.37	15.37	15.4		
24		Vacancy WTE	1.4		1.18	1.81	1.82	1.76	1.32	1.32	1.25	1.25	1.25	1.6	1.6	2.56	1.6		
25		Vacancy (hrs)	232.5		191.7	294.12	295.7	286	214.5	214.5	203.12	203.1	203.1	260	260	416	253.5		
26	**Temporary Staffing** excluding RMN	Agency Use	0		0	0	0	0	0	0	0	0	0	0	0	0	0		
27		Bank Use-all staff	201.9		321.75	192.75	287.7	276	184	120.25	91.95	94.95	165	175.9	150	193.05	187.78		
		Bank Use-non-clinical														0			
29	**Sickness-all staff**	Hours	75.7		139	48	32	0	144	236.5	38	37.5	32	50	79	81.5	76.458		
30		%	3.6%	3%	5.5%	1.9%	1.3%	0.0%	5.8%	9.5%	1.5%	1.5%	1.3%	2.0%	3.2%	3.3%	3.06%		Sickness increased in month, all managed appropriately within Trust policy
	Sickness-non-clinical	Hours														0			
		%														0.0%			
33	**Maternity**	Hours	0.0%		0	0	0	0	0	0	0	0	0	0	0	0	0		
34	**Budget Position**	YTD Position	-130815	>0	-12043	-8463	-11769	-12216	-8281	-15901	-6350	-25810	-23590	-24185			-112380		
35	**Statutory & Mandatory**	Mandatory training	94%	95%	94%	97%	98%	92%	91%	92%	96%	98%	94%	93%	92%	98%	95%		
36		Appraisal	96%	95%	80%		94%	95%	100%	100%	100%	100%	100%	100%	95%	95%	96%		Compliance at 95%
37	**Uniform Audit**	Compliance with uniform policy %	76%	95%					70%	80%	90%	N/S	70%	70%	90%	70%	77%		2 Nurses and 1 Doctor did not have clealry dsiplayed ID badges with retracable holders and one Nurse failed to have her hair tied back. Email sent, with uniform policy attached, to highlight this to staff. Will also discuss with staff at the OPD huddles to increase compliance and adherence to policy. HoN and Matron to be copied into uniform audit results when completed to ensure issues can be acted upon at the earliest oppotunity.

NURSING METRICS - 12 MONTH ROLLING
MARGARET DUNCOMBE

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 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	May	Year to Date Actual	Trend	Comments
SAFE																			
1	**Incidents**	Total reported - All incidents	180	_	8	13	14	9	15	20	17	17	19	12	3	14	161		
2		Total reported - Patient safety	118	_	4	9	10	6	13	15	11	10	13	9	3	9	112		
3		Formal internal investigation	5	0	0	2	0	0	1	1	0	0	0	0	0	0	4		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	14	0	0	2	2	0	1	1	1	1	2	0	0	1	11		ID21786 (04/05/2019): Unwitnessed Fall. No Harm
6		Falls - With harm	4	0	0	0	1	0	0	0	1	0	0	0	0	0	2		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	2	0	0	0	0	0	0	0	0	0	0	2		
8	**Inoculation Injury**	Reported incidents	0	0	0	0	1	0	1	0	0	0	0	0	0	0	2		
9	**MRSA Screening**	Elective patients	97.4%	95%	98%	98%	100%	91%	96%	98%	98%	96%	94%	97%	94%	92%	96%		Met with Clinical Educator to see how to ensure staff are swabbing patients. Suggested an 'admission pack' or moving where the swabs are kept. To be discussed with staff to ensure improvement. Further email sent to all staff explaining the importance of nursing metrics and safety.
10		Trauma patients	95.4%	95%	96%	100%	94.8%	97%	96%	93%	95%	96%	100%	95%	96%	97%	96%		
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
13	**Hand Hygiene**	Hand hygiene	100%	95%	100%	100%	N/S	100%	100%	100%	100%	90%	90%	80%	100%	90%	95%		Staff are spot checked regularly and challenged if not compliant
14		Bare below the elbows	94.7%	95%	100%	100%	N/S	100%	78%	80%	90%	85%	80%	80%	100%	90%	89%		Staff are spot checked regularly and challenged if not compliant
15	**Drug Assessments**	% staff compliant	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
16	**Medication Audit**	Missed dose			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
17		Omitted dose			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
18		Total doses			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
19	**Medication Errors**	Reported errors	32	0	2	0	4	2	3	4	5	1	3	1	1	2	28		ID21817 (24 April 2019 - reported 9 May 2019): Dr incorrectly prescribed 10mg TDS for hydrocortisone instead of 20mg, 10mg, 10mg for a long stay (Addisons) patient. Patient received this dose for 12 days before it was discovered. ID21935 (28/05/2019): CD error. Patient given 8mg buprenorphine. Later discovered the correct dose to treat moderate to severe pain is 200-400micrograms. The correct dose was then prescribed. Anaesthetist and patient informed.
20	**Safety Thermometer**	Harm Free Care %	97.0%	95%	100%	93%	100%	85%	100%	100%	100%	100%	86%	100%	100%		97%		
21		New Harm Free %	99%	95%	100%	93%	100%	92%	100%	100%	100%	100%	100%	100%	100%		99%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	98.0%	95%	100%	87%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	98%		
23		Monthly screening % (Informatics)	97.0%	95%	99%	99%	97%	97%	97%	93%	96%	92%	95%	100%			96%		
24	**Shift meets requirement** Day %	RN	98.0%	95%	99%	99%	98%	97%	96%	97%	101%	100%	96%	99%	99%	98%	98%		
25		HCA	99.0%	95%	104%	98%	102%	100%	95%	93%	96%	100%	100%	98%	100%	96%	99%		
26	**Shift meets requirement** Night %	RN	99.0%	95%	96%	96%	98%	97%	102%	100%	100%	98%	97%	98%	99%	103%	99%		
27		HCA	92.0%	95%	86%	82%	100%	88%	90%	88%	90%	100%	90%	91%	86%	93%	90%		Dependant upon patient acuity
EFFECTIVE																			
28	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	97%	95%	92%	80%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	97%		
29		7 day review (Safety Thermometer)	92.0%	95%	100%	80%	33%	100%	100%	100%	100%	100%	93%	100%	100%	100%	92%		
30	**Compliance in Practice** (CiP)	Inspection score		80%	ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					#DIV/0!		
CARING																			
31	**Friends & Family Test**	Patient numbers (eligible to respond)	1624	_	125	128	131	111	140	147	159	144	132	139	144	138	1638		
32		% return rate	55.0%	40%	55%	58%	57%	60%	41%	41%	47%	61%	49%	60%	51%	50%	52%		
33		% recommendation (v likely/likely)	99.0%	90%	99%	100%	97%	100%	98%	100%	100%	100%	100%	98%	100%	100%	99%		
34		% unlikely/extremely unlikely	0.0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		

RESPONSIVE																			
35	**Complaints**	No. recorded	6	0	0	1	1	2	1	1	0	0	0	0	0	0	6		
WELL-LED																			
36	**Vacancy** Establishment=	Full Team WTE	49.2		48.67	49.04	49.54	49.54	49.54	49.54	49.54	48.66	48.66	48.66	48.66	48.66	49.1		
37		Vacancy WTE	11		11.13	12.16	12.74	12.12	13.72	13.22	10.67	9	7.16	7.16	7.08	6.08	10.2		
38		Vacancy (hrs)	1784		1808	1976	2070	1970	2229.5	2148.3	1733.9	1462.5	1163.5	1164	1150.5	988	1655.3		
39	**Temporary Staffing** excluding RMN	Agency Use	1258		1242.5	1207	1789	1775.8	1642.8	1566.5	814	369.5	713.5	994	670.5	709	1124.5		We have used 319 hours of agency over our vacancy.
40		Bank Use-all staff	856		899	901	823.5	673	851.75	847.3	717	794.75	970.2	1119	985	1053.7	886.3		
		Bank Use-non-clinical														27.25			
42	**Sickness-all staff**	Hours	216.2		306	132	165	193	157.75	180.5	310.5	261.5	177.75	277	481.5	417.5	255.0		
43		%	2.7%	3%	3.8%	1.6%	2.0%	2.4%	2.0%	2.2%	3.9%	3.3%	2.3%	3.5%	6.1%	5.3%	3.2%		High sickness in April and may due to long term sickness
44	**Sickness-non-clinical**	Hours													21	10			
45		%													0.3%	0.1%			
46	**Maternity**	Hours			69	69	69	0	0	0	0	0	37.5	37.5	37.5	37.5	######		
47	**Budget Position**	YTD Position		>0	-96771	-102720	-214295	-273162		-391542	-419366	-420659	-450392	-515942			-2884849		
48	**Statutory & Mandatory**	Mandatory training	94%	95%	93%	90%	91%	91%	92%	94%	96%	95%	96%	96%	95%	93%	94%		Matron is following up staff who are out of date.
49		Appraisal	93%	95%	94%	88%	92%	90%	86%	90%	98%	98%	98%	98%	96%	85%	93%		All out of date appraisals have been booked. Matron off sick for a month.
50	**Uniform Audit**	Compliance with uniform policy %	87%	95%					89%	80%	80%	95%	90%	87%	100%	100%	90%		

NURSING METRICS - 12 MONTH ROLLING

ROSS TILLEY

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No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	155	_	10	18	10	12	20	12	12	9	13	13	5	7	141		
2		Total reported - Patient safety	96	_	9	8	2	8	15	8	8	7	10	7	4	4	90		
3		Formal internal investigation	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	12	0	2	0	0	2	1	2	0	1	0	2	0	1	11		ID21785 (03/05/2019): Unwitnessed fall from bed
6		Falls - With harm	1	0	0	0	0	1	0	0	0	0	0	0	0	1	2		ID21785 (03/05/2019): As above - Minor Harm (cut to cheek - wound dressed))
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1		
9	**MRSA Screening**	Elective patients	98.0%	95%	100%	100%	98%	94.9%	100%	97%	97%	98%	97%	100%	100%	95%	98%		
10		Trauma patients	96.0%	95%	97%	95%	94%	94.9%	93.4%	94.7%	92.9%	98.0%	95.0%	97.0%	98.0%	94.0%	95%		An email has been sent to all staff outlining nursing metrics and the importance of safety.
11		Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
12	**C Difficile**	Reported cases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
13	**Hand Hygiene**	Hand hygiene	97%	95%	100%	100%	N/S	100%	100%	90%	90%	100%	100%	90%	100%	90%	96%		Staff are spot checked and challanged when not being compliant.
14		Bare below the elbows	93.0%	95%	100%	100%	N/S	100%	100%	70%	90%	100%	100%	100%	100%	90%	95%		Staff are spot checked and challanged when not being compliant.
15	**Drug Assessments**	% staff compliant	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	99%		One member of staff is due there assessment
16	**Medication Audit**	Missed dose			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
17		Omitted dose			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
18		Total doses			ported 1/	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
19	**Medication Errors**	Reported errors	31	0	1	3	1	2	7	4	3	0	2	3	2	0	28		
20	**Safety Thermometer**	Harm Free Care %	100.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	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%	93%	95%	100%	100%	100%	100%	94%	100%	95%	100%	94%	100%	98%		April 1 patient not screened, met with Clinical Eductor to discuss how to ensure VTE assessments are complete. Planning for an 'admisssion pack' that would have a checklist to complete.
23		Monthly screening % (Informatics)	95.0%	95%	94%	97%	94%	94%	94%	94%	92%	97%	91%	97%			94%		
24	**Shift meets requirement** Day %	RN	98.0%	95%	98%	100%	98%	97%	97%	97%	99%	100%	97%	98%	100%	100%	98%		
25		HCA	98.0%	95%	98%	96%	102%	96%	92%	98%	100%	98%	98%	102%	100%	102%	99%		
26	**Shift meets requirement** Night %	RN	95.0%	95%	90%	88%	97%	99%	99%	98%	98%	94%	97%	93%	96%	94%	95%		Dependent upon patient acuity.
27		HCA	92.0%	95%	97%	88%	85%	90%	97%	100%	68%	100%	100%	89%	90%	96%	92%		
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%	n/a	75%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	97%		
30	**Compliance in Practice** (CiP)	Inspection score	88%	80%	ported 1/	Reported 1/4ly			88.2%			ported 1/4ly					88%		
CARING																			
31	**Friends & Family Test**	Patient numbers (eligible to respond)	2254	_	203	196	194	204	190	173	184	166	199	178	203	228	2318		
32		% return rate	40.0%	40%	39%	29%	43%	31%	37%	39%	40%	48%	35%	44%	38%	34%	38%		Matron continues to promote the importance of this
33		% recommendation (v likely/likely)	99.0%	90%	95%	100%	100%	98%	99%	100%	100%	97%	99%	99%	97%	97%	98%		
34		% unlikely/extremely unlikely	0.0%	0%	1%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%		

RESPONSIVE																			
35	**Complaints**	No. recorded	3	0	0	0	0	1	1	0	0	0	0	0	0	0	2		
WELL-LED																			
36	**Vacancy** Establishment=	Full Team WTE	49.2		48.67	49.04	49.54	49.54	49.54	49.54	49.54	48.66	48.66	48.66	48.66	48.66	49.1		
37		Vacancy WTE	11	10%	11.13	12.16	12.74	12.12	13.72	13.22	10.67	9	7.16	7.16	7.08	6.08	10.2		
38		Vacancy (hrs)	1784	10%	1808	1976	2070	1970	2229.5	2148	1734	1463	1164	1163.5	1150.5	988	1655.4		
39	**Temporary Staffing** excluding RMN	Agency Use	1258	10%	1242.5	1207	1789	1776	1643	1566.5	814	369.5	713.5	994	670.5	709	1124.5		We have used 320 hours of agency/bank over our vacancy.
40		Bank Use-all staff	856	10%	899	901	823.5	673	851.8	847.3	717	794.75	970.2	1118.5	985	1053.7	886.23		
		Bank Use-non-clinical														27.25			
42	**Sickness-all staff**	Hours	216.2		306	132	165	193	157.75	180.5	310.5	261.5	177.75	277	481.6	417.5	255.01		
43		%	2.7%	3%	3.8%	1.6%	2.0%	2.4%	2.0%	2.2%	3.9%	3.3%	2.3%	3.5%	6.1%	5.3%	3.2%		Sickness managed as per policy
44	**Sickness-non-clinical**	Hours													21	10			
45		%													0.3%	0.1%			
46	**Maternity**	Hours	50.6%		69	69	69	0	0	0	0	0	37.5	37.5	37.5	37.5	29.75		
47	**Budget Position**	YTD Position		>0	-96771	-102720	-214295	-273162	-333679	-391542	-419366	-420659	-450392	-515942			-3218528		
48	**Statutory & Mandatory**	Mandatory training	94.0%	95%	93%	90%	91%	91%	92%	94%	96%	95%	96%	96%	95%	93%	94%		Matron is following up staff who are out of date.
49		Appraisal	93.0%	95%	94%	88%	92%	90%	86%	90%	98%	98%	98%	98%	96%	85%	93%		All out of date appraisals have been booked. Matron off sick for a month,
50	**Uniform Audit**	Compliance with uniform policy %	95%	95%					100%	90%	90%	100%	100%	90%	100%	90%	95%		Regular spot checks and staff being challenged when not complying to the policy.

NURSING METRICS - 12 MONTH ROLLING
MAX FAC OUTPATIENTS

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QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr				
SAFE																			
1	Incidents	Total reported - All incidents	50	_	5	3	4	1	3	4	3	5	7	6	4	2	47		
2		Total reported - Patient safety	19	_	0	0	2	1	3	1	2	1	2	4	3	0	19		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	Falls	Falls - All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
6		Falls - With harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
7	Pressure Damage	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8	Inoculation Injury	Reported incidents	2	0	0	0	0	0	0	0	1	0	0	0	0	0	1		
9	MRSA	Reported cases	0	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	0		
11	Hand Hygiene	Hand hygiene	99%	95%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%		
12		Bare below the elbows	100%	95%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%		
13	Medication Audit	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
14		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
15		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
16	Medication Errors	Reported errors	3	0	0	0	0	1	0	0	0	0	0	1	0	1	3		ID21807 (08/05/2019): Neck of midazolam ampule shattered when opening. Shard of glass went in the midazolam solution. Discarded ampoule and shattered parts into sharps bin. Recorded in controlled drug book.
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	_	1378	1477	1442	1371	1683	1524	1107	1464	1191	1368	1476	1437	16918		
19		% return rate	18.0%	20%	17%	17%	19%	16%	19%	17%	17%	17%	18%	18%	12%	7%	16%		Changes to trust data capture due to IG concern in April and May
20		% recommendation (v likely/likely)	93.0%	90%	93%	94%	93%	94%	94%	93%	95%	96%	92%	93%	95%	97%	94%		
21		% unlikely/extremely unlikely	2.0%	0%	1%	1%	3%	1%	3%	2%	1%	3%	4%	4%	1%	2%	2%		

RESPONSIVE																		
22	**Complaints**	No. recorded	8	0	1	2	0	0	0	2	0	0	0	0	0	0	5	
WELL-LED																		
23	**Vacancy** Establishment=	Full Team WTE	21.4					21.37	21.37	21.37	21.37	21.37	21.37	21.37	21.37	21.37	21.4	
24		Vacancy WTE	1.9		1.76	1.76	1.76	1.34	3.34	2.42	2.42	3.22	1.72	0.72	0.92	0.92	1.9	
25		Vacancy (hrs)	311.2		286	286	286	218	543	393.25	393.25	523.25	279.5	117	149.5	149.5	302.02	
26	**Temporary Staffing** excluding RMN	Agency Use	0		0	0	0	0	0	0	0	0	0	0	0	0	0	
27		Bank Use-all staff	153.9		245	115.5	120.75	162	169.25	117.9	76.75	149.55	140.15	158.75	158.45	154.5	147.38	
		Bank Use-non-clinical														0		
29	**Sickness-all staff**	Hours	139.7		120.5	133.8	33.75	198.5	55.5	171.25	62	219.25	313.67	89.25	95.5	87.5	131.71	
30		%	3.9%	3%	3.5%	3.8%	0.9%	5.7%	1.6%	4.9%	1.8%	6.3%	9.0%	2.6%	2.8%	2.5%	3.8%	
31	**Sickness-non-clinical**	Hours													0	0		
32		%													0.0%	0.0%		
33	**Maternity**	Hours	12.5%		0	0	0	0	0	0	0	0	0	150	150	150	37.5	
34	**Budget Position**	YTD Position		>0	1333	3754	6041	7423	14672	17258	27014	37739	44777	31684			191695	
35	**Statutory & Mandatory**	Mandatory training	92%	95%	92%	88%	89%	90%	94%	93%	97%	96%	94%	93%	95%	98%	93%	
36		Appraisal	97%	95%	90%	92%	96%	100%	100%	100%	100%	100%	96%	100%	100%	96%	97%	
37	**Uniform Audit**	Compliance with uniform policy %	100%	95%					100%	100%	100%	100%	100%	100%	100%	100%	100%	

NURSING METRICS - 12 MONTH ROLLING

PEANUT WARD

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QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	**Incidents**	Total reported - All incidents	179	_	28	25	11	11	16	10	11	13	8	9	21	22	185		
2		Total reported - Patient safety	20	_	3	1	1	2	1	1	1	1	4	1	4	2	22		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	**Falls**	Falls - All	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
6		Falls - With harm	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8	**Inoculation Injury**	Reported incidents	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
9	**MRSA**	Reported cases	0	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	0		
11	**Hand Hygiene**	Hand hygiene	78.0%	95%	70%	44%	N/S	70%	90%	90%	90%	80%	90%	80%	100%	100%	82%		
12		Bare below the elbows	97.0%	95%	90%	100%	N/S	100%	100%	90%	90%	100%	100%	100%	100%	100%	97%		
13	**Drug Assessments**	% staff compliant	93.0%	100%	94%	94%	100%	100%	93%	93%	84%	85%	87%	87%	93%	93%	92%		1 LTS staff member now returned and completing mandatory and competencies
14	**Medication Audit**	Missed dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
15		Omitted dose			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
16		Total doses			ported 1	Reported 1/4ly			Reported 1/4ly			ported 1/4ly					0		
17	**Medication Errors**	Reported errors	4	0	1	0	0	0	0	1	0	0	1	0	2	0	5		
18	**Safety Thermometer**	Harm Free Care %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
19		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
20	**BMI Monthly**	Total no. of ward patients	2398	_	145	213	210	188	243	199	165	217	199	215	236	237	2467		
21		No. patients screened & documented	2263	_	143	202	201	174	236	194	151	210	168	205	217	221	2322		
22		Patients with documented BMI %	94%	95%	99%	95%	96%	93%	97%	97%	92%	96%	93%	97%	92%	93%	94%		Some trauma patients seen and discharged with no treatment needed.
	VTE (Venous Thrombo Embolism)	Assessment of patients (S. Therm)		95%											100%	100%			VTE screening applies to 16 and over from April 2019
		Monthly screening % (Informatics)		95%															
25	**Shift meets requirement** Day %	RN	98.0%	95%	95%	98%	98%	99%	101%	98%	97%	98%	97%	96%	99%	97%	98%		
26		HCA	98.0%	95%	103%	96%	100%	96%	97%	97%	97%	95%	97%	88%	103%	100%	97%		
27	**Shift meets requirement** Night %	RN	86.0%	95%	84%	85%	90%	80%	70%	70%	81%	97%	100%	95%	88%	79%	85%		Dependent on patient acuity, staff sickness.
28		HCA	100%	95%	100%	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	_	199	201	199	164	200	185	152	189	170	187	206	223	2275		
31		% return rate	34.0%	40%	33%	28%	38%	45%	31%	32%	36%	49%	23%	17%	34%	20%	32%		Staff are reminded regularly to give out FFT.
32		% recommendation (v likely/likely)	98.0%	90%	98%	98%	95%	100%	100%	100%	98%	99%	100%	100%	97%	97%	99%		
33		% unlikely/extremely unlikely	0.0%	0%	0%	1%	0%	0%	0%	0%	2%	0%	0%	0%	1%	1%	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	20.37	20.37	20.2		
36		Vacancy WTE	0.6		1.5	1.18	1.18	1.08	-0.08	-0.08	-1.08	0.38	0.3	0.94	0.94	0.94	0.6		
37		Vacancy (hrs)	92.11		244	191.75	191.8	175.5	-13	-13	-175.5	61.75	48.75	152.75	152.75	152.8	97.529		
38	**Temporary Staffing** excluding RMN	Agency Use	60.52		71	92.5	68.5	69.5	74	69.5	0	48.5	41.5	53.25	73.5	89	62.563		
39		Bank Use-all staff	309.8		472.5	488.4	366.5	284.5	339.55	321.25	223	189	238.75	189.5	214.25	227.4	296.22		
		Bank Use-non-clinical														4			
41	**Sickness-all staff**	Hours	130.1		161.5	84	24	40	96	181	76	220.25	205.95	212	266.5	112.5	139.98		
42		%	3.7%	3%	4.9%	2.6%	0.7%	1.2%	3.0%	5.7%	2.4%	6.7%	6.2%	6.4%	8.1%	3.4%	4.3%		LTS staff member now back on reasonable adjustments
43	**Sickness non clinical**	Hours													45	65			
44		%													1.3%	2.0%			
45	**Maternity**	Hours															#DIV/0!		
46	**Budget Position**	YTD Position		>0	7514	4051	2932	7797	13962	17375	11940	30457	33223	43873			173124		
47	**Statutory & Mandatory**	Mandatory training	93%	95%	93%	93%	91%	94%	95%	94%	94%	93%	92%	91%	89%	92%	93%		Head of Nursing has emailed each member of staff outlining what needs to be booked. Many staff are booked in June or updates, a small improvement from last month.
48		Appraisal	88%	95%	91%	91%	91%	96%	96%	92%	92%	83%	92%	71%	80%	80%	88%		This percentage is not representative, some appraisals completed but workforce had not been informed.
49	**Uniform Audit**	Compliance with uniform policy %	88%	95%					100%	100%	90%	70%	80%	90%	90%	100%	90%		Spot checks. Ward matron to identify trends

NURSING METRICS - 12 MONTH ROLLING

SLEEP DC

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No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20		Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May			
SAFE																			
1	Incidents	Total reported - All incidents	25	_	2	3	2	1	1	2	4	1	1	5	2	3	27		
2		Total reported - Patient safety	9	_	0	0	2	0	0	1	2	1	1	1	1	0	9		
3		Formal internal investigation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
5	Falls	Falls - All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
6		Falls - With harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
7	Pressure Damage	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8	Inoculation Injury	Reported incidents	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
9	MRSA	Reported cases	0	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	0		
11	Hand Hygiene	Hand hygiene	100%	95%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%		
12		Bare below the elbows	100.0%	95%	N/S	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%		
13	Medication Errors	Reported errors	4	0	0	0	1	0	0	1	1	0	0	1	0	0	4		
14	VTE	Monthly screening % (Informatics)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
EFFECTIVE																			
15	Compliance in Practice (CiP)	Inspection score	91%	80%	ported 1/	Reported 1/4ly			90.6%			ported 1/4ly					91%		
CARING																			
16	Friends & Family Test	Patient numbers (eligible to respond)	10086	_	919	896	792	653	921	907	559	939	794	867	837	935	10019		
17		% return rate	19.0%	20%	17%	22%	24%	19%	19%	16%	22%	22%	16%	19%	13%	14%	19%		
18		% recommendation (v likely/likely)	97.0%	90%	96%	97%	97%	97%	98%	97%	95%	96%	98%	98%	99%	97%	97%		
19		% unlikely/extremely unlikely	1.0%	0%	2%	1%	1%	1%	1%	2%	2%	2%	1%	0%	0%	3%	1%		
RESPONSIVE																			
20	Complaints	No. recorded	1	0	0	0	0	0	0	1	0	0	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	Sickness non clinical	Hours																	
29		%																	
30	Maternity	Hours															#DIV/0!		
31	Budget Position	YTD Position		>0													0		
32	Statutory & Mandatory	Mandatory training		95%													#DIV/0!		
33		Appraisal		95%													#DIV/0!		
34	Uniform Audit	Compliance with uniform policy %	100%	95%					100%	100%	100%	100%	100%	100%	100%	100%	100%		

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**111-19**	
Report title:	**National inpatient survey results 2018**				
Sponsor:	Jo Thomas, Director of nursing				
Authors:	Jo Thomas, Director of nursing Care Quality Commission				
Appendices:	Report				
Executive summary					
Purpose of report:	To provide assurance about the quality of patient experience at QVH, comparing trust performance with previous year and national benchmarks.				
Summary of key issues	The survey ranked QVH as one of only eight acute specialist trusts to be given the CQC's branding of 'much better than expected' by patients.				
Recommendation:	The Board is asked to **NOTE** the results of the National Inpatient Survey 2018				
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:	This report links primarily to KSO1 which has been reviewed and amended following publication of the full report				
Corporate risk register:	There are several corporate risk which relate directly to patient experience this has been reviewed following publication of this report				
Regulation:	None: It is part of the Trust's regulatory requirement to undertake the annual CQC inpatient survey				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	24/06/19	Decision	**Noted**	
Previously considered by:					
	Date:		Decision:		
Next steps:	Action plan will be completed and will be overseen and monitored by the patient experience manager at the patient experience group with feedback to Q&GC.				

Report to:	Board Directors
Agenda item:	110-19
Date of meeting:	4 July 2019
Report from:	Jo Thomas, Director of nursing
Report author:	Jo Thomas, Director of nursing
Date of report:	25 June 2019
Appendices:	A: CQC Patient survey report 2018

National inpatient survey results 2018

Introduction

This report provides assurance about the quality of patient experience at QVH, comparing trust performance with previous year and national benchmarks.

Executive summary

In its 16th year the survey shows how 148 NHS trusts in England score against each other in 62 different questions (exempt from 2 A&E questions) looking at different aspects of the inpatient experience including the hospital and ward, doctors and nurses, care and treatment and operations and procedures.

Situation

The key messages are that in comparison with other Trusts, QVH is significantly better on 48 questions significantly worse on 1 question and about the same on 11 questions. Most results for the 2018 Adult Inpatient Survey (England) have slightly declined since last year or remained static which was not mirrored at QVH with 64 % of comparable question improving or staying static.

The survey ranked QVH as one of only eight acute specialist trusts to be given the CQC's branding of 'much better than expected' by patients.

Assessment

Eligibility and participation

- Number of QVH participants 556: (England: 76,668)
- Response rate: 45 per cent for QVH and England
- Age range: 16 years and older
- Time period: patients discharged from hospital during July 2018
- Eligibility: patients aged 16 years or older, who had at least one overnight stay
- Exclusion: patients whose treatment related to maternity or, patients admitted for planned termination of pregnancy, daycase patients, private patients (non-NHS)

Significant positive improvements for patients at QVH:

- Patients received answers that they could understand when they had an important question to ask the doctor
- Doctors didn't talk in front of patients as if they weren't there
- Patients received answers that they could understand when they had an important question to ask the nurse
- Patients felt they got enough emotional support from hospital staff during the admission
- After a procedure staff explained how the operation had gone in a way the patient could understand

- Doctors or nurses gave family friends or carers all the information they needed to help care for the patient

There were no significant areas of decline; however areas in need of improvement in patient experience were:

- Length of time on waiting list, admission date changed by the hospital
- Rating of hospital food / help from staff to eat food
- Enough notice about when you were going
- Staff taking family/home situation into account when planning the discharge
- Written advice about medications
- Being asked about the quality of the care.

Recommendation

The Board is asked to **NOTE**:

- The results of the National Inpatient Survey 2018.
- That this report was not presented at the Q&GC 19 June as it was not published until the 20 June.
- That this report forms part of our assurance that patient experience is being sustained and improved which is notable given the challenges in our workforce, as well as demonstrating that patient experience as a whole is not compromised due to the financial and operational challenges faced by the organisation.

Patient survey report 2018

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

NHS Patient Survey Programme
Adult Inpatient Survey 2018

The Care Quality Commission

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

Adult Inpatient Survey 2018

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

The 2018 survey of adult inpatient (sixteenth iteration of the survey) involved 144 acute and specialist NHS trusts. 76,668 people responded to the survey, yielding an adjusted response rate of 45%.

Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2018[1]. Trusts counted back from the last day of July 2018, including every consecutive discharge, until they had selected 1,250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2018). Fieldwork took place between August 2018 and January 2019.

Surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2018. Although questionnaire redevelopments took place over the years, the survey results for this year are largely comparable to those from previous iterations.

The Adult Inpatient Survey is part of a wider programme of NHS patient surveys which covers a range of topics, including children and young people's services, community mental health services, urgent and emergency care services and maternity services. To find out more about the programme and to see the results from previous surveys, please see the links in the 'Further information' section.

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold providers to account for the outcomes they achieve. NHS Improvement will use the results to inform their oversight model for the NHS.

This research was carried out in accordance with the international standard for organisations conducting social research (accreditation to ISO20252:2012; certificate number GB08/74322).

Interpreting the report

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with most other trusts. For more information on the expected range, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

[1] 39 trusts sampled additional months because of small patient throughputs.

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

Standardisation

People's characteristics, such as age and gender, can influence their experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' the data, which means we apply a weight to individual responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by age, gender and method of admission (emergency or elective) of respondents to reflect the 'national' age-gender-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile. It therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this standardisation will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

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

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trust. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom the following questions do not apply. An example of a routing question would be Q44 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see 'Further information' section).

Section scoring is computed as the arithmetic mean of questions' score after weighting is applied.

Graphs

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

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

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts. If there is no text, the score is 'about the same.' These groupings are based on a rigorous statistical analysis of the data, as described in the following 'Methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it

performs significantly above or below what would be expected. If it is within this range, we say that its performance is ‘about the same’. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, it is very unlikely to have occurred by chance.

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

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (and the corresponding section[2]). This is because the uncertainty around the result is too great.

A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see ‘Further information’ section).

Tables

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

Scores from last year's survey are also displayed where available. The column called 'Change from 2017' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2017. A statistically significant difference means that the change in the result is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test with a significance level of 0.05.

Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Where a result for 2017 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance.

Comparisons are also not able to be shown if a trust has merged with other trusts since the 2017 survey, or if a trust committed a sampling error in 2017.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q50 and Q51: The information collected by Q50 “On the day you left hospital, was your discharge delayed for any reason?” and Q51 “What was the main reason for the delay?” are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital.

The combined question in this report is labelled as Q51 and is worded as: “Discharge delayed due to wait for medicines/to see doctor/for ambulance.”

Q52: Information from Q50 and Q51 has been used to score Q52 “How long was the delay?” This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q53 and Q56: Respondents who answered Q53 “Where did you go after leaving hospital?” as “I was transferred to another hospital” were not scored for Q56 (“Before you left hospital, were you given any written or printed information about what you should or should not do after leaving

[2]The section score is not displayed as it would include fewer questions compared with other trusts hence it is not a fair comparison.

hospital?"). This decision was taken as there is not a requirement for hospital transfers.

Trusts with female patients only

Q11: If your trust offers services to women only, the score for Q11 "While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E department.

Notes on question comparability

The following questions were new questions for 2018, and it is therefore not possible to compare with previous years:

Q66. *Was the care and support you expected available when you needed it?* (section 9 "Leaving hospital")

Q69. *During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?* (section 10 "Overall views of care and services")

The following question was removed from the 2018 questionnaire (2017 numbering):

Q59. *Were you told how to take your medication in a way you could understand?*

For more information on questionnaire redevelopment and the rationale behind adding or removing individual questions please refer to the Survey Development Report, available here:
http://nhssurveys.org/survey/2117

Further information

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

The results for England, and trust level results, can be found on the CQC website. You can also find a 'technical document' here which describes the methodology for analysing the trust level results:
http://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2017 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology for the survey, including questionnaires, letters sent to patients, instructions for trusts and contractors to carry out the survey, and the survey development report, are available at:
http://www.nhssurveys.org/surveys/1203

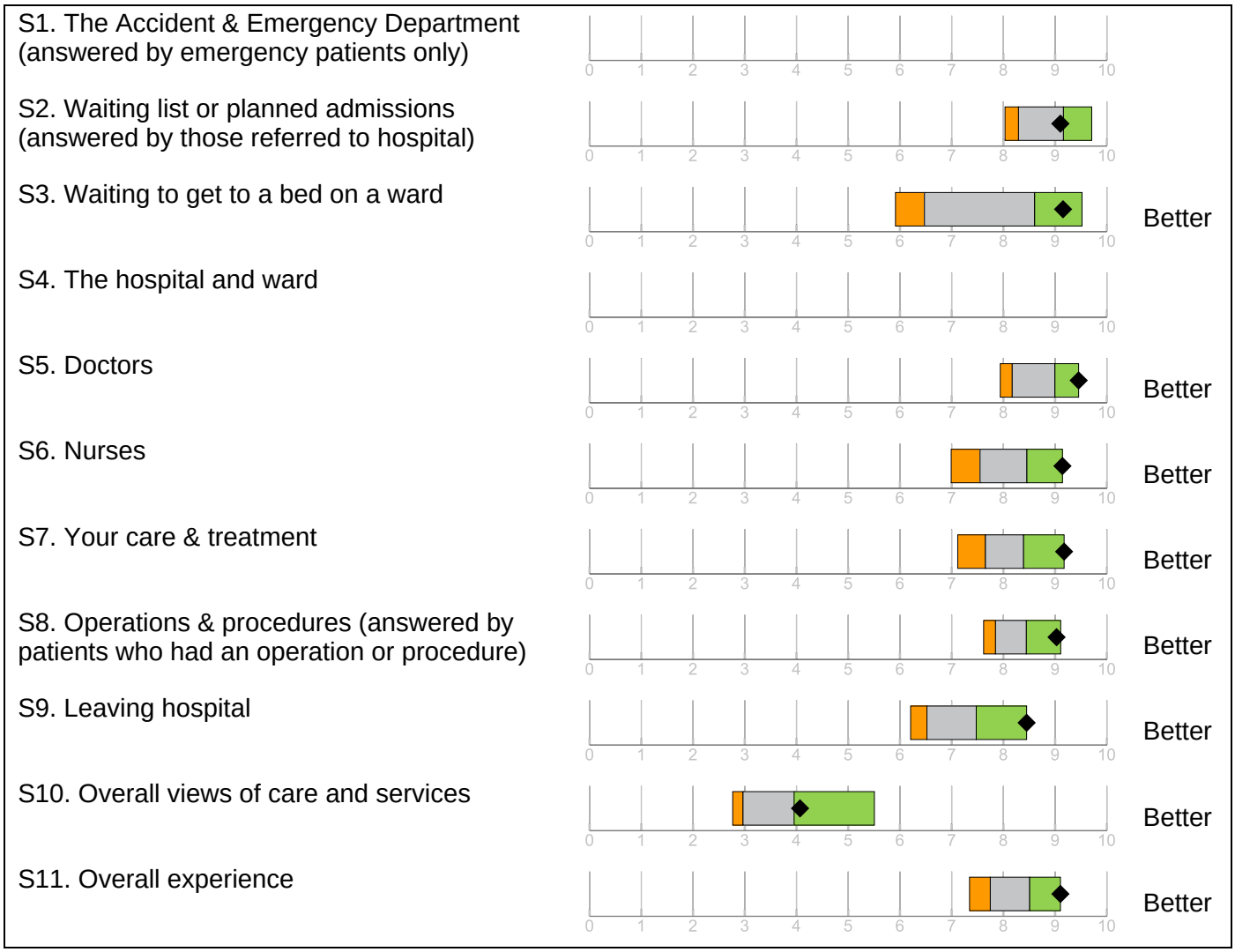
More information on the NHS Patient Survey Programme, including results from other surveys and a schedule of current and forthcoming surveys can be found at:
http://www.cqc.org.uk/content/surveys

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

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

Section scores



Best performing trusts

About the same

Worst performing trusts

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

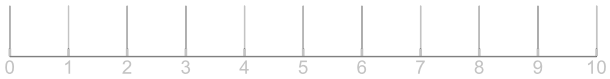
◆ — This trust's score (NB: Not shown where there are fewer than 30 respondents)

Adult Inpatient Survey 2018

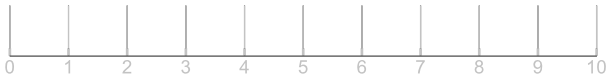
Queen Victoria Hospital NHS Foundation Trust

The Accident & Emergency Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

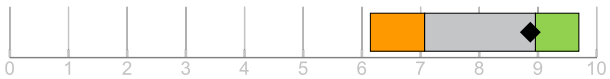


Q4. Were you given enough privacy when being examined or treated in the A&E Department?



Waiting list or planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?



Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

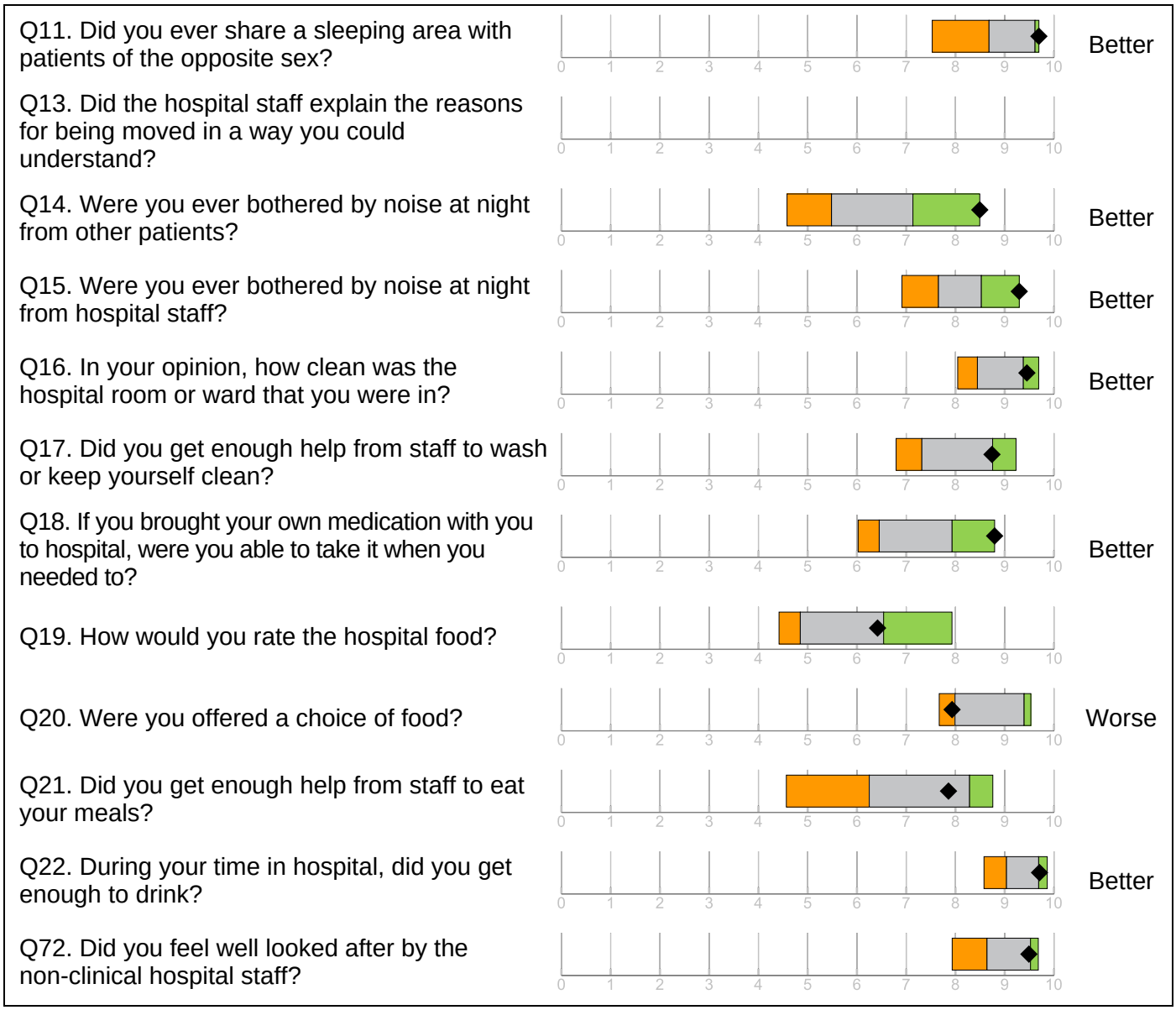
Better

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

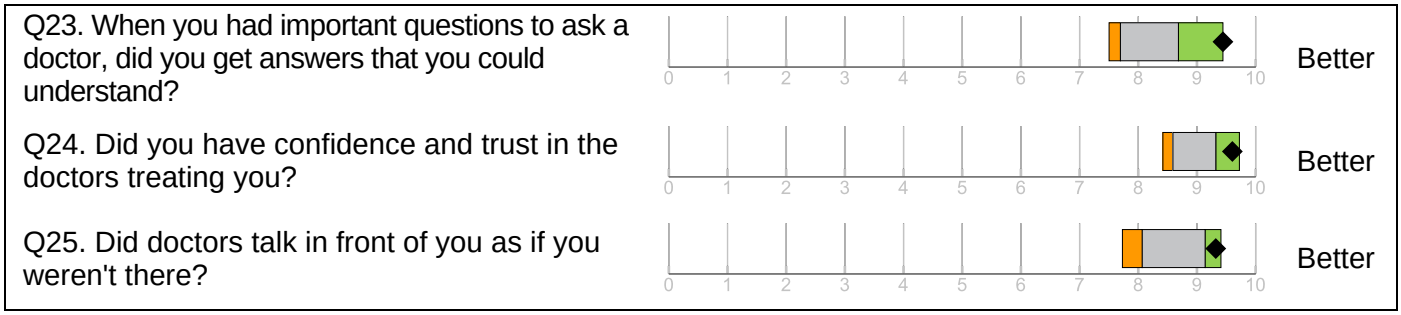
Adult Inpatient Survey 2018

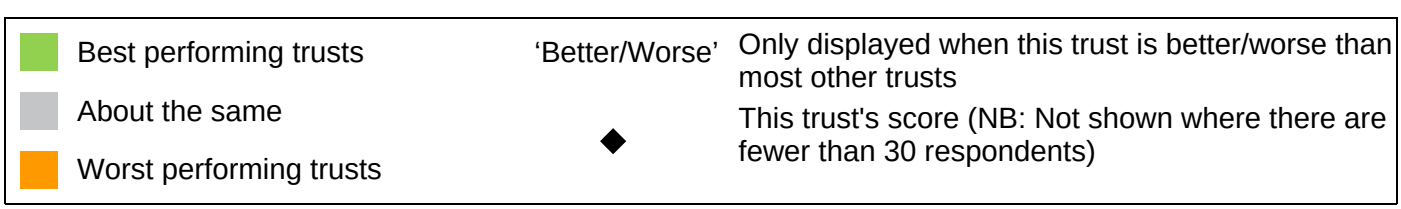
Queen Victoria Hospital NHS Foundation Trust

The hospital and ward



Doctors

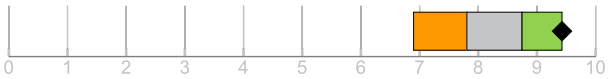
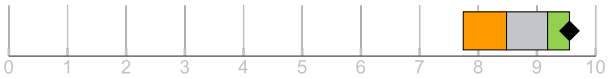
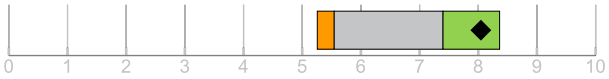




Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

Nurses

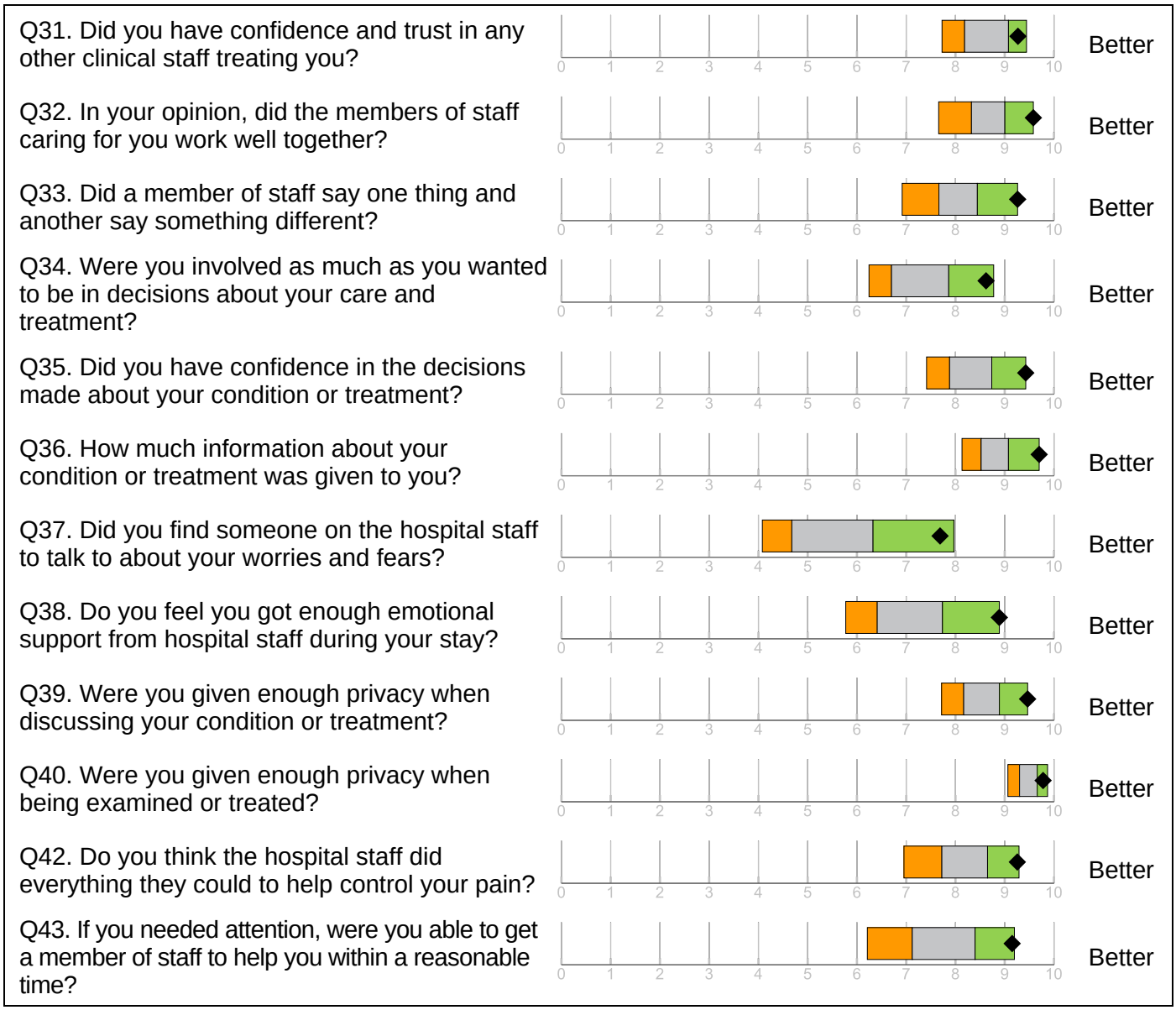
Q26. When you had important questions to ask a nurse, did you get answers that you could understand?		Better
Q27. Did you have confidence and trust in the nurses treating you?		Better
Q28. Did nurses talk in front of you as if you weren't there?		Better
Q29. In your opinion, were there enough nurses on duty to care for you in hospital?		Better
Q30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)		Better

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

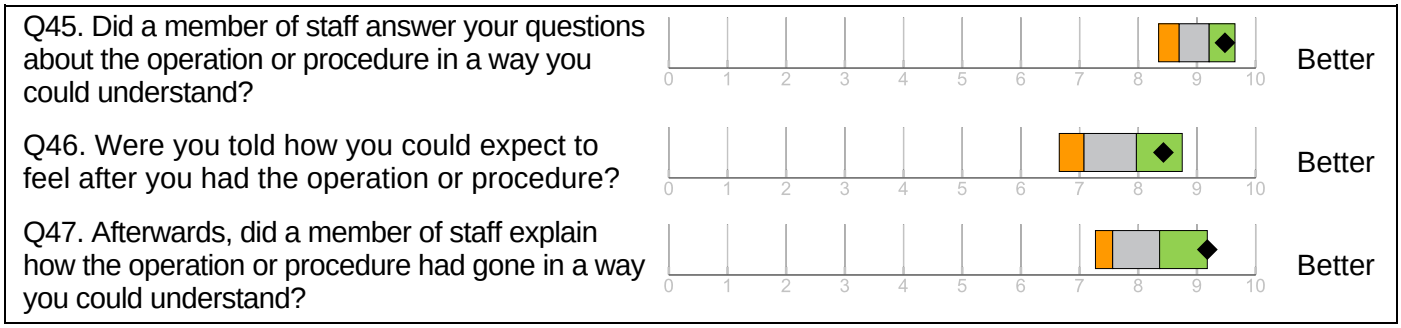
Adult Inpatient Survey 2018

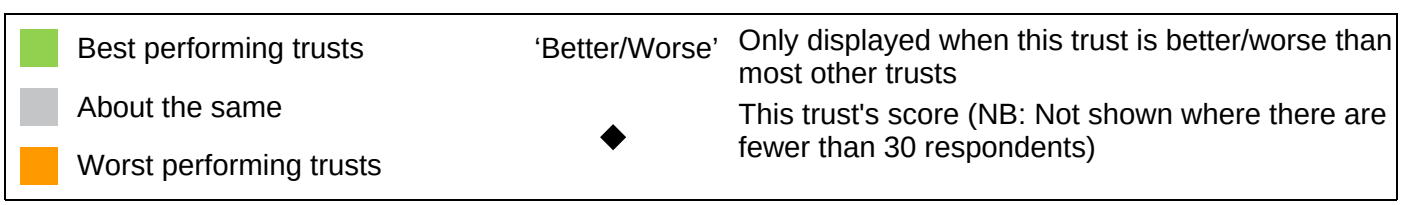
Queen Victoria Hospital NHS Foundation Trust

Your care & treatment



Operations & procedures (answered by patients who had an operation or procedure)

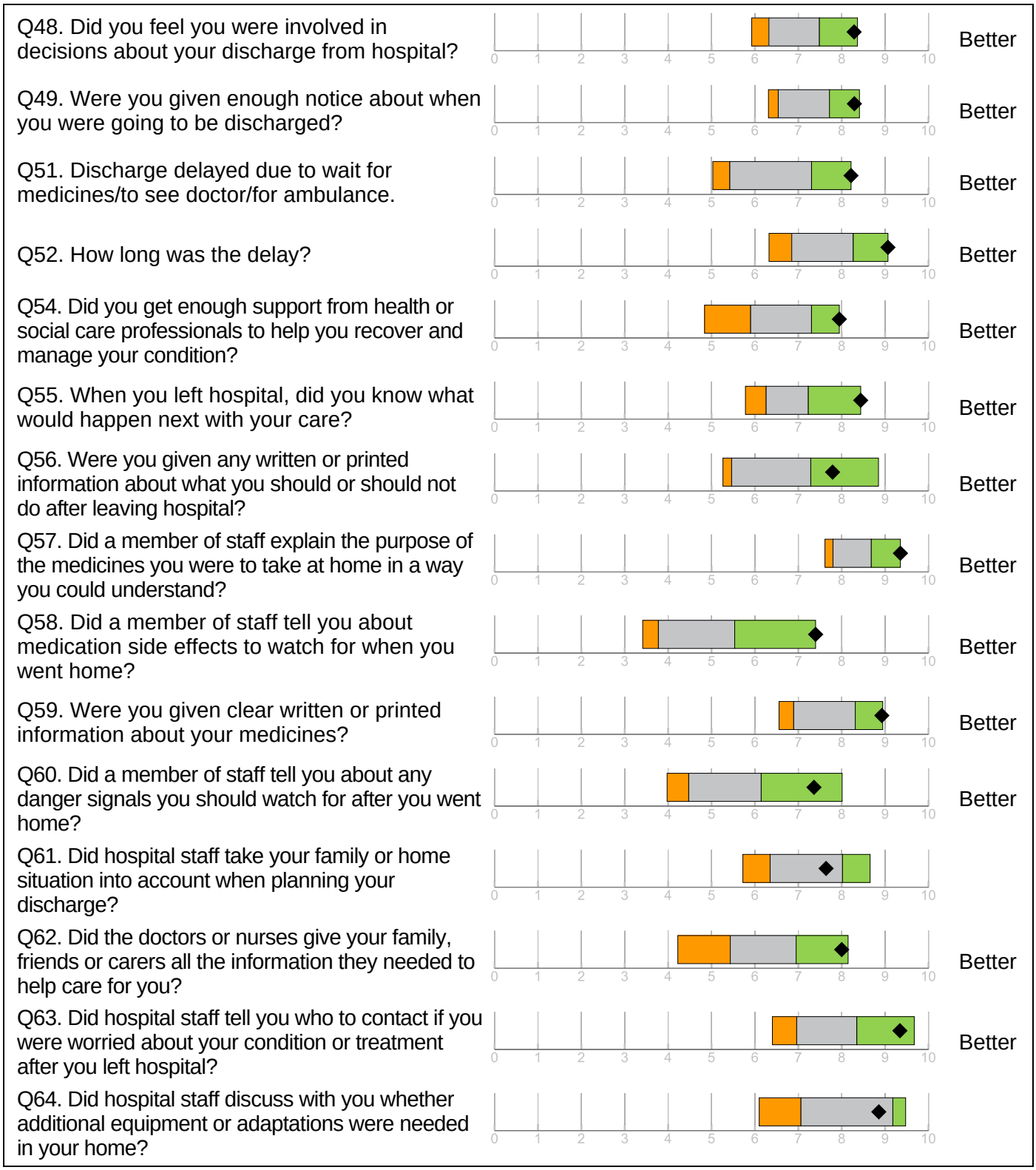




Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

Leaving hospital

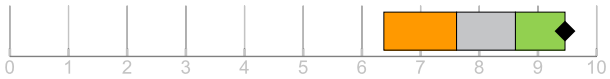


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2018

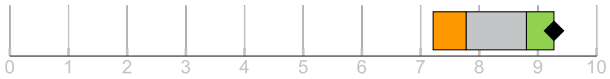
Queen Victoria Hospital NHS Foundation Trust

Q65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



Better

Q66. Was the care and support you expected available when you needed it?



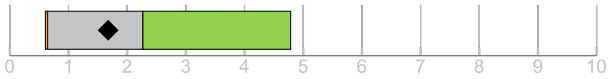
Better

Overall views of care and services

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

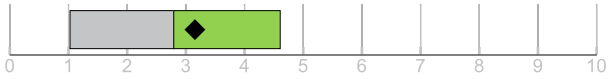
Better

Q69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?



Q70. During your hospital stay, were you ever asked to give your views on the quality of your care?

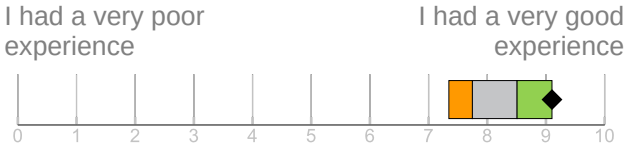
Q71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Better

Overall experience

Q68. Overall...



Better

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

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
The Accident & Emergency Department (answered by emergency patients only)							
S1	Section score	-	7.7	9.1			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	-	7.4	9.0			
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	-	7.7	9.5			
Waiting list or planned admissions (answered by those referred to hospital)							
S2	Section score	9.1	8.0	9.7			
Q6	How do you feel about the length of time you were on the waiting list?	8.9	6.1	9.7	436	9.2	
Q7	Was your admission date changed by the hospital?	9.4	8.3	9.9	439	9.5	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.0	7.9	9.6	434	9.3	
Waiting to get to a bed on a ward							
S3	Section score	9.2	5.9	9.5			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	9.2	5.9	9.5	549	9.1	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
The hospital and ward							
S4	Section score	-	6.9	8.8			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.7	7.5	9.7	552	9.8	
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	-	4.7	8.8			
Q14	Were you ever bothered by noise at night from other patients?	8.5	4.6	8.5	549	8.4	
Q15	Were you ever bothered by noise at night from hospital staff?	9.3	6.9	9.3	547	9.1	
Q16	In your opinion, how clean was the hospital room or ward that you were in?	9.5	8.0	9.7	550	9.4	
Q17	Did you get enough help from staff to wash or keep yourself clean?	8.7	6.8	9.2	270	8.9	
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	8.8	6.0	8.8	320	8.7	
Q19	How would you rate the hospital food?	6.4	4.4	7.9	409	6.7	
Q20	Were you offered a choice of food?	7.9	7.7	9.5	517	7.9	
Q21	Did you get enough help from staff to eat your meals?	7.9	4.6	8.8	118	8.2	
Q22	During your time in hospital, did you get enough to drink?	9.7	8.6	9.9	523	9.8	
Q72	Did you feel well looked after by the non-clinical hospital staff?	9.5	7.9	9.7	417	9.6	
Doctors							
S5	Section score	9.5	7.9	9.5			
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	9.4	7.5	9.4	482	9.0	↑
Q24	Did you have confidence and trust in the doctors treating you?	9.6	8.4	9.7	542	9.7	
Q25	Did doctors talk in front of you as if you weren't there?	9.3	7.7	9.4	546	8.9	↑

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Nurses							
S6	Section score	9.1	7.0	9.1			
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	9.4	6.9	9.4	482	9.0	↑
Q27	Did you have confidence and trust in the nurses treating you?	9.6	7.7	9.6	545	9.5	
Q28	Did nurses talk in front of you as if you weren't there?	9.5	7.8	9.6	549	9.5	
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	9.1	6.1	9.1	543	8.7	
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	8.0	5.3	8.4	542	8.1	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Your care & treatment							
S7	Section score	9.2	7.1	9.2			
Q31	Did you have confidence and trust in any other clinical staff treating you?	9.3	7.7	9.4	313	9.4	
Q32	In your opinion, did the members of staff caring for you work well together?	9.6	7.7	9.6	518	9.2	
Q33	Did a member of staff say one thing and another say something different?	9.3	6.9	9.3	553	9.0	
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.6	6.2	8.8	545	8.2	
Q35	Did you have confidence in the decisions made about your condition or treatment?	9.4	7.4	9.4	547	9.2	
Q36	How much information about your condition or treatment was given to you?	9.7	8.1	9.7	542	9.5	
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	7.7	4.1	8.0	269	6.9	
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	8.9	5.8	8.9	290	8.1	↑
Q39	Were you given enough privacy when discussing your condition or treatment?	9.5	7.7	9.5	546	9.1	
Q40	Were you given enough privacy when being examined or treated?	9.8	9.1	9.9	546	9.8	
Q42	Do you think the hospital staff did everything they could to help control your pain?	9.3	7.0	9.3	264	9.2	
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	9.2	6.2	9.2	446	8.9	
Operations & procedures (answered by patients who had an operation or procedure)							
S8	Section score	9.0	7.6	9.1			
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.5	8.3	9.6	400	9.1	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	8.4	6.7	8.7	414	7.8	
Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	9.2	7.3	9.2	416	8.1	↑

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Leaving hospital							
S9	Section score	8.4	6.2	8.4			
Q48	Did you feel you were involved in decisions about your discharge from hospital?	8.3	5.9	8.4	529	8.1	
Q49	Were you given enough notice about when you were going to be discharged?	8.3	6.3	8.4	551	8.5	
Q51	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	8.2	5.0	8.2	529	8.0	
Q52	How long was the delay?	9.1	6.3	9.1	529	8.8	
Q54	Did you get enough support from health or social care professionals to help you recover and manage your condition?	7.9	4.8	7.9	238	7.5	
Q55	When you left hospital, did you know what would happen next with your care?	8.4	5.8	8.4	492	8.4	
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	7.8	5.3	8.8	532	7.6	
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.4	7.6	9.4	345	9.6	
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	7.4	3.4	7.4	264	7.6	
Q59	Were you given clear written or printed information about your medicines?	8.9	6.6	8.9	292	9.4	
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	7.4	4.0	8.0	362	8.0	
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	7.6	5.7	8.7	260	8.1	
Q62	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	8.0	4.2	8.1	280	6.7	↑
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	9.3	6.4	9.7	511	9.1	
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.9	6.1	9.5	96	8.5	
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	9.5	6.4	9.5	199	8.7	
Q66	Was the care and support you expected available when you needed it?	9.3	7.2	9.3	363		

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2017 scores for this NHS trust	Change from 2017
Overall views of care and services							
S10	Section score	4.1	2.8	5.5			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.7	8.2	9.8	549	9.6	
Q69	During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	1.7	0.6	4.8	441		
Q70	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.8	0.5	3.7	433	2.5	
Q71	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.2	1.1	4.6	381	3.4	
Overall experience							
S11	Section score	9.1	7.3	9.1			
Q68	Overall...	9.1	7.3	9.1	540	9.1	

↑ or ↓	Indicates where 2018 score is significantly higher or lower than 2017 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2017 data is available.

Adult Inpatient Survey 2018
Queen Victoria Hospital NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	556	76668
Response Rate (percentage)	45	45

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	48	48
Female	52	52
Age group (percentage)	(%)	(%)
Aged 16-35	12	5
Aged 36-50	14	8
Aged 51-65	32	23
Aged 66 and older	42	64
Ethnic group (percentage)	(%)	(%)
White	90	89
Multiple ethnic group	1	1
Asian or Asian British	3	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	5	5
Religion (percentage)	(%)	(%)
No religion	27	18
Buddhist	1	0
Christian	65	75
Hindu	0	1
Jewish	0	0
Muslim	1	2
Sikh	0	1
Other religion	2	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	95	94
Gay/lesbian	0	1
Bisexual	0	0
Other	1	1
Prefer not to say	3	4

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Date last reviewed : 19 June 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 [CRR 1125]
- Performance challenges across OMFS, plastics and eyes
- Spoke site links and pathways
- Vacancy levels in theatre staffing and theatre capacity [CRR 1077]
- Vacancy levels in sleep [CRR 1116]
- Specialist nature / complexity of some activity
- Administrative vacancies
- 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
- Ongoing medical vacancies in corneo [CRR 1143]
- Sentinel Lymph Node demand [CRR 1122]

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
- 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
- Corneo fellow vacancies
- Breast capacity

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Finance & Performance
Date last reviewed: 20th June 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 2)

- Month 2 position YTD £200k behind plan due to income shortfall (improvement post month 1 freeze included – reported position £500k)
- Current run rate forecast deficit of £11m (**CRR877)**
- CIP performance £85k/£125k for YTD Month 2 - slippage offset by non recurrent underspends
- Finance & Use of Resources – 3 (planned 4)
- 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£0.6m
- Agency staffing pressure continuing
- 2019/20 Operation plan submission (May) –£7.4m deficit – with Board agreement
- 2018/19 final audit position £4.1m deficit

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
- Lack of outside resource for CIP Delivery - NHSI

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 and performance reports to the board.
- ~~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
- Finance & Performance Committee in place, forecasting from month 3 onwards
- Audit Committee with a strengthened Internal Audit Plan
- Budget Setting and Business Planning Processes (including capital) all approved for clinical areas
- CIP Governance processes strengthened
- 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 – draft transformation plan for board developed
- Additional Finance staff restructure approved

Gaps in controls / assurances

- Structure, systems and process redesign and enhanced cost control
- Model Hospital Review and implementation
- Roll out of management information, development into service line reporting, spoke site service reviews and more granular speciality reporting.
- Enhanced pay and establishment controls including performance against the agency cap
- Increased frequency of Finance and procurement training to budget holders – 18 staff attended courses in the last month
- Establishment review and reconciliation between the ledger and ESR nearly complete

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**114-19**	
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:	The purpose of this report is to provide the Board with assurance as to performance under finance, operational performance and workforce.				
Summary of key issues					
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:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	Finance and performance committee				
	Date:	24/06/19	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	04 July 2019
Reference no:	114-19
Report from:	John Thornton, Senior independent director and committee Chair
Report date:	26 June 2019

Finance and performance committee assurance report
Meeting held on 24 June 2019

Operations
There is evidence of continued improvement in delivery against 18WW target and that action plans are in place to maintain the momentum. The target is still to achieve 92% by March 2020 but there is acknowledgement that this may be stretching.

All specialisms are contributing to the improvement with the exception of ophthalmology which is experiencing difficulties with medical resources. If this cannot be resolved soon then a more fundamental review of how this specialism is organised and delivered will be carried out.

Overall activity levels are improving but not sufficiently to deliver the necessary patient income. The budget includes meaningful uplifts in the next few months which may be at risk. Committee noted the significant efforts being made to improve efficiency and effectiveness and the improved data now being provided.

Finance.
Delivery of patient income for the first two months is behind plan and activity needs to increase. Total costs are running under plan but not at a sufficient rate to offset the income shortfall.

Our cost improvement plan target for the year is now £1.7m including the recent uplift. Of this £800k has been identified. Significant efforts will be required to identify the balance and committee was pleased to hear that a dedicated cost improvement plan meeting has been established for the executive team each week.

Cash Management
As a result of our monthly deficits we will not generate sufficient cash for our needs and will need to borrow money from the NHS Funds. A draw down of £1.2m has already been made and loan conditions are being discussed by the Board. In this section of the meeting the outstanding debtors were discussed at some length and a regular report will be provided to F&P.

Workforce.
We continue to see improvements across many of the key metrics on the workforce dashboard.

A discussion took place on the level of agency staff and the committee asked for a trajectory to be established showing our plans for reduction in numbers to reflect our increase in substantive staff and our need to reduce overall workforce costs to underpin the budget.

EDM Update
A brief discussion took place and committee was advised that the roll out will recommence with the plastics section. Also advised that an external consultant has been appointed to assess any clinical risks within the project. Committee agreed to dedicate more time for this topic for a fuller discussion at the next meeting.

Other
Given the number of issues and challenges being faced at the present time and the need to monitor progress closely it was agreed to reinstate the F&P meeting in August.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**115-19**	
Report title:	**Operational Performance**				
Sponsor:	Abigail Jago, Director of Operations				
Author:	Operations Team				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide the Board with an update on current operational performance				
Summary of key issues	Key items to note in the operational report are: • Delivery of diagnostic waiting time standards • Delivery of open pathway performance trajectory • 52 week performance behind plan by 2 patients • Challenges in month with 2ww cancer standard • Delivery of 62 day cancer standards • Delivery of MIU 4 hour standard • Ongoing delivery of theatre improvement programme • Ongoing delivery of outpatient improvement programme				
Recommendation:	The Board is asked to **NOTE** the contents of this report				
Action required				Assurance	
Link to key strategic objectives (KSOs):			KSO3:		
			Operational excellence		

Implications	
Board assurance framework	Potential risks are managed through a series of controls as described on the KSO3 BAF (item 113-19)
Corporate risk register:	Gaps in controls are set out in the KSO3 BAF (item 113-19) Related CRR risks include: 1143, 1125, 1122, 1116, 1077 (item 108-19)
Regulation:	None
Legal:	Implications in respect of patient access. 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:	None

Assurance route				
Previously considered by:	Finance and performance committee			
	Date:	24/06/2019	Decision:	Noted
Next steps:	NA			

Operational Performance Report

Abigail Jago, Director of Operations

Board of Directors July 2019

Final version

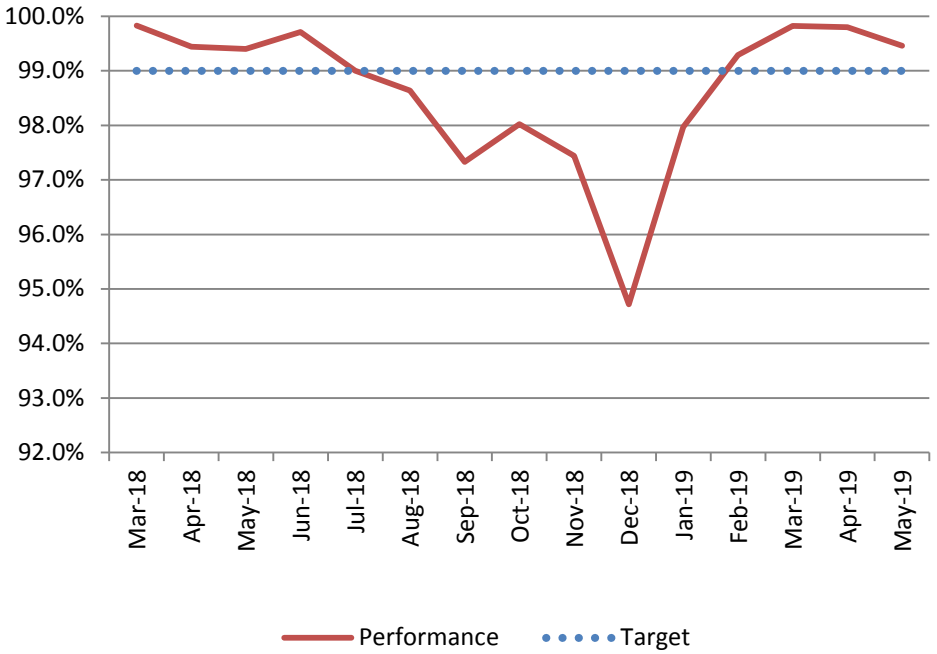
Summary

Key items to note in the operational report are:

- Delivery of diagnostic waiting time standards
- Delivery of open pathway performance trajectory
- 52 week performance behind plan by 2 patients
- Challenges in month with 2ww cancer standard
- Delivery of 62 day cancer standards
- Delivery of MIU 4 hour standard
- Ongoing delivery of theatre improvement programme
- Ongoing delivery of outpatient improvement programme

Diagnostic Waits (DM01)

Queen Victoria Hospital NHS
NHS Foundation Trust

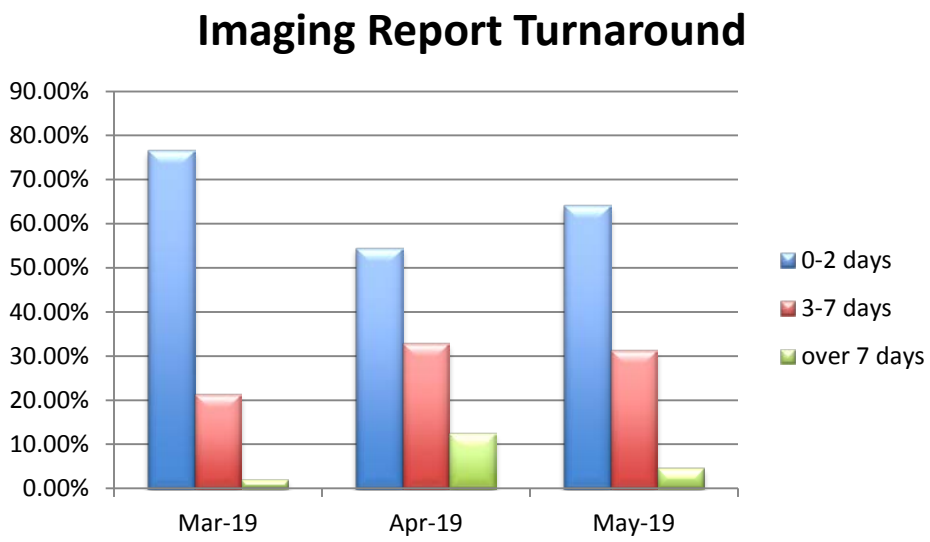


(Last reporting period – Apr19)			(This reporting period – May19)		
Modality / test	Breaches	Perf.	Modality / test	Breaches	Perf.
CT	0	100.00%	CT	0	100.00%
ECHOCARDIOGRAPHY	0	100%	ECHOCARDIOGRAPHY	0	100%
MRI	0	100.00%	MRI	2	96.60%
NON-OBSTETRIC ULTRASOUND	2	97.73%	NON-OBSTETRIC ULTRASOUND	1	99.86%
SLEEP STUDIES	0	100.00%	SLEEP STUDIES	2	93.30%

Performance commentary	Forward look / performance risks
Diagnostic Imaging • Ultrasound performance has improved with the ongoing use of waiting list initiative lists and agency sonographer. • MRI breaches due to specialist outsourcing for breast /paediatric scanning **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 ongoing breach risk **Sleep Studies** • Recruitment process underway for a Consultant • Staffing/skill mix/activity service review undertaken • No anticipated breaches

Diagnostic Imaging – Reporting turnaround times

Queen Victoria Hospital NHS
NHS Foundation Trust



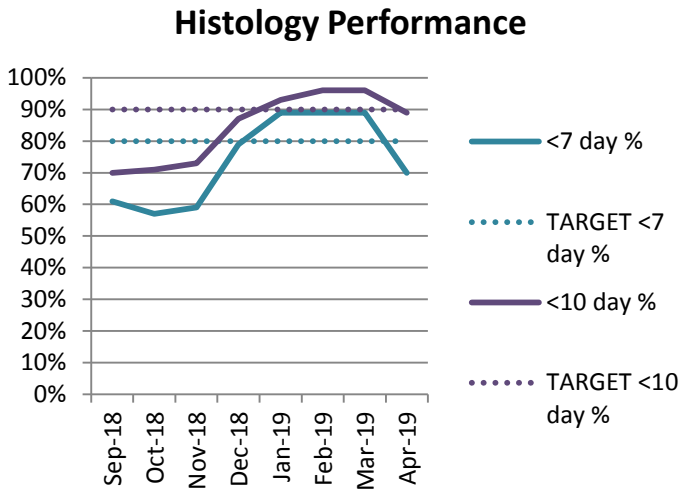
95% of imaging was reported within 7 days in month

Performance commentary	Forward look / performance risks
• Improved reporting turnaround in month. • Ongoing use of an outsourced solution to support service delivery. • Work is underway to develop a job plan and associated approval for radiologist vacancy appointment.	• Substantive reporting radiographer started at QVH on the 3rd June which should improve reporting performance and resilience.

Histology

Queen Victoria Hospital NHS
NHS Foundation Trust

Month	<7 day %	TARGET <7 day %	<10 day %	TARGET <10 day %	<7 days	7<10 days	TOTAL SPECIMENS RECEIVED	Total Cases Reported
Sep-18	61%	80%	70%	90%	503	77	1310	829
Oct-18	57%	80%	71%	90%	685	160	1635	1196
Nov-18	59%	80%	73%	90%	680	157	1518	1144
Dec-18	79%	80%	87%	90%	908	87	1433	1149
Jan-19	89%	80%	93%	90%	849	42	1519	954
Feb-19	89%	80%	96%	90%	895	68	1413	1004
Mar-19	89%	80%	96%	90%	895	68	1413	1004
Apr-19	70%	80%	89%	90%	606	165	1317	870
May-19		80%		90%				
Jun-19		80%		90%				
Jul-19		80%		90%				
Aug-19		80%		90%				
Sep-19		80%		90%				



Performance commentary	Forward look / performance risks
• 3 weeks of Consultant Histopathologists' annual leave in April which has impacted turnaround times as many cases require the expertise of specific consultants within the department.	• 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 – 19/20

	Quarter 4 18/19			Quarter 1 19/20			Quarter 2 19/20			Quarter 3 19/20			Quarter 4 19/20		
	Jan-19	**Feb-19**	**Mar-19**	**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	75.3%	76.2%	77.3%	78.3%	79.2%	80.0%	81.3%	81.3%	82.3%	83.8%	85.3%	85.3%	87.7%	90.3%	92%
RTT Actual	75.87%	76.61%	78.47%	79.51%	81.11%										
52 week plan	91	68	60	50	40	30	20	10	0	0	0	0	0	0	0
52 week actual (total)	81	68	62	47	42										
52 week patient choice					17										
Ophthalmology	**Jan-19**	**Feb-19**	**Mar-19**	**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	77.2%	77.9%	78.5%	78.0%	77.4%	76.8%	76.9%	76.9%	79.0%	81.0%	83.4%	85.4%	86.3%	89.4%	92%
RTT Actual	76.31%	76.68%	76.15%	75.68	74.67%										
52 weeks plan	6	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0
52 weeks actual (total)	5	2	0	2	7										
52 week patient choice					3										
OMFS	**Jan-19**	**Feb-19**	**Mar-19**	**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	66.4%	67.7%	69.2%	71.4%	73.6%	75.9%	75.9%	75.9%	78.9%	82.2%	85.8%	85.8%	90.1%	90.1%	92%
RTT Actual	66.27%	68.03%	72.46%	74.71	78.09%										
52 weeks plan	45	34	30	25	20	15	10	5	0	0	0	0	0	0	**0**
52 weeks actual	42	32	32	25	18										
52 week patient choice					2										
Plastics	**Jan-19**	**Feb-19**	**Mar-19**	**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	77.3%	77.4%	77.7%	77.7%	77.7%	77.8%	78.8%	79.9%	81.0%	82.7%	84.5%	84.5%	87.8%	87.8%	92%
RTT Actual	79.16%	80.0%	80.05%	80.32%	81.99%										
52 week plan	36	32	28	25	20	15	10	5	0	0	0	0	0	0	**0**
52 weeks actual	34	34	30	20	17										
52 week patient choice					11										
Sleep	**Jan-19**	**Feb-19**	**Mar-19**	**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	90.3%	89.0%	87.8%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
RTT Actual	92.44%	90.65%	93.09%	94.90%	96.26%										
52 weeks plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks actual	0	0	0	0	0										
Clinical Support	Jan-19	Feb-19	Mar-19	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	95.9%	95.9%	95.9%	95.9%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
RTT Actual	96.41%	95.27%	96.74%	96.9%	96.26%										
52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52 weeks actual	0	0	0	0	0										

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	Apr 19	May 19	Change
0-17 (<18)	10977	10862	10823	11389	11078	10401	10056	9621	9895	9704	9508	↓
18-30	2390	2211	2477	2425	2420	2412	2175	1983	1891	1767	1486	↓
31-40	821	896	827	809	697	734	694	695	598	537	511	↓
41-51	405	445	363	325	313	325	248	191	164	149	176	↑
>52	145	135	127	120	95	92	81	68	62	47	42	↓
Total Pathways	14738	14549	14617	15068	14603	13964	13254	12558	12610	12204	11723	↓
Breaches	3761	3687	3794	3679	3525	3563	3198	2937	2715	2500	2215	↓
Performance	74.48%	74.66%	74.04%	75.58%	75.86%	74.48%	75.87%	76.61%	78.47%	79.51%	81.11%	↑
Clock starts		3339	3132	3870	3272	2493	3395	2849	3349	2929	3291	↓

SUMMARY:RTT INCOMPLETE PATHWAYS									
Speciality	<18	18-30	31-40	41-51	>52	Total	Perf. This Month MAY19	Perf Last Month April 19	Perf. Change
Plastic Surgery	2900	401	154	65	17	3537	81.99%	80.32%	↑
Ophthalmology	1928	483	133	31	7	2582	74.67%	75.68%	↓
Oral Surgery	3075	552	215	78	18	3938	78.09%	74.71%	↑
Sleep	1058	35	5	1	0	1099	96.27%	94.90%	↑
Clinical Support	437	13	3	1	0	454	96.26%	96.90%	↓

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 has fallen.

In month there has been an increase in 41-51 week cohort which is being reviewed with OMFS and plastics.

All services are on plan except eyes where this is a deteriorating position primarily due to medical capacity.

RTT18 – Incomplete pathways – patients waiting 18 weeks +

As reported for May 2019	% Patients Waiting with a Confirmed Date of Surgery	Weeks Wait					Grand Total Open Pathways
		Under 18W	18-30	31-40	41-51	52+	
Oral Surgery	**Total open pathways**	**3075**	**552**	**215**	**78**	**18**	**3938**
	With TCI	111	70	38	25	6	**250**
	No TCI	2964	482	177	53	12	3688
	% with TCI	***3.61%***	***12.68%***	***17.67%***	***32.05%***	***33.33%***	***6.35%***
Plastic Surgery	**Total open pathways**	**2900**	**401**	**154**	**65**	**17**	**3537**
	With TCI	348	128	72	37	12	**597**
	No TCI	2552	273	82	28	5	2940
	% with TCI	***12.00%***	***31.92%***	***46.75%***	***56.92%***	***70.59%***	***16.88%***
Ophthalmology	**Total open pathways**	**1928**	**483**	**133**	**31**	**7**	**2582**
	With TCI	51	85	54	17	3	**210**
	No TCI	1877	398	79	14	4	2372
	% with TCI	***2.65%***	***17.60%***	***40.60%***	***54.84%***	***42.86%***	***8.13%***
All	**Total open pathways**	7903	1436	502	174	42	10057
	With TCI	510	283	164	79	21	1057
	No TCI	7393	1153	338	95	21	9000
	% with TCI	***6.45%***	***19.71%***	***32.67%***	***45.40%***	***50.00%***	***10.51%***

As reported for May 2019	% Patients Waiting with a Decision to Admit	Weeks Wait					Grand Total Open Pathways
		Under 18W	18-30	31-40	41-51	52+	
Oral Surgery	**Total open pathways**	**3075**	**552**	**215**	**78**	**18**	**3938**
	With DTA	277	112	66	34	11	**500**
	No DTA	2798	440	149	44	7	3438
	% with DTA	***9.01%***	***20.29%***	***30.70%***	***43.59%***	***61.11%***	***12.70%***
Plastic Surgery	**Total open pathways**	**2900**	**401**	**154**	**65**	**17**	**3537**
	With DTA	777	227	126	53	13	**1196**
	No DTA	2123	174	28	12	4	2341
	% with DTA	***26.79%***	***56.61%***	***81.82%***	***81.54%***	***76.47%***	***33.81%***
Ophthalmology	**Total open pathways**	**1928**	**483**	**133**	**31**	**7**	**2582**
	With DTA	684	355	108	26	5	**1178**
	No DTA	1244	128	25	5	2	1404
	% with DTA	***35.48%***	***73.50%***	***81.20%***	***83.87%***	***0.00%***	***45.62%***
All	**Total open pathways**	7903	1436	502	174	42	10057
	With DTA	1738	694	300	113	29	2874
	No DTA	6165	742	202	61	13	7183
	% with DTA	***21.99%***	***48.33%***	***59.76%***	***64.94%***	***69.05%***	***28.58%***

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**	**Apr-19**	**May-19**
Plastic Surgery	432	369	519	491	445	565	503	359	459	499
Ophthalmology	240	240	224	213	221	298	301	213	153	199
Oral Surgery	177	179	230	278	181	304	287	309	236	225
Other	107	100	111	127	103	127	123	150	163	127
Ear, Nose & Throat (ENT)	7	20	10	8	11	10	11	5	6	5
Total	**963**	**908**	**1094**	**1117**	**961**	**1304**	**1225**	**1036**	**1017**	**1055**

In Month Clock Stops Non Admitted										
Reported Specialty	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**
Oral Surgery	726	819	859	805	605	938	832	858	850	903
Plastic Surgery	477	381	434	485	354	461	356	368	430	451
Other	194	136	169	137	165	274	171	255	182	257
Ear, Nose & Throat (ENT)	151	299	262	359	291	365	277	271	59	213
Ophthalmology	120	111	103	103	91	175	113	103	130	176
Cardiology	35	17	43	47	39	73	29	38	33	43
Trauma & Orthopaedics	5	6	5	2	1	3	5	4	6	3
Rheumatology	5	8	9	20	12	12	10	19	6	14
Total	**1713**	**1777**	**1884**	**1957**	**1558**	**2301**	**1793**	**1916**	**1696**	**2060**

In Month RTT Clock Starts										
Reported Specialty	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**
Oral Surgery	1176	1072	1306	960	681	1002	891	1127	955	1031
Plastic Surgery	1051	917	1066	971	810	1038	925	1015	919	1072
Ophthalmology	414	530	581	546	408	567	457	523	535	492
Other	337	390	420	373	276	473	373	470	356	457
Ear, Nose & Throat (ENT)	307	181	445	337	267	275	190	183	144	213
Cardiology	39	33	37	76	42	28	7	19	9	20
Trauma & Orthopaedics	9	1	4	3	5	3	5	6	4	3
Rheumatology	6	8	11	6	7	9	1	6	7	3
Total	**3339**	**3132**	**3870**	**3272**	**2496**	**3395**	**2849**	**3349**	**2929**	**3291**

In month increase in admitted and non admitted clock stops.

Clock starts have also increased compared to the previous month.

RTT18

Performance and trajectories

- The trust over achieved the open pathway performance in April but 2 patients behind plan for patients waiting > 52 weeks
- All specialities are on track with the exception of eye where performance has deteriorated due to corneo clinical fellow cover. The service have advertised the vacancy 3 times and are out to locum agencies to identify further capacity. Plans for ongoing service resilience are being reviewed
- Primary risks are corneo and breast due to medical capacity
- Significant risk re 52 week trajectory with patient choice impact

Capacity and pathways

- Additional capacity ongoing for OMFS at Uckfield and McIndoe
- Additional OMFS outpatient clinics are ongoing at Maidstone, Dartford and Medway.
- Plans ongoing for the use of the McIndoe for ophthalmology lists including corneo over the next month
- Detailed subspecialty level capacity and demand work is planned for ophthalmology
- Dental triage work is continuing and a review of the programme of work is underway

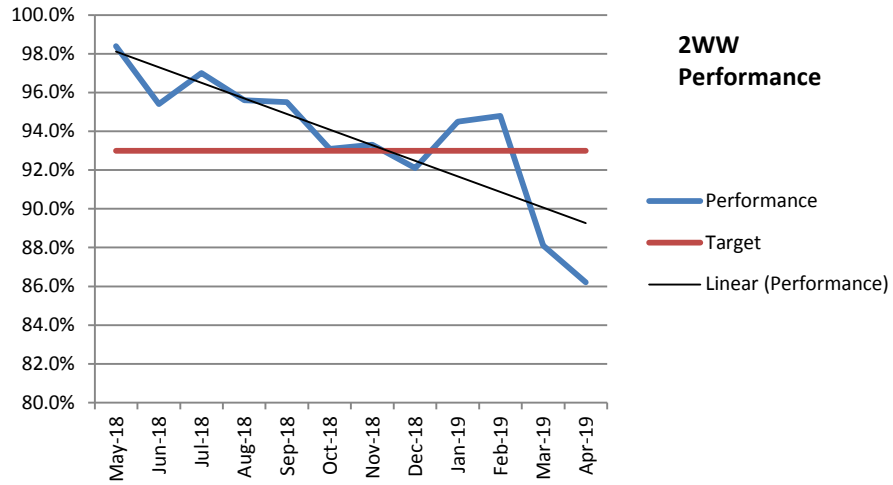
Theatre Efficiency

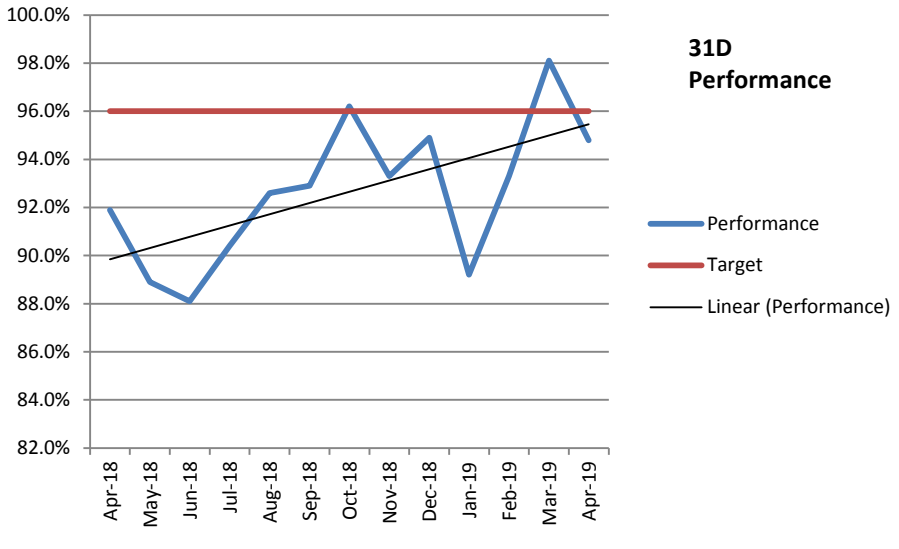
- Theatre utilisation programme is continuing post the departure of Fours Eyes and is being led within the operations business management team.
- Trust reporting dashboard continues to be developed

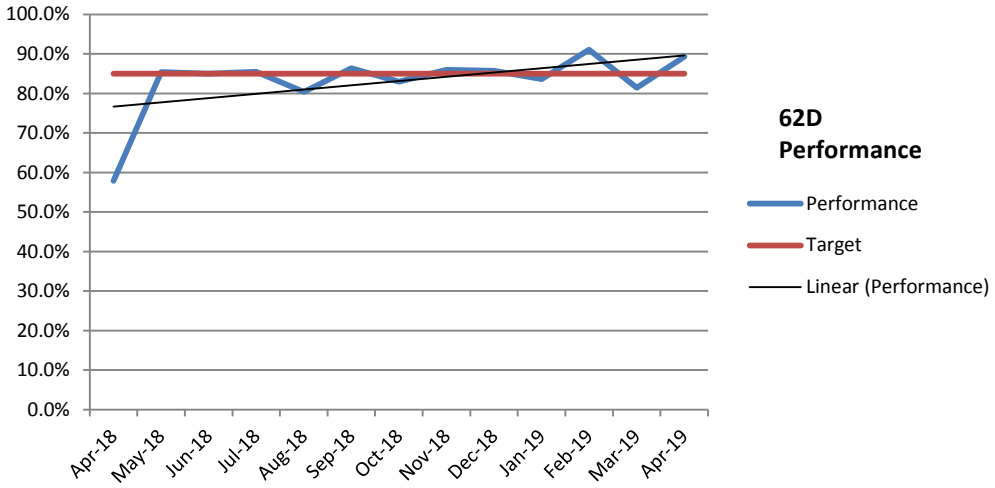
Outpatient Improvement

- Outpatient efficiency programme is ongoing and will support the RTT position.

Cancer standards







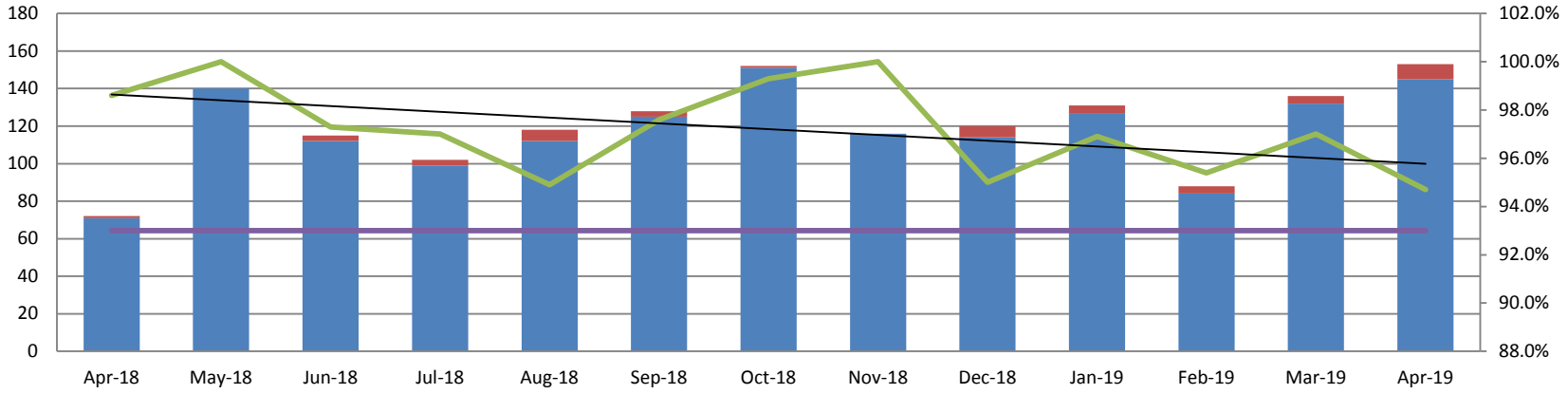
The 2WW target was not met (86.2%) in the reporting month (Apr). Skin achieved the target at 94.7%, however Head and Neck did not achieve the target at 79.4%. Challenges in the month were:

1. 21% increased in referral compared to Jan / Feb
2. Full clinic cancellation at DVH as patient acutely unwell in clinic and needed to be accompanied to A&E
2. eRS / DeRS incident re triage and booking error
3. Head and Neck capacity due to annual leave
4. DVH admin process delay
5. Patient choice

The 62 day target was met (89%) in the reporting month (Apr).

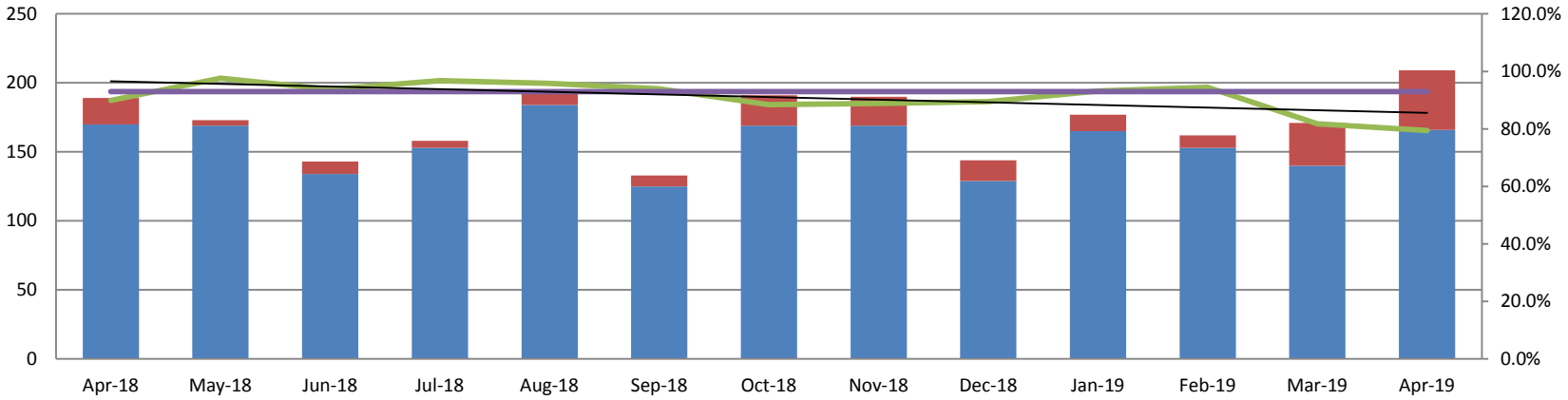
The 31D target (94.8%) was not met in the reporting month (Apr). However we are seeing an upward trade in performance in with concentrated effort in regards to escalation processes and training. The breaches for this month were due to patient sickness, complex pathway and theatre cancellation due to a major case.

Skin Two Week Wait Performance



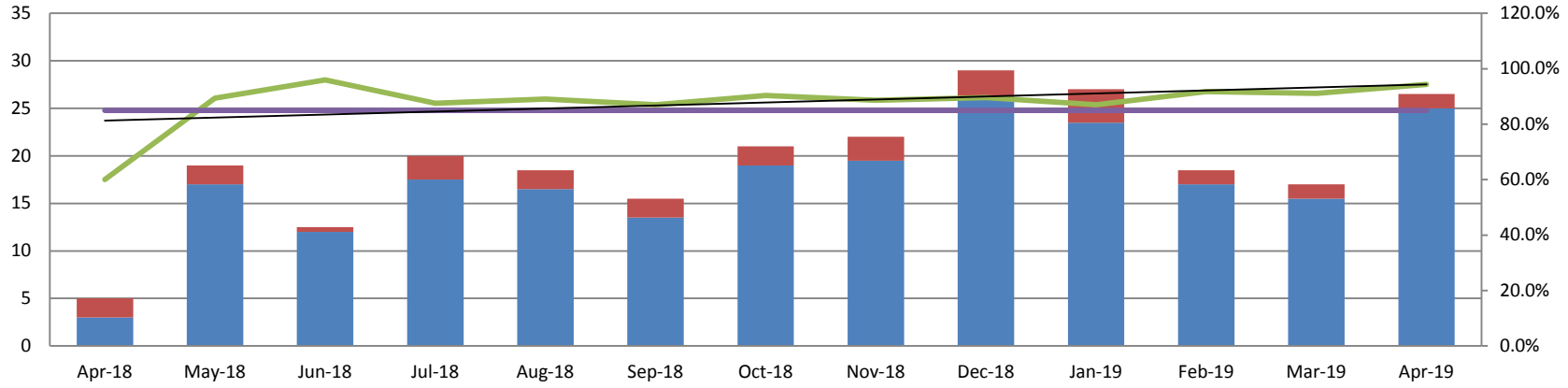
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Breaches	1	0	3	3	6	3	1	0	6	4	4	4	8
Total	71	140	112	99	112	125	151	116	114	127	84	132	145
Performance	98.6%	100.0%	97.3%	97.0%	94.9%	97.6%	99.3%	100.0%	95.0%	96.9%	95.4%	97.0%	94.7%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

Head and Neck Two Week Wait Performance



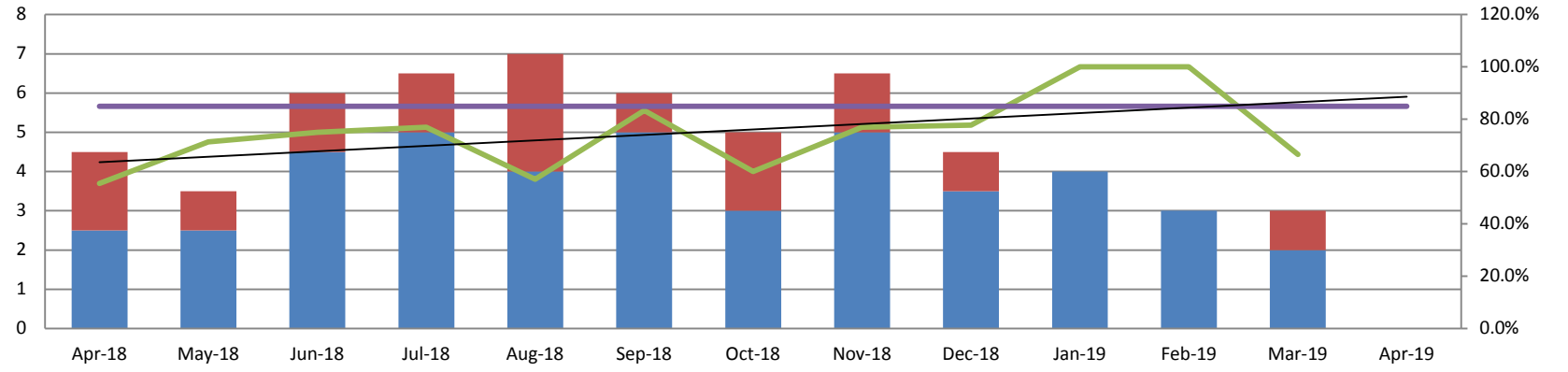
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Breaches	19	4	9	5	8	8	22	21	15	12	9	31	43
Total	170	169	134	153	184	125	169	169	129	165	153	140	166
Performance	89.9%	97.6%	93.7%	96.8%	95.8%	93.9%	88.4%	88.9%	89.5%	93.2%	94.4%	81.8%	79.4%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

Skin 62 Day Referral to Treatment



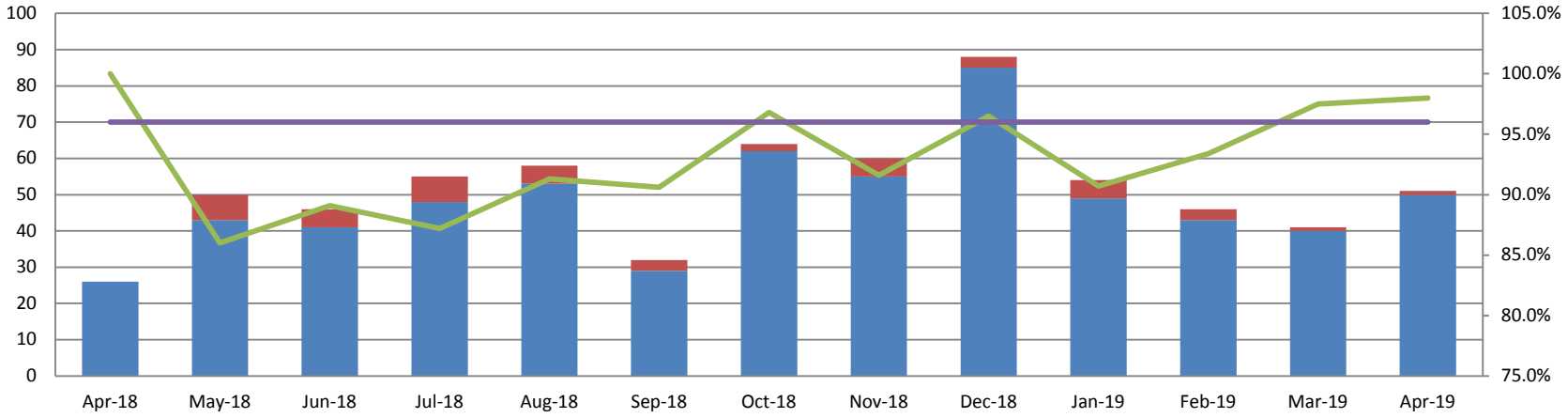
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Breached	2	2	0.5	2.5	2	2	2	2.5	3	3.5	1.5	1.5	1.5
Compliant	3	17	12	17.5	16.5	13.5	19	19.5	26	23.5	17	15.5	25
Performance	60.0%	89.4%	96.0%	87.5%	89.1%	87.0%	90.4%	88.6%	89.6%	87.0%	91.8%	91.1%	94.3%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Head and Neck 62 Day Referral to Treatment



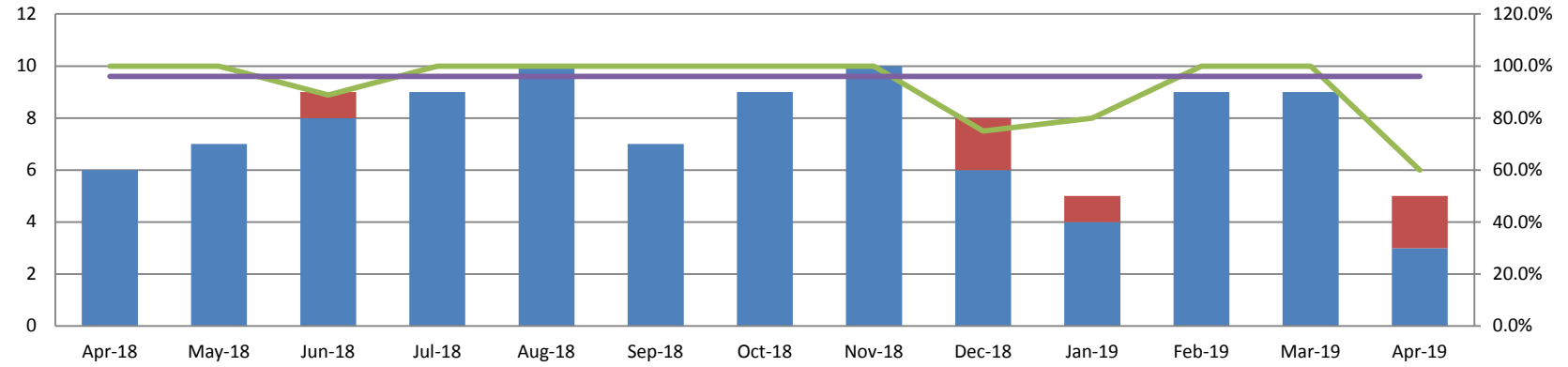
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Breached	2	1	1.5	1.5	3	1	2	1.5	1	0	0	1	0
Compliant	2.5	2.5	4.5	5	4	5	3	5	3.5	4	3	2	0
Performance	55.5%	71.4%	75.0%	76.9%	57.1%	83.3%	60.0%	76.9%	77.7%	100.0%	100.0%	66.6%	
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Skin 31 Day Decision to Treat



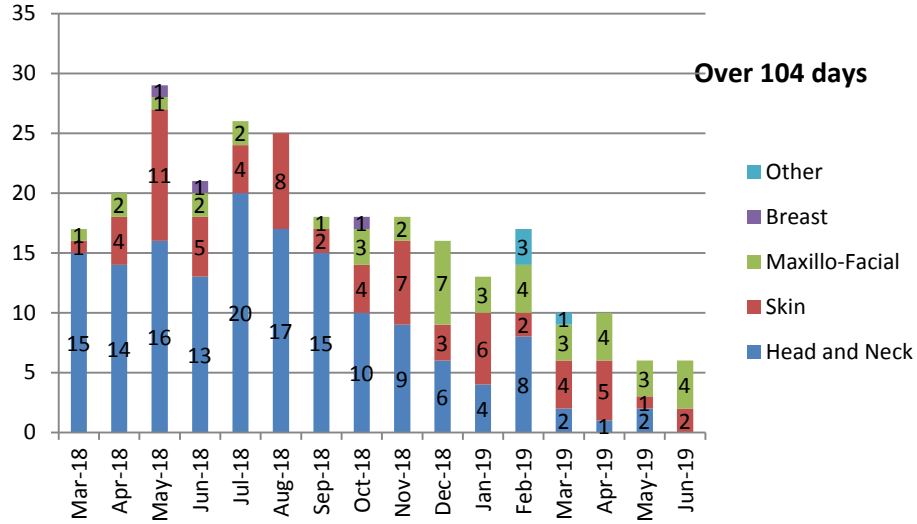
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Breached	0	7	5	7	5	3	2	5	3	5	3	1	1
Compliant	26	43	41	48	53	29	62	55	85	49	43	40	50
Performance	100.0%	86.0%	89.1%	87.2%	91.3%	90.6%	96.8%	91.6%	96.5%	90.7%	93.4%	97.5%	98%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

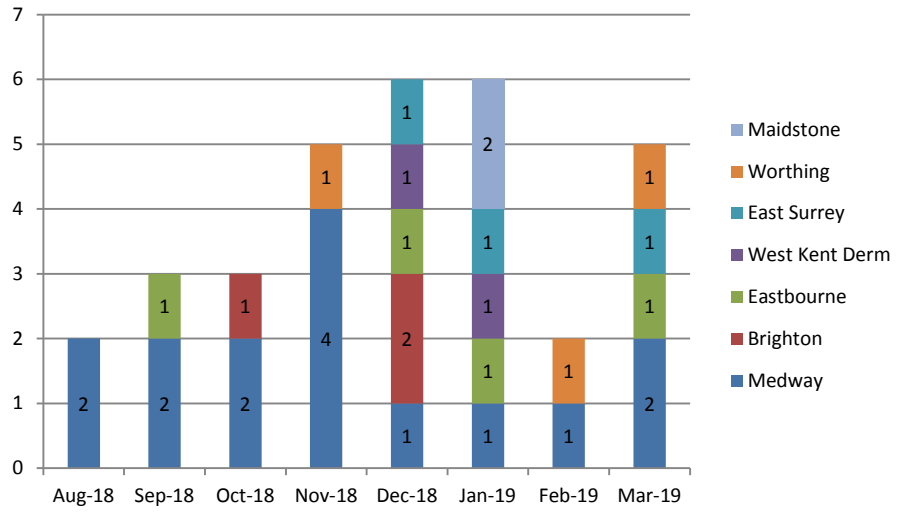
Head and Neck 31 Day Decision to Treat



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Breached	0	0	1	0	0	0	0	0	2	1	0	0	2
Compliant	6	7	8	9	10	7	9	10	6	4	9	9	3
Performance	100.0%	100.0%	88.8%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	80.0%	100.0%	100.0%	60%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Performance: 104 days and 38 day 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

- The 1 patient over 104 days has had treatment, histology is pending. The delay in the pathway was 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

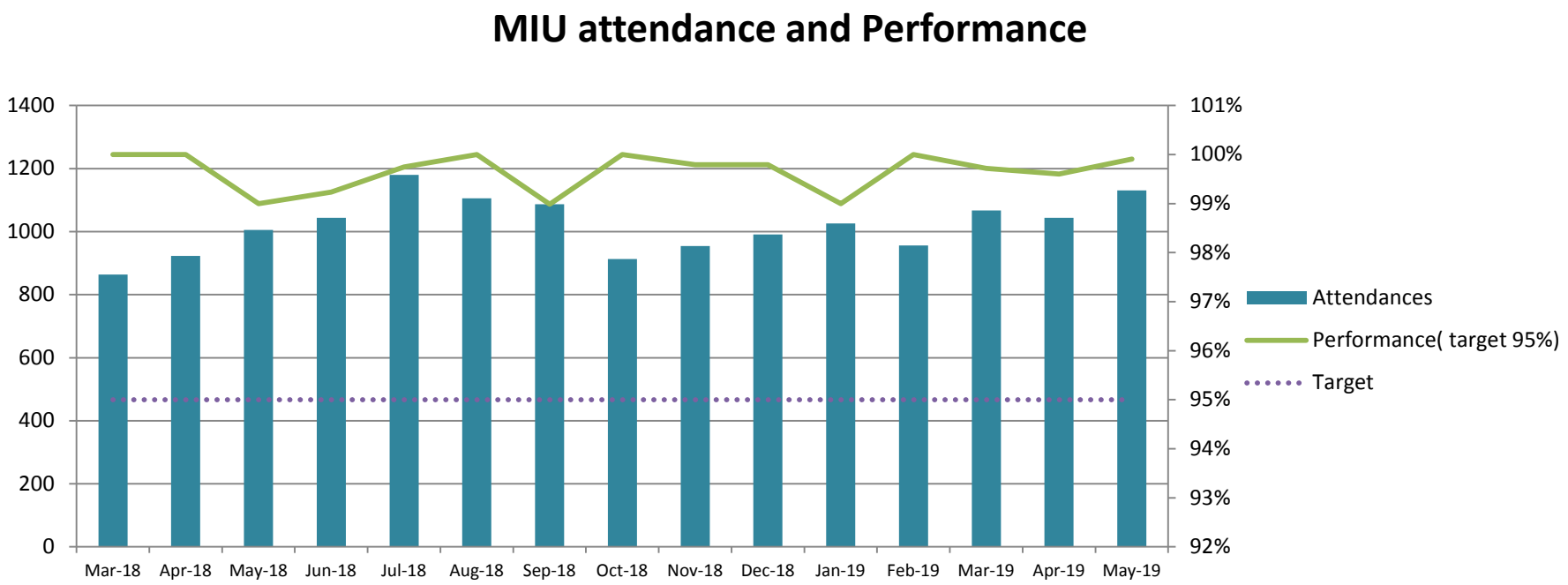
- Challenges remain in referring patients for oncology treatment by day 38 to the treating trust. So far this year H&N have sent 9 late referrals. Through the project management support from Surrey and Sussex Cancer Alliance a timed pathways are being designed to help become compliant with the 38 day 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 (Skin and Breast)

- Challenges remain in receiving late referrals and treating within 24 days. In the month of Mar we treated 4 patients where the referral was sent past 38 days, 3 of those pathways were past 62 days.
- Within this number only 1 were treated within 24 days. Bottlenecks remain in outpatient capacity.
- For breast referrals the challenge remains in organising the surgery date with the visiting breast surgeon.

Minor Injuries Unit (MIU)

MIU Performance v Target



Performance commentary	Forward look / performance risks
• Activity continues to increase from last year.	• Work is being started to move MIU into the Integrated Primary and Urgent Care plan. This work is being piloted in MIU with support from the CCG due to the current level of integration that is already in place in MIU and the extended hours GP service. This will include the request for direct booking from 111 by the end of 2019 and proof of concept to be completed by September2020.

Outpatient Improvement Programme

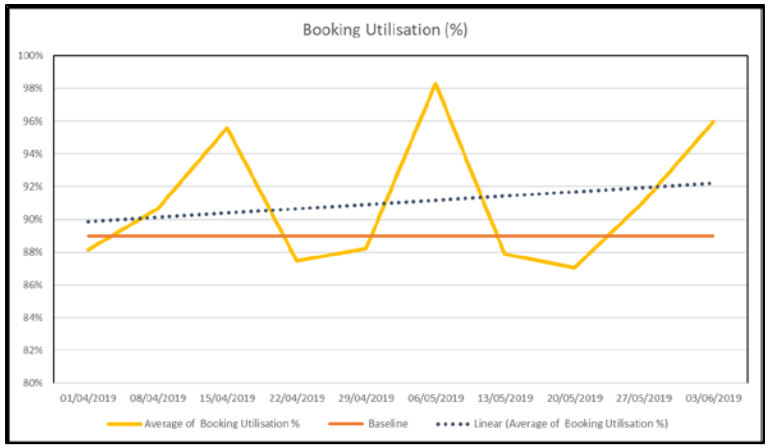
Outpatient Improvement Steering Group meets monthly and the task and finish groups are established fortnightly.
The following KPIs are under development for the programme. These are supported by the four eyes developed dashboard.

	Programme key performance indicators	Baseline*	Target	Target date / milestone	May Performance	Notes
1	Increase attended clinic utilisation by a minimum of 2%	TBD	2% increase from baseline	July 2019	Please see next slide.	Ongoing validation of baseline position due to data anomalies
2	Reduction in Do Not Attend (DNA) rate by 0.5%	TBD	0.5% improvement	September 2019		The DNA definition is under review to ensure data accuracy and understanding of agreed exclusions for the denominator
3	Reduction in patient on the day cancellations by 25%	2.2%	1.6%		1.56%	Potential impact regarding accurate recording of DNAs
	Reduction in hospital cancellations <6weeks	12.89% (12 month average)	8%	October 2019	10%	
4	Launch Skype clinic by 1st June 2019 and Glaucoma virtual clinic by 10th June	N/A			Skype go live in place Glaucoma behind plan with go live now 2nd July	Delayed go live for glaucoma due to hardware/ software issues
5	eRS Directory of Services to be clinically and operationally reviewed	N/A	100%	30th June 2019	N/A	
6	Delivery of GP referrals via eRS	98.70%	99.75%		98.5%	Review of paper referrals underway to identify referrer and speciality issues
7	To meet the national Appointment Slot Issue (ASI) rate	6.18%	4.00%	October 2019	4.08%	
8	To roll out e-vetting of referrals on eRS	0%	75% of services e-vetting	October 2019	Pilot areas commenced	
9	95% FFT rating	95%	95%	April 2019	96%	
10	To reduce the clinic letter turnaround to 7 days (baseline information is currently being validated)	12.2 days	7 days	December 2019	Baseline taken from G2 however variable systems in the trust and so subject to review.	Programme of work to be defined

Clinic utilisation

Booking Utilisation

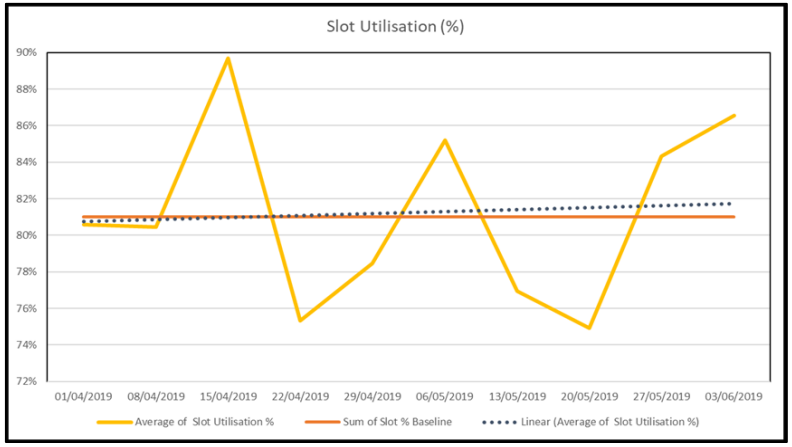
The number of slots that have been booked into has moved from 88% in April 2019 to 96% in the first week of June 2019. The average for the period is 91% which is 2% above baseline.



Row Labels	Average of Booking Utilisation %	Baseline
01/04/2019	88%	89%
08/04/2019	91%	89%
15/04/2019	96%	89%
22/04/2019	87%	89%
29/04/2019	88%	89%
06/05/2019	98%	89%
13/05/2019	88%	89%
20/05/2019	87%	89%
27/05/2019	91%	89%
03/06/2019	96%	89%
Grand Total	**91%**	**89%**

Attended Utilisation

The number of slots that had patients attended has improved by 2% above baseline since 1 April to 3 June 2019. With the OPD improvement drive and the 642 meeting, this figures moved to 87% in the first week of June.



Row Labels	Average of Slot Utilisation %	Slot % Baseline
01/04/2019	81%	81%
08/04/2019	80%	81%
15/04/2019	90%	81%
22/04/2019	75%	81%
29/04/2019	78%	81%
06/05/2019	85%	81%
13/05/2019	77%	81%
20/05/2019	75%	81%
27/05/2019	84%	81%
03/06/2019	87%	81%
Grand Total	**83%**	**81%**

Outpatient Improvement Programme

Programme workstream updates are as follows:

Task and Finish Group	Key Actions to date
Productivity	**2 way text reminder service implementation** • Specification written and three suppliers invited to present and bid • Scoring mechanism agreed and used to assess submissions by scoring panel • Outline business case drafted • Risk regarding procurement timescale and four eyes implementation support **Outpatient efficiency dashboard** • Extensive validation of clinic codes with specialty managers and nursing to identify appropriate exclusions • Online dashboard access set up for Trust staff • Multiple drop-in and 1:1 training sessions held with key Trust stakeholders • Risks relating to trust wide management of clinics **Outpatients 642 meetings launched for Plastics, Max Fac and Ophthalmology.** • Use of the vacant slot data to highlight areas of capacity opportunity • Use of the weekly utilisation tracker to review performance and areas for action
Communication	**Letter transcription, printing and postage** • Scoping of current service delivery underway in terms of letter transcription, printing and postage. • Exploration of options for deliver via NHS Commercial Solutions and Homerton webinar • Outline business cases under development

Outpatient Improvement Programme

Workstream	Key Actions to date
Virtual Clinics	• Glaucoma review clinic model has been developed and will be piloted during July to enable staff training • Therapy Skype clinic pilots for follow up have launched in Hand, Facial Palsy and Burns. 15 contacts expected in July. Please see next slide for press release • Desk top review has identified potential 19% discharge and 13% non F2F from waiting list – to be discussed and actioned with Consultants
eRS/DeRS Electronic referral system and Dental electronic referral system	• All Directories of Service (DoS), 2WW and Routine, now with Clinical Teams for updating. • Review of DeRS Triage complete and Standard Operating Procedure updated. Next steps review meeting planned • Online review of eRS referrals piloting for 4 weeks in several services, (Rheumatology, Oral & Maxillofacial, Facial nerve/vascular, Cardiology). • KPI reporting model agreed and implemented • QVH referral guide updated
Process Redesign	• 2 process redesign sessions have been held to continue redesign work • Internal lead identified take forward internally • Risk regarding capacity in taking forward at pace

Virtual clinic go-live – QVH goes 'virtual' with new Skype clinics – Press release

Patients will be offered 'virtual appointments' in some clinics at Queen Victoria Hospital (QVH) as part of a trial aimed at improving patient experience and accessibility to its services.

Skype appointments are being rolled out in three of the hospital's specialty areas – facial palsy therapy, burns therapy and hand therapy. These clinics provide rehabilitation services to people across the country who have been significantly affected by life changing accidents, conditions or disorders..

It means many patients will now benefit from fewer hospital visits.

Only patients who meet a set of strict criteria will be offered Skype appointments at this stage. Patients will not be seen 'virtually' for their first appointment, for example.

Marc Tramontin, QVH therapy services manager, said: "Improving the patient experience is one of our top priorities. Some of our patients travel extremely long distances to be treated here, and offering them 'virtual' appointments will not only help to reduce the stress that's so often associated with travel, but save them time and money too. Research shows that the standard of clinical care is not compromised by delivering services in this way which is also extremely important".

"It's hoped these clinics will reduce the number of on-the-day cancellations, which increase waiting times and are costly. They'll also help to reduce patients' reliance on hospital transport and lead to fewer vehicles using the car park which can be busy at times."

Case study
Janet Robb, 43, travels to Queen Victoria Hospital from Belfast to receive treatment for facial palsy. She has had two surgeries at the hospital and attends for regular follow-up therapy. So far she has had two appointments with her QVH therapist via Skype.

"I have facial palsy after contracting Lyme disease in 2013 and, after struggling to get treatment back home, I was eventually referred to QVH about three years ago. There are no words to explain what it felt like for someone to finally understand the pain and psychological issues that come with a diagnosis of facial palsy.

"I've had two big surgeries. When you've gone home you're frightened because you're away from your medical team. You wonder 'what if something happens because your local doctor doesn't know what to do with it?'

"And then there are the trips for ongoing treatment. Psychologically, having facial palsy is pretty rubbish but add to that having to make the long journey for therapy – you've nobody to hold your hand, it's lonely. My mood is low and there are usually tears, these trips are difficult.

"I'm presently travelling to East Grinstead every three months. It's usually a two-day trip for what's sometimes a half hour appointment and as you can imagine, it's expensive. You can claim your expenses in Northern Ireland, but it's a long, drawn out, stressful process and you never get the full amount.

"I've had two Skype appointments so far, the first was post-surgery a couple of months ago. It was so great to be able to talk to someone that understood, who was able to tell me what I was feeling in my face was normal, what I should expect, what my exercises should be. I was still recovering and I was so tired and weak – if I'd had to travel, I would not have attended that appointment. To have my therapist smile at me on the camera and reassure me was invaluable.

"I don't feel I'm missing out on my therapy by being on screen. Many of my appointments are visual not manual assessments; the therapist wouldn't be touching my face even if I was in the room.

"My dream is to be able to access the treatment I need closer to home but until then, having access to these specialists without having to travel is a pot of gold."

The trial is expected to last at least three months. It is hoped virtual clinics will be rolled out to other departments and services in due course

Theatre productivity update

Theatre productivity remains a priority with the following operational structure in place:

- Weekly 6-4-2 & scheduling meetings
- Performance board in theatres with weekly updates re KPIs
- Weekly theatre executive review meeting

Theatre User Group – jointly chaired by anaesthetic and surgical leads and current priorities include:

- Review and oversight of KPIS and performance
- Oversee task and finish groups / programmes of work relating to productivity
- Supporting 'On Time Starts' programme
- Exploring ORSOS capability to include utilisation on scheduling screen to provide visibility to the teams

Cancellation Task and Finish Group – driving a programme of work to minimise cancellations and current priorities include:

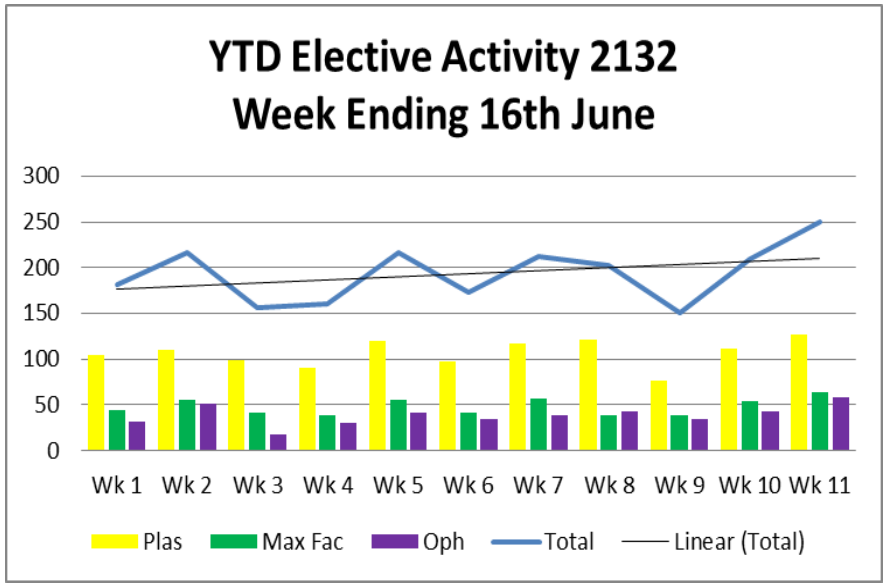
- Ongoing review of call out process and developing potential links to text messaging proposal
- Reducing on the day patient cancellations due to hypertension particularly in ophthalmology
- Weekly review of all on the day cancellations to identify themes and required areas of focus

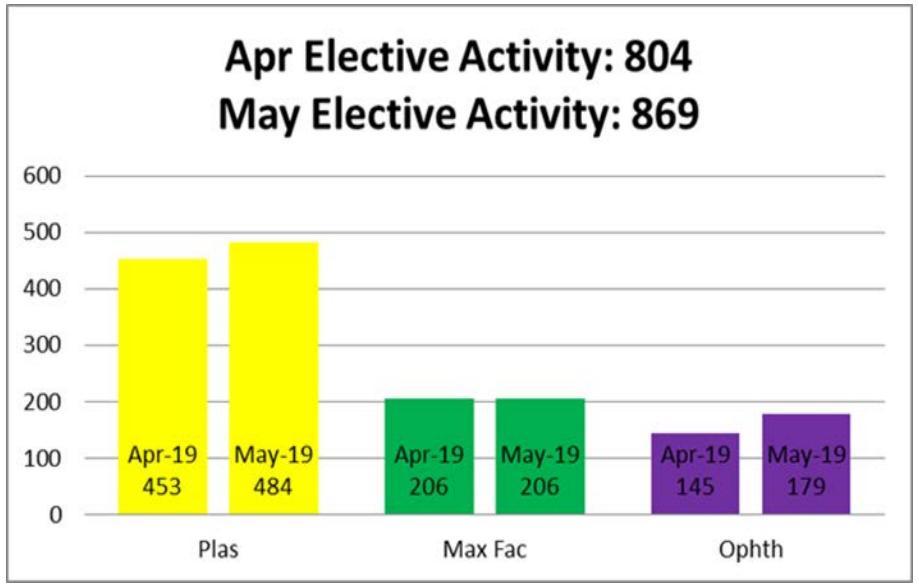
On time start programme of work

- Go live of on time starts initiative
- Planned new 'perfect morning' initiative which include embedding the golden case, utilising recover as a holding bay, improved timeliness between ward and theatre, actual theatre start time to be visible on each theatre, WHO checklist and role call

Start: WC 10th June: Report to be submitted in July

KPI 1 - Theatre Activity – Case Count
Target – delivery of on site activity plan





Performance commentary

Total Elective Activity for May : 869

- Plas Total : 484
- OMFS Total : 206
- Ophthalmology Total : 179

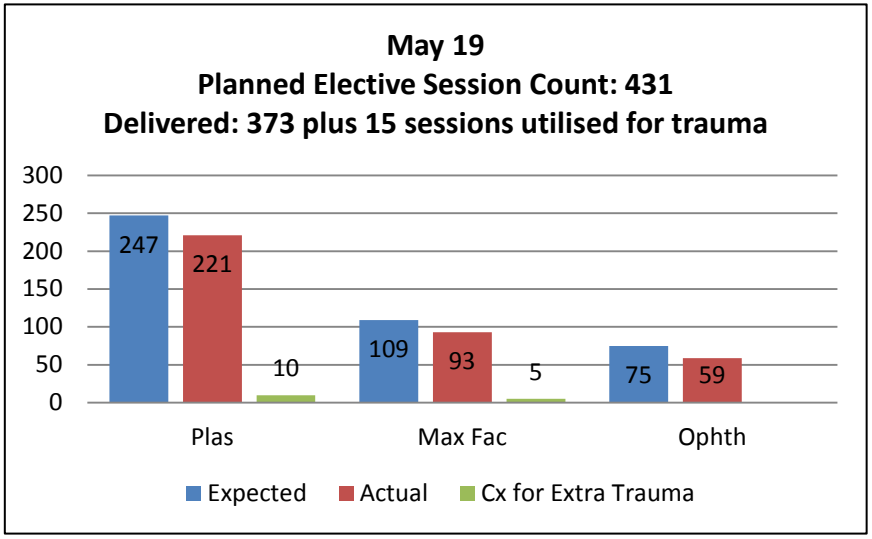
Main issues for May

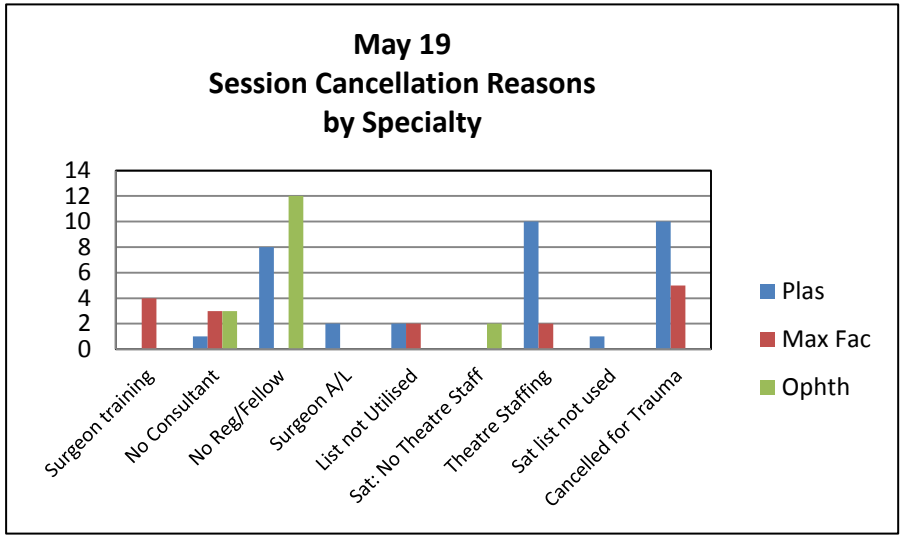
- Sessions lost due to extra trauma capacity required
- Theatre staffing levels due to sickness on the day
- Surgeon gaps in corneo
- Max OMFS: Long Term Sickness- Surgeon

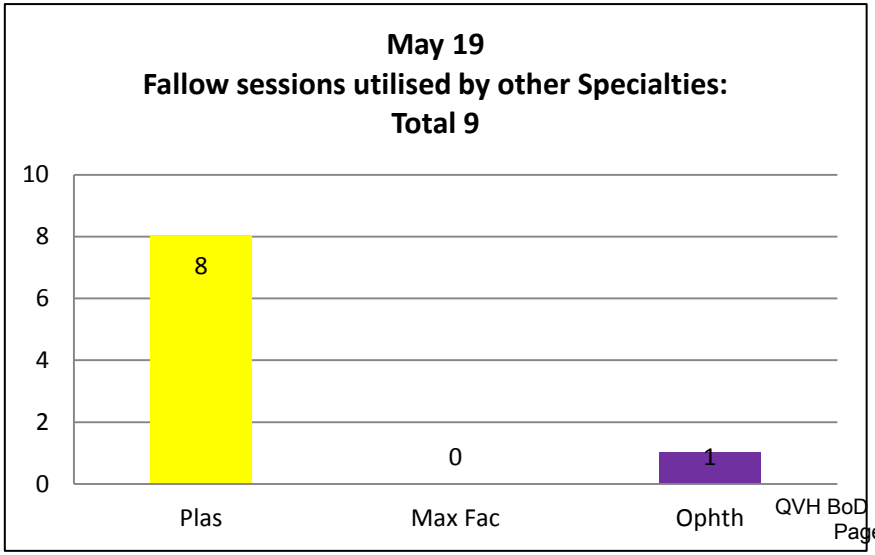
Forward look / performance risks

- OMFS surgeon phased return to work plan
- Increased utilisation of fallow lists by other specialties
- Ophthalmology surgeon appointed, due to start in July ongoing gaps within corneal
- Skin locum contract extended to support skin activity

KPI 2 - Session Count May 19

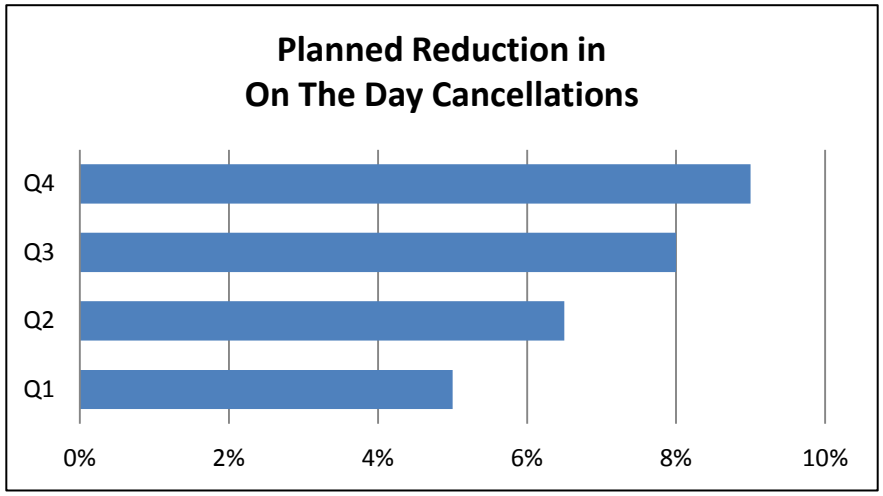


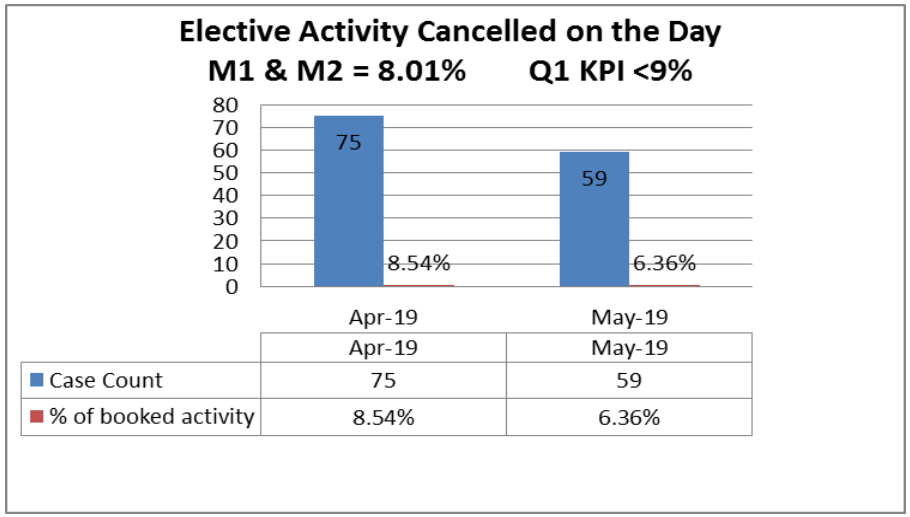


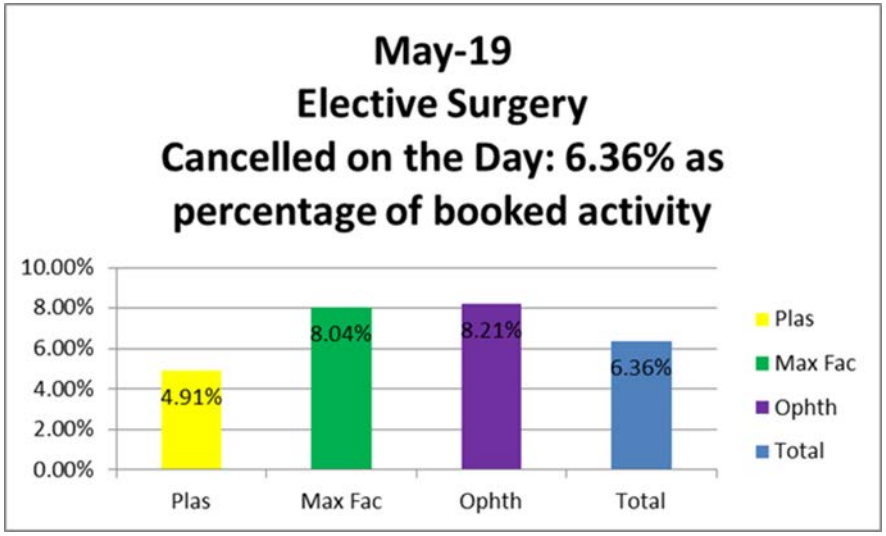


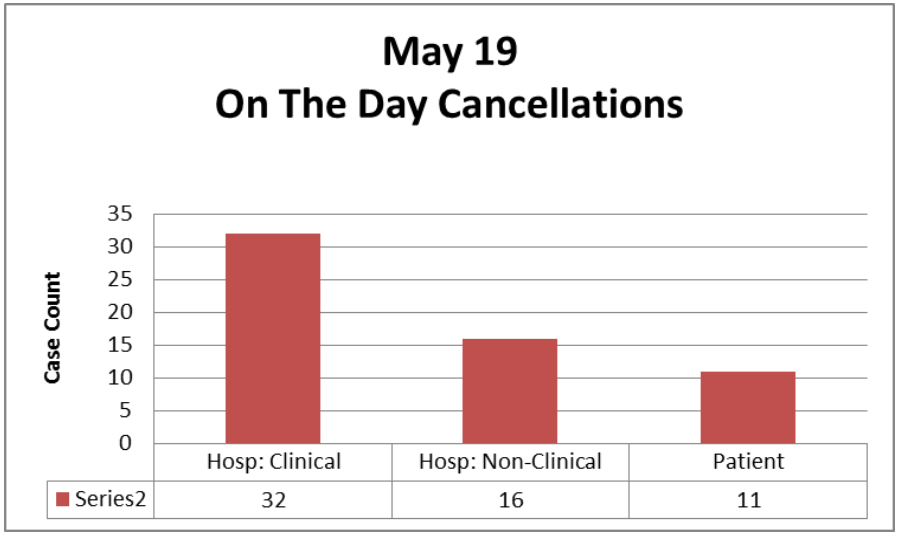
Work is ongoing to fully utilise all available sessions.
Cancellation reasons are now recorded and reported to identify trends and issues.
Surgeon availability, theatre staffing and trauma were the most common reasons in May.

KPI 3 - Cancellations



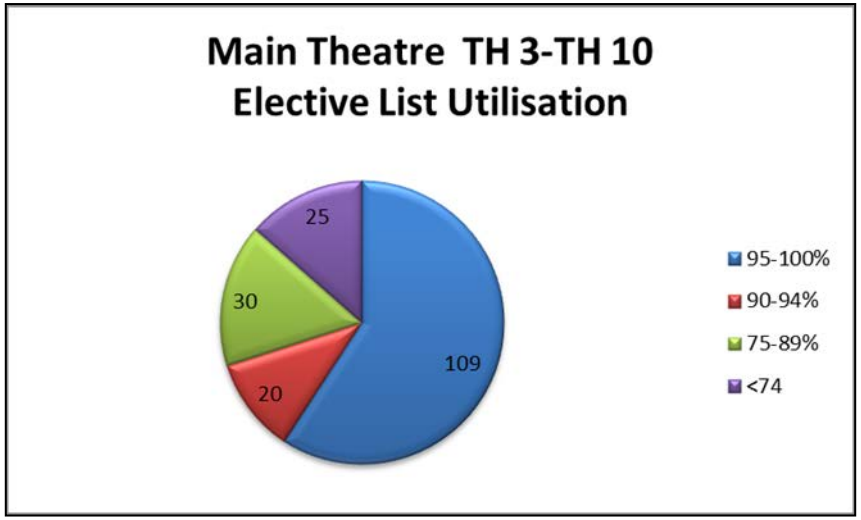




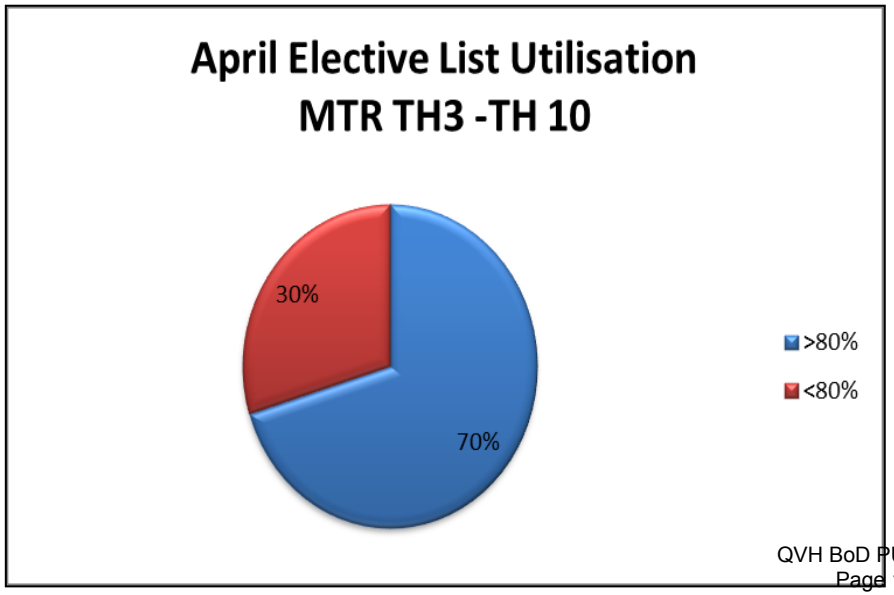


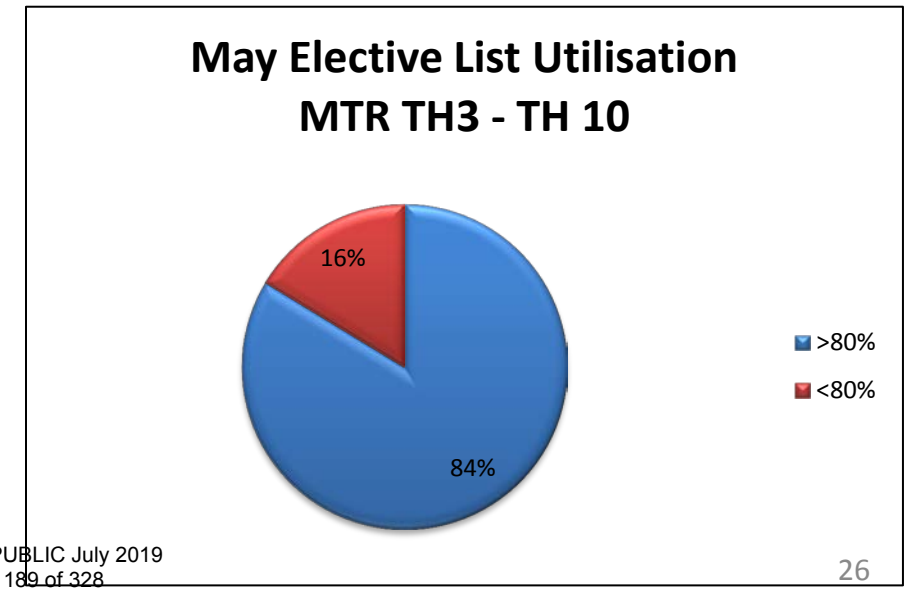
- In month improvement in on the day cancellation. Work is ongoing to reduce cancellation rates further.

KPI 4 – Utilisation – Trust level

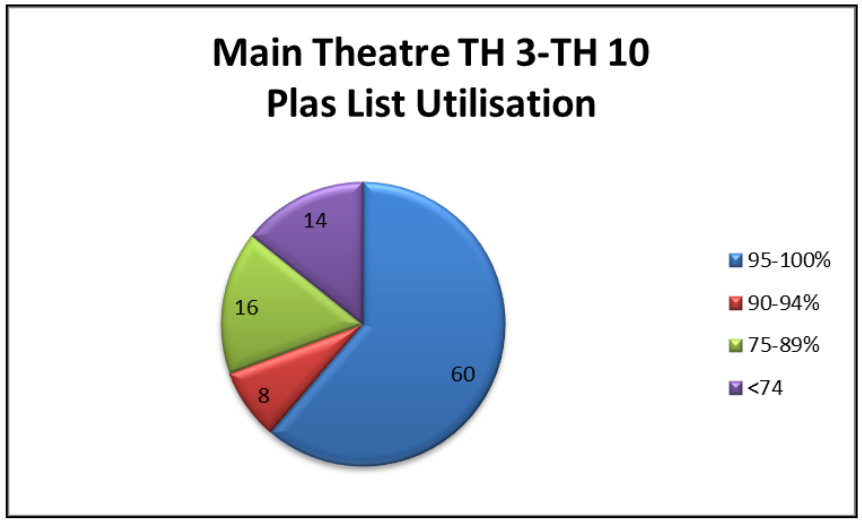


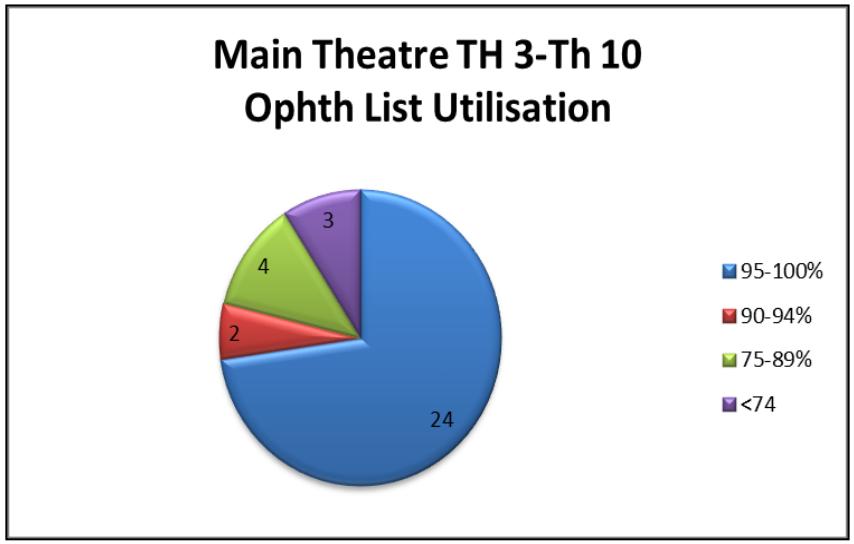
In month improvement of lists with > 80% utilisation

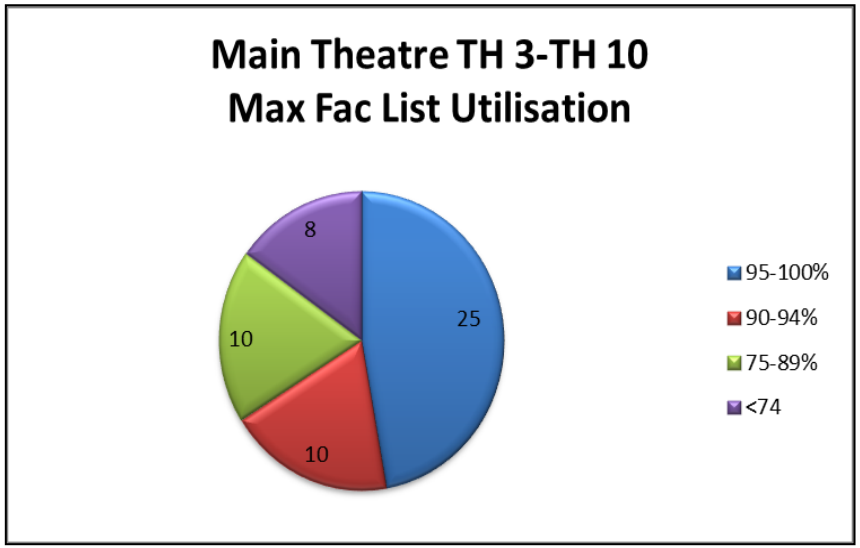


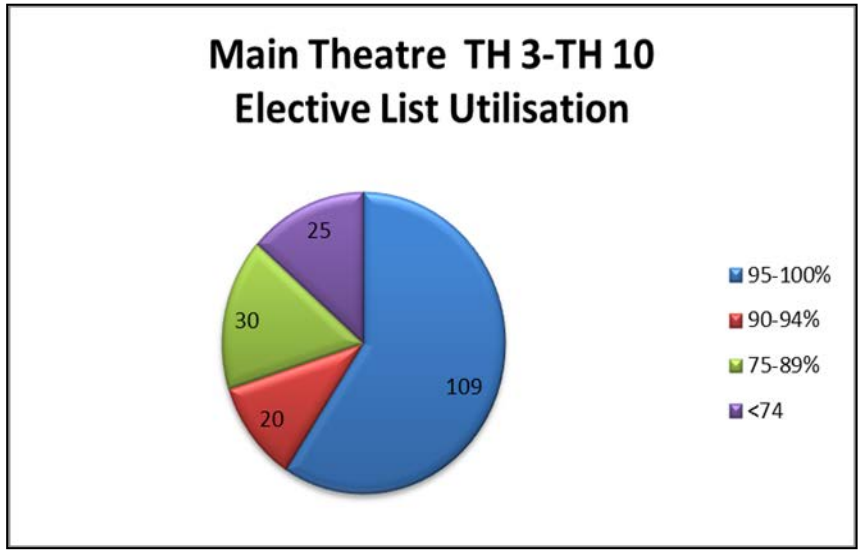


KPI 4 – Utilisation by speciality









Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**116-19**	
Report title:	**Financial performance (M02 May 2019)**				
Sponsor:	Michelle Miles, Director of Finance & Performance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust financial position.				
Summary of key issues	The Trust delivered a deficit of £2.1m YTD; £0.5m worse than plan. Clinical income under-recovery has been partially offset by expenditure underspends. The completion of patient activity M01 coding after the closure of month end has identified a further coding gain to the position of circa £0.3m which would reduce variance to £0.2m behind plan. The Trust is expected to meet forecast at the year end. However there are some risks especially in relation to activity delivery. The current run rate forecast for the year would be a deficit of £11m; £3.6 worse than the annual plan. Detailed forecasting will commence from M03 onwards.				
Recommendation:	The Board is asked to **note** the contents of this report.				
Action required					**Review**
Link to key strategic objectives (KSOs):			**KSO3:**	**KSO4:**	**KSO5:**
			Operational excellence	***Financial sustainability***	***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				
Regulation:	The Finance Use of Resources rating is 3.				
Legal:					
Resources:	Nil above current resources				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	24.06.19	Decision:	Noted	
Previously considered by:					
	Date:		Decision:		
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
May 2019

Executive Director: Michelle Miles

Contents

2019/20 M02 Financial Performance

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure		Annual Plan	In Month £'000 Plan	In Month £'000 Actual	In Month £'000 Favourable/(Adverse)	Year to Date £'000 Plan	Year to Date £'000 Actual	Year to Date £'000 Favourable/(Adverse)
Income	Patient Activity Income	67,624	5,494	4,992	(502)	10,877	9,998	(879)
	Other Income	4,654	388	438	51	776	787	11
Total Income		**72,278**	**5,882**	**5,430**	**(451)**	**11,653**	**10,785**	**(868)**
Pay	Substantive	(51,500)	(4,268)	(3,824)	444	(8,487)	(7,726)	760
	Bank	(491)	(41)	(194)	(153)	(82)	(380)	(298)
	Agency	(240)	(20)	(175)	(155)	(40)	(361)	(321)
Total Pay		**(52,232)**	**(4,329)**	**(4,193)**	**136**	**(8,609)**	**(8,467)**	**141**
Non Pay	Clinical Services & Supplies	(13,301)	(1,108)	(1,296)	(187)	(2,217)	(2,090)	127
	Drugs	(1,532)	(128)	(118)	10	(255)	(235)	20
	Consultancy	(79)	(7)	7	14	(13)	(1)	12
	Other non pay	(7,572)	(681)	(560)	121	(1,362)	(1,251)	111
Total Non Pay		**(22,484)**	**(1,924)**	**(1,966)**	**(42)**	**(3,847)**	**(3,578)**	**270**
Financing		(5,006)	(417)	(438)	(21)	(834)	(876)	(42)
Total Expenditure		**(79,723)**	**(6,670)**	**(6,597)**	**311**	**(13,290)**	**(12,921)**	**369**
Surplus / (Deficit)		**(7,445)**	**(788)**	**(1,166)**	**(378)**	**(1,638)**	**(2,136)**	**(498)**

YTD performance

The Trust delivered a deficit of £2.1m; £0.5m worse than the YTD plan of a £1.6m deficit.

The income position is under plan by £0.9m YTD due to patient care clinical income under recovery. Planned & non-elective activity are £1.1m under delivered against plan year to date which is due mainly to case mix rather than volumes largely within the Oral and Plastics (Burns/skin) business units. Critical care is under plan by £130k largely due to casemix. Outpatient activity reported an overall favourable variance of £120k.
The pay position is underspent by £141k YTD. All staffing groups with the exception of Medical & Dental are underspending. Within Medical & Dental there is a cost pressure currently being reviewed in plastics relating to recharges. In addition the use of agency for doctors in training cover is above establishment (3.0 wte). Across the Trust agency expenditure is materially below historic trend due in part to enhanced control environment and the increased number of substantive staff in post.

The non pay position is favourable to YTD plan by £270k. This was delivered mainly through underspends within clinical services (activity volume) expenditure and other non-pay.

Overview

The Trust delivered a deficit of £2.1m YTD; £0.5m worse than plan. Clinical income under-recovery has been partially offset by expenditure underspends.

The completion of patient activity M01 coding after closure of month end has identified a further coding gain to the position of circa £0.3m which would reduce the variance to £0.2m behind plan.

The Trust is expected to meet forecast at the year end. However there are some risks especially in relation to activity delivery. The current run rate forecast for the year would be a deficit of £11m; £3.6 worse than the annual plan. Detailed forecasting will commence from M03 onwards.

In month performance

The Trust delivered a deficit of £1.2m in month; £378k worse than plan.

The income position is £451k below plan. Clinical income under recovered by £502k and other income over recovered by £51k education and training income.

The key underperformance for patient activity income in month is largely within Oral - £290k (Elective casemix, non elective volume) and the Plastics business unit £303k (Elective, day case and Emergency casemix); partially offset by additional recovery in month within the Eyes and Sleep business units.

The pay position is a £136k favourable to plan due to vacancies within all staff groupings with the exception of medical. There has been a decrease within agency staff usage largely within Nursing when compared to the last 6 months of 2018/19.

The non pay position is slightly over budget with clinical supplies overspends offsetting other non pay underspends. In month there was some categorisation of expenditure adjustments between clinical services and other non pay and the YTD is a better reflection of performance.

Summary Trend position - Income and Expenditure Trend

Queen Victoria Hospital NHS Foundation Trust

Board Line	Actual M10 18/19	Actual M11 18/19	Actual M12 18/19	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Annual Plan
Patient Activity Income	5,792	5,120	7,458	5,006	4,992	5,466	5,796	5,730	5,664	6,234	5,657	5,275	5,736	5,333	5,856	67,624
Other Income	(5)	504	(722)	348	438	388	388	388	388	388	388	388	388	388	388	4,654
Total Income	**5,787**	**5,624**	**6,736**	**5,354**	**5,430**	**5,854**	**6,184**	**6,118**	**6,052**	**6,622**	**6,045**	**5,663**	**6,124**	**5,721**	**6,244**	**72,278**
Substantive	(3,596)	(3,660)	(3,913)	(3,902)	(3,824)	(4,252)	(4,303)	(4,305)	(4,262)	(4,348)	(4,320)	(4,280)	(4,301)	(4,280)	(4,363)	(51,500)
Bank	(161)	(117)	(346)	(186)	(194)	(41)	(41)	(41)	(41)	(41)	(41)	(41)	(41)	(41)	(41)	(491)
Agency	(185)	(250)	(216)	(186)	(175)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(240)
Total Pay	**(3,942)**	**(4,027)**	**(4,476)**	**(4,274)**	**(4,193)**	**(4,313)**	**(4,364)**	**(4,366)**	**(4,323)**	**(4,409)**	**(4,381)**	**(4,341)**	**(4,362)**	**(4,341)**	**(4,424)**	**(52,232)**
Clinical Services & Supplies	(1,204)	(1,179)	(1,175)	(794)	(1,296)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(13,301)
Drugs	(122)	(116)	(108)	(118)	(118)	(128)	(128)	(128)	(128)	(128)	(128)	(128)	(128)	(128)	(128)	(1,532)
Consultancy	34	(49)	(229)	(8)	7	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(79)
Other non pay	(765)	(484)	(477)	(691)	(560)	(681)	(681)	(681)	(681)	(581)	(581)	(581)	(581)	(581)	(581)	(7,572)
Total Non Pay	**(2,057)**	**(1,828)**	**(1,989)**	**(1,612)**	**(1,966)**	**(1,924)**	**(1,924)**	**(1,924)**	**(1,924)**	**(1,824)**	**(1,824)**	**(1,824)**	**(1,824)**	**(1,824)**	**(1,824)**	**(22,484)**
Financing	(379)	(374)	(423)	(441)	(439)	(418)	(418)	(418)	(418)	(418)	(418)	(418)	(418)	(418)	(418)	(5,018)
Total Expenditure	**(6,378)**	**(6,230)**	**(6,887)**	**(6,327)**	**(6,598)**	**(6,655)**	**(6,706)**	**(6,708)**	**(6,665)**	**(6,651)**	**(6,623)**	**(6,583)**	**(6,604)**	**(6,583)**	**(6,666)**	**(79,734)**
Surplus / (Deficit)	**(591)**	**(606)**	**(151)**	**(972)**	**(1,168)**	**(801)**	**(522)**	**(590)**	**(613)**	**(29)**	**(578)**	**(920)**	**(480)**	**(862)**	**(422)**	**(7,456)**

Summary

- The current forecast is for Operating Plan Delivery with detailed forecast to be completed after Q1.
- Income appears to be declining due to a change in case mix in both inpatient & outpatient activities even though there are some reductions in NEL & Elective activity. Further work has identified a further income benefit of £0.3m from coding completion for month 1 that would improve the YTD M02 position.
- Pay is decreasing compared to the prior period. Substantive is slightly reducing & agency has decreasing over a sustained period including in month.
- Non pay has risen from prior period and is currently higher than trend this reporting period, this is the key adverse variance to prior month trend. Clinical quarterly stocktake may alleviate this occurrence next month.

Activity Performance by POD based on income and activity plan : M2 2019/20

Queen Victoria Hospital 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	994	1,126	132	82	93	11	1,908	2,168	260	158	179	21
Elective (Daycase)	Spells	1,021	1,086	65	1,130	1,084	(46)	2,007	2,003	(4)	2,214	2,052	(162)
Elective	Spells	323	349	26	890	618	(273)	636	691	55	1,751	1,256	(495)
Non Elective	Spells	450	444	(6)	1,222	1,023	(199)	907	873	(34)	2,463	1,976	(487)
XS bed days	Days	75	40	(35)	22	11	(11)	148	164	16	44	50	7
Critical Care	Days	96	74	(22)	128	62	(66)	196	163	(33)	262	130	(132)
Outpatients - First Attendance	Attendances	3,700	4,206	506	538	615	77	7,342	8,080	738	1,066	1,184	118
Outpatients - Follow up	Attendances	9,739	10,826	1,087	718	783	65	19,415	20,983	1,568	1,426	1,531	105
Outpatient - procedures	Attendances	2,388	1,698	(690)	338	226	(112)	4,773	4,124	(649)	674	572	(102)
Other	Other	3,907	2,747	(1,160)	352	382	30	7,583	5,559	(2,024)	695	814	118
Prior Period Adjustments and WIP					73	95	21				123	253	130
					5,494	**4,992**	**(502)**	**44,916**	**44,808**	**(108)**	**10,877**	**9,998**	**(879)**

Summary

The May in month position was adversely impacted by £500k case mix losses in inpatient and emergency spells deteriorated YTD to £0.9m. However completion of casemix coding for M01 has improvement April income positon by £0.3m that has not been factored into the analysis below.

Key areas for focus are inpatient Corneo, Skin and OMFS specialties activity, casemix issue within burns for emergency activity and casemix within critical care bed days.

Day case activity in month is 65 spells above plan not generated income below plan by £46k. Whilst the Eyes & Oral business units suffered like for like drops in activity & income, Plastics had a favourable spells activity (+66) but reported a drop in income of £94k below plan.

Elective activity in the month is 26 spells above plan in month delivering income below plan of £273k. YTD is 55 spells above plan but £495k below plan. This is brought about by Oral; having both a price & volume variance and Plastics; having a price variance.

Activity Financial Performance	In Month			Year to Date		
Service Line	Plan £k	Actual £k	Var £k	Plan £k	Actual £k	Var £k
Perioperative Care	0	0	0	0	0	0
Clinical Support	527	467	(60)	1,034	979	(55)
Eyes	527	538	11	1,080	987	(93)
Oral	1,259	969	(290)	2,522	1,984	(538)
Plastics	2,641	2,327	(314)	5,179	4,640	(539)
Sleep	375	272	(104)	747	682	(65)
Other incuding WIP/ coding	164	419	254	315	726	411
Grand Total	**5,494**	**4,992**	**(502)**	**10,877**	**9,998**	**(879)**

Non-elective activity has under performed by just 6 spells but £199k in month . The YTD position reports an under performance of 34 spells and £487k . £400k of this adverse NEL income is due from Plastics despite having 19 spells over performance YTD. The remainder is due to Oral YTD under performance of activity by 40 spells and income of £98k

Critical care days have under performed by 22 days in month and £66k. The YTD position is also under performing to plan by 33 spells & £132k.

Outpatient attendances (FA/FU/OProcs) are 903 attendances and £30k above plan in month and YTD 162 attendances and £1,657k above plan. Within this block Outpatient procedures are below plan by 690 attendances and £112k under plan in month. YTD these stand at 649 attendances & £102k below plan. The compensatory effect of follow-up appointments above plan is sufficiently adequate to cover the below plan outpatient procedures.

Overall - The YTD under performance is largely driven by reduced income from a change in case mix in Plastics across inpatient care activity (Elective & NEL) . Other favourable income is offset by below plan activity & income in Oral Electives .

Actions

A mitigations work plan is to be introduced as part of the forecast outturn commencing in month 3 which may include a cost reduction to meet the operating Plan.

Activity Trends by Point of delivery (POD) – M2 2019/20

Queen Victoria Hospital NHS Foundation Trust

	Activity Trend																
POD	Actual M10 18/19	Actual M11 18/19	Actual M12 18/19	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	PLAN 19/20 In Month	Actuals 19/20 In Month
Minor injuries	798	745	863	1,042	1,126	1,032	1,166	1,094	1,074	904	944	980	1,012	946	1,054	994	1,126
Elective (Daycase)	1,107	992	905	917	1,086	1,004	1,130	1,070	1,135	1,294	1,215	1,103	1,246	1,141	1,246	1,021	1,086
Elective	284	297	317	342	349	312	348	327	342	380	353	295	365	333	365	323	349
Non Elective	418	399	386	429	444	475	466	446	439	464	395	393	359	372	404	450	444
XS bed days	33	52	98	124	40	72	80	77	79	86	81	73	79	76	80	75	40
Critical Care	126	81	49	89	74	111	94	96	116	89	107	62	70	62	71	96	74
Outpatients - First Attendance	3,763	3,153	3,644	3,874	4,206	3,641	3,731	3,795	3,958	4,441	4,135	3,729	4,267	3,895	4,265	3,700	4,206
Outpatients - Follow up	10,480	9,107	10,132	10,157	10,826	9,541	10,125	10,139	10,366	11,880	11,067	10,034	11,418	10,430	11,412	9,739	10,826
Outpatient - procedures	2,737	2,233	1,565	2,426	1,698	2,363	2,318	2,454	2,507	2,832	2,611	2,367	2,715	2,475	2,715	2,388	1,698
Other	4,288	3,826	3,142	2,812	2,747	3,906	4,005	3,865	4,026	4,365	4,103	3,608	4,292	3,796	4,059	3,907	2,747
Work in progress and coding adjustment																	
	24,034	20,885	21,101	22,212	22,596	22,459	23,462	23,364	24,044	26,737	25,011	22,644	25,824	23,525	25,670	22,694	22,596

	£'000 Trend																
POD	Actual M10 18/19	Actual M11 18/19	Actual M12 18/19	Actual M1	Actual M2	Plan M3	Plan M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	PLAN 18/19 In Month	Actuals 18/19 In Month
Minor injuries	59	55	64	86	93	85	96	90	89	75	78	81	84	78	87	82	93
Elective (Daycase)	1,329	1,186	1,014	968	1,084	1,108	1,279	1,185	1,269	1,447	1,364	1,237	1,395	1,278	1,394	1,130	1,084
Elective	765	780	746	638	618	869	937	896	978	1,072	1,006	887	1,032	943	1,031	890	618
Non Elective	1,056	996	951	953	1,023	1,288	1,256	1,198	1,178	1,247	1,059	1,058	972	1,011	1,104	1,222	1,023
XS bed days	9	15	27	39	11	21	24	23	23	25	24	22	23	23	24	22	11
Critical Care	189	87	54	68	62	148	125	128	155	120	143	82	93	82	95	128	62
Outpatients - First Attendance	518	419	501	569	615	529	551	549	582	649	606	546	624	570	624	538	615
Outpatients - Follow up	799	691	768	748	783	702	757	742	775	879	823	744	846	773	846	718	783
Outpatient - procedures	363	300	210	346	226	334	329	347	356	401	370	335	384	350	384	338	226
Other	430	410	494	432	382	352	346	361	353	400	370	331	389	347	376	352	382
Work in progress and coding adjustment					95											73	95
	5,518	4,939	4,829	4,848	4,992	5,437	5,700	5,519	5,761	6,315	5,844	5,324	5,843	5,457	5,963	5,494	4,992

- Activity & £ trend increase for MIU, Outpatients First & Follow-ups and all inpatient spells, with a decrease in Outpatient procedures.
- Reviewing Coding and case mix of non elective in ongoing given above plan activity against below plan income .
- Other includes Excluded Devices & Drugs, CQUIN, Diagnostics Direct Access & Unbundled and AQP contracts.

Financial Position by Business Unit – M2 2019/20

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	(264)	(580)	83	63	(64)	(82)	7	(34)	25,155	1,988	1,750	(238)	69%	3,875	3,242	(633)	15%
1.2 Oral	(251)	(385)	(4)	(11)	(20)	(65)	43	105	8,583	676	444	(232)	42%	1,355	999	(356)	10%
1.3 Eyes	51	(18)	20	23	6	18	26	23	4,863	305	409	104	69%	637	682	46	13%
1.4 Sleep	178	160	(0)	0	2	9	(36)	(66)	2,063	165	310	144	127%	327	430	103	12%
1.5 Clinical Support	(10)	9	(50)	(51)	71	39	52	134	(2,536)	(229)	(166)	63		(480)	(348)	131	
1.6 Perioperative Care	(0)	(0)	1	3	(19)	(2)	(22)	81	(12,907)	(1,077)	(1,116)	(39)		(2,154)	(2,071)	82	
1.7 Operational Nursing	(93)	(239)	2	(1)	74	133	(42)	(27)	(6,029)	(506)	(565)	(59)		(1,005)	(1,138)	(134)	
Operations Total	**(388)**	**(1,054)**	**52**	**26**	**50**	**49**	**29**	**218**	**19,192**	**1,322**	**1,065**	**(257)**		**2,556**	**1,795**	**(761)**	
Nursing & Clinical Infrastructure																	
2.1 Clinical Infrastructure	0	0	(3)	(7)	4	6	13	20	(1,197)	(101)	(88)	13		(203)	(183)	19	
2.5 Director Of Nursing	-	-	(10)	(20)	(15)	(42)	(89)	(58)	(3,059)	(258)	(347)	(89)		(517)	(636)	(120)	
Nursing & Clinical Infrastructure	**0**	**0**	**(13)**	**(26)**	**(11)**	**(36)**	**(76)**	**(38)**	**(4,256)**	**(360)**	**(435)**	**(76)**		**(719)**	**(819)**	**(100)**	
Corporate Departments																	
3.1 Non Clinical Infrastructure	-	-	23	43	(16)	(36)	16	8	(4,621)	(385)	(370)	16		(770)	(755)	15	
3.2 Commerce & Finance	-	-	(1)	(2)	24	(2)	107	56	(3,417)	(288)	(181)	107		(576)	(524)	52	
3.4 Finance Other	(114)	175	(33)	(55)	96	143	(133)	45	(11,349)	(823)	(956)	(133)		(1,621)	(1,313)	308	
4.1 Human Resources	-	-	19	19	0	0	37	17	(1,093)	(93)	(56)	37		(186)	(150)	36	
5.4 Corporate	-	-	4	7	(7)	23	(72)	(78)	(1,901)	(161)	(233)	(72)		(322)	(370)	(48)	
Corporate Total	**(114)**	**175**	**11**	**11**	**98**	**128**	**(46)**	**48**	**(22,381)**	**(1,750)**	**(1,796)**	**(46)**		**(3,475)**	**(3,112)**	**363**	
Surplus / (Deficit)	**(502)**	**(879)**	**51**	**11**	**136**	**142**	**(92)**	**228**	**(7,445)**	**(788)**	**(1,166)**	**(378)**		**(1,638)**	**(2,136)**	**(498)**	

Summary

Patient Activity Income: The main areas of under performance in month are, Plastics largely within skin and burns specialties (Elective, Daycases & Non Elective), Oral (mainly elective & daycase),) and Critical care. There has been a change in the case mix adversely affecting income. YTD underperformance of patient care income of £0.9m is mainly within Plastics (Non Elective (Burns casemix) & outpatients), Oral services (Daycases, Outpatients & H&N Top up) partially offset by Sleep services (Daycases & Outpatients volumes). This is also added to by Operational Nursing (casemix of critical care bed days due to high portion of lower priced 0 organs supported HRGs from Burns and OMFS).

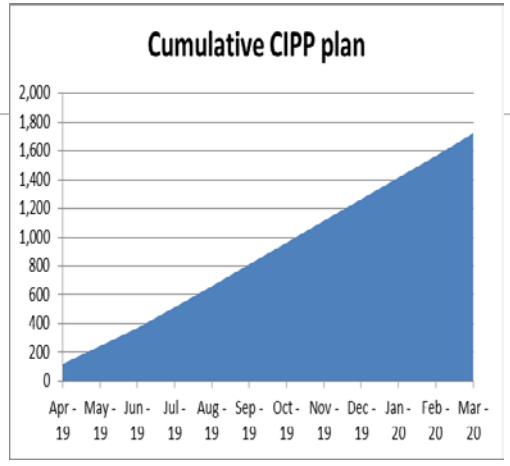
Other income: In month is above plan by £51k mainly due from Plastics due to additional income from Health Education England. Clinical Support income is below plan in month but this is due to delayed verification of ad-hoc income but this expected to be resolved in M3.

Pay: In month is under spent £136k in month and £142k YTD. The main drivers of under spend are uncovered vacancies in operational nursing with qualified nursing being the largest staffing group with vacancies. These under spends more than compensate for the medical staff over spends in Plastics & Oral which occur in all Medical staffing which is currently being reviewed.

Non Pay: In month is over spent by £92k; under spent YTD £228k. Clinical supplies underspends seen in month 1 have not continued in month 2 but expected to stabilise post Q1 stock count.

Trust CIP Dashboard for the period to 31 May 2019

CIPP Profile						
Month	19/20 Target	Pay	Non-Pay	Income	Total Actual	Variance
Apr - 19	59	9	33	0	42	(17)
May - 19	62	9	35	0	44	(18)
Jun - 19	65					
Jul - 19	68					
Aug - 19	69					
Sep - 19	73					
Oct - 19	221					
Nov - 19	222					
Dec - 19	219					
Jan - 20	221					
Feb - 20	221					
Mar - 20	225					
Total	1,724	18	68	0	85	(35)



Summary Identfied			
Business Units	19/20 Target	Identified	Unidentified
Clinical Support	280	144	136
Eyes	72	41	31
Plastics	219	23	195
Sleep	95	95	0
Commerce & Finance	84	20	64
Human Resources	32	0	32
Oral	190	37	153
Operational Nursing	210	40	170
Director of Nursing	69	6	63
Non Clinical Infrastructure	130	127	3
Perioperative Care	328	306	22
Performance & Access	30	0	30
Corporate	49	0	49
Reserves	(63)	0	(63)
Total	1,724	840	885

As per the Operational Plan submitted to NHSI, the Trust has a 19/20 CIPP target of £1.72m.

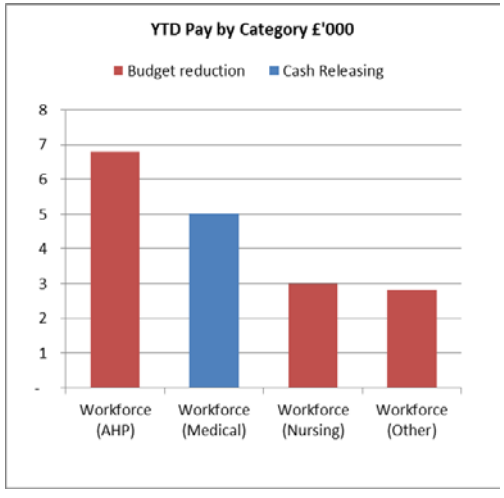
£840k CIPP has been identified. Unidentified CIPP is phased to start from M7. The largest proportion of cash releasing savings is planned by Perioperative Care, £306k.

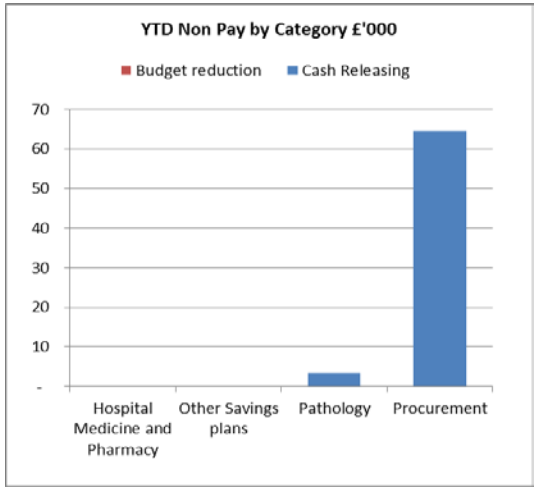
At M2 £85k cost saving has been recorded against a YTD plan of £121k. £68k of this saving has been made against non pay

Whilst performance to date is lower than plan, further work is being undertaken to validate underperformance in next few weeks. YTD slippage has non recurrently been offset by expenditure underspends across the Trust.

Work is ongoing to reduce the number of high risk schemes and to continue identifying more schemes against the target.

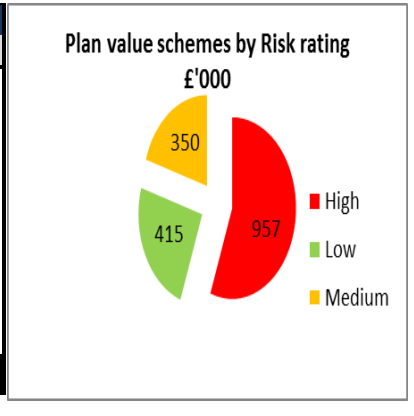
Business Unit Summary YTD			
Business Units	Target	Actual	Variance
Clinical Support	23	13	(10)
Eyes	2	0	(2)
Plastics	4	0	(4)
Sleep	10	5	(5)
Commerce & Finance	4	0	(4)
Human Resources	0	0	0
Oral	6	0	(6)
Operational Nursing	7	3	(4)
Director of Nursing	1	0	(1)
Non Clinical Infrastructure	20	20	0
Perioperative Care	44	45	0
Performance & Access	0	0	0
Corporate	0	0	0
Reserves	0	0	0
Total	121	85	(35)

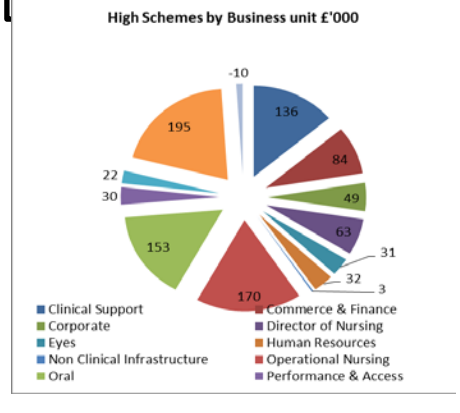




YTD Actual Summary			
Business Units	Cash Releasing	Budget Reduction	Total
Clinical Support	3	10	13
Eyes	0	0	0
Plastics	0	0	0
Sleep	5	0	5
Commerce & Finance	0	0	0
Human Resources	0	0	0
Oral	0	0	0
Operational Nursing	0	3	3
Director of Nursing	0	0	0
Non Clinical Infrastructure	20	0	20
Perioperative Care	45	0	45
Performance & Access	0	0	0
Corporate	0	0	0
Reserves	0	0	0
Total	73	13	85

YTD Summary by Category			
Category	Target	Actual	Variance
Pay (Skill mix)	11	12	1
Pay (WTE reductions)	7	6	(1)
Non pay	101	68	(33)
Income (Patient Care Activities)	2	0	(2)
Income (Other operating income)	0	0	0
Unidentified	0	0	0
Total	121	85	(35)





Balance Sheet – M02 2019/20

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet as at the end of May 2019	2018/19 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	51,173	50,836	51,075
Other Receivables	-	-	-
Sub Total Non-Current Assets	51,173	50,836	51,075
Current Assets			
Inventories	1,275	1,274	1,263
Trade and Other Receivables	10,210	8,974	8,362
Cash and Cash Equivalents	3,944	332	2,382
Current Liabilities	(13,164)	(10,094)	(10,595)
Sub Total Net Current Assets	2,265	486	1,412
Total Assets less Current Liabilities	53,438	51,322	52,487
Non-Current Liabilities			
Provisions for Liabilities and Charges	(608)	(627)	(627)
Non-Current Liabilities >1 Year	(5,045)	(5,045)	(5,045)
Total Assets Employed	**47,785**	**45,650**	**46,815**
Tax Payers' Equity			
Public Dividend Capital	12,249	12,249	12,249
Retained Earnings	22,395	20,260	21,425
Revaluation Reserve	13,141	13,141	13,141
Total Tax Payers' Equity	**47,785**	**45,650**	**46,815**

NB Analysis is subject to rounding differences

Summary

- The capital asset net value has decreased in year by £337k, and is expected to remain so, due to current depreciation and the timing and level of this year's capital spend.
- Net current assets have decreased in year by £1.8m reflecting the current year operating losses and capital spend.
- Inventories: The stock inventory will continue to be routinely assessed quarterly during 2019-2020.
- Trade and other receivables have decreased by £1.2m in year, reflecting a reduction in NHS debtors and receipts for year end invoicing.
- Cash has decreased by £3.6m. This is due to the operating loss, reduction in creditors and a peak of capital payments relating to the prior year. Cash is being reviewed on a daily basis and interim loans arranged with the DHSC, as per the operating plan 2019-20.
- Current liabilities have decreased by £3m in year, as 18-19 quarter 4 capital project payments became due and other invoice backlog s are cleared.
- Non current liabilities - no material change.

Issues

- Sufficient cash balances are not being generated by the Trust to provide liquidity, service the capital plan or to meet future loan principal repayment obligations. This necessitates borrowing cash from the DHSC as interim loans to manage liquidity requirements until the Trust achieves a net cash operating surplus.

Actions

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

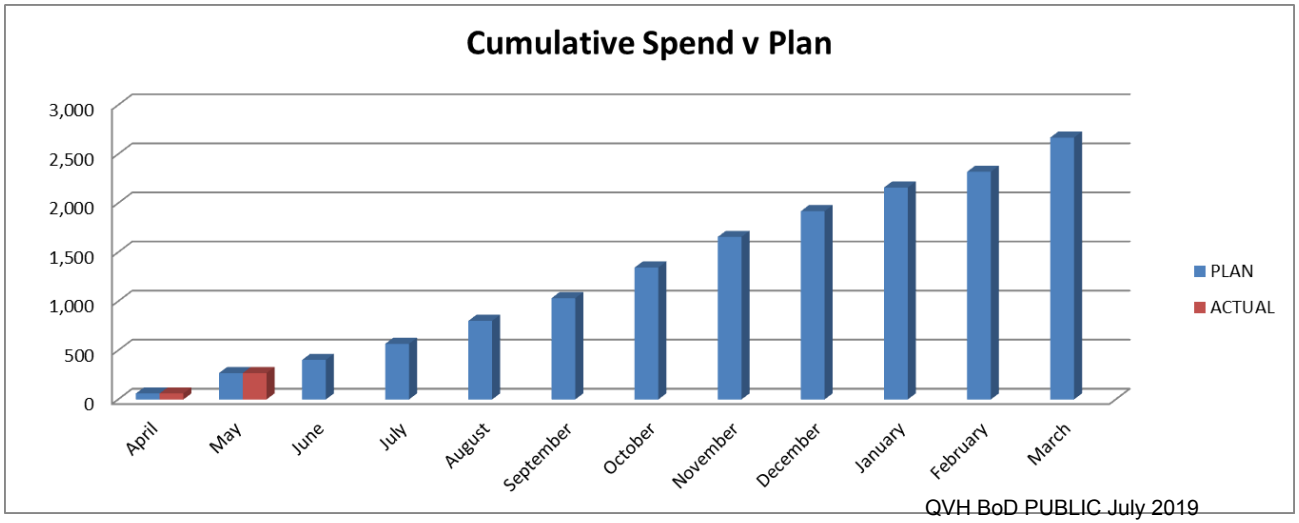
Capital – M02 2019/20

Queen Victoria Hospital NHS
NHS Foundation Trust

Month 2 - May 2019	Annual Plan £000s	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Full Year Forecast £000s	Full Year Variance £000s
Estates projects						
Carried over from 2018/19:						
Emergency lighting	120	38	38	-	120	-
Other	180	144	144	-	180	-
2019/20 projects:						
Air handling / air conditioning	141	-	-	-	141	-
Other	70	12	12	-	70	-
Estates projects	**511**	**194**	**194**	**-**	**511**	**-**
Medical Equipment	**480**	**-**	**-**	**-**	**480**	**-**
Information Management & Technology (IM&T)						
Windows 10 implementation	692	-	-	-	692	-
Electronic Document Management	200	38	38	-	200	-
IP Telephony	200	-	-	-	200	-
PAS upgrade	100	-	-	-	100	-
Other	275	37	37	-	301	(26)
Information Management & Technology (IM&T)	**1,467**	**75**	**75**	**-**	**1,493**	**(26)**
Contingency	**210**	**-**	**-**	**-**	**184**	26
Total	**2,668**	**269**	**269**	**-**	**2,668**	**-**

Summary

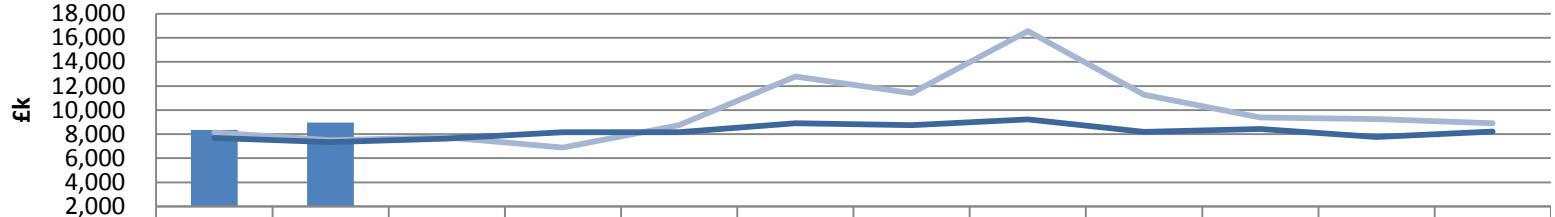
- The Capital plan for 2019/20 is £2,668k. This is a 33% reduction from the 2018/19 spend excluding donations, necessary because of the reduced availability of funds.
- The capital programme has been developed through the 2019/20 business planning process with EMT and Board approval.
- Because of the reduced budget it has been necessary to hold back expenditure on the estate. Commitments from the 2018/19 programme will be completed but new works will be restricted to absolute essentials.
- Expenditure on medical equipment has also been restricted, being 75% of the spend in 2018/19. There is a need for major expenditure on medical imaging which cannot be met through the current capital programme. Alternative procurement approaches are being investigated.
- The IM&T programme centres on the implementation of Windows 10 across the trust. There will be further significant expenditure to complete the EDM project and to upgrade the PAS and telephony systems, all of which are needed to keep abreast of current and foreseen information and communication requirements.
- Expenditure to the end of May was £269k.



Debtors – M02 2019/20

Queen Victoria Hospital NHS Foundation Trust

Debtor Trend



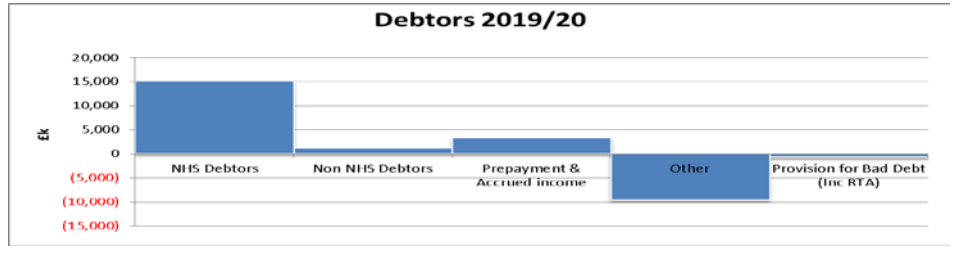
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total 2019/20	8,362	8,974										
Total 2018/19	8,147	7,492	7,743	6,878	8,763	12,787	11,417	16,556	11,283	9,400	9,247	8,904
Total 2017/18	7,679	7,330	7,639	8,168	8,172	8,901	8,756	9,233	8,206	8,419	7,778	8,217

Summary

- The debtor balance has increased by £0.6m (7%) from month 1.
- The month 2 debtor balance of £9.0m is 9% below the average monthly balance in 2018-19.
- At month 2 there are income and prepayment accruals of £3.2m. This is £2.0m of accrued commissioning income for activity over-performance and NCAs ; £0.6m for other income including health education and clinical excellence award funding; Prepayment adjustments are £0.6m – being the re-profiling of expenditure for annual or periodic contracts and licences .

Next Steps

- Debtor management procedures have been revised and enhanced to better mange the cash position given current challenges.



May Aged Debtors £k				
POD	30 Days	60 Days	90 Days	90+ Days
NHS	874	749	255	3,003
Non NHS	96	452	47	94
Total	**970**	**1,201**	**302**	**3,096**

Change in Aged Debtors on the month £k				
POD	30 Days	60 Days	90 Days	90+ Days
NHS	(793)	627	349	(227)
Non NHS	(419)	406	37	5
Total	**(1,213)**	**1,034**	**386**	**(222)**

Cash – M02 2019/20

Queen Victoria Hospital NHS Foundation Trust

Cash Flows 2019/20	Actual (£m)		Forecast:									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Opening Balance	**3.94**	**2.38**	*0.33*	*2.87*	*3.43*	*4.36*	*4.14*	*2.69*	*2.33*	*2.23*	*1.50*	*1.30*
Receipts from invoiced income	5.62	4.48	*7.47*	*5.33*	*5.33*	*5.33*	*5.33*	*5.33*	*5.33*	*5.33*	*5.33*	*5.33*
Receipts from non-invoiced income	0.13	0.25	*0.32*	*0.87*	*0.48*	*0.85*	*0.50*	*0.48*	*0.84*	*0.49*	*0.28*	*0.86*
2018/19 PSF funding					*0.53*							
Interim Cash Loans			*1.24*	*0.65*	*0.70*	*1.08*		*0.55*	*1.27*	*0.38*	*0.86*	*1.60*
Total Receipts	**5.76**	**4.73**	**9.03**	**6.84**	**7.04**	**7.25**	**5.83**	**6.36**	**7.43**	**6.20**	**6.46**	**7.78**
Payments to NHS Bodies	(0.33)	(0.34)	*(0.52)*	*(0.50)*	*(0.50)*	*(0.80)*	*(1.00)*	*(0.80)*	*(0.80)*	*(1.00)*	*(0.80)*	*(1.00)*
Payments to non-NHS bodies	(3.06)	(2.42)	*(1.52)*	*(1.76)*	*(1.55)*	*(1.85)*	*(2.26)*	*(1.85)*	*(2.24)*	*(1.85)*	*(1.84)*	*(2.25)*
Net payroll payment	(2.26)	(2.30)	*(2.26)*	*(2.29)*	*(2.34)*	*(2.29)*	*(2.29)*	*(2.34)*	*(2.29)*	*(2.34)*	*(2.29)*	*(2.29)*
PAYE, NI & Levy payment	(1.07)	(1.11)	*(1.09)*	*(1.11)*	*(1.11)*	*(1.11)*	*(1.11)*	*(1.11)*	*(1.11)*	*(1.11)*	*(1.11)*	*(1.11)*
Pensions Payment	(0.61)	(0.63)	*(0.64)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*	*(0.62)*
PDC Dividends Payment	-	-	-	-	-	*(0.80)*	-	-	-	-	-	*(0.80)*
Theatre Loan Repayment	-	-	*(0.47)*	-	-	-	-	-	*(0.47)*	-	-	-
Total Payments	**(7.32)**	**(6.78)**	(6.49)	(6.28)	(6.12)	(7.47)	(7.28)	(6.72)	(7.53)	(6.92)	(6.67)	(8.08)
Actual Closing Balance	**2.38**	**0.33**										
Forecast Closing Balance			*2.87*	*3.43*	*4.36*	*4.14*	*2.69*	*2.33*	*2.23*	*1.50*	*1.30*	*1.00*
NHSI Plan	**2.76**	**2.06**	**1.01**	**1.00**	**1.00**	**1.00**	**1.09**	**1.00**	**1.00**	**1.00**	**1.00**	**1.00**
Variance to NHSi plan	(0.38)	(1.73)	1.86	2.43	3.36	3.14	1.60	1.33	1.23	0.50	0.30	0.00

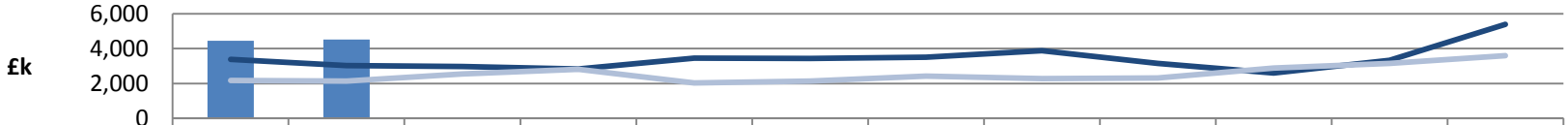
Summary

- The continuing operating deficit position results in the liquidity cash position having to be maintained through interim revenue support cash loans from the DHSC. These loan requirements were included in the NHSi operating plan for 2019-20 but will have to be flexed in response to actual cash flows , income and operating performance results.
- The cash balance at the end of month 2 is below original plan due to the payment of significant creditor invoices (including prior year capital projects being finalised) and late payment of contract invoices for some commissioners.
- The cash position will continue to be reviewed and managed on a daily basis; and loan requirements reviewed monthly in liaison with NHSi.
- Financial services will work with commissioners to ensure payments are made in a timely manner and older debts controlled.

Creditors – M02 2019/20

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	4,455	4,512										
2018/19	3,377	3,033	2,967	2,825	3,446	3,443	3,501	3,886	3,157	2,606	3,335	5,392
2017/18	2,175	2,140	2,543	2,810	2,022	2,129	2,422	2,283	2,318	2,882	3,157	3,598

Summary

- The trade creditors balance at month 2 is £4.5m compared to an average of £3.4m during 2018-19.
- The Trust's BPPC percentage has decreased in month by 2% and the average days to payment increased to 25 days. Accounts payable are continuing to work through the backlog of invoices awaiting approval in order to address this and maintain the improvement on last year's outturn.
- Cash flow management resulted in a delay in payments for the final week of May thus increasing the level of AP creditors and impacting the future BPPC results by @£800k.
- Reviews will continue to target older NHS SLA balances with our key partner Trusts.

Next Steps

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

Better Payment Practice Code (18/19) May	2018/19 Outturn No Invs	2018/19 Outturn £k	Current Month No Invs	Current Month £k	YTD No Invs	YTD £k
Total **Non-NHS** trade invoices paid	20,536	34,881	1,457	4,926	3,036	9,046
Total **Non NHS** trade invoices paid within target	16,989	30,487	1,229	4,438	2,574	8,110
Percentage of Non-NHS trade invoices paid within target	**83%**	**87%**	**84%**	**90%**	**85%**	**90%**
Total **NHS** trade invoices paid	920	5,323	63	336	170	661
Total **NHS** trade invoices paid within target	580	3,324	52	302	149	606
Percentage of NHS trade invoices paid within target	**63%**	**62%**	**83%**	**90%**	**88%**	**92%**

May 2019: Aged Creditors £k				
POD	30 Days	60 Days	90 Days	90+ Days
NHS	368	570	355	1,290
Non NHS	821	975	306	141
Total	**1,189**	**1,545**	**661**	**1,432**

Change in Aged Creditors on the month £k				
POD	30 Days	60 Days	90 Days	90+ Days
NHS	(615)	295	73	282
Non NHS	(369)	872	226	126
Total	**(984)**	**1,167**	**298**	**407**

Appendices

Appendix 1: Finance Score (Single Oversight Framework)

Queen Victoria Hospital NHS Foundation Trust

Table 1

Single Oversight Framework						
Finance Score: May 2019						
	Metrics £k	Measure	Rating	Weight	Score	Plan
Continuity of Services:						
Capital Service Cover						
Operating surplus (Adj YTD)	(1,256)	-4.36	4	20%	0.80	4
Capital Servicing Obligation YTD	288					
Liquidity						
Working Capital	(788)	-3.99	2	20%	0.40	2
Operating Costs (per day)	197					
Financial Efficiency:						
Control Total Margin (%)						
Adj. Surplus (deficit) YTD	(2,095)	-19.4%	4	20%	0.80	4
Adj. Income year to date	10,785					
Margin Variance From Plan						
Adj. Actual surplus margin	-19.4%	-5.7%	4	20%	0.80	1
Adj. Plan surplus margin	-13.7%					
Agency Cap						
Agency Spend	362	33.09%	3	20%	0.60	4
Agency Cap	272					
Finance Score: May 2019			3		Plan:	4

Table 2

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

Summary

- The use of resources score is a 3 due to agency spend being less than planned
- Table 2 details a definition of each of the metrics and the scoring mechanism.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**117-19**	
Report title:	**Review of committee chairs and membership**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	The purpose of the report is for the Board to review and approve the distribution of committee responsibilities from October 2019.				
Summary of key issues	The recent appointment of two new NEDs and the departure of John Thornton at the end of September means that new committee chairs need to be appointed and NED attendance at committees agreed. Paul Dillon-Robinson has been appointed as a NED subject to ratification at the July council of governors meeting.				
Recommendation:	The Board of Directors is asked to **APPROVE** the distribution of committee responsibilities from October 2019.				
Action required *[highlight **one** only]*	**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:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	If the Board approves the Chair's recommendations contained within this report, they will take effect from 01 October 2019.				

Report to:	Board of Directors
Meeting date:	04 July 2019
Reference number:	117-19
Report from:	Beryl Hobson, Trust Chair
Authors:	Beryl Hobson, Trust Chair
Appendices:	N/A
Report date:	17 June 2019

Chairing and attendance at Board sub-committees

Background

1. The recent appointment of two new NEDs and the departure of John Thornton at the end of September means that new committee chairs need to be appointed and NED attendance at committees agreed.

2. Paul Dillon-Robinson has been appointed as a NED subject to ratification at the July council of governors meeting.

Process

3. The Trust's Standing orders (S5.4) state:

   'The Board of Directors shall approve the appointments to each of the Committees, which it has formally constituted. Where the Board of Directors determines and regulations permit that persons, who are neither Directors nor officers, shall be appointed to a Committee the terms of such appointment shall be determined by the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with its Constitution. The Board of Directors may elect to change the committees, sub-committees and joint-committees of the Board of Directors, as necessary, without requirement to amend these Standing Orders'.

4. The Reservation of Powers & Scheme of Delegation (2.3.3) state that the BoD should:

   Appoint and remove members of all committees or sub-committee of the Board of Directors or the appointment of a Trust representative to third party organisations.

5. The HFMA NHS Charitable Funds guide (8.5: 'Setting up a charitable funds committee') states that any FT charitable funds committee must be set up in accordance with procedures for sub-committees laid down in the NHS Act (2006) – ie mirror the foundation trust committees.

6. I have considered the various options and discussed the options with the NEDs. The following proposal maximises the resources available to the Board and as far as possible fairly distributes committee attendance across the NEDs. This is set out below:

Name	SID (required by Constitution) & Deputy Chair of Board & CoG	Audit (Statutory committee)	N&R (Statutory committee)	F&P	Q&G	Charity committee	Charity corporate trustee
JT (to 30 Sept)	X	X	X (until Sept)	X (Chair)			X
GN (from 01 Oct)	X		X		X	X (Chair)	X
KG		X (Chair)	X	X			X
KN		X (to review at end of year)	X		X (Chair)		X
P D-R (from 01 Oct)		X	X	X (Chair)			X
BH (Chair of Board & CoG)			X (Chair)	X		X	X (Chair)

Recommendation

The Board of Directors is asked to **APPROVE** the distribution of committee responsibilities from 01 October 2019.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**118-19**	
Report title:	**Appointment of Senior Independent Director**				
Sponsor:	Beryl Hobson, Chair				
Author:	Beryl Hobson, Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	The purpose of this report is for the Board to consider the Trust Chair's recommendation for the next Senior Independent Director in advance of consultation with the Council of Governors.				
Summary of key issues	The Trust's current Senior Independent Director, John Thornton completes his second term as a non-executive director on 30 September and will be stepping down from the Trust at this time. Section 36.1 of the Trust's Constitution states that a Senior Independent Director shall be appointed by the Board of Directors in consultation with the Council of Governors.				
Recommendation:	The Board is asked to **AGREE** the recommendation of the Chair that Gary Needle be appointed the new Senior Independent Director from October 2019 subject to consultation with the council of governors.				
Action required *[highlight **one** only]*	**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:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	If the Board approves the Chair's recommendations contained within this report, the new appointment will take effect from 01 October 2019.				

Report to:	Board of Directors
Meeting date:	04 July 2019
Reference number:	118-19
Report from:	Beryl Hobson, Trust Chair
Author:	Beryl Hobson, Trust Chair
Appendices:	N/A
Report date:	17 June 2019

Appointment of the Senior Independent Director

1. Introduction

1.1. The Trust's current Senior Independent Director, John Thornton completes his second term as a non-executive director on 30 September and will be stepping down from the Trust at this time.

1.2. Section 36.1 of the Trust's Constitution states that a Senior Independent Director shall be appointed by the Board of Directors in consultation with the Council of Governors.

1.3. The purpose of this paper is for the board to consider my recommendation for the next Senior Independent Director in advance of consultation with the Council of Governors.

2. Role of Senior Independent Director

2.1. Section A.4.1 of the FT Code of governance states that in consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chair and to serve as an intermediary for the other directors when necessary. At QVH the SID takes particular responsibility for carrying out the annual review of the performance of the Chair, in conjunction with the Chair of the Governors' Appointments Committee.

3. Proposal

3.1. Having discussed the appointment with the Non-Executive Directors, my recommendation is that Gary Needle should be the next Senior Independent Director, with effect from 01 October 2019.

3.2. If the board are happy with this recommendation I will ask for this to be put on the agenda of the next council of governors.

3.3. Gary Needle has expressed an interest in taking on the role of the SID, assuming council of governors and the board of directors are in agreement.

4. Recommendation

The Board is asked to:

- **AGREE** the recommendation of the Chair that Gary Needle be appointed the new Senior Independent Director from 01 October 2019 subject to consultation with the council of governors.
- **NOTE** that the Senior Independent Director also assumes the role of deputy chair to the council of governors.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**04/07/2019**		**Agenda reference:**	**119-19**	
Report title:	**Annual approval of Trust Standing Financial instructions**				
Sponsor:	Michelle Miles, Director of finance				
Authors:	Michelle Miles, Director of finance Jason McIntyre, Deputy director of finance				
Appendices:	Standing Financial Instructions (SFIs) with change tracking.				
Executive summary					
Purpose of report:	To provide the Board with an update on changes made to Trust Standing Financial Instructions and accounting policies over the last twelve months.				
Summary of key issues	The Audit committee has reviewed the attached and recommends Board approval Changes from the Audit committee are; Page 7 – removal of Monitor as the Trusts regulator				
Recommendation:	The Board is asked to **APPROVE** the revised SFIs				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit Committee				
	Date:	19/06/19	Decision	Recommended for approval	
Next steps:	If approved by the Board, these SFIs will take immediate effect.				

Queen Victoria Hospital NHS Foundation Trust

Standing financial instructions (also applicable to the Queen Victoria Hospital Trust Charitable Fund)

Approved by the Board of Directors 5 July 2018

Effective from 5 July 2018

Contents

1 INTRODUCTION TO STANDING FINANCIAL INSTRUCTIONS

1.1 Purpose of the Standing Financial Instructions

1.1.1 The Standing Financial Instructions ("**SFIs**") explain the financial responsibilities, policies and procedures to be adopted by Queen Victoria Hospital NHS Foundation Trust ("**the Trust**"). These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust, They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in all financial matter concerning the Trust. These SFIs should be used in conjunction with the Reservation of Powers to the Board and the Delegation of Powers adopted by the Trust.

1.1.2 These SFIs together with the Standing Orders and supported by the Reservation of Powers and Schemes of Delegation (SoD), provide a suite of governance documents for the Trust to operate within, and set the rules under which Directors, Officers and third parties contracted to the Trust are required to work.

1.1.3 These SFIs have been complied under authority of the Board of Directors of the Trust. They have been reviewed by the Audit Committee and by the Board of Directors and have their full approval.

1.1.4 Any questions relating to the SFIs should be referred to the Director of Finance & Performance, Deputy Director of Finance or their nominated Officer. Any questions relating to the Standing Orders should be referred to the Company Secretary. The SFIs and SoD are formally adopted by the Board of Directors and shall be reviewed annually by the Trust.

1.1.5 For the avoidance of doubt, the SFIs and SoD apply to all Trust and Charitable Funds activity, including research and development, training and education, joint ventures and special purpose vehicles, unless specific exceptions are described in the sections of this document covering those areas.

1.2 Interpretation and definitions

1.2.1 Save as otherwise permitted by law, at any meeting of the Board of Directors the Chair of the Trust (of the person presiding over the meeting) shall be the final authority on the interpretation of SFIs (on which he should be advised by the Chief Executive or the Director of Finance) and his decision shall be final and binding except in the case of manifest error.

1.2.2 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SFIs shall bear the same meaning as in the Standing Orders.

1.2.3 In these SFIs:

"**Budget**" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"**Budget Manager**" means the Director or Officer with delegated authority to manage finances (income and expenditure) for a specific area of the Trust;

"**Funds Held on Trust**" means those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable;

"**GBS**" means the Government Banking Service;

"**Officer**" means an employee of the Trust; and

"**SoD**" means the Scheme of Delegation.

1.2.4 Wherever the title Chief Executive, Director or other nominated Officer is used in these SFIs, this will include other officers who have been duly authorised to represent them.

1.2.5 References in these SFIs to 'Officer' shall be deemed to include all Officers of the Trust including any contractors/consultants, the Non-Executive Directors, temporary employees, locums and contracted staff.

1.3 Scope

1.3.1 These SFIs apply to all Officers in all locations, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs and SOs is a disciplinary matter that could result in dismissal.

1.4 Duties

1.4.1 All Officers of the Trust are required to comply with these SFIs. Delegation of duties can be found in the SoD.

1.5 Training and awareness

1.5.1 Post ratification, the document will be published to Trust's intranet and internet pages. The publication of the document will be highlighted to staff via communications issued by the Trust's corporate affairs department.

1.6 Equality

1.6.1 This document and protocol will be equality impact assessed in accordance with the Trust Procedural Documents Policy, the results of which are published on the Trust's internet page and recorded by the Trust's Equality and Diversity team.

1.7 Freedom of Information

1.7.1 Any information that belongs to the Trust may be subject to disclosure under the Freedom of Information Act 2000. This act allows anyone, anywhere to ask for information held by the Trust to be disclosed (subject to limited exemptions). Further information is available in the Freedom of Information Act 2000 Trust Procedure which can be viewed on the Trust Intranet.

1.8 Review

1.8.1 These SFIs will be reviewed on an annual basis from the date of ratification. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

1.9 Discipline

1.9.1 Failure to comply with or breaches of these SFIs will be investigated and may result in the matter being treated as a disciplinary offence under the Trust's disciplinary procedure, and may result in an employee's dismissal. Where such a breach results in clear financial loss, the Officer may be personally liable to compensate the Trust.

2 RESPONSIBILITIES AND DELEGATION

2.1 Overview

2.1.1 Roles and responsibilities of the Board of Directors, Committees, Directors and Officers of the Trust with regards to finance are set out below. Responsibilities are detailed in full in the SoD.

2.1.2 It should be noted that the Board of Directors remains accountable for all of its functions, even those delegated to the Chair, individual Directors or Officers, and should expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.2 Role of the Board of Directors

2.2.1 The Board of Directors shall exercise financial supervision and control by:

(a) agreeing the Trust's financial strategy;

(b) requiring the submission of and approving annual financial plans, including revenue, capital and financing;

(c) approving policies such as these SFIs, SoD and Standing Orders for the Board of Directors in relation to financial control and ensuring value for money; and

(d) defining specific responsibilities placed on members of the Board of Directors and Officers as indicated in the SoD.

2.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the SoD.

2.2.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the SoD adopted by the Trust.

2.3 Role of the Finance and Performance Committee

2.3.1 In accordance with Standing Orders for the Board of Directors, the Board of Directors shall formally establish a Finance and Performance Committee with clearly defined terms of reference, which will provide an independent and objective view of financial and operational performance by:

(a) reviewing, interpreting and challenging in-year financial and operational performance;

(b) overseeing the development and delivery of any corrective actions plans and advise the Board of Directors accordingly; and

(c) receiving, reviewing and providing guidance to the Board of Directors as to the approval of investment programmes, cost improvement programmes and business cases.

2.3.2 The terms of reference for the Finance and Performance Committee shall be considered as forming part of these SFIs.

2.3.3 Where the Finance and Performance Committee feel there is a need to amend or modify the Trust's strategic initiatives in the light of changing circumstances or issues arising from implementation, the Chair of the Finance and Performance Committee should raise the matter at a full meeting of the Board of Directors.

2.4 Role of the Chief Executive

2.4.1 Within these SFIs, it is acknowledged that the Chief Executive is the Accounting Officer of the Trust.

2.4.2 The Chief Executive is ultimately accountable to the Secretary of State for ensuring that the Board of Directors meets it obligation to perform the Trust's functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met.

2.4.3 The Chief Executive shall exercise all powers of the Trust that have not been retained as reserved by the Board of Directors or specifically delegated to a Committee. The SoD identifies functions that he/she shall perform personally and functions delegated to other Directors and Officers. All powers delegated by the Chief Executive can be re-assumed by them, should the need arise.

2.4.4 It is a duty of the Chief Executive to ensure that all existing Officers and new appointees are notified of their responsibilities within these SFIs.

2.4.5 The Chief Executive and Chair must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

2.4.6 The Chief Executive is responsible for ensuring that financial performance measures with reasonable targets have been defined and are monitored, with robust systems and reporting lines in place to ensure overall performance is managed and arrangements are in place to respond to adverse performance.

2.4.7 The Chief Executive may determine that powers devolved under this document and the detailed SoD be taken back to a more senior level – for example, areas of the Trust that are deemed to be in financial recovery may be given a reduced level of devolved autonomy.

2.4.8 In accordance with guidance issued by the Regulator, the Chief Executive is responsible for ensuring that the Trust provides an annual forward plan to the Regulator each year, together with quarterly reports (or more frequent if required

by ~~Monitor/~~ NHS improvement), which should be appropriately communicated to the Board of Directors and the Council of Governors.

2.4.9 If the Chief Executive is absent powers delegated to them may be exercised by the acting Chief Executive after taking appropriate advice from the Company Secretary, and consulting with the Chair as necessary.

2.5 Role of the Director of Finance

2.5.1 The Director of Finance is responsible for the following:

(a) advising on and implementing the Trust's financial policies and co-ordinating any corrective action necessary to further these policies;

(b) design, implementation and supervision of systems of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these SFIs;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to report, with reasonable accuracy, the financial position of the Trust at any time;

(d) provision of financial advice to other members of the Board of Directors and Officers; and

(e) preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.6 Corporate responsibilities of all members of the Board of Directors and Officers

2.6.1 All members of the Board of Directors and Officers of the Trust, are severally and collectively responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders for the Board of Directors, these SFIs, SoD and all Trust policies and procedures.

2.6.2 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2.6.3 For any Officers of the Trust who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and Officers of the Trust discharge their duties must be to the satisfaction of the Director of Finance.

2.7 Scheme of delegation

2.7.1 The principles of the SoD are as follows:

(a) no financial or approval powers can be delegated to an Officer in excess of the powers invested in the delegating Officer;

(b) powers may only be delegated to Officers within the organisational control of the delegating Officer;

(c) all delegated powers must remain within the financial and approval limits set out in the SoD;

(d) all powers of delegation must be provided in writing, duly authorised by the delegating Officer. Any variations to such delegated powers must also be in writing.

(e) all applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating Officer, prior to the period for which approval is sought.

(f) any Officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate written powers, before any financial commitments are made in respect of the transaction.

(g) powers may be delegated onwards unless this is specifically prohibited by the delegator; and

(h) conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3 AUDIT

3.1 References

3.1.1 The Board of Directors shall establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors.

3.2 Audit Committee

3.2.1 In accordance with Standing Orders for the Board of Directors, the Board of Directors shall formally establish an Audit Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing internal and external audit services (including agreeing both audit plans and monitoring progress against them);

(b) receiving reports from the internal and external auditors (including the external auditor's management letter) and considering the management response;

(c) monitoring compliance with Standing Orders for the Board of Directors and these SFIs;

~~(c) ;~~

(d) reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

(e) reviewing the information prepared to support the annual governance declaration statement prepared on behalf of the Board of Directors and advising the Board of Directors accordingly;

as set out in the terms of reference approved by the Board of Directors.

3.2.2 The terms of reference for the Audit Committee shall be considered as forming part of these SFIs.

3.2.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit Committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors.

3.3 Director of Finance's role in audit

3.3.1 In relation to audit, the Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;

(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) ensuring the production of the annual governance statement, and audited document for inclusion within the Trust's annual report, prepared in accordance with the prevailing guidance from the Regulator;

(d) provision of annual reports including a strategic audit plan covering the forthcoming three (3) years, a detailed plan for the next year, and progress against plan over the previous year, and regular reports on progress on the implementation of internal audit recommendations;

(e) ensuring that there is effective liaison with the relevant counter fraud services regional team or ~~NHS Protect~~NHS Counter Fraud Authority on all suspected cases of fraud and corruption and all anomalies which may indicate fraud or corruption before any action is taken; and

(f) deciding at what stage to involve the police in cases of misappropriation and other irregularities.

3.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transaction, including documents of a confidential nature. This includes work diaries;

(b) access at all reasonable times to any land, premises or members of the Board of Directors or Officers of the Trust;

(c) the production of any cash, stores or other property of the Trust under the control of a member of the Board of Directors of an Officer; and

(d) explanations concerning any matter under investigation.

3.4 Role of internal audit

3.4.1 The internal audit shall:

(a) provide an independent and objective assessment for the Chief Executive, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives;

(b) operate independently of the decisions made by the Trust and its Officers; and of the activities which it audits. No member of the team of the Internal Audit will have executive responsibilities.

3.4.2 Internal audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from fraud, bribery and other offences, waste, extravagance, inefficient administration, poor value for money or other causes.

3.4.3 Internal audit shall also independently assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the Regulator.

3.4.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, including any act which involves the giving or receiving of bribes, the Director of Finance must be notified immediately.

3.4.5 The lead internal auditor will normally attend meetings of the Audit Committee and have a right of access to all members of the Audit Committee, the Chair and Chief Executive of the Trust.

3.4.6 The lead internal auditor will be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Lead Internal Auditor. The agreement shall be in writing and shall be reviewed at least every three (3) years.

3.5 Role of external audit

3.5.1 The Trust is to have an external auditor appointed (or removed) by the Council of Governors based on recommendations from the Audit Committee, who must ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.

3.5.2 External audit responsibilities will vary from time to time in compliance with the requirements of the regulator, and are to:

(a) be satisfied that the statutory accounts, quality accounts and annual report (and the external auditor's own work) comply with the prevailing guidance including relevant accounting standards;

(b) be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources, reported by exception;

(c) issue an independent auditor's report to the Council of Governors, certify the completion of the audit and express an opinion on the accounts; and

(d) to refer the matter to the regulator if an Officer makes or is about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

3.5.3 External auditors will ensure that there is a minimum of duplication of effort between, them, internal audit and other relevant regulators, recognising the limitations that apply to external audit being able to rely on other work to inform their own work.

3.5.4 The Trust will provide the external auditor with every facility and all information which it may reasonably require for the purposes of its functions.

3.6 Fraud and corruption

3.6.1 In line with their responsibilities, the Chief Executive and the Director of Finance shall monitor and ensure compliance with guidance issued by the Regulator or the NHS Counter Fraud Authority ~~NHS Protect~~ on fraud and corruption in the NHS.

Comment [J1]: NHS protect no longer exists anjd has been replaced by the The NHS Counter Fraud Authority was launched on 1 November to replace.its funcitons

3.6.2 The Director of Finance is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, he will ensure that the Trust co-operates with ~~NHS Protect~~NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

3.6.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist, as specified by the NHS Counter Fraud Authority~~NHS Protect~~.

3.6.4 The Director of Finance will ensure that the Trust's local counter fraud specialist received appropriate training in connection with counter fraud measures and that he is accredited by the Counter Fraud Professional Accreditation Board.

3.6.5 Where the Trust appoints a local counter fraud specialist whose services are provided to the Trust by an outside organisation, the Director of Finance must be satisfied that the terms on which those services are provided are such to enable the local counter fraud specialist to carry out his functions effectively and efficiently and, in particular, that he will be able to devote sufficient time to the Trust.

3.6.6 The local counter fraud specialist shall report directly to the Director of Finance and shall work with ~~NHS Protect~~NHS Counter Fraud Authority.

3.6.7 The local counter fraud specialist and the Director of Finance will, at the beginning of each Financial Year, prepare a written work plan outlining the local counter fraud specialist's projected work for that Financial Year.

3.6.8 The local counter fraud specialist shall be afforded the opportunity to attend Audit Committee meetings and other meetings of the Board of Directors, or its committees, as required.

3.6.9 The Director of Finance will ensure that the local counter fraud specialist:

(a) keeps full and accurate records of any instances of fraud and suspected fraud;

(b) reports to the Board any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;

(c) has all necessary support to enable him to efficiently, effectively and promptly carry out his functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;

(d) receives appropriate training and support, as recommended by ~~NHS Protect~~NHS Counter Fraud Authority; and

(e) participates in activities which ~~NHS Protect~~NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

3.6.10 The Director of Finance must, subject to any contractual or legal constraints, require all Officers to co-operate with the local counter fraud specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

3.6.11 The Director of Finance must also prepare a “fraud response plan” that sets out the action to be taken both by persons detecting a suspected fraud and the local counter fraud specialist, who is responsible for investigating it.

3.6.12 Any Officer discovering or suspecting a loss of any kind must either immediately inform the Chief Executive and the Director of Finance or the local counter fraud specialist, who will then inform the Director of Finance and/or Chief Executive.

Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the local counter fraud specialist.

3.6.13 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

(a) the Board of Directors; and

(b) the auditor.

3.7 Staff expenses

3.7.1 The Director of Finance shall be responsible for establishing procedures for the management of expense claims submitted by Officers on forms approved by the Director of Finance. The Director of Finance shall arrange for duly approved expense claims to be processed locally or via the Trust's payroll provider. Expense claims shall be authorised in accordance with the SoD.

3.7.2 Expenses should be claimed monthly. Any claims older than three months will not be paid unless approval is obtained from the Director of Finance.

3.8 Acceptance of gifts, hospitality and sponsorship by Officers

3.8.1 The Company Secretary shall ensure that all Officers are made aware of the Trust's Standards of Business Conduct Policy, and any additional rules that the Trust may hold or adopt in respect of preventing corruption and complying with the Bribery Act 2010.

3.8.2 All Officers will be responsible for notifying the Company Secretary who will record in writing, any gift, hospitality or sponsorship accepted (or refused) by Officers on behalf of the Trust.

3.8.3 Any offers for gifts, hospitality or sponsorship that do not comply with the Trust's Standard of Business Conduct Policy, should be courteously but firmly refused and the firm or individual notified of the Trust's procedures and standards.

3.9 Overriding Standing Financial Instructions

3.9.1 If, for any reason, these SFIs are not complied with, full details of the non-compliance, any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for action or ratification.

3.9.2 All members of the Board of Directors and Officers have a duty to disclose any non-compliance with these SFIs to the Director of Finance as soon as possible.

4 ANNUAL PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

4.1 Annual business planning

4.1.1 The Chief Executive shall compile and submit to the Board of Directors and the Regulator, strategic and operational plans in accordance with the guidance issued about timing and the Trust's financial duties within the regulator's compliance framework. This will include:

(a) income and expenditure budgets;

(b) consistency with the overall activity and workforce plans and other aspects of the annual plan;

(c) identification of potential risks and opportunities within the plan; and

(d) plans for capital expenditure, including both replace and refresh of existing assets and new projects.

4.1.2 The operational plan shall be reconcilable to regular updates of the financial pro-formas, which the Director of Finance will prepare and submit to the Finance and Performance Committee, the Board of Directors and the regulator.

4.1.3 The Director of Finance will also be required to compile and submit to the Board of Directors such financial estimates and forecasts, both revenue and capital, as may be required from time to time.

4.1.4 Officers shall provide the Director of Finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.

Budgets, budgetary control and monitoring

4.2 Role of the Board of Directors

4.2.1 In advance of the financial year to which they refer, the Board of Directors will approve Budgets within the forecast limits of available resources and planning policies submitted by the Director of Finance.

4.2.2 Budgets will be in accordance with the aims and objectives set out in the Trust's annual plan.

4.2.3 The Director of Finance will devise and maintain systems of budgetary control incorporating the reporting of, and investigation into, financial, activity or workforce variances from budget. All Officers whom the Board of Directors may empower to engage Officers, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems.

4.2.4 The Director of Finance shall be responsible for providing budgetary information and advice and training to enable the Chief Executive and other Officers to carry out their budgetary responsibilities. All Officers of the Trust have a responsibility to meet their financial targets as agreed in the annual plan approved by the Board of Directors.

4.2.5 The Chief Executive may delegate management of a budget or part of a budget to Officers to permit the performance of defined activities. The SoD shall include a clear definition of individual and group responsibilities for control of expenditure. In carrying out those duties, the Chief Executive shall not exceed the budgetary

limits set by the Board of Directors, and Officers shall not exceed the budgetary limits set them by the Chief Executive.

4.3 Responsibilities of all budget managers

4.3.1 Control of spending is maintained within budget and if applicable income targets and efficiency targets are achieved, through regular monitoring. Where a Budget Manager is responsible for both income and expenditure targets, the Director of Finance may agree that a budget manager's accountability is defined as meeting their bottom line contribution target rather than individual income targets and expenditure Budgets.

4.3.2 At the time expenditure is committed there are sufficient resources in their budget to finance such expenditure along with other known commitments and anticipated costs for the remainder of the financial year.

4.3.3 Procedures in relation to procuring or ordering goods and services are adhered to.

4.3.4 Any likely overspending or underperformance against income targets is forecast, understood and escalated through the budget manager's hierarchy to the Director of Finance.

4.3.5 Corrective action is put in place, with the support from the budget manager's designated finance representative, in the event that financial targets are forecast to be missed.

4.3.6 Budgets are used for the purpose for which they were set, subject to the rules of virement (i.e. Budget transfer) as set out in the SoD.

4.3.7 Workforce is maintained within budgeted establishment unless expressly authorised by a manager or a member of the Board of Director within their delegated authority.

4.3.8 Non-recurring budgets are not used to finance recurring expenditure.

4.3.9 No agreements are entered into without the proper authority (for example, leases or service developments).

4.4 Role of the Finance and Performance Committee

4.4.1 The Finance and Performance Committee shall provide the Board of Directors with an in year oversight of the Trust's financial performance against the Trust's annual plan and advise the Board of Directors of any variances.

4.4.2 The Finance and Performance Committee shall keep the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting Budgets and shall advise on the financial and economic aspects of future plans and projects.

4.4.3 The Finance and Performance Committee shall oversee the development and delivery of any corrective actions plans and advise the Board of Directors accordingly.

4.4.4 The Finance and Performance Committee shall oversee the development, management and delivery of the Trust's annual capital programme and other agreed investment programmes.

4.4.5 The Finance and Performance Committee shall report to the Board of Directors any significant in-year variance from the annual plan and advise the Board of Directors on the action to be taken.

4.4.6 Any funds not required for their designated purpose shall revert to the immediate control of the Chief Executive.

4.4.7 Expenditure for which no provision has been made in an approved budget (including expenditure exceeding a delegated Budget) and which is not subject to funding under the delegated powers of virement, shall only be incurred after authorisation by the Chief Executive or the Board of Directors as appropriate.

5 ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance, on behalf of the Trust, will prepare financial returns in accordance with the guidance given by the regulator and the Secretary of State for health, the Treasury the Trust's accounting policies and generally accepted accounting principles.

5.2 The Director of Finance will prepare annual accounts which must be certified by the Chief Executive. The Director of Finance will submit them, and any report of auditor on them, to the regulator.

5.3 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process set out in the Audit Code for NHS Foundation Trusts and the NHS Foundation Trust Code of Governance issued by the regulator.

5.4 The Trust will publish an annual report, in accordance with guidelines on local accountability and present it at a public meeting of the Council of Governors. The document will include the audited annual accounts of the Trust.

5.5 The annual report will be sent to the Regulator.

6 BANK ACCOUNTS

6.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the regulator. The Board of Directors shall approve the banking arrangements.

6.2 The Director of Finance is responsible for all bank accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

6.3 The Director of Finance is responsible for ensuring payments from commercial banks or Government Banking Service (GBS) accounts do not exceed the amount credited to the account except where arrangements have been made. Further they must report to the Board of Directors all arrangements with the Trust's bankers for accounts to be overdrawn.

6.4 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include the conditions under which each bank and GBS account is to

be operated, the limit to be applied to any overdraft and those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.5 The Director of Finance must advise the Trust's bankers in writing of the condition under which each account will be operated.

6.6 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7 FINANCIAL SYSTEMS AND TRANSACTION PROCESSING

Director of Finance's role in financial systems and transaction processing

7.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper and prompt recording, invoicing, collection, banking and coding of all monies due. This includes responsibility for an effective credit control system incorporating procedures for recovery of all outstanding debts due to the Trust. Income not received should be dealt with in accordance with losses procedures.

7.2 The Director of Finance is also responsible for ensuring a procedure is in place for the prompt banking of all monies received.

7.3 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Regulator, the Secretary of State or statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.4 The Director of Finance is responsible for approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

7.5 The Director of Finance is responsible for prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

7.6 The Trust shall adhere to the National Tariff system and the regulator and Secretary of State's guidance and codes of conduct.

7.7 The setting of fees and charges other than those within the National Tariff or set by statute, including private patient prices, remains the responsibility of the members of the Board of Directors and budget managers, subject to prior approval of the Director of Finance unless specifically delegated in the SoD.

7.8 All invoices must be raised by Officers within the finance function, unless specifically agreed otherwise by the Director of Finance.

7.9 All Officers must inform their designated finance representative promptly of money due arising from transactions which they initiate/deal with, including providing copies of all contracts, leases, tenancy agreements, private patient undertakings and any other type of financial contract.

7.10 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS), or by crossed cheques and drawn up in

accordance with these instructions, except with the agreement of the Director of Finance. Uncrossed cheques shall be regarded as cash.

7.11 Official money shall not under any circumstances be used for the encashment of private cheques nor will the trust accept I.O.U's.

7.12 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.13 The holders of safe keys shall not accept unofficial funds for depositing in their safe unless such deposits are in sealed envelopes (signed and dated across the seal) or lockable containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

Money laundering

7.14 Under no circumstances will the Trust accept cash payments in excess of £1,000 or the equivalent in any other currency, in respect of any single transaction. Any attempts by an individual to effect payment above this amount should be notified immediately to the Director of Finance.

8 CONTRACTS FOR PROVISION OF SERVICES TO CUSTOMERS

8.1 The Director of Finance, supported by other Officers (nominated by the Director of Finance), is responsible for negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.

8.2 In carrying out these functions, the Director of Finance should take into account the appropriate advice regarding national pricing and contracting policy, standards and guidance.

8.3 Contracts with commissioners shall be devised to minimise risk. Unless agreed otherwise, contracts with commissioners are legally binding and appropriate legal advice, identifying the Trust's liabilities under the terms of the contract should be considered.

8.4 The Director of Finance is responsible for setting the framework and overseeing the process by which provider to provider contracts, or other contracts for the provision of services by the Trust, are designed and agreed.

8.5 The Trust will comply with its responsibilities under its Licence to maintain an up to date record of commissioner-requested services (as defined in the Licence).

9 CONTRACTS, TENDERS AND HEALTHCARE SERVICE AGREEMENTS

9.1 Overview

9.1.1 The financial value of a project, contract or order against which the thresholds in the SoD apply is the total cost, including (as appropriate) all works, furniture, equipment, fees, land and VAT, for the whole expected life of the contract. Splitting or otherwise changing orders in a manner devised so as to avoid the financial thresholds is forbidden.

9.1.2 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. It is the

responsibility of all Officers to ensure value for money at all times and to review all contracts prior to signing (or submitting for signature).

9.1.3 The Director of Finance shall:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained;

(b) be responsible for establishing procedures to ensure that competitive quotations and tenders are invited for the supply of goods and services under contractual arrangements; and

(c) ensure that an electronic register is established and maintained by the Head of Procurement of all formal tenders.

9.1.4 The Trust will ensure policies and procedures are put in place for the control of all tendering activity.

9.2 Directives and guidance

9.2.1 Directives by the Council of the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs. European Union Directives shall take precedence wherever non-conformity occurs.

9.2.2 The Trust shall comply as far as is practicable with the requirements of any other regulation/guidance issued by the Secretary of State or the Regulator.

9.2.3 If the sources of advice appear to conflict or there is ambiguity as to which advice takes precedence, the head of procurement should be consulted.

9.3 Quotations: competitive and non-competitive

General position on quotations

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

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

Competitive quotations

9.3.2 Quotations should be obtained from the number of firms/individuals shown in the table above based on specifications or terms of reference prepared by, or on behalf of, the Trust.

9.3.3 Quotations should be received in writing or via e-mail.

9.3.4 All quotations should be treated as confidential and should be retained for inspection and attached to the requisition/order for the goods or services.

9.3.5 The Chief Executive or their nominated Officer should evaluate the quotation and select the quote which gives the best value for money and the reasons why should be recorded in a record of quotations.

9.3.6 The Trust's procurement department should maintain a record of quotations.

9.3.7 In circumstances where competitive quotation is not possible due to lack of quotations, the Director of Finance of their nominated Officer will ensure that best value for money is obtained and the decision to proceed should be recorded in a record of quotations.

9.4 Formal competitive tendering

9.4.1 The Director of Finance shall be responsible for establishing procedures to carry out financial appraisals and shall instruct the appropriate requisitioning Officer to provide evidence of technical competence.

9.4.2 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles, management consultancy services, design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and disposals; subject to thresholds the SoD.

9.4.3 Formal tendering procedures need not apply to disposals, where expenditure is not reasonably expected to exceed £50,000 or where a nationally agreed NHS contract exists.

9.5 Contracting/tendering procedure

Invitation to tender

9.5.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

9.5.2 All invitations to tender shall state that no tender will be considered for acceptance unless submitted electronically using the Trust's E-Tendering Tool (Delta).

9.5.3 Issue of all tender documentation will be undertaken electronically through the secure website with controlled access using secure login, authentication and viewing rules.

9.5.4 Every tender for goods, materials, services, (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tender must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

9.5.5 Every tender for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal (JCT) or Department of Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the work is primarily engineering, the General

Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or in the case of civil engineering work the General Conditions of Contract recommended by the Institute of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects.

Opening tenders

9.5.6 The Director of Finance shall be responsible for establishing procedures to ensure that tenders are opened and documented appropriately and within an agreed timescale.

Admissibility

9.5.7 If for any reason the designated Officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive or Director of Finance.

9.5.8 Where only one tender is sought and/or received the Chief Executive and Director of Finance shall ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Late tenders

9.5.9 Tenders received after the due time and date, but prior to the opening of the other tenders, will not be accepted. However, they may be considered if the Director of Finance or their nominated Officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

Acceptance of formal tenders

9.5.10 Any discussion with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender. Any such discussions must be entered through the e-tendering portal unless agreed otherwise with the Head of Procurement. Failure to comply will disqualify the tender

9.5.11 The most economically advantageous tender, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in the contract file or other appropriate record.

9.6 Financial standing and technical competence of contractors

9.6.1 The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

9.7 Awarding of contracts

9.7.1 Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following Officers:

(a) Board of Directors;

(b) Chief Executive;

(c) Director of Finance;

(d) Dd~~d~~esignated budget managers.

9.7.2 The levels of authorisation are in the SoD.

9.7.3 Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in the minutes of the meeting of the Board of Directors.

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

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

(a) the Trust shall use the NHS Supply Chain, NHS Commercial Solutions, Crown Commercial Services or other agreed NHS contracts for procurement of all goods and services unless the Chief Executive or nominated Officers deem it inappropriate or better value for money can be obtained elsewhere. The decision to use alternative sources must be documented; or

(b) If the Trust does not use the NHS Supply Chain, NHS Commercial Solutions, Crown Commercial Services or other NHS contracts where tenders or quotations are not required, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

9.9 Tender reports to the Board of Directors

9.9.1 Reports to the Board of Directors will be made on an exceptional circumstances basis only.

9.10 Waiving of tenders

9.10.1 There are five allowable reasons for waiving tenders, which should never be used to avoid competition or for administrative convenience. It should be noted that approval by this means will not be automatic:

(a) in very exceptional circumstances where the Chief Executive and Director of Finance decide that formal tendering procedures would not be practicable and the circumstances are detailed in an appropriate Trust record;

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not regarded as a justification for a single tender waiver action;

(c) specialist expertise is required and is available from only one source;

(d) the task is essential to complete a project and engaging different consultants for the new task would compromise completion of the project; or

(e) for the provision of legal advice in relation to the obtaining of Counsel's opinion.

9.10.2 It should be noted that waving of tender procedures only applies to internal tender procedures and cannot be applied for contracts with values greater than the OJEU limits.

9.10.3 ~~Waiver request forms will be issued by the Trust's procurement department upon receipt of a requisition meeting the criteria mentioned above. Waiver forms must be return to the procurement department before any official order is placed on behalf of the trust. A waiver is not required where goods or services have been purchased under a framework already in use and where further competition is not required by that framework~~Waiver request forms are available through the trust intranet or supplied by the Trust's procurement department upon request. Waiver forms must be returned to the procurement department before any official order can be placed on behalf of the trust. A waiver is not required where goods or services have been purchased under a framework where value for money has been sought, and where further competition is not required by that framework.

~~9.10.3~~9.10.4 .

~~9.10.4~~9.10.5 The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

~~9.10.5~~9.10.6 Where it is decided that competitive tendering is not applicable and should be waived, the waiver and the reasons for it should be documented in an appropriate Trust record and reported to the Audit Committee at each meeting.

~~9.10.6~~9.10.7 Items estimated to be below the limits set in these SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

9.11 Health care services

9.11.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990, as amended, and administered by the Trust. Contracts with other Foundation Trusts', being Public Benefit Corporations, are legally binding and are enforceable in law.

9.11.2 The Chief Executive shall nominate Officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors.

9.11.3 Where the Trust elects to invite tenders for the supply of healthcare services these SFIs shall apply as far as they are applicable to the tendering procedure.

9.11.4 Health care services falls within the 'Light Touch Regime' (LTR) of the Procurement Regulations 2015. Any tendering for these services should be discussed with the head of procurement to identify suitability to the LTR process.

~~9.11.3~~

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9.12 Compliance requirements for all contracts

9.12.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

(a) the Trust's Standing Orders and these SFIs;

(b) EU directives and other statutory provisions; and

(c) Contracts with NHS Foundation Trusts must be in a form compliant with appropriate NHS guidance.

9.12.2 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.12.3 In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

9.13 Disposals

9.13.1 Competitive tendering or quotations procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined, or pre-determined in a reserve, by the Chief Executive or their nominated Officer;

(b) obsolete or condemned articles, which may be disposed of in accordance with the accounting procedures of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis; or

(d) items arising from works of construction, demolition or site clearance, which should be deal with in accordance with the relevant contract.

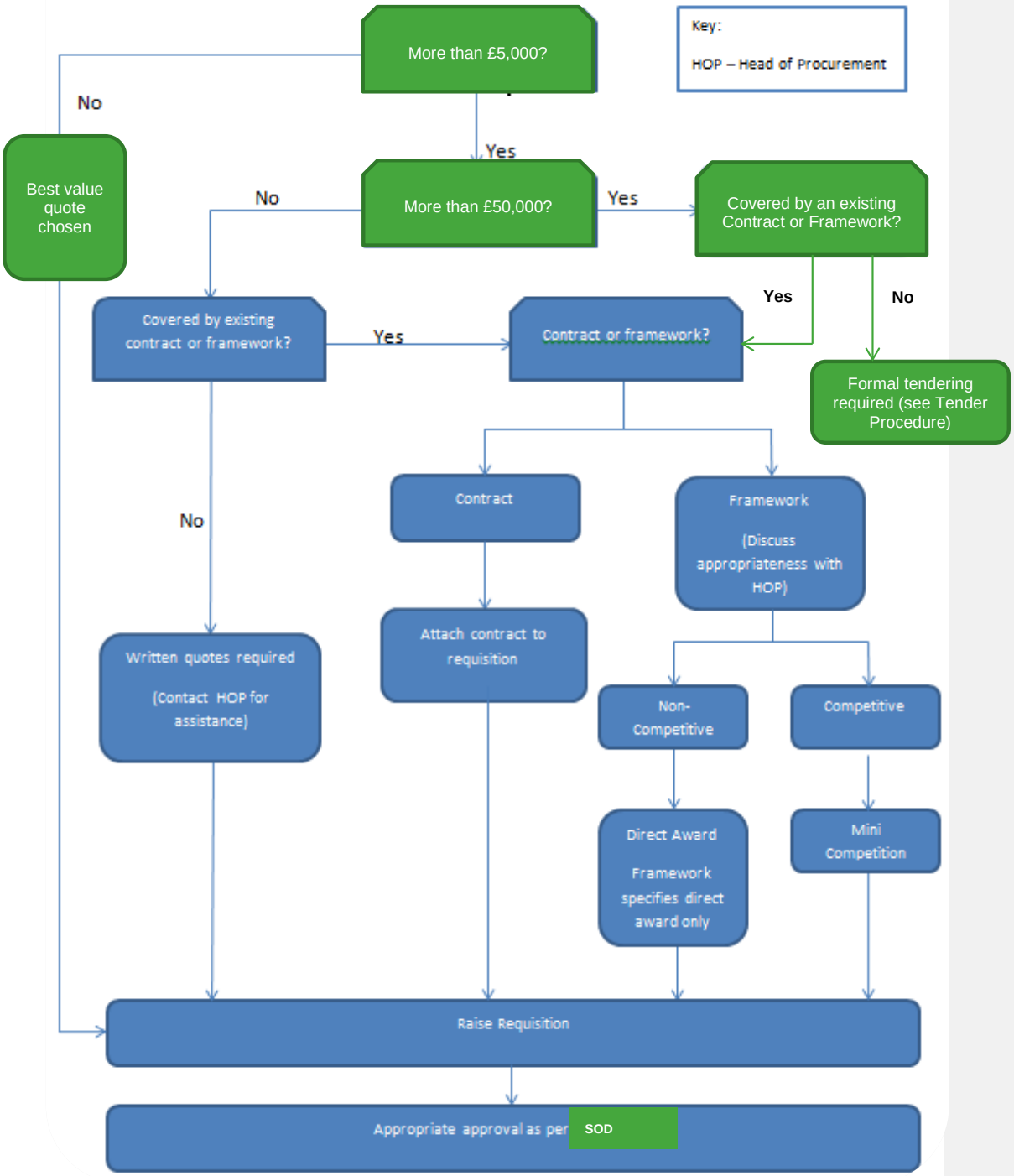
9.14 In-house services

9.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

9.15 Applicability of SFIs on tendering and contracting for Funds Held on Trust including charitable funds

9.15.1 These SFIs shall not only apply to expenditure of revenue funds but also to works, services and goods purchased from the charitable fund or any Funds Held on Trust.

Works, Goods & Services



10 TERMS OF SERVICE, STAFF APPOINTMENTS AND PAYMENTS

10.1 Nomination and Remuneration Committee

10.1.1 In accordance with Standing Orders and the Code of Governance, the Board of Directors shall establish a Nomination and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

10.1.2 The terms of reference shall be considered as forming part of these SFIs.

10.2 Staff appointments

10.2.1 No Director or Officer may re-grade Officers, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration ~~,~~unless authorised to do so by the Director of Human Resources and Director of Finance; and within the limit of the approved Budget and funded establishment.

10.2.2 No Director or Officer may engage, re-engage, either on a permanent or temporary nature, or hire agency staff, unless within the limit of the approved Budget and funded establishment.

10.2.3 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, etc., for Officers.

10.3 Contracts of employment

10.3.1 The Board of Directors shall delegate responsibility to the Director of Human Resources for:

(a) ensuring that all Officers and Executive Directors are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

10.4 Payroll

10.4.1 The Director of Finance shall make arrangements for the provision of payroll services to the Trust to ensure the accurate determination of any entitlement and to enable prompt and accurate payment to Officers.

10.4.2 The Director of Finance, in conjunction with the Director of Human Resources, shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay including where appropriate, timetables and specifications for submission of properly authorised notification of new Officers, leavers and amendments to standing pay data and terminations.

10.4.3 The Director of Finance will issue detailed procedures covering payments to Officers including rules on handling and security of bank credit payments.

10.5 Advances of pay

10.5.1 Advances of pay will only be made in exceptional circumstances subject to the approval of at least one of either the Director of Finance, the Deputy Director of Finance, the Director of Human Resources and/or the Deputy Director of Human Resources.

11 NON-PAY EXPENDITURE

11.1 Delegation of authority

11.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the financial limits for requisitions and the system for authorisation above that level.

11.1.3 Budget managers may appoint nominees who must be approved by the Director of Finance. The budget manager remains responsible for the actions of nominees when they act in place of the budget manager.

11.1.4 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.1.5 The advice of the Trust's procurement department shall be sought before seeking alternative professional advice regarding the supply of goods and services.

11.2 Choice, requisitioning, ordering, receipt and payment for goods and services

11.2.1 The requisitioner, in choosing the item to be supplied or the service to be performed, shall always obtain best value for money for the Trust. In so doing, the advice of the Trust's procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and/or the Chief Executive shall be consulted.

11.2.2 If the requisition is for a new medical device then an order can only be placed once approval is obtained from the Medical Devices Committee and funding has been agreed.

11.2.3 The Director of Finance is responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms. The Director of Finance must be provided with a copy of all contracts and service level agreements.

11.3 Director of Finance's role in non-pay expenditure

11.3.1 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be

obtained; and once approved, the thresholds should be incorporated in these SFIs or the SoD (as appropriate) and regularly reviewed;

(b) prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;

(e) ensure a system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

(f) maintain a list of Officers, including specimens of their signatures, authorised to certify any type of payment. It is the responsibility of Budget Managers to inform the Director of Finance of changes to authorised Officers;

(g) delegate responsibility for ensuring that payment for goods and services is only made once the goods/services are received, except where a prepayment is made; and

(h) prepare and issue procedures regarding Value Added Tax..

11.4 Role of all Trust Officers

11.4.1 All Officers must comply fully with the procedures and limits specified by the Director of Finance, ensuring that:

(a) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(b) where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice;

(c) no order shall be issued for any item or items to any firm that has made an offer of gifts, reward or benefit to Directors or Officers, other than:

(i) isolated gifts of a trivial nature or inexpensive seasonal gifts, such as calendars; and/or

(ii) conventional hospitality, such as lunches in the course of working visits.

(d) no requisition/order (including the use of purchasing cards) is placed for any item/service for which there is no Budget provision unless authorised by the Director of Finance;

(e) all Officers shall adhere to the procedures regarding verbal orders developed by the Director of Finance. These shall be issued only in cases of emergency by the procurement department following receipt of a

properly completed requisition. The Trust's procurement department will place the verbal order and then issue an official order marked 'confirmation order' no later than the next working day. The Trust's procurement department shall maintain a register of emergency orders issued. Persistent use of this method of purchasing goods or services to circumvent the ordering procedures will result in their withdrawal from use and if the circumstances warrant, the instigation of disciplinary procedures;

(f) orders are not split or otherwise placed in a manner devised so as to circumvent the financial thresholds; and

(g) upon receipt of an invoice that has not been processed by the Trust's finance department, it is immediately passed to the Trust's finance department for processing.

11.5 Prepayments

11.5.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) the financial advantages must outweigh the disadvantages i.e. cash flows must be discounted to Net Present Value (NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director must make a clear written request to the Director of Finance, which specifically addresses the risk of the supplier being unable to meet its commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangement proceed (taking into account the relevant provisions of these SFIs and the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the Director of Finance if problems are encountered.

11.6 **Official orders**

11.6.1 Official orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.6.2 All goods, services or works, including works and services executed in accordance with a contract, shall be ordered using an official order, raised following receipt by the procurement department of a properly authorised requisition via the i-Procurement system and contractors/suppliers shall be

notified that they should not accept orders unless on an official order form. The expenditure items listed below are excluded:

(a) contract taxi services;

(b) courses, conferences and lecture fees if approved via the Staff Development Centre;

(c) rent of property or rooms;

(d) services provided by high street opticians;

(e) utility services – including all communication services; and

(f) travel claims.

11.6.3 Goods and services for which Trust or national contracts are in place should be purchased within those contracts. Any purchasing request made outside such contracts must be referred, in the first instance, to the Head of Procurement for approval.

11.6.4 Goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.6.5 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Health Building Note 00-08. The technical audit of these contracts shall be the responsibility of the Director responsible for the Estates function.

11.7 Contracts with individuals

11.7.1 Directors and Officers have a responsibility to ensure that contracts with individuals or with individuals working through a limited company are appropriately authorised, provide value for money and do not expose the Trust or the individual to tax and HMRC compliance risks (for example if HMRC later deems the individual to be an employee rather than a contractor).

12 INVESTMENTS, EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND MERGERS & AQUISITIONS

12.1 Investments

12.1.1 The Director of Finance will produce an investment policy in accordance with any guidance received from the Regulator, for approval by the Board of Directors. Investments may include investments made by forming or participating in forming, bodies corporate and/or otherwise acquiring membership of bodies corporate.

12.1.2 The policy will set out the Director of Finance's responsibilities for advising the Board of Directors concerning the performance of investments held.

12.1.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.2 External borrowing and Public Dividend Capital

12.2.1 The Director of Finance will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay the Public Dividend Capital (PDC) and any proposed commercial borrowing, within the limits set by the Trust's authorisation, which is reviewed annually by the Regulator (the Prudential Borrowing Code). The Director of Finance is also responsible for reporting periodically to the Board of Directors concerning the Public Dividend Capital and all loans and overdrafts.

12.2.2 Any application for a loan or overdraft will only be made by the Director of Finance or by an Officer acting on their behalf and in accordance with the SoD, as appropriate.

12.2.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.2.4 All short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

12.2.5 All long term borrowing must be consistent with and outlined in the Trust's current annual plan.

12.3 Special purpose vehicles, joint ventures and mergers and acquisitions

12.3.1 The Board of Directors is responsible for the review and approval of special purpose vehicles, joint ventures with other entities, whether private, public or third sector.

12.3.2 The Board of Directors must approve any mergers or acquisitions. For all the above, advice should be sought from the Trust's finance and commerce teams prior to taking proposals for approval, and it is essential that current legislation, including procurement and competition law as well as the prevailing Health and Social Care Act 2012, is adhered to in the process.

13 CAPITAL INVESTMENT AND ASSETS

13.1 Responsibilities of the Chief Executive

13.1.1 Ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.2 Being responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost.

13.1.3 Ensuring that the investment is not undertaken without confirmation, where appropriate, of responsible director's support and the availability of resources to finance all revenue consequences, including capital charges, depreciation and PDC dividend implications.

13.2 Responsibilities of the Director of Finance

13.2.1 The Director of Finance, in conjunction with other member of the Board of Directors as appropriate, shall be responsible for preparing detailed procedural

guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in Treasury guidance.

13.2.2 The Director of Finance shall implement procedures to comply with guidance on valuation contained within the Treasury's guidance, including rules on indexation, depreciation and revaluation.

13.2.3 The Director of Finance, in conjunction with other members of the Board of Directors as appropriate, shall establish procedures covering the identification and recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget manager and be validated by reference to appropriate supporting documentation.

13.2.4 The Director of Finance shall also develop procedures covering the physical verification of assets on a periodic basis.

13.2.5 The Director of Finance, in conjunction with other members of the Board of Directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

14 STORES AND RECEIPTS OF GOODS

14.1 Control of stores

14.1.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stocks and stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental Officers, subject to such delegation being within the SOD and being entered in a record available to the Director of Finance.

14.1.2 Stores should be:

(a) Kept to a minimum

(b) subject to a stocktake annually as a minimum

(c) Valued at the lower of cost and net realisable value

14.1.3 The control of any pharmaceutical stocks shall be the responsibility of the designated pharmaceutical Officer.

14.1.4 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager or pharmaceutical Officer. Wherever practicable, stocks should be marked Trust property.

14.1.5 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues and returns to stores, and losses.

14.1.6 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

14.1.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.2 Goods supplied by NHS Supply Chain (NHSSC)

14.2.1 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those Officers authorised to requisition and accept goods from NHSSC. The authorised Officers shall check receipt against the delivery note before forwarding this to the Procurement Department. The Finance Department shall satisfy themselves that the goods have been received before accepting the recharge.

15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Procedures

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to members of the Board of Directors and relevant Officers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking into account professional advice where appropriate.

15.2 Disposal of unserviceable articles

15.2.1 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an Officer authorised for that purpose by the Director of Finance;

(b) recorded by the condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

15.2.2 All entries shall be confirmed by the countersignature of a second Officer authorised for the purpose by the Director of Finance.

15.2.3 The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take appropriate action.

15.3 Losses and special payments

15.3.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

15.3.2 Any Officer discovering or suspecting a loss of any kind must immediately inform their manager, who must immediately inform the Chief Executive and Director of Finance.

15.3.3 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

15.3.4 In cases of fraud or corruption, the Director of Finance must inform the Trust's local counter fraud specialist and ~~NHS Protect~~NHS Counter Fraud Authority.

15.3.5 The Director of Finance must notify the Audit Committee, the Trust's local counter fraud specialist and the external auditors of all frauds.

15.3.6 For losses apparently caused by theft, arson, or neglect of duty, except if trivial, or gross carelessness, the Director of Finance must immediately notify:

(a) the Board of Directors;

(b) the external auditor; and

(c) the Audit Committee, at the earliest opportunity.

15.3.7 The Board of Directors shall delegate its responsibility to approve the writing-off of losses and to authorise special payments in accordance with the 'Reservation of Powers to the Board of Directors' and SoD.

15.3.8 The Director of Finance shall:

(a) be authorised to take any necessary steps to safeguard the Trust's interest in bankruptcies and company liquidations;

(b) consider whether any insurance claim can be made for any losses incurred by the Trust;

15.3.9 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Director of Finance shall report losses and special payments to the Audit Committee on a regular basis.

15.3.10 No special payment exceeding delegated limits shall be made without the prior approval of the Board of Directors, or contrary to any guidance or best practice advice issued by the Regulator or the Secretary of State.

16 INFORMATION TECHNOLOGY

16.1 Role of the Director of Finance in relation to information technology

16.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate and reasonable protection of the Trust's data, programmes and computer hardware for which the Director of Finance is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998, the Freedom of Information Act 2000 and any other relevant legislation;

(b) ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy,

accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as the Director of Finance may consider necessary, are being carried out;

(e) ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, the Director of Finance must obtain from that organisation assurances of adequacy prior to implementation; and

(f) publish and maintain a Freedom of Information (FOI) Publication Scheme, which is a complete guide to the information routinely published and describes the classes or types of information about the Trust which are publicly available.

16.2 Contracts for computer services with other health service body or other agency

16.2.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another Health Service Body or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.2.2 Where another Health Service Body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.3 Risk Assessments

16.3.1 The Director of Finance shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation of and testing of, appropriate disaster recovery plans.

16.4 Requirements for computer systems which have an impact on the Trust's corporate financial systems

16.4.1 Where computer systems have an impact on the Trust's corporate financial systems, the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's information technology strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely and that an audit trail exists;

(c) Trust's finance Officers have access to such data; and

(d) Such computer audit reviews are carried out as necessary.

17 PATIENTS' PROPERTY

17.1 The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients (hereafter referred to as "property"), in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 Subject to paragraph 17.1 above, the Trust will not accept responsibility or liability for patients' property brought into the Trust's premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

17.3.1 notices and information booklets;

17.3.2 hospital admission documentation and property records;

17.3.3 the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property.

17.4 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

17.5 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.6 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18 RETENTION OF RECORDS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the regulator and/or Secretary of State guidelines.

18.2 The Chief Executive will produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained. The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Records and information held in accordance with latest the Regulator and/or Secretary of State guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive. Proper details shall be maintained of records and information so destroyed.

19 RISK MANAGEMENT AND INSURANCE

19.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS guidelines, which shall be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

19.2.1 a process for identifying and quantifying risks and potential liabilities;

19.2.2 engendering amongst all levels of Officers a positive attitude towards the control and management of risk;

19.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

19.2.4 contingency plans to offset the impact of adverse events;

19.2.5 audit arrangements including; Internal Audit, clinical audit, health and safety review;

19.2.6 decisions on which risks shall be included in the NHSLA risk pooling schemes; and

19.2.7 arrangements to review the Trust's risk management programme.

19.3 The Chief Executive will be responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the annual report and annual accounts.

19.4 The Director of Finance shall ensure that insurance arrangements exist in accordance with the Trust's risk management policy.

20 FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 The Standing Orders state the Trust’s responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all Funds Held on Trust.

20.2 The reserved powers of the Board and the SoD make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Members of the Board of Directors and Officers must take account of that guidance before taking action. These SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

20.3 As management processes overlap most of the sections of these SFIs will apply to the management of Funds Held on Trust.

20.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

20.5 The Director of Finance has primary responsibility to the Board of Directors for ensuring that Funds Held on Trust (charitable funds) are administered in line with statutory provisions, the Trust's governance documents and Charity Commission guidance. The Director of Finance will prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of Funds Held on Trust (charitable funds) for the discharge of the Board of Directors responsibilities as the Corporate Trustee.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**4 July 2019**	**Agenda reference:**	**120-19**		
Report title:	**Approval of Trust Standing Orders and Reservation of Powers and Scheme of Delegation**				
Sponsor:	Michelle Miles – Director of Finance and Performance				
Authors:	Clare Pirie, Director of communications and corporate affairs Michelle Miles – Director of Finance and Performance Hilary Saunders, Deputy company secretary				
Appendices:	Standing orders Reservation of powers and scheme of delegation with change tracking				
Executive summary					
Purpose of report:	To provide the Board with an update on changes made to Trust Standing Orders and Reservation of Powers and Scheme of Delegation over the last year				
Summary of key issues	The Audit committee reviewed the attached on 19 June and recommends to the Board for approval. Changes noted in the Audit committee; (all previous amendments were agreed) **Hospital Management Team** means the Clinical Directors and the decision making senior team of the Trust including all directors Audit Committee • 3.1.1.5 Approve specific policies and procedures relevant to the committee's remit; • Finance and performance committee • 3.5.1.2 Review, by way of the finance report, the Approve submission of monthly quarterly monitoring reports to the regulator; • 3.5.1.4 Recommend to the Board the Approve submission of the Trust's annual plan to the regulator; and All members of the board of directors • 4.5.1 Share corporate responsibility for all decisions of the voting members of the Board of Directors. Department of Health Interim Revenue Support • 7 - Where the Trust is trading at a deficit there will be a cash support requirement from the Department of Health and Social Care (DHSC) to maintain operations. The total cash support requirement will be approved by the Board as part of the annual planning process. • The cash support will be provided via an interim revenue support loan from the DHSC. The approval of the loan for the drawdown of the cash will be authorised per the limits below. Details of all loan agreements are reported to and overseen by the Finance and Performance Committee with prior approval by the Board through the agreement of the Operating Plan submission.				
Recommendation:	The Board is asked to **APPROVE** the standing orders and reservations of powers/scheme of delegation				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient	*World-class clinical*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*

	experience	*services*			
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	These documents are integral parts of the Trust's primary governing documents and are required by the regulator.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit committee				
	Date:	19/06/2019	Decision	Recommend for approval	
Next steps:	If approved these documents will take immediate effect.				

Queen Victoria Hospital NHS Foundation Trust

Reservation of powers and scheme of delegation

Approved by the Board of Directors 5 July 2018

Effective from 5 July 2018

1. Introduction

1.1. The *NHS foundation trust code of governance* requires the board of directors of NHS foundation trusts to draw up a "schedule of matters specifically reserved for its decision" (2014, A.1.1) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities.

1.2. The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3. All powers of the trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the chief executive. The scheme of delegation identifies those functions, which the chief executive shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

1.4. Where the Trust Board or one of its committees has reached a decision under its terms of reference, the subsequent documentation committing the Trust to that decision will be signed by the Chair of the committee or the Chief Executive.

1.5. It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases.

1.6. Each corporate function is constrained by its agreed annual plan, which governs manpower, facilities and financial resources. Corporate functions may not exceed agreed budgets or deviate from approved plans without prior agreement of the Chief Executive.

1.7. All projects are bound by these schemes of delegation even where funded partly or wholly from charitable or third party funds. Approval for business cases, and subsequent approval to commit expenditure must be in strict accordance with the detailed scheme of delegation, in addition to the requirement for approval to release funds which are set out in the Trust's charitable fund procedures.

1.8. This document covers only matters delegated by the Trust to its senior Officers. Each Director is responsible for delegations within their function and should produce their own scheme of delegation, which should be distributed to all relevant staff, including the finance department.

1.9. Director schemes of delegation may not exceed the limits set out in this framework but they may restrict delegation further. All such schemes of delegation should include the requirement that all officers with delegated authority must make formally documented arrangements to cover their delegations in circumstances where they are absent for more than 48 hours.

Caution over the use of delegated powers

1.10. Powers are delegated to Directors and Officers on the understanding they will not exercise delegated powers in a manner which in their judgement is likely to be a cause for public concern.

Directors' ability to delegate their own delegated powers

1.11. The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust. A Director's delegated power may be delegated to designated deputies.

Absence of Directors (or deputy) or Officer to whom powers have been delegated

1.12. In the absence of a Director or deputy/Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been identified in the Scheme of Delegation or approved by the Director/Officer's superior.

1.13. In circumstances where the Chief Executive has not nominated an Officer to act in his/her absence, the Board of Directors shall nominate an Officer to exercise the powers delegated to the Chief Executive in his/her absence.

Definition and interpretations

1.14. Words importing the singular shall import the plural and vice-versa in each case.

1.15. In this document:

Budget manager means an Officer with clear delegated authority from a Director or level 2 manager to manage income and/or expenditure budgets. Delegated authority only applies to a budget manager's specific area of the Trust for which they are responsible for the budget.

Chief Executive means that, as Accounting Officer, the Chief Executive is accountable for the funds entrusted to the Trust. The Chief Executive has overall responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control. The Chief Executive should also ensure that he/she complies with the NHS foundation trust accounting officer memorandum.

Director means a Director of the Trust who is a voting member of the Trust Board (Chief Executive, Director of Finance and, Medical Director and Director of Nursing).

Executive management team means the executive directors of the Board of Directors, the director of operations, the director of human resources and organisational development and the director of communications and corporate affairs

Hospital Management Team means the Clinical Directors and the decision making senior team of the Trust including all directors

Level 2 manager means Officers in the following posts, in relation to their own area of the Trust only:

- Business unit managers
- Deputies to Directors (when not formally deputising in the Director's absence)
- Heads of functions directly reporting to a Director (e.g. head of commerce, medical workforce manager).

1.16. Unless specified otherwise, all amounts set out in this document exclude Value Added Tax (VAT).

2. Reservation of powers to the Board of Directors

2.1	**General enabling provision**	2.1.1 The Board of Directors may determine any matter it wishes within its statutory powers at a meeting of the Board of Directors convened and held in accordance with the Standing Orders for the Board of Directors. The Board of Directors also has the right to determine that it is appropriate to resume its delegated powers.
2.2	**Regulation and control**	2.2.1 Approve Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business and other arrangements relating to standards of business conduct. 2.2.2 Approve a Scheme of Delegation of powers from the Board of Directors to Officers which has been prepared by the Chief Executive under SO 6.5 (Delegation to Officers) of the SOs. 2.2.3 Delegate executive powers to be exercised by committees or sub-committees, or joint committees of the Board of Directors, and the approval of the terms of reference and specific executive powers of such committees under SO 6.3 (Delegation to committees) of the SOs. 2.2.4 Require and receive the declarations of interest of members of the Board of Directors which may conflict with those of the Trust and determine the extent to which a member of the Board of Directors may remain involved with the matter under discussion. 2.2.5 Approve arrangements for dealing with complaints. 2.2.6 Approve disciplinary procedure for Officers of the Trust. 2.2.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of

		business by the Trust and agree modifications thereto. For clarity, this will comprise of details of the structure of the Board of Directors and its committees and sub-committees. Organisational structures below Executive Director are the responsibility of the Chief Executive who may delegate this function as appropriate. 2.2.8 Ratify any urgent or emergency decisions taken by the Chair and Chief Executive in accordance with SO 3.4 (Emergency Powers) of the SOs. 2.2.9 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 2.2.10 Approve arrangements relating to the discharge of the Trust's Responsibilities as a bailee for patients' property. 2.2.11 Approve proposals of the Nomination and Remuneration Committee regarding Board members and senior Officers and those of the Chief Executive for Officers not covered by the Nomination and Remuneration Committee. 2.2.12 Discipline Executive Directors who are in breach of statutory requirements or the SOs. 2.2.13 Subject to the provisions of paragraph 5 below, the authorisation of the use of the Seal. 2.2.14 Suspension of the SOs. 2.2.15 Amendment of the Constitution, in accordance with the Constitution (amendments are subject to approval from the Council of Governors). 2.2.16 Approval and authorisation of institutions in which cash surpluses may be held.
	Committees	2.3.1 Appoint and dismiss committees of the Trust that are directly responsible to the Board of Directors. 2.3.2 Establish terms of reference and reporting arrangements for all committees of the Board.

		2.3.3	Appoint and remove members of all committees or sub-committee of the Board of Directors or the appointment of Trust representative to third party organisations.
		2.3.4	Receipt of reports from committees of the Trust including those which the Trust is required by its Constitution, or by the Regulator or by the Secretary of State, or by any other legislation, regulations, directions, or guidance to establish and to take appropriate action thereon.
		2.3.5	Confirm the recommendations of the Trust's committees where the committees do have executive powers.
2.4	**Strategy, business plans and budgets**	2.4.1	Define the strategic aims and objectives of the Trust.
		2.4.2	Approve the Trust's forward plan and budget in respect of each financial year setting out the application of available financial resources.
		2.4.3	Approve and monitor the Trust's policies and procedures for the management of risk. Approve key strategic risks.
		2.4.4	Subject to paragraph 54 (Significant Transactions) of the Constitution, ratify proposals for the acquisition, disposal or change of use of land and/or buildings or the creation of any mortgage charge or other security over any asset of the Trust.
		2.4.5	Approve proposals for ensuring quality and developing clinical governance and risk management in services provided by the Trust, having regard to the guidance issued by the Regulator and/or the Secretary of State.
		2.4.6	Approve proposals for ensuring equality and diversity in both employment and the delivery of services.
		2.4.7	Approve the Trust's investment policy and authorise institutions with which cash surpluses may be held.
		2.4.8	Approve the Trust's borrowing policy, which will include other long term financing arrangements

		such as leases. 2.4.9 Authorise any necessary variations to total budget spend of capital schemes of more than 10% or £25,000, whichever is the greater. Authorise any increase in the total capital programme. 2.4.10 Approve the Trust's banking arrangements. 2.4.11 Approve the Trust's Annual Business Plan. 2.4.12 Consider a merger, acquisition, separation or dissolution of the Trust. An application for a merger, acquisition, separation or dissolution of the Trust may only be made with the approval of more than half the members of the Council of Governors. 2.4.13 Consider a significant transaction as defined in the Constitution. A significant transaction may only be entered into if approved by more than half of the members of the Council of Governors voting in person at a meeting of the Council of Governors.
2.5	**Monitoring**	2.5.1 Continuously appraise the affairs of the Trust by means of the receipt of reports as it sees fit from members of the Board of Directors, committees, and Officers of the Trust. All monitoring returns required by the Regulator and the Charity Commission shall be reported, at least in summary, to the Board of Directors. 2.5.2 Consider and approve the Trust's Annual Report and Annual Accounts, prior to submission to the Council of Governors and the Regulator. 2.5.3 Receive and approve the Annual Report and Accounts for funds held on trust. 2.5.4 Receive reports from the Director of Finance on financial performance against budget and the annual business plan. 2.5.5 All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.

2.6	**Audit arrangements**	2.6.1	Receive reports of Audit Committee meetings and take appropriate action.
		2.6.2	Receive the annual management letter from the external auditor and agree action on the recommendations where appropriate of the Audit Committee.
		2.6.3	Receipt of a recommendation of the Audit Committee in respect of the appointment of Internal Auditors (note: the recommendation in respect of External Auditors is made by the Audit Committee to the Council of Governors),
2.7	**Policy determination**	2.7.1	Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of Officers.

3. Committee delegation

The Board of Directors may determine that certain powers shall be exercised by committees of the Board of Directors. The composition and terms of reference of such committees shall be determined by the Board of Directors from time to time taking into account where necessary the requirements of the Regulator and/or the Charity Commission (including the need to appoint an Audit Committee and a Remuneration Committee). The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with the SOs committees of the Board of Directors may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors. The Board of Directors have delegated decisions/duties to the following committees:

- Audit Committee
- Nomination and Remuneration Committee
- Charity Committee
- Quality and Governance Committee
- Finance and Performance Committee

A list of committees, along with their terms of reference, shall be maintained by the Deputy Company Secretary.

	Committee	Delegated items	Related documents
3.1	**Audit committee**	3.1.1 The Committee is authorised by the Board of Directors to: 3.1.1.1 investigate any activity within its terms of reference; 3.1.1.2 commission appropriate independent review and studies; 3.1.1.3 seek relevant information from within the Trust and from all Officers; 3.1.1.4 Obtain relevant legal or other independent advice and to invite professional with	SFIs 3.2, SO 5.6

		relevant experience and expertise to attend meetings of the Audit Committee. 3.1.1.5 Approve specific policies and procedures relevant to the committee's remit; 3.1.2 The Committee's role focuses on the scrutiny of all Trust activity and maintenance of an effective system of governance, risk management and internal control, including financial, clinical, operational and compliance controls and risk management systems. 3.1.3 The Committee is responsible for maintaining an appropriate relationship with the Trust's internal and external auditors.	
3.2	**Nomination and remuneration committee**	3.2.1 The Committee is authorised by the Board of Directors to: 3.2.1.1 set remuneration for all Executive Directors and other posts which report to the Chief Executive, including pension right and any compensation payments; 3.2.1.2 consider any activity within its terms of reference; 3.2.1.3 seek relevant information from within the Trust; 3.2.1.4 instruct independent consultants in respect of Executive Director remuneration; 3.2.1.5 request the services and attendance of any other individuals and authorities within relevant experience and expertise if it considers this necessary to exercise its functions. 3.2.2 On behalf of the Board of Directors, the Committee has the following responsibilities: 3.2.2.1 to identify and appoint candidates to fill posts within its remit as and when they arise; 3.2.2.2 to be sensitive to other pay and employment conditions in the Trust;	SFI 10.1, SO 5.6

		3.2.2.3 to keep leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy; 3.2.2.4 to give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors; 3.2.2.5 to sponsor the Trust's leadership development and talent management programmes; 3.2.2.6 to work with the Appointments Committee of the Council of Governors to ensure that processes for the nomination and remuneration and performance appraisal of the Chair and Non-Executive Directors and Chief Executive and Executive Directors are aligned.	
3.3	**Charity committee**	3.3.1 The Committee will: 3.3.2 Ensure Funds Held on Trust (charitable funds) are managed in accordance with the Trust's SOs and SFIs, as approved by the Board of Directors. 3.3.3 Receive regular reports from the Director of Finance covering: 3.3.3.1 Number and value of funds 3.3.3.2 Purpose of funds 3.3.3.3 Income and expenditure analysis 3.3.4 Decide upon expenditure criteria. 3.3.5 Ensure that the requirements of the Charities Acts and the Charities Commission are met. 3.3.6 Provide reports for the Board of Directors (acting as the Corporate Trustee) as appropriate. 3.3.7 Review the Annual Accounts prior to submission to the Corporate Trustee for formal approval.	SO 5.7.3

3.4	**Quality and governance committee**	3.4.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.4.1.1 approve specific policies and procedures relevant to the Committee's purpose, responsibilities and duties; 3.4.1.2 engage with the Trust's auditors in cooperation with the Audit Committee; 3.4.1.3 seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.4.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of : 3.4.2.1 the Trust's performance against the three domains of quality, safety, effectiveness and patient experience; 3.4.2.2 compliance with essential regulatory and professional standards, established good practice and mandatory guidance; 3.4.2.3 delivery of national, regional, local and specialist care quality (CQUIN) targets.	
3.5	**Finance and performance committee**	3.5.1 The Board of Directors has delegated authority to the Committee to take the following actions on its behalf: 3.5.1.1 Approve specific policies and procedures relevant to the committee's remit; 3.5.1.2 Review, by way of the finance report, the ~~Approve~~ submission of monthly ~~quarterly~~ monitoring reports to the regulator; 3.5.1.3 Approve other exception or ad-hoc reports required by the regulator; 3.5.1.4 Recommend to the Board the ~~Approve~~ submission of the Trust's annual plan to	

		the regulator; and 3.5.1.5 Seek any information it requires from within the Trust and to commission independent reviews and studies if it considers these necessary. 3.5.2 On behalf of the Board of Directors, the Committee will be responsible for the oversight and scrutiny of the Trust's: 3.5.2.1 monthly financial and operational performance; 3.5.2.2 estates and facilities strategy and maintenance programme; and 3.5.2.3 information management and technology (IM&T) strategy, performance and development. 3.5.3 The Committee will make recommendations to the Board of Directors in relation to: 3.5.3.1 capital and other investment programmes; 3.5.3.2 –cost improvement plans; and 3.5.3.3 Business development opportunities and business cases.	

4. Board member delegation

	Board member	Duties delegated
4.1	Chief executive	4.1.1 Accounting Officer to Parliament for stewardship of Trust resources. 4.1.2 Sign the accounts on behalf of the Board of Directors. 4.1.3 Ensure effective management systems that safeguard public funds and assist the Chair to implement requirements of corporate governance including ensuring managers: 4.1.3.1 Have a clear view of their objectives and the means to assess achievements in relation to those objectives 4.1.3.2 Be assigned well defined responsibilities for making best use of resources 4.1.3.3 Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
4.2	Chief executive and director of finance	4.2.1 Ensure the accounts of the Trust are prepared under principles and in a format directed by the regulator. 4.2.2 Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.
4.3	Chair	4.3.1 Leadership of the Board of Directors, ensuring its effectiveness on all aspects of its role and setting its agenda for meetings of the Board of Directors. 4.3.2 Ensuring the provision of accurate, timely and clear information to the Directors and the Council of Governors. 4.3.3 Ensuring effective communication with Officers, patients and the public. 4.3.4 Arranging the regular evaluation of the performance of the Board of Directors, its Committees and individual Directors.

		4.3.5 Facilitating the effective contribution of Non-Executive Directors and ensuring constructive relations between Executive and Non-Executive Directors.
4.4	Board of directors	4.4.1 Meet regularly and to retain full and effective control over the Trust 4.4.2 Collective responsibility for adding value to the Trust, for promoting the success of the Trust by directing and supervising the Trust's affairs 4.4.3 Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed 4.4.4 Set the Trust's strategic aims, ensure that the necessary financial and human resources are in place for the Trust to meet its objectives, and review management performance 4.4.5 Set the Trust's values and standards and ensure that its obligations to patients, the local community and the Regulator are understood and met.
4.5	All members of the board of directors	4.5.1 Share corporate responsibility for all decisions of the voting members of the Board of Directors.
4.6	Non-executive directors	4.6.1 To bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Regulator and to the local community by: 4.6.1.1 Constructively challenge and contribute to the development of strategy 4.6.1.2 Scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance 4.6.1.3 Satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible 4.6.1.4 Determine appropriate levels of remuneration of executive directors and have prime role in appointing and where necessary , removing senior management and in succession planning 4.6.1.5 Ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

		4.6.2 Sitting on Committees of the Board of Directors.

5. Scheme of delegation of powers from standing orders

So ref	Delegated to	Duties delegated
1.2	Chair	Final authority on the interpretation of the SOs.
1.2	Chief executive	Advise the Chair on the interpretation of the SOs.
2.9	Board of directors	Appointment of a Senior Independent Director.
3.2	Board of directors	To act as the Corporate Trustee of the Queen Victoria Hospital Trust Charitable Fund.
3.6	Chief executive	Responsible for the overall performance of the executive functions of the Trust. Responsible for ensuring the discharge of obligations under applicable financial directions, the Regulator guidance and in line with the requirements of the NHS foundation trust accounting officer memorandum.
3.7	Finance director	Responsible for the provision of financial advice to the Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems.
3.8	Director of nursing	Responsible for effective professional leadership and management of nursing Officers of the Trust and is the Caldicott guardian.
3.11	Chair	Responsible for the operation of the Board of Directors.
3.11	Chair	Chair all meetings of the Board of Directors and associated responsibilities.
4.2	Chair	Call meetings of the Board of Directors.
4.4	Chair	Sign notices of meetings of the Board of Directors.

4.11	Chair	Give final ruling to permit late requests for items to be included on the agenda for meetings of the Board of Directors.
4.13	Secretary	Include any petition received by the Trust on the agenda for the next meeting of the Board of Directors.
4.25	Chair	Chair all meetings of the Board of Directors.
4.28	Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
4.33	Chair	Have a second or casting vote.
4.39	Board of directors	Suspension of SOs.
4.43	Board of directors	Variation or amendment of SOs.
4.45	Secretary	Prepare minutes of the proceedings of the meetings of the Board of Directors and submit minutes for agreement at the next meeting of the Board of Directors.
4.45	Chair	Sign minutes of the proceedings of meetings of the Board of Directors.
4.48	Chair	Issue directions regarding arrangements for meetings of the Board of Directors and accommodation of the public and press.
5.1	Board	Subject to such directions as may be given by the Secretary of State, the Board may appoint Committees of the Board. The Board shall approve the membership and terms of reference of Committees and shall if it requires to, receive and consider reports of such Committees.
5.17	All	Duty of confidentiality regarding all matters reported to the Board of Directors, or otherwise dealt with by the committee, sub-committee or joint committee if the Board of Directors, or committee or sub-committee has resolved that it is confidential.
6.2	Chair and Chief	The powers which the Board of Directors has reserved to itself with the SOs may in emergency or for an

	Executive	urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification.
6.6	Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors
6.9	All	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.4	Secretary / Chair	Where a Director has any doubt about the relevance of an interest, this should be discussed with them.
7.6	Secretary	A register of interests shall be established and maintained.
7.15	Directors	Duty not to solicit for any person any appointment under the Trust or recommend any person for such appointment, and disclose informal discussions outside appointment panels or committees to the panel or committee.
7.18	All	Disclose relationship between self and candidate for Officer appointment. (Chief Executive to report the disclosure to the Board of Directors).
7.19	Executive directors	Prior to acceptance of any appointment, disclose to the Chief Executive whether you are related to any other Director or holder of any officer under the Trust.
7.20	Directors	On appointment, disclose to the Board of Directors whether you are related to any other Director or holder of any officer under the Trust.
8.1	Directors and Officers	Comply with the Trust's standards of business conduct policy and relevant codes of conduct.
10.1	Secretary	Keep the Trust's Seal in a secure place.
10.2	Chair and one executive director	Sign to authenticate the seal.

10.3	Finance director and Chief Executive	Approve and sign any building, engineering, property or capital document.
11.1	Chief executive /nominated executive director	Approve and sign all documents which will be necessary in legal proceedings.
11.2	Chief Executive/ nominated officer	Authority to sign any agreement or document (save for deeds) the subject matter of which has been approved by the Board of Directors or a committee thereof.
12.1	Chief Executive	Ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and SFIs.

6. Scheme of delegation of powers from standing financial instructions

SFI ref	Delegated to	Duties delegated
1 Introduction		
1.2.1	Chair	Final authority on interpretation of the SFIs.
1.2.1	Chief Executive / director of finance	Advise the Chair on the interpretation of the SFIs.
1.4.1	All	All officers of the trust must comply with the SFIs.
2 Responsibilities and delegation		
2.1.2	Board of directors	Accountable for all of trust functions, even those delegated to the Chair, individual directors or officers.
2.4.1	Chief executive	The chief executive is the trust's accounting officer.
2.4.4	Chief executive	To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.
2.4.5	Chief Executive & Chair	To ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.
2.4.6	Chief Executive	To ensure that financial performance measures with reasonable targets have been defined and are monitored, with robust systems and reporting lines in place to ensure overall performance is managed and arrangements are in place to respond to adverse performance.
2.4.7	Chief Executive	Determine whether powers devolved under the SFIs and the scheme of delegation be taken back to a more senior level.
2.4.8	Chief Executive	To ensure that the trust provides an annual forward plan to the regulator each year.
2.5.1	Director of finance	Responsible for: • Advising on and implementing the trust's financial policies;

		• Design, implementation and supervision of systems of internal financial control; • Ensuring that sufficient records are maintained to show and explain the trust's transactions, in order to report; • Provision of financial advice to other directors of the board and employees; and • Preparation and maintenance of records the trust may require for the purpose of carrying out its statutory duties.
2.6.1	All	All members of the board of directors and officers of the trust are severally and collectively responsible for security of the trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to the SOs, SFIs and all trusts policies and procedures.
3 Audit		
3.2.1	Audit committee	Provide an independent and objective view of internal control by: • Overseeing internal and external audit services (including agreeing both audit plans and monitoring progress against them);receiving reports from the internal and external auditors (including the external auditor's management letter) and considering the management response; • Monitoring compliance with SOs and SFIs; • Reviewing schedules of losses and compensations and making recommendations to the board of directors; • Reviewing the information prepared to support the annual governance declaration statement.
3.2.3	Chair of the audit committee	Where audit committee considers there is evidence of ultra vires transactions or improper acts or important matters that the audit committee wishes to raise, the matter shall be raised at a full meeting of the board of directors.
3.3.1	Director of finance	In relation to audit, the director of finance is responsible for: • Ensuring there are arrangements to review, evaluate and report on effectiveness of internal financial control by establishment of internal audit function; • Ensuring the internal audit is adequate and meets the NHS mandatory audit standards; • Ensuring the production of annual governance statement for inclusion in trust's annual report;

		• Provision of annual reports; • Ensuring effective liaison with relevant counter fraud services regional team or NHS protect; and • Deciding at what stage to involve police in cases of misappropriation or other irregularities.
3.3.2	Director of finance/ designated auditors	Entitled to require and receiver without prior notice: • Access to all records, documents, correspondence relating to any financial or other relevant transactions; • Access at all reasonable times to any land, premises or members of the board of directors or officers of the trust; • Production of any cash, stores or other property of the trust under the control of a member of the board of directors or officers; and • Explanations concerning any matter under investigation.
3.4.2	Internal audit	To review, appraise and report on compliance with policies, plans and procedures; adequacy of control, suitability of financial and management data and the extent to which the trust's assets and interests are accounted for.
3.4.3	Internal audit	To assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the regulator.
3.4.4	Internal audit	To notify the director of finance should any matter arise which involves, or is thought to involve, irregularities concerning cash, stores or other property.
3.4.5	Lead internal auditor	Accountable to the director of finance. Attend meetings of the audit committee and have right of access to all members of the audit committee, the Chair and the chief executive of the trust.
3.5.1	Council of Governors	Appoint external auditor to the trust.
3.5.1	Audit committee	To ensure that external audit is providing a cost effective service that meets the prevailing requirements of the

		regulator and other regulatory bodies.
3.6.1	Chief Executive and director of finance	Monitor and ensure compliance with guidance issued by the regulator or NHS protect on fraud and corruption in the NHS.
3.6.2	Director of finance	Responsible for the promotion of counter fraud measure within the trust and ensure that the trust co-operate with NHS protect in relation to the prevention, detection and investigation of fraud in the NHS.
3.6.4	Director of finance	Ensure the trust's local counter fraud specialist receives appropriate training in connection with counter fraud measures.
3.6.5	Director of finance	Be satisfied that the terms on which the services of a local counter fraud specialist from an outside organisation are provided are such to enable the local counter fraud specialist to carry out his functions effectively and efficiently.
3.6.7	Director of finance and local counter fraud specialist	At the beginning of each financial year, prepare a written work plan outlining the local counter fraud specialist's projected work for that financial year.
3.6.11	Director of finance	Prepare a 'fraud response plan' that sets out the action to be taken in connection with suspected fraud.
3.6.12 3.6.13	Director of finance	Inform police if theft or arson is involved. For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness (except if trivial and where fraud is not suspected), immediately notify the board of directors and the auditor.
3.7.1	Director of finance	To establish procedures for the management of expense claims submitted by officers.
3.7.2	Director of finance	Approval of any expense claims receive older than 3 months.
3.8.1	Secretary	Ensure that all officers are made aware of the trust's standards of business conduct and additional rules in respect of preventing corruption and complying with the bribery act 2010.

3.8.2	All	To notify the secretary of any gift, hospitality or sponsorship accepted (or refused) by any officer on behalf of the trust.
3.8.2	Secretary	To record in writing, notification of any gift, hospitality or sponsorship accepted (or refused) by officers on behalf of the trust.
3.9.1	Director of finance	Report non-compliance with SFIs to the audit committee.
3.9.2	All	To disclose any non-compliance with the SFIs to the director of finance as soon as possible
4 Annual planning, budgets, budgetary control and monitoring		
4.1.1	Chief Executive	Compile and submit to the board of directors and the regulator, strategic and operational plans.
4.1.2	Director of finance	Prepare and submit the operational plan to the financial and performance committee, the Board of Directors and the regulator
4.1.3	Director of finance	Compile and submit financial estimates and forecasts for both revenue and capital to the Board of Directors.
4.1.4	All	To provide the director of finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.
4.2.4	Director of finance	Ensure adequate training is delivered on an ongoing basis to enable the Chief Executive and other Officers to carry out their budgetary responsibilities.
4.4.1	Finance and performance committee	Submit budgets to the board of directors for approval.
4.2.4	All directors	To meet their financial targets as agreed in the annual plan approved by the board of directors.
4.3	All	Ensure income and expenditure is contained within budgets.

		Ensure workforce is maintained within budgeted establishment unless expressly authorised. Ensure non-recurring budgets are not used to finance recurring expenditure. Ensure no agreements are entered into without the proper authority.
4.4.7	Board of Directors/ Chief Executive	Approval of expenditure for which no provision has been made in an approved budget.
5 Annual accounts and reports		
5.1	Director of finance	Prepare financial returns in accordance with the guidance given by the regulator and the secretary of state for health, the treasury, the trust's accounting policies and generally accepted accounting principles
5.2	Chief Executive	Certify annual accounts.
5.2	Director of finance	Prepare annual account. Submit annual accounts and any report of auditor on them to the regulator.
6 Bank accounts		
6.1–6.6	Director of finance	Manage the trust's banking arrangements including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
6.1	Board of Directors	Approve banking arrangements.
7 Financial systems and transaction processing		
7.1-7.8	Director of finance	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
7.9	All	Duty to inform designated finance representatives of money due from transactions which they initiate/deal with.
7.12	Director of finance	Approve arrangements for making disbursements from cash received.
7.14	All	Notify the director of finance if an individual attempts to effect payment in cash over the value of £1,000.

8 Contracts for provision of services to customers		
8.1	Director of finance	Negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.
8.4	Director of finance	Setting the framework and overseeing the process by which provider to provider contracts, or other contracts for the provision of services by the trust, are designed and agreed.
9 Contracts, tenders and healthcare service agreements		
9.1.2	Chief Executive	Ensure that best value for money can be demonstrated for all services provided under contract or in-house.
9.1.2	All	Ensure contracts are best value for money at all times and to review all contracts prior to signing.
9.1.3	Director of finance	Advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained, establish procedures to ensure that competitive quotations and tenders are invited for the supply of goods and services and ensure that a register is maintained of all formal tenders.
9.4.1	Director of finance	Establish procedures to carry out financial appraisals and shall instruct the appropriate requisitioning officer to provide evidence of technical competence.
9.5.6	Director of finance	Establish procedures to ensure that tenders are opened and documented appropriately and within an agreed timescale.
9.5.7	Chief Executive/ director of finance	Approval of awarding of contracts for which tendering is deemed not strictly competitive.
9.5.8	Chief Executive/ Director of finance	Where one tender is received will assess for value for money and fair price.
9.5.9	Director of finance	Decision to accept tenders after the deadline but before opening of the other tenders.
9.6.1	Director of finance	Enquiries concerning the financial standing and financial suitability of approved contractors.

9.10.4	Director of finance	Ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
9.11.2	Chief Executive	Nominate officers to commission service agreements with providers of healthcare.
9.12.3	Chief Executive	Nominate an officer who shall oversee and manage each contract on behalf of the trust.
9.14.1	Chief Executive	Ensure that best value for money can be demonstrated for all services provided on an in-house basis.
10 Terms of service, officer appointments and payments		
10.1.1	Board of Directors	Establish a nomination and remuneration committee.
10.2.3	Chief executive	Present to the board of directors procedures for determination of commencing pay rates, conditions of service etc. for Officers.
10.3.1	Board of Directors	Delegate responsibility to the director of human resources for: • Ensuring that all officers and executive directors are issued with a contact of employment in a form approved by the board of directors and which complies with employment legislation; and • Dealing with variations to, or termination of, contracts of employment.
10.4.1	Director of finance	Make arrangement for the provision of payroll services to the trust to ensure the accurate determination for any entitlement and to enable prompt and accurate payment to officers.
10.4.2	Director of finance and director of human resources	Responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay.
10.4.3	Director of finance	Issue detailed procedures covering payments to officers.
10.5.1	Director of finance, director of human resources	Approve advances of pay.

11 Non-pay expenditure		
11.1.1	Board of Directors	Approve the level of non-pay expenditure on an annual basis.
11.1.1	Chief Executive	Determine the level of delegation to budget managers.
11.1.2	Chief Executive	Set out the list of managers who are authorised to place requisitions for the supply of goods and services, and , the financial limits for requisitions and the system for authorisation above that level.
11.1.3	Budget managers	To appoint nominees who must be approved by the director of finance, and to remain responsible for the actions of nominees when they act in place of the budget manager.
11.1.4	Chief executive	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
11.2.1	All	In choosing the item to be supplied or the service to be performed, shall always obtain best value for money for the trust.
11.2.3	Director of finance	Responsible for the prompt payment of accounts and claims.
11.3.1	Director of finance	• Advise the board of directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. • Prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services. • Be responsible for the prompt payment of all properly authorised accounts and claims. • Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. • Ensure a system for submission to the director of finance of accounts for payment. • Maintain a list of officers, including specimens of their signatures, authorised to certify any type of payment. • Delegate responsibility for ensuring that payment for goods and services is only made once goods/services are received. • Prepare and issue procedures regarding vat.
11.4.1	All	Fully comply with the procedures and limits specified by the director of finance.

11.5.1	Director of finance	Approve proposed prepayment arrangements.
11.2.9	Chief Executive/ director of finance	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within health building note 00-08.
11.3.1	All	Ensure that contracts with individuals or with individuals working through a limited company are appropriately authorised, provide value for money and do not expose the trust or the individual to tax and HMRC compliance risks.
12 Equity investments, external borrowing, public dividend capital and mergers and acquisitions		
12.1.1	Director of finance	Produce an investment policy in accordance with any guidance received from the regulator.
12.1.3	Director of finance	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
12.2.1	Director of finance	Advise the board of directors concerning the trust's ability to pay interest on, and repay the public dividend capital (PDC) and any proposed commercial borrowing.
12.2.2	Director of finance	Applications for a loan or overdraft.
12.2.3	Director of finance	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
12.2.4	Director of finance	Approval of short terms borrowing requirements.
12.3.1	Board of Directors	Review and approval of special purpose vehicles, joint ventures with other entities and mergers and acquisitions.
12.3.2	Board of Directors	Approve any mergers or acquisitions in accordance with the constitution.
13 Capital investment and assets		
13.1.1	Chief Executive	• Ensure adequate appraisal and approval processes are in place for determining capital expenditure

		priorities. • Management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost. • Ensure investment is not undertaken without confirmation, where appropriate, of responsible director's support and the availability of resources to finance all revenue consequences.
13.2.1	Director of finance	Prepare detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register.
13.2.2	Director of finance	Implement procedures to comply with guidance on valuation contained within the treasury's guidance.
13.2.3	Director of finance	Establish procedures covering the identification and recording of capital additions.
13.2.4	Director of finance	Develop procedures covering the physical verification of assets on a periodic basis.
13.2.5	Director of finance	Develop policies and procedures for the management and documentation of asset disposals.
13.3.1	Chief Executive	Responsible for the maintenance of registers of assets, taking account of the advice of the director of finance regarding the form of any register.
14 Stores and receipts of goods		
14.1.1	Chief Executive	Delegate overall responsibility for the control of stores.
14.1.1	Director of finance	Responsible for systems of control.
14.1.3	Pharmaceutical officer	Responsible for the control of any pharmaceutical stocks.
14.1.5	Director of finance	Set out procedures and systems to regulate the stores including records for receipt of goods, issues and returned to stores and losses.
14.1.6	Director of finance	Agreed stocktaking arrangements.

14.1.7	Director of finance	Approval of alternative arrangements where a complete system of stores control is not justified.
14.2.1	Chief executive	Identify those officers authorised to requisition and accept goods from the NHS supply chain.
15 Disposals and condemnations, losses and special payments		
15.1.1	Director of finance	Prepare detailed procedures for the disposal of assets including condemnations, and ensure members of the board of directors and relevant officers are notified of this.
15.1.2	Head of department	Advise the director of finance of the estimated market value of the item to be disposed of.
15.2.1	Director of finance	Approve form to in which to record the condemning of unserviceable assets and provide a list of officers to countersign entries.
15.2.3	Condemning officers	Report evidence of negligence in use of assets to the director of finance.
15.3.1	Director of finance	Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.
15.3.2	All	Report discovered or suspected losses of any kind to their manager.
15.3.2	Managers	Report discovered or suspected losses of any kind to the chief executive and director of finance.
15.3.3	Director of finance	Immediately inform the police if theft or arson is involved in a suspected criminal offence.
15.3.4	Director of finance	Inform the trust's local counter fraud specialist (LCFS) and NHS Protect in cases of fraud or corruption.
15.3.5	Director of finance	Notify the audit committee, LCFS and the external auditors of all frauds.
15.3.6	Director of finance	Notify the board of directors, external auditor and the audit committee, at the earliest opportunity of losses

		apparently caused by theft, arson, or neglect of duty, except if trivial, or gross carelessness.
15.3.8	Director of finance	Take steps to safeguard the trust's interest in bankruptcies and company liquidators. Consider whether any insurance claim can be made for any losses incurred by the trust.
15.2.8	Director of finance	Maintain a losses and special payments register in which write-off action is recorded and regularly report losses and special payments to the audit committee on a regular basis.
16 Information technology		
16.1	Director of finance	Responsible for the accuracy and security of the computerised financial data of the trust and shall: • Devise and implement any necessary procedures to ensure adequate and reasonable protection of the trust's data, programmes and computer hardware; • Ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output; • Ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment; • Ensure that an adequate audit trail exists through the computerised system; • Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation; and • Publish and maintain a freedom of information (FOI) publication scheme.
16.2.1	Director of finance	Ensure that contracts for computer services for financial applications clearly define the responsibility of all parties and ensure rights of access for audit purposes.
16.2.2	Director of finance	Periodically seek assurances that adequate controls are in operation.
16.3.1	Director of finance	Ensure that risks to the trust arising from the use of information technology are effectively identified, considered and appropriate action taken to mitigate or control risk.
16.4.1	Director of finance	• Ensure that systems acquisition, development and maintenance are in line with corporate policies such as the trust's information technology strategy.

		• Ensure that data produced is complete and timely and accessible to the trust's finance officers. • Ensure computer audit reviews are carried out as necessary.
17 Patients' property		
17.3	Chief Executive	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
17.4	Director of finance	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients.
17.5	Senior officers	Inform officers, on appointment, their responsibilities and duties for the administration of the property of patients.
18 Retention of records		
18.1	Chief Executive	Maintain archives for all documents required to be retained in accordance with the regulator and/or secretary of state guidelines.
18.2	Chief Executive	Produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained.
19 Risk management and insurance		
19.1	Chief Executive	Ensure that the trust has a programme of risk management which shall be approved and monitored by the board of directors.
19.3	Chief Executive	Responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the annual report and annual accounts.
19.4	Director of finance	Ensure that insurance arrangements exist in accordance with the trust's risk management policy.
20 Funds held on trust (charitable funds)		

20.5	Director of finance	Ensure that funds held on trust (charitable funds) are administered in line with statutory provisions, the trust's governance documents and charity commission guidance. Prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of the funds held on trust (charitable funds) for the discharge of the board of directors responsibilities as the corporate trustee.

7 Financial limit delegation

REF	Duties delegated	Delegated to
1	**Virements (reallocation of budgets)**	
	Within a Business Unit/Directorate	Level 2 Officers responsible for cost centres
	Between Business Units/Directorates	Responsible Directors
	All other virements (e.g. Between revenue and capital)	Responsible Directors AND Director of Finance

2 approval of business cases and service developments (Does not include setting of pay and non-pay budgets as part of annual planning process) **Note: Applies to self-funding business cases and service developments and those within budgetary limits only.**		
2.1	**Revenue expenditure (5 year value)**	
	Up to £200,000	Executive Management Team
	£200,001 to £1,000,000	Hospital Management Team
	Over £1,000,000	Board of Directors

2.2	**Capital expenditure and disposals** Up to £1,000,000 Over £1,000,000	 Executive Management Team Board of Directors

3 Quotations, tenders and selection of suppliers Also refer to the Procurement Department for further guidance: in many cases goods and services will already have been subject to a competitive exercise and there may be no requirement for further quotations or competition.		
3.1	**Capital/revenue expenditure** Up to £5,000 £5,001 to £50,000 £50,001 to OJEU Threshold (contact procurement department for current value) Over OJEU threshold (see note below – threshold is different for works and non-works)	**Minimum requirements** 1 Written quote (Authorised by Budget Manager) 3 Written quotes (Authorised by Budget Manager) Competitive Tender Exercise (Level 2 Manager AND Director of Finance) EU Directive Requirements (Relevant Director AND Director of Finance)

	Note: Written quotes may be accepted via email, and may not be required if a particular requirement has already been completed under a framework whose terms do not require further competition (the Head of Procurement must be consulted and give approval in such cases). "Competitive Procurement Exercise" indicates that the Head of Procurement should be consulted for advice as to the nature of the exercise (e.g. tender, mini-competition against a framework). **All thresholds apply to the aggregate value of orders, which may be across different areas of the Trust.** All Officers should consult the Procurement Department for guidance if they are unsure, who are jointly responsible with the approver for ensuring that thresholds are not breached trust-wide. The OJEU threshold refers to the EU Directive threshold for a procurement exercise to include publication in the Official Journal of the European Union (OJEU). As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all Officers should consult the Procurement department for guidance.	
3.2	**Quotation and tenders process waivers** Waiving of tender and quotation procedures for items where estimated expenditure is less than £25,000 Waiving of tender and quotation procedures for items where estimated expenditure is over £25,000 and not expected to exceed EU procurement thresholds.	Deputy Director of Finance Director of Finance, Deputy Directors of Finance (when Director of Finance is unavailable) or Chief Executive (when Director of Finance has commissioned the item)
3.3	**Opening tenders** Electronic tenders received through DELTA	Head of Procurement or Deputy Director of Finance (in

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		absence of Head of Procurement)

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

	Unlimited	Chief Executive on behalf of Board of Directors
4.3	**Granting and termination of equipment leases and credit finance** Trust's employee lease car scheme Leases/arrangements up to £3,000,000 (total primary lease term payments or credit finance obligations) Over £3,000,000 (total primary lease term payments or credit finance obligations)	 Deputy Director of Finance Chief Executive Board of Directors
4.4	**Agreements and licences** Letting or licencing of premises to or from other organisations (see also section 5 below for guidance on who can sign these agreements) Where annual charge does not exceed £10,000 and term does not exceed five years Where annual charge exceeds £10,000 or term exceeds 5 years Signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	 Associate Director of Estates Associate Director of Estates Director of Finance Associate Director of

		Estates & Director of Finance
4.5	**Condemning and disposal** Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively Up to £5,000 (carrying value) Over £5,000 (carrying value) Transfer or sale of assets to another organisation	 Responsible Director Director of Finance (may be delegated in specific cases in writing, but no lower than to a level 2 manager) Director of Finance Director of Finance
4.6	**Losses, write-offs and compensation**	

4.6.1	Losses of cash, Damage or loss of buildings, fittings, furniture, equipment or property in stores, Compensation payments made under legal obligation (excluding clinical negligence), Write off of Debtors (including Salary Overpayments) Up to £10,000 Up to £50,000 Over £50,001	 Deputy Director of Finance Director of Finance Board of Directors
4.6.2	Fruitless Payments (including abandoned capital schemes) Up to £10,000 Up to £50,000 Over £50,001	 Deputy Director of Finance Director of Finance Board of Directors
4.6.3	Ex-Gratia payments to patients and Officers for loss of personal effects. Police report required for losses over £100. Up to £10,000 Up to £50,000 Over £50,001	 Deputy Director of Finance Director of Finance Board of Directors

4.6.4	Ex-Gratia payments for clinical negligence or personal injury claims involving negligence or any other ex-gratia payments (where legal advice obtained and followed) up to £50,000 £50,001 to £100,000 over £100,000	 Director of Finance Chief Executive and Director of Finance Board of Directors
4.6.5	Reimbursement of patients monies	Financial Services Manager
4.6.6	Removal expenses, excess rent and house purchase	Director of Workforce
4.6.7	Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors. Up to £20,000 Over £20,000 **Note:** All special payments require Treasury approval and shall be submitted via the Director of Finance to the Regulator for Treasury approval.	 Director of Workforce Chief Executive
4.7	**Expenditure from charitable funds** Up to £1,000 Up to £20,000 Over £20,000	 Two from relevant fund holder, Director of Finance, Deputy Director of Finance QVH Charity Corporate Trustee

5 signature of legally binding documents **(All individuals signing contracts have a responsibility to review and assure themselves that they provide value for money and that due care has been exercised in their preparation, with formal legal advice provided if necessary. This applies to contracts that appear to have no financial value, as these might have financial or non-financial implications from termination)**		
5.1	Signature to approve invoices or otherwise commit expenditure (e.g. engagement letter), without any further legally binding obligations.	See Section 4 (Committing Expenditure)
5.2	Signature of any document that will be a necessary step in legal proceedings involving the Trust(excluding valuation tribunal appeals and similar day-to-day property-related matters).	Chief Executive (unless the Board has specifically given the necessary authority to another individual for the purposes of such proceedings)
5.3	Signature of the following property documents when part of day to day business and within approved business plans and financial envelopes: • Notices to activate rent reviews and lease expiries • Notices requiring signature on the granting of leases and licences • Licences permitting alterations or minor works by us in third party property or by others in our properties.	Associate Director of Estates

5.4	Signature of other contracts or other legally binding documents not required to be executed as a deed (see Standing Orders for guidance on documents to be executed as a deed), the subject matter and nature of which has been approved by the Board or committee to which the Board has delegated appropriate authority. Up to £10,000 Up to £50,000 Up to £100,000 Up to £250,000 Up to £1,000,000 Over £1,000,000	 Budget Manager Level 2 Manager (Officer) Responsible Director Director of Finance Director of Finance AND Chief Executive Board of Directors
5.5	~~Signature of contracts or agreements (for goods or services) that contain committed values or volumes of expenditure that will later be subject to approval via purchase order, where this will include consignment stock agreements, non-disclosure agreements, framework access agreements, commitment charters, pricing agreements.~~	Director of Finance
	~~**Note:** The guidance above in relation to signature of contracts applies equally to variations and exit of existing contracts, unless specifically delegated otherwise.~~	

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6 setting of fees, charges and income		
6.1	Private patient, overseas visitors, income generation and other patient related services	Head of Commerce

6.2	Price of NHS contracts Setting fees and charges for contracts up to £50,000 per annum Setting fees and charges for contracts over £50,000 per annum	 Relevant director Director of Finance
6.3	Authorisation of income credit notes £500 £5,000 £50,000 £250,000 £500,000 Over £500,000	 Budget managers Level 2 managers, Financial Services Manager and Reporting and Planning Manager (Officer) Deputy Director of Finance Director of Finance Chief Executive Board of Directors
7	Department of Health Interim Revenue Support Where the Trust is trading at a deficit there will be a cash support requirement from the Department of Health and Social Care (DHSC) to maintain operations. The total cash support requirement will be approved by the Board as part of the annual planning process. The cash support will be provided via an interim revenue support loan from the DHSC. The approval of the loan for the drawdown of the cash will be authorised per the limits below. Details of all loan agreements are reported to and overseen by the Finance and Performance Committee with prior approval by the Board through the agreement of the Operating Plan submission.	
7.1	 £0- £1,000,000	 Director of Finance

	£1000,001 - £2,000,000 Above £2,000,000	Director of Finance and Chief Executive Board of Directors

Queen Victoria Hospital NHS Foundation Trust

Standing orders for the Board of Directors

Approved by the Board of Directors at its meeting on 5 July 2018

Contents

Introduction

Statutory framework

Queen Victoria Hospital NHS Foundation Trust ("**the Foundation Trust**"), became a Public Benefit Corporation on 1 July 2004 following the approval by the Regulator pursuant to the National Health Service Act 2006 ("**the 2006 Act**"). The Foundation Trust is governed by the 2006 Act, the Constitution and the Licence granted by the Regulator ("**the Regulatory Framework**"). The functions of the Foundation Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Board of Directors to adopt Standing Orders for the Board of Directors for the regulation of its proceedings and business. The Foundation Trust must also adopt Standing Financial Instructions which set out various responsibilities of individuals.

The Foundation Trust's principle place of business is the Queen Victoria Hospital, Holtye Road, East Grinstead, West Sussex RH19 3DZ.

As a Public Benefit Corporation, the Foundation Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Foundation Trust also has a common law duty as a bailee for patient's property held by the Foundation Trust on behalf of patients.

These Standing Orders ("SOs"), together with the Reservation of Powers and Scheme of Delegation and the Standing Financial Instructions, provide a comprehensive framework for the functions of the Trust. All Executive Directors, Non-Executive Directors and Officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

1 Interpretations and definitions

1.1 Any expression to which a meaning is given in the 2006 Act or any regulations or orders made under the 2006 Act shall have the same meaning in these SOs and in addition, defined terms used in these SOs have the same meaning as in the Constitution unless the context requires otherwise, or a contrary intention is evident.

1.2 Save as otherwise permitted by law, at any meeting of the Board of Directors, the Chair of the Foundation Trust shall be the final authority on the interpretation of these SOs (on which he/she should be advised by the Secretary).

1.3 Words importing the singular shall import the plural and vice-versa in each case.

1.4 In these SOs:

The 2006 Act is the National Health Service Act 2006 (as amended);

Accounting Officer means the person who, from time to time, discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;

Audit Committee means a committee of the Board of Directors established in accordance with paragraph 47 of the Constitution;

Board of Directors means the Board of Directors of the Foundation Trust, constituted in accordance with the Constitution;

Chair means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Foundation Trust as a whole. The expression "the Chair" shall include the Deputy Chair or any other Non-Executive Director appointed if the Chair or Deputy Chair is absent or is otherwise unavailable;

Chief Executive means the Chief Executive of the Foundation Trust;

Clear Day means a day of the week not including a Saturday, Sunday or public holiday;

Committee means a committee appointed by the Board of Directors;

Conflict shall have the meaning ascribed to "Conflict" in paragraph 40.11.1 of the Constitution;

Constitution means the Queen Victoria Hospital NHS Foundation Trust Constitution and all annexes to it;

Council of Governors means the Council of Governors as constituted in accordance with the Constitution and which has the same meaning as the Council of Governors in paragraph 7 of Schedule 7 to the 2006 Act;

Deputy Chair means the Deputy Chair of the Foundation Trust appointed in accordance with paragraph 36 of the Constitution;

Director means a member of the Board of Directors;

Executive Director means an executive member of the Board of Directors of the Foundation Trust;

Financial Year means each successive period of 12 months beginning with 1 April and ending with 31 March;

Foundation Trust means the Queen Victoria Hospital NHS Foundation Trust;

Funds held on Trust means those funds which the Trust holds at the date of Licence, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Section 47(2)(c) of the 2006 Act. Such funds may or may not be charitable;

Licence means the licence granted to the Foundation Trust under Section 88 of the 2012 Act;

Meeting Chair means the person presiding over a meeting, committee or event;

Nomination and Remuneration Committee means a committee constituted in accordance with paragraph 37.4 of the Constitution;

Non-Executive Director means a Non-Executive Director of the Foundation Trust;

Officer means an employee of the Foundation Trust or any other person holding a paid appointment or office with the Foundation Trust;

Principal Purpose means the purpose set out in Section 43(1) of the 2006 Act;

Regulatory Framework means the 2006 Act, the Constitution and the Licence;

Secretary means a person whose function shall be to provide advice on corporate governance issues to the Board of Directors, Council of Governors and the Chair and monitor the Foundation Trust's compliance with the Regulatory Framework. The Secretary shall be appointed and removed by the Chief Executive and Chair of the Foundation Trust acting jointly;

Senior Independent Director means a Non-Executive Director appointed in accordance with paragraph 36 of the Constitution;

Pecuniary Interest means an indirect interest in a contract if the Director:

- Or a nominee of him/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same; or,
- is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

The interest of a Director's spouse, civil partner (as defined in the Civil Partnerships Act 2004) or co-habitee shall, if known to the person, be deemed for the purposes of these SOs to be also an interest of the person.

A director shall not be regarded as having a pecuniary interest in any contract if: neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member; or,

- any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract; or
- those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of these SOs.

Standing Financial Instructions (SFIs) means the Queen Victoria Hospital NHS Foundation Trust's Standing Financial Instructions;

Standing Orders (SOs) means the basic rules and procedures for the Queen Victoria Hospital NHS Foundation Trust's Board of Directors.

2 The Foundation Trust Board of Directors

Composition of the Board of Directors

2.1 The composition of the Board of Directors is set out at paragraph 31 of the Constitution.

Appointment of the Chair and other members of the Board of Directors

2.2 The Chair and other members of the Board of Directors shall be appointed in accordance with paragraphs 34 and 37 of the Constitution.

Terms of office of the Chair and other members of the Board of Directors

2.3 The period of tenure, suspension and removal of the Chair and other members of the Board of Directors shall be in accordance with paragraphs 34, 35, 37 and 38 of the Constitution.

Appointment and powers of the Deputy Chair

2.4 The Deputy Chair shall be appointed in accordance with paragraph 36 of the Constitution.

2.5 Any appointment as Deputy Chair shall be for a period not exceeding the remainder of his existing term of office as a Non-Executive Director or as specified by the Council of Governors on appointment.

2.6 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. Thereupon, the Council of Governors may appoint another Non-Executive Director as Deputy Chair in accordance with paragraph 36 of the Constitution.

2.7 The Deputy Chair may act as Chair in accordance with paragraph 36.6 of the Constitution or if the Chair of the Foundation Trust has died or has ceased to hold office.

2.8 In the event of circumstances provided by paragraph 36.6 of the Constitution and/or 3.1.4.4 of the Standing Orders, references to the Chair in these Standing Orders shall be taken to include references to the Deputy Chair.

Appointment of a Senior Independent Director

2.9 The Board of Directors may appoint a Non-Executive Director to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a member of the Board of Directors, as they may specify on appointment him. The appointment for the Senior Independent Directors shall be made in accordance with paragraph 36 of the Constitution.

2.10 If a Non-Executive Director resigns from the office of Senior Independent Director (in accordance with paragraph 36.3 of the Constitution), the Board of Directors may appoint another Non-Executive Director as Senior Independent Director in accordance with the provisions of Standing Order 2.9.

3 Role of members of the Board of Directors

Corporate role of the Board of Directors

3.1 All business shall be conducted in the name of the Foundation Trust.

3.2 All funds received in trust shall be held in the name of the Foundation Trust as corporate trustee.

3.3 The powers of the Foundation Trust established under statute shall be exercised by the Board of Directors meeting in public session except as otherwise provided by paragraph 39 and Annex 6 (Conduct of meetings of the Council of Governors and the Board of Directors) of the Constitution.

3.4 The Board of Directors will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Foundation Trust in carrying out its statutory and other functions.

3.5 The Foundation Trust has the functions conferred on it by the Regulatory Framework. Directors acting on behalf of the Trust as corporate trustees are acting as quasi trustees. Accountability for charitable Funds held on Trust is to the Charity Commission and to the Regulator. Accountability for non-charitable Funds held on Trust is only to the Regulator.

Chief Executive

3.6 The Chief Executive shall be responsible for the overall performance of the executive functions of the Foundation Trust. The 2006 Act designates the Chief Executive of an NHS foundation trust as the accounting officer. The Chief Executive shall be responsible for ensuring the discharge of obligations under applicable financial directions, the Regulator's guidance and in line with the requirements of the NHS foundation trust accounting officer memorandum.

Finance director

3.7 The finance director shall be responsible for the provision of financial advice to the Foundation Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems. The finance director shall be responsible along with the Chief Executive for ensuring the discharge of obligations under applicable financial directions and the regulator's guidance.

Medical director

3.8 The medical director shall be responsible for effective professional leadership and management of medical staff of the Foundation Trust and shall be the responsible officer for NHS medical revalidation. The medical director shall provide advice to the Chief Executive and the Board of Directors on key strategic medical efficacy issues and matters relating to the medical workforce of the Foundation Trust.

Director of nursing

3.9 The director of nursing shall be responsible for effective professional leadership and management of nursing staff of the Foundation Trust and is the Caldicott guardian. The director of nursing shall provide advice to the Chief Executive and the Board of Directors on

key strategic care quality issues and matters relating to the nursing workforce of the Foundation Trust.

Non-Executive Directors

3.10 The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Foundation Trust. They may, however, exercise collective authority when acting as the Board of Directors or when chairing a Committee of the Board of Directors which has delegated authority to act on behalf of the Board of Directors.

Chair

3.11 The Chair shall be responsible for the operation of the Board of Directors and shall chair all meetings of the Board of Directors when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

3.12 The Chair shall liaise with the Council of Governors and its appointments committee over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for the Non-Executive Directors' induction, portfolio of interests, assignments and performance.

3.13 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors.

3.14 The Chair shall ensure that the designation of lead roles or appointments of members of the Board of Directors as required by the Regulator or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

Corporate role of the Council of Governors

3.15 The Council of Governors shall fulfil its statutory duties in accordance with the Regulatory Framework.

Schedule of matters reserved to the Board of Directors and the Scheme of Delegation

3.16 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors meeting in formal session. These powers are set out in the Reservation of Powers and Scheme of Delegation and shall have effect as if incorporated into these Standing Orders.

3.17 Subject to the Regulatory Framework and such guidance or best practice as may be issued by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a Committee or sub-committee of the Board of Directors or by a Director or an officer in each case subject to such restrictions and conditions as the Board of Directors considered appropriate. The powers and decisions which the Board of Directors has delegated to Committees, sub-committees, Directors or Officers are set out in the Reservation of Powers and Scheme of Delegation.

4 Meetings of the Board of Directors

Calling meetings

4.1 Subject to Standing Orders 4.2 and 4.3 below, meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

4.2 The Chair may call a meeting of the Board of Directors at any time.

4.3 One third or more of the whole number of members of the Board of Directors may requisition a meeting in writing to the Chair. If the Chair refuses or fails to call a meeting within seven Clear Days of a requisition being presented, the members of the Board of Directors who signed the requisition may forthwith call a meeting of the Board of Directors.

Notice of meetings and the business to be transacted

4.4 Before each meeting of the Board of Directors, a written notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer authorised by the Chair to sign on his/her behalf shall be delivered to every Director (this includes email), or sent by post to the usual place of residence of such Director, so as to be available to him at least four Clear Days before the meeting

4.5 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.6 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.7 Before each meeting of the Board of Directors a public notice of the time and place of the meeting, and the public part of the agenda and associated papers shall be published on the Foundation Trust's website at least three (3) Clear Days before the meeting, save in the case of emergencies.

4.8 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SO 3.8 and (where relevant SO 3.11 above) shall not prevent the calling of, or invalidate, such a meeting without the requisite notice provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

Setting the agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted (“standing Items”).

4.9 A member of the Board of Directors who desires a matter to be included on an agenda, other than a Standing Item or a motion, should make his/her request in writing to the Chair at least ten (10) Clear Days before the meeting. Requests made less than ten (10) Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

4.10 No business shall be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chair, in his/her absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by

the Board of Directors as a matter of urgency. A decision by the Chair to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

Agenda and supporting papers

4.11 Before each meeting of the Board of Directors, an agenda of the meeting and any supporting papers will be provided electronically to each member of the Board of Directors at least three (3) Clear Days before the meeting, save in an emergency. Failure to serve such a notice on more than three (3) Directors will invalidate the meeting.

Petitions

4.12 Where a petition has been received by the Foundation Trust, the Secretary shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

Notice of motion

4.13 A Director desiring to move or amend a Motion shall send a written notice thereof at least ten (10) Clear Days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under these SOs. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda. A Motion may be proposed by the Chair of the meeting or any member of the Board of Directors present. It must also be seconded by another member of the Board of Directors.

Withdrawal of motion or amendments

4.14 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair

Motion to rescind a resolution

4.15 Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four (4) other members of the Board of Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within six (6) months; however the Chair may do so if he/she considers it appropriate.

Emergency motions

4.16 Subject to the agreement of the Chair, a member of the Board of Directors may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared by the Chair to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

Motions: procedure at and during a meeting

4.17 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.18 When a motion is under discussion or immediately prior to discussion it shall be open to a member of the Board of Directors to move:

4.18.1 an amendment to the motion; or

4.18.2 the adjournment of the discussion or the meeting; or

4.18.3 that the meeting proceed to the next item of business; (*) or

4.18.4 the appointment of an ad hoc committee to deal with a specific item of business; or

4.18.5 that the motion be now put (*); or

4.18.6 a motion resolving to exclude the public (including the press).

*In the case of Standing Orders denoted by (*) above to ensure objectivity motions may only be put by a member of the Board of Directors who has not previously taken part in the debate and who is eligible to vote.

4.19 No amendment to the motion shall be admitted if, in the opinion of the Chainman, the amendment negates the substance of the motion.

Written motions

4.20 In urgent situations and with the consent of the Chair, business may be effected by a member of the Board of Directors written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

4.21 If all members of the Board of Directors have been notified of the proposal and a simple majority of the member of the Board of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Secretary within five (5) Clear Days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gathered in one place.

4.22 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date a member of the Board of Directors who has previously indicated acceptance can withdraw and the motion shall fail.

4.23 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

Chair of meeting

4.24 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair (if the board has appointed one), if present, shall preside. If the Chair and any Deputy Chair are absent, such Non-Executive Director as the Chair has previously designated or, in the absence of such designation or the designated Non-Executive Director being absent, as the Directors present choose, will preside.

4.25 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair of the Board of Directors, if present, shall preside. If the Chair and Deputy Chair of the Board of Directors are absent, or are disqualified from participating, such Non-Executive Director as the Chair has previously designated or, in the absence of such designation or the designated Non-Executive Director being absent (on the grounds of declared conflict of interest or otherwise), as the Directors present shall choose, shall preside.

4.26 If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chair or the Non-Executive Directors as a class, neither the Chair nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under discussion. The Directors (excluding the Chair and the Non-Executive Directors) shall elect one of the number to preside during that period and that person shall exercise all the rights and obligations of the Chair, including (for the avoidance of doubt) the right to exercise a second or casting vote where the numbers of votes for and against a motion is equal. The Directors shall consider whether in fact the matter for consideration requires referral to the Council of Governors.

Chair's ruling

4.27 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of these Standing Orders and Standing Financial Instructions will be final.

Quorum

4.28 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the voting members of the Board of Directors are present, including at least one voting Executive Director and one Non-Executive Director.

4.29 In accordance with Annex 7 (Meetings of the Council of Governors and the Board of Directors – Electronic Communication) of the Constitution, members of the Board of Directors participating in meetings of the Board of Directors by telephone, video or computer link or other such agreed means shall count towards the quorum for so long as the members have the ability to communicate interactively and simultaneously with all members of the Board of Directors in attendance at the meeting, including all member attending by way of electronic communication.

4.30 An officer in attendance for an Executive Director member but without formal acting up status may not count towards the quorum.

4.31 If the Chair or another member of the Board of Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that individual will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be voted upon at that meeting. Such a position will be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting of the Board of Directors (for example when the Board of Directors considers the recommendations of the Remuneration Committee). The requirement for at least one Non-Executive Director to form part of the quorum shall not apply where the Non-Executive Directors are excluded from a meeting of the Board of Directors.

Voting

4.32 Subject to Standing Orders 4.38 to 4.41 or as otherwise provided by the Standing Orders, every question put to vote at a meeting shall be determined by a majority of the votes of the members of the Board of Directors present and voting on the question and in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

4.33 At the discretion of the Chair, all questions put to the vote will be determined by oral expression or by a show of hands. Any voting member of the Board of Directors attending by telephone, video or computer link shall cast their vote verbally and such action shall be recorded in the minutes of the meeting.

4.34 If at least one-third of the voting members of the Board of Director so request, the voting (other than by paper ballot) on any question may be recorded to show how each members present voted or abstained.

4.35 A paper ballot may be used if a majority of the voting members of the Board of Directors present so request, in which case any person attending by telephone, video or computer link shall cast their vote verbally and such action shall be recorded in the minutes of the meeting. If a Director so requests, his/her vote shall be recorded by name.

4.36 An officer, who has been appointed formally by the Board of Directors to act up for a voting Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, will be entitled to exercise the voting rights of the Executive Director. An officer attending the meeting of the Board of Directors to represent a voting Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Member. An officer's status when attending a meeting will be recorded in the minutes of the meeting.

4.37 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

Suspension of Standing Orders

4.38 Except where this would contravene any statutory provision of the Regulatory Framework or any guidance or best practice issued by the Regulator, any one or more of these Standing Orders may be suspended at any meeting of the Board of Directors, provided that at least two-thirds of the whole number of the voting members of the Board of Directors are present (including at least one voting Executive Director and one Non-Executive Director) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension will be recorded in the minutes of the meeting.

4.39 A separate record of matters discussed during the suspension of Standing Orders will be made and will be available to the Chair and members of the Board of Directors. This record of matters is separate from the minutes of the meeting of the Board of Directors.

4.40 No formal business may be transacted while Standing Orders are suspended.

4.41 The audit committee shall review every decision to suspend Standing Orders.

Variation and amendment of Standing Orders

4.42 These Standing Orders may be amended only if:

4.42.1 a notice of motion under Standing Orders 4.14 has been given;

4.42.2 upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting of the Board of Directors;

4.42.3 at least two-thirds of the member of the Board of Directors are present at the meeting where the variation is being discussed;

4.42.4 at least half of the Non-Executive Directors vote in favour of the amendment; and

4.42.5 the variation proposed does not contravene a statutory provision, direction or guidance or best practice advice issued by the Regulator, or the terms of the Foundation Trust's Constitution.

Minutes

4.43 The names of the Chair and members of the Board of Directors present shall be recorded in the minutes of the meeting.

4.44 The minutes of the proceedings of a meeting of the Board of Directors will be drawn up by the Secretary and submitted for agreement at the next ensuing meeting of the Board of Directors, to be signed by the person presiding at it.

4.45 No discussion will take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

Admission of the public and the press

4.46 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board of Directors but shall be required to withdraw upon the board resolving as follows:

"*That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest*".

4.47 The Chair or person presiding over the meeting of the Board of Directors will give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business can be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Board of Directors resolving as follows:

"*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board of Directors to complete its business without the presence of the public or press".*

4.48 Matters to be dealt with by the Board of Directors following the exclusion of representatives of the press, and other members of the public, shall be confidential to the members of the Board of Directors, nominated officers, officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any

discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.

Use of equipment for recording or transmission of meetings

4.49 Nothing in these Standing Orders shall require the Board of Directors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board of Directors.

Observers

4.50 The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any meetings of the Board of Directors and may change, alter or vary these terms and conditions as it deems fit.

5 Committees

5.1 Subject to the Regulatory Framework and such guidance issued by the Regulator, the Board of Directors may and, if directed by the Regulator shall, appoint Committees of the Trust, consisting wholly or partly of members of the Board of Directors of the Trust. The Board of Directors may only delegate its powers to such a Committee if that Committee consists entirely of Directors of the Trust.

5.2 A committee or joint committee appointed under this Standing Order 5 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be issued by the Regulator or the Board of Directors or other Health Service Bodies in question, appoint sub-committees consisting wholly or partly of members of the Committee (whether or not they are members of the Board of Directors); or wholly of persons who are not members of the Board of Directors subject to the same proviso as in this Standing Order 6.3 to 6.5 relating to membership of the Committee and delegation of powers.

5.3 The Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or sub-committees established by the Board of Directors. In such a case the term "Chair" is to be read as a reference to the Chair of the Committee or sub-committee as the context permits, and the term "Director" is to be read as a reference to a member of the Committee also as the context permits. (There is no requirement to hold meetings of Committees or sub-committees established by the Foundation Trust in public.)

5.4 The Board of Directors shall approve the appointments to each of the Committees, which it has formally constituted. Where the Board of Directors determines and regulations permit that persons, who are neither Directors nor officers, shall be appointed to a Committee the terms of such appointment shall be determined by the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with its Constitution. The Board of Directors may elect to change the committees, sub-committees and joint-committees of the Board of Directors, as necessary, without requirement to amend these Standing Orders.

5.5 The Board of Directors shall also determine the terms of reference of Committees and sub-committees and shall, if it requires to, receive and consider reports of such Committees

5.6 The Committees established by the Board of Directors are:

5.6.1 Audit Committee (also in accordance with paragraph 47 of the Constitution)

5.6.2 Nomination and Remuneration Committee (also in accordance with paragraphs 37.3 and 37.4 of the Constitution)

5.7 In addition, the Board of Directors shall establish and maintain the following Committees:

5.7.1 Finance and Performance Committee

5.7.2 Quality and Governance Committee

5.7.3 Charity Committee.

5.8 The Board of Directors may also establish such Committees as it requires to discharge the Foundation Trust's responsibilities.

5.9 Terms of reference for Committees established by the Board of Directors will be reviewed annually, approved by the Board of Directors and published on the Foundation Trust's website.

Appointments for statutory functions

5.10 Where the Board of Directors is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Regulator, and where such appointments are to operate independently of the Board of Directors, such appointment shall be made in accordance with the regulations and directions issued by the Regulator.

Joint committees[1]

5.11 Joint committees may be appointed by the Board of Directors, by joining together with one or more bodies consisting of, wholly or partly of the Chair and Directors of the Foundation Trust or other bodies, or wholly of persons who are not Directors of the Trust or other bodies in question.

5.12 Any Committee or joint committee appointed under this Standing Order may, subject to such directions or guidance as may be issued by the Regulator or the Foundation Trust, appoint sub-committees consisting wholly or partly of members of the Committee(s) or joint committee(s) or wholly of other persons provided that the Foundation Trust is always represented by an Executive Director on such Committees, joint committees or sub-committees.

Terms of reference

5.13 Each such Committee and sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting to the Board of Directors) as the Board of Directors shall decide and shall be in accordance with any legislation and/or guidance and/or best practice issued by the Regulator. Such terms of reference shall have effect as if incorporated in the Standing Orders. Where Committees are authorised to establish sub-committees they may not delegate executive powers to sub-committee unless expressly authorised by the Board of Directors.

Delegation of powers

5.14 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

5.15 In the event of an urgent decision required by the Board of Directors or a sub-committee, such a decision can be considered by a Committee by email or other electronic correspondence. This is subject to the quorum of the Board of Directors or sub-committee endorsing the required decision.

Confidentiality

5.16 A member of a committee, sub-committee or joint committee shall not disclose a matter dealt with, by, or brought before, the committee without its permission until the Committee, sub-committee or joint committee (as appropriate) shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

[1] Please note that all decisions of the joint committee will need to be ratified by the Board of Directors

5.17 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, sub-committee or joint committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee, sub-committee or joint committee shall resolve that it is confidential.

6 Arrangements for the exercise of board functions by delegation

6.1 Subject to the Regulatory Framework and such guidance or best practice as may be issued by the Regulator, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee or by a Director or an officer of the Foundation Trust in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

Emergency powers

6.2 The powers which the Board of Directors has reserved to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification (unless for reasons of the nature of the information for example it is privileged, not disclosable or of commercial sensitivity when it will need to go to the confidential session). The Board of Directors may also instruct the Chair to take certain actions and report back to a subsequent meeting.

Delegation to Committees

6.3 The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by Committees, or sub-committees, or joint committees, which it has formally constituted in accordance with the Constitution. The Constitution and the terms of reference of these Committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors.

6.4 When the Board of Directors is not meeting as the Foundation Trust in public session it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Foundation Trust in public session.

Delegation to Officers

6.5 Those functions of the Foundation Trust which have not been retained as reserved by the Board of Directors or delegated to a Committee or sub-committee or joint committee shall be exercised on behalf of the Foundation Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Foundation Trust.

6.6 The Chief Executive shall prepare the Scheme of Delegation and Reservation of Powers identifying his/her proposals, which shall be considered and approved by the Board of Directors, subject to any amendment, agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation and Reservation of Powers which shall be considered and approved by the Board of Directors.

6.7 Nothing in the Scheme of Delegation and Reservation of Powers shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director to provide

information to and advise the Board of Directors in accordance with statutory requirements. Outside these statutory requirements, the Finance Director shall be accountable to the Chief Executive for operational matters.

6.8 The arrangements made by the Board of Directors as set out in the Scheme of Delegation and Reservation of Powers shall have effect as if incorporated in these SOs, but for the avoidance of doubt, neither these SOs nor the Scheme of Delegation and Reservation of Powers form part of the Constitution.

Duty to report non-compliance with Standing Order

6.9 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or approval. All members of the Board of Directors and officers have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

7 Declaration of interests

7.1 These Standing Orders and Standing Financial Instructions must be read in conjunction with paragraph 40 and Annex 8 (Conflicts of Interest of Governors and Directors) of the Constitution which shall have effect as if incorporated in this Standing Order.

7.2 Notwithstanding the application of paragraph 40 of the Constitution, all members of the Board of Directors should declare the nature and extent of all relevant and material interests on appointment to the Foundation Trust and thereafter at the beginning of each financial year and when a declaration becomes inaccurate, incomplete or obsolete. Directors' interests should be recorded in the Board of Directors' minutes. Any changes of interests should be declared at the next meeting of the Board of Directors following the change occurring, recorded in the minutes of that meeting and added to the register of interests.

7.3 It is the obligation of the Director to inform the Secretary of the Trust in writing within seven (7) days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register of interest of Directors.

7.4 If members of the Board of Directors have any doubt about the relevance of an interest, this should be discussed with the Secretary or Chair.

7.5 During the course of a Board of Directors meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

Disability of Chair and Directors in proceedings on account of pecuniary interest

7.6 Subject to the provisions of this Standing Order, if the Chair or a member of the Board of Directors has any Pecuniary Interest, direct or indirect, in any contract, proposed contract or other matter is present a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.7 Subject to applicable legislation, the Regulator may, subject to such conditions as it may think fit to impose, remove any disability imposed by this standing order in any case in which it appears to it in the interests of the National Health Service that the disability should be removed

7.8 The Board of Directors may exclude the Chair or a member of the Board of Directors from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he/she has a Pecuniary Interest is under consideration.

7.9 This standing order applies to a Committee or a sub-committee and a joint committee as it does to the Board of Directors and applies to a member of any such Committee (whether or not he/she is also a Director) as it applies to a member of the Board of Directors.

Interests of officers in contracts

7.10 Any Director or Officer of the Foundation Trust who comes to know that the Foundation Trust has entered into or proposes to enter into a contract in which he/she or their spouse, civil partner or co-habitee has any Pecuniary Interest, direct or indirect, the Director or officer shall declare their interest by giving notice in writing of such fact to the Secretary as soon as practicable.

7.11 A Director or Officer should also declare to the Secretary any other employment or business of other relationship of his, or of its spouse, civil partner or co-habitee that conflicts, or might reasonably be predicted could conflict with the interests of the Foundation Trust.

7.12 The Foundation Trust will require interests, employment or relationships so declared to be entered in a register of interests of members of staff.

Fit and proper person test

7.13 As established by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**the Regulations**"), the Trust has a duty not to appoint a person or to 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 persons test”.

7.14 In accordance with its fit and proper person requirements policy, the Trust requires Executive and Non-Executive Directors of the Board of Directors to declare on appointment and thereafter annually that they remain a fit and proper person to be employed as a Director.

7.15 If members of the Board of Directors have any doubt about the Regulations or declarations, this should be discussed with the Secretary or Chair.

7.16 The consequences of false, inaccurate, or incomplete information by individuals subject to the Regulations may be their removal from office pending the outcome of an investigation.

Duty of candour

7.17 As established by Regulation 20 of the Regulations, the Trust has a duty to act in an open and transparent way with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

7.18 In accordance with its being open / duty of candour policy, the Trust requires that all relevant Officers apply the following key principles of candour when communicating with patients, their families and carers following a patient safety incident, complaint or claim where a patient was harmed:

7.18.1 acknowledge, apologise and explain when things go wrong;

7.18.2 conduct a thorough investigation into the patient safety incident and reassuring patients, their families and carers that lessons learned will help prevent the patient safety incident recurring;

7.18.3 provide support for those involved to cope with the physical and psychological consequences of what happened.

C**anvassing of and recommendations by Directors in relation to appointments**

7.19 Directors or members of any Committee of the Board of Directors may be approached by candidates wishing to increase their understanding of the organisation during the appointment process. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the appointing panel or committee.

7.20 Directors shall not solicit for any person any appointment under the Foundation Trust or recommend any person for such appointment; but this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Foundation Trust.

~~7.21 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.~~

Relatives of Directors or Officers

~~7.22~~7.21 Candidates for any staff appointment under the Foundation Trust shall, when making an application, disclose in writing to the Chief Executive whether they are related to any Director or the holder of any office under the Foundation Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

~~7.23~~7.22 The Chair and every Director and officer of the Foundation Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Board of Directors on any such disclosure made.

~~7.24~~7.23 Prior to acceptance of any appointment, Executive Directors should disclose to the Chief Executive whether they are related to any other Director or holder of any office under the Foundation Trust.

~~7.25~~7.24 On appointment, Directors should disclose to the Board of Directors whether they are related to any other Director or holder of any office under the Foundation Trust.

7.267.25 Where the relationship to a Director of the Foundation Trust is disclosed, Standing Orders in respect to the 'Disability of Chair and Directors in proceedings on account of pecuniary interest' shall apply.

8 Standards of business conduct policy

8.1 Directors and officers should comply with the Foundation Trust's standards of business conduct policy and relevant codes of conduct.

8.2 Members of the Board of Directors must also comply with the Foundation Trust's annual declarations by Directors process.

9 Overlap with other policy statements, procedures, regulations and standing financial instructions

Policy statements: general principles

9.1 The Board of Director, Committees, sub-committees and joint committees will from time to time agree and approve policy statements and procedures which will apply to all or specific groups of officers of the Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate meeting minutes and will be deemed where appropriate to be an integral part of the Foundation Trust's Standing Orders and Standing Financial Instructions.

Specific policy statements

9.2 These Standing Orders and the Standing Financial Instructions should be read in conjunction with the following policy statements:

9.2.1 Standards of business conduct policy

9.2.2 Disciplinary policy and procedure

9.2.3 Appeals policy and procedure

9.2.4 Raising concerns (whistleblowing) policy

all of which shall have effect as if incorporated in these Standing Orders.

Specific guidance

9.3 These Standing Orders and the Standing Financial Instructions must be read in conjunction with current legislation and guidance and any other relevant guidance issued by the Regulator.

10 Custody of seal and sealing of documents

Custody of seal

10.1 The Secretary shall keep the seal of the Foundation Trust in a secure place.

Sealing of Documents

10.2 Documents can only be sealed once they have been authorised by a resolution of the Board of Directors or of a committee thereof, or where the Board of Directors has delegated its powers.

10.3 Building, engineering, property or capital documents do not require authorisation by Board of Directors or a committee thereof, but before presenting for seal these documents do require the approval and signature of the Finance Director (or an officer nominated by him/her) and the authorisation and countersignature of the Chief Executive (or an officer nominated by him/her who shall not be within the originating directorate).

10.4 The fixing of the seal shall be authenticated by the signature of the Chair (or the Deputy Chair in the absence of the Chair) and one Executive Director.

Register of sealing

10.5 An entry of every sealing shall be made in a record provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least annually. The report shall contain details of the description of the document and date of sealing.

11 Signature of documents

11.1 Where any document will be a necessary step in legal proceedings on behalf of the Foundation Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or nominated Executive Director.

11.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Foundation Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any Committee, sub-committee or joint committee with delegated authority.

12 Miscellaneous

Standing Orders to be given to Directors and Officers

12.1 It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of SOs.

Documents having the standing of Standing Orders

12.2 SFIs and the Scheme of Delegation shall have effect as if incorporated into these Standing Orders.

Review of Standing Orders

12.3 Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in the Standing Orders.

Joint finance arrangements

12.4 The Board of Directors may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 75 of the 2006 Act. The Board of Directors may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 75 of the 2006 Act.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**4 July 2019**		**Agenda reference:**	**121-19**	
Report title:	**Audit committee assurance**				
Sponsor:	Kevin Gould, committee Chair				
Author:	Kevin Gould, 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 19 June 2019				
Summary of key issues	The Committee received updated assurance on KSO1 & KSO2. It also received updates and actions taken to address issues raised by KPMG in the 2018/19 audit and reports and updates from Internal Audit (Mazars). The Internal Audit and Counter Fraud plans for 2019/20 were presented by RSM and approved by the Committee.				
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:	Reviewed BAF for KSO 1 & 2				
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:	4 July 2019
Reference number:	121-19
Report from:	Kevin Gould, Chair
Author:	Kevin Gould, Chair
Appendices:	N/A
Report date:	25 June 2019

Audit Committee report
Meeting held on 19 June 2019

1. The Committee received an assurance update on KSO1 and KSO2 from the Director of Nursing and Medical Director. The committee was assured by the mitigation in place to address the risks identified.

2. The Committee received a review of the 2018/19 financial accounts production process and external audit. It was agreed that the Director of Finance and Chair of Audit Committee would meet with KPMG to discuss the process for the next year.

3. The Committee received a report from Finance detailing actions against the issues raised by KPMG and Internal Audit. It will continue to monitor progress at each meeting.

4. An update of the discrepancies found by KPMG on operational data was also received, and the Committee was assured that plans are in place to address the underlying issues.

5. Mazars advised that seven internal audit reports had been issued since the March meeting as follows:
    - Assurance Framework and Risk Management (substantial Assurance, no issues)
    - Patient and Staff Safety including Serious Incidents (satisfactory assurance)
    - Key Financial Controls (satisfactory assurance)
    - Data and Security Protection (DSP) Toolkit (satisfactory assurance)
    - Information Technology – Kainos Evolve Application Audit (satisfactory assurance)
    - Consultants Contracts (satisfactory assurance)
    - Estates and Capital Planning (limited assurance, one high priority recommendation)

    Two reports remain outstanding although both have now been issued in draft.

6. RSM, the new Internal Audit and Counter Fraud provider presented its plan for 2019/20. After some discussion, this was approved by the Committee.

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

8. The Committee reviewed changes to standing orders, Reservation of Powers & Scheme of Delegation. It also reviewed standing financial instructions, and changes to accounting policies. With minor changes, all were recommended for approval by the board.

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