Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 5 September 2019

Session in public
10am – 1pm

Archibald McIndoe meeting room
Queen Victoria Hospital
Holtye Road
East Grinstead
West Sussex
RH19 3DZ

Queen Victoria Hospital
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 5 September 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
Director of Communications and Corporate Affairs	-	Clare Pirie
Deputy Company Secretary (minutes)	-	Hilary Saunders
Lead governor	-	Peter Shore

Annual declarations by directors 2019/20

Declarations of interests

As established by section 40 of the Trust's Constitution, a director of the Queen Victoria Hospital NHS Foundation Trust has a duty:

- to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust.
- not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
- to declare the nature and extent of any relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the
- foundation trust to the other directors.

To facilitate this duty, directors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the Deputy Company Secretary.

Register of declarations of interests

	Relevant and material interests						
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	• Director: Professional Governance Services Ltd • Director, Longmeadow Views Management Co Ltd	Part owner of Professional Governance Services Ltd	NA	Nil	PGS charity clients may contract with NHS organisations, (not QVH)	Nil	Nil
Kevin Gould Non-Executive Director	• Director, Sharpthorne Services Ltd. • Director CIEH Ltd	Nil	Nil	• Trustee and Deputy Chair, Chartered Institute of Environmental Health • Independent member of the Board of Governors at Staffordshire University	Nil	Nil	Nil
Gary Needle Non-Executive Director	• Director, Gary Needle Ltd, (management consultancy) • Director, T& G Property Ltd	Nil	Nil	• Chair of Board of Trustees at East Grinstead Sports Club Ltd (registered sport and lifestyle activities charity)	Nil	Nil	Nil

Karen Norman Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	Nl
John Thornton Senior Independent Director	Chair: Golden Charter Ltd	Nil	Nil	Nil	Nil	Nil	Nil
Steve Jenkin Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Michelle Miles, Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Ed Pickles Medical Director	Nil	Nil	Nil	Nil	I am a member of EGAS (East Grinstead Anaesthetic Services). A partnership of QVH anaesthetic consultants who provide some perioperative and anaesthetic care to patients in local independent sector hospitals. This is predominantly private patients, but may include NHS patients where QVH or other trust has commissioned NHS care to be provided by an independent hospital. Time spent working in the independent sector is clearly delineated in my QVH job plan.	Nil	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Abigail Jago Director of operations	Nil	Nil		Nil	Nil	Nil	Nil
Geraldine Opreshko Director of HR & OD	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Pirie Director of Communications & Corporate Affairs	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper person declarations

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director of the trust under given circumstances known as the "fit and proper person test".

By completing and signing an annual declaration form, QVH directors confirm their awareness of any facts or circumstances which prevent them from holding office as a director of QVH NHS Foundation Trust.

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	NA	NA	NA	NA	NA	NA	NA
Kevin Gould Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Gary Needle Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
John Thornton Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Karen Norman Non-Executive Director	NA	NA	NA	NA	NA	NA	NA
Steve Jenkin Chief Executive	NA	NA	NA	NA	NA	NA	NA
Michelle Miles Director of Finance	NA	NA	NA	NA	NA	NA	NA
Ed Pickles Medical Director	NA	NA	NA	NA	NA	NA	NA
Jo Thomas Director of Nursing	NA	NA	NA	NA	NA	NA	NA
Other members of the board (non-voting)							
Abigail Jago Director of operations	NA	NA	NA	NA	NA	NA	NA
Geraldine Opreshko Director of HR & OD	NA	NA	NA	NA	NA	NA	NA

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Clare Pirie Director of Communications & Corporate Affairs	NA	NA	NA	NA	NA	NA	NA

Business meeting of the Board of Directors
Thursday 5 September 2019
10:00 – 13:00
Archibald McIndoe meeting room, Queen Victoria Hospital RH19 3DZ

Agenda: session held in public			
Welcome			
132-19	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*		
Standing items		**Purpose**	**Page**
133-19	**Patient story** *Jo Thomas, Director of nursing*	*assurance*	-
134-19	**Draft minutes of the meeting held in public on 04 July 2019** *Beryl Hobson, Chair*	*approval*	1
135-19	**Matters arising and actions pending** *Beryl Hobson, Chair*	*review*	10
136-19	**Chair's report** *Beryl Hobson, Chair*	*assurance*	11
137-19	**Chief executive's report** *Steve Jenkin, Chief executive*	*assurance*	14
138-19	**Freedom to speak up** *Sheila Perkins, FTSU guardian*	*assurance*	21
Key strategic objectives 3 and 4: operational excellence and financial sustainability			
139-19	**Board Assurance Framework** *Abigail Jago, Director of operations and* *Michelle Miles, Director of finance*	*assurance*	24
140-19	**Financial, operational and workforce performance assurance** *John Thornton, Committee chair*	*assurance*	26
141-19	**Operational performance** *Abigail Jago, Director of operations*	*assurance*	29
142-19	**Financial performance** *Michelle Miles, Director of finance*	*assurance*	63
Key strategic objectives 1 and 2: outstanding patient experience and world-class clinical services			
143-19	**Board Assurance Framework** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*assurance*	73

144-19	**Quality and governance assurance** *Karen Norman, Non-executive director*	*assurance*	75
145-19	**QVH risk appetite statement 2019/20** *Jo Thomas, Director of nursing*	*approval*	81
146-19	**Corporate risk register (CRR)** *Jo Thomas, Director of nursing*	*review*	87
147-19	**Quality and safety report** *Jo Thomas, Director of nursing, and* *Ed Pickles, Medical director*	*assurance*	93
148-19	**Paediatric burns update** *Ed Pickles, Medical director*	*information*	129
149-19	**Clinical strategy priorities update** *Ed Pickles, Medical director*	*assurance*	135
150-19	**Safeguarding annual report** *Jo Thomas, Director of nursing*	*approval*	149
151-19	**Infection prevention and control annual report** *Jo Thomas, Director of nursing*	*approval*	184
152-19	**Patient experience annual report** *Jo Thomas, Director of nursing*	*approval*	218
153-19	**Emergency Preparedness Resilience and Response and Business Continuity annual report** *Jo Thomas, Director of nursing*	*approval*	236
154-19	**Research and development annual report** *Ed Pickles, Medical director*	*approval*	246
155-19	**Consultant revalidation annual report** *Ed Pickles, Medical director*	*approval*	275
Key strategic objective 5: organisational excellence			
156-19	**Board assurance framework** *Geraldine Opreshko, Director of workforce and OD*	*assurance*	285
157-19	**Workforce monthly report including:** 1. Workforce Race Equality Standard (WRES) 2. Workforce Disability Equality Standard (WDES) *Geraldine Opreshko, Director of workforce and OD*	*assurance*	286
Governance			
158-19	**Nomination and remuneration committee assurance** *Beryl Hobson, Chair*	*assurance*	-
Any other business (by application to the Chair)			
159-19	*Beryl Hobson, Chair*	*discussion*	-

Questions from members of the public			
160-19	*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**: 07 November 2019 at 10:00	**Council of governors** **Public**: 14 October 2019 at 16:00

For accuracy, it should be noted that items [119-19] and [120-19] were taken ahead of [117-19]

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 4 July 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)
	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 98-19)**
	Dave Hurrell (DH)	Deputy director of workforce
Apologies:	Geraldine Opreshko (GO)	Director of workforce and OD (non-voting)
Public gallery:	Five members of the public including three governors.	

Welcome	
97-19	**Welcome apologies and declarations of interest** The Chair opened the meeting and welcomed members of the public. She noted GO's apologies and welcomed DH who was representing her at today's meeting. There were no new declarations of interest.
Standing items	
98-19	**Patient story** A patient (Mr S.) had written recently to the Director of Nursing commending the quality of care he had received from the team in MIU. His wife (Mrs S.) had subsequently agreed to join today's meeting to feedback on his experience. She opened by explaining that although her husband had been attending MIU following a fall, he was also managing a range of co-morbidities. Gill McMurdie, the nurse treating him had been concerned at how he had presented initially and urged him to attend East Surrey Hospital for further investigations. As a result of this assessment, Mr S. had subsequently been admitted by East Surrey NHS Trust for emergency surgery which had probably saved his life. Whilst he was still very frail his mobility had improved and Mrs S. applauded the holistic care and attention provided by Gill, and also praised Lesley Fritter, the receptionist on duty at the time. Whilst noting that this case reflected the majority of care provided at QVH, the Board asked if there was anything that could have improved their overall experience. Although not affected directly, Mrs S. remarked on the frustration expressed by other patients at the length of waiting times. JMT advised that the Trust was currently looking into the feasibility of an MIU appointments system, which may go some way to addressing this. The Chair thanked Mrs S. for attending today's meeting and on behalf of the Board would write to thank Gill McMurdie and Lesley Fritter.**[Action: BH]**
99-19	**Draft minutes of meeting held in public on 2 May 2019** The draft minutes of the meeting held in public on 2 May were **approved** as a correct record, subject

	to the following amendments: • 82-19 (Paediatric burns business case): The wording of the Board's decision to engage with commissioners and the LSEBN to seek support for provision of additional mitigations, (including a temporary divert of inpatient paediatric burns patients), would be made more explicit. • 87-19: Operational performance to read: *'… e-Vetting has been rolled out on DeRS; eRS e-vetting is being piloted with a view to roll out but will be dependent on fit with other projects*.'
100-19	**Matters arising and actions pending** The Board received and approved the current record of matters arising and actions pending. As part of this, the Board formally **approved** a decision taken at the June seminar (acting on the advice of CQC) regarding revised Statutory and Mandatory training requirements. The new standard would now be 90%.
101-19	**Chair's report** The Chair presented her report, asking the Board to note that this should have read: *'at the last board meeting we congratulated the **Maxfacs** team for a significant improvement in their waiting times, which is due to a great team effort.'* There were no further comments and the Board **noted** the contents of the update.

102-19	**Chief executive's report**
	SJ presented the content of his regular update as follows:
	
	<u>CEO report:</u>
	Highlights of his report included:
	• Publication of the Care Quality Commission (CQC) report, with QVH retaining its overall Good rating and maintaining Outstanding for the caring domain.
	• Results of the NHS inpatient survey 2018, with only eight acute specialist trusts categorised within the highest band, including QVH.
	• Thanks to the League of Friends which had been a tremendous supporter of the hospital, last year committing expenditure of over £475,000.
	• The recent Volunteers coffee morning, which SJ and JMT had attended to thank all volunteers for their work in supporting the hospital.
	• National issues:
	  • The Provider sector deficit was £571m at year-end, £177m worse than the planned deficit of £394m.
	  • The number of patients waiting longer than 52 weeks is improving significantly, although QVH is an outlier in this respect, partly as a result of patient choice.
	  • Following concerns raised in respect of child cancer standards, SJ noted parallels with regard to the Trust's provision of inpatient paediatric burns; although safety and clinical outcomes remained of a very high standard at QVH, the Trust has always been cognisant of the national direction of travel around children's services and will ensure any relevant learning from this review will be carefully considered.
	
	The Board sought additional clarification in respect of the Patient First initiative, noting that the Executive Management Team (EMT) would consider priorities against available resources. Some elements had been introduced immediately, for example the performance review process is now aligned directly to the Trust's KSOs.
	
	<u>BAF</u>
	The entire BAF had been reviewed at its meeting on 17 June, together with the corporate risk register.

	Improvements had been seen in Workforce, although key risks remained in respect of financial sustainability. <u>Dashboard</u> The Board reviewed the latest integrated performance dashboard summary which highlighted key indicators from all areas within the Trust. It showed sustained improvement in workforce and also that KSOs 1 and 2 were performing well, but also highlighted deteriorating performance of the financial plan YTD. Focus on achieving CIP was continuing. The Board suggested that an additional statistic might be included relating to waiting lists. It was agreed that EMT would consider this proposal further. Feedback would be provided through the Finance and performance committee (F&PC). **[Action: SJ]** <u>Media</u> The Board focused on the article published in The Guardian raising concerns about the Trust's gender pay gap. CP emphasised that equal pay for equal work is of course the law, and that the gap was due to 54 of our highest-earning consultants being male, compared with only 18 female consultants. It was anticipated that this ratio would improve as more female consultants join the Trust, and as current female doctors progress into more senior roles, but this would take a prolonged period of time. The Board commended a video which had been produced recently by Kathryn Langley, Trust Communications manager, thanking staff for all their hard work following publication of the CQC inspection report. There were no further comments and the Board **noted** the content of the update.
Key strategy objective 5: organisational excellence	
103-19	**Board assurance framework** DH presented the latest BAF for KSO5, noting in particular progress in finalising ESR hierarchy with the ledger which should be complete by the end of July. MM commended the effort by all teams, (including operations and nursing), in achieving this. DH also noted that the NHS interim people plan had now been published.
104-19	**Workforce monthly report** DH presented the latest workforce report asking the Board to note in particular: • The continued improvement in annualised rolling turnover position. • The referendum being undertaken by the BMA with junior doctor members around proposed changes to the 2016 terms and conditions. • The quarterly update on the People and OD strategy. QVH had been awarded the full allocation of £51k funding for the 2018/19 CQUIN due to its detailed health & wellbeing plan. • The Board was asked to disregard the final sentence in the KPI appraisals narrative, which had been carried over from a previous report. The Board sought and received clarification in respect of the following: • As the risk regarding recruitment and workforce team constraints had been reduced following appointment of a permanent recruitment manager, it was noted that resource implications on the report's front cover should be updated. **[Action: GO]** • How the diverse range of intelligence gathered from the online staff feedback initiative would be utilised. DH explained that analysis would take around 2/3 weeks after which key themes would be fed back through the Hospital Management Team. It was agreed results would also be reported at the August Finance and performance committee. **[Action: GO]** Wider corporate

	communications would include *'you said, we did'* updates through Connect and the CEO blog. • Key themes from the national interim people plan included the need to address the acute shortage of nurses; however, there were no tangible plans at present, and whilst discussions around reintroduction of bursaries had opened, no progress had been made to date. • The reasons why there had not been a corresponding fall in use of bank and agency staff, despite high levels of substantive staff now in post. DH explained that some recent appointments were recruited to support operational requirements and whilst there had been some early success following the international recruitment programmes, a fall in bank and agency staff might not become apparent until at least Q4. • When the Trust might expect to be able to establish its business as usual running costs. AJ reminded the board that in parallel the theatres and outpatient productivity work would also support a drive towards this. However, it was noted that given national shortages, it would be unrealistic to expect zero use of bank and/or agency staff. There were no further comments and the Board **noted** the contents of the update.
Key strategy objectives 1 and 2: outstanding patient experience and world-class clinical services	
105-19	**Board assurance framework** <u>KSO1</u> Given the extensive programme of backlog maintenance undertaken over the last year, EMT had met to consider whether KSO1 (risk 2) relating to the condition of the estate was still relevant. The proposal was for wording to change to *'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'.* The Board sought and received assurance that controls and assurance would be updated accordingly, and **approved** the revised statement. <u>KSO2</u> There were no changes to current risk ratings for KSO2. The Board also noted that KSOs 1 and 2 had been subject to the routine 'deep dive' assurance process at the June Audit committee meeting. The Board went on to discuss the difference between *'Future risks – specialised commissioning future intentions'* and *'Future opportunities – QVH led specialised commissioning',* receiving additional clarification as to the distinction. There were no further comments and the Board **noted** the contents of the update.
106-19	**CQC inspection report** JMT formally apprised the Board of the outcome of its Care Quality Commission (CQC) inspection. The Trust had retained 'Good' overall with 'Outstanding' patient care. The report had listed 14 minor recommendations which had been added to the action plan, together with a further five minor actions identified following review of the CQC evidence appendix report. The action plan will be monitored on a monthly basis by the Clinical Governance Group and implementation evidence will be stored and presented to the CQC for assurance. JMT would meet with CQC to establish how the Trust might move from 'Good' to 'Outstanding' overall. The Board considered the report and associated action plan and sought clarification as follows: • CQC do not rate effectiveness in Outpatients anywhere, because there is a lack of nationally reported data specific to outpatients that would allow them to make that assessment.

	• The Patient First methodology, which the Trust was introducing, would be the overarching strategy into which all action plans were aligned. Adopting this continuous improvement programme was part of the CQC action plan, but no detailed plan for this was in place at this stage. • Organisations with significant challenges are often still awarded an Outstanding rating if they are able to provide clear assurance as to how such challenges are being managed. There were no further comments and the Board **noted** the outcome of the CQC inspection and subsequent action plan. It also commended JMT and her team for the way in which this process had been managed.
107-19	**Quality and governance assurance** KN presented a verbal update following the recent Quality and governance committee meeting, asking the Board to note in particular: • The risk which had been added to the corporate risk register relating to reduced numbers of Corneo Fellows. This was being carefully monitored by the executive lead and business unit manager. • Concerns cited in the Ofsted report for West Sussex Safeguarding. There were no comments and the Board **noted** the contents of the update.
108-19	**Corporate risk register (CRR)** In addition to the risk previously highlighted by KN, the Board was again reminded that the risk regarding recruitment and workforce team constraints and limitations had been reduced following the appointment of a permanent recruitment manager. The Board queried whether the risk relating to Canadian Wing staffing vacancies could be reduced in light of the success of the international recruitment programme; however, JMT advised that this rating should be maintained until staff had been fully inducted into the organisation. There were no further comments and the Board **noted** the contents of the update.
109-19	**Quality and safety report** JMT presented the KSO1 element of the Quality and safety report, asking the Board to note in particular details of the South East Critical Care Network's visit to the Trust's critical care unit and improvements seen since its last visit. The network had fully accepted that our service provision was safe. EP provided an update on discussions around networked care between BSUH, QVH, WSHT and ESHT as follows: • 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 but may require significant investment from both trusts. The immediate risk regarding lower limb orthoplastic surgery remains, and a small number of cases are being referred from BSUH to other orthoplastic centres. • EP and SJ had attended the first Sussex Acute Collaboration Network meeting. Draft terms of reference and governance structure had been developed and would be brought to the September board meeting. **[Action: EP]** The Board sought and received assurance that QVH was still looking towards Kent as part of the overall solution and would not divert all its energy to Sussex. There were no comments and the Board **noted** the contents of the update.

110-19	**National inpatient survey results** JMT presented the results of the 2018 national inpatient survey which had ranked QVH as one of only eight acute specialist trusts to be given the CQC's branding of 'much better than expected' by patients, and drew the Board's attention in particular to the significant positive improvements reported for patients at QVH. In response to questions raised by the Board, JMT confirmed: • The Trust had anticipated the comments regarding rating of hospital food (relating to choice rather than quality), but significant work had since been undertaken to improve this. • The survey coordination centre used the same methodology in every hospital to ensure consistency of results. There were no further comments and the Board **noted** the results of the 2018 national inpatient survey.
111-19	**Paediatric burns update** EP provided an update following the Board's decision to engage with commissioners and the LSEBN to identify additional mitigations in respect of the current paediatric inpatient burns service. Key points included: • With the support of the burns network and NHS England, the Trust was now making arrangements for a temporary divert from 01 August 2019 of all inpatient paediatric burns patients from Kent, Surrey and Sussex to the specialist centre for children's burns at St Andrew's Burn Centre, Broomfield Hospital, Chelmsford or the specialist unit for children's burns at Chelsea and Westminster Hospital, London. • This was a temporary divert only at this stage as the Trust would still wish to consider if this could eventually be managed as a shared service with BSUH, following opening of new buildings in 2021. • A reminder of the longer term impact this may have on other paediatric inpatient and outpatient burns care at QVH. • The communications plan ensuring full engagement with the Health Oversight and Scrutiny Committee (HOSC), Healthwatch, commissioners, governors and other stakeholders. A further report would be provided to the Board at its meeting in September. There were no more comments and the Board **noted** the contents of the update.
112-19	**Clinical strategy priorities update** EP reported that priorities would be aligned to the Trust's strategy of people, productivity and partnerships; a formal paper would be presented to the Board at its meeting in September.
Key strategy objectives 3 and 4: operational excellence and financial sustainability	
113-19	**Board assurance framework** <u>KSO3</u> The KSO3 BAF had been reviewed at the recent Finance and performance committee (F&PC). Changes since the last report were highlighted, with risks aligned to the corporate risk register. <u>KSO4</u> MM drew the Board attention in particular to: • 2019/20 cost improvement plan gap and under delivery year to date. • Detailed forecasting will commence from M03 onwards, earlier than in previous years. • All clinical areas had signed budgets, and there was evidence of better engagement this year. There were no further comments and the Board **noted** the contents of the update.

114-19	**Financial, operational and workforce performance assurance** JT presented his assurance report following the (F&PC) meeting on 24 June. The highlights included: • Evidence of continued improvement in Operations, but a lower level of assurance within Finance. • EDM roll out will recommence in plastics. An external consultant has been appointed to assess any clinical risks within the project. This was a significant project and more time would be dedicated to this subject at the next F&PC. There were no further comments and the Board **noted** the contents of the update.
115-19	**Operational performance** The Board received the latest update on current operational performance, seeking additional clarification as follows: • Whilst it may still be a challenge to achieve 52 week performance targets by September, (excluding the patient choice factor), risks continued to reduce. • Plans in place to reverse the decline of performance in Ophthalmology, including the appointment of a short term locum, capacity and demand managed at sub-speciality level and the appointment of a new business unit manager whose focus would be on this specialty. • Clinical outcomes of virtual follow up clinics had not been specifically factored into an evaluation plan, although the Board was assured that the model adopted by QVH had been tested and was already in use elsewhere. There was a brief discussion as to the reason for the 21% rise in increase in referrals under the two week wait standard compared to January/February data. AJ confirmed that she was monitoring this and would include any indicators of the drivers of this in future F&PC reports. The Board commended the Total pathways metric which provided additional assurance on data. There were no further comments and the Board **noted** the contents of the update.
116-19	**Financial performance** MM presented the latest financial performance update asking the Board to note in particular: • QVH was one of only four providers nationally not to agree their control total. Instead the Board had agreed to submit a revised operating plan for 2019/20 with a forecast deficit of £7.4m. • The Trust had delivered a deficit of £2.1m year to date (YTD) which was £0.5m worse than plan. A backlog in clinical coding had created a reporting lag which would result in an adjustment of £0.2m behind plan. Capacity within the coding team had now been increased. • YTD under performance was largely due to reduced income from change in case mix in inpatient Plastics. Improvements in income elsewhere had been offset by reduced activity and income in Oral electives. • The pay position is £136k above plan due to vacancies within all staff groupings, apart from medical. Compared to the last six months of 2018/19 there had been a decrease in use of agency staff largely within Nursing. • The non pay position was slightly over budget due to clinical supplies overspends. • The cost improvement plan (CIP) dashboard showed the Trust on plan for MO2, but an additional £600k was yet to be identified. In June, NHSI/E had met with the executive team to help pinpoint additional opportunities to close the unidentified CIP gap but this had led to the identification of only minimal gains so far. • As a result of monthly deficits the Trust has had to borrow money from NHS Funds, which it has

	started to draw down. The Board discussed the latest update noting in particular: • Disappointment that central support to achieve its CIPs had not been forthcoming as this had been part of the basis on which the Trust submitted the revised deficit plan. In the meantime, performance reviews considered ways in which to drive down costs, and the executive team continued to meet on a bi-weekly basis with a specific focus on CIPs. • Whilst the Trust had little influence over underperformance of non-elective activity, this impacted detrimentally on income. • A brief discussion on the likelihood of the Trust meeting forecast at year-end. Key priorities included achieving the 92% referral to treatment standard, eliminating 52-week waits, and addressing challenges around costs. • Cash flow management had resulted in a delay in payments in the final week of May and the Board sought assurance that invoices would be approved on a timely basis, particularly remaining mindful of small suppliers. There were no further comments and the Board **noted** the contents of the update.
Governance	
117-19	**Review of committee chairs and membership** The recent appointment of two new NEDs and the planned departure of JT at the end of September meant that new committee chairs needed to be appointed and NED attendance at committees agreed. BH presented a report which included a proposal maximising resources available to the Board and as far as possible fairly distributed committee attendance across the NEDs. There were no comments and the Board **approved** the recommendation.
118-19	**Appointment of Senior Independent Director** The Chair presented a report with a recommendation for GN to become the next Senior Independent Director with effect from 01 October 2019. BH confirmed that GN had expressed an interest in taking on this role, assuming Council of Governors and the Board of Directors were in agreement. The Board sought and received assurance that GN would be available for the additional commitments this role would require. There were no further questions, and BH confirmed that Council would be consulted on this recommendation at its meeting in July.
119-19	**Annual approval of Standing financial instructions** MM provided the Board with an update on changes made to Trust Standing Financial Instructions and accounting policies over the last twelve months. The current Standing Financial Instructions (SFIs), showing tracked changes were appended to the report. MM advised that Audit committee had recently reviewed these and was recommending to the Board for approval. After due consideration, the Board **approved** the revised SFIs, noting these would come into effect immediately.
120-19	**Annual approval of Standing orders and reservation of power/scheme of delegation** MM provided the Board with an update on changes made to Trust Standing Orders, and Reservation

	of Powers and Scheme of Delegation over the last year. Changes were itemised on the report's cover sheet. The Audit committee had reviewed these and was recommending to the Board for approval. Following a short discussion, the Board **approved** the revised Standing orders and reservation of power/scheme of delegation, noting these would come into immediate effect.
121-19	**Audit committee assurance** The Board received an assurance report following the meeting held on 19 June.
122-19	**AOB** On behalf of the Board, BH thanked John Belsey who had been the lead governor for almost three years. He had stepped down this year due to his many other commitments but will remain as a governor. BH had appreciated in particular his wise counsel and support.
123-19	**Questions from members of the public** A member of the public gallery commended the level of scrutiny applied to the business discussions today.

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
	July 2019	98-19	Patient story	Standing items	Chair to write to staff members to commend their treatment of patient	BH	ASAP	Letters sent by BH to staff concerned	Closed
1	July 2019	102-19	Chief Executive's report	Standing items	EMT to consider which additional statistic might be added to dashboard relating to waiting lists. Feedback to be provided to F&PC	SJ	Sep-19		Pending
2	July 2019	104-19	Workforce	KSO5	Resource implications on w/f front cover to be updated following reduction in risk rating for recruitment and workforce team constraints	GO	Sep-19		Pending
3	July 2019	104-19	Workforce	KSO5	Results of Clever Together iniative to be reported back through HMT and August F&PC	GO	Aug-19	On September private board agenda	Pending
4	July 2019	109-19	Quality & Safety	KSO2	Draft terms of reference of Sussex Acute Collaboration Network to be reviewed by BoD in September	SJ	Sep-19	On September private board agenda	Pending
5	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	Update: Board confirmed approval on 4 July 2019	Closed
6	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	Presented at July JHGM	Closed
7	March 2019	56-19	Quality and safety	KSO2	Board to reconsider if risks associated with continued provision of paediatric burns services should be included on the corporate risk register.	EP	Jul-19	**Update 4 July 2019** CRR 1059 and 968 have been updated with details of pathway changes.	Closed
8	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	On September public board agenda	Pending

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**136-19**	
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	NA				
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:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:	NA				
	Date:		Decision:		
Next steps:	NA				

Report to:	Board of Directors
Meeting date:	Thursday 5 September 2019
Agenda item reference no:	136-19
Report from:	Beryl Hobson, Chair
Date of report:	25 July 2019

Chair's Report

Overview

1. This will be the last public board meeting for both John Thornton (non-executive director) and Dr Ed Pickles (medical director).

2. John Thornton joined the board six years ago and took on the role of chair of the finance and performance committee from its initial meeting following the governance review in 2015. John has developed the committee to ensure adequate scrutiny and challenge of the Trust's finance, operational and workforce plans. He has also served on the audit and nomination and remuneration committees. As a board member John has managed to balance support for the executive with appropriate challenge and has combined this with a great sense of humour. On behalf of the Board I would like to thank John for his commitment and contribution to QVH and to wish him all the best in the future.

3. Dr Ed Pickles has been medical director of the Trust since October 2015 and has combined this with his clinical role as an anaesthetist. For several reasons QVH has traditionally recruited a medical director from amongst its own consultants (rather than going out to external advertisement). This can mean that it is a difficult role to fulfil as the medical director may have to undertake some duties which may not be popular with his/ her peers. Ed has undertaken this role well and we are grateful for his pragmatic, patient centred, questioning and cheerful approach to the role. We will miss him at Board but will hopefully still see him around the hospital as he returns to an increased clinical commitment. On behalf of us all I would like to say thank you to Ed.

Chair's activities

4. Since the last Board meeting, I have attended a number of meetings and walk rounds including:
    a. Governor induction – Hilary Saunders, deputy company secretary, ensures that new governors receive a thorough induction into the Trust and it was a pleasure to support her on the most recent event.
    b. Visits to:
        - Minor Injuries Unit (to thank the staff members involved in the patient story at last Board meeting)
        - Physiotherapy and occupational therapy
        - Theatres – observing a 10 hour ENT/Maxfacs removal of tumour and flap insertion
        - Human resources
        - Library
    c. Chair and CEO breakfast and afternoon tea
    d. Meeting between myself, Steve Jenkin and the Chair and chief executive of Western/ BSUH

Governor activity

5. The governors met on 29 July. In addition to their usual business items they received an update on the paediatric inpatient burns service and initiated a discussion about the 2019/20 quality indicators.

6. At our meeting today we are delighted to welcome Peter Shore in his new role as lead governor. Peter is well known to the Board in his previous role as governor representative to the finance and performance committee. We look forward to working with him and the other committee lead governors in their new roles.

AGM

7. We were delighted to welcome more than 70 people to the Annual General Meeting on 29 July. In addition to the regular AGM business, we received a fascinating presentation by one of our consultant plastic surgeons, Lt Colonel Tania Cubison who spoke about her experience of treating wounded service personnel in Afghanistan and what she has brought from this experience to the NHS.

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 19/08/19 alongside the corporate risk register. KSO 1 and 2 were also reviewed at the Quality and Governance Committee, 22/08/19. KSO 3, 4 and 5 were reviewed 27/08/19 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 September trust board .

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

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**137-19**	
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 • Outpatients improvement programme • Sussex & E Surrey STP becomes Sussex Health & Care Partnership • New government and Prime Minister - capital investment in the NHS				
Recommendation:	For the Board to **NOTE** the report				
Action required	Approval **Y/N**	**Information Y/N**	Discussion **Y/N**	Assurance **Y/N**	Review **Y/N**
Link to key strategic objectives (KSOs):	KSO1: **Y/N**	KSO2: **Y/N**	KSO3: **Y/N**	KSO4: **Y/N**	KSO5: **Y/N**
	Outstanding patient experience	*World-class clinical services*	*Operational excellence*	*Financial sustainability*	*Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:	None				
Regulation:	N/A				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	EMT				
	Date:	19/08/19	Decision:	Review BAF	
Next steps:					

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2019

TRUST ISSUES

Annual General Meeting

Our Annual General Meeting took place at East Court on 29 July 2019 with over 70 members of the public in attendance. Presentations from the CEO and Neil Hewitson, KPMG, were followed by a talk by Lieutenant Colonel Tania Cubison, consultant plastic surgeon "What we have learnt from 10 years in Afghanistan".

Outpatients Productivity

You may have heard or seen the recent media coverage of our virtual clinics pilot in the West Sussex County Times or on BBC South East TV, BBC Sussex and BBC Surrey. Virtual clinics in therapies are just one area we have been focusing on as part of our programme aimed at improving services for patients.

Some glaucoma patients are initially tested by a technician at the hospital. Results are later reviewed 'virtually' by a consultant before a decision is made about whether the patient should be discharged, remain in the virtual clinic for follow-up testing, or be booked in for a face to face appointment if necessary. This system will allow us review about 157 extra patients per year.

Our wider outpatients improvement programme has some key deliverables this year. One of the next areas of focus for the programme will be reducing did not attend (DNA) rates with the help of a two-way text system. Patients will receive a text seven to 10 days in advance of their appointment, asking them to let us know by reply whether they are still planning to attend. Then two days before their appointment the patient will receive a simple reminder text.

Brexit

The legal default in UK and EU law remains that, unless and until a deal is agreed and ratified, there is a possibility of a no deal exit at the end of the extension period on 31 October 2019. The team overseeing our preparations continue to meet regularly as EU Exit Business Continuity remains a priority for QVH as we near 31 October. We are working on plans to ensure safe services for patients can continue to be provided in the event that the UK leaves the EU without a deal.

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 19 August 2019 alongside the corporate risk register. KSO 1 and 2 were also reviewed at the Quality and Governance Committee on 21 August 2019. KSO 3, 4 and 5 were reviewed on 27 August 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 June and July 2019.

SECTOR ISSUES

Sussex Health and Care Partnership

The NHS Long-Term Plan sets an expectation for health and care partners to work more collaboratively across local systems and, as far as possible, across local authority areas, assuming a collective responsibility for the populations they serve.

On 15 July 2019, E Surrey Clinical Commissioning Group, Surrey and Sussex Healthcare NHS Trust and First Community Health and Care became part of Surrey Heartlands Integrated Care System (ICS). This means that they will no longer form part of the current Sussex and E Surrey Sustainability Transformation Partnership (STP). This move supports closer alignment with Surrey County Council and their integration agenda.

This means the Sussex and E Surrey STP has now following discussions with NHS and local authority partners become the Sussex Health and Care Partnership. It give us a geographical identity that is better recognised by our public, partners and stakeholders

NATIONAL ISSUES

New government and Prime Minister

Following the resignation of Theresa May on 24 July, Boris Johnson became Prime Minister soon afterwards and immediately made significant changes to the government with less than half of the previous Cabinet remaining in post. Matt Hancock remains in post as the Secretary of State for Health and Social Care (DHSC), with Caroline Dineage and Baroness Blackwood also continuing in his ministerial team. They are joined by Chris Skidmore, Jo Churchill and Nadine Dorries.

Capital investment in the NHS

The government announced on 5 August 2019 an extra £1.8bn worth of capital investment for the NHS. This includes £850m funding for 20 hospitals to upgrade outdated facilities and equipment. An additional £950m will be set aside to increase the DHSC capital budget, allowing a number of existing upgrade programmes to proceed. There have also been commitments from the Prime Minister to solve the pension tax issue affecting senior NHS staff.

Advancing our health: prevention in the 2020s

The Cabinet Office and the Department of Health and Social Care published the consultation and green paper on prevention and public health on 22 July 2019. It argues that people need to view health as an asset to invest in throughout their lives. It outlines proposals for more targeted support, tailored lifestyle advice, personalised care and greater protection against future threats.
The proposals will support the work that the NHS is doing as set out in the long term plan chapter on prevention. The consultation closes at 11.59pm on 14 October 2019.

Hospital Food

The Department of Health and Social Care (DHSC) will launch a formal review on hospital food, it announced on 23 August. Hospitals serve 140 million meals to patients every year. The review states that it will focus on driving up quality to make food safer, healthier and more sustainable. It will make recommendations on how to bring hospital catering in-house and increase the use of local, fresh and seasonal produce.

Steve Jenkin
Chief Executive

September Integrated Dashboard Summary
Key indicators at a glance - July 2019

All data relates to July 2019 and has been extracted from Director's September Board papers unless otherwise stated.

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)	3
PUs hospital acquired - category 2 plus	0
Falls (mod or above)	0
Contacts	20495
Complaints	4
Closed <30 days	4
FFT	
In-patient	99%
Day surgery	98%
MIU	95%
Trauma	95%
O/Ps	95%

KSO3 Operational Excellence	
MIU <4hrs	9960.00%
RTT 18 weeks	80.63%
Cancer 2ww	94%*
Cancer 62 day	81.5%*
Diagnostics <6weeks	99.86%
52ww	37
(patient choice)	15
Referrals via eRS	99.3%*

*June data

KSO4 Financial Sustainability	
Financial plan YTD	(£2,958k)
Variance to plan YTD	(£182k)
Patient activity income variance YTD	(£558k)
CIP delivery YTD	£318k
Agency spend % of pay bill in month	5.70%

KSO5 Organisational Excellence	
Vacancy rate	11.34%
Turnover rate	16.38%
Sickness rate	2.77%*
Appraisal rate	87.41%
MAST	92.88%
Q1 Staff FFT (work at QVH)	74.60%
Q1 Staff FFT (care at QVH)	97.62%

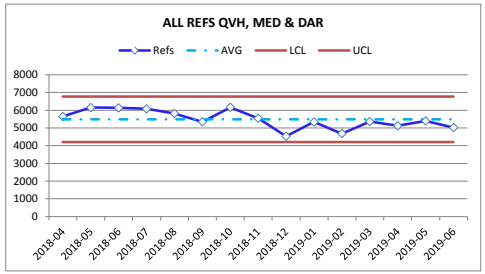
*June data

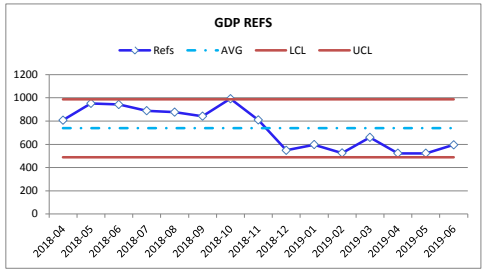
Activity - M4*	Plan	Actual	2018/19
MIU attendances	1,039	1,321	1,179
Elective (day case)	1,234	1,153	1,013
Elective	441	388	323
Non-elective	463	559	464
Critical care	83	113	86
O/P first attendance	4,169	4,111	3,984
O/P follow up	11,373	11,409	10,639
O/P procedures	2,733	1,966	2,588
Other	4,315	4,490	3,888

SLAM data - internal finance report

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 – July and August 2019


Chance to recognise outstanding treatment

Two of last year's winners, nurse specialists Rebecca Spencer and Pam Golton with nursing director Jo Thomas

Chance to recognise outstanding treatment
The **East Grinstead Gazette** printed a story about this year's QVH staff awards with details of how to nominate and a photo of two of last year's winners, breast care nurses Rebecca Spencer and Pam Golton.


East Grinstead Gazette

Friday, July 26, 2019

QVH patients are offered 'virtual appointments'


Patients offered 'virtual appointments' at Sussex hospital

'Virtual' appointments are being offered at Queen Victoria Hospital

QVH goes virtual with new Skype clinics
The **East Grinstead Gazette** dedicated its entire front page to our story about virtual clinics being offered to some therapies patients at QVH, and the **West Sussex County Times** also featured the story prominently. This is on top of the coverage we secured the previous month on **BBC South East TV**, and the **BBC Surrey** and **BBC Sussex** breakfast radio shows. The story lead the whole programme on BBC Sussex – with mentions every 15 minutes and interviews with the then head of therapies, Marc Tramontin, a patient case study, and a patient representative's group which was supportive of the project.


Specialist doctor to talk about work in Afghanistan

Rebuilding lives and facing the future
The **East Grinstead Gazette** previewed this year's QVH annual general meeting at which Tania Cubison, QVH consultant plastic surgeon and Lieutenant Colonel in the Royal Army Medical Corps, will speak.

Planned changes to care for children with severe burns
Susy Radio published a story on its website about planned changes to care for the most severely burned children. The story was a cut and paste of the QVH press statement. **The HSJ** also covered the story in a longer piece with the misleading headline: "Trust to close specialist children's service."


SUSY NEWS

QUEEN VICTORIA HOSPITAL: CHANGES TO CARE FOR CHILDREN WITH SEVERE BURNS

JULY 8, 2019 NEWS

Queen Victoria Hospital in East Grinstead has announced some changes to the care for children with the most severe burns.

From the 1st August the very small number of children who are so badly burned that they need inpatient care, will be taken to the specialist burns centres at St Andrew's Burn Centre in Chelmsford or to Chelsea and Westminster Hospital in London.

For 98% of children experiencing a burn, care will remain at the Queen Victoria Hospital only. The clinically-led decision means that 2 % of children who are so badly burned that they need to stay in overnight will receive their inpatient care in a hospital that also has paediatric intensive care.

Brits on red alert as almost 600 admitted to hospital with severe sunburn in three years
QVH gets a mention in the Daily Star in a story about people being admitted to hospital with sunburn. The item refers to a one-month old baby who was treated at the hospital in June 2017 for severe burns.


'I heard this horrendous scream': 'Girl's legs burnt after Primark nail glue spills on leggings'
Lilly Worsfold has been referred to a burns unit and may need to have a skin graft

Girl burnt after glue spills on leggings
QVH also gets a mention in a story on **Surrey Live** about a girl who was burnt after glue spilled on her leggings. This story is also featured in the **Metro** and the **Daily Mail**.

Pensioner sent away from doctor dies of skin cancer


Gillingham pensioner George Hobbs' giant black growth couldn't be removed at Queen Victoria Hospital as he 'looked too ill'

There are other mentions for QVH in a series of stories by **Kent Online** about George Hobbs who was diagnosed with cancer after being sent away by his doctor with paracetamol. Mr Hobbs was eventually referred to Queen Victoria Hospital for specialist skin cancer care but could not have surgery as he was too ill. Sadly Mr Hobbs died at Medway Maritime Hospital at the end of July. This story is also featured in the **Daily Mail**, the **Mirror,** the **Express** and the **Sun**.

QVH on social media
Among the most popular content on our social media channels this month were posts about virtual clinics, the AGM and the staff awards.

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

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

- Your chance to nominate outstanding staff for annual hospital awards
- Planned changes to care for the most severely burned children
- Rebuilding lives and facing the future
- QVH goes 'virtual' with new Skype clinics

For more information… please contact **Michelle Baillie**, communications manager, at michelle.baillie@nhs.net

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 September 2019**		**Agenda reference:**	**138-19**	
Report title:	Freedom to Speak Up Guardian's report				
Sponsor:	Steve Jenkin, chief executive				
Author:	Sheila Perkins, Freedom to Speak Up Guardian				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of this report is to update the Board on the work of the Freedom to Speak Up Guardian.				
Summary of key issues					
Recommendation:	The board of directors is asked to **NOTE** the contents of this report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	**KSO5:** ***Organisational excellence***
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None.				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:					

Report to:	Board of Directors
Meeting date:	5 September 2019
Reference number:	138-19
Report from:	Sheila Perkins, FTSU guardian
Author:	Sheila Perkins, FTSU guardian
Appendices:	None
Report date:	27 August 2019

Freedom to speak up

1. In the last six months I have attended a FTSU Guardian training day and have made contact with the local FTSU network.

2. There are updated guidelines which have been circulated to all Trusts; the updated guidelines aim to clarify the Trusts' responsibilities, and where possible, standardize the role and responsibilities of the FTSU Guardians. I get weekly bulletins from the National Guardians office and I completed the National Survey. There was only a 49% return rate from Trusts and it hasn't been reported on yet.

3. I have completed training in workplace mediation with The London School of Mediation.

4. I continue to introduce the Freedom to Speak Up role at the new staff induction every month to ensure that 'Speaking Up' becomes embedded in the culture of the hospital. I will continue to publicize the availability of the different mechanisms whereby staff can speak out about their concerns.

5. October is 'Speak Up' month so I plan to put together some posters and materials, with the support of the National Office, to promote this. I would like to send some 'evidence' of the event back to The National Office to demonstrate QVH investment in and commitment to encouraging 'Speaking Up'.

6. I will continue to publicize the availability of the different mechanisms whereby staff can speak out about their concerns.

7. I have had six new contacts:

- One staff member had already raised a concern to their line manager and was seeking support
- One was an exit interview – information from which was passed to HR with the person's consent
- Three contacts were staff who I signposted to their own managers – one of whom asked for support with that conversation
- One was a member of staff who was able to manage their own concerns having been given an opportunity to be 'heard'.

I continue to offer support to staff who have voiced concerns, whatever route they have chosen.

Sheila Perkins, FTSU Guardian

Risk Owner – Director of Operations
Date last reviewed : 18 August 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 in corneo plastics and associated recruitment challenges
- Initial recruitment to breast locum not successful
- Ongoing medical vacancies in corneo [CRR 1143]
- Sentinel Lymph Node demand [CRR 1122]
- Anaesthetic cover over summer period
- Pension rules impacting medical staff willing to provide additional capacity

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 21st August 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 4)

- Month 4 position YTD £182k behind plan due to income shortfall
- Current run rate forecast deficit of c£9.4m (**CRR877)**
- CIP performance £318k/£279k for YTD Month 4 –slightly over plan
- 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
- 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
- Backlog in coding is causing reporting issues for financial and audit. An external company has been instructed to assist with additional onsite resources and agency staff employed. Further work is needed to ensure that the team is equipped to deliver the coding in a timely basis moving forward.

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
- Development of accelerated Integrated Care System

Controls / Assurances

- Performance Management regime in place and performance reports to the board.
- Contract monitoring process
- Finance & Performance Committee in place, forecasting from month 5 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 – backlog at present which is being activity managed and monitored on a daily basis.
- 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, recruitment underway.
- Spoke site, Service line reporting and service review information widely circulated

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~~ Training being delivered and well attended.
- ~~Establishment review and reconciliation between the ledger and ESR~~ Completed through budget setting and being reconciled

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 September 2019**		**Agenda reference:**	**140-19**	
Report title:	**Finance and performance committee assurance**				
Sponsor:	John Thornton, committee chair				
Author:	John Thornton, committee chair				
Appendices:	NA				
Executive summary					
Purpose of report:	Board Assurance				
Summary of key issues	Operational grip continues to improve but required level of patient activity income not being delivered. Cost savings not sufficient to offset income shortfall and increased deficit is possible.				
Recommendation:	For noting				
Action required *[highlight **one** only]*	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: x *Operational excellence*	KSO4: x *Financial sustainability*	KSO5: x *Organisational excellence*
Implications					
Board assurance framework:					
Corporate risk register:					
Regulation:					
Legal:					
Resources:					
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

Report to: Board of Directors
Meeting date: 5 September 2019
Reference no: 140-19
Report from: John Thornton, Committee Chair
Report date: 29 August 2019

Finance and performance assurance report

1. Operational performance

For the first time this calendar year the achievement against the RTT18 target was slightly below trajectory. However following discussion committee was assured that grip on the process continues to improve and further improvement will be seen. The initial target is to move performance into the mid 80%s which is a more typical national performance and then continue to move towards 90%.

There has been a small reduction in out 52ww patients but the figure is still above the agreed trajectory. This figure continues to have high profile at the centre. As a result the NHSI intensive support team had revisited QVH to review how we are handling this aspect of the waiting list. Overall their report concluded that QVH was managing the process well and made a few suggestions on how it could be strengthened. These will be implemented.

The reduction in our overall waiting list across the profile and the lower number of clock starts (especially in dental) may in the short term make achievement of our targets harder by reducing the denominator. But it was agreed that we should retain our current trajectory rather than reduce the targets.

Committee discussed in detail our current utilisation of theatre capacity and the number of cancellations. It was disappointing to see that on time starts was still an issue. In July over 8% of available operating time was lost due to on the day cancellations. However committee took assurance from the detailed analysis and understanding of the issues and the breakdown into sub sections of the key business areas such as dental. Committee was also pleased to see that as performance improves the goals for efficiency are being raised for example the target for elective list utilisation of available time is being increased from 80 to 85% and the aim is to reach 90%.

Overall there is still the opportunity to drive increased patient income this year through improved efficiency and effective use of our theatre capacity. But this will be hampered by a lack of medical capacity in key areas. The current pension issue for consultants is making this more difficult. Committee considers it is unlikely that we will see the required uplift in activity income to meet the plan in the second half of the year and to fill the shortfall in the year to date.

2. Workforce performance

Recruitment continues to show a positive trend leading to our lowest level of vacancies and of rolling staff turnover in the last twelve months. The overseas recruitment campaign continues to successfully deliver against its targets. The overall position is also helped by a low level of sickness absence across the Trust.

The improving picture is reflected in the highest levels of compliance in Statutory and Mandatory training and completion of Appraisals in the last twelve months.

Committee's key concern was that despite the increase in staff in post the utilisation of Bank staff in still increasing and is now at the highest point in the last three years. At the same time utilisation of agency staff is down year on year but has been at the same level now for the last four months with no further signs of reduction. Given shortages in specific keys areas committee didn't receive any assurance that this is likely to improve soon.

It should be noted that at the July F&P the Workforce Disability Equality Standard and the Workforce Race Equality Standard reports were reviewed prior to their uploading to the system.

Committee supported the changes made to the Strategic Objective in the BAF page for KSO5. Committee was also very supportive of the change to the Workforce report to organise the data provided under the Five Goals of the Trust's workforce strategy.

3. Financial performance

Although patient activity income in the month shows as over budget this was following the inclusion of an additional £500k of income to reflect a catch up of under reported income in Q1. This was as a result of a delay in coding reconciliation in Q1. There are still problems within the coding team but committee was told that the accrual within month 4 and going forward would be accurate. Committee's view is that this needs to be very closely monitored.

The net result is that patient income after 4 months is £558k (2.5%) behind budget for the year to date. The budget includes an increased level of patient activity and income as the year progresses. Expenditure on pay and non pay are both under plan but not sufficiently to offset the shortfall in income. As a result our deficit for the year so far is higher than planned.

The CIP cost savings achieved in June and July were both ahead of plan. But the monthly required CIP savings in H2 increases significantly and as yet there aren't sufficient identified savings to hit this target. Although it receives a summary Committee didn't consider it had enough insight into the CIP plan for the balance of the year. It was agreed that a more detail presentation of the CIP plan would be presented for discussion in October.

Looking at the overall picture Committee is concerned that if the current run rate continues without additional interventions the Trust is likely to exceed its planned deficit for the year.

As previously discussed it was agreed that for the September meeting the executive would provide a high level reforecast for the full year based on the projected patient income, likely costs taking into account know CIP initiatives and a projected full year deficit. This would provide a platform for initial discussions on potential actions to remove any predicted shortfall - income improvement and cost reduction.

Recognising that the budget challenge was increased following discussion with NHSI it was requested that SJ should increase the level of dialogue around what they can do to support our initiatives.

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**141-19**	
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 • Open pathway performance trajectory behind plan • 52 week performance behind plan • Delivery of 2ww cancer standard • 62 day cancer standard under target • Delivery of 31 day standard • 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:	27/08/2019	Decision:	Noted
Next steps:	NA			

Operational Performance Report

Abigail Jago, Director of Operations

September 2019

Board of Directors

Summary

Key items to note in the operational report are:

- Delivery of diagnostic waiting time standards
- Open pathway performance trajectory behind plan
- 52 week performance behind plan
- Delivery of 2ww cancer standard
- 62 day cancer standard not met
- Delivery of 31 day standard
- Delivery of MIU 4 hour standard
- Ongoing delivery of theatre improvement programme
- Ongoing delivery of outpatient improvement programme

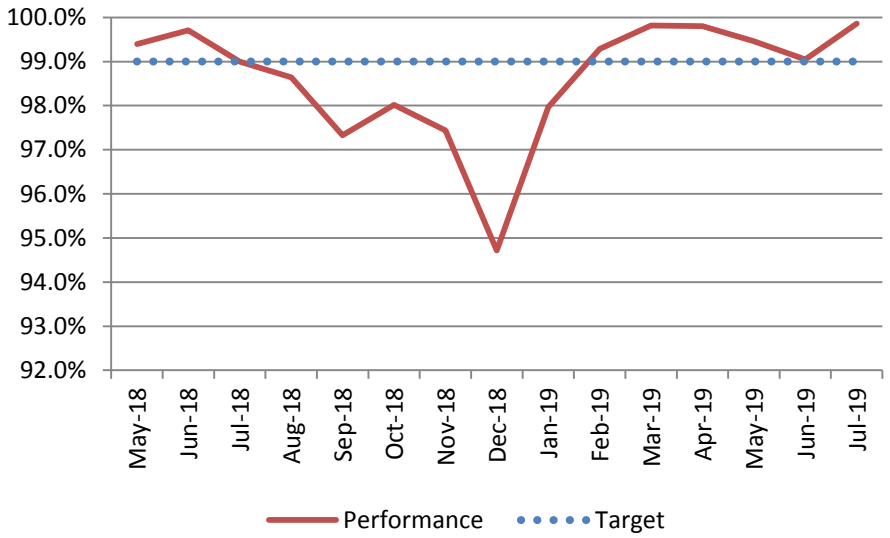
Performance summary

Queen Victoria Hospital NHS
NHS Foundation Trust

KPI	Target / metric	Target source	April	May	June	July
DMO1 Diagnostic waits	99% < 6 weeks	National	99.8%	99.46%	99.05%	99.86%
Histology Turnaround Time	90% < 10 days	Local	89%	95%	86%	-
Imaging reporting	% < 7 days	Target to be reviewed	87.47%	95.47%	96.66%	97.41%
RTT – % patients <18 weeks	Agreed trajectory	National with commissioner agreed trajectory	79.51%	81.11%	80.90%	80.63%
RTT52	Agreed trajectory	National with commissioner agreed trajectory	47	42	39	37
Minor injuries unit - % patients treated/ discharge within 4 hours	95%	National	99.6%	99.91%	99.80%	99.6%
Cancer 2WW	93%	National	86.2%	97.8%	94%	-
Cancer 62 day	85%	National	89.3%	85%	81.5%	-
Cancer 31 day	96%	National	94.8%	93.7%	96.1%	-
Theatre utilisation	% total lists > 80%	Target to be reviewed	70%	84%	88%	83%
Theatre on the day cancellations	<8% quarter 2	Local	8.54%	6.36%	5.45%	7.98%
Outpatient utilisation (booked)	2% improvement from baseline of 89%	Local	-	-	92.4%	91.5%
Outpatient utilisation (attended)	2% improvement from baseline of 81%	Local	-	-	82.6%	82.1%

Diagnostic Waits (DM01)

Queen Victoria Hospital NHS
NHS Foundation Trust

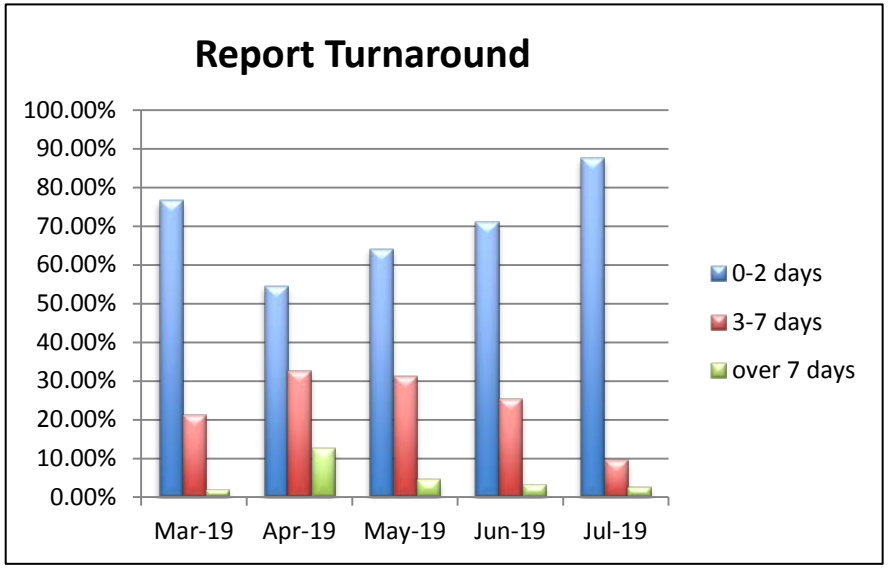


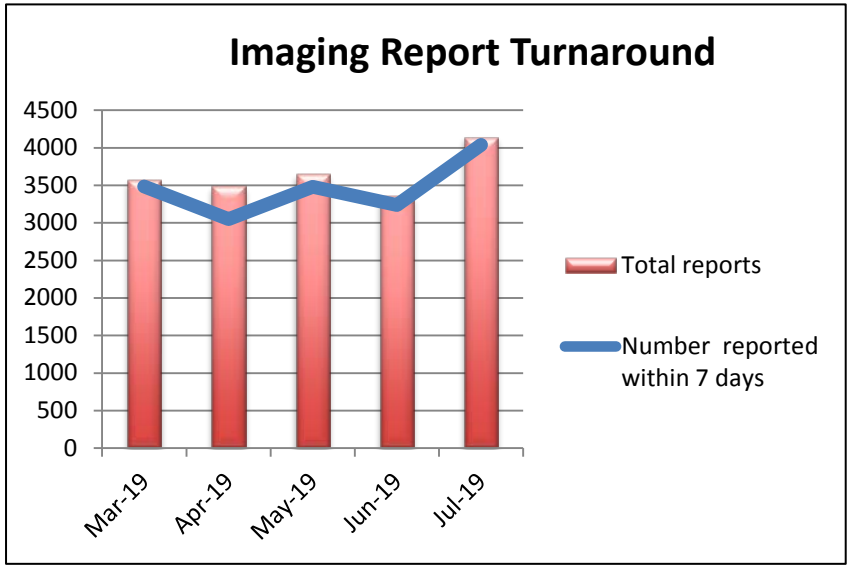
(Last reporting period – Jun19)			(This reporting period – Jul19)		
Modality / test	Breaches	Perf.	Modality / test	Breaches	Perf.
CT	0	100.00%	CT	0	100%
ECHOCARDIOGRAPHY	0	100%	ECHOCARDIOGRAPHY	0	100%
MRI	2	97.70%	MRI	0	100%
NON-OBSTETRIC ULTRASOUND	3	99.36%	NON-OBSTETRIC ULTRASOUND	1	99.97%
SLEEP STUDIES	2	95.00%	SLEEP STUDIES	0	100.00%

Performance commentary	Forward look / performance risks
Trust wide Target met – performance of 99.05% against a target of 99% **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 when cancellations occur.	**Diagnostic imaging** • Ultrasound remains a risk area due to staffing capacity, vacancies and annual leave during the summer period • Head and neck consultant radiologist post and a sonographer post out to advert **Sleep Studies** • Fixed term Consultant to start in August • Senior technician post is out to advert • Recruiting to senior sleep vacancies • 2 anticipated breaches for August

Diagnostic Imaging – Reporting turnaround times

Queen Victoria Hospital NHS
NHS Foundation Trust



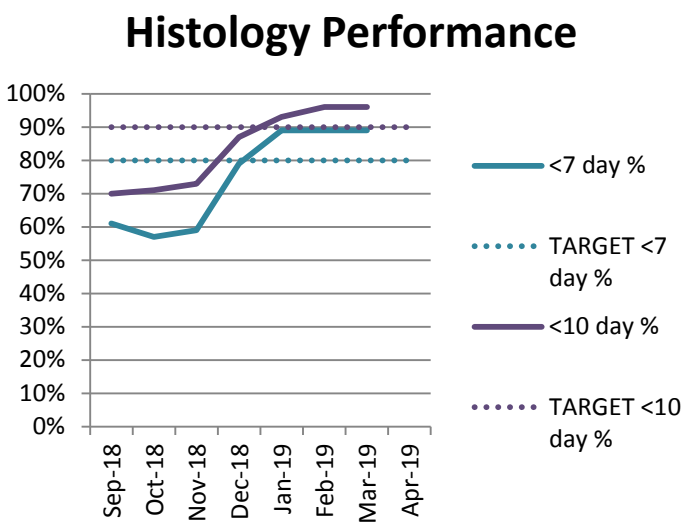


Performance commentary	Forward look / performance risks
• Improved reporting turnaround in month. >97% of imaging reported within 7 days. • Reporting radiographer commenced in June which has positively impacted report turnaround • Consultant head & neck radiologist out to advert • Sonographer post due for shortlisting	• Anticipate sustainability and improvement in performance due to reporting radiographer in post • If recruitment of consultant radiologist and sonographer posts are successful, this will improve resilience within the department in achieving report turnaround.

Histology Turnaround Time (TAT)

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	75%	80%	95%	90%	766	202	1383	1024
Jun-19	70%	80%	86%	90%	698	157	1422	998
Jul-19		80%		90%				
Aug-19		80%		90%				
Sep-19		80%		90%				



Performance commentary	Forward look / performance risks
• 1 week each of Consultant Histopathologists' (x2) annual leave in June which meant a dip in TATs 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. • 10PA Consultant Histopathologist vacancy out to advert. Further Consultant Histopathologist will be retiring at the end of September leaving an additional 10PA vacancy. • A locum consultant histopathologist is now being sought on a short-term basis to cover • 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%	80.90%	80.63%								
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	39	37								
52 week patient choice					17	20	15								
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%	74.16%	73.96%								
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	10	4								
52 week patient choice					3	5	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%	77.95%	76.15%								
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	8	10								
52 week patient choice					2	4	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%	81.16%	81.78%								
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	21	23								
52 week patient choice					11	11	10								

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%	95.28%	94.48%								
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	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%	96.03%	97.46%								
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	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	Jun 19	Jul 19	Change
0-17 (<18)	10977	10862	10823	11389	11078	10401	10056	9621	9895	9704	9508	9149	8790	↓
18-30	2390	2211	2477	2425	2420	2412	2175	1983	1891	1767	1486	1481	1530	↓
31-40	821	896	827	809	697	734	694	695	598	537	511	475	396	↓
41-51	405	445	363	325	313	325	248	191	164	149	176	165	149	↓
>52	145	135	127	120	95	92	81	68	62	47	42	39	37	↓
Total Pathways	14738	14549	14617	15068	14603	13964	13254	12558	12610	12204	11723	11309	10902	↓
Breaches	3761	3687	3794	3679	3525	3563	3198	2937	2715	2500	2215	2160	2112	↓
Performance	74.48%	74.66%	74.04%	75.58%	75.86%	74.48%	75.87%	76.61%	78.47%	79.51%	81.11%	80.9%	80.63%	↑
Clock starts		3339	3132	3870	3272	2493	3395	2849	3349	2929	3291	2993	3240	↑

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

Performance has however dipped due to a fall in patients waiting less than 18 weeks.

SUMMARY:RTT INCOMPLETE PATHWAYS									
Speciality	<18	18-30	31-40	41-51	>52	Total	Perf. This Month Jul19	Perf. Last Month Jun 19	Perf .Change
Plastic Surgery	2836	429	116	64	23	3468	81.78%	81.16%	↑
Ophthalmology	1892	493	142	27	4	2558	73.96%	74.16%	↓
Oral Surgery	2382	546	132	58	10	3128	76.15%	77.95%	↓
Sleep	975	51	6	0	0	1032	94.48%	95.28%	↓
Clinical Support	346	9	0	0	0	355	97.46%	96.03%	↑

All services are on plan except eyes where this is a deteriorating position primarily due to medical capacity. A full service review is underway.

RTT18 – Incomplete pathways

Specialty Breakdown

PLASTICS											
Open Pathways	**201809**	**201810**	**201811**	**201812**	**201901**	**201902**	**201903**	**201904**	**201905**	**201906**	**201907**
0-17 weeks	3215	3253	3233	3033	2945	2908	3033	2894	2900	2821	2836
18-30 weeks	604	531	511	520	523	483	517	476	401	420	429
31-40 weeks	197	196	168	153	138	149	158	154	154	143	116
41-51 weeks	83	74	91	91	81	61	51	59	65	71	64
52+ weeks	51	45	41	39	34	34	30	20	17	21	23
Total Open Pathways	**4150**	**4099**	**4044**	**3836**	**3721**	**3635**	**3789**	**3603**	**3537**	**3476**	**3468**
Total 18 week breaches	935	846	811	803	776	727	756	709	637	655	632
Clock starts in month	**917**	**1066**	**971**	**810**	**1038**	**925**	**1015**	**919**	**1072**	**963**	**1093**
Total Stops in month	**750**	**953**	**976**	**799**	**1026**	**859**	**727**	**889**	**950**	**894**	**919**

Work is ongoing across all specialities to maximise capacity and throughput for clock stop activity (both admitted and non admitted).

CORNEO											
Open Pathways	**201809**	**201810**	**201811**	**201812**	**201901**	**201902**	**201903**	**201904**	**201905**	**201906**	**201907**
0-17 weeks	2014	2038	1994	1920	1884	1838	1928	1985	1928	1906	1892
18-30 weeks	442	450	475	438	405	369	444	477	483	501	493
31-40 weeks	82	96	102	134	142	154	120	128	133	136	142
41-51 weeks	19	14	23	26	33	34	40	31	31	17	27
52+ weeks	12	14	8	8	5	2		2	7	10	4
Total Open Pathways	**2569**	**2612**	**2602**	**2526**	**2469**	**2397**	**2532**	**2623**	**2582**	**2570**	**2558**
Total 18 week breaches	555	574	608	606	585	559	604	638	654	664	666
Clock starts in month	**530**	**581**	**546**	**408**	**567**	**457**	**523**	**535**	**492**	**467**	**575**
Total Stops in month	**351**	**327**	**316**	**312**	**473**	**414**	**316**	**283**	**375**	**371**	**476**

OMFS											
Open Pathways	**201809**	**201810**	**201811**	**201812**	**201901**	**201902**	**201903**	**201904**	**201905**	**201906**	**201907**
0-17 weeks	3907	4029	3729	3436	3379	3216	3291	3185	3075	2719	2382
18-30 weeks	1335	1310	1298	1323	1148	1007	840	746	552	496	546
31-40 weeks	541	511	422	440	396	376	306	250	215	188	132
41-51 weeks	258	237	199	207	134	96	73	57	78	77	58
52+ weeks	64	61	46	45	42	32	32	25	18	8	10
Total Open Pathways	**6105**	**6148**	**5694**	**5451**	**5099**	**4727**	**4542**	**4263**	**3938**	**3488**	**3128**
Total 18 week breaches	2198	2119	1965	2015	1720	1511	1251	1078	863	769	746
Clock starts in month	**1072**	**1306**	**960**	**681**	**1002**	**891**	**1127**	**955**	**1031**	**822**	**751**
Total Stops in month	**998**	**1089**	**1083**	**786**	**1241**	**1119**	**1167**	**1086**	**1128**	**1027**	**953**

RTT18 – Incomplete pathways – patients waiting 18 weeks +

As reported for July 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**	**2382**	**546**	**132**	**58**	**10**	**3128**
	With TCI	100	45	27	14	5	**191**
	No TCI	2282	501	105	44	5	2937
	% with TCI	***4.20%***	***8.24%***	***20.45%***	***24.14%***	***50.00%***	***6.11%***
Plastic Surgery	**Total open pathways**	**2836**	**429**	**116**	**64**	**23**	**3468**
	With TCI	329	104	52	42	17	**544**
	No TCI	2507	325	64	22	6	2924
	% with TCI	***11.60%***	***24.24%***	***44.83%***	***65.63%***	***73.91%***	***15.69%***
Opthamology	**Total open pathways**	**1892**	**493**	**142**	**27**	**4**	**2558**
	With TCI	57	83	66	20	3	**229**
	No TCI	1835	410	76	7	1	2329
	% with TCI	***3.01%***	***16.84%***	***46.48%***	***74.07%***	***75.00%***	***8.95%***
All	**Total open pathways**	7110	1468	390	149	37	9154
	With TCI	486	232	145	76	25	964
	No TCI	6624	1236	245	73	12	8190
	% with TCI	***6.84%***	***15.80%***	***37.18%***	***51.01%***	***67.57%***	***10.53%***
	Performance last month	7.01%	17.15%	32.55%	38.79%	74.36%	

As reported for July 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**	**2382**	**546**	**132**	**58**	**10**	**3128**
	With DTA	201	86	45	21	7	**360**
	No DTA	2181	460	87	37	3	2768
	% with DTA	***8.44%***	***15.75%***	***34.09%***	***36.21%***	***70.00%***	***11.51%***
Plastic Surgery	**Total open pathways**	**2836**	**429**	**116**	**64**	**23**	**3468**
	With DTA	665	235	88	56	23	**1067**
	No DTA	2171	194	28	8	0	2401
	% with DTA	***23.45%***	***54.78%***	***75.86%***	***87.50%***	***100.00%***	***30.77%***
Opthamology	**Total open pathways**	**1892**	**493**	**142**	**27**	**4**	**2558**
	With DTA	660	391	126	27	4	**1208**
	No DTA	1232	102	16	0	0	1350
	% with DTA	***34.88%***	***79.31%***	***88.73%***	***100.00%***	***0.00%***	***47.22%***
All	**Total open pathways**	7110	1468	390	149	37	9154
	With DTA	1526	712	259	104	34	2635
	No DTA	5584	756	131	45	3	6519
	% with DTA	***21.46%***	***48.50%***	***66.41%***	***69.80%***	***91.89%***	***28.79%***
	Performance last month	21.30%	49.39%	57.60%	58.79%	84.62%	28.13%

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**	**Jun-19**	**Jul-19**
Plastic Surgery	432	369	519	491	445	565	503	359	459	499	529	494
Ophthalmology	240	240	224	213	221	298	301	213	153	199	216	265
Oral Surgery	177	179	230	278	181	304	287	309	236	225	227	213
Other	107	100	111	127	103	127	123	150	163	127	122	160
Ear, Nose & Throat (ENT)	7	20	10	8	11	10	11	5	6	5	5	11
Total	**963**	**908**	**1094**	**1117**	**961**	**1304**	**1225**	**1036**	**1017**	**1055**	**1099**	**1143**

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**	**Jun-19**	**Jul-19**
Oral Surgery	726	819	859	805	605	938	832	858	850	903	800	740
Plastic Surgery	477	381	434	485	354	461	356	368	430	451	365	425
Other	194	136	169	137	165	274	171	255	182	257	264	284
Ear, Nose & Throat (ENT)	151	299	262	359	291	365	277	271	59	213	171	267
Ophthalmology	120	111	103	103	91	175	113	103	130	176	155	211
Cardiology	35	17	43	47	39	73	29	38	33	43	20	47
Trauma & Orthopaedics	5	6	5	2	1	3	5	4	6	3	2	5
Rheumatology	5	8	9	20	12	12	10	19	6	14	6	7
Total	**1713**	**1777**	**1884**	**1957**	**1558**	**2301**	**1793**	**1916**	**1696**	**2060**	**1783**	**1986**

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**	**Jun-19**	**Jul-19**
Oral Surgery	1176	1072	1306	960	681	1002	891	1127	955	1031	822	751
Plastic Surgery	1051	917	1066	971	810	1038	925	1015	919	1072	963	1093
Ophthalmology	414	530	581	546	408	567	457	523	535	492	467	575
Other	337	390	420	373	276	473	373	470	356	457	532	626
Ear, Nose & Throat (ENT)	307	181	445	337	267	275	190	183	144	213	185	164
Cardiology	39	33	37	76	42	28	7	19	9	20	11	23
Trauma & Orthopaedics	9	1	4	3	5	3	5	6	4	3	7	3
Rheumatology	6	8	11	6	7	9	1	6	7	3	6	5
Total	**3339**	**3132**	**3870**	**3272**	**2496**	**3395**	**2849**	**3349**	**2929**	**3291**	**2993**	**3240**

RTT18

Performance and trajectories

RTT 52 performance is currently behind plan. Patient choice is a challenge within this. Due to this variance, at the request of the regional NHSI team the Intensive Support Team have been back to the QVH to undertake a review of the trust's approach to managing 52 weeks including:

1. Understanding the reasons for the breaches and where the pathways have occurred
2. Ensure long wait patients are treated as soon as possible, minimising future delays
3. The trust's oversight of long waits, identification of key themes and action to reduce recurrence of long waits
4. The trust's approach to managing patient choice
5. The trust's processes for breach analysis and clinical harm review

A report has been developed and fed back to the regional team with the following conclusions:

1. The IST was assured that the trust had an appropriate approach to managing long wait patients and reviewing all patients that breach 52 weeks for possible clinical harm
2. The trust has made significant progress in improving it's approach to waiting list management including focused work to improve theatre utilisation, referral management and booking processes.
3. The trust has a good understanding of the reasons for breaches and identifies actions to try to reduce the recurrent of long waits
4. The trust has appropriate oversight of long waiters to ensure action is taken to minimise further delays to treatment
5. The trust management of patient choice is correct, however a more proactive approach in discussing readiness for treatment and expected timelines with patients would support clinical decision making in situations where discharging a patient back to their

RTT18

Performance and trajectories

RTT 52 performance is currently behind plan. Patient choice is a challenge within this. Due to this variance, at the request of the regional NHSI team the Intensive Support Team have been back to the QVH to undertake a review of the trust's approach to managing 52 weeks including:

1. Understanding the reasons for the breaches and where the pathways have occurred
2. Ensure long wait patients are treated as soon as possible, minimising future delays
3. The trust's oversight of long waits, identification of key themes and action to reduce recurrence of long waits
4. The trust's approach to managing patient choice
5. The trust's processes for breach analysis and clinical harm review

A report has been developed and fed back to the regional team with the following conclusions:

1. The IST was assured that the trust had an appropriate approach to managing long wait patients and reviewing all patients that breach 52 weeks for possible clinical harm
2. The trust has made significant progress in improving it's approach to waiting list management including focused work to improve theatre utilisation, referral management and booking processes.
3. The trust has a good understanding

In month the trust is behind plan for both open pathway performance and RTT52.

- Although reducing the total patients waiting over 52 weeks is behind traject
- At trust leavel In regard to open pathway performance the number of breaches has fallen however the denominator has also reduced.
- All specialities are on track with the exception of corneo plastics where performance has deteriorated due to medical cover. There have been some challenges with temporary cover and plans are in place to address this but ongoing delivery remains a high risk. A wider recovery plan is in place including capacity and demand analysis at a subspecialty level, plans for a full service review and increased managerial capacity.
- Delivery of the breast trajectory is challenged due to the inability to recruit to an additional locum post. Alternative options are being reviewed.

Capacity and pathways

- *Additional capacity ongoing for OMFS at Uckfield and OMFS, corneo plastics and hands McIndoe*
- *Additional OMFS outpatient clinics are ongoing at Maidstone, Dartford and Medway.*
- *Dental triage work is continuing which has reduced demand for simple tooth extractions*

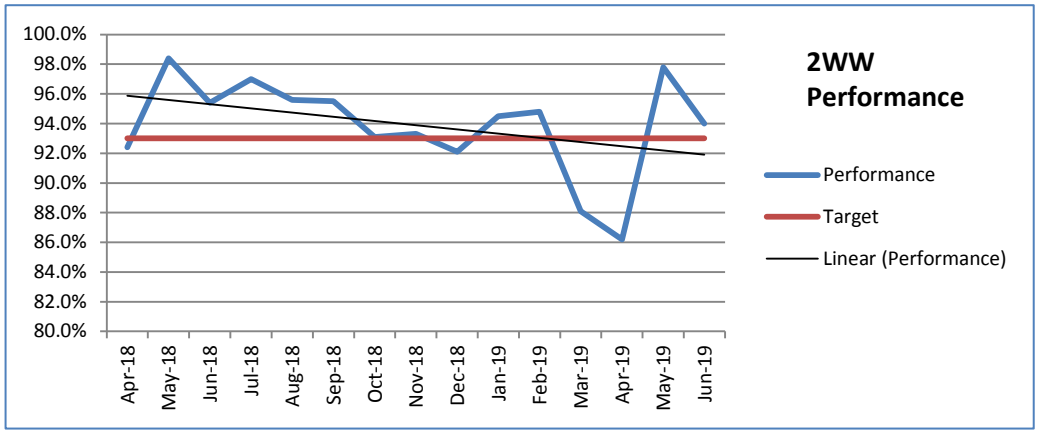
Theatre Efficiency

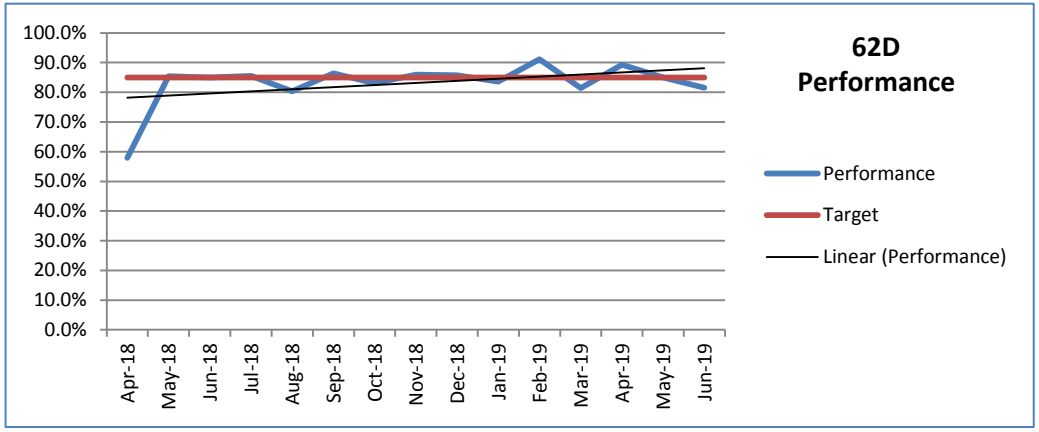
- *Theatre utilisation programme is continuing post the departure of Fours Eyes and is being led within the operations business management team.*
- *Trust reporting dashboard continues to be developed*

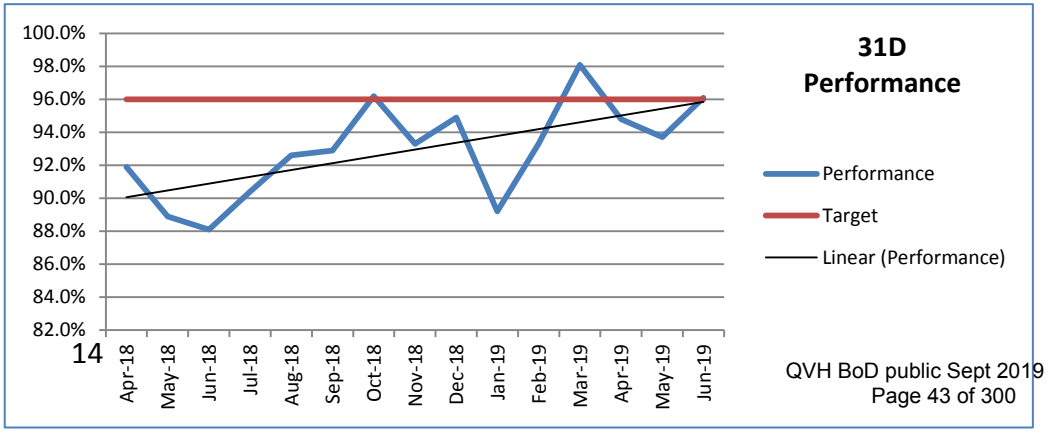
Outpatient Improvement

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

Cancer standards







2WW Performance: 94%
The 2WW target was met in the month of June, reporting 15 breaches. 13 breaches were due to patient choice, 2 H&N breaches were due to off site capacity challenges (Maidstone).
Quarter 1 performance is currently at 92.2%

62D Performance: 81.5%
The 62D target was not met in the month of June.
For Skin the breaches were a mixture of patient choice and medical delays. Two breaches were late referrals into the trust with both patients delaying their first appointment at QVH which meant we did not treat within 24 days to avoid the breach. One patient had their surgery date cancelled due to a high INR. For H&N, 2 breaches were due to the number of diagnostics needed and 1 was due to a change in the treatment plan. For Breast, the full breach was allocated to QVH as the patient was referred by day 38. The delay in treating the patient was theatre capacity.
Quarter 1 performance is currently at 85%

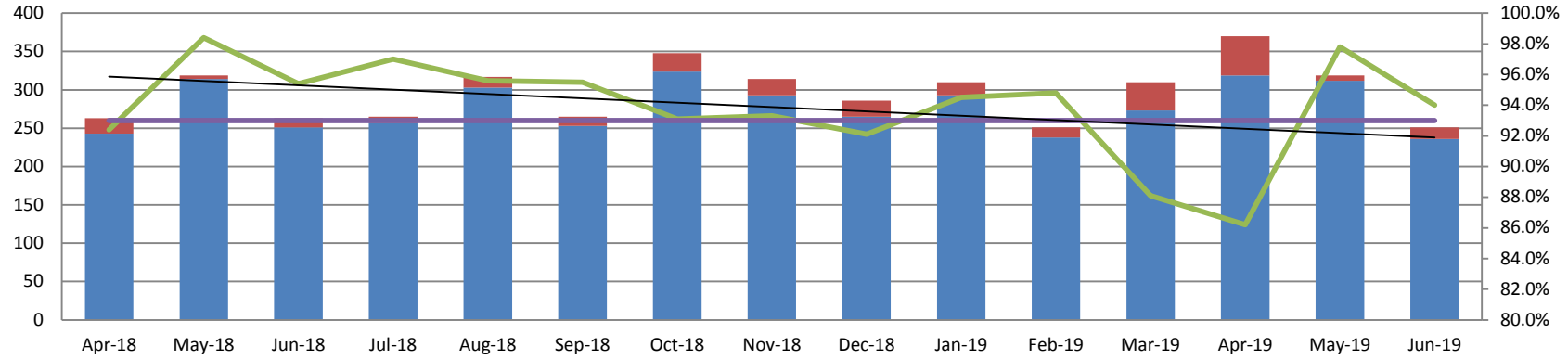
Screening Performance: N/A
We did not treat any patients on the screening pathway in the month of June. Challenges remain in the breast pathway, joint operations, theatre capacity and late referrals.
Quarter 1 performance is currently at 50%.

Consultant Upgrade Performance: 100%
The consultant upgrade target was met in the month of June.
Quarter 1 performance is currently at 100%.

31D Performance: 96.1%
The 31D decision to treat target was met in the month of June, reporting 3 breaches. Skin failed the target with 3 breaches; 2 breaches were due to the surgery being cancelled as the patient was unwell and 1 breach due to theatre capacity. H&N and Breast were achieving 100% compliance.
Quarter 1 performance is currently at 94.9%

31D Subsequent Performance: 72.7%
The 31D subsequent target was not met in the month of June. We had 3 breaches in month, 1 due to the surgery date being cancelled as they were unwell and 2 as a result of needing an external consultant to perform a joint operation.
Quarter 1 performance is currently at 81.5%

QVH Two Week Wait Performance

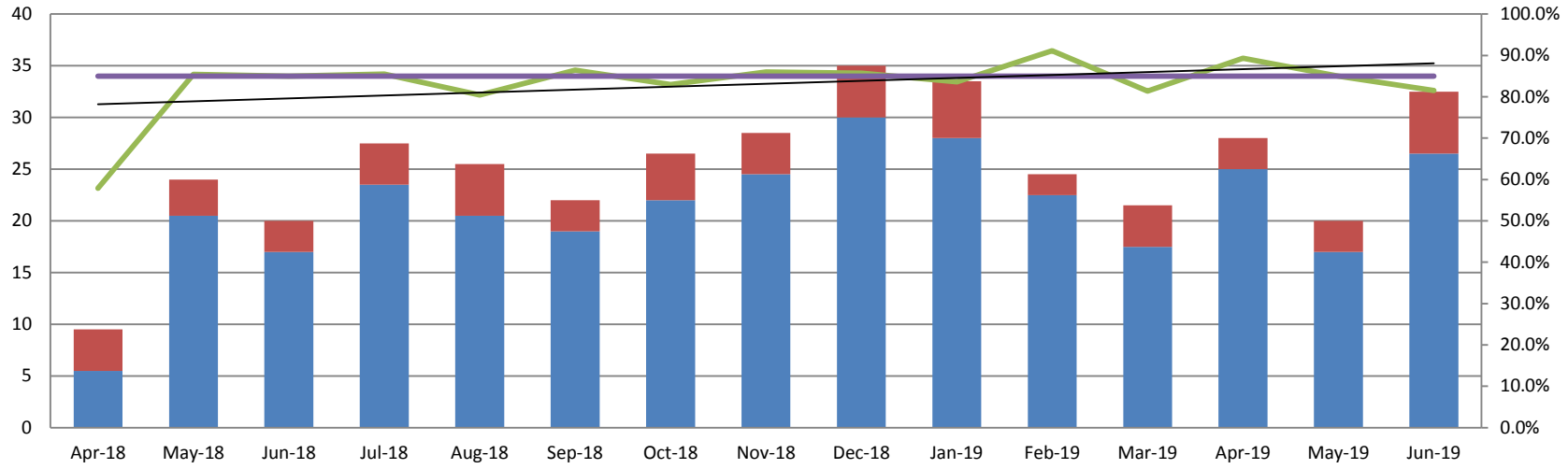


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Breached	20	5	12	8	14	12	24	21	21	17	13	37	51	7	15
Compliant	243	314	251	257	303	253	324	293	265	293	238	273	319	312	236
Performance	92.4%	98.4%	95.4%	97.0%	95.6%	95.5%	93.1%	93.3%	92.1%	94.5%	94.8%	88.1%	86.2%	97.8%	94.0%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

SKIN 2WW PERFORMANCE															
Month	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	May-19	Jun-19
Total	71	140	112	99	112	125	151	116	114	127	84	132	145	142	117
Breaches	1	0	3	3	6	3	1	0	6	4	4	4	8	1	5
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%	99.3%	95.9%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

HEAD AND NECK 2WW PERFORMANCE															
Month	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	May-19	Jun-19
Total	170	169	134	153	184	125	169	169	129	165	153	140	166	167	113
Breaches	19	4	9	5	8	8	22	21	15	12	9	31	43	6	9
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%	96.5%	92.6%
National Standard	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%

QVH 62 Day Referral to Treatment



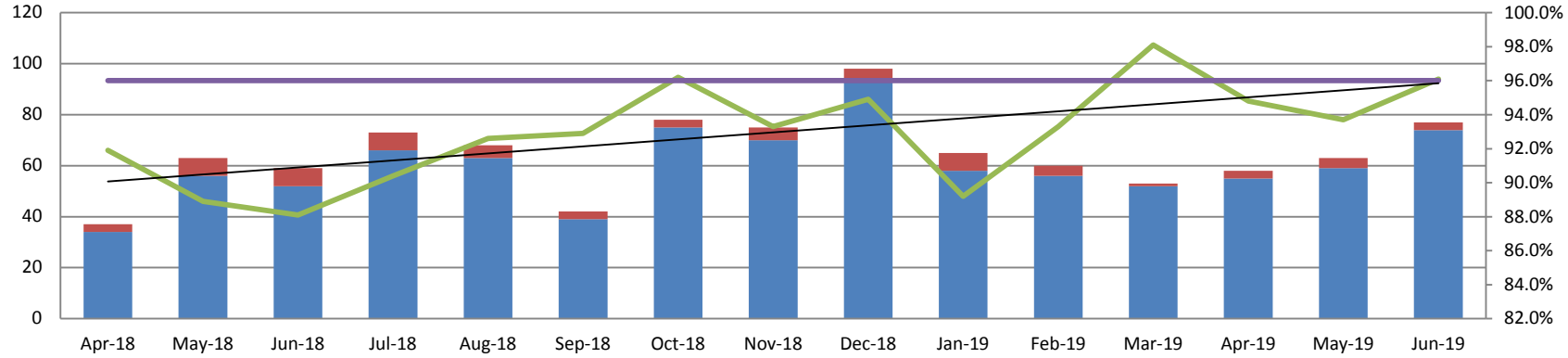
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Breached	4	3.5	3	4	5	3	4.5	4	5	5.5	2	4	3	3	6
Compliant	5.5	20.5	17	23.5	20.5	19	22	24.5	30	28	22.5	17.5	25	17	26.5
Performance	57.9%	85.4%	85.0%	85.5%	80.4%	86.4%	83.0%	86.0%	85.7%	83.6%	91.1%	81.4%	89.3%	85.0%	81.5%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

SKIN 62 DAY PERFORMANCE															
Month	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	May-19	Jun-19
Compliant	3	17	12	17.5	16.5	13.5	19	19.5	26	23.5	17	15.5	25	16	26
Breached	2	2	0.5	2.5	2	2	2	2.5	3	3.5	1.5	1.5	1.5	1.5	1.5
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%	91.4%	94.5%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

HEAD AND NECK 62 DAY PERFORMANCE															
Month	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	May-19	Jun-19
Compliant	2.5	2.5	4.5	5	4	5	3	5	3.5	4	3	2	0	1	0.5
Breached	2	1	1.5	1.5	3	1	2	1.5	1	0	0	1	0	1	3
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%		50.0%	14.2%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

BREAST 62 DAY PERFORMANCE															
Month	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	May-19	Jun-19
Compliant	0	1	0.5	0.5	0	0	0	0	0	0	0.5	0	0	0	0
Breached	0	0.5	0.5	0	0	0	0.5	0	1	2	0.5	0.5	0	0.5	1
Performance		66.6%	50.0%	100.0%			0.0%		0.0%	0.0%	50.0%	0.0%		0.0%	0.0%
National Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

QVH 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	May-19	Jun-19
Breached	3	7	7	7	5	3	3	5	5	7	4	1	3	4	3
Compliant	34	56	52	66	63	39	75	70	93	58	56	52	55	59	74
Performance	91.9%	88.9%	88.1%	90.4%	92.6%	92.9%	96.2%	93.3%	94.9%	89.2%	93.3%	98.1%	94.8%	93.7%	96.1%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

SKIN 31 DAY PERFORMANCE

Month	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	May-19	Jun-19
Compliant	26	43	41	48	53	29	62	55	85	49	43	40	50	47	65
Breached	0	7	5	7	5	3	2	5	3	5	3	1	1	4	3
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%	92.1%	95.50%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

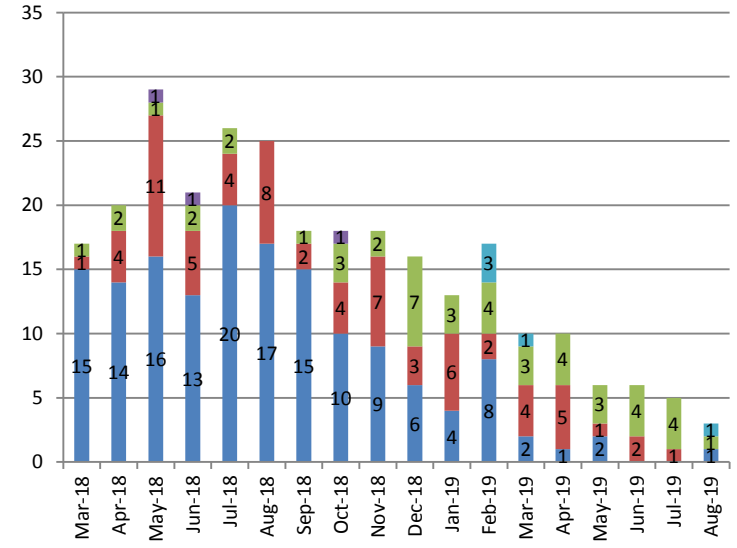
HEAD AND NECK 31 DAY PERFORMANCE

Month	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	May-19	Jun-19
Compliant	6	7	8	9	10	7	9	10	6	4	9	9	3	7	8
Breached	0	0	1	0	0	0	0	0	2	1	0	0	2	0	0
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%	100.0%	100%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

BREAST 31 DAY PERFORMANCE

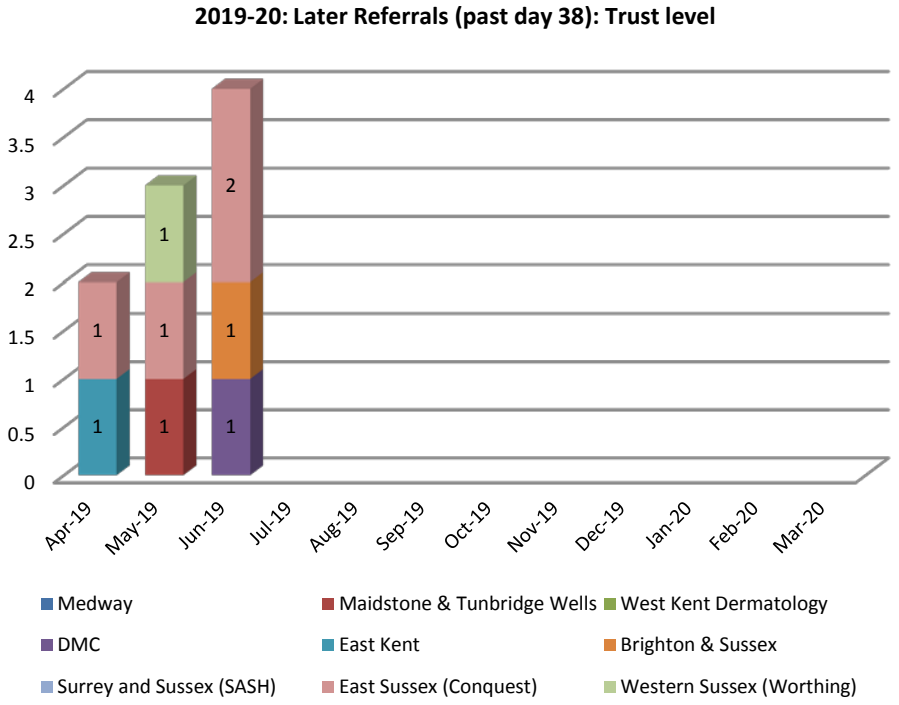
Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Compliant	2	6	3	8	0	3	3	2	2			3	2	5	1
Breached	3	0	1	0	0	0	1	0	0			0	0	0	0
Performance	40.0%	100.0%	75.0%	100.0%		100.0%	75.0%	100.0%	100.0%			100.0%	100.0%	100.0%	100%
National Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Performance: 104 days and 38 day allocation



Over 104 days

- Other
- Breast
- Maxillo-Facial
- Skin
- Head and Neck



Over 104 Days

The number of patients over 104 days is reducing, across all specialities, with the trust currently reporting 3 patients over 104 days.

Two patients are under the care of a different trust, having started on a Head and Neck pathway and are now on a Haematology pathway. We are seeing delays for patients moving between these pathways. We need focused work on this pathway to avoid patient's experiencing delays.

One patient is having a follow-up appointment this month – the delay in this pathway is due to multiple diagnostics and patient cancellations.

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

For 2018-19 QVH received 53 cancer referrals past 38 days (this doesn't include the referrals which have come back as non cancer):

- ❑ 32 for skin
- ❑ 13 for breast
- ❑ 11 for Head and Neck

- ❑ Kent and Medway = 28 (Medway sending the highest)
- ❑ Surrey and Sussex = 25 (East Sussex sending the highest)

For quarter 1 QVH has received 9 cancer referrals past 38 days – 5 have been treated within 24 days resulting in 2.5 saved breaches.

There is more focus on treating within 24 days at the PTL, with the 24 day breach date being visible on the tracking notes.

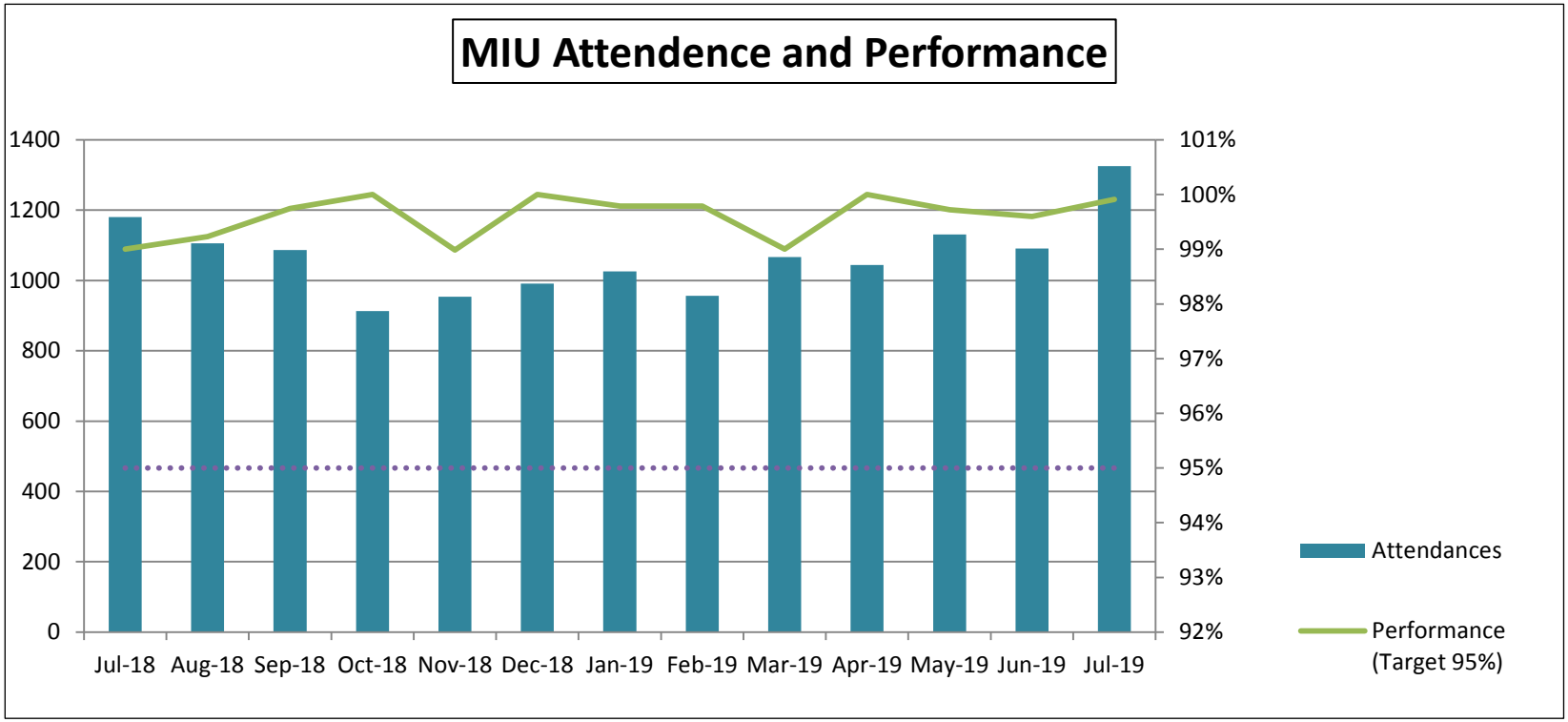
Cancer Update

Quarter Performance	2017-18					2018-19					2019-20				
	QTR 1	QTR 2	QTR 3	QTR 4	YTD	QTR 1	QTR 2	QTR 3	QTR 4	YTD	QTR 1	QTR 2	QTR 3	QTR 4	
Two Week Wait	94.3%	91.1%	94.3%	90.3%	**92.5%**	95.6%	95.9%	93.0%	92.3%	**94.1%**	92.2%				
62 Day Referral to Treatment	73.5%	73.7%	76.4%	77.0%	**75.0%**	80.3%	84.0%	85.0%	85.5%	**84.0%**	85.0%				
62 Day Screening	33.3%	50.0%	100.0%	N/A	**55.5%**	66.6%	100.0%	0.0%	50.0%	**60.0%**	50.0%				
62 Day Upgrade	98.3%	98.3%	90.4%	60.0%	**96.6%**	100.0%	100.0%	95.4%	83.3%	**95.0%**	100.0%				
31 Day Decision to Treat	96.5%	95.6%	95.6%	86.4%	**94.0%**	89.3%	91.8%	94.8%	93.2%	**92.6%**	94.9%				
31 Day Subsequent Treatment	95.4%	95.3%	90.5%	82.6%	**90.6%**	88.5%	88.1%	80.0%	91.6%	**86.8%**	81.5%				

- The newly established Cancer Board has met twice, July and August. The Cancer Board is a permanent trust wide meeting, comprised of clinical and non-clinical staff members involved with the treatment and care of cancer patients seen and referred to The Queen Victoria Hospital. The main purpose of the Cancer Board is to facilitate the delivery of high quality care to cancer patients including compliance with waiting times targets and compliance with NICE standards, NHS England specialist commissioning and external peer review, improving outcomes guidance and ensuring data quality.
- The trust has agreed to fund the purchase of Somerset Cancer Register. Key staff members attended a Somerset Cancer Register Webinar, including clinical leads. This was a brief demo of the system itself and how it fits into the patient pathway and its capabilities, focusing on data collection and the reporting aspect of the system. The next step is to hold a conference call with SCR, with an IT representative to ensure that all the requirements from a technical perspective are covered.
- Ongoing work is taking place to improve the pathways for our cancer sites, with particular focus on the Head and Neck pathway as this is our low compliance pathway. This works involves the planning to achieve the new Faster Diagnosis Standard. The new pathway is working towards same day diagnostic investigations, this has been piloted with same day MOS appointments for the highly suspicious cancer patients. This pilot is going well and we are seeing a quicker diagnosis for these patients.
- There is a lot of focus for the trust to move to a 7 day first appointment target, instead of a 14 days, especially in the high priority pathways. This is to support in achieving the 62 day standard but also the new Faster Diagnosis Standard.

Minor Injuries Unit (MIU)

MIU Performance v Target



Performance commentary / service update	Service forward look
• The July activity was the most seen in MIU since 2016 at 1325 patients seen and treated in the month. • The new Clinical Guidelines have been ratified by the Clinical Governance Group which has now removed the lack of these in MIU from the risk register.	• Recruitment to ensure a resilient workforce for the Emergency Nurse Practitioners and the removal of the HCA position in MIU over the next few months. • QVH is moving towards bookable appointments for MIU from the 111 service with an IT solution to be in place by December

Outpatient Improvement Programme – KPI update

	Programme key performance indicators	Baseline*	Target	Target date / milestone	Actions to deliver	May Performance	June Performance	July Performance		Notes
1a	Increase attended clinic utilisation by a minimum of 2%	Booking Utilisation 89%	91%	July 2019	6-4-2 Meetings		92.4%	91.5%		Utilisation rates are a key feature of 6-4-2 process. Slight decrease in July but there was a significant increase in number of slots made available for booking. Remains above target
1b		Attended Utilisation 81%	83%	July 2019	6-4-2 Meetings		82.6%	82.1%		The introduction of two way text messaging is expected to push performance above target
2	Reduction in Do Not Attend (DNA) rate by 0.5%	7.38% (FEI) 6.19% (QVH)	6.88% (FEI) 5.69% (QVH)	September 2019	2 way SMS text reminder	7.88% (FEI) 6.57% (QVH)	7.41% (FEI) 6.41% (QVH)	7.08% (FEI) 6.04% (QVH)		Introduction of new 2 Way SMS service is behind schedule but business case to be shared with EMT before end of August
3a	Reduction in patient on the day cancellations by 25%	2.2%	1.6%		2 way SMS text reminder	1.56%	2.42%	2.22%		As above
3b	Reduction in hospital cancellations <6weeks	12.89% (12 month average)	8%	October 2019	6-4-2 Meetings/ Annual Leave Policy	10.0%	16.0%	13.9%		Performance varies by speciality (see following slides). If Corneo excluded, overall Trust figure would be 9.2%

Outpatient Improvement Programme

	Programme key performance indicators	Baseline*	Target	Target date / milestone	Actions to deliver	May Performance	June Performance	July Performance		Notes
4	Launch Skype clinic by 1st June 2019 and Glaucoma virtual clinic by 10th June	N/A			Virtual Clinic group	Skype went live in June	Glaucoma went live 2nd July	Glaucoma went live 2nd July		In place and to be evaluated post 3 months of implementation
5	eRS Directory of Services to be reviewed	77 in total	100%	Jun 2019	eRS Workplan	17/77	33/77	37/77		All DoS still outstanding have been resent to service leads with request for urgent review – raised at HMT
6	Delivery of GP referrals via eRS	98.70%	99.75%		eRS Workplan	98.5%	99.3%	tbc		Only 2 referrals outside of eRS in July
7	Meet national Appointment Slot Issue (ASI) rate	6.18%	.00%	Oct 2019	eRS Workplan	4.08%	4.02%	4.14%		
8	To roll out e-vetting of referrals on eRS	0%	75% of service	Oct 2019	eRS Workplan		Pilot areas commenced	Pilot areas continuing		Pilots underway
9a	95% FFT rating	95%	95%	Apr 2019	All OPD Programme	96%	95%	95%		
9b	Response rate for OPD FFT	12%	20%	Dec 2019	All OPD Programme	8%	9%	9%		Information Governance issue has caused recent reduction in response rates
10	To reduce the clinic letter turnaround to 7 days (baseline information is currently being	12.2 days	7 days	Dec 2019	Letter transcription and delivery projects	Baseline taken from G2 however variable systems in the trust				Scoping of current practice complete. Roll out of Windows 10 has accelerated the timescale for dictation project. Identifying and confirming current models of

Outpatient Improvement Programme – Speciality performance

ALL		May	June	July
Booking Utilisation	%	92.7	92.4	91.4
Attended Utilisation	%	81.5	82.6	82.1
DNA	%	7.9	7.4	7.1
On the Day Pt canc	%	1.9	2.2	2.2
DNA + Pt Canc	%	9.8	9.7	9.3
Canc by QVH <6 weeks	Actuals	1221	1518	1680
Canc by QVH <6 weeks	%	13.0	16.0	13.9

PLASTICS		May	June	July
Booking Utilisation	%	90.6	93.1	89.8
Attended Utilisation	%	67.8	75.2	73.1
DNA	%	8.4	7.5	8.0
On the Day Pt canc	%	2.8	3.2	2.9
DNA + Pt Canc	%	11.2	10.5	10.9
Canc by QVH <6 weeks	Actuals	190	189	222
Canc by QVH <6 weeks	%	8.5	8.2	7.8

MAXFACS		May	June	July
Booking Utilisation	%	93.9	95.5	94.2
Attended Utilisation	%	90.8	93.6	91.4
DNA	%	8.3	7.7	6.7
On the Day Pt canc	%	2.7	3.0	3.2
DNA + Pt Canc	%	11.0	10.7	9.9
Canc by QVH <6 weeks	Actuals	191	277	354
Canc by QVH <6 weeks	%	7.7	11.5	10.0

OPTHAMOLOGY		May	June	July
Booking Utilisation	%	102.0	101.0	104.9
Attended Utilisation	%	94.8	89.8	95.2
DNA	%	6.1	7.6	6.6
On the Day Pt canc	%	0.4	0.6	0.4
DNA + Pt Canc	%	6.5	8.2	7.0
Canc by QVH <6 weeks	Actuals	547	781	777
Canc by QVH <6 weeks	%	29.8	42.6	35.2

SLEEP		May	June	July
Booking Utilisation	%	98.7	97.1	97.8
Attended Utilisation	%	87.2	86.9	88.3
DNA	%	8.8	8.0	7.8
On the Day Pt canc	%	2.6	2.0	2.6
DNA + Pt Canc	%	11.4	10.0	10.4
Canc by QVH <6 weeks	Actuals	112	112	122
Canc by QVH <6 weeks	%	11.9	10.5	8.4

Outpatient Improvement Programme

FEI finished work with the Trust at the end of July. Handover of key documentation and reporting tools completed
Steering Group Held 6th August. Update for all staff provided via Connect on 12th August
Programme task and finish group updates are as follows:

Task and Finish Group	Key Actions to date
Productivity	**2 way text reminder service implementation** • Outline business case to be submitted to EMT with recommended provider identified • Materials to support implementation (script for texts, posters) collated • Internal review of process undertaken to identify lessons for future procurements **Outpatient efficiency dashboard** • FEI met 50+ staff before their departure, to ensure staff are familiar with the dashboard and have valid log in details. • Dashboard and Tracker underpin the 6-4-2 process **Outpatients 642 meetings running in Plastics, Max Fac, Sleep and Ophthalmology** • Use of the vacant slot data to highlight areas of capacity opportunity • On-going use of the weekly utilisation tracker to review performance and areas for action • Confirm clinic schedule 6-8 weeks in advance with all key stakeholders • SOP agreed for making changes to clinics – to be rolled out in September • On-going monitoring of additional clinics • Room booking floorplan/timetable has been produced and is available on network to identify spare capacity

Outpatient Improvement Programme

Workstream	Key Actions to date
Communication	**Letter transcription, printing and postage** • Scoping of current service delivery in terms of letter transcription, printing and postage has uncovered significant variances in practice across QVH. • Current G2 dictation software is not compatible with Windows 10 which is being rolled out across QVH from October, so we have met G2 to urgently explore options and costs for upgrade to their SpeechReport product which is Windows 10 compatible • EMT have agreed to expand scope of Synertec project to include all clinic letters (DNA, rejection, rescheduling etc.) • Outline business cases under development with input from IM&T, Finance, Procurement and users
Virtual Clinics	• Glaucoma review clinic model went live on 2nd July • Therapy Skype clinic pilot ongoing and evaluation is planned • Phone clinics have been set up in orthodontics • Significant positive media coverage of model (TV, radio and newspaper) • Two new areas to be scoped – Kerataconus remote monitoring and Skin/plastics remote monitoring • Project lead identified to continue opportunities for virtual roll out trust wide.
eRS/DeRS Electronic referral system and Dental electronic referral system	• Further reminder to service leads to complete the review of remaining eRS Directories of Service. • Online review of eRS referrals pilots underway and will be reviewed to support roll out across other services. • KPI reporting model agreed and implemented – only 2 referrals received outside of eRS in July • Proactive identification of opportunities to reduce polling ranges in progress and several reduced • Identified potential for clinic letters to be sent to GDP via REGO
Process Redesign	• Process mapping summary report taken to OPD Steering Group • Work underway to map tertiary referrals – this will include identifying opportunities for electronic referral between consultants

Theatre productivity update:

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

- Utilisation of elective lists monitored daily and teams notified of gaps.
- Effective utilisation of anaesthetist during scheduling to ensure lists that require an anaesthetist are over 80% general anaesthetic or sedation required on the list.
- Performance board in theatres updated regularly.
- Weekly theatre operational review meeting embedded, look back and forward look at activity and operation performance
- Patient Call-Outs in place, improvement in communication with patients prior to surgery, staff discuss fasting, analgesia, expected time of arrival, need for escort and any other patient concerns as appropriate.
- Anaesthetic Lead Clinician reviewing on the day cancellations, plan to reduce avoidable cancellations wherever possible, lessons learned.
- The majority of lists continue to achieve > 80% utilisation. The percentage of utilisation does not take into account cancellations on the day.
- On Time Starts still remains an operation issue, senior clinicians supporting the embedment of this initiative with surgeons, anaesthetists and the wider multi disciplinary team.

On The Day Cancellations

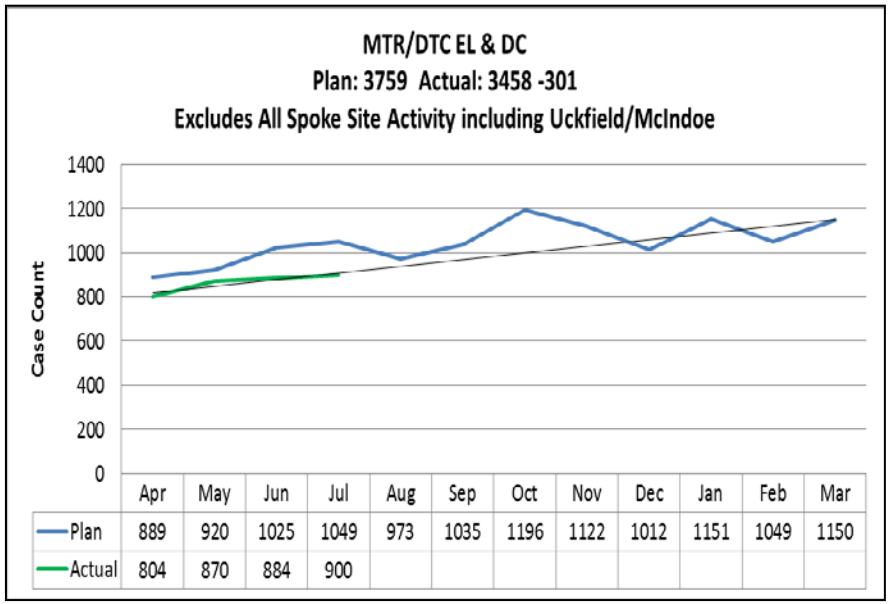
In July 8.11% of estimated available operating time available lost due to on the day cancellations.

Total Of: 6325 Mins: 105.41 hours of surgery time lost,

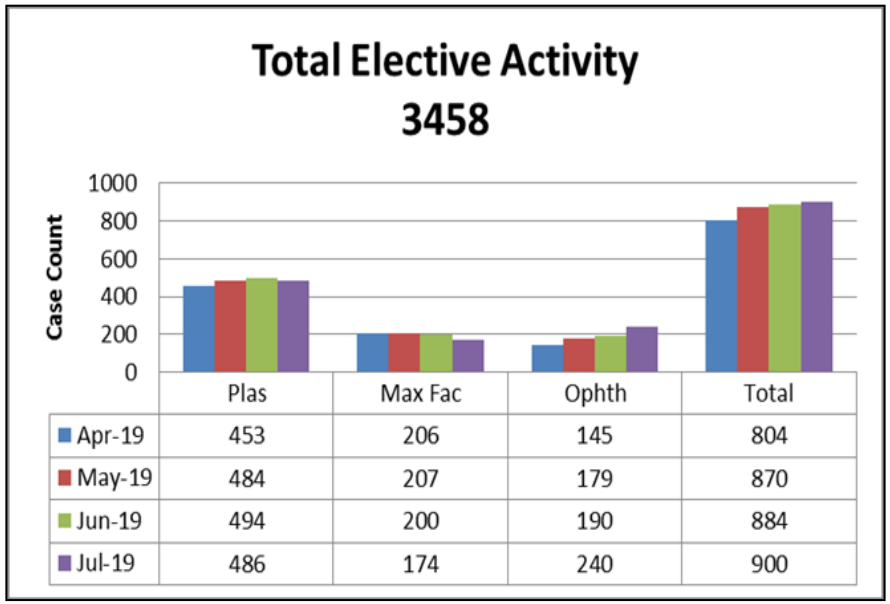
Significant rise on June: (62.75 hours lost)

By Specialty:
Plastics: 2,735 Min's
Max Fac: 2,300 Min's
Ophth: 1,290 Min's

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	889	920	1025	1049	973	1035	1196	1122	1012	1151	1049	1150
Actual	804	870	884	900								



	Plas	Max Fac	Ophth	Total
Apr-19	453	206	145	804
May-19	484	207	179	870
Jun-19	494	200	190	884
Jul-19	486	174	240	900

Performance commentary

Total Elective Activity for July: 900 against a phased activity plan of 1049

- Plas Total : 486
- OMFS Total : 174
- Ophthalmology Total : 240

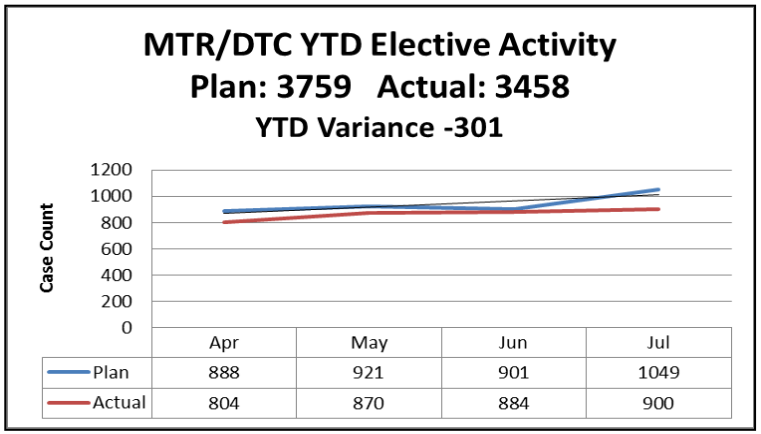
Main issues for July

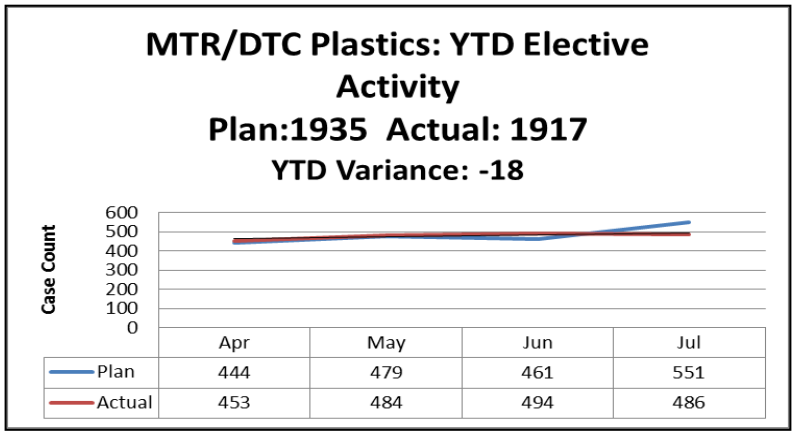
- Phased return to work Max Fac Consultant
- Corneal Locums were not suitable
- Cancellations due to urgent trauma

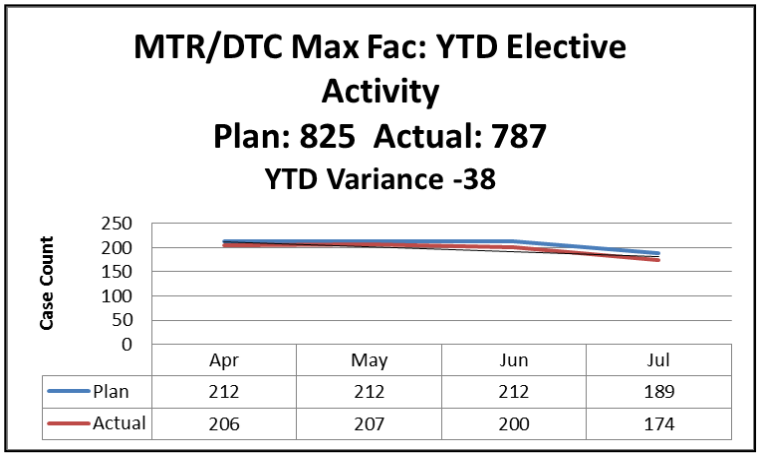
Forward look / performance risks

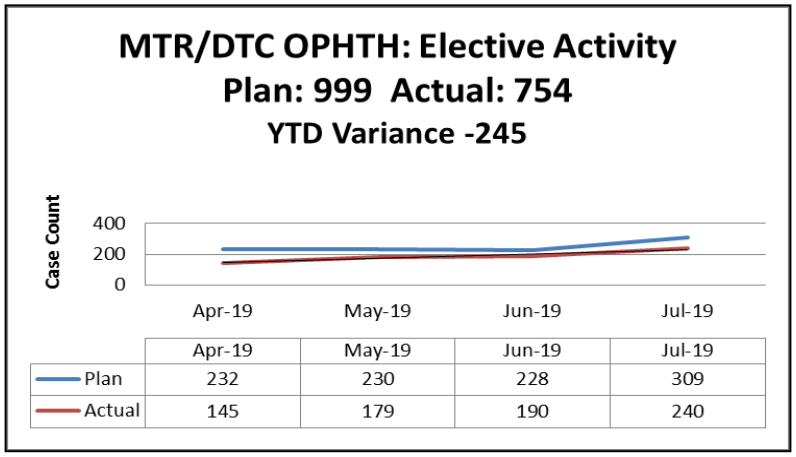
- Reduced theatre sessions running during August
- Substantive Consultant Anaesthetist due to start in September has withdrawn
- Replacement Ophthalmology Locum to be recruited to
- New plastic Consultant picking up additional sessions
- Recruitment ongoing for locum and substantive Anaesthetists
- Anticipating a high number of referrals for trauma, following previous seasonal trends and Bank Holiday.
- Reduced activity associated with loss of water supply in theatres

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







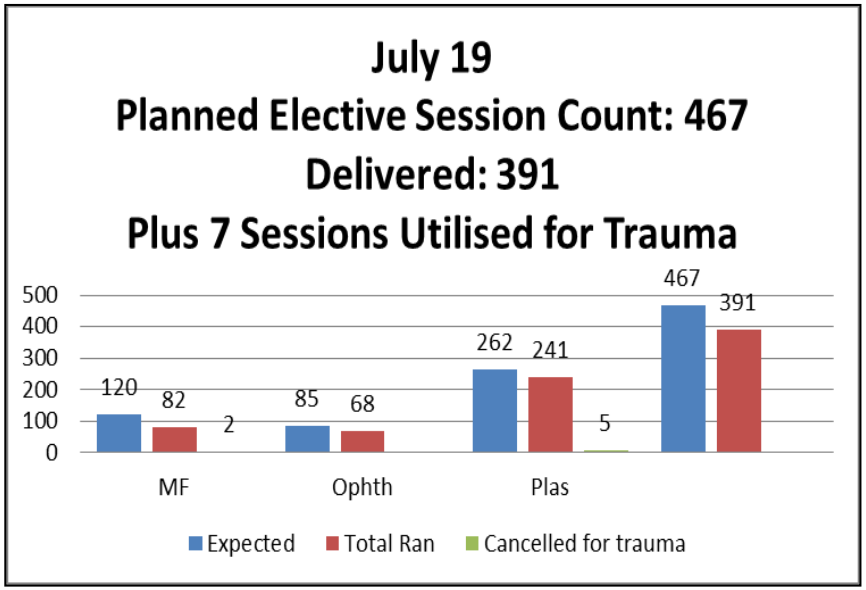


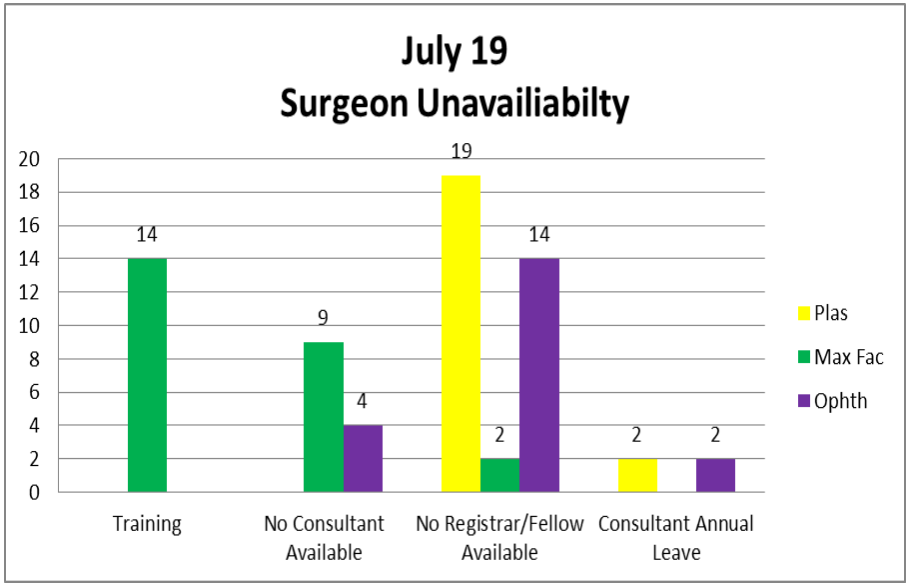
This excludes off site and independent sector activity

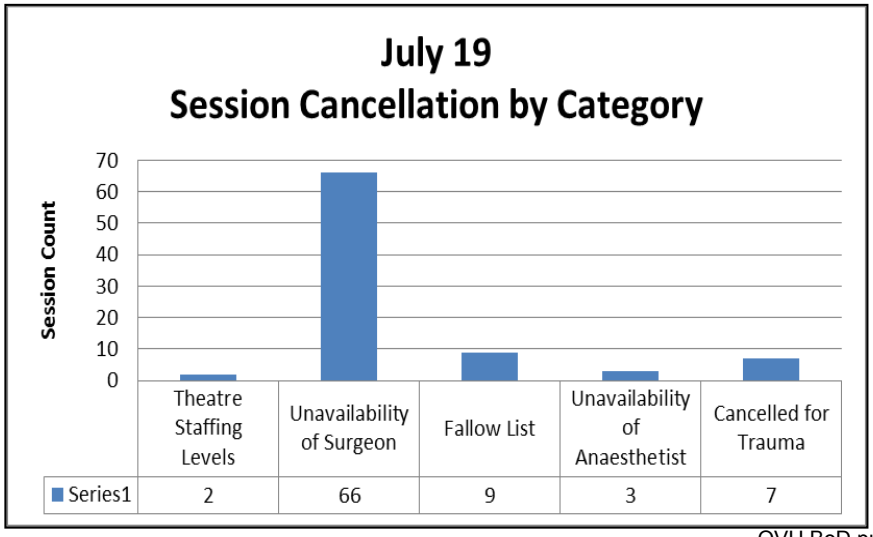
Plan to recruit a locum Corneal Fellow, Locum and substantive Consultant Anaesthetists.

Consultant on a phased return to work plan, this has negatively impacted on service delivery for Max Fac.

KPI 2 - Session Count June 19

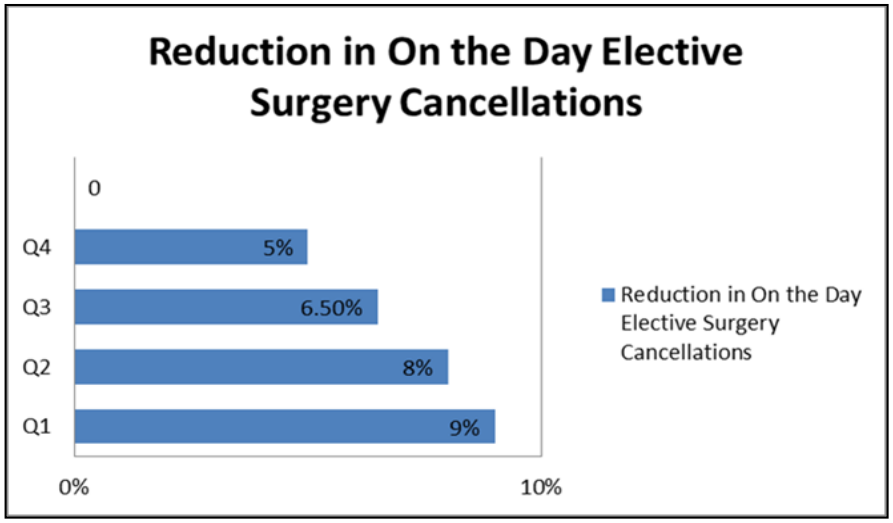


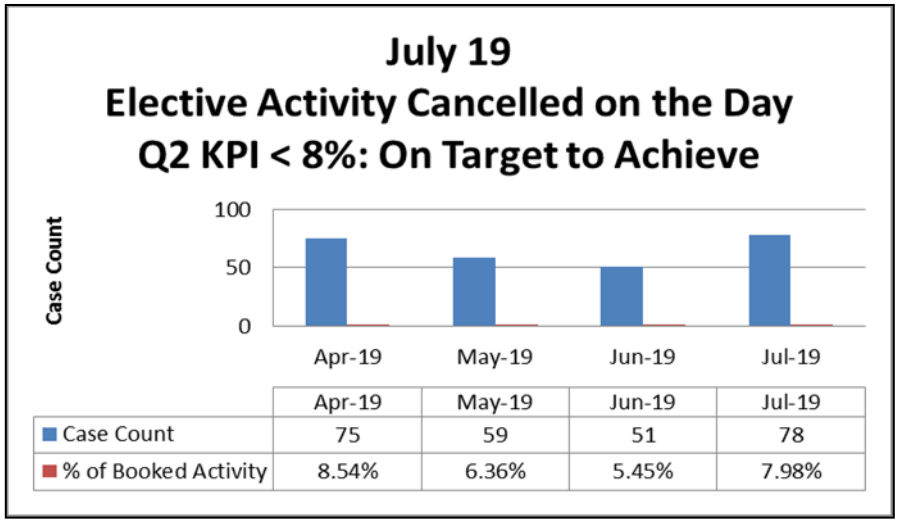


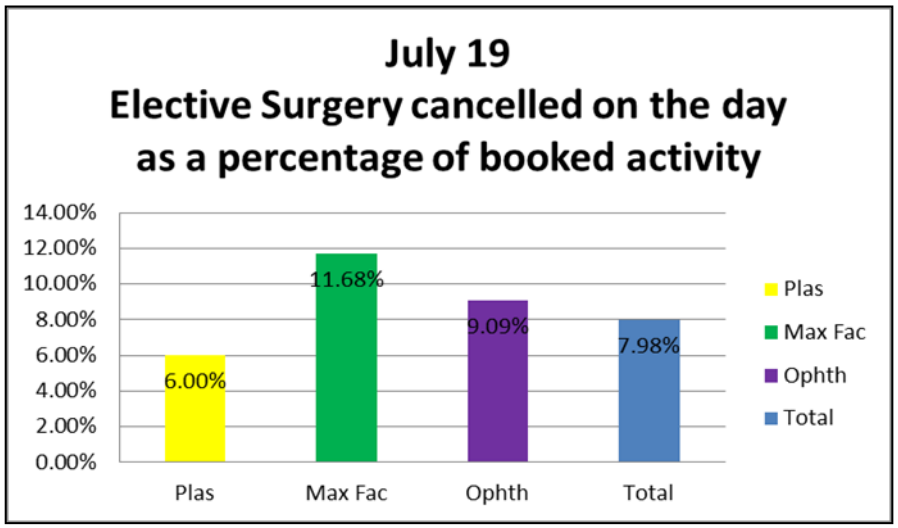


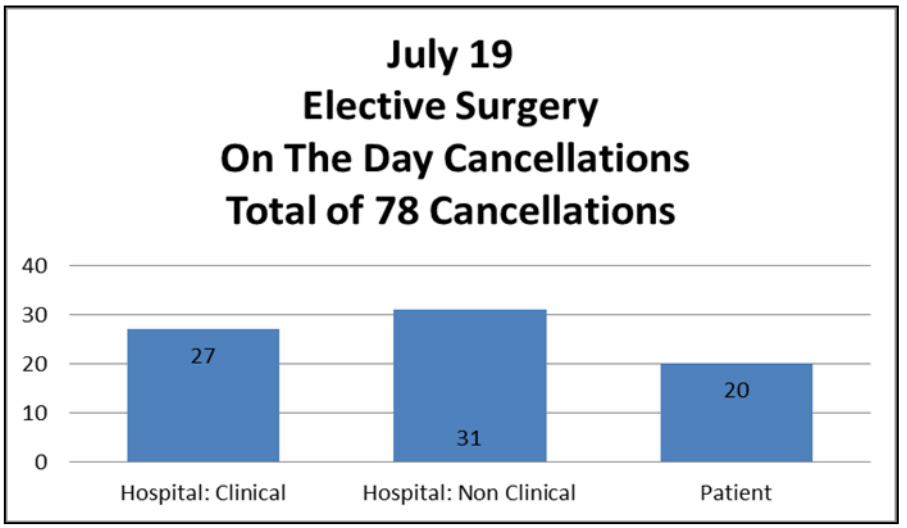
- Max Fac's conference and department training day resulted in reduced session's running plus a consultant on a phased return to work plan.
- No consultant available: MF pool oncology lists not always used & sickness.
- 11 fallow sessions picked up by other specialties; 6 plastics, 5 ophthalmology
- Reduced Opthalmology Consultant and Clinical Fellow availability resulted in a high level of cancellations
- Plastics lost 19 sessions and ophthalmology lost 14 sessions due to rota gap/vacancies in registrar/clinical Fellow positions.
- Teams continue to work together in order to re-utilise sessions available from other specialties.
- Prioritisation given to Ophthalmology and plastics breast cases during 6-4-2

KPI 3 - Cancellations



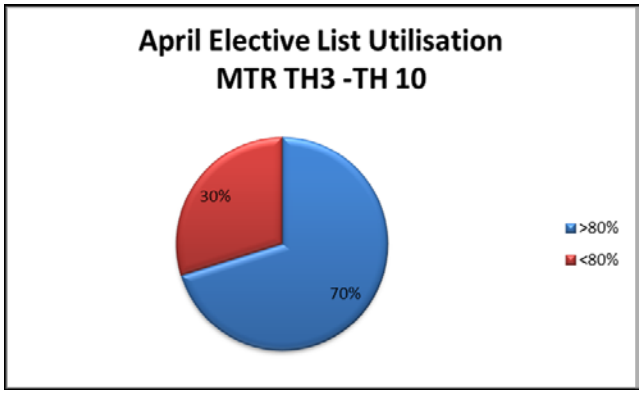


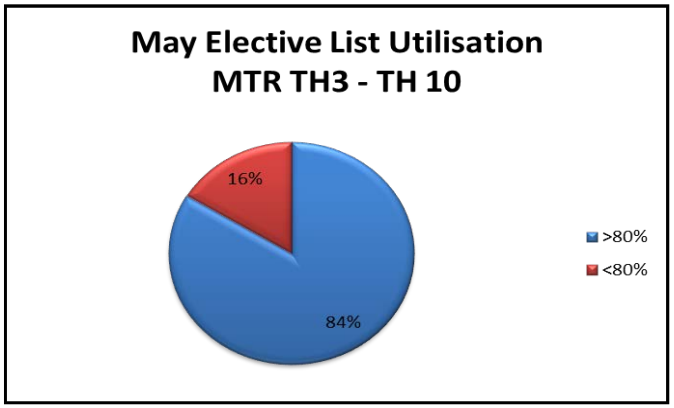


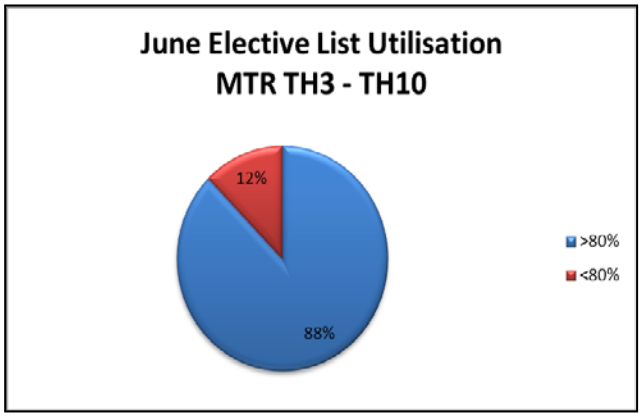


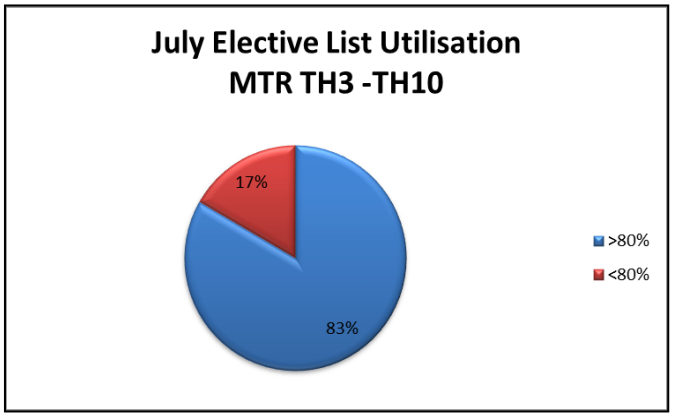
- Deterioration in on the day cancellations driven by extra trauma and short notice cancellation of Locum Corneal Fellow appointment.
- All on the day cancellations are continuing to be reviewed by Pre Assessment Clinic Team Lead
- Monthly reducing cancellations Task and Finish group, continue to review themes and focus on specific areas of improvement.

KPI 4 – Utilisation



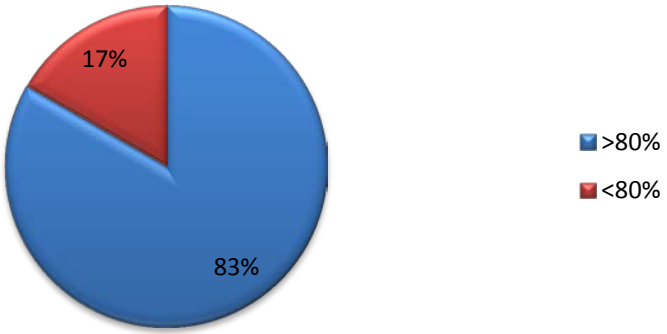




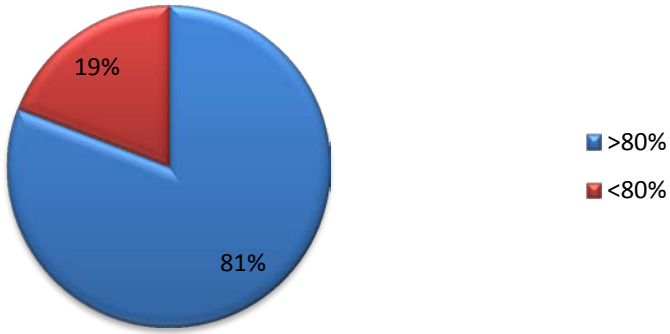


In month we have seen a reduction in elective list utilisation driven by a high number of on the day cancellations.
10 patients cancelled on the day for corneal surgery, an estimated 670 minutes of surgery time lost, in addition to 1,720 estimated minutes of surgical time lost due to patients being unwell on the day of surgery.

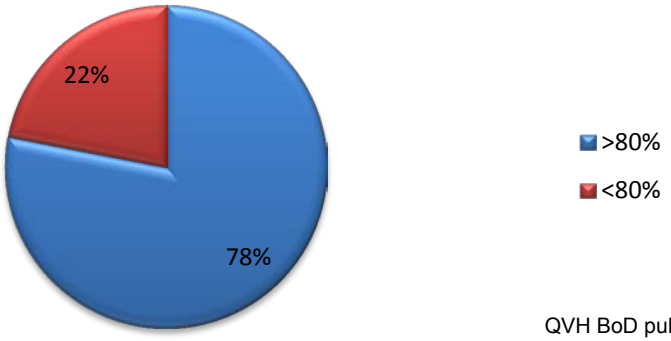
July Elective List Utilisation
MTR TH3 - TH10



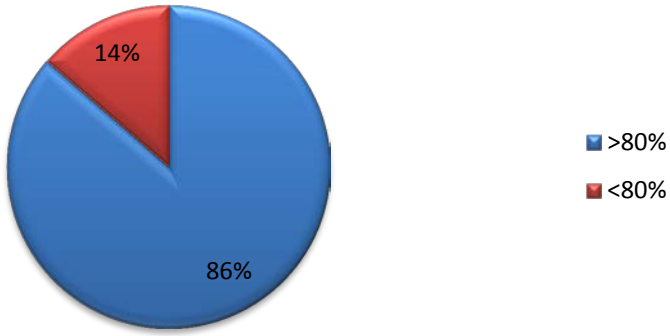
Max Fac July
MTR List Utilisation

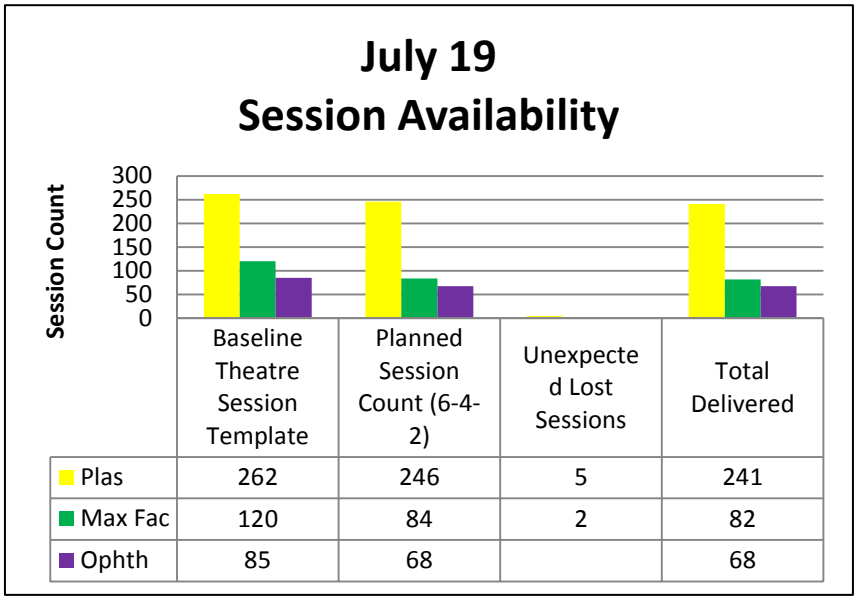


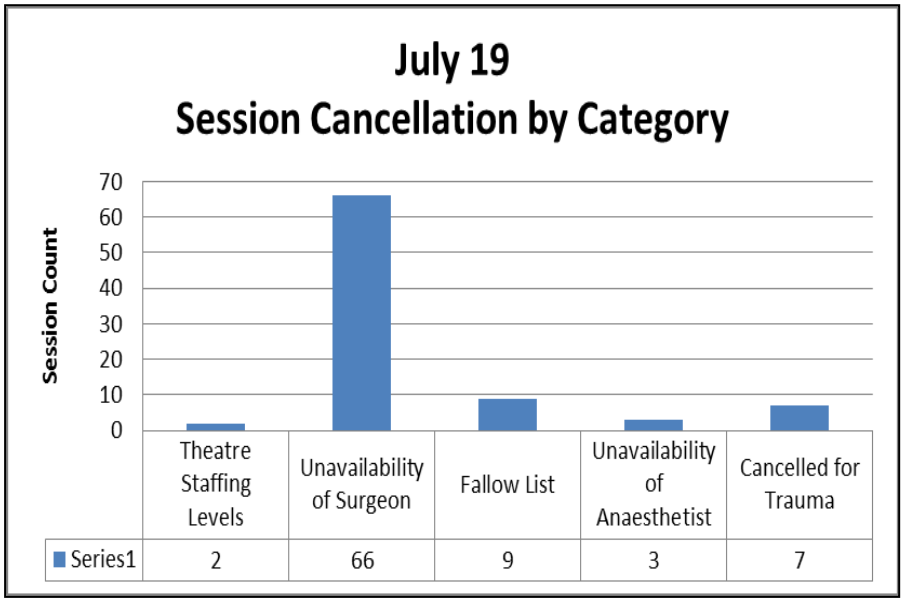
Ophth July
MTR List Utilisation

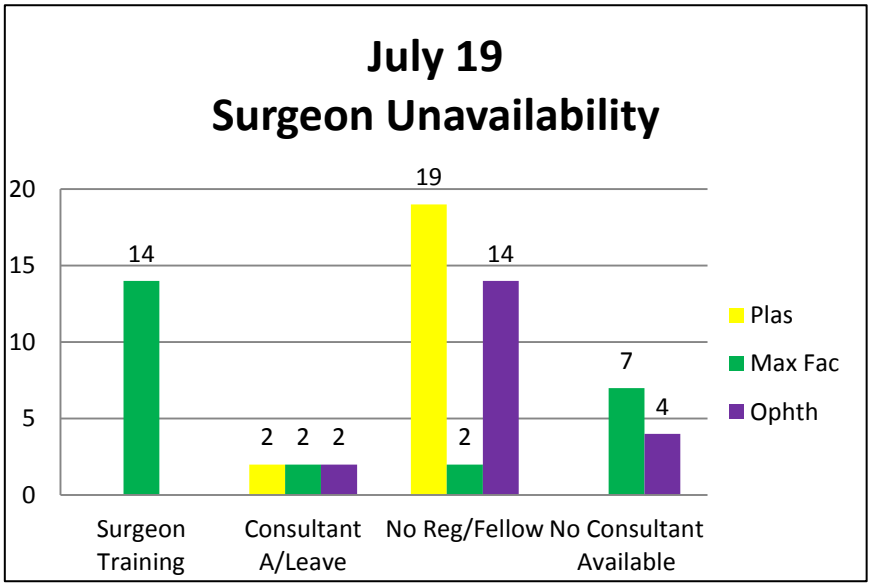


Plastics July
MTR List Utilisation




July 19
Session Availability
Session Count
300
250
200
150
100
50
0
Baseline Theatre Session Template
Planned Session Count (6-4-2)
Unexpected Lost Sessions
Total Delivered
Plas 262 246 5 241
Max Fac 120 84 2 82
Ophth 85 68 68


July 19
Session Cancellation by Category
Session Count
70
60
50
40
30
20
10
0
Theatre Staffing Levels
Unavailability of Surgeon
Fallow List
Unavailability of Anaesthetist
Cancelled for Trauma
Series1 2 66 9 3 7


July 19
Surgeon Unavailability
20
15
10
5
0
14
2 2 2
19
2
14
7
4
Plas
Max Fac
Ophth
Surgeon Training
Consultant A/Leave
No Reg/Fellow
No Consultant Available

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**142-19**	
Report title:	**Finance Report 2019/20 – Mth4 (July)**				
Sponsor:	Michelle Miles, Director of Finance & Performance				
Author:	Jason McIntyre, Deputy Director of Finance				
Appendices:	Finance Performance Month 04 - Report				
Executive summary					
Purpose of report:	To provide the Board with an overview of the Trust's financial performance				
Summary of key issues	The Trust delivered a deficit of £3.1m YTD; £0.2m worse than plan. Clinical income under-recovery has been partially offset by expenditure underspends The Trust is expected to achieve forecast at the year end. However there are some risks especially in relation to activity delivery and unidentified CIPs. The current run rate forecast for the year would be a deficit of £9.4m; £2m worse than the annual plan.				
Recommendation:	The committee 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:	KSO4 Financial Sustainability				
Corporate risk register:	CRR877 Financial Sustainability				
Regulation:	NHSI Single oversight framework : The "Use of Resources" score is 3, against the plan of 4,				
Legal:	N/A				
Resources:	N/A				
Assurance route					
Previously considered by:	EMT				
	Date:	19.08.19	Decision:	N/A	
Previously considered by:	Finance and Performance Committee				
	Date:	27.08.19	Decision:	N/A	
Next steps:	N/A				

Queen Victoria Hospital
NHS Foundation Trust

Trust Board - Finance Report
July 2019

Executive Director: Michelle Miles

Contents

2019/20 M04 Financial Performance

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance		Annual	In Month £'000			Year to Date £'000		
Income and Expenditure		Plan	Plan	Actual	Favourable/(Adverse)	Plan	Actual	Favourable /(Adverse)
Income	Patient Activity Income	67,624	5,796	5,961	165	22,139	21,581	(558)
	Other Income	4,654	388	381	(7)	1,551	1,544	(7)
Total Income		**72,278**	**6,184**	**6,342**	**158**	**23,690**	**23,125**	**(565)**
Pay	Substantive	(51,264)	(4,221)	(3,813)	408	(16,971)	(15,345)	1,626
	Bank	(799)	(130)	(286)	(156)	(253)	(922)	(669)
	Agency	(193)	(16)	(248)	(232)	(64)	(836)	(772)
Total Pay		**(52,255)**	**(4,367)**	**(4,347)**	**20**	**(17,288)**	**(17,103)**	**186**
Non Pay	Clinical Services & Supplies	(13,162)	(1,062)	(1,089)	(27)	(4,387)	(4,334)	53
	Drugs	(1,532)	(128)	(142)	(14)	(511)	(496)	15
	Consultancy	(79)	(7)	(1)	6	(26)	(4)	22
	Other non pay	(7,688)	(724)	(645)	80	(2,767)	(2,628)	140
Total Non Pay		**(22,461)**	**(1,921)**	**(1,876)**	**45**	**(7,691)**	**(7,462)**	**229**
Financing		(5,006)	(417)	(384)	33	(1,669)	(1,701)	(32)
Total Expenditure		**(79,723)**	**(6,704)**	**(6,607)**	**97**	**(26,649)**	**(26,265)**	**383**
Surplus / (Deficit)		**(7,445)**	**(521)**	**(265)**	**255**	**(2,958)**	**(3,141)**	**(182)**

YTD performance

The Trust delivered a deficit of £3.1m YTD; £0.2m less than the plan of a £3m deficit.

The income position is under plan by £0.6m within patient activity income. There is an adverse case mix (£0.7m) of elective activity largely within Oral, Plastic and Eyes business units. There is an adverse volume/ casemix variance of £0.9m for emergency activity within Oral and Plastics business units. Critical care underperformance (casemix/ volume) of £0.2m. These have been offset by coding accrual of £0.4m (£0.29m Plastics & £0.11m Oral), Outpatient above plan by £0.2m and other overperformance – largely non PBR of £0.4m.

The pay position is underspent by £186k YTD. Overspends within Medical staffing £0.16m and Allied Health Professionals (£0.3m), largely due to and temporary staffing premium. These have been offset by underspends within other staff categories.

The non pay position is underspent by £229k. This is partially due to activity related underspends within clinical supplies and drugs and impact of materials management saving schemes offset by additional non PBR costs . There has also been non recurrent savings within other non pay die to review of GRNI (good received notification) accruals in corporate areas which have benefited the position.

Overview

The Trust delivered a deficit of £3.1m YTD; £0.2m worse than plan. Clinical income under-recovery has been partially offset by expenditure underspends There has been delays in coding of clinical activity in month, although this is expected to be resolved within the next 6 weeks.

The Trust is expected, by our regulators, to at a minimum to achieve forecast at the year end. However there are some risks especially in relation to activity delivery and unidentified CIPs. A draft forecast will be presented in month to the clinical and non clinical areas for review and will be compiled by month 5 to report.

The current run rate forecast for the year would be a deficit of £9.4m; £2m worse than the annual plan.

In month performance

The Trust delivered a deficit of £0.26m in month; £0.25m above plan.

The income position is £158k above plan. Clinical income over recovered by £0.165m due to the completion of coding for M03 which was better than anticipated and generated an additional £0.5m over and above the WIP accrual last month. There is an underlying underperformance of clinical income within M04 of c£0.3m post robust accrual being made based on Q1 outturn. This includes a provision for anticipated coding gain due to high level of uncoded spells in month based on Q1 performance.

The pay position is £20k favourable to plan due to vacancies within all staff groupings with the exception of qualified nursing and AHPs.

The non pay position is £45k favourable to plan largely due to non recurrent benefits within other non pay due review of GRNI adjustments and overachievement of CIP. Clinical supplies includes £140k of PBR excluded devices (Sleep devices/ Corneo grafts) which is offset by clinical income. Capital charges estimate has been revised in month in line with estimated depreciation and expected PDC payment.

2019/20 - Income and Expenditure Trend

Queen Victoria Hospital NHS Foundation Trust

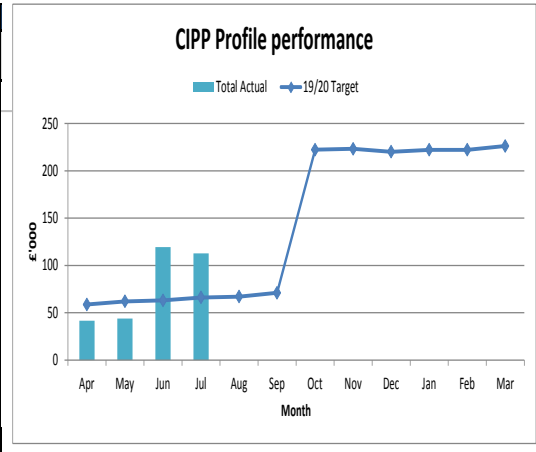
Board Line	Actual M10 18/19	Actual M11 18/19	Actual M12 18/19	Actual M1	Actual M2	Actual M3	Actual M4	Plan M5	Plan M6	Plan M7	Plan M8	Plan M9	Plan M10	Plan M11	Plan M12	Annual Plan
Patient Activity Income	5,792	5,120	7,458	5,006	4,992	5,621	5,961	5,730	5,664	6,234	5,657	5,275	5,736	5,333	5,856	67,624
Other Income	(5)	504	(722)	348	438	377	381	388	388	388	388	388	388	388	388	4,654
Total Income	**5,787**	**5,624**	**6,736**	**5,354**	**5,430**	**5,998**	**6,342**	**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)	(3,706)	(3,813)	(4,305)	(4,262)	(4,348)	(4,320)	(4,280)	(4,301)	(4,280)	(4,363)	(51,500)
Bank	(161)	(117)	(346)	(186)	(194)	(256)	(286)	(41)	(41)	(41)	(41)	(41)	(41)	(41)	(41)	(491)
Agency	(185)	(250)	(216)	(186)	(175)	(248)	(248)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(240)
Total Pay	**(3,942)**	**(4,027)**	**(4,476)**	**(4,274)**	**(4,193)**	**(4,210)**	**(4,347)**	**(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)	(1,156)	(1,089)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(1,108)	(13,301)
Drugs	(122)	(116)	(108)	(118)	(118)	(119)	(142)	(128)	(128)	(128)	(128)	(128)	(128)	(128)	(128)	(1,532)
Consultancy	34	(49)	(229)	(8)	7	(2)	(1)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(79)
Other non pay	(765)	(484)	(477)	(691)	(560)	(732)	(645)	(681)	(681)	(581)	(581)	(581)	(581)	(581)	(581)	(7,572)
Total Non Pay	**(2,057)**	**(1,828)**	**(1,989)**	**(1,612)**	**(1,966)**	**(2,009)**	**(1,876)**	**(1,924)**	**(1,924)**	**(1,824)**	**(1,824)**	**(1,824)**	**(1,824)**	**(1,824)**	**(1,824)**	**(22,484)**
Financing	(379)	(374)	(423)	(441)	(439)	(440)	(387)	(418)	(418)	(418)	(418)	(418)	(418)	(418)	(418)	(5,018)
Total Expenditure	**(6,378)**	**(6,230)**	**(6,887)**	**(6,327)**	**(6,598)**	**(6,658)**	**(6,609)**	**(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)**	**(660)**	**(267)**	**(590)**	**(613)**	**(29)**	**(578)**	**(920)**	**(480)**	**(862)**	**(422)**	**(7,456)**

Summary

- The current forecast is to deliver the operating plan of £7.4m deficit. There are some risks to fully year delivery within activity and unidentified savings.
- A draft forecast has been developed and is going to form part of the performance meetings this month to engage the clinical and non clinical areas as to what mitigation or run rate changes are anticipated by the end of the financial year.
- Income has recovery previous months underperformance as clinical coding has been completed.
- Clinical Income is averaging £5.4m per month – the average monthly plan for the remainder of the year is £5.7m. This is a key challenge for the Trust going forward the delivery of this additional activity cost effectively.
- Temporary staffing spend is increasing but not at a level which fully absorbs the substantive pay under spends. The last 2 months expenditure has increased with temporary staffing representing 12% of total pay expenditure.
- Non pay has reduced from the prior period and is currently returning to trend this reporting period, this is the key improved variance to prior month trend. Its important to note that non pbr expenditure is overperforming masking clinical supplies underpinning run rate.

Trust CIP Dashboard for the period to 31 July 2019

CIPP Profile £'000						
Month	19/20 Target	Pay	Non-Pay	Income	Total Actual	Variance
Apr	59	9	33	0	42	(17)
May	62	9	35	0	44	(18)
Jun	63	9	111	0	119	56
Jul	66	12	101	0	113	47
Aug	67					
Sep	71					
Oct	222					
Nov	223					
Dec	220					
Jan	222					
Feb	222					
Mar	226					
Total	1,724	39	279	0	318	68



Summary Identified £'000			
Business Units	19/20 Target	Identified	Unidentified
Clinical Support	280	170	109
Eyes	72	72	0
Plastics	219	50	168
Sleep	72	72	0
Commerce & Finance	84	20	64
Human Resources	32	0	32
Oral	190	37	153
Operational Nursing	210	58	152
Director of Nursing	69	6	63
Non Clinical Infrastructure	130	127	3
Perioperative Care	328	306	22
Access & Outpatients	30	30	(0)
Corporate	49	0	49
Reserves	(40)	0	(40)
Total	1,724	949	775

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

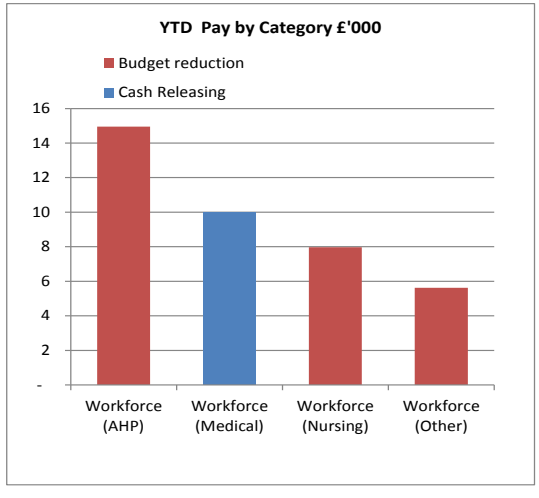
To date £949k CIPP has been identified. Unidentified CIPP is phased to start from M7.
The value of unidentified CIPP has decreased from £885k at M3 to £775k following the identification of new schemes in various areas.

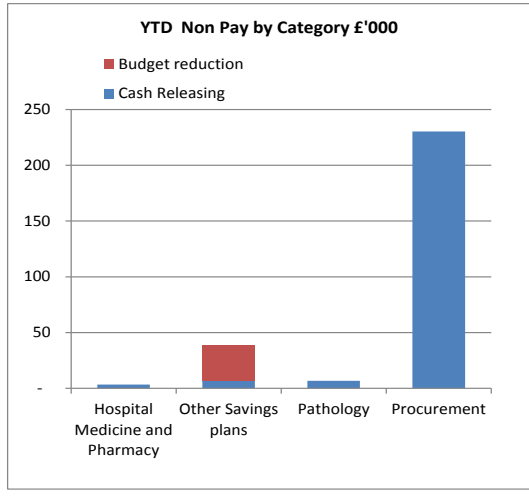
The largest proportion of cash releasing savings is planned by Perioperative Care, £306k.

YTD M4 shows an overall favourable CIPP performance of £68k above target.

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

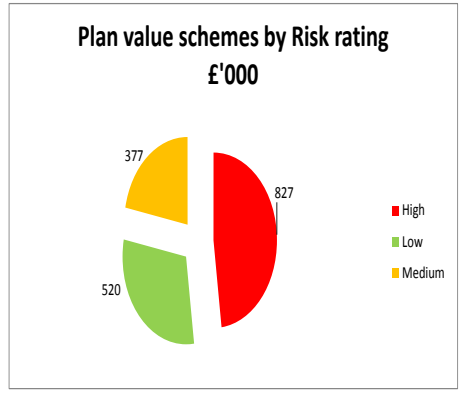
Business Unit Summary YTD £'000			
Business Units	Target	Actual	Variance
Clinical Support	46	56	10
Eyes	8	19	12
Plastics	8	12	4
Sleep	20	24	4
Commerce & Finance	8	7	(1)
Human Resources	0	0	0
Oral	12	19	6
Operational Nursing	13	17	4
Director of Nursing	2	3	1
Non Clinical Infrastructure	40	42	2
Perioperative Care	93	109	15
Access & Outpatients	0	10	10
Corporate	0	0	0
Reserves	0	0	0
Total	250	318	68

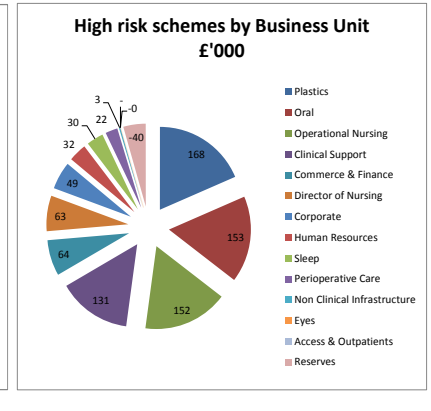




YTD Summary by Category £'000			
Category	Target	Actual	Variance
Pay (Skill mix)	22	25	3
Pay (WTE reductions)	14	14	(1)
Non pay	210	279	69
Income (Patient Care Activities)	4	0	(4)
Income (Other operating income)	0	0	0
Unidentified	0	0	0
Total	250	318	68

Budget Reduction - YTD Summary £'000			
Category	Target	Actual	Variance
Workforce (Other)	8	6	(3)
Workforce (AHP)	14	15	1
Workforce (Nursing)	6	8	2
Procurement	0	0	0
Other Savings Plans	0	32	32
Total	28	61	33





Balance Sheet – M04 2019/20

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet as at the end of July 2019	2018/19 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	51,173	50,567	50,694
Other Receivables	-	-	-
Sub Total Non-Current Assets	51,173	50,567	50,694
Current Assets			
Inventories	1,275	1,295	1,285
Trade and Other Receivables	10,210	6,805	7,631
Cash and Cash Equivalents	3,944	3,770	1,835
Current Liabilities	(13,164)	(10,620)	(10,011)
Sub Total Net Current Assets	2,265	1,250	740
Total Assets less Current Liabilities	53,438	51,817	51,434
Non-Current Liabilities			
Provisions for Liabilities and Charges	(608)	(627)	(627)
Non-Current Liabilities >1 Year	(5,045)	(6,547)	(5,897)
Total Assets Employed	**47,785**	**44,643**	**44,910**
Tax Payers' Equity			
Public Dividend Capital	12,249	12,249	12,249
Retained Earnings	22,395	19,253	19,520
Revaluation Reserve	13,141	13,141	13,141
Total Tax Payers' Equity	**47,785**	**44,643**	**44,910**

NB Analysis is subject to rounding differences

Summary

- The capital asset net value has decreased in month by £127k, and is expected to continue to reduce through the year due to the timing and level of this year's capital plan.
- Net current assets have decreased in year by £1m reflecting the current year operating losses and capital spend and partly offset by revenue loans.
- Inventories: The stock inventory will continue to be monitored during 2019-2020. An adjustment for stock take of circa £120k will be completed in M05 to reduce value of inventory.
- Trade and other receivables have decreased by £0.8m in month, reflecting a reduction in NHS debtors following invoicing and payment of contract performance and 19-20 contract agreements.
- Cash has increased by £1.9m in month. This is due to the receipt of activity income and the DHSC interim cash loan of £0.65m. 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 increased by £0.6m in July, reflecting a high volume of purchase ledger invoices.
- Non current liabilities: In July the Trust received a further revenue support loan of £0.65m, adding to the June loan of £1.241m and repayment made on the theatre loan of £0.39m.

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.

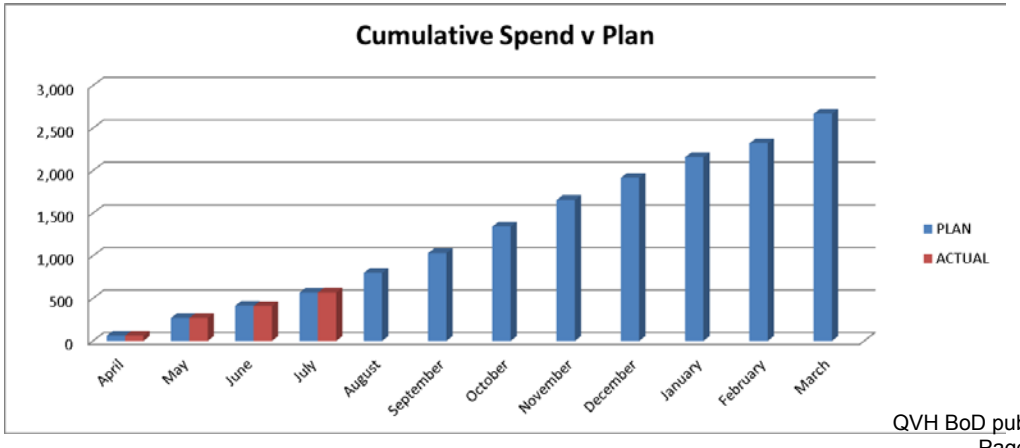
Actions

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

2019/20 M04 - Capital

Queen Victoria Hospital NHS Foundation Trust

Month 4 - July 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	98	94	4	120	-
Other	180	180	171	9	180	-
2019/20 projects:						
Air handling / air conditioning	141	-	-	-	141	-
Other	70	24	22	2	70	-
Estates projects	**511**	**302**	**287**	**15**	**511**	**-**
Medical Equipment	**480**	**19**	**11**	**8**	**488**	**(8)**
Information Management & Technology (IM&T)						
Windows 10 implementation	692	55	78	(23)	692	-
Electronic Document Management	200	72	68	4	200	-
IP Telephony	200	-	16	(16)	205	(5)
PAS upgrade	100	11	-	11	100	-
Other	275	97	108	(11)	270	5
Information Management & Technology (IM&T)	**1,467**	**235**	**270**	**(35)**	**1,467**	**-**
Contingency	**210**	**-**	**-**	**-**	**202**	8
Total	**2,668**	**556**	**568**	**(12)**	**2,668**	**-**



Summary

- The Capital plan for 2019/20 is £2,668k. This is a 33% reduction from the 2018/19 spend excluding donations.
- The capital programme has been developed through the 2019/20 business planning process with EMT/ HMT prioritisation before Board approval.
- Due to the limited budget Estates schemes are less than prior years. Commitments from the 2018/19 programme will be completed but new works will be restricted to prioritised schemes. The planned projects relate to air handling/air conditioning in three locations and are presently at the planning stage.
- Expenditure on medical equipment has also been restricted, representing 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. Procurement of the planned purchases is moving ahead.
- The IM&T programme centres on the implementation of Windows 10 across the Trust. This is making substantial progress. Further significant expenditure is required to complete the EDM project and to upgrade the PAS system. The proposed allocation for the telephony system has now been reduced due to the significant call on the contingency that the Trust is currently facing.
- The capital programme contains a modest reserve for contingencies. Calls against this are mounting and being reviewed by EMT. To enable essential unplanned expenditure it may be necessary to re-phase some planned projects.
- Expenditure to the end of July is £568k, in line with the indicative plan.

Appendices

Appendix 1: Finance Score (Single Oversight Framework)

Table 1

Single Oversight Framework						
Finance Score: July 2019						
	Metrics £k	Measure	Rating	Weight	Score	Plan
Continuity of Services:						
Capital Service Cover						
Operating surplus (Adj YTD)	(1,438)	-1.56	4	20%	0.80	4
Capital Servicing Obligation YTD	921					
Liquidity						
Working Capital	(45)	-0.22	2	20%	0.40	3
Operating Costs (per day)	201					
Financial Efficiency:						
Control Total Margin (%)						
Adj. Surplus (deficit) YTD	(3,059)	-13.2%	4	20%	0.80	4
Adj. Income year to date	23,120					
Margin Variance From Plan						
Adj. Actual surplus margin	-13.2%	-1.0%	2	20%	0.40	
Adj. Plan surplus margin	-12.2%					
4						
Agency Spend	837	53.86%	4	20%	0.80	4
Agency Cap	544					
Finance Score: July 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 3, against the plan of 4, due to agency spend being lower than plan and an improvement in the working capital position.
- Table 2 details a definition of each of the metrics and the scoring mechanism.

KSO1 – Outstanding Patient Experience

Risk Owner: Director of Nursing and Quality
Committee: Quality & Governance
Date last reviewed: 7th August 2019

Strategic Objective
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.

Risk 1) Trust is not able to recruit and retain workforce with right skills at the right time.
2.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

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

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

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

- 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 including interim divert of inpatient paed burns from 1 August via existing referral pathway.
- Developing QVH simulation faculty to enhance safety and learning culture
- Clear written guidance for safe staffing levels in theatres and critical care
- Working with NHS E on inpatient paediatric burns service move and presentation at KSS HOSC chairs meeting / communication with SE burns network, COG, regulators and Healthwatch July 2019

Gaps in controls / assurance

- International recruitment material benefits to workforce anticipated in Q2 and Q3 2019/20 Links to CRR 1094,1077,1035,1035
- Increase in negative FFT and PALS contacts re appointments/waiting times Links to CRR 1125, 1143
- Unknown Specialist commissioning intention for some of QVH services eg inpatient paediatric Sussex based service and head and neck pathway 968,1059

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Date last reviewed: 28h August 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 burn derogation
- Paediatric inpatient standards and co-location
- ~~Incomplete~~ Caveats in 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
- Pension and taxation arrangements threatening work above 10PA contracts

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

- ~~MoU and collaboration with BSUH~~ Sussex Acute Care Network Collaboration
- STP networks and collaboration
- Efficient team job planning
- Research collaboration with BSMS
- ~~New~~ CEA scheme and potential for incentive
- New services – glaucoma, virtual clinics & 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
- Temporary diversion of inpatient paediatric burns patients to alternative network providers

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:	**5 September 2019**		**Agenda reference:**	**144-19**	
Report title:	**Quality and governance assurance report**				
Sponsor:	NA				
Author:	Karen Norman, committee Chair				
Appendices:	NA				
Executive summary					
Purpose of report:	To provide assurance to the board on matters discussed at the Q&GC seminar on 21 July, and extraordinary meeting to receive annual reports from Q&GC groups on 24 July and the Q&GC committee meeting held on 21 August.				
Summary of key issues	Good assurance was received for most areas				
Recommendation:	The Board is asked to **NOTE** the contents of the report, the assurance provided and areas where further assurance has been sought.				
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:	As above				
Corporate risk register:	Strong assurance given through most annual reports that this is reviewed and updated regularly, actions taken, new risks identified and brought to the attending of the board where appropriate.				
Regulation:	Agreed that front sheets from groups reporting into Q&GC will identify legal issues relevant to their priorities and work plans.				
Legal:	Agreed that front sheets from groups reporting into Q&GC will identify legal issues relevant to their priorities and work plans.				
Resources:	As raised as part of annual report recommendations will be considered via the business planning process.				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	As detailed in the reports provided by each group reporting into the Q&GC committee.				

Report to: Board Directors
Agenda item: 144-19
Date of meeting: 05/09/2019
Report from: Karen Norman, committee Chair
Report author: Karen Norman, committee Chair
Date of report: 26/08/2019
Appendices: NA

Quality and Governance Assurance

Introduction

This report summarises items discussed at the Quality and Governance Committee seminar held on 21.7.19, the Extraordinary Meeting to receive Annual Reports from all QGC subcommittees on 24.7.19 and the Quality and Governance Committee meeting on 21.8.19. It aims to provide a summary of the most significant matters for the attention for the Board of Directors for information and assurance.

Executive Summary

Quality and Governance Committee Seminar 21. 7.19.
This seminar provided a forum for members to discuss how the Committee was working, our performance against objectives and identify any changes they may wish to make in the forthcoming year. Participants agreed that the Committee functioned well, as evidenced by the recent CQC report. A candid discussion of points to address how to move from a CQC rating of 'good' to 'outstanding' in all areas identified the following proposals:

- Revise the methods for seeking assurance in member visits to subcommittees and to reschedule and complete all remaining visits by the end of the year.
- Review clinical benchmarking activity with QVH teams and Commissioners.
- Confirm the strategic approach to Quality Improvement (QI) methodology for QVH.
- Review and agree the committee workplan for the year (to include cross sub - group priorities, e.g. learning lessons, policy implementation, QI training, communication strategy to/from QGC, role of governance leads).
- Utilise the report front sheets for all sub-committees as 'live' documents as a summary of plans and progress, review throughout the year to ensure assurance work plans are on track.
- Review process for ensuring all policies and procedures updated on time.
- Explore new ways to identify and measure clinical practice that reflects the priorities identified by clinicians and patients.
- Review assurance methods for 'Spoke' sites.
- Include claims reports in 'Lessons Learned' reviews .
- Review structure of sub committees reporting to Q&G.

Participants felt the seminar provided a valued opportunity to reflect together on our work, and reflect on successes and areas for improvement. It was agreed to hold our next seminar in July 2020.

Extraordinary Meeting to receive Annual Reports from all QGC subcommittees (24.7.19)
This extraordinary meeting is held annually to receive presentations on each of the submitted annual reports from all the QGC subcommittees for scrutiny and assurance. The committee commended subcommittees for the quality, and comprehensiveness of the reports and their hard work in year. For brevity, this summary focuses on areas of specific note and those on which additional assurance was sought.

It was noted that QVH sustained an overall 'good' and 'outstanding' for care in the CQC inspection. The committee also noted 14 recommendations and 5 minor action points which it will be monitored by the Committee as part of its ongoing work plan.

1. Patient Safety Annual Report 2018/19
Measurable improvement noted in Patient Safety and Datix system. Two Serious Incidents noted in year: i)RTT 18 Pathway, (previously reported to BoD. Action plan and clinical harm reviews ongoing, to date no patients reported as having suffered any harm). ii) Retained trochar sheath, following which a new standardised procedure has been implemented as confirmed in an onsite visit by the CCG and specialist commissioners. **Report received and approved by the committee, no further assurance requested.**

2. Health & Safety Annual Report 2018/19
Good progress against Risk Management Strategy objectives. Committee noted inoculation(sharps) injuries was the highest reported category of incident. **Report received and approved by the committee. Further assurance regarding sharps injuries will be sought throughout the year.**

3. Infection Prevention & Control Annual Report 2018/19
Noted strong compliance with national guidance, trust policy, and national targets (subject to ongoing work on staff compliance with infection control policy). **The report was received by the committee and recommended for submission to the Board.**

4. Clinical Audit Annual Report 2018/19
Noted achievement against the strategy, participation in National Clinical Audit & Patient Outcomes programme with local audits and improvement cycles demonstrated. Compliance assured with national mandated audits and internal priorities. **The report was received and approved by the committee, and (subject to it being uploaded to Qnet) no further assurance requested.**

5. Research & Development Annual Report 2018/19
Noted CQC rating 'Outstanding'. 64% increase in total activity (n=887) with 640 recruited into National Portfolio Studies. Core funding increased by CRN by 143%. Commended the significant number of QVH staff securing publication in journals. **Report received, approved and commended for the impressive scope and ambition of the R&D group. More detailed paper on research governance arrangements requested for assurance at October meeting.**

6. Safeguarding (Adults & Children) Annual Report 2018/19
Noted strong assurance and quality of advice and expertise in the team. Main challenges noted were training and succession planning, with assurance given these are being addressed. **Report received and approved by the committee with no further assurance requested. Recommended for submission to the Board.**

7. Patient Experience Annual Report 2018/19
54 complaints in year (comparable to previous year). Strong performance on Family and Friends test(FFT). Likewise on inpatient survey (QVH 99% National 96% (i.e. QVH amongst the best in the country). High scores on emotional support and clear communication which patients understand. Area's for improvement include: waiting times, admission date changes, food, discharge planning, medication advice, and if patients routinely asked about their quality of care. Standards on acknowledgement of complaints within 3 days and complaint closure within 1 month pose a challenge when Patient Experience Manager unavailable. **Report received subject to minor amendments with no further assurance requested. Report recommended for submission to the Board and publication on the QVH website.**

8. Emergency Preparedness, Resilience & Response & Business Continuity Annual Report 2018/19
Noted assurance process, and processes to ensure lessons learned from incidents. CCG rated compliance with national targets as 'partial' but confirmed meeting 'essential' requirements. Advised work plan in place to assure 'substantial' compliance in 2019 review. Committee requested revised work plan and priorities for forthcoming year. **Report received and approved by the committee, subject to the action plan being updated. Further assurance requested at December QGC meeting following the joint annual assessment by QVH and Local Health Resilience partnership.**

9. Information Governance Annual Report 2018/19
Noted significant work undertaken and concern at non compliance on Information Governance training "standard not met' (76%). Candid assessment given of challenges of meeting target this year. **Report received and further assurance sought with respect to addressing outstanding compliance issues.**

10. Medical Devices Annual Report 2018/19
Assurance given on processes for approval, purchasing and management of medical devices. Noted improvements in year including Medical Devices link structure. Training and maintenance remain an ongoing challenge. **Report received and no further assurance requested.**

12. Medication Safety Annual Report 2018/19
Strong assurance given regarding robust systems for investigation of medication incidents, governance of medicines management, systems in place for learning from incidents and actions taken on alerts within required deadlines. Staffing remains the a significant challenge. **Report received and no further assurance requested.**

13. Antimicrobial Annual Report 2018/19
CQIN data submitted by deadline. Data to date suggests we may meet the 2% reduction for total antibiotic consumption and the increased use of Access antibiotics. Unlikely the carapenum reduction will be made. Guideline for hand trauma developed as antibiotic usage high. National antibiotic shortage managed with minimum impact on care. Ongoing challenge to reduce total usage of antibiotic usages, particularly of broad spectrum antibiotics. **Report received for assurance with a request for updates on the latter item.**

14. Appraisal & Revalidation Annual Report 2018/19
Processes in place and progress made in year. 90 completed, 8 'unapproved, incomplete or missed.' Trained appraisals and appraisers. Action plan in place to secure improvement next year. **Report noted, along with the difficulties in securing all appraisals in year. It was agreed to keep this under review following the implementation of the Deputy Medical Director role.**

15. Guardian of Safe Working Annual Report 2018/19
Noted exception reports for Trainees, overruns of rostered hours and lost educational opportunities. Low levels of exception reporting, with good feedback from trainees on improvements to facilities, Concerns raised regarding MaxFax rota and need for 'acting down policy'**. Report received, noting recommendation for MaxFax recommendations be fed into business planning process for due consideration.**

Quality and Governance Committee meeting on 21.8.19
The Committee received the following reports.

1) The Risk Exception Report for the period 1.6.19-31.7.19, noting that no Serious Incidents were reported during this period, 3 formal internal investigations were commenced and there was an increase in the documentation of incidents on the Datix system, of which medication errors continue to be the highest reported number of safety incidents. Assurance given on relevant actions taken, follow up reviews and processes in place to ensure lessons learned.

2) Two changes were made to the Corporate Risk Register: i) Environmental temperature control in histopathology laboratory and ii) Clinical coding backlog. The risk scoring for i) recruitment of skilled critical care staff , ii) recruitment and retention in theatres and iii) medical staff provision to the sleep center were all reduced following the success of recruitment initiatives leading to improved staffing.

3) The Infection Prevention and Control report advised of the reporting of 1 E Coli bacteraemia, which was not acquired in hospital. MRSA screening is compliant with the 95% target and rigorous efforts continue to improve this further. Uptake on infection control training has improved following Infection Control Nurse led educational initiatives.

4) The Patient Experience report confirmed 13 new complaints, none of which required referral to the PHSO, 13 complaints were closed, with 11 upheld or partially upheld and 2 unsupported. The 'Friends and Family Test' recommendation rate for June and July confirmed 99% of inpatients would recommend QVH to friends and family.

5) The Committee noted the National Inpatient Survey confirmed QVH as one of only eight specialist Trusts to be given the CQC branding of 'much better than expected' by patients and congratulated all staff involved for this excellent result.

6) The Committee noted the 'Gosport report – QVH safeguarding recommendations July 2019' and were assured that no new safeguarding actions were identified as part of the review and discussion.

7) The 2019 GMC National Training Survey reported significantly improved results for QVH. A full report will be presented to the Board.

8) The clinical harm reviews for patients waiting over 52 weeks and cancer patients waiting more than 104 days continue, with nil harms identified thus far.

9) The Quality Report Priorities Update confirmed that the Outpatient Improvement Programme initiative to introduce virtual clinics, and the review of patient treatment pathways in head and neck have both been successfully achieved. The implementation of the e-observation tool was partially achieved. This is because central funding award has been delayed prohibiting further progress of the e-Obs programme. The committee sought further assurance to ensure full delivery.

10) The Compliance In Practice Bi-Annual report confirmed an overall rating of 'good'. Therapies secured 'outstanding.' Inspection will now be bi annual and action plans are in place where non-compliance was noted.

11) Minutes were received and noted from the following: Clinical Governance Group, Medicines Management and Optimisation Governance group, Nursing Quality Forum, Infection, Prevention and Control Group, Strategic Safeguarding Group and Health and Safety Group.

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/0919**		**Agenda reference:**	**145-19**	
Report title:	**QVH risk appetite statement 2019/20**				
Sponsor:	Jo Thomas, Director of nursing				
Author:	Jo Thomas, Director of nursing				
Appendices:	3				
Executive summary					
Purpose of report:	To agree the QVH risk appetite statement for 2019/20.				
Summary of key issues	The current risk profile of the organisation and the amount of risk it is currently exposed to has been reviewed and amended (appendix 3). This has not resulted in a material change to the risk appetite statement for 2019/20. The risk tolerance should be used as part of our horizon scanning to identify emerging risks that are both within our control and external to our control.				
Recommendation:	The Committee is asked to **approve** the risk appetite statement prior to publication on the Trust website.				
Action required *[highlight **one** only]*		Discussion			
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	The risk appetite forms part of the board assurance, the BAF was reviewed and key strategic risks form part of the risk appetite assessment				
Corporate risk register:	The CRR was also reviewed and the key risks are included in the risk appetite assessment				
Regulation:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Legal:	As above				
Resources:	Additional resources have been provided from commissioners to support the RTT/organisational performance challenges				
Assurance route					
Previously considered by:	EMT and Q&GC				
	Date:	12 July 2019 21/8/19	Decision:	For submission to Q&GC No changes to risk appetite requested	
Next steps:	For Board approval and publication on trust website				

Queen Victoria Hospital Risk Appetite Statement 2019-2020

Introduction

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

The Foundation Trust Code of Governance states that *"the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives*

QVH Risk Management Strategy (2016-2020) *Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.*

The Queen Victoria Hospital (QVH) risk strategy was written in 2016 and provided a 4 year plan of the key risks within the trust (appendix 1). It should be used as a reference point for trust staff and the Board in identifying, reporting and managing organisational risks. It set out the principles and core processes, responsibilities and accountabilities for this aspect of our corporate governance.

The Board of Directors is accountable for ensuring a system of internal control which supports the achievement of the organisation's objectives is in place. The system of internal control ensures that:

- How much and what type of risk is acceptable for the organization: its risk appetite
- The Trust's Key Strategic Objectives are agreed.
- Principal risks to those objectives are identified
- Controls which eliminate or reduce these risks are implemented.
- The effectiveness of these controls is independently assured.
- Reports on unacceptable or serious risks and the effectiveness of control mechanisms are received from the Executive Directors and independent assurors.
- Action plans are agreed to improve control over serious or unacceptable risks.
- Policies are in place to determine what level of risks should be retained or accepted.

The current and emerging challenges facing the trust require a more detailed description of the trust's risk appetite and the level of assurance across the risks to achieving the key strategic objectives. These internal challenges include greater financial pressures, access and performance issues and workforce sustainability. The greatest external challenges are the strategic approach to network care solutions and commissioning intentions which could impact both positively and negatively on the trust

QVH key strategic objectives

The 5 key strategic objectives were agreed as part of the QVH 2020 strategy work, which was widely consulted on with staff throughout the trust. The KSOs are reviewed at the committees of the Board, KSO1 and 2 at the Quality and Governance Committee (Q&GC) and KSO3, 4 and 5 at the Finance and Performance Committee (F&PC) and all periodically at the Audit Committee (KSOs in Appendix 1).

Risk appetite

The purpose of the risk appetite statement is to give guidance to the decision maker on the Board appetite for risk taking to achieve the KSOs. The nature and business of healthcare organisations make them risk averse, the intention of having a risk appetite statement is to make the trust more risk aware.

The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated. Definitions for grading risk appetite are in Appendix 2.

The current risk profile of the organisation and the amount of risk it is exposed to has been reviewed and amended (Appendix 3) by responsible directors at EMT 12 August and discussed at the Quality and Governance Committee 21 August. The risk tolerance; the maximum amount of risk QVH is prepared to tolerate above the risk appetite for current and emerging risks will need responsive review during 2019/20, particularly in relation to commissioner intentions regarding network care delivery models which presents both threats and opportunities. The risk appetite statement has been reviewed and there are no material changes to the 2019/20 statement.

This risk appetite assessment reflects our current understanding and may change if the risk assessment is undertaken again at a later date.

The 2019/20 QVH risk appetite statement

This statement has been reached by considering the QVH risk strategy, the KSOs, Board Assurance Framework, Corporate Risk Registers and emerging challenges facing the trust.

The Trust will not accept risks that materially impact on patient safety.

The Trust is keen to pursue innovation and research opportunities and this is our area of highest risk appetite.

At QVH we recognise that the trust's longer term sustainability will depend upon the delivery of our strategic objectives and our positive and constructive relationships with our patients, the public and partners in the local health economy. In this, we are willing to challenge working practices and take potential moderate reputational risk where positive gains can be achieved. This will always be within the constraints of our regulatory environment

RECOMMENDATION

The Board is asked to approve the risk appetite statement for 2019/20.

Appendix 1

Key Strategic Objectives				
Director of Nursing	Medical Director	Director of Operations	Director of Finance	Director of HR & OD
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 stream-lined 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

Appendix 2

The table below provides definitions for grading risk appetite.

Appetite	**Approach to risk**	**Described as**
None	Avoid	The avoidance of risk and uncertainty is a key organizational objective
Low	Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk. The balance of risk has to be weighed up against the potential reward even with a low risk appetite
Moderate	Cautious	Preference for safe delivery options that have a low degree of inherent risk. The balance of risk has to be weighed up against the potential reward even with a moderate risk appetite
High	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and value for money
Significant	Seek	Eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk

Appendix 3

Themes	Link to KSO	Issue	Risk appetite
Patient Experience	KSO 1, 2,3,4,5	Implemented a People and Organisational Development strategy to support the retention and recruitment of the workforce, sustain high quality care and patient experience and deliver activity plan. Strong progress with recruitment and retention and we continue to implement new elements and continue progress. The medium to long-term strategy of international recruitment of nurses and theatre practitioners has commenced and continues for theatre practitioners during the latter part of 2019/20. New health care roles recruited to impact not yet assessed as cohort still in training.	Low
		We do not achieve the short to medium term plans to improve booking and scheduling of appointments and theatres and patients continue to have longer than necessary delays in treatments pathways particularly in Corneo plastics.	Low
		Continue to provide safe commissioned care, collaborating with commissioners and NHS England to ensure change to patient pathways (for co-location issues or inability to meet national guidance) is understood and fully communicated to patients and families.	Low
Safety and Quality	KSO 1,2,3,4	QVH participation in the system approach to networked care and continued horizon scanning of the threats and opportunities this presents to the trust in terms of high quality safe patient pathways, fit with QVH clinical strategy and trust financial sustainability.	Low
		Patients, clinicians and commissioners lose confidence in services regarding patient safety by failing to treat patients within national treatment pathways due to lack of effective governance in the management of these processes.	Low
		Re inspection by CQC, Jan and Feb 2019 sustained overall rating of good and outstanding for care rating of good.	Low
Innovation and research	KSO 1,2,3,4,5	Sustain clinician and commissioner confidence in services by maintaining levels of research activity and ability to recruit to trials.	High
		Research/Innovation potential – are we implementing research evidence and promoting our endeavors sufficiently.	High
		Trust is unable to support innovation due to investment financially being greater than the return	Moderate
Access and Performance	KSO 1,2,3,4,5	Regulators and commissioners lose confidence in our ability to provide timely and effective treatment due to breach in the conditions of our foundation trust license for RTT18, and 52 week breaches.	Low
		Spoke site service review has commenced jointly with operations and finance; next steps are to incorporate this intelligence into trust clinical strategy and business planning cycle.	Moderate
		Sustain improvements made by embedding Four Eyes work to provide assurance regarding theatre productivity and related productivity schemes.	Low
		Trust doesn't continue to achieve the recovery trajectory for access and performance within agreed timescales or doesn't sustain the confidence of the NHSI intensivist support team or control total agreed with NHSI.	Low

Financial sustainability	KSO 3,4,5	Loss of confidence in the long term financial sustainability of the trust if it fails to achieve its NHSI submitted plan and create a long term plan for the Trust to return to a break even position.	Moderate
		The trust is unable to agree its control total in 2019/20 and has submitted a deficit positon of £7.4m to NHSI. This is due to increasing costs to ensure safe staffing levels and increasing the capacity within theatres which has not been matched with an increase in income to offset all of the additional costs.	Low
		Developed service line reporting and spoke site reporting which has been shared with the clinical leads for the Trust. This information will be continually refined to ensure clearer attribution to services and fully understand the spoke site activity and flow. From this we will be able to review where improvements and efficiency opportunities exist. This work will be continuous.	Moderate
		The business planning cycle process has developed to ensure the triangulation of activity with workforce and financial planning. All clinical plans have been agreed and signed off. These plans have resulted in the submitted deficit to NHSI. The Trust is maintaining the agreed budgets and broadly on plan with activity. The next stages will be to understand where efficiencies are able to be delivered to reduce spend.	Low
Culture	KSO 1,2,3,4,5	Establishing a positive, supportive culture which is allied to accountability for safe care and delivery of service was identified in the recent CQC inspection and we have values based recruitment process. The Trust will address areas of concerns when raised.	Moderate
		Staff could lose confidence in the trust as a place to work due to perceived failure of line managers to act on staff feedback, however recent staff survey are demonstrating improved engagement of the workforce.	Low
		Staff could lose confidence in the trust as a place to work due to variation in fairness and equality. The recent WRES data shows an improved experience for BAME staff supported by staff feedback and the Best Place to Work initiative.	Moderate
Workforce	KSO 1,2,3,4,5	Patients, clinicians, deanery and commissioners could lose confidence in services due to a fall in teaching standards so increased focus from clinical tutors has demonstrated significant improvements in Junior Doctors experiences in the last two years.	Low
		Training, development and education are a priority for the Trust and a key part of retention is to enable access to all levels of the workforce to ensure that staff don't lose confidence in the trust as a place to work due to insufficient training and development opportunities.	Low
		A major priority for the Trust reflected in a number of KSO's has been a significant focus on recruitment and retention at all levels within the Trust demonstrated in improvements in workforce KPI's.	Low
		Improvements to bank pay, recruitment and retention initiatives have started to have the desired effect of attracting staff to join QVH and retaining existing workforce staff retention	Moderate
		Perception amongst staff that the trust has not articulated how we will deliver our strategy underpinned by widely communicated and owned supporting delivery plans, resulting in a reluctance to take strategic decisions. This could lead to difficulty in identifying clinical service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.	Low

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**5 September 2019**		**Agenda reference:**	**146-19**	
Report title:	**Corporate Risk Register**				
Sponsor:	Jo Thomas, Director of nursing				
Author:	Karen Carter-Woods, Head of Risk and Patient Safety				
Appendices:	None				
Executive summary					
Purpose of report:	For assurance that the Trust risk management process is being followed; new risks identified and current risks reviewed and updated in a timely way.				
Summary of key issues	The Committee is requested to note the Corporate Risk Register information and the progress from the previous report. There were two key changes to the CRR this period: ➢ Two new risks added ➢ Three risk scores reviewed & reduced: two remained on CRR, one moved to LRR				
Recommendation:	Quality & Governance Committee is asked to note the Corporate Risk Register information and the progress from the previous report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services*	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	The entire BAF has been reviewed by EMT alongside the CRR, The corresponding KSOs have been linked to the corporate risks.				
Corporate risk register:	This document				
Regulation:	All NHS trust are required to have a corporate risk register and systems in place to identify & manage risk effectively.				
Legal:	Compliance with regulated activities and requirements in Health and Social Care Act 2008.				
Resources:	Actions required are currently being delivered within existing trust resources				
Assurance route					
Previously considered by:	The Corporate Risk Register is considered monthly by the **Executive Management Team**.				
	Date:	19.08.19	Decision:	Reviewed and updated	
Previously considered by:	**Q&GC**				
	Date:	21.08.19	Decision:	For assurance	
Next steps:	Committee assured not updates requested to the BAF prior to Board.				

Corporate Risk Register Report
June and July 2019 Data

Key updates:

Corporate Risks added between 01/06/2019 and 31/07/2019: 2

Risk Score (CxL)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
3x5=15	1147	Environmental Temperature Control in Histopathology Laboratory	UKAS ISO 15189 inspection
4x3=12	1148	Clinical coding backlog	DoF and Head of BIU

Corporate Risks rescored this period: 3

Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
1035	Inability to recruit adequate numbers of skilled critical care nurses across a range of Bands	4x4=16	**3x4=12**	Vacancy rate reducing; international staff arriving	r/v with DoN
1077	Recruitment and retention in theatres	4x4=16	**3x4=12**	Improving staffing levels	R/V BU Manager
1116	Inability to provide sufficient medical provision to the Sleep Disorder Centre	3x4=12	**2x4=8**	Professor to increase hours, plan to increase medical support and will go out to recruit part time Consultant	r/v with 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 triangulated 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 68 risks currently on the Trust Risk Register as at 9th August 2019, of which 16 are corporate, with the following modifications occurring during this reporting period (June / July):

- Two new risks added: corporate
- Nine risks closed: all local
- Three corporate risk scores reviewed: two remained on CRR and one moved to local register

Risk registers are reviewed & updated at the Business Unit Meetings, Team Meetings and with individual risk owners including regrading of scores and closures; risk register management shows ongoing improvement as staff own & manage their respective risks accordingly.

Risk Register Heat map
The heat map shows the 68 risks open on the trust risk registers: risks which score 12 or more are managed via the Corporate Risk Register.
Five of the 16 corporate risks are within the higher grading category:

	No harm 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1					
Unlikely 2		**1**	**8**	**1**	**1**
Possible 3		**3**	**33**	**3** ID: 968, 1059, 1133	
Likely 4		**3**	**8** ID: 1035 1040, 1077, 1094, 1117, 1122, 1139, 1148	**1** ID: 1136	
Certain 5		**2**	**2** ID1143, 1147	**1** ID: 1125,	**1** ID: 877

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

ID	Opened	Title (Policies)	Hazard(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Target Rating	Actions	Progress/Updates	KSO
1148	24/07/2019	Clinical coding backlog	Coding backlog now at significant level □ Potential to impact income recovery	-overtime approved□ -agency approved: restraints obtaining agency workers□ -monitoring reports 3x weekly□	Michelle Miles	Dan Brecht	Finance	12	6			KSO4
1147	14/06/2019	Environmental Temperature Control in Histopathology Laboratory	UKAS ISO 15189 inspection:□ The Histopathology Laboratory environment is not being managed in a controlled way. The Ambient temperatures fluctuate daily and currently the only way to cool the lab down is by opening windows and doors. This is affecting the performance of air extract equipment. The fluctuating temperatures also affect reagents/chemicals used in the lab as they must be stored within specific temperature ranges: this may result in inaccurate test results leading to wrong treatment / diagnosis / management plan	The controls in place to help keep the lab cool enough to work in are to open windows and doors. This action can cause problems with the safety/ extraction/ downdraught equipment and causing them to not function correctly.□ Appropriate environmental temperature control (air conditioning) should be in place.	Michelle Miles	Phil Montague	Estates Infrastructure & Environment	15	2		15/7/19: Data loggers installed to monitor the temperatures, identified that radiators had 'heat creep'- resolved. On-going monitoring around high heat times: if is solar then windows to be re-filmed with a darker solar reflective film. □ AC or forced air ventilation is currently not an option as it affects the laboratory work □	KSO3
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		June update: Posts x2 advertised, minimal response.□ Corneo team reviewed post and have re-advertised for a sub-specialty fellow.	KSO5
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 [illegible]	Dr Edward Pickles	Paul Gable	Patient Safety	12	6		July update: Provisional agreement for three new consultant appointments jointly to QVH & BSUH. Temporary diversion of complex lower limb trauma to other network providers. Flowchart and SOP for cases that can be undertaken at QVH developed.□ June update: Director of Strategy and MD met with BSUH regarding QVH proposal for lower limb orthoplastics service; response awaited from BSUH & Western MD's□ 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
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".□	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. -New project manager appointed in August 2018 & analysis undertaken of the extent of the hazards within EDM: new team built to manage the business as usual, and to plan further rollout of EDM. -Project remediation plan developed to address critical issues and to roll out EDM to all remaining areas.□ -Quality assurance of scanning now in place with improved administration process. □ -On-site Documentation availability process improved with centralisation of pre scan preparation: further work needed to increase collection frequency.□ -Off-site availability of clinical documentation: rollout of laptops with 4G functionality and remote access in place for those sites that do have native connectivity through the host	Michelle Miles	Jason Mcintyre	Patient Safety	16	6		1/6/2019 update: changes to the configuration of the anti-virus software in the trust have improved speed of application. Accelerated scanning of active health records library now underway. IPads running evolve in native app now deployed to a number of Ward clinic and theatre areas. New process for charging iPads within theatres have been implemented and are currently bedding in as part of an end-to-end admissions / theatre processes review. Patients with scanned notes are now being seen in Plastics (not live) as part of multi-disciplinary and/or parallel care pathways. Options to mitigate this impact and associated risk are urgently being investigated.□ 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	5/7/19: one vacant post 8a awaiting job evaluation in order to be advertised. Another 8a still on reduced hours. Other vacant posts recruited into, started at trust and require training. Ongoing apprenticeship training still having affect.□ 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
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		5/7/19: R/V with Exec Lead - RTT open pathway performance on track with trajectory; 52 week waits challenges ongoing regarding patient choice - national issue, escalated to NHSI and commissioners□ 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		5/7/19: R/V with Exec Lead - additional independent sector capacity ongoing. BC for substantive consultant post in progress.□ 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
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 [illegible]	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		July 2019 Moving forward with JAC upgrade □ 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

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.	05/07/2019 - Vacancy rate has improved with 2 international nurses' arrival, our vacancy rate is 2.55 WTE.□ 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.□ 11-9-18: update, 12.12 vacancies, recruitment ongoing with some success.□ 13/8/18: +/- 45 posts offered: awaiting uptake and detail□ 4/7/18 - some further leavers but some recruited staff starting. □ 14/5 (CGG): some success with international recruitment, minimal success with social media campaign□ 9/4/18: Update - interest from campaign, small number of applications received□ 12/2/18: Update - Social media recruitment campaign underway Pegasus) □ January 2018 update:□ - enhanced bank rates to include C-Wing□ - new ward matron in post	KSO1 KSO2
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	12	10	Actions to date	July 2019 recruitment campaign continuing. Overseas nurses working through a programme to be able to obtain PIN numbers. Score reviewed.□ 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.□ □ Recruitment process underway for new staff to include international recruits.□ Dubai recruitment: +/- 45 posts offered: awaiting uptake and detail□ 9/7/18: TUG agreed to pilot different minor procedure staffing model from July '18□ Practice Educator in Dubai to interview potential staff□ □ 12/6/18: further work on theatre establishment & budget. Testing feedback from staff re: skill mix□ 14/5 (CGG): Pre-assessment almost at full establishment□ 12/2/18: recruitment to pre-op assessment plus social media recruitment drive□ January 2018 update:all HCA's now in post	KSO1 KSO2
1059	22/06/2017	Remote site: Lack of co-location with support services for specific services	Lack of co-location with clinical specialities & facilities which may be required to manage complications of procdures undertaken at QVH	SLA with BSUH re: CT scanning, acute medical care, paediatric care and advice□ Guidelines re: pre-assessment & admission criteria, to QVH□ Skilled and competent medical and nursing staff with mandatory training focused on QVH specific risks□ Clinical governance oversight of scope of practice at QVH	Dr Edward Pickles	Dr Edward Pickles	Patient Safety	12	10	Actions to date PEG service review	18/7/19: Formation of Sussex Acute Care network - discussing areas of clinical risk on all sites across the STP. Agreement for appointment of QVH Physician, bringing total physician cover to four days per week. Network agreement for OMFS trauma cover near completion & agreement for orthoplastics progressing. □ May 2019 update: CT scanning services working well; exploring out of hours provision going forward. MoU discussions 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 clinical use. Plan to replace 1 US machine for 2019-2020□	Abigail Jago	Paul Gable	Patient Safety	12	2		09-07-2019- Asked to provide more information about the fluoroscopy equipment for EMT so they can prioritise their urgent needs to charitable funds. US may have been agreed by trust.□ □ 18-06-19 - Radiology asked to prioritise equipment. Fluoroscopy and US machine requested. Requested for charitable funds to fund fluoroscopy equipment - decision awaited□ □ June update: Bid to charity funds / League of Friends□ 19-03-2019: r/v at CSS meeting - outcome awaited re: Capital bids□ 08-03-2019: CBCT replaced in August 2018. CT installed & operational in □ 28-01-2019 - For business planning 2019/2020 QVH radiology has prioritised key pieces of equipment that require capital investment this financial year.□ 1- Replace the Fluoroscopy/CR room - current room has had multiple failures this year. □ 2- Replace one mobile X-Ray machine- QVH has 2 mobile machines, both are currently broken (extended period) and one has been replaced by a loan machine supplied by the maintenance company. This loan machine has also recently failed. □ 3- Replace one of the Ultrasound - the oldest machine that is used for Head & Neck work is showing image quality resolution □ Dec 2018. New fluoro room, a new US machine and 1 new portable xray machine highlighted for capital funding - response awaited.□ October update - included within capital bids for 2018/19□ 17-07-2018: reviewed at CSS meeting - new capital now available for this□ 14-05-2018 (CGG): procurement process continues□ 13-12-2017- Cone Bean CT scanner in procurement phase□ 1 Ultrasound machine in procurement phase□ Business planning 2018-2019 has plan for rolling capital replacement of radiology equipment □ 06-09-2017- business planning for 2017-2018 agreed for the CBCT and 1 US machine imaging equipment to be replaced. □ 14-03-2017: Replacement items to be included in Business Plan for 2018/19	KSO1 KSO2 KSO3
1035	09/01/2017	Inability to recruit adequate numbers of skilled critical care nurses across a range of Bands	* Failure to recruit adequate numbers of skilled critical care nurses across a range of Bands□ * Intensive Care Society recommends 50% of qualified nurses working on CCU team should have ITU course: this is currently complied with due to existing workforce, new staff joining from C-Wing and transfer of vacancy rates□ * move of step-down beds to CCU has increased the vacancy rate□ * potential for cases to be cancelled	1. Burns ITU has a good relationship with 3 nursing agencies. Via these agencies we have a bank of 8 - 10 nurses who regularly work on our unit,and are considered part of our team.□ temporary staff are formally orientated to the unit with a document completed and kept on file.□ 2. A register is kept of all agency nurses working in CCU:they all have ITU Course or extensive experience□ 3. Concerns are raised and escalated to the relevant agencies where necessary and any new agency staff are fully vetted and confirmed as fully competent to required standards□ 4. Recruitment drive continues & review of skill mix throughout the day and appropriate changes made □ 5. Review of patient pathway undertaken following move of step-down patients to CCU: for review October 2017□ 6. International recruitment undertaken, appropriate staff moving through required checks. Continue to advertise registered staff positions.□ 7. Paper agreed at HMT to support current staffing issues in CCU. Vacancy remain high with long term sickness and maternity leave. Must ensure 50:50 split between CCU substantive staff and agency. Staff aware of the action.	Jo Thomas	Nicola Reeves	Patient Safety	12	9	Actions update	5/7/19: Band 6 vacancy rate: 1.28 WTE - r/v with DoN and rescored□ International nurses not yet arrived, passed OSCEs or ready to work clinically so although recruitment is improved bank staff continue to be required □ 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 □ • International recruitment plan continues, awaiting dates for candidates to complete required process - recruitment delays evident□ • 6 new trained staff appointed □ • Re-advertise for Band 6 positions to enhance senior leadership within the team□ • Enhanced bank rates continue for both full and part time staff □ Dec update: further success with agency staff nurses recruiting into Bank and substantive posts.□ October update: Good uptake of offers from Dubai recruitment; continued scrutiny around use of agency & skill mix to ensure safe care.□ 13/8/18: Dubai recruitment: +/- 45 posts offered: awaiting uptake and detail□ 16/7/18: Paper to HMT to agree Risk Appetite for agency usage in Critical Care□ 9/7/18: Update - Practice Educator in Dubai to interview potential staff□ 12/6/18: necessity for substantive staff to change / cover shifts at short notice resulting in impact upon health & wellbeing. □ February 2018: social media recruitment drive launched□ January 2018 update:□ - Increased Bank rates implemented□ -'recommend a friend' staff incentive scheme□ Dec vacancy rate = 6.01wte	KSO1 KSO2
968	20/06/2016	Delivery of commissioned services whilst not meeting all national standards/criteria for Burns and Paeds	-Potential increase in the risk to patient safety□ -on-call paediatrician is 1 hour away in Brighton□ -Potential loss of income if burns derogation lost□ -no dedicated paediatric anaesthetic lists	*Paeds review group in place□ *Mitigation protocol in place surrounding transfer in and off site of Paeds patients□ *Established safeguarding processes in place to ensure children are triaged appropriately, managed safely□ *Robust clinical support for Paeds by specialist consultants within the Trust□ *All registered nursing staff working within paediatrics hold an appropriate NMC registration *Robust incident reporting in place□ *Named Paeds safeguarding consultant in post□ *Strict admittance criteria based on pre-existing and presenting medical problems, including extent of burn scaled to age.□ *Surgery only offered at selected times based on age group (no under 3 years OOH)□ *Paediatric anaesthetic oversight of all children having general anaesthesia under 3 years of age.□ *SLA with BSUH for paediatrician cover: 24/7 telephone advice & 3 sessions per week on site at QVH	Jo Thomas	Nicola Reeves	Compliance (Targets / Assessments / Standards)	12	4	To be reviewed in July following Clinical Cabinet discussions Paper to be presented at Clinical Cabinet in June 2016 Paediatric review group met in August, paper to private board in September 2016.	July update: KSS HOSC Chairs meeting (10/7) to share interim divert plans - QVH patient pathway continuing to follow established larger burns protocol with patients being treatewd at C&W or Chelmsford; HOSC supportive of safety rationale & aware that further engagement & review of commissioned pathway required - to be led by NHSE Specialist commissioning. □ June update: Inpatient paeds BC for transfer of services to BSUH not approved. Interim arrangements with Burns Centres commenced. Plan for QVH inpatient paeds burns to go to other providers from 1st August. LSEBN aware & involved in discussions.□ 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 workforce plans underway.□ 13/8/18: sub-group convened and meetings commenced□ 12/7/18: meeting held with Brighton to progress pathway□ 12/6 update: Darzi fellow in post (1yr), reviewing paediatric inpatient burns□ 14/5 update: position paper presented at March HMT - nil new changes	KSO2 KSO3 KSO5

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	July 2019 2018/19 Performance Month 2 position YTD £200k behind plan due to income shortfall Current run rate forecast deficit of £11m (CIP performance £85k/£125k for YTD Month 2 - slippage offset by non recurrent underspends Finance & Use of Resources – 3 (planned 4) 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 April 2019 2019/20 Final Operating Plan plan submitted £8.6m deficit. March 2019 NHSI review of Draft operating plan £8.6m deficit with Trust senior executives. February 2019 2019/20 Draft Operating plan submitted £8.6m deficit. January 2019: R/V by Exec Lead; increased forecast deficit to 5.9M Oct update: reviewed - nil change 05/06/18: Reviewed; updated target risk to reflect BAF 3/10/17: reviewed at senior team meeting = no change 06/12/2016: Reviewed by Senior Management Team. DoF to review further to ensure score accurately reflects current status.	KSO4

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**02/09/19**		**Agenda reference:**	147-19	
Report title:	Quality & Safety Board Report				
Sponsor:	Jo Thomas, Director of Nursing and Quality, Ed Pickles, Medical Director				
Author:	Kelly Stevens, Head of Quality and Compliance				
Appendices:	a) Nursing metrics b) General Medical Council National Training Survey				
Executive summary					
Purpose of report:	To provide updated quality information and assurance that the quality of care at QVH is safe, effective, responsive, caring and well led.				
Summary of key issues	The Committee's attention should be drawn to the following key areas detailed in the reports: • Improvement on the GMC National Training Survey published in July 2019 • Update on interim paediatric inpatient burns divert • Progress with clinical harm reviews				
Recommendation:	The Committee is asked to be assured that the contents of the report reflect the quality and safety of care provided by QVH				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	*Financial sustainability*	***Organisational excellence***
Implications					
Board assurance framework:	The Quality Report contributes directly to the delivery of KSO 1 and 2, elements of KSO 3 and 5 also impact on this.				
Corporate risk register:	CRR reviewed as part of the report compilation –and the workforce and RTT18 risk impact the most on quality, safety and patient experience.				
Regulation:	The Quality Report contributes and provides evidence of compliance with the regulated activities in Health and Social Care Act 2008 and the CQC's Essential Standards of Quality and Safety.				
Legal:	As above The Quality and Safety Report uphold the principles and values of The NHS Constitution for England and the communities and people it serves – patients and public – and staff.				
Resources:	The Quality and Safety Report was produced using existing resources.				
Assurance route					
Previously considered by:	EMT and Q&GC				
	Date:	19/8/19 21/8/19	Decision:	EMT: awaiting medical director updates Q&GC; full assurance 1 amendment made, addition of GMC NTS narrative and report as an appendix to be included in final Board paper	
Next steps:	For Board approval				

Executive Summary - Quality and Safety Report, September 2019

Domain	Highlights
Director of Nursing and Quality	In July the Clinical Commissioning Group undertook an assurance visit to assess whether QVH has effective safeguarding arrangements in place for children, young persons and vulnerable adults. This review was led by the Designated Nurse for Safeguarding Children and the Designated Nurse for Safeguarding Adults in Sussex and East Surrey CCGs. A comprehensive safeguarding assessment tool was used as part of the CCG's safeguarding standards review. This tool cross-references the safeguarding plans with trust core business plans and includes standards and targets relating to safeguarding. The report concluded there are clear safeguarding procedures that are followed in practice, monitored and reviewed, which are consistent with the local multi-agency safeguarding policy and procedures for children and adults, which set out the responsibilities of all workers to operate within it. Information was clear and up-to-date regarding who/how to contact for advice and support. Staff understood the aspects of the safeguarding processes that are relevant to them, including MCA and role of the IMCA (Independent Mental Capacity Advocate). There were no concerns or recommendations raised. The medical director and I attended the Kent, Surrey and Sussex Health Overview and Scrutiny Committee Chairs meeting in July to update them on the interim divert plans for paediatric inpatient burns. There was also a formal quality meeting with NHS E in July to ensure appropriate plans were in place prior to the divert commencing. The decision to divert inpatient paediatric burns to other burns units in the South is a safety decision which is fully supported by Specialised Commissioning NHSE and the London and South East Burns Network (and has previously been supported at the trust Board). The interim divert follows the same established referral pathway already in place for children requiring inpatient care with larger burns, The HOSC has previously been briefed on the intended management of inpatient paediatric burns moving from QVH and were supportive of the reasons for the interim divert, they will expect further updates/ consultation led by NHSE regarding this service. This interim divert commenced on the 1 August 2019.

Medical Director	The 2019 GMC National Training Survey (see appendix) was published in July 2019, with significantly improved results for the Queen Victoria Hospital. Of 18 domains for each specialty, the QVH results included three green flags (significantly better than average results) for anaesthetics, nine green flags for Core Surgical Training and three green flags for OMFS training. We received one red flag for higher plastics training relating to rota design. The results are a credit to the whole medical education team, particularly the clinical tutors, and the significant improvements in Core Surgical Training reflect the focus this group has received from the whole trust over the previous 12 months. BSUH have agreed to a QVH proposed business plan for the appointment of three new plastic surgery consultants, with job plans based predominately at the Royal Sussex County Hospital in Brighton. With contributions from existing QVH consultants with an orthoplastic interest, this will enable a robust, sustainable on-call and lower limb trauma service to the region. Similarly, we have advertised for two new joint oral and maxillofacial surgery posts, with job plans split between QVH, ESHT and BSUH, to enable a network solution to OMFS cancer and trauma surgery.

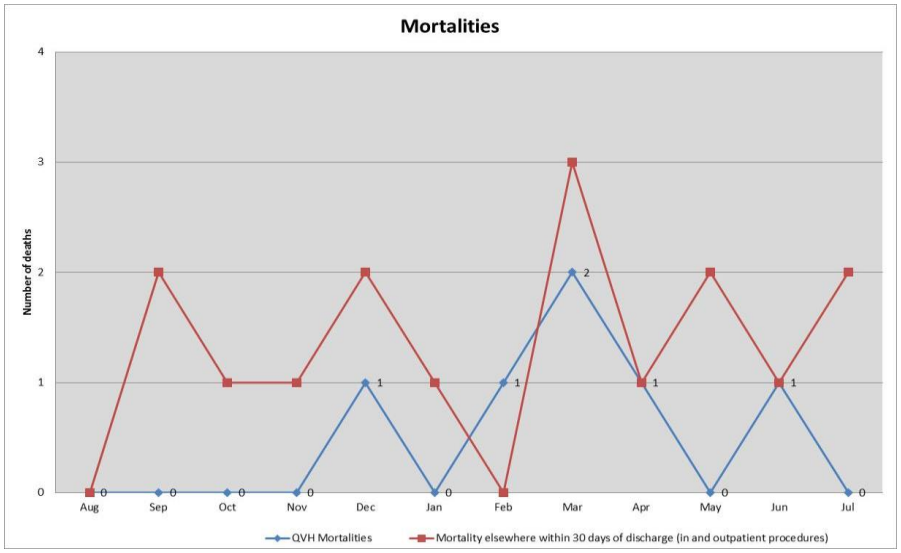
Report by Exception - Key Messages

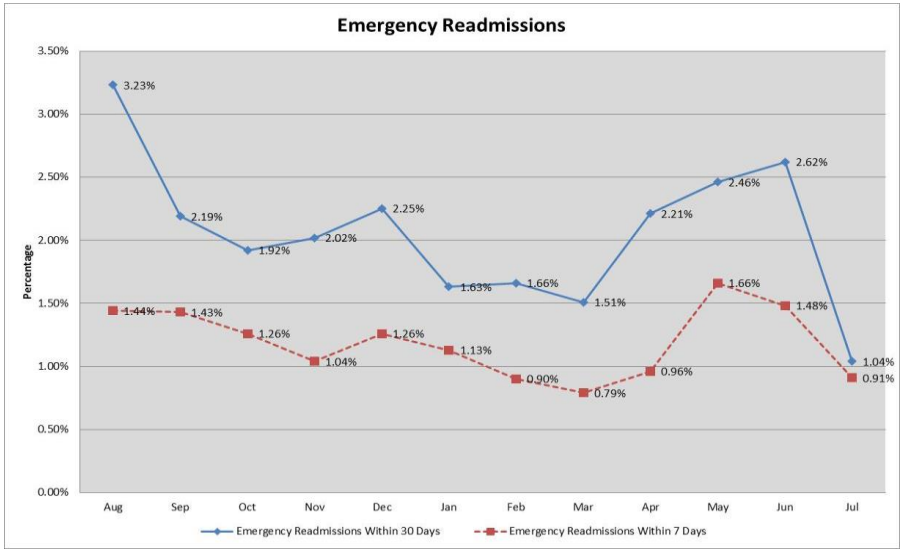
Domain	Issue raised	Action taken
Safe: clinical harm reviews	Clinical Harm Review meetings: Trust continues to reduce the 52 week breaches against an agreed trajectory with regulators and commissioners to achieve zero 52 week breaches by September 2019.	Clinical Harm Review meetings were established 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 Fax (Dental) and Plastics and any that cannot be confirmed at the time of review as 'no harm' are followed up until point of treatment to ascertain if any harm has been caused: there have been nil harms identified so far. To the end of July 495 reviews have been undertaken: - July: 40 – MaxFax and plastics; Aug: 129 – MaxFax and plastics; Sept: 75 – plastics / Corneo / H&N plus Medway MaxFax; Oct: 35 – MaxFax / H&N / plastics and skin; - Nov: 30 – plastics, MaxFax and Corneo; Dec / Jan: 36 – MaxFax and plastics; Feb: 53 - MaxFax and plastics; March: 32 – plastics; April / May: 10 – MaxFax and plastics and June / July: 55 – MaxFax and plastics (incl. D Valley). Patients have been under surveillance as follows: 26 Plastics: all no harm and 14 MaxFax: all no harm There are five patients currently under surveillance. The Head of Risk & Patient Safety meets monthly with the CCG to discuss the cases reviewed for assurance purposes.

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 2 2018/19		Quarter 3			Quarter 4			Quarter 1 2019/20			Quarter 2	12 month total/ rolling average
		Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	
Infection Control														
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA colonisation										1	1	0	0	2
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	1	0	0
MRSA screening - elective	>95%	98%	97%	98%	99%	96%	96%	97%	97%	94%	95%	96%	94%	97%
MRSA screening - trauma	>95%	95%	96%	95%	96%	95%	96%	96%	96%	98%	94%	94%	98%	96%
Incidents														
Never Events	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Serious Incidents	0	1	0	0	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	4	8	3	2	1	1	4	0	1	6	6	38
Paediatrics under 3 years: Induction of anaesthetic was between 18:00 and 08:00	0	0	1	0	0	0	0	0	0	0	0	0	0	1
WHO quantitative compliance		98%	99%	99%	98%	99%	98%	99%	99%	99%	99%	98.7%	99.3%	99%
Non-clinical cancellations on the day		6	7	22	14	18	22	22	11	19	17	7	31	196
Needlestick injuries				4	2	1	1	3	3	2	0	1	1	18
Pressure ulcers (all grades)				1	0	0	1	0	0	1	0	0	0	3
Paediatric transfers out (<18 years)		0	0	0	2	0	1	0	1	2	0	1	0	7
Medication errors														
Total number of incidents involving drug / prescribing errors		8	7	16	13	9	7	16	10	7	8	13	21	135
No & Low harm incidents involving drug / prescribing errors		8	7	16	13	9	7	16	10	7	8	13	21	135
Moderate, Severe or Fatal incidents involving drug / prescribing errors		0	0	0	0	0	0	0	0	0	0	0	0	0
Medication administration errors per 1000 spells		1.2	0.6	2.2	2.2	0	0.5	1.1	1.2	0.6	0.5	0.6	1.1	1.0
Harm free care rate (QVH)	>95%	100%	93%	100%	100%	100%	96%	97%	100%	97%	100%	97%	TBC	98.2%
Harm free care rate (NATIONAL benchmark) - one month delay	>95%	93.9%	94.3%	94.1%	94.3%	94.3%	93.8%	93.8%	93.9%	93.8%	93.8%	93.8%	TBC	94%
Pressure Ulcers														
Hospital acquired - category 2 or above	15	0	0	0	1	0	1	0	0	0	0	1	0	3
VTE initial assessment (Safety Thermometer)	>95%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	93.0%	100.0%	100.0%	100.0%	99.2%
Patient Falls														
Patient Falls assessment completed within 24 hrs of admission	>95%	98%	100%	97%	100%	100%	100%	89%	100%	100%	92%	100%	100%	97.8%
Patient Falls resulting in no or low harm (inpatients)		3	3	4	5	2	3	3	2	0	2	2	3	32
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		2.6	2.62	3.05	3.79	2.11	3.03	2.97	1.82	0	1.69	1.78	2.58	2.55

Effective - Performance Indicators





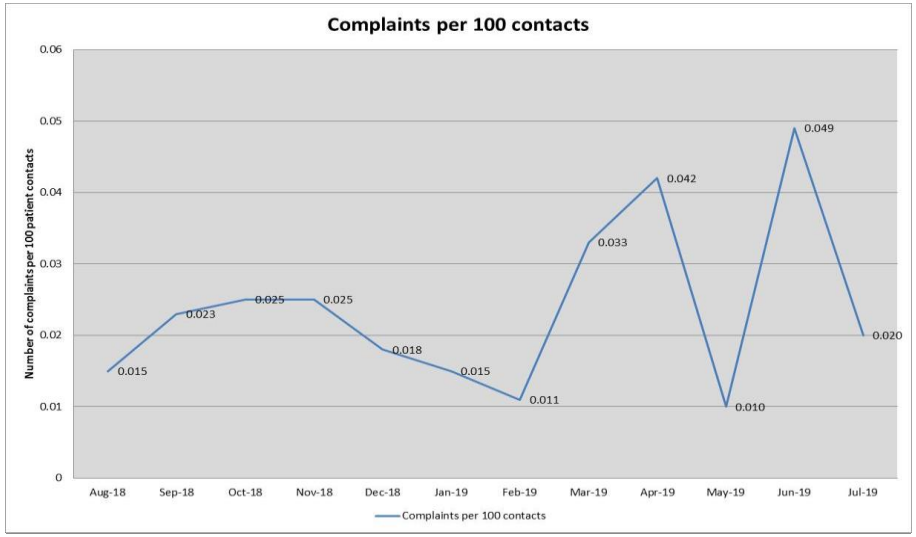
	Quarter 2 2018/19		Quarter 3			Quarter 4			Quarter 1 2019/20			Quarter 2
	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Number of deaths on QVH site	0	0	0	0	1	0	1	2	1	0	1	0
Number of deaths off- site within 30 days of IP or OP procedure	0	2	0	1	2	1	0	3	0	2	1	3
No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

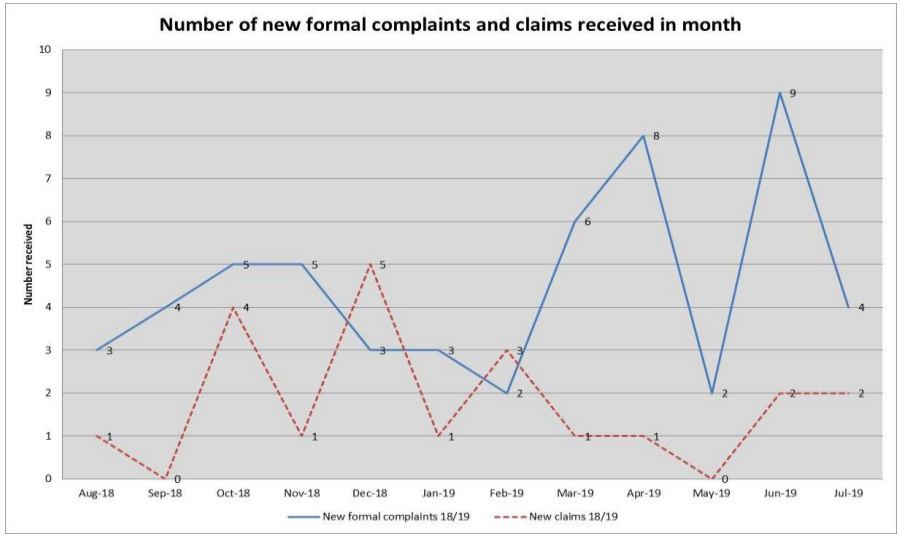
* to be completed

Learning from deaths

The process of preliminary case note reviews for all off-site deaths, and structured judgement reviews for all on-site deaths continues, led by the Medical Director. The annual Learning from Deaths report will be authored in October 2019 and submitted to Quality and Governance Committee.

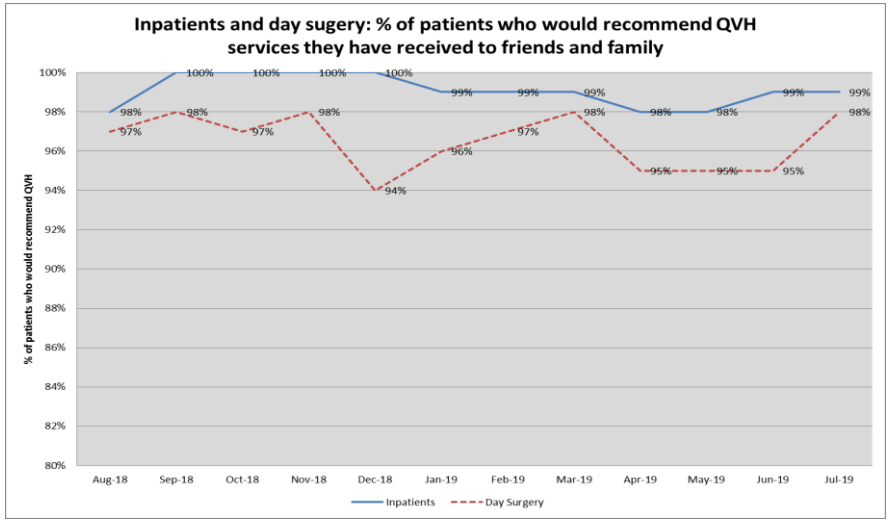
Caring - Current Compliance - Complaints and Claims

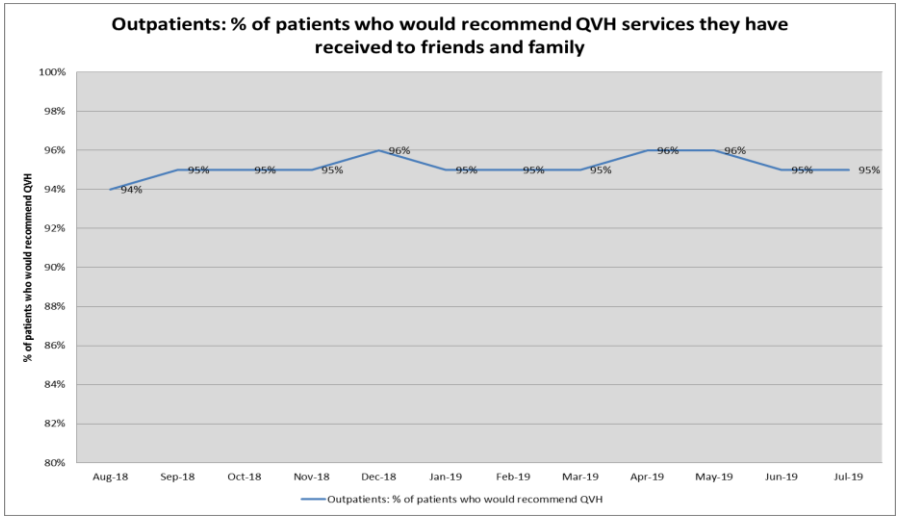


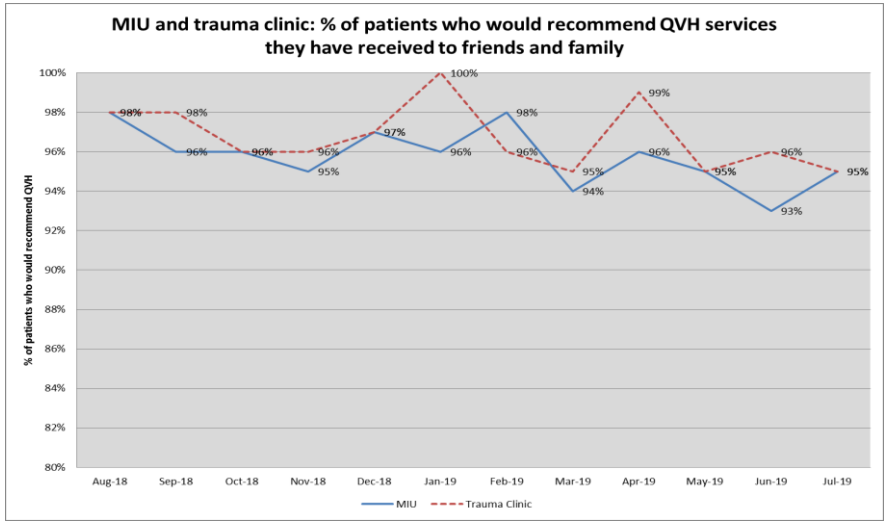


	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Contacts (IP+OP+MIU, all sites)	19406	17496	20263	20100	16384	20469	18089	18446	18979	19793	18278	20495
Complaints	3	4	5	5	3	3	2	6	8	2	9	4
Complaints per 100 contacts	0.015	0.023	0.025	0.025	0.018	0.015	0.011	0.033	0.042	0.010	0.049	0.020
Number of complaints referred to the Ombudsman for 2nd stage review	1	0	0	0	0	0	0	0	0	0	0	0
Number of complaints re-opened	0	0	0	0	0	0	1	0	0	0	0	1

Caring - Current Compliance - FFT







Nursing Workforce - Current Compliance

Domain	Compliance	Actions
Ross Tilley	During June and July there were 9/122 occasions where staffing numbers did not meet planned levels (7/122 in April and May). 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 June and July there were 10/122 occasions where staffing numbers did not meet planned levels (8/122 in April and May). 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. Below template shift dates have been triangulated with Datix safety incidents, ward FFT scores and complaints information. There was one fall recorded on a shift that was down 1 HCA (Datix report no harm).
Burns	During June and July there were 1/122 occasions where staffing numbers did not meet planned levels 3/122 in April and May). 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 June and July there was 11/122 occasion where staffing numbers did not meet planned levels (9/122 in April and May). All escalated to site practitioner as per trust protocol.	Two senior nurses on long term absence during June and July, The ward was closed at 19:30 on nine nights in June, 12 inpatients over 10 nights, one child transferred for clinical reasons. The ward closed at 19:30 on nine nights in July, 19 inpatients over 15 nights, one patient was held at referring hospital overnight and admitted the next following day. 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 June and July there was 0/122 occasions where staffing numbers did not meet planned levels(2/122 in April and May).	Staffing according to bed occupancy and acuity staff redeployed to other areas where occupancy /safety allowed to support short notice sickness. There were no shifts that went above the agreed agency threshold of 50% for agency staff in CCU during this reporting period. In June 2/60 shifts that had 50% agency cover, 13/60 shifts had 20-33% agency cover and 45/60 shifts no agency staff required. In July 2/62 shifts that had 50% agency cover, 19/62 shifts with 20-33% agency cover and 43/62 shifts with no agency staff required.
Site Practitioner Team	During June and July there were 13/122 occasions where staffing numbers did not meet planned levels (9/122 in April and May).	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.

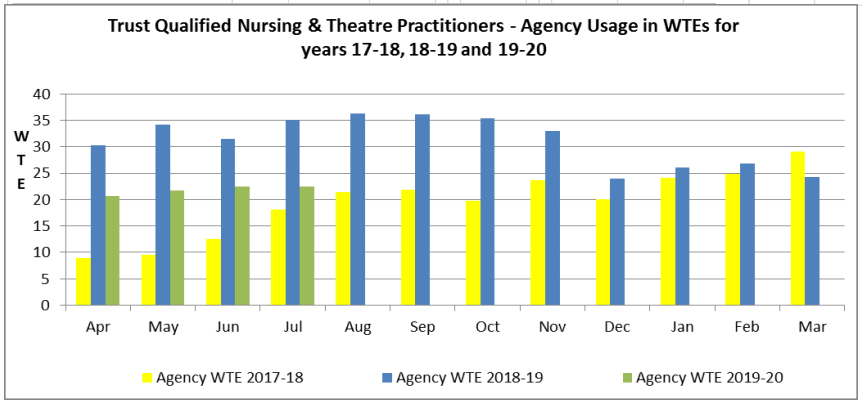
Data extracted from the workforce score card in appendix 1

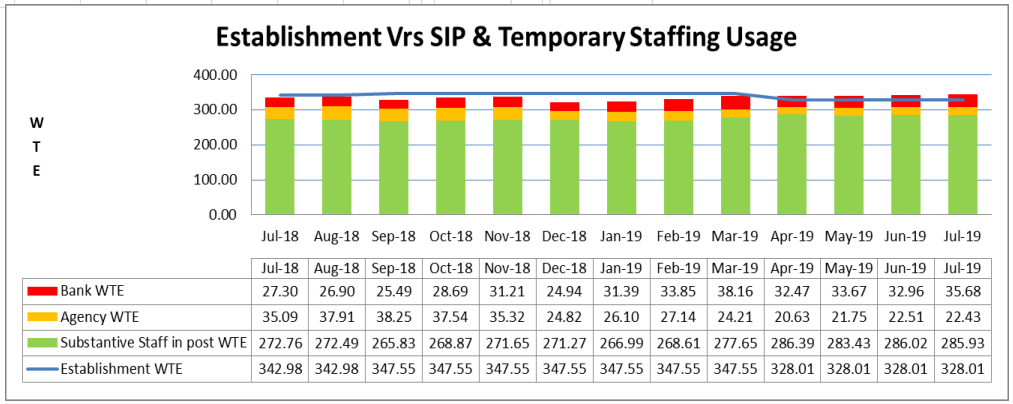
Nursing Workforce - Performance Indicators

ALL QUALIFIED & UQUALIFIED NURSING

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19 & 2019-20			Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Compared to Previous Month
Establishment WTE (Establishment includes 12% headroom from 01/09/2018)				361.20	361.20	347.55	347.55	347.55	347.55	347.55	347.55	347.55	328.01	328.01	328.01	328.01	◄►
Staff In Post WTE				272.76	272.49	265.83	268.87	271.65	271.27	266.99	268.61	277.65	286.39	283.43	286.02	**285.93**	▼
Vacancies WTE				61.89	62.16	81.72	78.68	75.90	76.28	80.56	78.94	69.90	41.62	44.58	41.99	**42.08**	▲
Vacancies %	>18%	12%<>18%	<12%	22.69%	22.81%	23.51%	22.64%	21.84%	21.95%	23.18%	22.71%	20.11%	12.69%	13.59%	12.80%	**12.83%**	▲
STARTERS WTE (Excluding rotational doctors)				3.00	4.68	1.12	5.64	6.70	5.81	1.41	4.44	7.61	10.94	2.00	2.56	**2.00**	▼
LEAVERS WTE (Excluding rotational doctors)				1.97	6.00	9.17	3.80	2.43	6.42	2.00	1.64	1.00	3.08	2.00	4.51	**3.00**	▼
Starters & Leavers balance				-0.97	-2.32	-8.05	1.84	4.27	-0.61	-0.59	2.80	6.61	7.86	0.00	-1.95	**-1.00**	
Agency WTE (Data From Healthroster)				35.09	37.91	38.25	37.54	35.32	24.82	26.10	27.14	24.21	20.63	21.75	22.51	**22.43**	▲
Bank WTE (Data From Healthroster)				27.30	26.90	25.49	28.69	31.21	24.94	31.39	33.85	38.16	32.47	33.67	32.96	**35.68**	▲
Trust rolling Annual Turnover %	>=12%	10%<>12%	<10%	18.35%	19.95%	20.06%	20.11%	19.63%	18.79%	17.96%	16.02%	14.45%	14.53%	14.68%	15.90%	**16.20%**	▲
Monthly Turnover				0.76%	2.31%	3.52%	1.50%	0.75%	1.94%	0.77%	0.63%	0.38%	1.12%	0.72%	1.63%	**1.08%**	▼
Sickness Absence %	>=4%	4%<>3%	<3%	4.94%	*4.34%*	3.63%	4.86%	*4.39%*	3.45%	4.45%	4.42%	4.23%	4.60%	4.24%	4.24%	***TBC***	

Note 1. 2019/20 budget implimented in June 19 backdated to April 19 taken from Finanace Ledger
Note 2. All data taken from ESR unless stated otherwise.
Note 3. Staff included are Qualified Nurses, Emergency Practitioners, Theatre Practitioners, HCA's,Student OPD's, Trainee Nurse Associates/Practitioners,Nurse Associates, Play Specialists, Oversea's Nursing awaiting PIN. Staff Excluded are Dental Nurses





	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Bank WTE	27.30	26.90	25.49	28.69	31.21	24.94	31.39	33.85	38.16	32.47	33.67	32.96	35.68
Agency WTE	35.09	37.91	38.25	37.54	35.32	24.82	26.10	27.14	24.21	20.63	21.75	22.51	22.43
Substantive Staff in post WTE	272.76	272.49	265.83	268.87	271.65	271.27	266.99	268.61	277.65	286.39	283.43	286.02	285.93
Establishment WTE	342.98	342.98	347.55	347.55	347.55	347.55	347.55	347.55	347.55	328.01	328.01	328.01	328.01

Medical Workforce - Performance Indicators

Metrics	2017/18 total / average	Target	Quarter 2 2018/19		Quarter 3			Quarter 4			Quarter 1 2019/20			Quarter 2	Year to date actual/ average
			Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Jul	
Medical Workforce															
Turnover rate in month, excluding trainees	21.63% 12Mth rolling	<1%	1.60%	2.42%	0%	0%	1.16%	3.44%	0.96%	3.97%	0%	1.15%	0.78	1.16	16.54% 12 mth Rolling
Turnover in month including trainees 9%	45.43% 12Mth rolling		3.15%	2.10%	1.35%	0.68%	2.79%	2.77%	8.85%	2.46%	6.81%	2.53%	0.49	1.45	42.08% 12 mth rolling
Management cases monthly		0	1	1 ongoing	1 ongoing	1 ongoing	1 ongoing	0	0	0	0	0	0	0	1
Sickness rate monthly on total medical/dental headcount	1.43%		2.05%	1.18%	0.94%	1.19	1.09	1.19%	1.59%	1.99%	2.25%	0.88	1.46	Available Sep 19	1.52%
Appraisal rate monthly (exclude deanery trainees)	88.96% Mar 18		82.83%	79.38%	83.54	89.09	88.13%	84.62%	79.73%	85.16%	82.67	80.77%	83.77%	79.35%	79.35%
Mandatory training monthly		95%	81%	77%	78.7%	83%	84%	84%	87%	87%	88%	87%	88%	89%	85%
Exception Reporting – Education and Training			0	0	0	0	0	1	0	0	4	1	5	8	19
Exception Reporting – Hours			0	0	0	0	0	0	0	1	0	0	2	0	3

Medical & Dental Staffing

There are currently 100 doctors for whom the QVH is their designated body. The current appraisal rate is 79%. This is being addressed. All doctors are revalidated with a licence to practice.

Mr Keith Altman, Consultant Oral and Maxillofacial Surgeon will take over as Medical Director and Responsible Officer from 30th September 2019. Ed Pickles will be returning to full time clinical practice.

A new Deputy Medical Director will be appointed in September, the role potentially being shared by more than one individual. The role will provide support to the Clinical Governance and Medical Staffing, Appraisal and Revalidation portfolios.

We are in the process of recruiting to replacement consultant roles in OMFS Head and Neck Surgery and Histopathology.

Education	The multidisciplinary Local Academic Board met in July 2019, receiving reports from all medical training specialties, the Guardian of Safe Working, and the Clinical Practice Development Group. The number of exception reports is beginning to increase, with exception reports predominately submitted for missed educational opportunities. This arises when junior doctors are moved from training lists or clinics to service delivery roles to maintain clinical productivity. No fines have arisen from exception reports submitted thus far. The junior doctors forum in July hosted the inaugural Junior Doctor Awards, with awards to junior and senior trainees in the categories of 'Rising Star', 'Multidisciplinary team hero' and 'Best contribution to research or innovation', with voting open to all hospital employees. The winners received certificates and token gifts. In future, the awards will be linked with the QVH Staff Awards or the Joint Hospital Clinical Governance meeting.

NURSING METRICS - 12 MONTH ROLLING
BURNS WARD

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20			Quarter 2			Rolling Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep			
SAFE																							
1	**Incidents**	Total reported - All incidents	106	_	12	17	6	8	12	9	8	6	6	3	6	10	6	14			80		
2		Total reported - Patient safety	53	_	7	4	2	4	8	6	3	5	3	2	5	7	3	8			50		
3		Formal internal investigation	0	0	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	0			0		
5	**Falls**	Falls - All	7	0	1	0	1	0	1	0	1	1	1	0	0	0	1	0			5		
6		Falls - With harm	3	0	1	0	0	0	1	0	0	0	1	0	0	0	1	0			3		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0			0		
9	**MRSA Screening**	Elective patients	99.0%	95%	94%	100%	100%	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%	100%	91%			98%		This relates to 1 patient, Matron looking into the detail of this.
11		Reported cases	1	0	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	0			0		
13	**Hand Hygiene**	Hand hygiene	98%	95%	100%	N/S	80%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%			100%		
14		Bare below the elbows	100%	95%	100%	N/S	100%	100%	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%	100%				93%		
16	**Medication Audit**	Missed dose			eported 1/	Reported 1/4ly			Reported 1/4ly			eported 1/4ly									0		
17		Omitted dose			eported 1/	Reported 1/4ly			Reported 1/4ly			eported 1/4ly									0		
18		Total doses			eported 1/	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	0	2			9		ID22251 (17/07/2019) CD Measurement Discrepancy ID22371 (31/07/2019) Label error by patients OWN PHARMACY - NOT a QVH ERROR.
20	**Safety Thermometer**	Harm Free Care %	97.0%	95%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%			95%		
21		New Harm Free %	99%	95%	83%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	96%	95%	100%	50%	100%	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%	88%	100%	100%	93%	100%	100%	97%			98%		
25	**Shift meets requirement** Day %	RN	97.0%	95%	96%	97%	96%	97%	99%	101%	99%	98%	96%	91%	95%	100%	100%	99%			98%		
26		HCA	94.0%	95%	64%	97%	93%	97%	84%	94%	95%	100%	100%	103%	100%	100%	97%	100%			97%		
27	**Shift meets requirement** Night %	RN	98.0%	95%	100%	97%	97%	97%	100%	100%	97%	100%	96%	98%	100%	100%	100%	100%			99%		
28		HCA	105.0%	95%	100%	100%	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%	100%	100%		100%		
30		7 day review (Safety Thermometer)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	na	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	21				203		
33		% return rate	60%	40%	7%	31%	100%	100%	62%	100%	100%	60%	75%	47%	100%	90%	67%				78%		
34		% recommendation (v likely/likely)	98.0%	90%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%				99%		
35		% unlikely/extremely unlikely	0%	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				0		
WELL-LED																							
37	**Vacancy** Establishment=	Full Team WTE	31.2									32.46	29.99	29.99	29.99	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	8.34	7.34	7.34		9		
39		Vacancy (hrs)	1311.1	10%	1092	1053	1263	1220	1465.8	1319.5	1465.8	1511.25	1602.3	1503.12	1355.25	1355.25	1355	1192.8	1193		1393		
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	113	186			260		
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	494.5	745			577		
		Bank Use-non-clinical														60.26	116.5	159.75					
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	38	199			84		
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%	0.8%	4.1%			2%		All managed within policy
45	**Sickness non clinical**	Hours													0	7.5	7.5	11					
46		%													0.0%	0.2%	0.2%	0.2%					
47	**Maternity**	Hours										0	0	0	0	0	0	0			0		
48	**Budget Position**	YTD Position	-86992	>0	-39429	-44803	-40236	-10887	-704	-10195	354	-49955	5311	105659	-147240	-87633	-64118						
49	**Statutory & Mandatory**	Mandatory training	93.0%	90%	89%	91%	92%	93%	96%	97%	94%	94%	95%	94%	93%	95%	94%	95%			95%		
50		Appraisal	89.0%	95%	93%	92%	84%	88%	92%	79%	92%	88%	100%	96%	96%	92%	85%	86%			91%		Matron working with staff, dates in plan to esnure compliance is improved
51	**Uniform Audit**	Compliance with uniform policy %	98%	95%					100%	100%	100%	100%	100%	90%	95%	90%	80%	100%			96%		

NURSING METRICS - 12 MONTH ROLLING

CORNEOPLASTIC OPD

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 2019/20			Qrt 2			Rolling Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Jun	July	Aug	Sep			
SAFE																							
1	**Incidents**	Total reported - All incidents	71	_	3	11	6	7	5	11	2	5	2	5	8	3	7	7			55		
2		Total reported - Patient safety	30	_	0	7	1	3	2	2	1	3	2	2	5	2	4	3			26		
3		Formal internal investigation	0	0	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	0			0		
5	**Falls**	Falls - All	2	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1			3		ID22188 (09/07/2019) Pt leaving Corneo to return to ward caught foot on door and fell
6		Falls - With harm	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0			1		
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		
8	**Inoculation Injury**	Reported incidents	0	0	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	0			0		
10	**C Difficile**	Reported cases	0	0	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%	100%	100%			100%		
12		Bare below the elbows	100%	95%	100%	100%	100%	100%	N/S	100%	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	16	0	0	4	0	1	0	1	1	1	1	1	1	1	2	1			10		ID22219 (10/07/2019) Dr handed 2 drug charts and updated the wrong one
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	1864				17790		
19		% return rate	21.0%	20%	20%	24%	21%	20%	19%	19%	26%	21%	19%	22%	13%	5%	4%				16%		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%	92%				94%		
21		% unlikely/extremely unlikely	3.0%	0%	2%	4%	3%	1%	3%	1%	2%	3%	3%	3%	2%	4%	4%				3%		

RESPONSIVE																							
22	**Complaints**	No. recorded	6	0	1	2	0	0	1	1	0	0	0	0	0	0	0	1			3		During warm weather patient became dehydrated. Matron involved in this incident, patient offerred drinks and cold compress
WELL-LED																							
23	**Vacancy** Establishment=	Full Team WTE	18.1									18.06	18.06	18.06	18.06	18.06	18.06	18.11	18.11		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	2.7	2.27	2.15		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	438.75	368.88	349.37		447		
26	**Temporary Staffing** excluding RMN	Agency Use	0	10%	0	0	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	209.25	216.5			235		
		Bank Use non-clinical														0	0	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	120	142			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%	4.1%	4.8%			2.7%		Sickness absence all currently managed through Trust policy
31	**Sickness-non-clinical**	Hours													0	0	0	0					
32		%													0.0%	0.0%	0.0%	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	521464	>0	49650	65400	76928	93558	30102	30917	44629	50376	25393	50721	-38974	4906	-17366						
35	**Statutory & Mandatory**	Mandatory training	96%	90%	92%	91%	94.6%	94%	97%	96%	97%	99%	100%	99%	94%	97%	94%	93%			97%		
36		Appraisal	97%	95%	90%	95%	100%	95%	100%	100%	100%	89%	100%	95%	100%	100%	100%	95%			98%		Compliance at 95% Matron new in post, dates in place to complete outstanding apprasials for all staff
37	**Uniform Audit**	Compliance with uniform policy %	82%	95%					N/S	95%	85%	45%	85%	100%	100%	100%	100%	94%			89%		Further information requested from IPACT team regarding this.

NURSING METRICS - 12 MONTH ROLLING
CRITICAL CARE UNIT

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

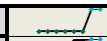
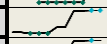
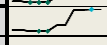
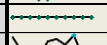
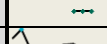
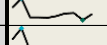
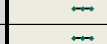
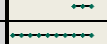
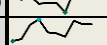
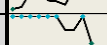
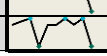
No.	Indicator	Description	2018/19 total/ average	Target	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20			Qrt 2			Rolling Year to Date Actual	Trend	Comments
					July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August	Sep			
SAFE																						
1	**Incidents**	Total reported - All incidents	181	_	8	18	25	17	15	7	15	16	17	11	11	18	13			140		5 x Unplanned Admissions, 1 x Transfer Out
2		Total reported - Patient safety	145	_	8	17	23	13	12	7	10	16	12	9	10	16	12			117		
3		Formal internal investigation	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0			1		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		
5	**Falls**	Falls - All	5	0	0	0	1	0	2	0	0	0	0	0	0	0	0			2		
6		Falls - With harm	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0			1		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0			1		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0			0		
9	**MRSA Screening**	Elective patients	100%	95%	n/a	n/a	100%	100%	n/a	n/a	100%	n/a	n/a	n/a	100%	n/a	n/a			100%		
10		Trauma patients	99.0%	95%	100%	100%	100%	100%	100%	100%	n/a	89%	100%	100%	100%	100%	100%			99%		
11		Reported cases	0	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			0		
13	**Hand Hygiene**	Hand hygiene	97.0%	95%	93%	100%	N/S	100%	100%	100%	92%	87%	100%	100%	100%	100%	100%			98%		
14		Bare below the elbows	97.0%	95%	93%	100%	N/S	100%	89%	100%	100%	89%	100%	100%	100%	100%	100%			96%		
15	**Drug Assessments**	% staff compliant	98.0%	100%	93%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%		
16	**Medication Audit**	Missed dose			Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
19	**Medication Errors**	Reported errors	6	0	0	0	1	0	0	0	0	1	1	0	1	1	1			5		ID22149 (02/07/2019): Gabapentin returend to Pharmacy and labelled "contaminated" after a bug was found floating in the liquid.
20	**Safety Thermometer**	Harm Free Care %	96.0%	95%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	67%	100%			92%		
21		New Harm Free %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
22	**VTE** (Venous thromboembolism)	Assessment of patients (S. Therm)	100.0%	95%	100%	100%	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%	88%	100%	na	100%	100%				98%		
25	**Shift meets requirement** Day %	RN	96.0%	95%	90%	99%	98%	94%	100%	90%	100%	99%	100%	98%	98%	100%	101%			98%		
26		HCA	98.0%	95%	96%	100%	96%	96%	105%	96%	100%	91%	100%	96%	100%	100%	95%			98%		
27	**Shift meets requirement** Night %	RN	94.0%	95%	88%	95%	88%	89%	93%	87%	100%	100%	100%	99%	100%	100%	100%			97%		
28		HCA	115.0%	95%	50%	100%	100%	113%	100%	88%	91%	87%	100%	100%	100%	100%	85%			96%		HCA shifts not required for all shifts, dependant upon patient acuity, managed appropriately, safe staffing maintained
EFFECTIVE																						
29	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	97.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
30		7 day review (Safety Thermometer)	83.0%	95%	n/a	n/a	n/a	n/a	100%	100%	100%	100%	na	na	na	na	100%	na		100%		
31	**Compliance in Practice** (CiP)	Inspection score		80%	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	27.57	27.79	27.79		28	
34		Vacancy WTE	10.5	10%	10.48	10.98	11.02	11.92	11.73	10.73	9.44	9.44	9.44	7.1	6.19	7.13	6.35	6.18		9	Ward Establishment = 29.37 WTE
35		Vacancy (hrs)	1699	10%	1703	1784	1791	1937	1906	1743	1534	1534	1534	1153.8	1005.87	1158.6	1031.9	1004.3		1413	
36	**Temporary Staffing** excluding RMN	Agency Use	751.7	10%	918	965	940.5	884.5	828	218	347.5	437	520.5	259.5	237.5	224	230			419	
37		Bank Use-all staff	414.4	10%	171	271	327.5	432.25	691.05	667.25	591.75	499.5	677.75	510.5	549.75	694.5	847			616	
		Bank Use-non-clinical													0	0	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	212	39			333	
40		%	6.5%	3%	7.7%	4.6%	3.9%	8.9%	7.5%	7.6%	9.3%	8.9%	8.2%	7.0%	9.8%	4.7%	0.9%			7%	
41	**Sickness non clinical**	Hours												0	0	0	0				
42		%												0.0%	0.0%	0.0%	0.0%				
43	**Maternity**	Hours											0	0	0	0	0			0	
44	**Budget Position**	YTD Position	-217834	>0	-108905	51653	56696	11881	-2451	-118838	30575	16517	-78903	-50761	(75,608)	39526				-62872	
45	**Statutory & Mandatory**	Mandatory training	89%	90%	87%	86%	88%	87%	84%	90%	96%	96%	94%	93%	94%	91%	97%			92%	
46		Appraisal	83.0%	95%	90%	85%	84%	89%	80%	89%	90%	81%	75%	87%	84%	81%	92%			85%	Dates set for outstanding appraisals - compliance improving picture although further work required
47	**Uniform Audit**	Compliance with uniform policy %	76%	95%				93%	64%	91%	92%	50%	69%	71%	64%	68%	53%			71%	Compliance poor, further information requested from IPACT to understand reasosn for this

NURSING METRICS - 12 MONTH ROLLING
MAIN OUTPATIENTS

Contact Nicky Reeves on 6607 for any formatting queries

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			Quarter 2 2019/20			Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep			
SAFE																							
1	**Incidents**	Total reported - All incidents	155	_	14	12	16	12	15	18	10	20	12	19	21	15	13	11			154		
2		Total reported - Patient safety	42	_	1	3	4	2	7	5	5	2	6	5	10	6	5	5			56		
3		Formal internal investigation	2	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0			2		
4		Serious incidents and Never Events	0	0	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	1	1			3		ID22136 (02/07/2019): Patient Fainted (No harm)
6		Falls - With harm	1	0	0	1	0	0	0	0	0	0	0	0	0	1	1	0			2		
7	**Pressure Damage**	G2 or above (hospital acquired)	1	0	0	0	0	0	0	1	0	0	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	0	0			2		
9	**MRSA**	Reported cases	0	0	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	0			0		
11	**Hand Hygiene**	Hand hygiene	89.0%	95%	N/S	80%	100%	100%	90%	80%	60%	N/S	100%	100%	90%	100%	100%	N/S			90%		Situation discussed with Matron, action in place to address to ensure audit is completed in future, role is shared between two members of staff
12		Bare below the elbows	100.0%	95%	N/S	100%	100%	100%	100%	100%	100%	N/S	100%	100%	100%	100%	100%	N/S			100%		As Above
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	0			4		
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	11721				110980		
19		% return rate	17.0%	20%	16%	16%	16%	17%	18%	16%	17%	18%	16%	17%	12%	8%	9%				15%		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%				95%		
21		% unlikely/extremely unlikely	2.0%	0%	2%	2%	3%	2%	2%	2%	2%	2%	2%	2%	2%	2%	3%				2%		

RESPONSIVE																						
22	**Complaints**	No. recorded	2	0	1	0	1	0	0	0	0	0	0	0	0	0	0				0		
WELL-LED																							
23	**Vacancy** Establishment=	Full Team WTE	15.4									15.37	15.37	15.37	15.37	15.37	15.37	16.38	16.38		15.6		
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	2.56	2.57	2.57		1.8		
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	416	417.63	417.6		293.2		
26	**Temporary Staffing** excluding RMN	Agency Use	0		0	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	91.5	122.25			138.89		
		Bank Use-non-clinical														0	0	0					
29	**Sickness-all staff**	Hours	75.7		139	48	32	0	144	236.5	38	37.5	32	50	79	81.5	7.5	69.5			77.55		
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%	0.3%	2.6%			3.09%		Sickness increased in month, all managed appropriately within Trust policy
	Sickness-non-clinical	Hours														0	0	0					
		%														0.0%	0.0%	0.0%					
33	**Maternity**	Hours	0.0%		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	-47561	6442	7998				-112380		
35	**Statutory & Mandatory**	Mandatory training	94%	90%	94%	97%	98%	92%	91%	92%	96%	98%	94%	93%	92%	98%	97%	97%			95%		
36		Appraisal	96%	95%	80%		94%	95%	100%	100%	100%	100%	100%	100%	95%	95%	100%	89%			98%		Matron to identify dates to complete staff appraisals to ensure compliance is reached
37	**Uniform Audit**	Compliance with uniform policy %	76%	95%					70%	80%	90%	N/S	70%	70%	90%	70%	90%	N/S			79%		Non submission, Matron addressing with link role staff to ensure compliance is improved.

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 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20			Quarter 2			Year to Date Actual	Trend	Comments
					July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep			
SAFE																						
1	Incidents	Total reported - All incidents	180	_	13	14	9	15	20	17	17	19	12	3	14	7	18			142		
2		Total reported - Patient safety	118	_	9	10	6	13	15	11	10	13	9	3	9	4	14			101		
3		Formal internal investigation	5	0	2	0	0	1	1	0	0	0	0	0	0	0	0			2		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		
5	Falls	Falls - All	14	0	2	2	0	1	1	1	1	2	0	0	1	1	1			9		ID22355 (30/07/2019): Unwitnessed fall in toilet - Minor Harm
6		Falls - With harm	4	0	0	1	0	0	0	1	0	0	0	0	0	0	1			2		As Above - cut to head (stitched) + Steristrips applied to end of nose
7	Pressure Damage	G2 or above (hospital acquired)	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0			0		
8	Inoculation Injury	Reported incidents	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0			1		
9	MRSA Screening	Elective patients	97.4%	95%	98%	100%	91%	96%	98%	98%	96%	94%	97%	94%	92%	100%	96%			96%		
10		Trauma patients	95.4%	95%	100%	94.8%	97%	96%	93%	95%	96%	100%	95%	96%	97%	94%	98%			96%		MRSA audit to be commenced in order to gather data on how these are eing missed in practice.
11		Reported cases	0	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			0		
13	Hand Hygiene	Hand hygiene	100%	95%	100%	N/S	100%	100%	100%	100%	90%	90%	80%	100%	90%	100%	100%			95%		
14		Bare below the elbows	94.7%	95%	100%	N/S	100%	78%	80%	90%	85%	80%	80%	100%	90%	100%	100%			88%		
15	Drug Assessments	% staff compliant	99.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
16	Medication Audit	Missed dose			Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
17		Omitted dose			Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
18		Total doses			Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
19	Medication Errors	Reported errors	32	0	0	4	2	3	4	5	1	3	1	1	2	1	5			26		ID22156 (05/07/2019): Prescribing Error ID22158 (04/07/2019): Prescribing Error ID22192 (10/07/2019): Prescribing Error (PODS not charted) ID22286 (10/07/2019): Medicine in a patients medication locker belonged to another patient ID22287 (11/07/2019): Medicine in a patients medication locker belonged to another patient
20	Safety Thermometer	Harm Free Care %	97.0%	95%	93%	100%	85%	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%			99%		
21		New Harm Free %	99%	95%	93%	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		
22	VTE (Venous thromboembolism)	Assessment of patients (S. Therm)	98.0%	95%	87%	100%	100%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%		99%		
23		Monthly screening % (Informatics)	97.0%	95%	99%	97%	97%	97%	93%	96%	92%	95%	100%	92%	89%	91%	87%			93%		
24	Shift meets requirement Day %	RN	98.0%	95%	99%	98%	97%	96%	97%	101%	100%	96%	99%	99%	99%	100%	97%			98%		
25		HCA	99.0%	95%	98%	102%	100%	95%	93%	96%	100%	100%	98%	100%	96%	95%	94%			97%		Dependent upon patient acuity
26	Shift meets requirement Night %	RN	99.0%	95%	96%	98%	97%	102%	100%	100%	98%	97%	98%	99%	100%	100%	100%			99%		
27		HCA	92.0%	95%	82%	100%	88%	90%	88%	90%	100%	90%	91%	86%	93%	93%	91%			91%		Dependant upon patient acuity
EFFECTIVE																						
28	Nutrition Assessment (MUST)	Initial (Safety Thermometer)	97%	95%	80%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		99%		
29		7 day review (Safety Thermometer)	92.0%	95%	80%	33%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	na	100%		99%		
30	Compliance in Practice (CiP)	Inspection score		80%	Reported 1/4ly			Reported 1/4ly			ported 1/4ly									#DIV/0!		
CARING																						
31	Friends & Family Test	Patient numbers (eligible to respond)	1624	_	128	131	111	140	147	159	144	132	139	144	138	154				1297		
32		% return rate	55.0%	40%	58%	57%	60%	41%	41%	47%	61%	49%	60%	51%	50%	49%				50%		
33		% recommendation (v likely/likely)	99.0%	90%	100%	97%	100%	98%	100%	100%	100%	100%	98%	100%	100%	100%				100%		
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	1	1	2	1	1	0	0	0	0	0	0	0				2		
WELL-LED																						
36	**Vacancy** Establishment=	Full Team WTE	49.2		49.04	49.54	49.54	49.54	49.54	49.54	48.66	48.66	48.66	48.66	48.66	48.66	53.66	53.66		49.8		
37		Vacancy WTE	11		12.16	12.74	12.12	13.72	13.22	10.67	9	7.16	7.16	7.08	6.08	4.08	8.78	9.78		8.8		
38		Vacancy (hrs)	1784		1976	2070	1970	2229.5	2148.3	1733.9	1462.5	1163.5	1164	1150.5	988	663	1426.8	1589.3		1429.0		
39	**Temporary Staffing** excluding RMN	Agency Use	1258		1207	1789	1775.8	1642.8	1566.5	814	369.5	713.5	994	670.5	709	766	636			888.2		
40		Bank Use-all staff	856		901	823.5	673	851.75	847.3	717	794.75	970.2	1119	985	1053.7	948.25	847			913.4		
		Bank Use-non-clinical													27.25	17.5	0					
42	**Sickness-all staff**	Hours	216.2		132	165	193	157.75	180.5	310.5	261.5	177.75	277	481.5	417.5	374.5	311.5			295.0		
43		%	2.7%	3%	1.6%	2.0%	2.4%	2.0%	2.2%	3.9%	3.3%	2.3%	3.5%	6.1%	5.3%	4.7%	3.6%			3.7%		Some long term sickness.
44	**Sickness-non-clinical**	Hours												21	10	0	37					
45		%												0.3%	0.1%	0.0%	0.4%					
46	**Maternity**	Hours			69	69	0	0	0	0	0	37.5	37.5	37.5	37.5	37.5	37.5			######		
47	**Budget Position**	YTD Position		>0	-102720	-214295	-273162		-391542	-419366	-420659	-450392	-515942		17061	11641				-2169199		
48	**Statutory & Mandatory**	Mandatory training	94%	90%	90%	91%	91%	92%	94%	96%	95%	96%	96%	95%	93%	95%	94%			95%		All staff requiring training have been emailed to book training.
49		Appraisal	93%	95%	88%	92%	90%	86%	90%	98%	98%	98%	98%	96%	85%	96%	96%			94%		
50	**Uniform Audit**	Compliance with uniform policy %	87%	95%				89%	80%	80%	95%	90%	87%	100%	100%	100%	20%			84%		Matron has asked for further details as this is unually low. The matron regularly challenges staff over uniform.

NURSING METRICS - 12 MONTH ROLLING
ROSS TILLEY

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 2019/20			Quarter 2			Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep			
SAFE																							
1	**Incidents**	Total reported - All incidents	155	_	10	18	10	12	20	12	12	9	13	13	5	7	10	16			117		
2		Total reported - Patient safety	96	_	9	8	2	8	15	8	8	7	10	7	4	4	5	11			79		
3		Formal internal investigation	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0			1		
4		Serious incidents and Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0		
5	**Falls**	Falls - All	12	0	2	0	0	2	1	2	0	1	0	2	0	1	1	0			8		
6		Falls - With harm	1	0	0	0	0	1	0	0	0	0	0	0	0	1	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	0			0		
8	**Inoculation Injury**	Reported incidents	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0			0		
9	**MRSA Screening**	Elective patients	98.0%	95%	100%	100%	98%	94.9%	100%	97%	97%	98%	97%	100%	100%	95%	96%	98%			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%	96.0%	100.0%			96%		Two week audit planned to monitor where patients are being missed in practice.
11		Reported cases	0	0	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	0			0		
13	**Hand Hygiene**	Hand hygiene	97%	95%	100%	100%	N/S	100%	100%	90%	90%	100%	100%	90%	100%	90%	100%	100%			96%		
14		Bare below the elbows	93.0%	95%	100%	100%	N/S	100%	100%	70%	90%	100%	100%	100%	100%	90%	100%	100%			95%		
15	**Drug Assessments**	% staff compliant	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%			99%		
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	0	5			26		ID22213 (05/07/2019): Patient discharged with in-patient stock (orange sticker) ID22264 (17/07/2019): Prescribing Error ID22280 (18/07/2019): Prescribing Error ID22283 (12/07/2019): Prescribing Error ID22290 (22/07/2019): Prescribing Error
20	**Safety Thermometer**	Harm Free Care %	100.0%	95%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%			100%		
21		New Harm Free %	100.0%	95%	100%	100%	100%	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%	100%	100%	100%		98%		
23		Monthly screening % (Informatics)	95.0%	95%	94%	97%	94%	94%	94%	94%	92%	97%	91%	97%	96%	93%	92%	95%			94%		
24	**Shift meets requirement** Day %	RN	98.0%	95%	98%	100%	98%	97%	97%	97%	99%	100%	97%	98%	100%	100%	98%	97%			98%		
25		HCA	98.0%	95%	98%	96%	102%	96%	92%	98%	100%	98%	98%	102%	100%	102%	98%	94%			98%		Dependent of patient acuity
26	**Shift meets requirement** Night %	RN	95.0%	95%	90%	88%	97%	99%	99%	98%	98%	94%	97%	93%	96%	96%	97%	96%			96%		Wards amalgamated at weekends
27		HCA	92.0%	95%	97%	88%	85%	90%	97%	100%	68%	100%	100%	89%	90%	96%	92%	93%			93%		Wards amalgamated at weekends
EFFECTIVE																							
28	**Nutrition Assessment** (MUST)	Initial (Safety Thermometer)	100.0%	95%	100%	100%	100%	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%	100%	100%	50%		95%		1 patient not rescreened at 7 days
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	221				1742		
32		% return rate	40.0%	40%	39%	29%	43%	31%	37%	39%	40%	48%	35%	44%	38%	34%	43%				40%		
33		% recommendation (v likely/likely)	99.0%	90%	95%	100%	100%	98%	99%	100%	100%	97%	99%	99%	97%	97%	98%				98%		
34		% unlikely/extremely unlikely	0.0%	0%	1%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	1%				0%		

RESPONSIVE																						
35	**Complaints**	No. recorded	3	0	0	0	0	1	1	0	0	0	0	0	0	0	0				1	
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	48.66	53.66	53.66		49.8	
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	4.08	8.78	9.78		8.8	
38		Vacancy (hrs)	1784	10%	1808	1976	2070	1970	2229.5	2148	1734	1463	1164	1163.5	1150.5	988	663	1426.8	1589.3		1429	
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	766	636			888.2	
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	948.3	847			913.36	
		Bank Use-non-clinical														27.25	17.5	0				
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	374.5	311.5			295.01	
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%	4.7%	3.6%			3.7%	Sickness managed as per policy
44	**Sickness-non-clinical**	Hours													21	10	0	37				
45		%													0.3%	0.1%	0.0%	0.4%				
46	**Maternity**	Hours	50.6%		69	69	69	0	0	0	0	0	37.5	37.5	37.5	37.5	37.5	37.5			22.5	
47	**Budget Position**	YTD Position		>0	-96771	-102720	-214295	-273162	-333679	-391542	-419366	-420659	-450392	-515942		17061	11641				-2502878	
48	**Statutory & Mandatory**	Mandatory training	94.0%	90%	93%	90%	91%	91%	92%	94%	96%	95%	96%	96%	95%	93%	95%	94%			95%	Staff emailed and reminded to book training,
49		Appraisal	93.0%	95%	94%	88%	92%	90%	86%	90%	98%	98%	98%	98%	96%	85%	96%	96%			94%	
50	**Uniform Audit**	Compliance with uniform policy %	95%	95%					100%	90%	90%	100%	100%	90%	100%	90%	100%	0%			86%	Matron has requested further detail as this is very inconsistent with previous compliance. Matron challenges staff regularly on uniform compliance.

NURSING METRICS - 12 MONTH ROLLING
MAX FAC OUTPATIENTS

Contact Nicky Reeves on ext. 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20			Quarter 2			Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep			
SAFE																							
1	**Incidents**	Total reported - All incidents	50	_	5	3	4	1	3	4	3	5	7	6	4	2	4	6			44		
2		Total reported - Patient safety	19	_	0	0	2	1	3	1	2	1	2	4	3	0	0	5			21		
3		Formal internal investigation	0	0	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	0			0		
5	**Falls**	Falls - All	0	0	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	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	0			0		
8	**Inoculation Injury**	Reported incidents	2	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0			2		
9	**MRSA**	Reported cases	0	0	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	0			0		
11	**Hand Hygiene**	Hand hygiene	99%	95%	N/S	100%	100%	N/S	100%	100%	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%	100%			100%		
13	**Medication Audit**	Missed dose			ported 1/4ly	Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
14		Omitted dose			ported 1/4ly	Reported 1/4ly			Reported 1/4ly			ported 1/4ly									0		
15		Total doses			ported 1/4ly	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	0	1			3		ID22263 (18/07/2019): Prescribing Error
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	1328				12578		
19		% return rate	18.0%	20%	17%	17%	19%	16%	19%	17%	17%	17%	18%	18%	12%	7%	11%				15%		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%				94%		
21		% unlikely/extremely unlikely	2.0%	0%	1%	1%	3%	1%	3%	2%	1%	3%	4%	4%	1%	2%	4%				3%		
RESPONSIVE																							
22	**Complaints**	No. recorded	8	0	1	2	0	0	0	2	0	0	0	0	0	0	0				2		
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	21.37	20.21			21.3		
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	1.12	-0.64			1.6		
25		Vacancy (hrs)	311.2		286	286	286	218	543	393.25	393.25	523.25	279.5	117	149.5	149.5	182	-104			262.63		
26	**Temporary Staffing** excluding RMN	Agency Use	0		0	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	124.8	120.25			137.04		
		Bank Use-non-clinical														0	0	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	58.75	43			119.57		
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%	1.7%	1.3%			3.4%		
31	**Sickness-non-clinical**	Hours													0	0	0	0					
32		%													0.0%	0.0%	0.0%	0.0%					
33	**Maternity**	Hours	12.5%		0	0	0	0	0	0	0	0	0	150	150	150	150				66.667		
34	**Budget Position**	YTD Position		>0	1333	3754	6041	7423	14672	17258	27014	37739	44777	31684	-47246	8125	12742				146765		
35	**Statutory & Mandatory**	Mandatory training	92%	90%	92%	88%	89%	90%	94%	93%	97%	96%	94%	93%	95%	98%	99%	98%			96%		
36		Appraisal	97%	95%	90%	92%	96%	100%	100%	100%	100%	100%	96%	100%	100%	96%	100%	100%			99%		
37	**Uniform Audit**	Compliance with uniform policy %	100%	95%					100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		

NURSING METRICS - 12 MONTH ROLLING
PEANUT WARD

Contact Nicky Reeves on 6607 for any formatting queries

QVH

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 1 2018/19				Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20			Quarter 2			Year to Date Actual	Trend	Comments
					June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep			
SAFE																										
1	**Incidents**	Total reported - All incidents	179	_	28	25	11	11	16	10	11	13	8	9	21	22	16	19			145		NB: Includes 14 x Child Safeguarding Incidents
2		Total reported - Patient safety	20	_	3	1	1	2	1	1	1	1	4	1	4	2	1	3			19		
3		Formal internal investigation	0	0	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	0			0		
5	**Falls**	Falls - All	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1			1		ID22143 (03/07/2019): Fall from bed (Minor Harm)
6		Falls - With harm	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1			1		As Above - Bump on head - ice pack applied
7	**Pressure Damage**	G2 or above (hospital acquired)	0	0	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	0			0		
9	**MRSA**	Reported cases	0	0	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	0			0		
11	**Hand Hygiene**	Hand hygiene	78.0%	95%	70%	44%	N/S	70%	90%	90%	90%	80%	90%	80%	100%	100%	70%	90%			88%		
12		Bare below the elbows	97.0%	95%	90%	100%	N/S	100%	100%	90%	90%	100%	100%	100%	100%	100%	70%	100%			95%		
13	**Drug Assessments**	% staff compliant	93.0%	100%	94%	94%	100%	100%	93%	93%	84%	85%	87%	87%	93%	93%	100%	100%			92%		
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	0	1			5		ID22229 (15/07/2019): 2 x doses of analgesia administerd too close together
18	**Safety Thermometer**	Harm Free Care %	100%	95%	100%	100%	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%	100%			100%		
20	**BMI Monthly**	Total no. of ward patients	2398	_	145	213	210	188	243	199	165	217	199	215	236	237	212	221			2144		
21		No. patients screened & documented	2263	_	143	202	201	174	236	194	151	210	168	205	217	221	188	210			2000		
22		Patients with documented BMI %	94%	95%	99%	95%	96%	93%	97%	97%	92%	96%	93%	97%	92%	93%	89%	95%			93%		
	VTE (Venous Thrombo Embolism)	Assessment of patients (S. Therm)		95%											100%	100%	na	na	na				VTE screening applies to 16 and over from April 2019
		Monthly screening % (Informatics)		95%												17%	82%	100%					
25	**Shift meets requirement** Day %	RN	98.0%	95%	95%	98%	98%	99%	101%	98%	97%	98%	97%	96%	99%	97%	100%	97%			98%		
26		HCA	98.0%	95%	103%	96%	100%	96%	97%	97%	97%	95%	97%	88%	103%	100%	100%	100%			97%		Dependent on patient acuity, staff sickness.
27	**Shift meets requirement** Night %	RN	86.0%	95%	84%	85%	90%	80%	70%	70%	81%	97%	100%	95%	88%	89%	92%	66%			85%		Dependent on patient acuity, staff sickness impacting on shift cover
28		HCA	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		Staff sickness and shortage of night staff, HCA used to support staff member.
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	178				1690		
31		% return rate	34.0%	40%	33%	28%	38%	45%	31%	32%	36%	49%	23%	17%	34%	20%	15%				29%		Staff are regularly 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%	100%				99%		
33		% unlikely/extremely unlikely	0.0%	0%	0%	1%	0%	0%	0%	0%	2%	0%	0%	0%	1%	1%	0%				0%		

RESPONSIVE																						
34	**Complaints**	No. recorded	0	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	20.37	21.46			20.4	
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	0.54	1.63			0.4	
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	87.75	264.87			71.992	
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	100.25	110			65.95	
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	191.15	329.5			246.34	
		Bank Use-non-clinical														4	0	0				
41	**Sickness-all staff**	Hours	130.1		161.5	84	24	40	96	181	76	220.25	205.95	212	266.5	112.5	247.5	486.5			210.42	
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%	7.5%	14.0%			6.3%	Two members of staff on long term sick.
43	**Sickness non clinical**	Hours													45	65	37	165.5				
44		%													1.3%	2.0%	1.1%	4.7%				Admin staff on long term sick.
45	**Maternity**	Hours																			#DIV/0!	
46	**Budget Position**	YTD Position		>0	7514	4051	2932	7797	13962	17375	11940	30457	33223	43873		-7044	-10519				133267	
47	**Statutory & Mandatory**	Mandatory training	93%	90%	93%	93%	91%	94%	95%	94%	94%	93%	92%	91%	89%	92%	93%	94%			93%	A small improvement from last month, key members of staff have been individually contacted for an update.
48		Appraisal	88%	95%	91%	91%	91%	96%	96%	92%	92%	83%	92%	71%	80%	80%	76%	76%			84%	Appraisalas that were booked at to be postponed due to high clincal demand. All staff out of date emailed by HON to find out booked dates. Dates of appraisals received by HON, to follow up over the next two weeks.
49	**Uniform Audit**	Compliance with uniform policy %	88%	95%					100%	100%	90%	70%	80%	90%	90%	100%	100%	100%			92%	

NURSING METRICS - 12 MONTH ROLLING

SLEEP DC

Contact Nicky Reeves on 6607 for any formatting queries

No.	Indicator	Description	2018/19 total/ average	Target	Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19			Quarter 1 2019/20				Year to Date Actual	Trend	Comments
					July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul			
SAFE																				
1	Incidents	Total reported - All incidents	25	_	3	2	1	1	2	4	1	1	5	2	3	0	1	23		
2		Total reported - Patient safety	9	_	0	2	0	0	1	2	1	1	1	1	3	0	1	13		
3		Formal internal investigation	0	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	0		
5	Falls	Falls - All	0	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	0		
7	Pressure Damage	G2 or above (hospital acquired)	0	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	0		
9	MRSA	Reported cases	0	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	0		
11	Hand Hygiene	Hand hygiene	100%	95%	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
12		Bare below the elbows	100.0%	95%	100%	100%	N/S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
13	Medication Errors	Reported errors	4	0	0	1	0	0	1	1	0	0	1	0	0	0	0	4		
14	VTE	Monthly screening % (Informatics)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%		
EFFECTIVE																				
15	Compliance in Practice (CiP)	Inspection score	91%	80%	Reported 1/4ly			90.6%			ported 1/4ly							91%		
CARING																				
16	Friends & Family Test	Patient numbers (eligible to respond)	10086	_	896	792	653	921	907	559	939	794	867	837	935	877		9081		
17		% return rate	19.0%	20%	22%	24%	19%	19%	16%	22%	22%	16%	19%	13%	14%	15%		18%		
18		% recommendation (v likely/likely)	97.0%	90%	97%	97%	97%	98%	97%	95%	96%	98%	98%	99%	97%	97%		97%		
19		% unlikely/extremely unlikely	1.0%	0%	1%	1%	1%	1%	2%	2%	2%	1%	0%	0%	3%	1%		1%		
RESPONSIVE																				
20	Complaints	No. recorded	1	0	0	0	0	0	1	0	0	0	0	0	0	1		2		
WELL-LED																				
21	Vacancy Establishment=	Full Team WTE			22.46	32.17	32.17	32.17	32.17	32.17	32.17	32.17	32.17	32.17	32.17	32.17		32.2		
22		Vacancy WTE		10%	-1.85	7.64	8.64	8.06	7.46	6.86	6.65	5.72	6.52	6.38	6.17			7.0		
23		Vacancy (hrs)		10%	-69.37	286.5	324	302.25	279.75	257.25	249.37	214.5	244.5	239.25	231.37			262.87		
24	Temporary Staffing excluding RMN	Agency Use		10%	0	0	2	9	13	0	0	0	0	0	0	0		2.1818		
25		Bank Use		10%	4.38	4.63	3.47	3.55	3.67	2.51	2.49	3.55	2.86	3.27	4			3.4		
26	Sickness	Hours			111	27.5	150	45	0	0	86	44	92	191.25	77.5	81.5		72.25		
27		%		3%	15.9%	3.9%	21.4%	6.4%	0.0%	0.0%	12.3%	6.4%	13.1%	27.3%	11.0%	11.7%		10.3%		
28	Sickness non clinical	Hours			165	74.5	32.25	74.25	190.5	157.5	180	165.5	174.5	165	120.5	0				needs formula changing
29		%			39.5%	17.8%	7.7%	17.8%	45.6%	37.7%	43.1%	39.6%	41.8%	39.0%	28.8%	0.0%		29.0%		needs formula changing
30	Maternity	Hours			330	345	300	345	330	315	345	300	240	165	60	0		249.55		
31	Budget Position	YTD Position		>0	157	159	159	108	201	181	27	254	106	230	120	310		1855		
32	Statutory & Mandatory	Mandatory training		90%	75%	75%	70%	86%	100%	100%	100%	94%	90%	87%	93%	90%		89%		
33		Appraisal		95%	97%	96%	92%	90%	90%	92%	91%	94%	91%	93%	81%	88%		91%		
34	Uniform Audit	Compliance with uniform policy %	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		

GMC NATIONAL TRAINING SURVEY 2019
QVH ANALYSIS

Summary of results

Programme Group	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Team Work	Handover	Supportive environment	Induction	Adequate Experience	Curriculum coverage	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design
Anaest-etics	GREEN				GREEN	LIGHT GREEN												GREEN
CST	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN		LIGHT GREEN		GREEN		GREEN						GREEN
OMFS						GREEN	GREEN	LIGHT GREEN						GREEN				
Plastic surgery		PINK	PINK											PINK				RED

Red	Strong negative outlier	**Pink**	Negative in comparison to the average but not quite a negative outlier.
Green	Strong positive outlier	**Light Green**	Positive in comparison to the average but not quite a positive outlier.
White	Within the range of the average	**Grey**	Less than three trainees
Yellow	No trainees responded to questions relating to this indicator		

The 2019 results show an impressive improvement on 2018, particularly in core surgical training. It is also pleasing to see the numbers of green flags in anaesthetics and oral and maxillofacial surgery.

There is clearly still some work to do in plastic surgery, although the figures in the trend analysis (see page 5) show that the majority of areas are moving in the right direction.

It is important to remember that the results are based on very small numbers of HEE appointed trainees. The significance of the results is therefore not always easy to interpret, with the responses of one trainee potentially accounting for large swings. This does not detract from the importance given to the results.

NB: in 2019 there were only two radiology trainees in post and therefore their responses were not counted for QVH's survey results.

Detailed analysis

Areas of concern and also areas with improved and positive outcomes have been identified in this section for further examination. The trend analysis (reproduced on page 5) provides a comparison of mean scores across all 18 areas of the survey, compared against the previous years. An action plan is on page 8.

The detailed question answers are referred to throughout this section; spread sheets with further information on these questions are available in the Appendix at the end of this document.

1 Overall satisfaction

✓ All areas show an improvement in overall satisfaction in 2019, with green flags in Anaesthetics and CST (with an impressively improved score from 60.80 last year to 92.40 this year), and also improved scores in OMFS and Higher Plastic Surgery.

2 Clinical supervision

✘ Higher Plastic Surgery has received a pink flag, despite an improvement on last year's score. The detailed answers indicate that one person (of the eight respondents) feels that they are forced to cope with clinical problems beyond their competence or experience on a monthly basis. Two people also report that they know who their clinical supervisor is, but they are not easy to access, and one person reports that they do not always know who their clinical supervisor is, but there is usually someone that they can contact.

✓ CST received a green flag, with a score of 98.00.

3 Clinical supervision out of hours

✘ Higher Plastic Surgery has received a pink flag, despite an improvement on last year's score. The detailed answers indicate that three of the eight respondents feel forced to cope with problems beyond their competence or experience less than once a month out of hours. Two people also report that the quality of clinical supervision out of hours is neither good nor poor.

✓ CST received a green flag, with a score of 95.00.

4 Reporting systems

✓ All four specialities showed an improvement on last year's score, and CST received a green flag. No red or pink flags were received.

5 Work load

✘ Higher Plastic Surgery showed a slight drop on last year's score.

✓ Anaesthetics and CST received a green flag, and OMFS showed an improvement for this indicator on last year's score.

6 Teamwork

✓ All four specialities showed improved scores for this indicator. Anaesthetics received a light green flag and CST and OMFS both received a green flag.

7 Handover

✓ OMFS received a green flag, and the scores for Anaesthetics, CST and Higher Plastic Surgery all showed an improvement for this indicator.

8 Supportive environment

✓ All four specialities showed improved scores for this indicator. CST and OMFS both received a light green flag.

9 Induction

✗ Higher Plastic Surgery had a very slight drop on last year's score.

✓ Anaesthetics, OMFS and CST all improved on last year's score.

10 Adequate experience

✓ All four specialities showed improved scores for this indicator. CST received a green flag.

11 Curriculum coverage

✓ All four specialities showed improved scores for this indicator.

12 Educational governance

✗ OMFS had a drop on last year's score.

✓ Anaesthetics and Higher Plastic Surgery improved on last year's score, and CST received a green flag.

13 Educational supervision

✗ OMFS had a drop on last year's score.

✓ Anaesthetics, CST and Higher Plastic Surgery all showed an improvement on last year's score.

14 Feedback

✗ Higher Plastic Surgery received a pink flag. The detailed answers indicate that one trainee (of eight respondents) only receives informal feedback on a monthly basis. With regard to formal meetings with their educational supervisor, one trainee reported having a meeting but it wasn't useful, one trainee reported not having a meeting

(but it will happen), and one trainee reported not having a meeting but they would like to. The question relating to formal assessment of their performance shows that one trainee has not had formal assessment, but they felt that it wasn't necessary, and two trainees have not had formal assessment but would like to.

✓ OMFS received a green flag, and CST showed a large improvement on last year's score.

15 Local teaching

✘ Higher Plastic Surgery and OMFS both scored lower than last year.

✓ Anaesthetics showed an improvement on last year's score. CST also showed a large improvement on the previous year.

16 Regional teaching

✘ OMFS and Anaesthetics both scored lower than last year.

✓ Higher Plastic Surgery and CST showed an improvement on last year's scores.

17 Study leave

✘ Higher Plastic Surgery scored lower than last year.

✓ CST, Anaesthetics and OMFS all showed an improvement on last year's score.

18 Rota design

✘ Higher Plastic Surgery received a red flag for this indicator. The detailed results show that six of the eight respondents disagree with the statement: "In my current post, educational/training opportunities are rarely lost due to gaps in the rota". Additionally, four trainees disagree or strongly disagree that gaps with the rota are dealt with appropriately to ensure that education and training is not adversely affected (and three trainees neither agree nor disagree). Finally, to the question that the rota design helps to optimise trainee doctors' education and development, one trainee neither agrees nor disagrees, one disagrees, and one strongly disagrees. OMFS also received a lower score than last year.

✓ CST and Anaesthetics both received green flags for rota design.

Trend analysis

Red	Strong negative outlier	**Pink**	Negative in comparison to the average but not quite a negative outlier.
Green	Strong positive outlier	**Light Green**	Positive in comparison to the average but not quite a positive outlier.
White	Within the range of the average	**Grey**	Less than three trainees
Yellow	No trainees responded to questions relating to this indicator		

Programme Group	Indicator	2012	2013	2014	2015	2016	2017	2018	2019	Trend
Anaesthetics	Overall Satisfaction	96.00	88.57	93.50	97.00	86.40	91.71	93.14	95.83	↑
Anaesthetics	Clinical Supervision	98.38	96.14	96.09	96.50	89.90	97.14	98.57	97.50	↓
Anaesthetics	Clinical Supervision out of hours				96.19	94.95	95.71	93.75	93.75	↔
Anaesthetics	Reporting systems					77.50	73.57	72.86	80.83	↑
Anaesthetics	Work Load	63.28	70.54	49.22	56.25	57.50	66.07	67.86	65.63	↓
Anaesthetics	Teamwork						76.19	77.38	84.72	↑
Anaesthetics	Handover	67.19	42.86	31.25	100.00	80.00	86.91	70.54	76.04	↑
Anaesthetics	Supportive environment				88.75	82.00	74.29	75.71	82.50	↑
Anaesthetics	Induction	98.13	92.86	84.38	96.25	93.00	88.39	79.29	92.50	↑
Anaesthetics	Adequate Experience	96.25	88.57	92.50	96.25	80.00	93.57	91.79	96.25	↑
Anaesthetics	Curriculum Coverage						86.90	85.71	88.89	↑
Anaesthetics	Educational Governance						78.57	76.19	81.95	↑
Anaesthetics	Educational Supervision	93.75	82.14	81.25	96.88	90.00	92.86	86.61	96.88	↑
Anaesthetics	Feedback	83.86	70.84	52.38	86.46	85.42	83.33	75.00		
Anaesthetics	Local Teaching	84.50	78.86	76.75	79.13	73.20	79.43	81.43	81.94	↑
Anaesthetics	Regional Teaching	55.21	66.13	67.79	59.06	52.42	66.71	71.90	68.61	↓
Anaesthetics	Study Leave	70.71	82.22	81.67	94.05	70.00	78.27	61.61	78.13	↑
Anaesthetics	Rota Design							73.21	82.29	↑
CST	Overall Satisfaction	73.00	84.00	59.20	82.00	84.00	59.67	60.80	92.40	↑
CST	Clinical Supervision	84.88	88.63	57.00	86.50	87.00	61.67	87.00	98.00	↑

Programme Group	Indicator	2012	2013	2014	2015	2016	2017	2018	2019	Trend
CST	Clinical Supervision out of hours				85.83	95.75	83.33	87.50	95.00	↑
CST	Reporting systems					72.50	61.67	66.67	84.06	↑
CST	Work Load	50.00	50.00	45.00	50.00	40.63	62.50	71.25	62.50	↓
CST	Teamwork						63.89	65.63	81.67	↑
CST	Handover	76.56	92.19	80.00	100.00	85.42	63.89	47.50	70.42	↑
CST	Supportive environment				71.67	83.75	73.33	59.00	84.00	↑
CST	Induction	81.88	95.00	78.00	94.17	83.75	66.67	57.00	72.00	↑
CST	Adequate Experience	71.25	72.50	50.00	83.33	72.50	61.67	66.00	88.50	↑
CST	Curriculum Coverage						61.11	61.67	83.33	↑
CST	Educational Governance						66.67	71.67	83.33	↑
CST	Educational Supervision	93.75	81.25	65.00	87.50	100.00	75.00	77.50	83.75	↑
CST	Feedback	80.36	75.00	52.08	77.78	86.11		38.54	68.06	↑
CST	Local Teaching	65.63	61.25	57.40	65.67	59.75	51.33	47.67	73.33	↑
CST	Regional Teaching		57.33	61.75	54.90			38.83	64.00	↑
CST	Study Leave	57.67	66.67	56.33	73.89	89.58	27.78	39.06	70.83	↑
CST	Rota Design							47.50	80.00	↑
Oral and maxillo-facial surgery	Overall Satisfaction	92.80	90.67	88.00	93.00	87.33	81.00	85.67	92.75	↑
Oral and maxillo-facial surgery	Clinical Supervision	95.95	93.67	91.80	96.19	93.17	92.50	93.33	98.75	↑
Oral and maxillo-facial surgery	Clinical Supervision out of hours				97.75	96.00	93.75	95.83	98.44	↑
Oral and maxillo-facial surgery	Reporting systems					80.00	82.50	80.00	82.50	↑
Oral and maxillo-facial surgery	Work Load	40.00	52.08	52.50	51.56	41.67	46.88	41.67	50.00	↑
Oral and maxillo-facial surgery	Teamwork						87.50	91.67	93.75	↑
Oral and maxillo-facial surgery	Handover	77.50	91.67	84.38	100.00	75.00	85.42	89.58	84.38	↓
Oral and maxillo-facial surgery	Supportive environment				90.00	81.67	80.00	80.00	87.50	↑
Oral and maxillo-facial surgery	Induction	85.00	95.00	97.00	96.25	89.17	85.94	81.67	82.50	↑
Oral and maxillo-facial surgery	Adequate Experience	90.00	90.00	86.00	95.00	88.33	77.50	85.00	88.75	↑
Oral and maxillo-facial surgery	Curriculum Coverage						79.17	88.89	91.67	↑
Oral and maxillo-facial surgery	Educational Governance						89.59	88.89	79.17	↓
Oral and maxillo-facial surgery	Educational Supervision	80.00	75.00	85.00	100.00	95.83	88.54	93.75	85.94	↓
Oral and maxillo-facial surgery	Feedback	91.67	86.11	75.00	81.25	75.83	88.54	94.45	93.75	↓
Oral and maxillo-facial surgery	Local Teaching	66.20	52.33	64.00	68.00	61.83	51.50	86.11	82.08	↓
Oral and maxillo-facial surgery	Regional Teaching	71.50	69.83	79.40	81.13	76.70	71.75	94.45	81.67	↓

Programme Group	Indicator	2012	2013	2014	2015	2016	2017	2018	2019	Trend
Oral and maxillo-facial surgery	Study Leave	75.00	63.33	79.00	83.75	84.17	63.54	45.83	85.42	↑
Oral and maxillo-facial surgery	Rota Design							72.92	65.63	↓
Plastic surgery	Overall Satisfaction	93.82	81.50	90.67	82.00	84.00	72.38	84.60	86.88	↑
Plastic surgery	Clinical Supervision	92.18	85.25	92.33	87.83	87.44	89.69	91.50	92.50	↑
Plastic surgery	Clinical Supervision out of hours				92.00	92.89	89.29	92.50	92.97	↑
Plastic surgery	Reporting systems					75.56	66.88	75.56	82.14	↑
Plastic surgery	Work Load	47.16	48.44	46.88	41.67	42.59	49.74	50.63	46.09	↓
Plastic surgery	Teamwork						69.05	84.17	85.42	↑
Plastic surgery	Handover	93.18	78.57	95.83	97.92	81.48	68.45	68.33	70.31	↑
Plastic surgery	Supportive environment				75.83	81.11	63.13	79.00	85.00	↑
Plastic surgery	Induction	92.27	83.75	91.00	95.83	91.11	73.44	80.00	79.38	↓
Plastic surgery	Adequate Experience	89.09	80.00	91.67	80.00	75.56	68.75	84.00	84.69	↑
Plastic surgery	Curriculum Coverage						68.75	80.00	83.33	↑
Plastic surgery	Educational Governance						63.54	75.00	79.17	↑
Plastic surgery	Educational Supervision	77.27	84.38	83.33	83.33	97.22	88.02	85.00	90.63	↑
Plastic surgery	Feedback	56.25	64.88	57.50	78.47	81.95	66.67	78.13	73.96	↓
Plastic surgery	Local Teaching	74.09	73.00	72.00	72.17	63.56	57.13	70.33	65.42	↓
Plastic surgery	Regional Teaching	67.31	68.09	65.75	63.65	68.89	73.23	81.00	83.54	↑
Plastic surgery	Study Leave	53.17	41.46	56.94	45.00	54.44	60.72	57.92	54.43	↓
Plastic surgery	Rota Design							45.00	51.56	↑

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**5 September 2019**		**Agenda reference:**	**148-19**	
Report title:	**Paediatric Burns Update**				
Sponsor:	Dr E Pickles, Medical Director				
Author:	Dr E Pickles, Medical Director				
Appendices:	QVH / NHSE Flowchart for the Referral of Paediatric Burns Patients from Kent, Surrey and Sussex				
Executive summary					
Purpose of report:	To inform board of the temporary diversion of paediatric inpatient burns to London and South East Burns Network partners at Chelmsford and Chelsea and Westminster				
Summary of key issues	Diversion commenced on 01 August 2019. Patient safety maintained. Full service impact not yet able to be assessed. Next steps include development of strategic outline case for the provision of adult and children's burns services, aligned with the Major Trauma Centre in Brighton.				
Recommendation:					
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:	BAF KSO2				
Corporate risk register:	CRR 1059 & 968				
Regulation:	CQC, NHSE, National Burns Care Standards				
Legal:					
Resources:					
Assurance route					
Previously considered by:	Not previously considered				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:	Update Q&GC with service impact assessment at 1, 6 and 12 months.				

Update to QVH Board of Directors regarding Paediatric Inpatient Burns Services

Meeting Date 5th September 2019
Dr Edward Pickles, QVH Medical Director

1. Background

The Queen Victoria Hospital (QVH) has provided burns care services for paediatric and adult patients from the South East of England for several decades. Over the last 15 years a number of service reviews have made recommendations for the improvement burns care in the South East. National Burns Care Standards issued in 2013 specified that burns units must be co-located with a number of other clinical services, which are not available on the QVH site. Meeting the Burns Care Standards by providing these additional services would require significant infrastructure which are not considered possible on the QVH site.

Existing services have been assessed as being safe and able to deliver clinical appropriate care/outcomes under the derogation. Maintaining the current position was supported by London and South East Burns Network (LSEBN) and NHS England (NHSE).

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

QVH put in place extensive controls and mitigations to address the insufficiencies in the current service model including adjusting the clinical criteria for admission to the service to mitigate clinical risk. Children under six months old, and children with burns / scalds more than 10%, 15% or 20% (depending on the age of the child) were transferred directly to specialist burns teams in Chelmsford or Chelsea and Westminster Burns Centres.

These clinical criteria and a national downward trend have resulted in a decreasing number of paediatric inpatient burn patients attending QVH, reducing affordability and further increasing the risks to service sustainability.

In 2018/19 we examined again a number of options for the development of the paediatric service. The preferred option identified following initial evaluation (as detailed in the 2016 Strategic Outline Case), was for QVH to develop an acute inpatient paediatric burn service with an outpatient provision for the local population in collaboration with the Royal Alexandra Children's Hospital (RACH) in Brighton. The RACH is the only children's hospital in the South East, with an age appropriate A & E and Major Trauma Centre status and provides a comprehensive range of paediatric services including a paediatric High Dependency Unit (HDU). This option would utilise the expertise and resources of QVH's burns/plastics surgeons who currently provide a plastic surgery service at Brighton and Sussex University Hospitals (BSUH). This option also built on an existing clinical arrangement where medically unwell paediatric burn patients are transferred to the RACH. Offering additional outpatient provision at the RACH would increase patient choice and reduce travel times, therefore improving patient experience.

In order to ensure the evaluation of the options was robust, future inpatient numbers were estimated based on past activity and underlying trends. This analysis concluded that the future annual inpatient numbers would be approximately 40 (from a total number of burns referrals made annually of around 1200 patients) with an average length of stay of 3 days. This level of activity significantly impacted on the viability of the preferred option. Issues included:

Issues around staffing

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

Operational and clinical risks

The very low number of patients would not enable staff to maintain their skills, which is a clinical safety risk. In addition, this model generated a number of operational risks related to the need to provide highly specialised treatment and skilled staff to a low volume of patients with unpredictable levels of activity. Mitigations to these new risks have been explored but are not considered sufficiently robust to reduce the risks to acceptable levels.

Issues around cost

Financial evaluation of this model has demonstrated that the service cannot be provided within current resources. There would be a significant capital requirement to set up the service and in addition the revenue costs of implementation show that the service would result in an annual loss of £245k providing activity levels remain constant. The increase in cost is driven by additional staffing costs incurred by both QVH and BSUH to create the service and staffing infrastructure required to support delivery at the RACH.

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

2. Service risks

By failing to meet the burn care standards, both QVH and patients were at risk. The key risks that we are aiming to address include:

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

3. Temporary Diversion of Inpatient Burns Referrals from 1st August 2019

QVH already had thresholds in place around age of child and severity of burn. The QVH admission criteria were restricted to children over 6 months of age, and burns / scalds less than 10%, 15% or 20% depending on the age of the child. Injuries outside of these criteria were already transferred directly to Chelmsford or Chelsea.

With the agreement of the LSEBN and commissioners, QVH has made arrangements for a temporary divert of **all** inpatient paediatric burns patients from Kent, Surrey and Sussex to the specialist centre for children's burns at St Andrew's Burn Centre, Broomfield Hospital, Chelmsford or the specialist unit for children's burns at Chelsea and Westminster Hospital, London.

QVH is continuing to provide outpatient treatment from the QVH, and Royal Sussex County Hospital (RSCH) sites. This will include all aspects of longer term treatment including admission for the types of planned surgical procedures required in the ongoing management of a burns patient.

This will ensure that:

- Children who need inpatient treatment will be provided with care by a service that is able to meet the standards required to deliver the best possible outcomes
- The risks associated with unplanned transfer of children who become acutely unwell as a result of their burn injury will be reduced
- Children can continue to receive all aspects of their care that do not require an inpatient admission locally. The majority of care that children with burns need can be managed as an outpatient.

The potential risks are:

- Children and their families will have to travel further to receive inpatient care for a short period of time. Currently the average length of stay for an inpatient at QVH is 3 days
- Patient and carer experience is adversely impacted by the increased travel distance
- There will be some impact on the resources of the ambulance service
- Patients attending the QVH site for planned outpatient care may on occasion be assessed as needing inpatient care, resulting in a further transfer of care.
- Acute providers in Kent, Surry and Sussex refer directly to other burns care providers, thereby reducing outpatient activity at QVH.

4. Stakeholder Engagement

The following organisations were consulted and informed regarding the change in patient pathway.

- QVH staff, including Peanut and burns clinical staff
- NHS England / Improvement
- CQC
- NHSE Specialised Commissioning
- Clinical Commissioning Groups
- Chelsea and Westminster Hospital and St. Andrew's Burns Centre, Chelmsford
- London and South East Burns Network
- Kent, Surrey and Sussex Acute Providers and Emergency Departments and MIUs
- South East Coast Ambulance Service
- QVH Governors
- Healthwatch
- Health Overview Scrutiny Committee
- Member of Parliament

5. Impact

The diversion, agreed with NHS England Specialised Commissioning, commenced on the 1st August 2019. Numbers of paediatric burns referrals made to QVH, where the referrer is requested to make an onward referral to another network provider will be monitored, as will activity in the paediatric outpatient and burns assessment unit (PAU).

Anecdotal evidence from the first 3 weeks suggests that the numbers referred onwards are low (less than 5), but that numbers of patients being referred to the PAU has also reduced (approximately 65, compared to an average of 75 – 90 patients), suggesting that providers in Kent, Surrey and Sussex may be referring directly to Chelsea and Chelmsford without seeking triage from QVH first. There may be some normal and / or seasonal variation in the referral numbers.

6. Next Steps

The diversion of inpatient paediatric burns patients is considered temporary, however, it is very unlikely that the service would be able to be transferred back to the QVH due to the inability to meet burns care standards.

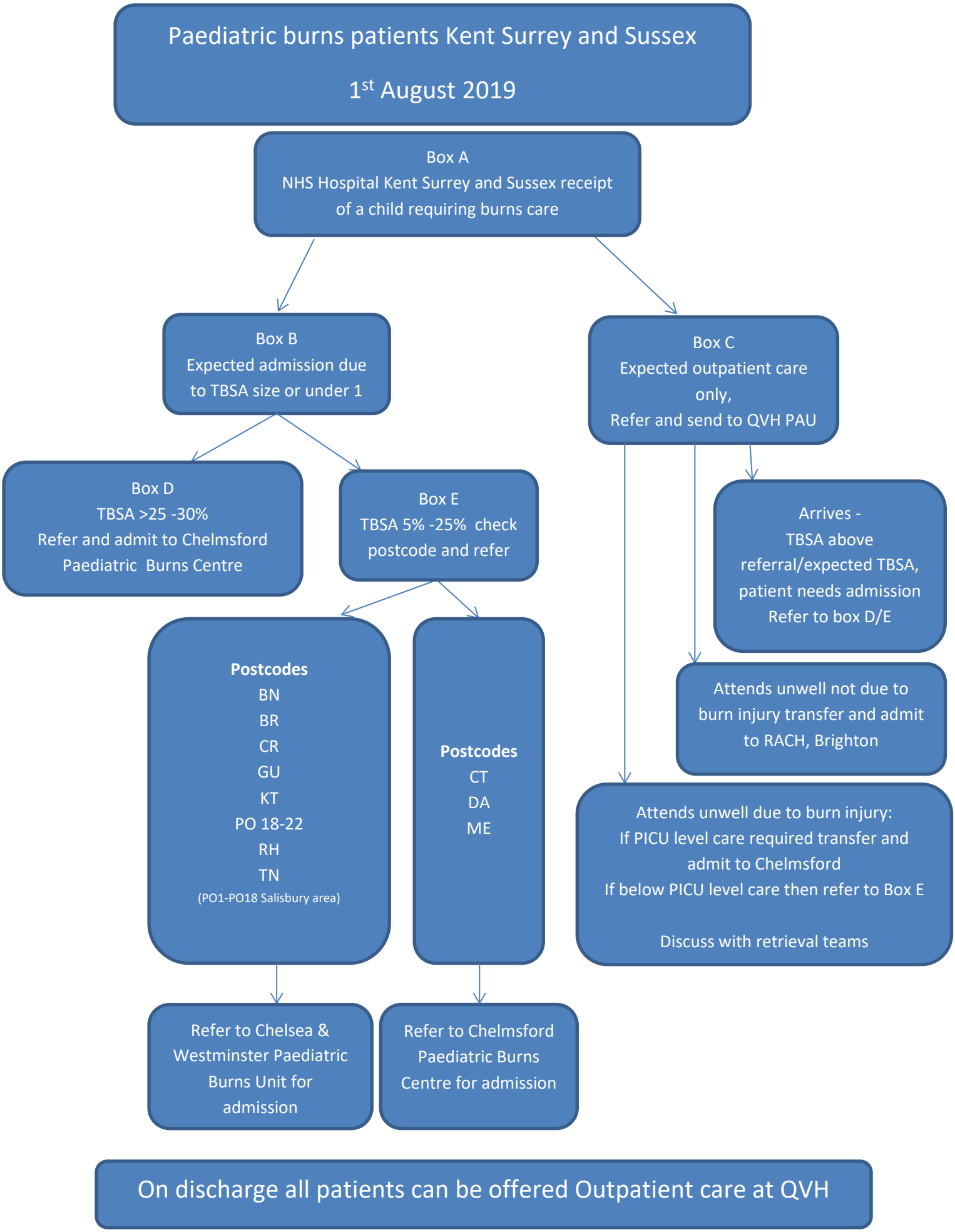
We wish to meet the following objectives in our future development of the service

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

The ambition to provide both adult and children's burn services, aligned with the major trauma centre at the Royal Sussex County Hospital and the Royal Alexandra's Children's Hospital is shared both by QVH and BSUH. BSUH have strategically committed to including adult burns services in the first wave of new capacity, as the '3Ts' build is completed in April 2021. In the meantime, we have reached agreement with BSUH for the appointment of 3 new plastic surgery consultants and the provision of a 1 in 6 rota on-call rota to improve the care of adult lower limb trauma patients. Whilst not directly related, this will help the transition to an adult burns service at RSCH, which will mitigate some of the difficulties of repatriation of the inpatient burns services to the RACH.

We are now commencing the data gathering to enable development of the strategic outline case, and are in discussion with LSEBN to ensure a burns service at Brighton, for the population of Kent, Surrey and Sussex, is in alignment with their vision of burns care in the South East of England.

E Pickles
August 2019


Paediatric burns patients Kent Surrey and Sussex
1st August 2019
Box A
NHS Hospital Kent Surrey and Sussex receipt of a child requiring burns care
Box B
Expected admission due to TBSA size or under 1
Box C
Expected outpatient care only,
Refer and send to QVH PAU
Box D
TBSA >25 -30%
Refer and admit to Chelmsford Paediatric Burns Centre
Box E
TBSA 5% -25% check postcode and refer
Arrives -
TBSA above referral/expected TBSA, patient needs admission
Refer to box D/E
Attends unwell not due to burn injury transfer and admit to RACH, Brighton
Postcodes
BN
BR
CR
GU
KT
PO 18-22
RH
TN
(PO1-PO18 Salisbury area)
Postcodes
CT
DA
ME
Attends unwell due to burn injury:
If PICU level care required transfer and admit to Chelmsford
If below PICU level care then refer to Box E
Discuss with retrieval teams
Refer to Chelsea & Westminster Paediatric Burns Unit for admission
Refer to Chelmsford Paediatric Burns Centre for admission
On discharge all patients can be offered Outpatient care at QVH

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05 September 2019**		**Agenda reference:**	**149-19**	
Report title:	**Clinical Strategy priorities update**				
Sponsor:	Dr E Pickles, Medical Director				
Author:	Dr E Pickles, Medical Director				
Appendices:	Nil				
Executive summary					
Purpose of report:	A QVH Clinical Strategy was submitted to Board in March 2019. The Board requested an update against the strategic priorities declared.				
Summary of key issues	Note good overall progress in trust wide strategy of 'People, Partnership and Performance' Note areas of planned clinical strategy that are not currently progressing at the intended rate (RAG rated red)				
Recommendation:	To note contents				
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:	KSO2				
Corporate risk register:	No				
Regulation:	No. Open to CQC review.				
Legal:					
Resources:					
Assurance route					
Previously considered by:	Not previously considered.				
	Date:		Decision:		
Previously considered by:					
	Date:		Decision:		
Next steps:					

QVH Clinical Strategy 2019/2020

Report on Progress to Board of Directors September 2019

A) Our Values			
A1	Continuous improvement of Care		
A2	Pride		
A3	Humanity		
A4	Quality		
B) Our Key Strategic Objectives			
B1	KSO1	Outstanding Patient Experience	Patients have confidence in the quality and safety of our services, the way in which they are delivered, and the environment in which we provide them.
B2	KSO2	World Class Clinical Services	Patients, clinicians and commissioners have confidence in our services because of our excellent safety, clinical outcomes, research and teaching standards.
B3	KSO3	Operational Excellence	Patients and commissioners have confidence in our ability to provide timely and effective treatment due to low waiting times and high productivity.
B4	KSO4	Financial Sustainability	Regulators have confidence in the long term financial sustainability of the Trust due to our ability to create adequate surpluses to fund operational and strategic investments.
B5	KSO5	Organisational Excellence	We maintain a well-led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce.

C) Our Trust Wide Focus in 2019 / 2020			
C1	Partnership	*"We will continue to work with Brighton and Sussex University Hospitals Trust (BSUH) and Western Sussex Hospitals Foundation Trust to align further both clinical and support services. Our approach to partnership will be focussed on delivering safe, effective and efficient services, and a secure future for the outstanding care provided by staff at QVH."*	• MoU with BSUH and WSHT superseded by formation of Sussex Acute Collaborative Network (SACN), including senior executive representation from BSUH, ESHT, WSHT and QVH. Initial programmes of work include transformational service reviews of the Sussex provision of dermatology, head and neck services and adult and children's burns care. Reports to STP Clinical and Professional Cabinet and STP Executive. • Network development of orthoplastic and maxillofacial surgery services – service specifications agreed and posts being appointed. • Separate QVH Strategic Programme Board working with commissioners and NHSI.
C2	Productivity	*"We will work to make sure we have full theatre lists and outpatient clinics and processes that ensure there are no unnecessary delays for patients. We will continue to seek efficiencies in how we work both clinically and in support services, making sure our data is accurate and our staffing and systems support us in providing the best patient care."*	• Theatres productivity Programme completed with implementation of 6-4-2 booking programme, and regular review of KPIs. Patient call-outs in place to reduce patient DNAs. Mini-RCAs for on the day cancellations. Ongoing audit around theatre start times. • Outpatient productivity programme underway,

			focusing on Communications, eRS, DeRs optimisation, productivity and DNAs, and virtual clinics.
C3	People	*"The knowledge, expertise, hard work and professionalism of our staff is at the heart of QVH. We will ensure staff are well led, well managed and motivated by meaningful work. We will continue to invest in professional and personal development, and to look after our staff health and well-being. We will work innovatively, through recruitment and new ways of working, to address the staff shortages which exist in some key areas and professional groups."*	• Initiatives including 'Best Place to Work' led by Clever Together, Trust wide leadership development, education and training initiatives, estates and facilities improvements for staff use, a renewed focus on quality appraisal and personal development reviews. • Innovative and varied approaches to attraction and retention have seen various areas with staffing difficulties, now much improved. • Staffing on Canadian Wing and Critical Care in particular, are no longer areas of significant concern, and improving staff survey engagement scores reflects the progress the trust has made.
D) Our QVH Clinical Cross Specialty Focus			
D1	IM&T	*We will continue the development of an electronic patient record through a clinical portal of e-solutions. Priority for 19/20 will be the safe and successful roll out of Evolve across all specialties.*	• EDM and Evolve implementation reviewed by NHS Digital Trust System Support Model in July 2019. Broad support for strategy. Evolve roll out monitored by EDM Programme Board, with Plastic Surgery rollout planned for November 2019
D2	GIRFT		• GIRFT fully participated in. Deep dive reviews in perioperative care, breast surgery, hospital

		We will participate fully in the Getting It Right First Time programme, benchmarking our outcomes, costs and performance, minimising variation, and ensure excellence in clinical care and value for money.	dentistry, ophthalmic surgery, oral and maxillofacial surgery. • Live action plan developed with GIRFT implementation team. Specific areas for audit and improvement identified. Clinical engagement with clinical coding commonly identified as area for review.
D3	Seven Day Services	*We will continue to develop resources on-site, and partnerships with providers in Kent and Sussex to ensure that patients have timely access to all diagnostics and interventions whenever they are required.*	• Note 7DS Board Assurance Framework reviewed by BoD, and development of local standards in agreement with commissioners. • Network arrangements for OMFS and plastic surgery will improve the ability to treat the correct patient in the correct location.
D4	Performance	*Through improved processes, efficiency and capacity we will meet RTT18, 2WW, 31 and 62 day cancer targets, with no patients waiting greater than 52 weeks except through choice, by the end of 2019/2020.*	• See performance report, and associated targets. RTT 80.9% (as improvement plan). 52 week waits 39 (plan 30, 20 patient choice). • 2WW and 62d targets currently being met. 31 day target significantly improved.
D5	Collaboration	*We will work in partnership with our patients, STPs, cancer alliances, commissioners and regulators to ensure safe, effective patient pathways and the sustainability of our services.*	• Partnership working with STP, Sussex Acute care Network, Cancer Alliances (new QVH Cancer Boards), NHSI, 'Good' CQC report, collaboration on paediatric burns, lower limb trauma and OMFS network care. • Further development of QVH Strategic Programme Board to examine potential options for improved sustainability and partnership.

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
E) Specialty Focus - Burns Care								
E1	Provide a shared pathway for paediatric burns care with the Royal Alexandra Children's Hospital, Brighton. In-patient paediatric burns care to be moved from QVH site	MD	MD / DoN / Clinical Lead Burns	08/2019	Pathway not achieved. Temporary diversion of paediatric inpatient burns to LSEBN partners implemented 1st August 2019. Safety prioritised.	**N**	**Y**	
E2	Commence planning for adult and paediatric burns service to move to BSUH to support Major Trauma Centre.	MD	MD / CL burns	03/2020	Commenced. Data collection stage.	**N**	**N**	
F) **Specialty Focus – Plastic Surgery**								
F1	Through theatre and OPD efficiencies, additional capacity and commissioner supported locum appointments, we will regain RTT18 position with no patients waiting > 52 weeks, except by choice.	D. Ops	All	03/2020	See operational updates. RTT progress on plan	**N**	**Y**	
F2	Establish QVH provided 24/7 support to BSUH, RACH and MTC. Orthoplastic lower limb trauma surgery to meet BOAST4 and NICE guidelines.	MD	MD / CD plastics / CL Brighton	03/2020	Service specification agreed. Appointments agreed. Job descriptions to Royal College.	**N**	**Y**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
F3	Review of spoke site provision, governance and efficiencies.	MD / DOF	All	03/2020	Spoke site financial and SLA review progressing well. Clinical Governance review not commenced.	**N**	**Y**	
F4	Introduction of virtual services in hand fracture management.	MD / D. Ops	CL hands	03/2020	Hands not commenced. Virtual clinics being trialled in glaucoma and telephone clinics in orthodontics, which will inform model. Skype therapies commenced in hands	**N**	**N**	
F5	Skin surgery and dermatology pathways to be reviewed, to include greater 'see and do' and 'one-stop' services.	MD	CL skin	03/2020	Implementation of see and treat clinics and proposal for co-located skin unit.	**N**	**N**	
F6	Demand and capacity management, particularly in sentinel lymph node biopsy and breast surgery.	MD / Dir.Ops	CL skin	03/2020	Completed. Likely demand will continue to increase. Capacity challenging.	**N**	**N**	
G) Specialty Focus – Head and Neck Surgery								
G1	Achieve and sustain 2WW, 31, 62 day and new 28 day cancer targets.	MD / Dir Ops	CL H&N		2WW, 62 day targets met. 31 day compliance not met, but improving significantly	**N**	**Y**	
G2	Networked provision of Sussex Head and Neck Cancer care with QVH, BSUH, WSHT and ESHT, in	MD	CD OMFS / CL H&N	Dec 2019	Applications open for consultant appointments to QVH / BSUH / ESHT joint posts	**N**	**Y**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
	collaboration with SaS Cancer Alliance.							
G3	Completed SLA for designated cancer surgery centre for Medway and West Kent MDT, with partnership ENT posts with Medway Maritime Hospital.	MD	Assoc Dir Business Dev. / CL H&N	Oct 2019	Partnership post with Medway for ENT filled (not commenced). SLA remains in development	**N**	**Y**	
G4	KSS provider for electrochemotherapy and sentinel lymph node biopsy.	MD	CL Skin CL H&N	Mar 2020	Largest volume provider in KSS. Capacity improved through partnership working	**N**	**N**	
G5	Continue to increase and strengthen contribution and partnerships in clinical research and innovation.	MD	CL H&N	Mar 2020	Research post in OMFS, funded by QVH Charity, with increase in multicentre trials, BSMS and CRN involvement.	**N**	**Y**	
H) Specialty Focus – Oral and Maxillofacial Surgery								
H1	Achieve sustained dentoalveolar RTT 18 week position through increased capacity at partner sites, and pathway and referral review with commissioners.	MD / Dir Ops	CD OMFS	Mar 2020	Good progress with triage of DeRS referrals. Improvement in RTT and 52 week in line with plan.	**N**	**Y**	
H2	Lead provider of network solution to	MD	CD OMFS	Mar 2020	Network agreed. In process of	**N**	**Y**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
	maxillofacial trauma surgery, including 24/7 support to the MTC at Brighton				appointing to posts. Lead of network to be appointed.			
I) Specialty Focus – Corneoplastic Surgery								
I1	Development of sustainable and safe IT solution for eye surgery diagnostics.	MD	CL IT CL Corneo	Mar 2020	Specification in development	**N**	**N**	
I2	Estate development.	DoF	CL corneo	Mar 2020	In process of reassessment, with timetabling review.	**N**	**N**	
I3	Service development in glaucoma, including remote and virtual services	D.Ops	CL corneo	Mar 2020	Pilot commenced. review in October 2019	**N**	**Y**	
I4	Work with commissioners to develop services and support innovation, eg corneal re-neurotisation	DoF	Assoc Dir Business Develop.	Mar 2020	Business case in development	**N**	**N**	
J) Specialty Focus – Sleep Disorder Centre								
J1	Develop sustainable staffing models and patient diagnostic and follow up	MD / D. Ops	CL sleep	Mar 2020	Further appointment made, substantially improving staffing.	**N**	**N**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
	pathways.				Further job description in development. Staffing not yet sustainable longer term.			
J2	Group set up for CPAP training.	MD / Dir Ops	CL / service manager sleep	Mar 2020	Developed	**Y**	**Y**	
J3	Networked training and development with provider in London or KSS.	MD	CL sleep	Mar 2020	New appointment improves ties with GSTT. Training opportunities to be re-explored.	**N**	**N**	
K) Specialty Focus – Community Services								
K1	Further develop GP services within MIU	Dir Ops	Bus Man	Mar 2020	Co-located services. Improved access service now embedded. Further development with directly bookable 111 appointments currently being scoped.	**N**	**Y**	
K2	Continue to support regional emergency care network, with ambition to host a Urgent Care Centre	Dir Ops	Bus man	Mar 2020	Ongoing discussion with commissioners.	**N**	**N**	
L) Specialty Focus – Perioperative Services								
L1	Introduction of electronic observations & embedding of				NEWS2 embedded and in process of auditing. e-Obs			

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
	NEWS2 and escalation protocols	MD / DoN	CL CCU / DoN	Mar 2020	funding agreement with NHS Digital agreed Aug 2019.	N	Y	
L2	Progress Royal College of Anaesthetists ACSA accreditation	MD	CD Periop	Mar 2020	Initiated, but not yet progressed significantly.	**N**	**N**	
L3	Implementation of new electronic anaesthetic record system	MD	CL Med Devices	Mar 2020	Business case and procurement agreed. Implementation imminent.	**N**	**Y**	
L4	Review of staffing with increased medical provision to pre-assessment clinic	MD	CD Periop	Mar 2020	Staffing requirements agreed. Not yet fully recruited. Service delivery impacted by current staffing.	**N**	**N**	
M) Specialty Focus – Critical Care								
M1	Networked CPD opportunities and support for CCU medical and nursing staff	MD / DoN	CL / Matron CCU	Mar 2020	Discussions and honorary contracts for SASH and BSUH secured for medical staff CPD	**N**	**N**	
M2	Network clinical support and agreed ITU partners within Kent and Sussex.	MD	CL CCU	Mar 2020	SLA BSUH secure, but under review	**N**	**N**	
M3	Co-located enhanced recovery and critical care unit	Exec	MD / DoN	Mar 2020	Not achievable with current capital resource	**N**	**N**	
M4	Separation of CCU and burns ward	Exec	MD / DoN	Mar 2020	Not achievable with current	**N**	**N**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
	entrance and anaesthetic cover				capital resource			
M5	Review of new critical care standards and central data submission, including ICNARC.	MD	CL CCU	Mar 2020	Review of new standards nearing completion. ICNARC considered and dismissed with advice from CCN, but data collection modified.	**N**	**N**	
N) Specialty Focus – Radiology								
N1	Development of core biopsy ultrasound service	MD / DirOps / DoF	CL Radiology	Mar 2020	Service being delivered at risk. Strengthened with new appointments planned. Requires estate development	**N**	**N**	
N2	Provision of on-site trans-locatable MRI service	MD / DoF	CL radiology	Mar 2020	Business plan in discussion.	**N**	**N**	
N3	Workforce development	MD	CL radiology	Mar 2020	AAC September			
O) Specialty Focus – Histopathology								
O1	Sustainable staffing model	MD	CL Histo	Mar 2020	Staffing currently challenging, with poor response to recruitment.	**N**	**N**	
O2	Support local GPs with sample analysis	MD	CL Histo	Mar 2020	Not yet progressed. Remains an ambition. Will improve when local GPs have ICE access.	**N**	**N**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
O3	Upgrade of laboratory management systems to further support cancer outcome data	MD	Bus Man	Mar 2020	Currently in testing. Upgrade imminent.	**N**	**N**	
O4	Growth of networked Mohs service with Sussex dermatology	MD	CL Histo	Mar 2020	Mohs service in place. No further networking. Under review.	**N**	**N**	
P) Specialty Focus – Therapies								
P1	Continued development of services in line with the therapy strategy (eg FEES, Video clinics, Scar injection clinics, hosting of spinal AP clinics for SMSKP).	Dir Ops	Therapy Services Manager		FEES – Charitable Funding secured. Video Skype Clinics – pilot commenced. Therapist delivering scar clinics with consultant. AP clinics hosting commenced.	**N**	**Y**	
P2	Review of local tariffs (for community therapy in particular).	Dir Ops	Assoc Dir Business Development	Mar 2020	In negotiation	**N**	**N**	
P3	Continued support for staff development	Dir. Ops	Therapy Services Manager	Mar 2020	Clinical Leads undertaken Leadership passport	**Y**	**Y**	
P4	Increase presence and familiarity of services locally.	Dir. Ops	Therapy Services Manager	Mar 2020	Enagaged with Communities of Practice to improve integration of care, and STP	**Y**	**Y**	

Ref	Action	Exec Lead	Responsibility	By When (end of)	Update on progress/ status	Completed	Evidence	RAG
P5	Increase involvement in IT strategy (eg EDM)	Dir. Ops	Therapy Services Manager	Mar 2020	Planned for roll out after successful plastics implementation	**N**	**N**	

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**150-19**	
Report title:	**Safeguarding Adults & Children's Annual Report 2018/19**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Pauline Lambert, Safeguarding Named Nurse and MCA lead				
Appendices:					
Executive summary					
Purpose of report:	Each year a safeguarding report is produced to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.				
Summary of key issues	Current challenges are: • Adult safeguarding specialist AHP has been on long term absence , this leaves the safeguarding named nurse to cover all adult safeguarding and MCA support and developments • QVH compliance with Mental Capacity Act is improving re-audit due during 2019-2020 • Demonstrating compliance with WRAP training to the required 85% target, currently 82% an improvement of 13% on the previous year • Adult safeguarding level 3 training has been recently introduced with a starting point of 0% and has already reached 67%. The planned target for level 3 during 2019 is 85% which we hope to reach by September 2019. Current achievements are: • Engagement of staff and recognition of safeguarding responsibilities • Datix reporting systems working effectively enable production of monthly Board metrics • Robust connections with West Sussex Safeguarding Boards • Systematic review of relevant QVH safeguarding polices, protocols, standards and guidance • National Child Protection Information System (CP-IS) being used by MIU and Paediatric Ward				
Recommendation:	The Committee is asked to **receive** the Safeguarding Adults & Children's Annual Report 2018/19.				
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:	Applicable to KSO 1,2, 3 and 5				
Corporate risk register:	Safeguarding level 3 training risk recently rescored and removed from CRR to local RR.				
Regulation:	All Boards must publish an annual safeguarding report and demonstrate to regulators that appropriate safeguards are in place to protect vulnerable adults and all children.				
Legal:	All health care providers are required to meet safeguarding criteria for adults- Care Act 2014. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to safeguard and promote the welfare of children.				
Resources:	No new resources required				

Assurance route				
Previously considered by:	Quality and Governance Committee			
	Date:	24/07/19	Decision:	The report has been received and full assurance has been given.
Next steps:	To QVH Board for approval			

Holtye Road,
East Grinstead
RH19 3DZ

Safeguarding

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2018 to March 2019

Document Control: committees and groups who have approved this report
Executive sponsor: Jo Thomas, Director of Nursing

Authors: **Pauline Lambert, Safeguarding Named Nurse**
Dr Oli Rahman, Safeguarding Children Named Doctor

Date: April 2019

Type: Annual Report
Version: FINAL V3
Pages: Number
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively. The report is reviewed and scrutinised by the Quality and Governance Committee before being shared with the Board for information. QVH safeguarding systems and arrangements continue to be improved and strengthened. Safeguarding support for staff is well established. Safeguarding Audits continue to provide assurance for the organisation and also identify any key development areas. **Current challenges are:** Adult safeguarding specialist AHP has been on long term absence , this leaves the safeguarding named nurse to cover all adult safeguarding and MCA support and developments QVH compliance with Mental Capacity Act is improving re-audit due during 2019-2020 Demonstrating compliance with WRAP training to the required 85% target, currently 82% an improvement of 13% on the previous year Adult safeguarding level 3 training has been recently introduced with a starting point of 0% and has already reached 67%. The planned target for level 3 during 2019 is 85% which we hope to reach by September 2019. **Current achievements are:** Engagement of staff and recognition of safeguarding responsibilities Datix reporting systems working effectively enable production of monthly Board metrics Robust connections with West Sussex Safeguarding Boards Systematic review of relevant QVH safeguarding polices, protocols, standards and guidance National Child Protection Information System (CP-IS) being used by MIU and Paediatric Ward

2.	Introduction
2.1	Each year a Safeguarding Report is produced for QVH Board to provide assurance that the Trust is undertaking its safeguarding duties and responsibilities safely and effectively.
2.2	QVH is registered with the Care Quality Commission (CQC). To be registered, QVH must be assured that those who use the services are safeguarded and that staff are suitably skilled and supported to provide effective safeguarding as part of health care delivery. As a Foundation Trust, QVH is licensed via NHS Improvement which is conditional upon

	registration with the CQC. In the last CQC inspection report (2019) the CQC report said: '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', 'Staff understood and complied with the relevant consent and decision-making requirements of legislation, including the Mental Capacity Act, 2005', and '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.' QVH must demonstrate that there is safeguarding leadership and commitment at all levels of the organisation and that staff are fully engaged. To support local accountability and assurance structures QVH safeguarding leaders need to engage with West Sussex Safeguarding Children Board (WSSCB), West Sussex Safeguarding Adults Board (WSSAB) and relevant commissioners. QVH must ensure a culture exists where safeguarding is every bodies business and poor practice is identified and tackled. QVH must have in place effective safeguarding arrangements to safeguard children and adults who are at risk of abuse or neglect. These arrangements include: safe recruitment, effective training for staff, effective supervision arrangements, working in partnership with other agencies, identification of a Named Doctor and Named Nurse for safeguarding children, plus a Named Nurse for adult safeguarding. The named professionals have a key role in promoting good professional practice within QVH, supporting local safeguarding systems and processes, providing advice and expertise, and ensuring safeguarding training is in place, is delivered and of a suitable quality. They are expected to work closely with QVH Director of Nursing, West Sussex Designated Professionals, WSSCB and WSSAB.
2.3	The effectiveness of safeguarding systems is assured and regulated by a number of mechanisms. They include: • Internal assurance processes and Board accountability • Partnership working with WSSCB and WSSAB • External regulation and inspection by Care Quality Commission (CQC) and NHS Improvement. • Local safeguarding peer review and assurance processes • Effective contract monitoring
2.4	QVH Board members review monthly safeguarding metrics at the Quality and Governance Committee and receive an annual safeguarding report which is provided so that the Board can be assured that the Trust is undertaking its safeguarding duties and responsibilities, as

	well as delivering its statutory safeguarding responsibilities safely and effectively. The Board should critically appraise the QVH safeguarding report by making sure patient safety, staff activity, governance arrangements and safeguarding data are transparent and clear so that they can confirm they are assured.

3.	**Legislative Frameworks and National Safeguarding Agenda.**
3.1	**Safeguarding Adults:** Safeguarding means *"protecting an adult's right to live in safety, free from abuse and neglect" (Care Act 2014)* The arena for safeguarding adults continues to evolve since the implementation of the Care Act (2014). However, the aims of safeguarding adults remain unchanged. Organisations such as QVH, must stop abuse or neglect wherever possible, prevent harm and reduce the risk of abuse or neglect to adults with care and support needs, safeguard adults in a way that supports them in making choices about how they want to live their lives and provide information in accessible ways to help adults understand how to stay safe and what to do to raise a concern. In order for staff at QVH to achieve these aims, it is necessary to ensure that all staff are clear about roles and responsibilities, create strong multi-agency partnerships and support the development of a positive learning environment. As an organisation, QVH adhere to the Sussex Safeguarding Adults policy & procedures as this provides an overarching framework to coordinate all activity undertaken where a concern relates to an adult experiencing or at risk of abuse or neglect. These procedures represent standards for best practice in Sussex and have been endorsed by Brighton & Hove, East Sussex and West Sussex Safeguarding Adults Boards. They are available online, with links to the website via the internal intranet (QNET). This document is reviewed and updated by the West Sussex Safeguarding Adults Board.
3.2	**Safeguarding Children:** *'The welfare of the child is paramount'* principle was enshrined in the Children Act 1989 and has driven the development of systems and arrangements used to safeguard and/or protect children since that time. Section 11 of The Children Act 2004 places a statutory duty on all NHS organisations to ensure that services are designed to safeguard and promote the welfare of children. National guidance also stipulates that each NHS trust must identify a lead nurse for Child Sexual Exploitation (CSE) and Looked After Children (LAC, sometimes referred to a 'children in care'). These responsibilities are part of the Safeguarding Named Nurse Job Description.
3.3	**Mental Capacity Act (MCA) 2005 & Deprivation of Liberty Safeguards (DoLS):** The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) have placed an emphasis on ensuring that the rights of vulnerable people (aged 16 and over) to make decisions are protected. Decisions made on behalf of people should only be made using the MCA legal framework. Capacity is described as a person's ability to make a specific decision at a specific time, for example - for specific serious medical treatment.

	The DOLS were added into the MCA and is an additional Safeguard providing guidance on procedures that ensures care and treatment for those who lack capacity to consent to their accommodation is only delivered in their best interest and using the least restrictive options to ensure their safety. To be lawful, it needs to be authorized by the local authority, but in the hospital urgent self-authorization can be used when necessary. QVH staff are required to understand and comply with the requirements set out in the MCA 2005. The QVH Mental Capacity and Deprivation of Liberties Policy was reviewed and updated during 2018. The existing QVH orange mental capacity assessment and best interest form has been reviewed and updated and is currently out for consultation with clinical staff. At year end compliance rates for Mental Capacity Act training are currently at **96%** across the organisation. A departmental risk assessment for MCA is in place until a clear organisational overview of implementation in practice is embedded using Datix to capture the required data. Currently the organisation is aware of cases reported to the MCA lead, re-audit of MCA processes is planned for this coming year should provide clearer assurance.
3.4	**PREVENT** The United Kingdom's long-term strategy for countering international terrorism is called 'CONTEST'. Published in 2006 and updated in 2009 and 2011, its aim is 'to reduce the risk to the UK and its interests overseas from terrorism, so that people can go about their daily lives freely and with confidence'. CONTEST comprises of four key elements: • Pursue: to stop terrorist attacks ~ detecting and disrupting threats of terrorism. It is targeted at those who have committed a crime or are planning to commit a crime. • Protect: to strengthen our protection against a terrorist attack ~ strengthening our infrastructure from an attack including buildings, public spaces and our borders. • Prepare: to mitigate the impact of a terrorist attack. Focuses on where an attack cannot be stopped and aims to reduce its impact by ensuring we can respond effectively. • Prevent: to stop people becoming terrorists or supporting terrorism. 'Prevent' is different from the other three in that it focuses on early intervention before any illegal activity takes place and hence operates in the non-criminal sphere. Involving a broad range of partners, it is about minimising the risk, at an early stage, of people adopting extremist views which support violence or terrorism. NHS providers are expected to contribute to the Prevent agenda. All clinical staff are expected to undertake Level 3 Prevent training which is currently at 82%. Prevent basic awareness training is provided to all QVH staff as part of safeguarding training sessions at levels 1 and 2 and is currently at 96%.

4.0	**Sussex Clinical Commissioning Groups (CCGs) Safeguarding Standards**
	During 2016-2017 the CCGs used the *Safeguarding Vulnerable People in the Reformed NHS : Accountability and Assurance Framework* (March 2013) to produce a set of Sussex Safeguarding Standards to make explicit their expectations of NHS providers in relation to safeguarding. The CCGs across Sussex have in place quality and safety systems, and processes in order to enable continuous improvements and the 'safeguarding standards guidance' now forms part of these arrangements. The nine standards were developed to enable assurance to be provided to demonstrate patients of all ages are safeguarded effectively. The standards enable all parties to identify key benchmarks to ensure an effective, systematic, auditable approach to enable the safeguarding of all patients, whatever their age. The standards were shared with the QVH Board at a safeguarding seminar during November 2016. The standards enable the safeguarding team at QVH, as well as commissioners to audit against benchmarks to ensure effective measures are in place. This section of the report is organised based on these standards.
4.1	**STANDARD 1: Strategic Leadership**
	The Executive Board Lead for safeguarding vulnerable people, MCA & DOLS is the Director of Nursing who oversees compliance with safeguarding legislation and trust responsibilities. The purpose of this role is to monitor protection of people who use services at QVH and to ensure these are understood by staff and implemented throughout the organisation**.** The QVH Safeguarding Strategy (2015) supports a progressive response to the changing landscape framing the delivery of healthcare services at QVH and is currently being reviewed and updated. Appendix D provides an overview of QVH safeguarding documents and information available for staff or the public via the Website or QNET intranet. QVH has robust safeguarding governance arrangements in place, which are led and supported by a team of specialist safeguarding clinicians. The QVH governance structure provides transparent lines of accountability, clear partnership connections with internal QVH meetings which are in place to support learning from practice and delivery of effective safeguarding. The QVH safeguarding team comprises of; • Jo Thomas, Director of Nursing and Quality, Executive Board Lead for Safeguarding • Pauline Lambert, Named Nurse for Safeguarding (covers: Children, Child Sexual Exploitation (CSE) lead and Looked After Children (LAC) lead, Adults, MCA & DoLS Lead and Prevent Lead) • Dr M Z (Oli) Rahman, Named Doctor Safeguarding Children (via BSUH SLA) • Debra Yeoh, Nurse Specialist Safeguarding Children • Katy Fowler, Nurse Specialist Safeguarding children & WRAP Training Facilitator • Francoise Yeoman, AHP Specialist Safeguarding Adults, MCA & DOLS. The purpose of this team is to continuously work to improve and update all staff including volunteers regarding their safeguarding knowledge and responsibilities. This is achieved

	through case discussions and supervision, advice, practice review and audit; provision of training; provision of policy, procedures, protocols and guidance. The Non-Executive Director who chairs the Quality and Governance Committee is working to support scrutiny of the agenda with 'Safeguarding' identified as a discreet responsibility. Across QVH there is a network of link champions for safeguarding from service areas. They attend a safeguarding steering group to discuss clinical issues, access information, review learning and to share practice improvement across the organisation. The Joint Hospital Governance Group provides a far reaching internal audience where safeguarding discussions are also undertaken, such as sharing learning from Safeguarding Reviews and Audit, and how improvements in practice might be applied in QVH. Driving improvement in all aspects of safeguarding practice is a continuous process and as such has to be reviewed, evaluated, developed and adapted over time. There is now one safeguarding learning and development strategy for the organisation to steer and facilitate staff competency development in all aspects of safeguarding. A sample of staff training evaluation summaries is included in APPENDIX A. The delivery of effective safeguarding is dependent on multiagency working. Across agency strategic work is set by the children and adult Safeguarding Boards in West Sussex and translated into work streams which are monitored by QVH Strategic Safeguarding Group or QVH Safeguarding Team to ensure relevant involvement and contributions from the trust. QVH through the safeguarding team has well established links with local and regional safeguarding networks and committees. **West Sussex Adult Safeguarding NHS Professionals Network:** This group is chaired by the Designated Nurse for safeguarding adults from Coastal West Sussex CCG. The Adult Safeguarding NHS Professionals group meet quarterly. Membership of these groups includes all adult safeguarding leads from across Sussex & Surrey, including Safeguarding Adult's Board representation. The forum is an arena in which to share learning, reflect on practice and support peers. QVH Safeguarding Named Nurse is a member of this group. **West Sussex Safeguarding Children NHS professional Networks:** This group is chaired by the West Sussex Designated Nurse for safeguarding children. The group meets quarterly. The group is attended by all West Sussex NHS Provider Trusts Named Nurses and provides a forum which can share learning from practice, inform and influence the WSSCB. QVH Paediatric Specialist nurses are members of this group. QVH has a case peer review system in place in the Burns Unit. Meetings to discuss paediatric and adult cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, medical and nursing treatment, risk assess, discuss any safeguarding issues, patient capacity or deprivation of liberties issues and agree actions required. Safeguarding supervision is offered to all QVH staff as required on a case by case basis and also via bespoke training sessions for teams or via discussions in team meetings. The purpose of these activities is to strengthen communication, networking and dissemination of

	safeguarding information and practice across the organisation. Regular safeguarding supervision is provided to the specialist safeguarding nurses on a regular basis by the West Sussex Designated nurses for safeguarding children and adult safeguarding. The Safeguarding Named Nurse continues to network with hospital consultants to discuss and review whether safeguarding systems are working for them and their teams. Safeguarding priorities are central to achieving high quality and safe care. Quality and component parts of safety, effectiveness and patient experience are at the heart of QVH values. As an organisation QVH are committed to the protection and prevention of abuse & neglect for all vulnerable people whilst in the care of Queen Victoria Hospital NHS Foundation Trust (QVH). The safeguarding team continue to review and strengthen systems, methods and arrangements for managing episodes where it might be considering or suspect abuse/neglect has occurred either within the organisation or prior to admission. Staff are provided with support to manage any concerns identified. Human Rights: Protecting the vulnerable and those at risk, is a key component of our trust objectives. Focussing on quality and patient experience we work alongside partner agencies to promote the safety, health and well-being of people who use our services. QVH has effective systems in place to highlight and respond to shortfalls in capacity which have an impact on the ability to meet safeguarding responsibilities. These are highlighted to the board through the internal DATIX reporting system, and regularly discussed at the strategic safeguarding group meetings and reviewed by the Safeguarding Named Nurse. There are currently no safeguarding corporate risks identified. There are four safeguarding departmental risks. • Not able to demonstrate full compliance with implementation of the MCA, currently data captured on the Datix system covers cases brought to the attention of the safeguarding team (risk rating 9 - LOW) Nursing and Quality department • Looked After Children safeguarding systems not fully in place, incorporating LAC into policy, strategy and reports is underway. The Paediatric Trauma proforma is nearly ready for release and covers LAC requirements. (risk rating 6 - LOW) Nursing and Quality department • Level 3 adult safeguarding and MCA training introduced during 2018. Initial update under 18%. But within 6 months 68% uptake has been achieved this risk will be reviewed and managed by the Strategic safeguarding Group. (risk rating 6 - LOW) Nursing and Quality department • Grade three and four pressure ulcers should be considered from a safeguarding perspective and an alert raised if appropriate. This needs to be incorporated in the hospital protocol. TVN is currently reviewing this document. An email has been sent to all staff to remind them of this whilst the protocol is updated (risk rating 6 - LOW) Nursing and Quality department QVH has a 3 year rolling safeguarding audit programme in place, which includes information on the audit methodology being used, involvement of managers and staff and how the

	findings from audit will be disseminated. 2018 audit analysis is included later in this report and overview of the audit programme can be found in Appendix C.
4.2	**STANDARD 2: Lead effectively to reduce the potential of abuse**
	QVH has policies, processes and procedures in place to enable staff to manage and when required to report any concerns they have for patients or members of the public attending QVH sites. If their concerns are not heard there are escalation processes which can be used. Escalation processes were used once during 2018-19 when there were concerns for a child who had not been assessed following a suicide attempt. Training and procedures highlight how peoples diversity, beliefs and values may influence the identification, prevention and response to safeguarding concerns. The QVH safeguarding 'documents and information overview' is provided for the organisation in APPENDIX D to demonstrate interaction between a range of policies and procedures when safeguarding is being considered. QVH has a clear, accessible and well-publicised complaints procedure. This includes information about how to complain to external bodies such as regulators and service commissioners, as well as relevant advocacy and advisory services. Information regarding Gillick competence, mental capacity and Lasting Powers of Attorneys (LPAs) is cross-referenced with other policies (such as consent) and safeguarding procedures. A data collection system to capture safeguarding (adults, children and MCA) practice and learning was set up using Datix for recording purposes. Safeguarding Datix reports are shared across the organisation to aid case discussion and to share learning. QVH place great importance on ensuring patients have an excellent experience. The trust continues to develop ways to engage and listen to patients, collecting views, comments and ideas from them, their families and carers which then inform future plans to further improve patient experience. Board committees review results from Family and Friends Tests and the NHS Annual Staff Survey. QVH safeguarding team review and update information produced for patients and their families. Including: • QVH safeguarding children and young people leaflet for families. • Information leaflet regarding attendance at the trust with dog bite injuries for all patients. • Next of Kin: understanding decision making authorities • Mental Capacity Act Guide for patients and their families Work on a set of QVH posters and leaflets encouraging patients to talk to staff, clinical managers, PALs and the safeguarding team if they have any concerns about a patient are available for services to display and can be seen across the hospital site. During 2018-19 audits were undertaken as aprt of a rolling programme of safeguarding audits. There have been some delays with the audit programme this year due to long term staff sickness, Catch up will occur during 2019. These audits are useful to enable development of practice, policies and training sessions.

	The recurring audit of quality of safeguarding referrals was undertaken during September to October 2018. The new audit process was based on West Sussex referral standards and demonstrated QVH adherence to these. An audit to assess the impact of the QVH safeguarding prompt cards was also undertaken was undertaken during February 2019. The report and results will now be shared in both the safeguarding strategic and steering groups.
4.3	**STANDARD 3: Responding effectively to allegations of abuse**
	QVH have arrangements in place to ensure that patients are safeguarded by responding appropriately to any allegation of abuse or neglect. <u>Safeguarding Adults Activity</u> The Safeguarding Named Nurse receives notification of any safeguarding concerns relating to adults via the DATIX reporting system. Each DATIX report is reviewed and investigated. Process issues and learning from each event is now shared using monthly and quarterly safeguarding Datix Reports. This approach provides oversight of all safeguarding adult referrals made to social care services across the region. The table in Appendix B provides details of the monthly safeguarding adult activity reported on DATIX for the past year. <u>Safeguarding Children Activity</u> The Paediatric Safeguarding team receive reports of any safeguarding children concerns which occur within QVH via a centralised email address. These are followed up by Specialist Paediatric Safeguarding Nurses providing support for staff managing these situations as well as a means to review case management, following up outcomes with statutory partners and to enable learning to be shared. All safeguarding children concerns are captured on the DATIX system. Enabling monthly Board metric reports to be provided to the Director of Nursing and Clinical Governance group. See Appendix B for overview of paediatric safeguarding activity during the past year. The QVH Electronic Document Management system (also known as Evolve) is currently being used it is not yet fully rolled out across the trust. There is a safeguarding section for all patients which can be used to file safeguarding information so that it is available for staff seeing the patient. There is a restricted access system in place so that anyone access this section is aware their access is being audited and they need give a reason for access too. The safeguarding section added to the QVH Electronic Discharge Summary will be audited this year. The purpose of this section is to enable handover of care to GP and other community health services and can provide an opportunity to inform others of concerns or create a contact request to obtain more information. The National Child Protection Information systems (CP-IS) is used by Minor Injuries Unit and Peanut Paediatric Ward to check whether children or young people have a child protection plan or are looked after by a local authority. This national data base provides the means for robust communication regarding vulnerable children across and between NHS and local authority systems nationwide.

	When Looked After Children attend the hospital for treatment we check who can provide consent, contact details for their Social Worker and which Looked After Children nursing team to liaise with. QVH safeguarding prompt cards provide guidance on managing information regarding privately fostered children and for those in the care of a local authority. <u>Allegations Against Staff</u> The Director/Deputy Director of Human Resources would manage the Trust response to any allegations against trust staff. *'Allegations against staff'* procedures are followed. During the last year, two concerns relating to staff have been raised. One situation involved numerous allegations which were found to be unsubstantiated. The second allegation resulted in a full investigation under Disciplinary Policy. Advice was sought from West Sussex County Council Local Authority Designated Officer and the safeguarding children Designated Nurse. We do not currently have any data with which to compare with other trusts.
4.4	**Standard 4: Safeguarding practice and procedures**
	The Safeguarding Team develop a wide range of guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. For a list of what is in place for QVH please refer to Appendix D. Documents are placed on the Website or QNET intranet. All documents are systematically reviewed and updated in collaboration with relevant services and governance groups. Information is monitored and reviewed regularly and updated on the QNET, including information on who to contact for advice and support. A set of laminated safeguarding prompt cards are given to staff at QVH during induction and are also shared at training and governance events. <u>Prevent:</u> The delivery of the '*Prevent*' agenda in the trust, is led by the Safeguarding Named Nurse who is 'Prevent Lead' for the trust and one of the Specialist Nurse for safeguarding who delivers all face to face level 3 Workshops. Staff are made aware of the Prevent delivery plan which is a tool kit for staff and is available to via the QNET. Level 3 Prevent training compliance data has increased to 82% across QVH. Face to face sessions will continue during 2019 as we are aiming to make this figure go above the 85% required nationally. Many of the trainee doctors who transfer to the trust have not undertaken the training in their previous organisations so this means our uptake data has been hard to improve. After discussion with the Regional Prevent Coordinator it was agreed that some staff who have been unable to attend face to face sessions will be able to undertake the new national Level 3 Prevent eLearning option. This has helped improve our training uptake data. QVH report Prevent data to NHS England quarterly, we have not made any Prevent referrals during 2018-19. Basic awareness of prevent will continue to be provided in adult and child safeguarding level

1 and 2 training sessions.

QVH Safeguarding Forms which are available via the QNET are written in accordance with the local and national guidelines.

Where a patient is identified as needing any form of control, restraint or therapeutic holding QVH have policies in place to protect all patients against the risk of such control or restraint being unlawful or excessive.

All QVH staff are required to understand their legal responsibilities under the Mental Capacity Act including undertaking mental capacity assessment, best interest decision making processes and when to complete a deprivation of liberties safeguard process. MCA data is now captured on the Datix system. Monthly reports are shared to aid case discussion and to share learning. The data captured includes cases brought to the attention of the MCA lead.

Domestic violence and abuse (DVA)

Managing domestic violence and abuse situations can be challenging for staff. Managing risks, keeping individuals safe and seeking the right specialist advice are all important aspects of patient care when DVA is being considered a possibility or has been confirmed. Raising awareness of and managing DVA situations is included in level 2 and 3 safeguarding training.

The QVH psychological therapies team and the QVH safeguarding team can undertake Domestic Abuse Stalking Honour (DASH) risk assessments to help inform next steps for a patient. Worth DVA specialist services and the police can provide advice and support to staff at QVH.

Patient DVA procedures are in place. Staff experiencing DVA policy is in place. Two members of staff experiencing DVA have been supported this year.

Safeguarding Audit

Audit of service efficacy is an integral element of the work of the Safeguarding Team. A three year cycle of audit activity has been developed including core elements such as NICE guidance alongside aspects of clinical practice. (see Appendix C)

The Trust Internal Auditors undertook an audit of specific procedures and controls in place over the process for Safeguarding Adults and Children in accordance with the 2017/18 Internal Audit Plan. The report provided substantial assurance. Three medium priority areas were followed up, they included: DBS Reminder Letters, Adult Safeguarding Training, Safeguarding Records. All three recommendations have been completed during 2018-19.

During 2018-19 the following audits were completed or delayed. Reports and action plans are reviewed and monitored either in the QVH strategic safeguarding group or on of the QVH safeguarding steering groups.

2017 Topic/s	Progress	Next Steps
Referrals audit – adult and children	Final report being completed.	Repeat next 2019
QVH safeguarding prompt card audit	Report being finalised	Repeat in 18 months
Child not brought to appointment protocol audit		Delayed to 2019 due to long term staff absence
EDN safeguarding audit		Delayed to 2019 due to long term staff absence
ASG MaxFax audit	Preparation nearly complete	Delayed to 2019 due to long term staff absence

Child Sexual Exploitation.

Recognition of Child Sexual Exploitation (CSE) or child sexual abuse requires careful assessment and consideration when concerns arise. The Safeguarding Named Nurse is the CSE lead for QVH and supports staff to access specialist advisors if required.

Looked After Children.

Looked after children (LAC) or Children in Care are a group of children and young people who are cared for by the local authority. There can be consent implications for these children and clinicians needs to understand what voluntary or court agreement is in place for each child. The Safeguarding Named Nurse is the LAC lead for QVH and supports staff to understand court orders and how to make contact with a child's social worker or NHS LAC team from the area in which they live.

If QVH staff comes across private fostering arrangements for children less than 16 years of age they need to notify social care services so that a social care assessment can be undertaken of the situation. Raising awareness of staff responsibilities in these situations is included in safeguarding training sessions.

The safeguarding team have close links with the communications team at QVH where there are strict guidelines for dissemination of information internally for all staff across the organisation, including updates and reviews.

Modern Slavery

No form of slavery and/or human trafficking (as defined by the Modern Slavery Act 2015) is permitted by its employees, subcontractors, contractors, agents, partners or any other organisation, entity, body, business or individual that the Trust engages or does business with.

The Trust's recruitment and selection procedures include appropriate pre-employment screening of all staff to determine right to work in the UK, and all salaries are above the National Living Wage. All employment agencies that are engaged also meet these standards as a minimum entitlement.

The Trust supply chain entails the purchasing of goods and services that support the operation of our core business of healthcare. Consumables purchased include medical supplies and equipment, office supplies, marketing materials, ICT equipment and estate and facilities services such as cleaning, waste management, office fixtures and fittings, security services and uniforms. Operating with integrity governs our approach and therefore our

	aspiration to be recognised by our stakeholders as an organisation which is a responsible corporate citizen in all our relationships. The Procurement Team is in the process of reviewing and updating any policies and procedures which relate to the Trust's corporate responsibility for slavery and human trafficking including any purchasing guidelines. There are expectations of suppliers in a number of areas including diversity, ethical, social, environment, health and safety issues and revisions are being made to provide further guidance on slavery and other human rights issues. The Trust's policies will also be reviewed and updated to ensure that where appropriate policies apply to suppliers as well as employees. The NHS Standard Terms and Conditions 2018 are referenced on all Trust purchase orders which include clauses around anti-slavery and human trafficking. The Trust also, where possible, will use the NHS Standard Terms and Conditions 2018 for its contracts or use NHS Framework Terms and Conditions. The Procurement team are also in the process of adding a new supplier's code of conduct, based on the United Nations Global Compact, and a modern slavery questionnaire in to its mandatory tender documentation. The Trust has not been informed of any incidents of slavery or human trafficking during the year. In the event of a slavery or human trafficking incident occurring or an allegation being made the matter will be reported and investigated using the Trust's safeguarding procedures to determine appropriate action. The Trust is committed to better understanding its supply chains and collaborating with stakeholders to improve transparency of its arrangements to ensure adequate safeguards in place to prevent incidents of slavery or human trafficking.
4.5	**STANDARD 5: Staff competence**
	QVH Staff have access to a comprehensive training programme regarding: safeguarding adults, safeguarding children, Mental Capacity Act and Prevent training programme across levels 1, 2 and 3 internally. Levels 1 and 2 are combined session including all aspects of safeguarding, MCA, Prevent, CSE, LAC, FGM and DVA. In addition to this, external training and conferences are also offered as options for staff requiring level 3 development to enhance knowledge and competencies where required. **Safeguarding Learning and development Strategy.** QVH Safeguarding learning and development strategy was produced in October 2018. This document is aligned with the core skills framework document and with national guidance from the NHS England regarding roles and competences for health care staff – from 4 intercollegiate documents (Prevent, LAC, Adults and Children). It provides transparent QVH expectations for staff including the Board with regard to safeguarding training and development. **Safeguarding Training:** During 2018 the safeguarding training programme on offer at QVH has been reviewed and

updated.

Session	Participants	At end of year training uptake is currently:
Safeguarding **Induction** Level 1 (includes: children, adults, Prevent, DVA, LAC and CSE)	Non-clinical staff	100%
Safeguarding **Induction** Level 2 (includes: children, adults, Prevent, DVA, LAC and CSE)	Clinical Staff (includes level 1 competencies)	100%
Safeguarding **Refresh Level 1** (covers children and adults) (includes: Prevent, DVA, LAC, CSE)	Non-clinical staff Required every three years	97%
Safeguarding **Refresh Level 2** (covers children and adults) (includes: Prevent, DVA, LAC, CSE)	Clinical Staff (includes level 1 competencies) Required every three years	96%
Safeguarding Children **Refresh level 3** (includes: Prevent, DVA, LAC and CSE)	For specified clinical staff (includes Level 1 and level 2 competencies) Required every three years Consultants attend QVH in-house training session, or undertake specified eLearning, or passport existing training evidence from another NHS trust	87%
Adult Safeguarding and MCA **Refresh Level 3** (includes: Prevent and DVA)	For specified clinical staff (includes Level 1 and level2 competencies) Required every three years Consultants attend QVH in-house training session, or undertake specified eLearning, or passport existing training evidence from another NHS trust	68% (started September 2018)
DVA DASH Workshops Level 3 Once every three years	For specified clinical staff	100%
Safeguarding Children and LAC **Refresh level 4**	Safeguarding Named Nurse as part of personal development Safeguarding Children Named Doctor as part of personal development	100%

Adult Safeguarding and MCA **Refresh Level 4**	Safeguarding Named Nurse as part of personal development	100%
Safeguarding **Induction**	Trainee Doctors Passport existing safeguarding training over or update to Level 2 (children and adults) whilst at QVH	100%
WRAP	All clinical staffx1	82%

Specialist Support

Provision of clinical supervision and support for specialist safeguarding staff is provided by West Sussex Designated professionals who are employed by Clinical Commissioning Groups. Trust policy requires that provision of specialist safeguarding advice and support to QVH staff is accessed on a case by case arrangement from safeguarding team members when required.

All staff job descriptions include a safeguarding section which identifies responsibilities for safeguarding and these are reviewed through an annual appraisal and personal development planning process.

4.6 STANDARD 6: Safer recruitment

QVH work to ensure that those working or who are in contact with children, young people and adults are safely recruited and Human Resource processes take account of the need to safeguard and promote the welfare of all. Making sure that QVH do everything we can to prevent appointing people who pose a risk to vulnerable people is an essential part of safeguarding practice and QVH recruit staff and volunteers following safer recruitment procedures.

All staff at the Trust are employed in accordance with the NHS Employers safe recruitment pre-employment check standards.

As part of their induction, new employees, including volunteers are expected to undertake mandatory training in safeguarding at either level 1 or 2.

In March 2019 the Trust approved a new 'Disclosure and Barring Service (DBS) Checks Policy' which confirmed the process for Disclosure and Barring Service (DBS) checks for applicants and employees within the Trust and the responsibilities of Recruiting Managers, the Recruitment and Workforce Services teams to ensure that suitable DBS checks are completed as required. This includes a new provision for undertaking 3-yearly periodic checks for current staff within the high risk areas of Paediatrics and Critical Care.

4.7 STANDARD 7: Learning from incidents

Statutory Safeguarding Reviews:

<u>Safeguarding Adult Reviews (SAR)</u>

Safeguarding Adult Boards (SABs) must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

	QVH were not directly involved in any SAR during 2018-19. But learning form SARs undertaken by WSSAB during 2018-19 were reviewed and shared. Serious Case Reviews (SCRs) When a child dies or is seriously harmed, including death by suspected suicide, and abuse or neglect is known or suspected to be a factor in the death, West Sussex safeguarding Children Board (WSSCB) is required to conduct a Serious Case Review into the involvement of organisations and professionals in the lives of the child and the family. The purpose of a Serious Case Review is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and, as a consequence, improve multi-agency working to better safeguard and promote the welfare of children. QVH were not directly involved in any SCR during 2018-19. But learning form SCR undertaken by WSSCB during 2018-19 were reviewed and shared. Child Death Reviews. The WSSCB is also required to conduct a review of every child death to identify whether there are any lessons to be learned to prevent child deaths in the future. QVH has not contributed to any child death reviews this year. Other types of reviews. The WSSCB carry out a range of learning activities in order to understand how to improve safeguarding. This includes reviews into individual cases and reviews of practice across areas of safeguarding. QVH has not contributed to other case reviews during the year. QVH Staff have access to specialist advice and support through the named nurse, specialist nurses and link staff. Where appropriate, staff and staff groups are provided with debriefing/supervision sessions by the Named Nurse and/or other senior staff at QVH. Bespoke safeguarding and MCA training sessions are all offered to teams and services.
4.8	**STANDARD 8: Commissioning**
	Contract Monitoring -Sussex Clinical Commissioning Groups (CCG's) Safeguarding Standards CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective safeguarding arrangements in place. A self-assessment tool is completed bi-annually for adult safeguarding and also a section 11 self-assessment audit for safeguarding children. These contribute to providing evidence of assurance in conjunction with assurance site visits and submission of quarterly exception reports.

	The section 11 safeguarding children self-assessment audit submitted to WSSCB during 2018provided assurance to WSSCB scrutiny panel that QVH has a good understanding of statutory requirements and is working in a positive way to ensure standards are met. The panel noted that evidence provided was excellent. Overall that a really good report was provided. CCG exception reports are provided by QVH Safeguarding Team in April, July, October and January of each year. No issues of concern were raised during the last year. **External regulation and inspection by CQC and NHSI** QVH CQC re-inspection during February 2019 overall the Trust sustained 'good' rating and also an 'outstanding' for care. There was no concerns raised regarding safeguarding. The CQC reported: '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.' Any safeguarding issues or concerns are captured and reported to the Board alongside the Board's monthly safeguarding metrics. • No specific paediatric safeguarding concerns were raised during the last year. • One adult safeguarding alert was raised with QVH during the year. Once the investigation had been completed, the concerns reported were unsubstantiated and the alert was closed by West Sussex Social Care.
4.9	**STANDARD 9: Safeguarding data requested by Department of Health**
	<u>Female Genital Mutilation (FGM)</u> Understanding of FGM and mandatory reporting duty is incorporated into QVH mandatory safeguarding training for staff. DH/NHS approved and recommended FGM e-Learning packages are also available to staff to enhance their knowledge and understanding of this subject and required practice. FGM guidance and information, with particular regard to risk assessment, mandatory reporting and recording, can be accessed by staff via the Trust QNET Safeguarding page. At QVH no FGM risk assessments were undertaken on any patients during the last year. <u>Prevent Returns</u> QVH submit quarterly reports to Regional Coordinator at NHS England with prevent information which reflects the number of prevent referrals and details of staff compliance with training. This information is also copied to the CCG for assurance. At QVH no PREVENT referrals were made during the last year.

5.0	Activity analysis/ achievement
5.1	Health care at QVH is patient centred and QVH works closely with partners to manage achievement of effective safeguarding for all vulnerable patients whether they are children, young people, adults or other family members. National metrics are reported on a monthly basis to CQC and DH including: FGM assessments and PREVENT referrals. QVH continuously strive to develop staff knowledge, competence and to support its staff to achieve the best outcomes for patients at risk of harm. A streamlined safeguarding training programme was introduced this year at Level 2. Level 3 adult safeguarding training sessions were introduced for Consultants as part of their mandatory training days in September 2018. QVH promotes a culture where staff are encouraged to raise concerns and to whistle blow without fear, this is evidenced in the staff survey. QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about. There are close working links with the Patient Experience Manager and the Director of Nursing. There have been 2 safeguarding plaudits this year.
5.2	Training for staff is reviewed annually and updated in line with legislative requirements. Training data uptake continues to improve each year. Paediatric safeguarding systems in QVH have been well established for many years. They continue to be strengthened. There is a transparent overview of what is in place and of paediatric safeguarding activity occurring in the organisation. The embedding of Adult Safeguarding was developed throughout 2016-17. During 2018-19 there has been a change in leadership arrangements, this has provided opportunities to streamline and rationalise systems and processes. Feedback from staff has been positive. Safeguarding governance arrangements are well embedded.
5.3	QVH has a range of internal assurance processes in place. An overview of adult and paediatric safeguarding, and MCA activities in QVH are in place using the Datix systems for reporting purposes. QVH staff training programmes for adult and paediatric safeguarding have been reviewed and continue to be updated and clinically focused. Staff provide evaluations which are used to identify areas in which to improve training. Evaluations are reviewed after each training session. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. Four safeguarding departmental risk assessments are in place. These are discussed at strategic safeguarding group quarterly, monitored monthly and details reviewed at least every 6 months by the Safeguarding Named Nurse.

5.4	QVH has local external regulation undertaken by the CCGs, WSSCB and WSSAB. WSSCB commentated QVH on its Section 11 self-assessment submission. NHS Improvement ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during February 2019. The report was published on 23rd may 2019 and is on the CQC website.
5.5	Local safeguarding peer review and assurance processes are in place. The Named Nurse for Safeguarding is well supported by the Director of Nursing, Deputy Director of Nursing, Heads of Nursing and the West Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians. This team are supported by Peanut Paediatric ward staff, Minor injuries Unit Staff, Site Practitioners and Heads of Nursing. Consultants now received level 3 training for all aspects of safeguarding.
5.6	Partnership working with WSSCB and WSSAB is in place.
5.7	Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCB, WSSAB, CCGs and the CQC.

6.	**Involvement & Engagement**
	There is involvement of staff members in safeguarding work streams via Joint Hospital Governance Group, Strategic Safeguarding Group, Safeguarding Steering groups, Nurse Quality Forum, Patient Information group, Volunteers forum and other QVH governance groups, to involve others in: • Identifying safeguarding priorities as part of discussions • Undertaking key areas of safeguarding work/projects • Sharing safeguarding information

7.	**Safeguarding Learning from Experience**
	Safeguarding learning and development is a continuous process; there are a number of key regular routes for this to occur. Experience without reflection does not always result in learning. It is through the reflective process that meaning is created and new insights gained. During the year: Patients' situations and experiences are regularly reviewed at Safeguarding Steering group. Learning is then shared more widely by Safeguarding Link Staff. This approach has been supported by minutes and also the use of the Datix reports for Adult Safeguarding, Safeguarding Children and MCA. Feedback back from other agencies, peers, patients and their families either written

	or verbal is used as part of safeguarding discussions to enable staff to understand the impact of care provided whilst at QVH.

8.	Recommendations
	Recommendations to take forward in the coming year include: • Continue specialist development and succession planning with the QVH safeguarding team • Continue to strengthen safeguarding support, advice and guidance for QVH staff, patient and their families. • Promote a culture where staff are encouraged to raise concerns and to whistle blow without fear. • Continue to streamline policies and training sessions whilst maintaining clear direction regarding legal requirements and maintain staff knowledge, competence and skills

9.	DELIVERING THE QVH SAFEGUARDING STRATEGY
	QVH Safeguarding strategy has been reviewed and updated during early 2019. Delivery of the safeguarding agenda at QVH will continue to include: • Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services. • Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments. • Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions. • Ensure there are effective arrangements in place to share information when required. • Safeguarding training and systems compliance will be monitored by safeguarding leads. • QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme • In addition to this a Human Rights Framework will be incorporated into the strategy to make transparent protection of vulnerable patients at QVH.

10.	Conclusions and assurance
	Incorporating safeguarding legal frameworks into every day clinical practice is a continuous process. Safeguarding patients and their families is everybody's responsibility. All health care at QVH is patient centred and QVH works closely with partners to ensure effective safeguarding is managed for all vulnerable patients whether they are children, young people, adults or other family members National metrics are reported to CQC and DH including: FGM assessments and PREVENT

	referrals. QVH continuously strives to develop staff knowledge, competence and support its staff to achieve the best outcomes for patients at risk of harm. QVH promotes a culture where staff encouraged to raise concerns and to whistle blow without fear, this is evidenced in the staff survey. QVH also promotes feedback from patients and encourages them to raise concerns about anything they see and are worried about. There are close working links with the Patient Experience Manager and the Director of Nursing. Safeguarding systems in QVH continue to be strengthened. There is a transparent overview of what is in place and of safeguarding activity occurring in the organisation. Safeguarding team membership and governance arrangements are well embedded. QVH has a range of internal assurance processes in place. QVH staff training programmes for safeguarding have been reviewed and continue to be strengthened. Staff provide feedback which identifies areas in which to improve training. Evaluations are reviewed after each training session. QVH has an overview of all relevant safeguarding information and documents, which are systematically developed, reviewed and/or updated. Four safeguarding departmental risk assessments are in place. These are discussed at strategic safeguarding group quarterly, monitored monthly and reviewed at least every 6 months. QVH has local external regulation undertaken by the CCGs, WSSCB and WSSAB. NHS Improvement ensures QVH are registered with the CQC. A Care Quality Commission (CQC) inspection occurred during 2019. Local safeguarding peer review and assurance processes are in place. The Safeguarding Team are well supported by the Director of Nursing, Deputy Director of Nursing, Heads of Nursing and the West Sussex Designated Professionals. QVH staff are guided and supported by a team of specialist safeguarding clinicians. This team are supported by Peanut Paediatric ward staff and Site Practitioners out of hours. Partnership working with WSSCB and WSSAB is in place. Effective contract monitoring is undertaken through audits and regular exception reporting to WSSCB, WSSAB, CCGs and the CQC.

11.	Report approval and governance
	The QVH safeguarding team present this report to provide assurance to the Board that the Safeguarding agenda is robustly overseen and managed within the trust and with partners.

APPENDIX A Safeguarding training – evaluations sample

Safeguarding Adults, Children, LAC, MCA and PREVENT Level 2 - Evaluations from session on 3.4.2019

Rate the Session	Poor	Satisfactory	Good	Excellent
Were aims and objectives of the session met?			2	13
How would you rate the quality of the content of the session?			2	13
How would you rate the skills and knowledge of the trainer for the session?			2	13
How well was the event organised?			5	10
Overall how would you rate the event?			3	12

Comments:
Really good session, however too rushed, needs 15-30 minutes extra. It would be nice to have more time to process all the information and ask questions about real life scenarios. Thank you for interesting session. **It is a good idea to have it all in one session, Examples are very helpful.** **Good informative morning.** **Much better to have one session for both adults and children.** **Very relevant hearing both session together** **Learning needs met from all sessions including the update, potentially learners on initial session/induction will have more needs that those updating, might be worth considering having a separate update session.** **A much better session, well presented and good focused content. Left with refreshed knowledge and confidence.** **Excellent that all included in one session this year.** **There is a lot of intense information to get through in s short space of time however Katie and Pauline manage to keep it engaging and interesting. Use of scenarios and examples add to the day and use of images to emphasise the types of safeguarding considerations really give attendees an idea of why it is all important.** **Appreciated the combined adult and child safeguarding as we could discuss differences and also discuss similar concerns.** **Always very informative. Relevant updates**

Adult Safeguarding, MCA and PREVENT Level 3

Presenters: Edel Parsons CCG MCA Lead, Ellie Dunn LD link Nurse, Safeguarding Named Nurse

Rate the Session	Poor	Satisfactory	Good	Excellent
Were aims and objectives of the session met?			2	5
How would you rate the quality of the content of the session?			1	6
How would you rate the skills and knowledge of the trainer for the session?				7
How well was the event organised?			2	5
Overall how would you rate the event?			1	6

Comments:
Case studies very interesting, good update session. **Clear information given, possibly could have a longer session with more scope for discussion.** **I was working with a colleague and this information would have helped me advise her on a safeguarding adult issue.** **Short but well informed session with excellent examples, thought provoking scenarios. Helpful thank you.** **Articulate and engaging** **Very good much better to discuss cases and enjoyed interactive component**

APPENDIX B Safeguarding Activity 2018-2019

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paediatric safeguarding activity	13	30	26	41	25	22	30	25	15	34	20	25
SCR – child	0	0	0	0	0	0	0	0	0	0	0	0
FGM assessments	0	0	0	0	0	0	0	0	0	0	0	0
Allegations against staff	0	0	0	0	0	0	1	0	0	0	0	0
Prevent referrals	0	0	0	0	0	0	0	0	0	0	0	0
MCA assessments	3	1	7	3	4	6	7	1	7	0	3	5
BI decision	1	1	4	3	2	4	6	1	5	0	2	2
DOLS application	0	0	0	1	0	1	0	0	0	0	0	0
Adult Safeguarding activity	5	4	5	7	4	3	8	7	5	4	6	7
Case Reviews – Adult	0	0	0	0	0	0	0	0	0	0	0	0

APPENDIX C SAFEGUARDING AUDIT PROGRAMME 2017-2018, 3 year cycle

2016 Topic/s	Progress	Next Steps
NICE PH50 DVA	Baseline assessment march 2016 Organisation audit to start August 2016	Completed Report had gone to Strategic Safeguarding Group
NICE CG89	Organisation audit to start August 2016	Completed Report had gone to Strategic Safeguarding Group

2017 Topic/s	Progress	Next Steps
Referrals audit – adult and children	Completed December 2017	Repeat next 2018
CG89 and PH 50 Survey monkey for medical staff	Competed February 2018	Report to Steering group Roll out across QVH medical staff
MCA staff knowledge audit	Completed December 2017	Report to SSG Action plan being monitored
MCA compliance audit	Completed December 2017	Report to SSG Action plan being monitored

2018 Topic/s	Progress	Next Steps
Referrals audit – adult and children	Due Sep to December 2018	Report being drafted
Safeguarding Prompts Card audit	Survey Monkey Sep 2018	Report drafted
Child not brought to appointment protocol audit	2018	Delayed to 2019
EDN safeguarding section audit	2018	Delayed to 2019
Adult safeguarding audit MaxFax	2018	Underway

2019 Topic/s	Progress	Next Steps
Referrals audit – adult and children	Due Sep to December 2019	
NICE PH50 DVA	Organisation audit to start August 2019	
NICE CG89	Organisation audit to start August 2019	
Child not brought to appointment protocol audit	2019	
EDN safeguarding section audit	2019	

APPENDIX D
Policy, procedures, protocols, guidance and information for QVH, staff and patients

QVH SAFEGUARDING DOCUMENTS AND INFORMATION January 2019

1	Item	Date	Location	Actions
1.1	QVH assurance statement	2019	Website	Reviewed 2019
1.2	QVH safeguarding strategy	2016	Website	Reviewed 2017 Update 2019
1.3	QVH Website and QNET	ongoing	Intranet	Ongoing review and update as required by QVH safeguarding leads
1.4	Sussex Child Protection and Safeguarding Procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.5	Sussex adult safeguarding procedures	Updated on line	Link via QNET	Ongoing review and update as required by WSSCB
1.5	QVH safeguarding annual report	2018-19		Next due April 19
1.6	QVH and BSUH Paediatric SLA			Copy with Deputy Director of Nursing
1.7	QVH Safeguarding Strategic Group terms of reference	October 2018		Held by PA for Director of Nursing
1.8	QVH Safeguarding Steering Group terms of reference	October 2018		Review 2019
1.9	QVH safeguarding prompt cards for staff	June 2017		In place , audit underway
1.10	QVH safeguarding volunteers guidance			Now use prompt cards
1.11	QVH NMC examples of revalidation forms- completion for safeguarding practice	2016		Available for staff on request
1.12	QVH Safeguarding Learning and Development strategy	2018	QNET	Reviewed and updated 2018 Approved by Safeguarding Strategic Group
1.13	QVH safeguarding risk assessments	ongoing	Overseen by strategic safeguarding Group	Dashboard updated quarterly

2	Item	Date	Location	Actions
2.1	QVH Managing allegations against staff	2018	QNET	Now guidance – reviewed by HR
2.2	QVH Whistle blowing policy		QNET	
2.3	QVH Handling complaints policy		QNET	
2.4	QVH producing user information policy		QNET	
2.5	QVH Translation and Interpreting policy		QNET	
2.6	QVH supervision support guidance		QNET	Discussed with Jo Davis new to post Practice Education lead
2.7	QVH Recruitment and selection policy (includes Checking and		QNET	

	DBS)			
2.8	QVH Risk management and incidents policy		QNET	
2.9	QVH Consents policy		QNET	Includes Gillick competence/Fraser Guidelines – staff development re implementation of Fraser guidelines offered by Named Doctor
2.10	QVH Information security policy,- Patient photographic and video recording		QNET	
	Police taking photographs on QVH site			Guidance added to Access Requests Procedures
2.11	QVH C&YP and Adults Chaperone Policy	2018	QNET	Review 2021
2.12	QVH information governance policy		QNET	
2.13	QVH Health records policy		QNET	Being updated to align with use of Evolve
2.14	QVH support for staff experiencing DVA guidance	2018		Updated by HR
2.15	QVH JD and person specification template		QNET	Includes safeguarding
2.16	QVH Restrictive Physical Interventions and Therapeutic Holding Policy	2016	QNET	Child section expanded and EQIA completed
2.17	QVH Abduction or suspected Abduction of an Infant/Child Policy	2016	QNET	Under review for April 2019
2.18	QVH Routine pregnancy screening anaesthetics and surgery			Set up 2018
2.19	QVH DVA procedures for patients	2017	QNET	Review 2020
2.20	QVH Guidance on management of risks posed by sex offenders/sex related crime /potentially dangerous offense whilst at QVH site	2019		Approved by Strategic safeguarding group

QVH SAFEGUARDING CHILDREN AND YOUNG PEOPLE

3	**Item**	**Date**	**Location**	**Actions**
3.1	QVH Child Protection and Safeguarding Policy and Procedures	2016	QNET	Review 2019 Includes • QVH Peanut missing children risk assessment • QVH children not brought to appointments risk assessment QVH Referral Form
3.2	QVH safeguarding children Trauma Proforma and child protection documents	Under review	QNET	Paediatric matron

3.3	NAI photographs Policy and protocol	Under review		Following up

QVH SAFEGUARDING ADULTS

4.	**Item**	**Date**	**Location**	**Actions**
4.1	QVH Safeguarding Adults Policy	2016	QNET	Requires review April 2019
4.2	QVH *Prevent* Delivery Plan	2019	Q-Net	Reviewed Jan 2019
4.3	QVH Mental Capacity Act and DOLS Policy & Procedures	2018	Q-Net	Updated and ratified

QVH leaflets for patients and families

5.	**Item**	**Date**	**Location**	**Actions**
5.1	QVH posters for patients • Information sharing • Do you need to tell us something	2017	QVH site	Information to be included in set of QVH standardised posters for wards
5.2	QVH leaflet for patients • Dog bites	2016	QNET	
5.3	QVH leaflet for families • Safeguarding children and young people	2016	QNET	
5.4	QVH MCA and next of kin leaflets	2018	QNET	
5.5	Children not on education roll	DRAFT		
5.6	QVH DVA information	Under review		
5.7	QVH adult safeguarding	DRAFT		
5.8	Adult patient caring for children - safeguarding	DRAFT		

APPENDIX E
TITLE: Safeguarding Strategic Group Action Plan

2018-19 work plan for group based on Safeguarding Strategy Objectives, which contribute to achieving key strategic objectives of the trust:

Outstanding patient care

- World class clinical services
- Operational excellence
- Financial stability
- Organizational excellence

Strategic Objective	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
1. To provide senior and Board leadership	QVH require: • Lead Board Director • Nominated Non-Executive Board Director • Safeguarding Adults and Children Named Nurse • Safeguarding Children Named Doctor • MCA & DOLs lead • Prevent lead • WRAP Facilliators • Child Sexual Exploitation Lead	Green	Review allocated specialist resources in coming year	Ongoing	Director of Nursing & Quality	Safeguarding Named Nurse & MCA Lead in post Specialist AHP Adult safeguarding, in post but on long term sickness Departmental risks in place KPIs to Board Annual Report to Board
2. Senior leadership responsibility and lines of accountability for safeguarding arrangements are clearly outlined to employees and members of QVH,	QVH require: • Safeguarding Accountability and communication document on Website • Safeguarding Strategy on website • Safeguarding QNET page	Green	Sustain systems Annual review and update training	Ongoing	Director of Nursing a & Quality with Named	Website safeguarding statement updated QNET update ongoing Quality assurance processes in place

as well as to external partners.	• Safeguarding Policy, standards, protocols, guidance • Information for staff • Information for patients • Safeguarding training strategy and program in place • safeguarding activity data via Datix system. • Patient information via Evolve, paper record, EDN		program Use Evolve/EDM safeguarding section as new system rolled out. Use Datix to capture data		professionals	Policy review and updates ongoing. Training uptake data and evaluations scrutinized monthly Datix - used to capture safeguarding and MCA data. Now being used permanently Development of new leaflets for patients and their family
3. QVH contribute to the work of West Sussex LSCB and SAB and their strategic Business Plans and priorities, and provide support to ensure that the Boards meet their statutory responsibilities.	QVH require; • Regular representation at LSCB • Regular representation at SAB • Completion of Section 11 self-audit • Bi-monthly reports to LSCB and SAB • Quarterly reports to CCGs • Quarterly reports to NHS England – *prevent* coordinator	Green	Overlap between reporting requirements – manage and sustain effectively Regular representation at LSCB and SAB Regular updates from NHSE and NHSi		Director of Nursing & Quality with Named professionals	Safeguarding Children Section 11 self-assessment updated Concerns regarding DVA systems addressed. Director of nursing attending WSSCB Safeguarding Named Nurse attending WSSAB
4. QVH support their safeguarding leads to contribute to and influence the work of the LSCB and SAB	QVH require; • Named professionals involvement in specific subgroups • Supervision from designated	Green	Input into NHS professionals groups		Director of Nursing a & Quality with	Supervision in place Attendance at Regional and national conferences

subgroups and other national and local safeguarding implementation networks.	professionals for named professionals • Attendance at West Sussex networks • Attendance at Regional Networks				Named professionals	

DELIVERING THE STRATEGY

Ensure all aspects of safeguarding work and practice are considered and incorporated into all QVH services.
Service developments take account of the need to safeguard all patients and are informed by service users and quality impact assessments.
Processes in place to disseminate, monitor and evaluate outcomes of all case review recommendations and actions.
Ensure there are effective arrangements in place to share information when required.
Safeguarding training and systems compliance will be monitored by safeguarding leads.
QVH will demonstrate it is meeting its statutory requirements via annual reporting and an audit programme.

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**151-19**	
Report title:	**Infection Prevention & Control Annual Report 2018/19**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Sarah Prevett, Infection Control Lead Nurse				
Appendices:	3				
Executive summary					
Purpose of report:	To provide assurance that there is a systematic leadership in place in the organisation for the effective management of infection prevention and control for patients, staff and visitors.				
Summary of key issues	The Committee's attention should be drawn to the following key areas of infection prevention and control management detailed in the report: The Trust has continued to achieve low rates of reportable infections with our targets being met in three of the four required areas and the fourth still remaining significantly lower than other specialist trusts. Assurance process has been maintained through a robust audit process however there remains room for improvement with compliance from all staff with regards to infection control policy.				
Recommendation:	The Committee is asked to seek assurance regarding the enhanced process and rigour of infection prevention and control in the Trust, and note developments/ work streams for 2019/20 to further increase the safety and effectiveness of patient care.				
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:	Infection Prevention & Control contributes directly to the delivery of KSO 1 and KSO 2				
Corporate risk register:	No impact on CRR , local risk registers also reviewed when compiling this report				
Regulation:	Section 21 of the Health and Social Care Act 2008 enables the Secretary of State for Health to issue a Code of Practice about healthcare associated infections. The Code contains statutory guidance about compliance with the registration requirement relating to infection prevention (regulation 12 (2) (h) and 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Providers should also note that Regulation 15 is also relevant.				
Legal:	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and Care Quality Commission Regulations 2009				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	24/07/19	Decision:	The report has been received and full assurance has been given.	
Next steps:	To QVH Board for approval.				

Holtye Rd,
East Grinstead
RH19 3DZ

Infection Prevention and Control

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2018 to March 2019

Document Control: committees and groups who have approved this report
Executive sponsor: Director of Nursing and DIPC

Authors: Lead Infection Control Nurse

Date:

Type: Annual Report
Version:
Pages:
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	The purpose of this report is to inform and provide assurance to the trust Board, patients, public and staff of the processes in place at The Queen Victoria NHS Foundation Trust (QVH) to prevent and control healthcare associated infections (HCAI). The trust has a statutory responsibility to comply with the Health and Social Care Act: Code of Practice for the prevention and control of Healthcare-Associated Infection 2008 (DH 2015). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report provides an overview of infection prevention and control activity at QVH for the reporting period from 1st April 2018 to 31st March 2019 and demonstrates compliance with the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The key findings of the report are: • The Trust has maintained compliance with Care Quality Commission regulations relating to Infection Prevention and Control. • Continued improvement in many audit results across the Trust which reflects both improvements in Infection Prevention and Control practices, but also the environment, due to close working with estates and facilities. Where audit data is showing no improvement learning needs identified and actions taken • Overall incidence of Healthcare Associated Infection remains low with one case of methicillin Sensitive Staphylococcus (MSSA) bacteraemia, one case of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and zero Clostridium Difficile (CDI) infections. With each of the positive results for reportable infections there was no transmission to other patients. • Transmission of colonisation of MRSA occurred due to an outbreak within CCU and Burns • Achieving the national target for staff influenza immunisations

2.	Introduction
	The purpose of this report is to provide the Board with information on trust performance and provide assurance that suitable processes are being employed to prevent and control infections. This paper provides the board with an overview of work completed during the previous year and goals for the continuing programme of infection prevention and control for the upcoming financial year. Healthcare associated infection remains a top priority for the public, patients and staff and remains one of the Trust's strategic objectives. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. During the year, the ICN's have worked with staff across all areas of the Trust to enable effective infection prevention and control and safe reliable services. The threats posed by increasing numbers of known antimicrobial resistant organisms and a new generation of highly resistant bacteria are becoming more and more evident with increasing numbers of patients being identified with these organisms. Carbapenemase Producing Enterobacteriaceae (CPE) is one example of the new generation of highly resistant organisms that are becoming more prevalent within UK hospitals. CPE are established in other parts of the world, such as Asia, the USA and Southern Europe, and are being identified more frequently in parts of the UK. These organisms threaten us with infections that are potentially untreatable with antibiotics. Our goal must be not only to maintain our current position but to improve on it and contribute to the prevention of CPEs becoming established in the UK.

Infection prevention and control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. A consistent approach to infection control is key to preventing the spread of infections. Standard precautions must be employed by all staff at all opportunities.
This annual report shows how we are performing, where we do well and where we would like to do better.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on environmental cleaning, linen decontamination and antimicrobial prescribing.

2.1 The Infection Prevention and Control Team

The objective of the infection control team is to continue promoting compliance with all aspects of Infection prevention and control to all staff within the Trust, enforcing the message that 'Infection Control is at the Heart of Everything we do' in order to maintain the low rates of infection, both reportable and non-reportable, that the Trust has sustained in 2018/2019.

The infection control service is delivered and facilitated by an infection control team which consists of:

- Director of Infection Prevention and Control
- Infection Lead Nurse and Decontamination Lead. (full time, 37.5 hours/week)
- Infection Control Nurse. Commenced position in February 2019. (part time 22 hours/week)
- Administration assistant. Commenced position in December 2018. The administrator is shared with the safeguarding team.
- Antimicrobial pharmacist.
- The microbiology and virology laboratory services are provided by Brighton and Sussex University Hospital (BSUH). As part of this service BSUH provide QVH with a Consultant Microbiologist who is on site once a week. Outside of this there is 24 hour advice and support via telephone or email to support safe provision of infection control services.

2.2 The Director of Infection Prevention and Control (DIPC)

The Infection Control Team reports directly to the DIPC, who is the trust Director of Nursing and Quality. The DIPC is directly accountable to the Chief Executive and has an overarching responsibility for the strategy, policies, implementation and performance relating to infection prevention and control. The DIPC attends the trust board and other meetings as planned or required, including the monthly infection control team meetings and quarterly infection control committees.

3. Service aim, objectives and expected outcomes

The Code of Practice (Part 2) sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements. The Trust's infection control policies set out a framework of compliance to these criteria and are published in the trust policy section of Qnet. These documents are reviewed and updated by the infection control nurses (ICN's) and relevant clinicians before being ratified by the Infection prevention and Control Group (IPCG).

The QVH infection prevention and control strategy 2018/19 utilises appropriate methods to prevent the acquisition of infection by patients and to prevent the transmission of organisms between patients. This report collates infection surveillance data, audit results, progress with actions identified on the annual programme and all information necessary to assure the board that suitable systems and processes are being employed within the trust to prevent and control infections.

Internal assurance processes and board accountability.
QVH has an infection prevention and control structure and processes in place which are led and supported by a team of specialist infection prevention and control clinicians. (See Appendix A for QVH infection prevention and control structure chart).

As an organisation QVH is committed to the prevention of health care associated infection (HCAI) for patients, staff and visitors whilst on the premises or in the care of the hospital. This is done through robust infection prevention and control programme involving policies and procedures for staff to follow which conform to current best practice guidance, an audit programme to ensure compliance against the policies and a team of specialist infection control staff to offer education, guidance and advice to all staff and patients on infection control. Mandatory surveillance of certain infections are undertaken to ensure that correct and timely advice on treatment and precautions required is given to the clinical staff in order to provide the best care possible for all patients.

The trust Infection Control Group (ICG) is a multidisciplinary trust group which meets quarterly. The group ensures that there are effective systems in place to reduce the risk of infection and where infection does occur to minimise its impact on patients, visitors and staff. The committee is chaired by the DIPC.
Membership of the ICG includes representation from key service areas:
Facilities, Estates, Pharmacy, Theatre, Infection Control Nurses, Microbiology Consultants, Heads of Nursing, Occupational Health, Risk and Safety, Representation from Public Health England and the Commissioning Support Unit.
Other trust staff may be invited to attend as required.
The QGC receives a quarterly infection control report on each of the key elements of infection control management. In addition, the DIPC also provides updates to the Clinical Governance Group, Hospital Management Team,
and Executive Management Team and to the Trust Board. There is also oversight of antimicrobial issues at this group via attendance of the trust antimicrobial pharmacist.

Members of the IPACT share infection control information and learning with a number of groups and committees which include:

- Quality & Governance Committee
- Health and Safety Group
- Clinical Audit
- Estates and Facilities Group
- Learning & Development Group
- Medicines Management Optimisation Governance Group (MMOGG)
- Patient Led Assessment of the Care Environment (PLACE)
- Pathology Meeting
- Nursing and Quality Forum
- Professional networks
- Clinical Audit Meeting

IPACT work closely with all clinical teams, Estates and Facilities and Hotel Services to ensure that infection prevention and control is included in the planning stages of every new project and development or refurbishments.

Infection Prevention and Control microbiology activity
All the trust microbiology specimens are processed by locally in accredited laboratories. The results of all microbiology samples including blood specimens and swabs are checked for positive colonisation or infection that may have the potential to spread and cause harm. A further check for any positive specimens from a daily lab report is undertaken by the ICN. Although labour intensive this scrutiny provides oversight of every specimen taken from QVH ensures that information and clinical advice is then given to the relevant ward/clinical staff. This process allows the ICN to monitor patterns in infection rates, identify samples that are multi-drug resistant (MDR) and identify clusters of positive results that are showing a pattern through either department of organism type. Significant or unexpected results are also relayed to the IPACT or the ward via the on-call microbiologist.

Infection prevention & control link persons (ICLP)
Infection prevention and control remains central to the maintenance and promotion of high standards throughout QVH. The ICLP Group meets every quarter. Its purpose is to provide a link between the IPACT and ward/departmental staff in all clinical and non-clinical areas in order to facilitate the dissemination of information and to promote compliance with infection control policies and the Health & Social Care Act (2015). Every meeting includes an educational element. The ICLP members are reviewed on an annual basis. Or more frequently if there has been staff changes. The link staff conduct monthly infection control audits and champion good infection control practices within their teams/departments.

External Meetings
Infection control remains high on the national agenda. The ICN has attended a seminar on infection control priorities and specifically preventing Gram-negative bloodstream infections for E. coli. Relevant sections of the resource pack have been shared within the trust.

Mandatory Surveillance
Mandatory surveillance data is required to be submitted to Public Health England (PHE) for the following alert organisms:

- *Staphylococcus aureus (S. aureus*) bacteraemia – both Meticillin Resistant *Staphylococcus aureus* (MRSA) and Meticillin sensitive *Staphylococcus aureus,* (MSSA)
- *Clostridium difficile* infection (CDI)
- *Escherichia coli* (E. coli) bacteraemia
- *Pseudamonas aeruginosa bacteraemia*

Glycopeptide Resistant *Enterococci* bacteraemia (GRE) and Vancomycin Resistant *Enterococcus* bacteraemia (VRE) are reported to the Commissioners as required and to Public Health England (PHE) on a quarterly basis.

In addition, bi-monthly reports are made to the Clinical Commissioning Group (CCG) and the Trust Board; these are also published on the Trust webpage for the public to read.

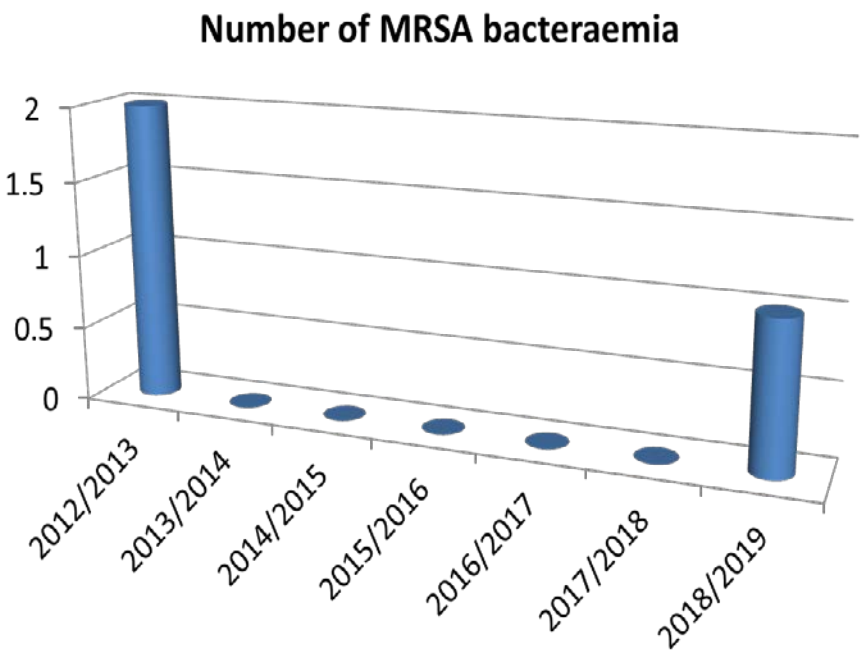
IPACT also monitor Urinary Tract Infection (UTI), *Acinetobacter, Pseudomonas, Klebsiella spp* and any other Multi Drug Resistant (MDR) organisms. An alert organism spreadsheet is in place to assist with this.

Root Cause Analysis (RCA)
The Trust continues with the protocol for RCA review for all reportable infections and, for all MRSA bacteraemia and the Post Infection Review (PIR) process.

MRSA Bacteraemia

QVH have a limit of zero cases of avoidable MRSA bacteraemia every year – the trust did not achieve this target in 2018/19 with one case identified. A full review of this case was conducted using the Performance review toolkit (PIR). This was done to review practice and look for any potential caused of this infection. Learning needs were identified and taken back to the relevant staff and departments.
Figure 1 shows previous year's performance.

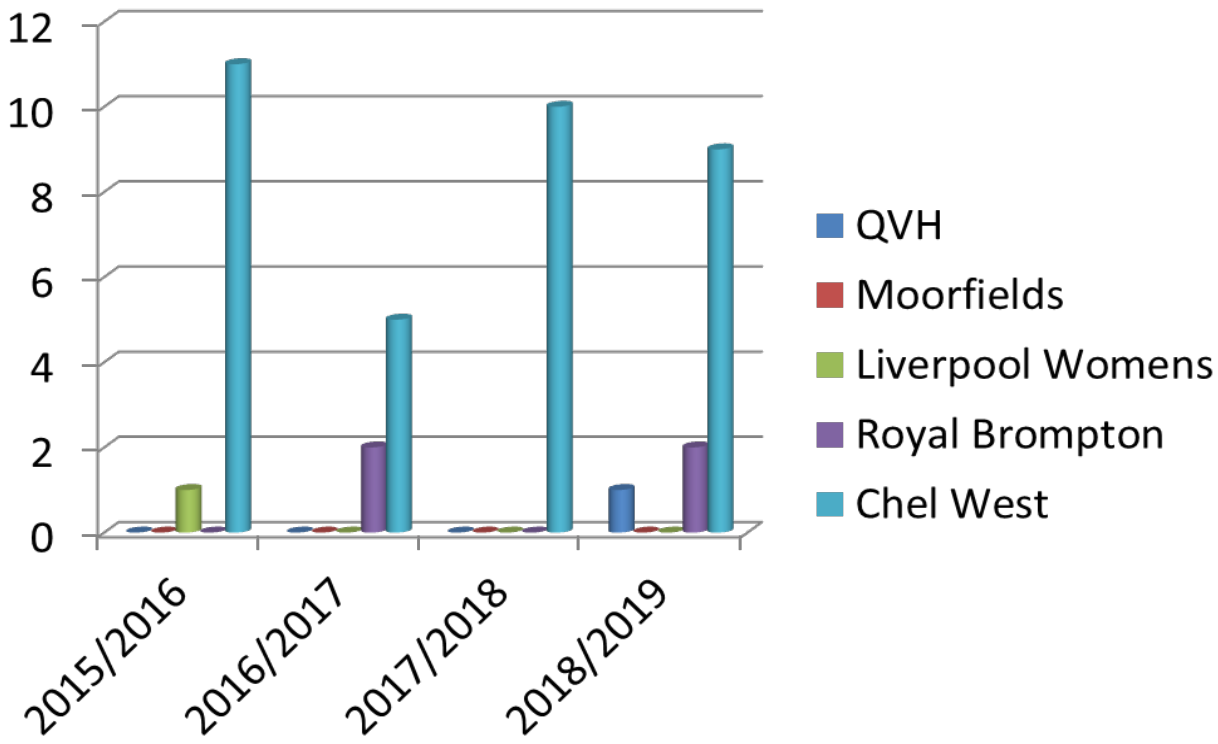
Figure 1



To date there has not been a revision of this target for 2019/20.

Figure 2 shows the 2018/19 Trust acquired MRSA bacteraemia benchmark against similar acute providers.

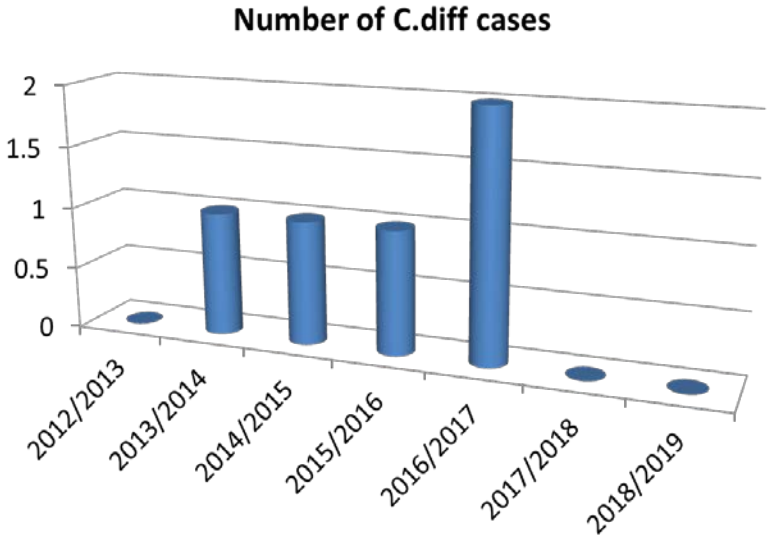
Figure 2



***Clostridium difficile* infection (CDI)**

In 2014/15 NHS England introduced a change in the methodology for calculating organisational CDI objectives and encouraged commissioners to consider sanctions for breach of CDI objectives only where those CDIs were associated with lapses in care. The CDI lapse in care objective target for QVH was set at zero. The Trust had no cases of CDI in 2018/2019 and therefore reached its objective. Figure 3 shows previous performance.

Figure 3

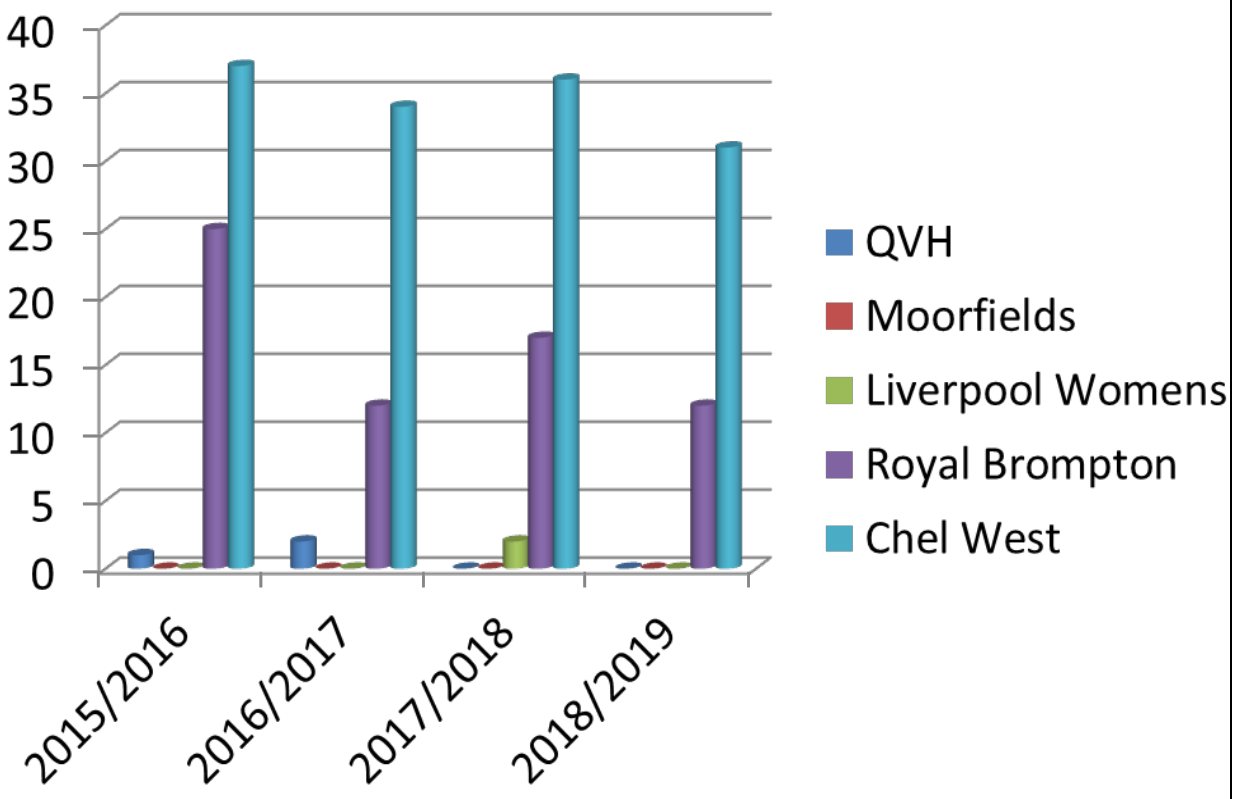


The CDI lapse in care objective target for the Trust remains at zero for 2019/2020.

The CCG will continue to review the details of any confirmed cases and determine if it should count towards the total/aggregate number of cases apportioned to the Trust. If the Commissioner concludes that there has not been a `lapse` in care the case may still be attributable to the Trust but a sanction unlikely. The contractual sanction if a breach is identified remains the same at £10,000 per positive case. Changes made to Nation Guidance of reporting of CDI coming into effect in 2019 may have a significant impact on the number of CDI attributable to the Trust. Current guidance states samples sent within 72 hours of admission which return a positive result are classed as acquired from another source, for example the community or referring healthcare provider. The changes in the guidance are dropping this to samples sent within 48 hours of admission.

Figure 4 shows the 2018/19 Trust acquired CDI benchmark against similar acute providers.

Figure 4



MSSA bacteraemia

No target has been set for MSSA bacteraemia to date. There has been a noticeable increase in cases. This is a National trend and has been noted by the DH. QVH have had one MSSA bacteraemia case in 2018/19 which is a significant decrease when compared to previous years. An investigation was undertaken using the root cause analysis process (RCA) which proved inconclusive to the cause of the bacteraemia however did highlight the vulnerability of the patient due to the nature of their injuries and multiple invasive procedures undertaken during the admission period.

Figure 5 shows the year on year numbers of trust acquired MSSA bacteraemia.

Figure 5

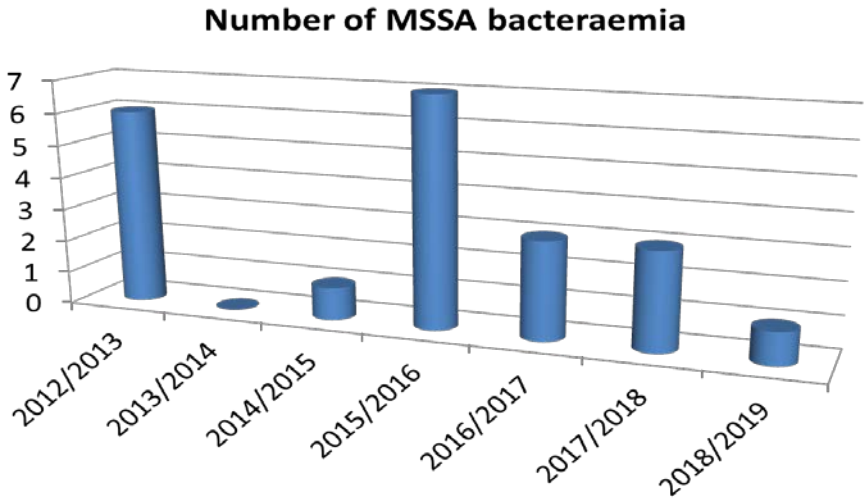
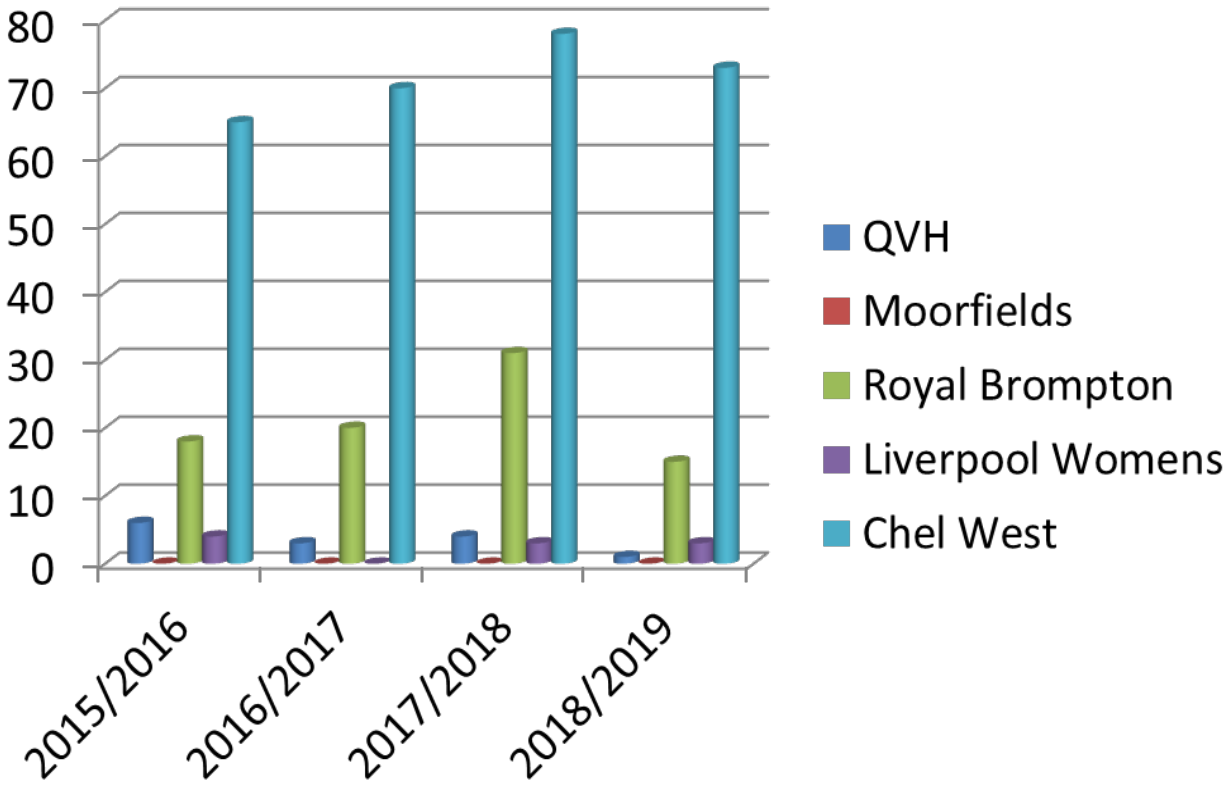


Figure 6 shows the 2018/19 Trust acquired MSSA bacteraemia benchmark against similar acute providers.

Figure 6



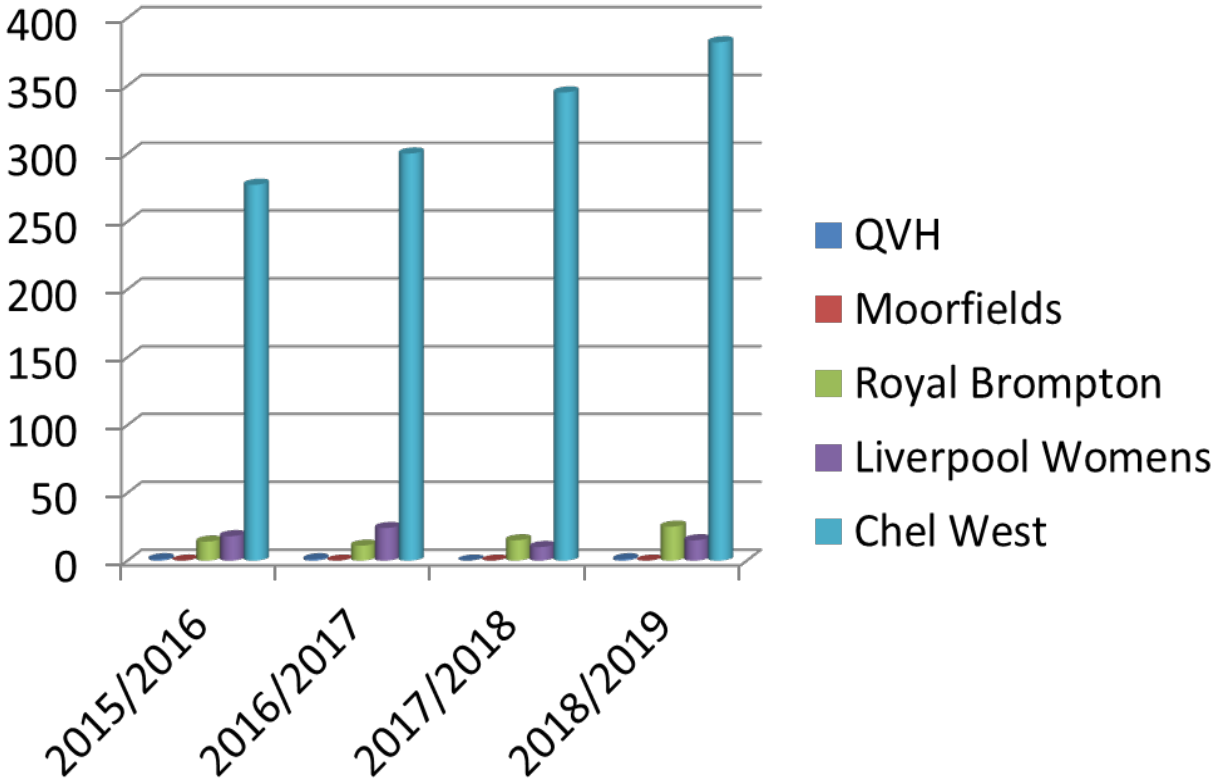
E. Coli bacteraemia

No DH target has been set for *E.coli* bacteraemia though the NHSI ambition to reduce gram negative bacteraemia by 10% year on year until 2020 through a Quality Premium remains. QVH had one Trust acquired *E.coli* bacteraemia in 2018/19. An investigation was undertaken using the root cause analysis process (RCA) which proved inconclusive to cause of the

bacteraemia however did highlight the vulnerability of the patient due to the nature of their injuries and multiple invasive procedures undertaken during the admission period.

Figure 7 shows the 2018/19 Trust acquired *E.coli* bacteraemia benchmark against similar acute providers.

Figure 7



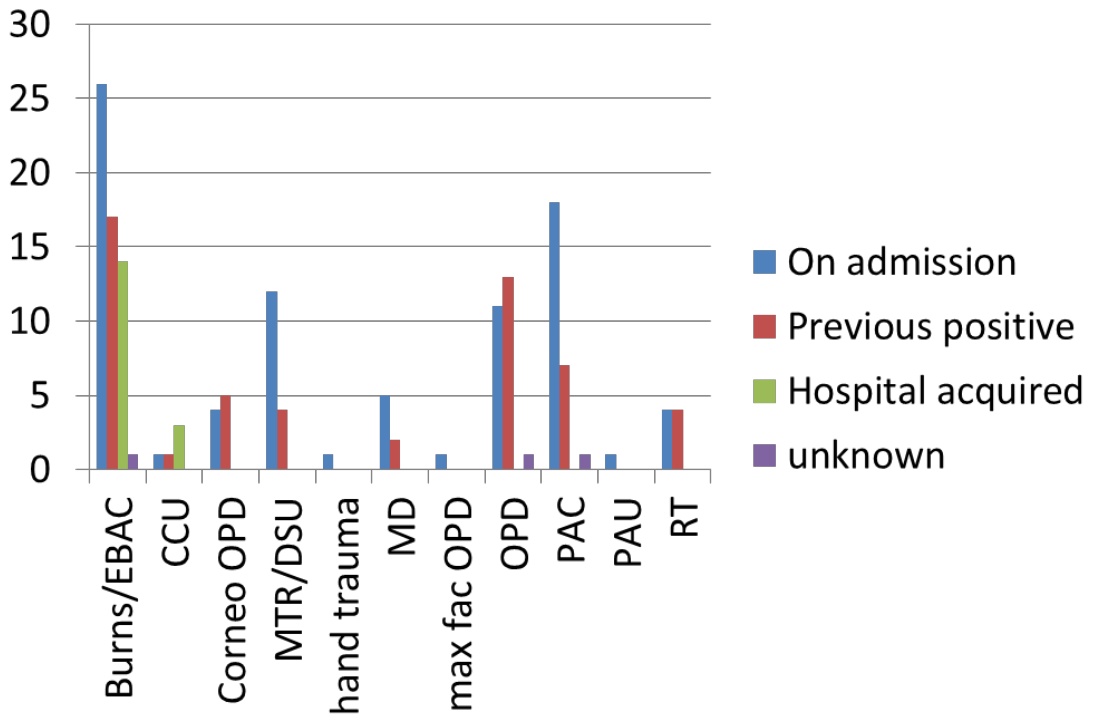
Glycopeptide resistant enterococci bacteraemia (GRE)

No reportable GRE's have been identified at the QVH. No target has been set by DH to date. There have been no Trust acquired GRE infections in the last 10 years.

MRSA positive patients April 2018 to March 2019 (Infected and colonised)

During the period of 2018/2019 there were 151 patients who were confirmed MRSA positive either colonised or infected. None of the positive results were acquired from blood cultures (bacteraemia) but from either surface swabs (such as nose and groin) or from wound swabs. Of these 17 were classed as healthcare associated or hospital acquired (HCAI), 84 were identified from admission or pre-admission swabs (O/A), 53 were from patients known to be previously positive (PP) and 3 patients it was difficult to determine the source of acquisition, these was either because they were not admitted at the time of the result and therefore could have acquired the MRSA during outpatient appointments or whilst at home/in the community or where positive results are received from paediatric patients as this group of patients are not routinely screened on admission therefore there is no baseline data to determine if the MRSA was acquired in the hospital setting or in the community before admission. RCA's are

completed for all HCAI cases to look at any lapses in care or areas of improvement.



4.	**Activity analysis/ achievement**

External regulation and inspection by Care Quality Commission (CQC), NHSI and commissioners
The CQC conducted a full Trust inspection in January 2019. Infection control policies and audit results were submitted to the inspection team for review and full engagement with the inspection was given by the IPACT. The results of this inspection showed the trust had sustained the overall rating of Good and also the overall rating of excellent for Care. The lead infection control nurse and the DIPC were interviewed as part of the well led inspection and not recommendations were raised by the CQC with regard to infection prevention and control management and monitoring within the trust.

The Trust Board
The Trust Board has responsibility for overseeing infection control arrangements and has been kept informed by the DIPC providing exception reporting and quarterly reports at the Quality and governance Committee and as part of the quality and safety public board papers. A key element of the role of DIPC is the direct line of communication with the Chief Executive and Medical Director.

Key Performance Indicators (KPIs)
KPI's set for the IPACT include monitoring hand hygiene compliance, monitoring MRSA screening compliance and monitoring trust acquired reportable infections. Results for these are all included within the document. Ensuring policies are in line with national guidance and within date, a list of all updated policies is included in this document, and that regular audits are completed to monitor compliance against the

policies. Completed audits are included in this report in the audit section of this report. The remaining KPI's are ensuring all members of the IPACT are attending mandatory training and are undertaking an annual appraisal. All members of the IPACT achieved this during the year April 2018 to March 2019.

Complaints
If necessary the IPACT will liaise with the Patient Experience Manager to assist with the investigation of complaints associated with infection prevention and control. The outcomes of these are fed back at the monthly IPACT and quarterly committee meetings. There were no complaints or claims made during 2018-2019 relating to infection control.

Infection Prevention and Control Learning and Development
Infection Prevention and Control is part of the Trust's mandatory training programme. Three sessions a month are held, two for clinical staff and one for non-clinical. Induction training days are also held monthly for all categories of staff, with separate sessions for new Doctors' Induction. Training is carried out by the ICN's.

The theme for 2018-2019 was once again "Infection Prevention & Control is everyone's responsibility" and the presentations were based on the National passport`s key learning outcomes. Topics covered included:

- How does infection spread?
- How staff can help prevent the spread of infection (looking after themselves and the environment)
- Hand hygiene and bare below the elbows
- Correct wearing of PPE
- Theatre clothing policy
- Spillage management
- Sharp safety
- Safe disposal of waste
- Compliance with DH *Pseudomonas* guidance
- Deep cleaning
- What is an HCAI
- CPE
- The history of infection control
- The Health and Social Care Act (2015)
- Food hygiene
- Flu preparations including FIT testing

Along with clinical, non-clinical and consultant mandatory training IPACT have also given additional teaching to staff on current issues highlighted through audit and surveillance relating to infection control. This has been incorporated into the department meetings and additional training session that have been identified as required through the RCA process following reportable infections.

The ICN also delivered 3 teaching sessions on hand hygiene to 2 local junior schools. This was to correspond with the topic of 'healthy bodies' the children were learning about. Feedback from the pupils and teachers was positive saying they found the sessions informative and interesting. The schools have asked if the ICN would be willing to deliver further sessions in the future.

Infection Prevention and Control audit

Clinical audit is a fundamental component of clinical governance and underpins the assurance process for a high-quality service (CQC, 2010). The following audits have been undertaken in the period April 2018 to March 2019. All Ward/Department Matrons are informed of audit results pertinent to their area as they are completed. They are asked to complete any recommendations made within the audit reports.

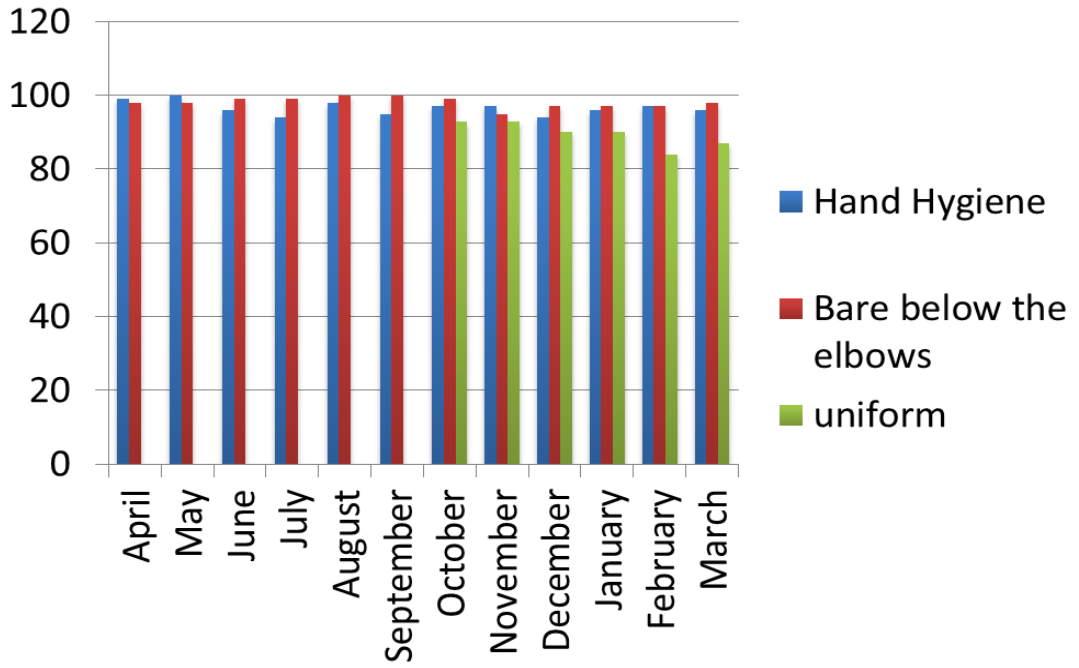
Saving Lives – Department of Health High Impact Intervention (HII) Audits
The Saving Lives Delivery Programme was revised in 2017 to change which procedures were being classed as HIIs. These were modified and now include:

- Prevention of ventilator associated pneumonia
- Prevention of infections associated with peripheral vascular access devices
- Prevention of infections associated with central venous access devices
- Prevention of surgical site infection
- Prevention of infections in chronic wounds
- Prevention of urinary catheter associated infections
- Promotion of stewardship in antimicrobial prescribing

The purpose is to deliver a programme which will reduce HCAIs and allow Trusts to demonstrate compliance with the Health and Social Care Act (DH, 2010), using techniques known as HIIs, of which there are seven. Data collection for this audit has proved to be problematic with many ways of auditing being tried. During 2018/2019 the Saving lives HII's were audited as part of the safety thermometer audit for quality and compliance however as this audit was conducted as a one day snap shot audit very little data was being collected for some of the 7 HIIs due to low patient numbers. Therefore the audit programme has been revised and was launched in April 2019 as a continuous monthly audit to be conducted by the Infection control link staff.
The data that was accrued using the safety thermometer audit showed that compliance with guidance is overall good however improvement is required in relation to documentation.

Surgical Site Infection (SSI) Audit
For this audit all patients undergoing either major breast surgery or major head and neck surgery were included. Patients highlighted as suitable for inclusion were asked to complete a consent form by the nursing staff on the admitting ward. Patients were only included in the audit if they consented. The audit period was set for 1 month however due to a poor result in consent forms being given to patients the audit period was extended to 2 months. Readmission to QVH following breast surgery, with confirmed infection is 16% (4/25) which is higher than in previous audits where >1% were re admitted with confirmed SSI. However it must be noted that the amount of patients included in this audit was significantly lower than in previous audits which has affect the percentages. If all patients that were given treatment for infections with or without swab results or readmission are included then this is a total infection rate of 24% it is difficult to determine as to whether the antibiotic therapy was given appropriately as whilst all treatment should be administered based on clinical need and symptoms best practice is to send samples for microbiology to ensure the appropriate antibiotic is prescribed.. Readmission to the QVH following head and neck surgery with confirmed infections was 0. Patients given treatment for infections post operatively was 20% (1/5) However it must again be noted that the amount of patients audited was very low which has affected the percentages.

Hand Hygiene Audits



Monthly hand hygiene and bare below the elbows compliance audits have continued. This audit is conducted by the Infection Control Link staff in their own areas. The audit tool is modelled on the NPSA 5 moments of hand hygiene. Overall compliance with hand hygiene and bare below the elbows has fluctuated between 94% and 100% compliance. Where areas drop below compliance staff are encouraged to identify members of staff not compliant. These staff are then spoken to and given additional training in the importance of compliance within infection control standards.
In October 2018 the hand hygiene audit was expanded to incorporate a monthly uniform audit. Compliance has been shown through this audit to vary between 84% and 93%. All staff are reminded at mandatory training sessions of the uniform policy and any staff seen not complying is spoken with by the department lead. Audit results show that the staff group who achieve the lowest compliance each month is the Medical staff. The IPACT ask that staff report the names of those not compliant so that they can be spoken to personally.

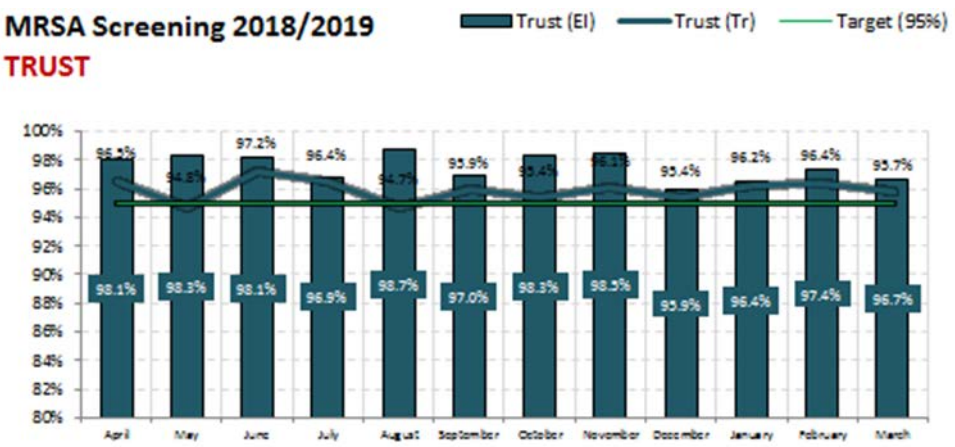
Aseptic Technique
The purpose of the annual audit was to ascertain the level of compliance to the Trusts Aseptic Technique policy. An aseptic technique ensures that only uncontaminated equipment and fluids come into contact with susceptible body sites. The audit was an observational audit carried out by the Practice Educators in their own departments. The aseptic technique is an annual audit however if poor compliance with the aseptic technique procedure is shown in the audit a re-audit will be done to ensure improvement is made. 91% of the audits were compliant having all 'yes' or 'N/A' answers which is a slight decrease on the previous audit which was 96%. The no answers that were given all apply to staff not decontaminating their hands at every opportunity.

Isolation Room Audit
The audit is conducted as a one day spot check and demonstrated that at the time of the audit the Trust was allocating its isolation rooms appropriately as all patients deemed to be an infection risk were nursed in side rooms. Where patients were in side

rooms who were not deemed to be infectious this was also appropriate as they were in the rooms for either privacy and dignity reasons or based on clinical need of the patient. At all times the IPACT are monitoring and ensuring, with the cooperation of the ward staff, that all patients deemed to be high risk are isolated as per Trust policy and where this is not possible risk assessments are completed with the advice of the consultant microbiologist to minimise any risk to both the patients and staff.

MRSA screening

Monthly audits are undertaken to ascertain the level of compliance with Trust policy for the mandatory screening of all elective and trauma in-patients.



MRSA Decontamination Audit

The aim of this audit is to establish Trust compliance against the decontamination protocol within the MRSA policy. This audit was conducted retrospectively, looking at the notes of all patients newly confirmed positive in January 2019. A total of 12 patients were audited of which 5 were planned admissions and 7 were emergency admissions. Three were in patients, three were day case patients and five were outpatients and one patient was to come in for operation date to be confirmed. All were admitted from home except one patient from a care home. Three had a previous MRSA history, three did not and six were unknown. Four patients had nose and groin swabs only. Five patients had nose, groin and wound swabs. One patient had nose and perineum swabs and two patients had wound swabs only (these were a paediatric and MIU patient so wouldn't routinely be screened nose and groin). The results show that improvement is still required around documentation and including microbiology results in the patient's notes. There is still some work to be done around use of universal precautions as often swabs taken on day of admission will not yield results until the patient has been discharged however IPACT promote standard precautions including hand washing and the use of PPE with all patients. Management of MRSA positive patients is incorporated into the annual clinical training sessions and the IPACT are attending departments to give localised training to ensure staff are aware of the correct procedure to follow.

MRSA Screening Audit of High Risk Patients

The audit was conducted as a one day snapshot, looking at all the patients currently admitted to any ward in the hospital, and comparing the date of their MRSA screen to the available information on them, taken from the trauma card and from Patient Centre, to ascertain if they were classed as high risk and therefore if they were screened as per policy. During this audit all patients were reviewed to ascertain if they had been screened as per policy for MRSA.

On the day of the audit there were 52 patients admitted to the hospital. Of these 12 were identified as being high risk. Out of these 8 were screened as per policy, this equals 66% compliance. A significant decrease from the previous audit of 80% Additional training is to be delivered by the IPACT through attendance at departmental meetings. IPACT will re-audit sooner than 12 months to monitor compliance.

Cleaning chart, mattress and documentation spot check
Overall areas appear clean and tidy. Cleaning charts that are for the Nursing staff are often not fully completed and staff in each area were spoken to at the time and reminded to complete these daily.

Environmental Audits
Environmental audits continue to be covered by the PLACE inspections. Resulting action points are logged on to the Estates Piranha system, prioritised and carried out by the Estates Department. It is the responsibility of the Department Mangers to ensure all actions for their area are completed and they must then inform Hotel Services all actions have been done.

Infection control issues noted include:
- De-cluttering of departments
- Repairing floor damage and an ongoing need for general repair and redecorating of the hospital structure
- General cleaning

Sharps Box Audit
16 Wards/Departments were visited during the audit and 128 sharps containers were sighted. The audit found 0 sharps containers with protruding sharps, 12 that were not properly assembled, (these were immediately assembled properly and staff were informed that sharps containers which were not assembled properly could lead to the lids coming off if dropped or during transportation) and 0 that were more than three quarters full, 0 sharps container had the wrong lid on the wrong base. 1 sharps containers were sited on the floor or at an unsuitable height or place, staff were advised to have them bracketed if possible or remove them from public areas. 2 containers were sighted with the label not fully endorsed. 0 sharps containers had significant inappropriate non sharp contents.10 sharps containers did not have the temporary closure in place when the container was left unattended or during movement. Small sharps containers and trays were available to take to the bedside. All results are an improvement on the previous year's audit.

Patient bedside equipment
A Trust wide check of the patient's bedside furniture including the lockers, armchairs, foot stools and over the bed tables was carried out as a one day spot check. The aim of the audit was to ensure all bedside equipment was clean, intact and fit for purpose. For example, not chipped or split which could inhibit cleaning and potentially create an infection control risk. During the audit some equipment was not able to be viewed due to patient activity. In these areas the nurse in charge was asked to check the equipment and report any concerns to the Infection Control team. In the Burns unit the patient's bedside lockers were looking worn through repeated cleaning. The edging strips had come off leaving exposed wood. All the lockers in this unit will need to be condemned and replaced as soon as possible, all other equipment sighted in the ward was clean and intact. In Peanut ward all patients' bedside equipment was, clean and intact. Sleep Studies has domestic bedside tables as well as standard hospital lockers. Sleep Studies are to replace the bedside tables with hospital approved ones as soon as possible. All other patient's bedside equipment was clean and intact. None

of the beside equipment is labelled in Sleep Studies as it was decided by the Infection Prevention and Control Team that this area was such a low risk area for outbreaks there is no need to label the equipment. In Ross Tilley and Margaret Duncombe. All the equipment sighted was intact however some of the tables and chairs were missing the number labels. Also the patient's bedside chairs were very faded and worn, and whilst they are intact they do not look good. Ideally these will need to be replaced. The bedside tables are in need of replacing.

Sink audit
Minor Injuries Unit, OPD, Pre-assessment, Peanut Assessment Unit, Rehab Unit, Photographic, radiology, Admissions Lounge, Peanut, Sleep, Main theatre including recovery, Rowntree and Maxillo Facial Unit all compliant with current guidance.
The Burns Unit and C Wing are no longer compliant as they only have one wash-hand basin per bay (they were compliant with guidance at the time of building). This has been mitigated by the placement of portable sinks in the Burns Unit and alcohol gel in the other areas. Ross Tilley bays contain six beds, Margaret Duncombe and Burns bays contain 4 beds. All single rooms, clinical rooms and sluices in the Trust comply with current guidance. In addition to the clinical sinks all wards and departments have alcohol gel at the ward entrance/exit, in the corridors and at each bedside.
The exception is Peanut Ward due to the nature of the patients; personal tottles are available to staff should they require them. Portable sinks are available as required.
Estates are aware to ensure all new builds and refurbishments comply with current HTM requirements on sink allocation. All projects are reviewed by IPACT before being open to use and sink inspection is part of this assessment therefore it has been agreed by the Infection control group that there is no need to audit sinks on annual basis.

Infection prevention and control policies, procedures and guidance for QVH staff and patients
IPACT have developed guidance for the organisation, staff and patients in the form of policy, procedures, protocol, guidelines and leaflets. All documents are placed on Qnet. All documents have been systematically reviewed and updated in collaboration with relevant services and governance groups (see Appendix C).

IPACT have produced information for patients about the main infection prevention and control issues which are generally raised. These are Pandemic Flu, Norovirus, MRSA, MRAB, Hand Hygiene, Group A Strep, GRE, and CDI. All these leaflets are available for the public and have been updated and approved by the patient information group.

The QVH Infection Prevention and Control team are available to speak to any patients, visitors or staff if they have any concerns about infection.

Local peer review and assurance processes
QVH has a case peer review system in place in the Burns Unit. Meetings to discuss cases occur every Monday (except Bank Holidays). These meetings review injury mechanism and explanation, treatment, risk assess, discuss any Infection Prevention and Control issues and agree actions required.

The purpose of these groups is to strengthen communication and dissemination of infection prevention and control information and practice across the organisation. The meeting is attended by the Consultant Microbiologist and the ICN's when capacity permits.

Influenza arrangements

During 2018/19 support has again been given to the management of influenza (flu), with the ICN's encouraging vaccination of staff within the annual flu vaccination programme. Uptake for the flu vaccination was higher than in previous years with an uptake of 61.3%. this is an improvement on the 2017/18 figure of 59.2%. As with last year, a CCG locally agreed variance to the CQUIN allowed us to include all staff officially declining the vaccination producing a final figure of 80.4%, exceeding the target of 75%.

The Emergency Planning Lead and the infection control nurse continue to co-ordinate the FIT testing programme for clinical staff to ensure safe practice is delivered, update the emergency plan and submit the Trust vaccination data as this is a mandatory requirement.

ImmForm Data Submission			% of staff group headcount
All Doctors	169	66	39.1% 6.7%
Qualified nurses	186	129	69.4% 13.0%
All other professional qualified	141	96	68.1% 9.7%
Support to clinical staff	493	315	63.9% 31.9%
ImmForm	989	606	61.3%
CCG	989	795	80.4%

Untoward Incidents including Outbreaks

This is a summary of events with further details having been included in the Infection Control quarterly reports.

<u>April 2018 to June 2018</u>

- MSSA bacteraemia: patient admitted to Burns on the 01/05/18 Blood cultures sent on 06/05/18 returned MSSA positive. Treatment discussed with the consultant microbiologist. Source probable contaminant.
- MRSA bacteraemia: patient admitted to CCU on the 13/05/18. All MRSA screens on admission returned negative. Routine MRSA screens sent on the 20/5/18 returned MRSA positive with a health care associated (HCA) MRSA. Following routine dressing change on the 25/5 patient spiked a temperature. When reviewed 24 hours later a blood culture was sent which returned MRSA positive. On investigation this was deemed to be a contaminant as there was no requirement to send the sample and the patient was not clinically unwell.
- Three patients identified as having HCA MRSA colonisation whilst being seen in EBAC. On investigation all strains are different therefore not cross contamination. Whilst all declared as hospital acquired and RCA's completed for each patient the investigations showed that there is the possibility the patients acquired the MRSA whilst in the community between their clinic appointments.
- Outbreak of MRSA declared 18/6/18 following three cases of HCA MRSA colonisation within the CCU. All 3 have the same antibiogram. Index case identified who tested positive to the same type of MRSA on admission. Enhanced infection control precautions implemented within the CCU and Burns unit.

Outbreak meetings held and no further cases as of the end of June. Situation monitored.

July 2018 to September 2018

- Four further patients identified during July with the same strain of MRSA. All samples sent for typing which confirmed they were the same MRSA with PVL toxin gene attached. Outbreak meetings held weekly. PHE, CCG and HPA kept informed of outbreak situation and actions being undertaken. Decision made to close the Burns unit, CCU and EBAC on the 23/07/18 and commence staff screening. All units double deep cleaned and environmental swabbing completed. Units reopened on the 7th August. 3 members of staff identified as MRSA positive but only 1 had the outbreak strain. All decolonised before being allowed to work clinically. Staff member with outbreak strain monitored closely by the ICN and occupational health. No further patients identified during August and decision made to close the outbreak on the 10/09/18.
- E.coli positive bacteraemia identified in a CCU patient. Patient transferred to ITU at Brighton. Infection control team at Brighton informed of the result.

October 2018 to December 2018

- One patient admitted to the Burns unit with multi drug resistant acinetabacter (MRAB) in their wound. Patient isolated on admission with full infection control precautions in place.

January 2019 to March 2019

- Patient admitted from BSUH who had sustained an injury whilst abroad. Patient highlighted as being at high risk of carrying CPE and correct precautions implemented on admission. CPE screening commenced. One swab returned positive to a fully resistant strain of Klebsiella, meaning there are no antibiotic treatment options for this organism. The patient is currently not clinically symptomatic of infection and is classed as colonised as the organism has only been found in the rectum and not in the wounds. Information given to the patient on the organism and good hygiene practices. Ward staff spoken to by the Infection control nurse and consultant microbiologist however this information was not relayed to the Plastic dressing clinic staff by the ward on the discharge of the patient. The ICN met with the matron for PDC and documented full instructions in the patient's notes.
- Positive blood culture result showing pseudamonas from a Burns inpatient. RCA completed which has highlighted areas of improvement. These include improvement in documentation, improvement in insertion technique and review of whether staff are taking samples appropriately. The infection control team will feedback the learning needs to the clinicians and nursing staff.

5. Involvement and Engagement

Antimicrobial report

This report is compiled and published by the antimicrobial pharmacist as a separate document.

Decontamination and disinfection report

Routine decontamination of nasendoscopes and specific theatre equipment continues through the Wassenburg (endoscope washer disinfector). Routine water testing and servicing of the wassenburg has been performed which has shown no problems or concerns. The Trust continues to have an AE from an external provider who conducts the annual audit and ensures compliance with national guidance.

Steris continue to provide the Trust with sterile services for all reusable equipment that cannot be processed through the wassenburg machine. They are an accredited company licensed to perform sterilisation for healthcare premises in line with national guidance and requirement.

Monthly meetings are held with Steris to ensure compliance with national sterilisation guidance and to monitor the contract.

All decontamination reports and audit results are taken to the Decontamination group meeting which has now been incorporated into the quarterly infection control group meeting.

Decontamination roles

The Lead Infection Control Nurse undertook the official Decontamination course in April 2018 to assume the role of Decontamination lead for the Trust and has been supported by the previous decontamination lead who will remain the lead for theatres. Sterile services is overseen by a member of the theatre supplies team and the management of the Wassenburg is overseen by a member of theatre staff.

Facilities report

In the last 6 months, the work has progressed to align the cleaning services with the National Standards of Cleanliness (2007). The daily cleaning checklists with 49 elements (items of cleaning as appropriate), area risk rating, audit frequency, corrective actions and deep cleaning programmes have been based on this national guideline. This provides greater assurance on uniformed cleaning methods and monitoring. The audit scores are presented at the monthly Estates & Facilities Steering Group.

Month	Cleaning Audits to be carried out	Cleaning Audits completed	Comments
April 2018		74 (13 re-audits)	Concerned area is public toilets
May 2018	69	76 (5 re-audits)	Concerned area is public toilets. The concern is that they are old and tired looking. They are being looked at being refurbished shortly
June 2018	80	89 (9 re-audits)	Trauma clinic failed, additional training given to staff member

July 2018	67	67 (10 re-audits)	No failed areas
August 2018	68	61 (3 re-audits)	Margaret Duncombe and Ross Tilley both failed audits, due to staff being deployed to Burns for outbreak cleaning
September 2018	79	83 (4 re-audits)	No failed areas
October 2018	64	60 (6 re-audits)	Rowntree failed, due to lack of staff
November 2018	70	71 (1 re-audit)	Rowntree failed, additional hours given to bring back up to standard
December 2018	79	85 (6 re-audits)	Theatres failed, due to curtains out of date. They were replaced immediatley
January 2019	67	71 (4 re-audits)	Theatres failed due to nursing cleaning issues
February 2019	68	68 (4 re-audits)	No failed areas
March 2019	68	68 (3 re-audits)	Public toilets failed, however they are now on a 3 phase work project to be refurbished.

Estates report – Associate Director of Estates
IPACT continues to work closely with the Estates department and are consulted on infection control issues as well as project works. Examples are;

- Carpet replacement programme in all clinical areas for 2019 is currently under review.
- General maintenance and improvement of facilities across the site including:
  - Refurbishment of all public toilets.
  - Part refurbishment of Hospital street.
  - Re-surfacing of Radiology & MIU car parks.
  - Re-development of Radiology department (cone beam rooms & CT scanner).
  - Installation of replacement radiator cabinets within Canadian wing.
  - Refurbishment of Surgeons Mess.
  - Site wide direction signage upgrades.
  - Numerous upgrades / replacements to existing fire doors.
  - Installation of Staff zone adjacent to Theatres.
  - Installation of new bed store adjacent to Canadian wing.
- Urgent works following poor weather conditions during winter freeze
- Urgent works following outbreaks
- Legionella monthly water sampling programme
- Pseudomonas 6 monthly water sampling programme.
- Project Works (as above)

Water Safety
The Trust continues to take monthly water sample (Approximately 25 tests per month) for the monitoring of legionella Pneumophila bacteria within the domestic water supplies. This work is undertaken by TSS and their attendance and performance continues to meet expectations.

All outlets are inspected for the presence of flexi pipes / dead legs / blind ends. Any

defects identified are rectified e.g. flexi pipes removed & replaced with copper hard piping. Dead Legs / blind ends to be removed as far as practically feasible. All sensor taps removed & replaced with manual equivalent (Markwik 21+) tap sets.TMV valves located and cleaned / chlorinated.

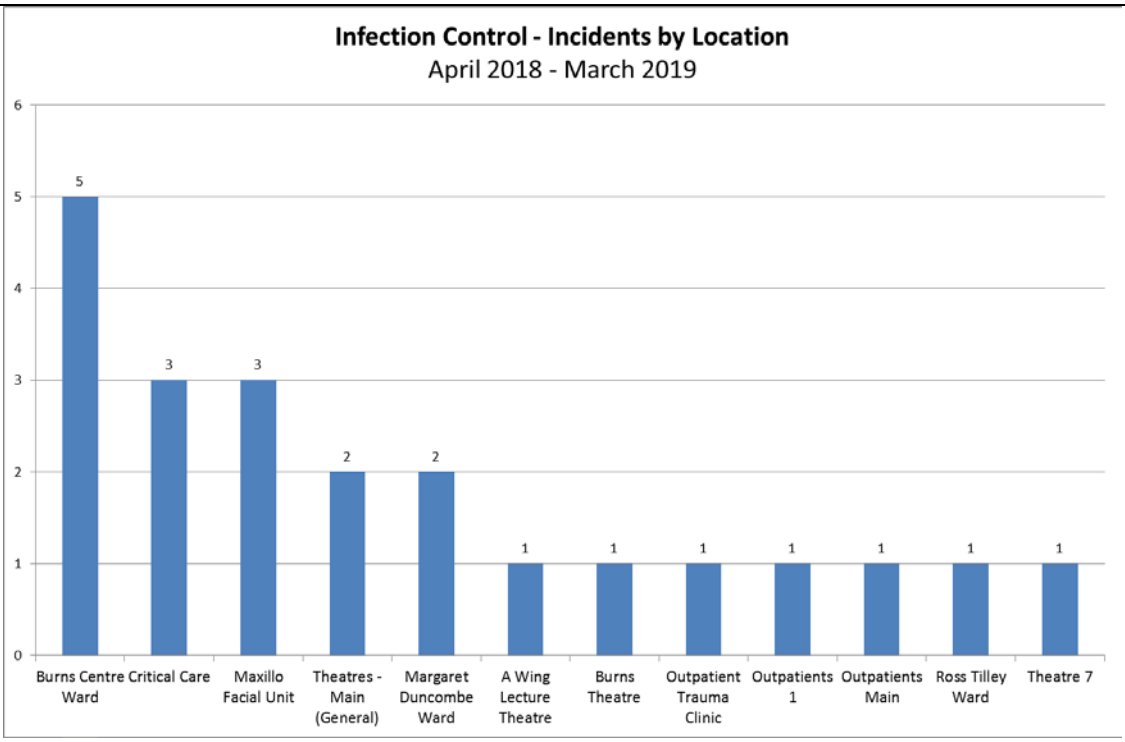
All Legionella sampling from November 2018 to April 2019 have all returned negative.

Pseudomonas samples taken in October 2018 & April 2019 have all returned negative.

The Trusts Water Management Policy has been reviewed & updated accordingly. The policy is now being reviewed by the Trust AE.

The Trust Pseudomonas Risk Assessment has also been updated

Infection Control Risks and incidents.
The ICN's receive notification of any suspected Infection Prevention and Control incidents via the Datix reporting system. The ICN's respond to each Datix report. The response may be in the form of advice or it may trigger further investigation. This activity allows the lead ICN to maintain oversight of all Infection Prevention and Control incidences
There were 22 Infection Risk Incidents reported on Datix for the period 1st April 2018 to 31st March 2019. Incidents reporting in this time period varied greatly. Some were in relation to patients being identified with an infectious organism, some around cleaning or lack of cleaning supplies, some around PPE usage.
Each risk identified on the Datix system is investigated by the ICN. Some risks require no input as they are dealt with at the time and entered onto the Datix system as a formal record, for example a case of a hospital acquired infection.
Each risk is reviewed and appropriate action taken if require by the IPACT or through an alternative department.



Contract monitoring -Sussex CCG Infection Prevention and Control Standards
CCG's as commissioners of local health services need to assure themselves that the organisations from which they commission services have effective Infection Prevention and Control arrangements in place. A self-assessment tool is completed annually and contributes to providing evidence of assurance in conjunction with assurance site visits and submission of audits as part of an audit programme.

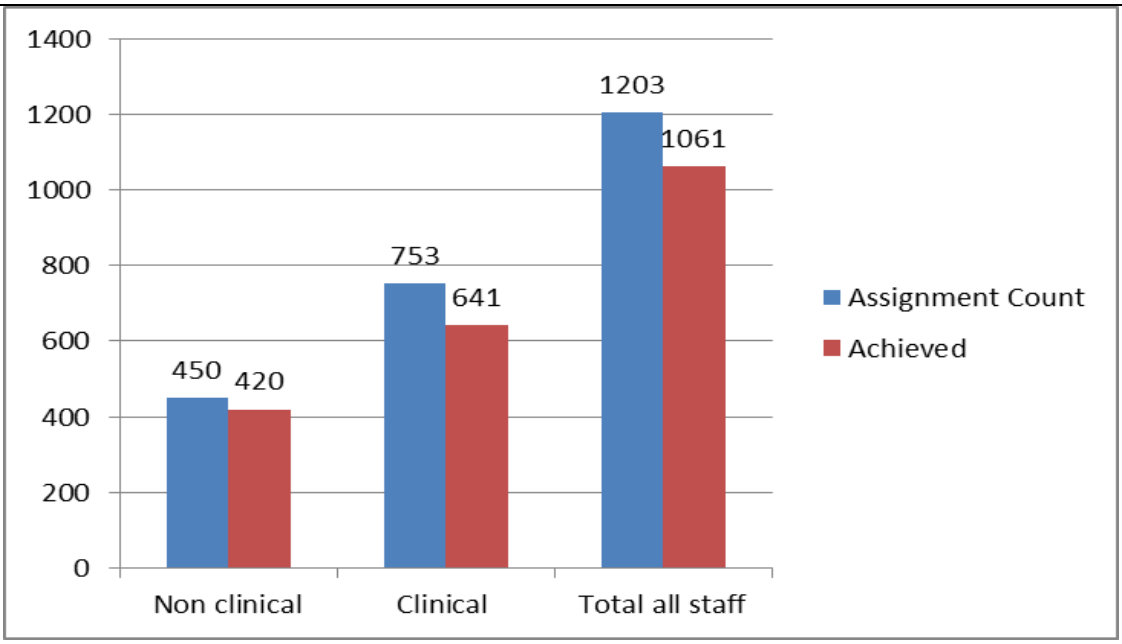
The commissioners were kept informed of the outbreak situation within CCU and Burns during the period of June-September 2018. They were advised of all actions being undertaken including ward closures, staff screening and positive patient numbers.

CCG exception reports are provided by QVH in April, July, October and January of each year. No areas of concern were noted.

Infection Prevention and Control mandatory training

Compliance as at 1 April 2019

Staff group	Assignment Count	Achieved	Compliance %
Non clinical	450	420	93.33%
Clinical	753	641	85.13%
Total all staff	1203	1061	88.20%



The infection control teams delivers all scheduled mandatory training sessions and offers staff the option of undertaking ward based or one on one training to ensure as many options for training are made available to staff as possible.
The infection control team attend departmental meetings to deliver additional infection control training and attend at night to ensure that the staff who work night shifts are able to achieve compliance with infection control training.
Infection Control with continue to work with the staff development co-ordinators to increase the percentage of staff compliant with mandatory training.

6.	Learning from Experience
	Patients and staff can be put at risk by failure to adhere to good infection control practice. The Trust continues to strive to improve compliance with all aspects of Infection Control in order to safeguard the patients, service users and staff through a robust programme of education, audit and reporting. Whilst the rates of both reportable and non-reportable infections remained low there is still improvement to be made. Most notably in relation to compliance with MRSA screening, compliance with hand hygiene and bare below the elbows and appropriate prescribing and usage of antibiotics. Improving compliance with antibiotic usage and maintaining excellent standards of hygiene both personal and environmental ensures the risk to patients and staff from hospital acquired infections remains as low as possible. The infection control team will continue to champion and promote the implementation of infection control to all staff in all departments with the emphasis on 2019/2020 programme being reinforcing compliance with infection control. This will be done through utilising multiple methods of engaging with staff to ensure they not only comply with infection control policies and practices but that they understand the importance of maintaining excellent standards at all times and for all patients. The infection control team aims to increase departmental based inspections, offer a variety of events for staff to learn more about infection control and ensure that the infection prevention and control team is a visible and constant presence within the Trust that is there for all staff to access to support compliance with infection control standards.

7.	Recommendations
	This report has evidenced the challenges faced for the trust's Infection Control team through the use of audit, training and engagement with key service providers across the Trust. The results of these have shown that overall, compliance with National guidance, Trust policy and National targets is good although there is still some improvement required. Looking forward, using the experiences and knowledge gained throughout the last financial year, further targeted work could be undertaken to improve the internal structure of key clinical areas. Additional education and training is indicated in the management of patients with specific organisms

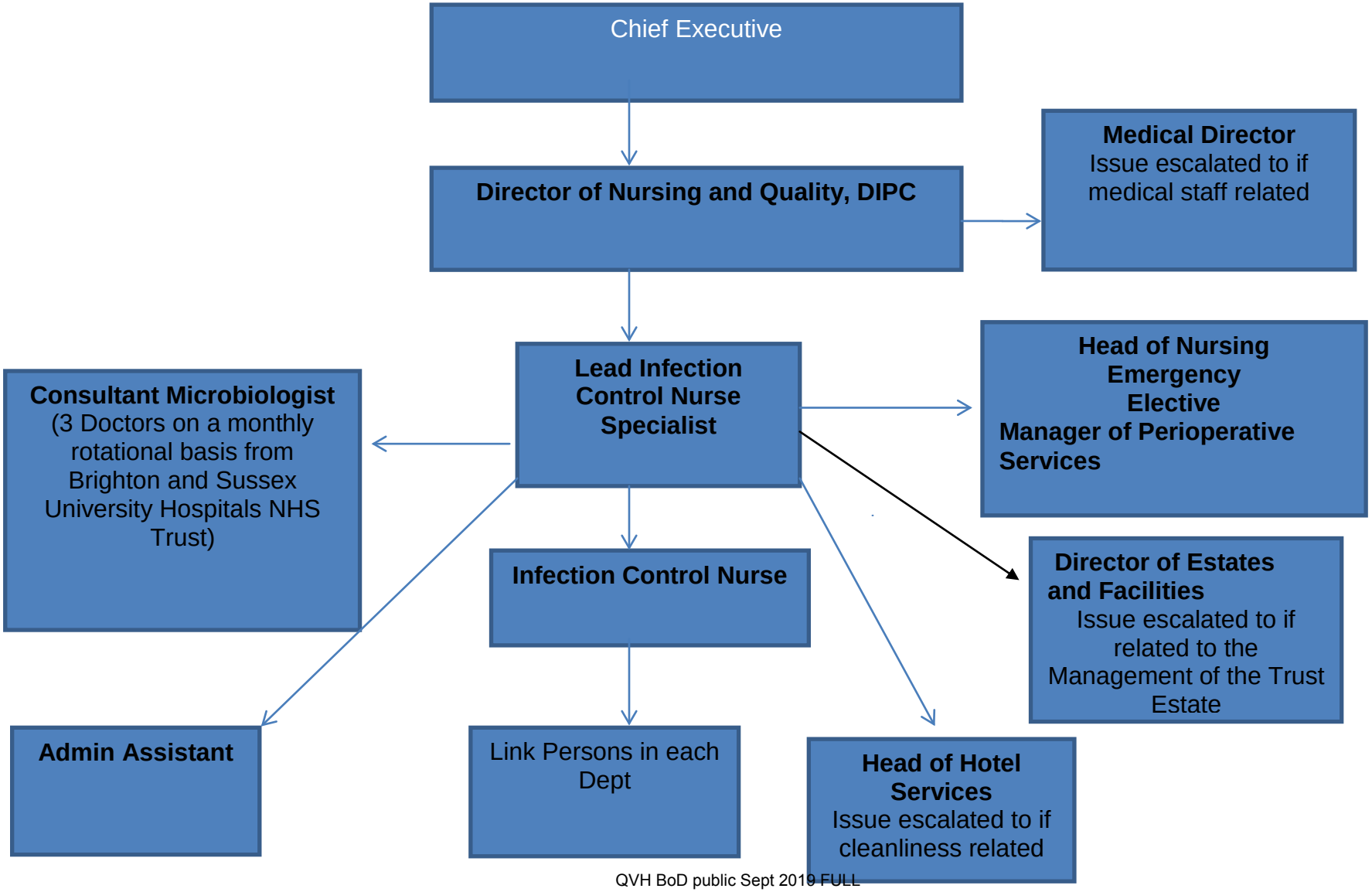
8.	Future Plans and Targets
	For the financial year 2019/2020, the aim of the Infection Control team is to increase our profile across all departments and service providers within the Trust. To allow staff to engage with the team in a variety of ways to promote an open, cohesive approach to Infection Control in order to increase compliance with all aspects. We plan to use a variety of strategies to achieve this including awareness events, increased visibility in clinical areas, acknowledging and rewarding exemplary practice shown by individuals or teams in support of Infection Control. By working closely with our Estates and Facilities team, we aim to formulate a current list of areas within the Trust that require improvement or maintenance to ensure a safe, clean environment in which to care for our patients. This list will be used to formulate a realistic and sustainable programme of work.

9.	Conclusions and assurance
	This report demonstrates the systems and processes in place to ensure that the trust meets the requirements of the Health and Social Care Act (2008): Code of Practice for the NHS on the prevention and control of healthcare related guidance. The completion of the infection control audit programme, teaching and alert organism surveillance is a proven method of achieving high standards across the trust and it is the ICN's implementation of this that ensures assurance processes are focused on patient, visitor and staff safety as a priority. This is done through the writing and implementing of policies in line with best practice guidance, a robust audit process and programme of education and staff engagement which has been detailed in this report. This has assisted in maintaining the Trusts low rate of healthcare associated infections across all departments. QVH also promotes feedback from patients and encourages them to raise concerns about any Infection Prevention and Control issues they see and are worried about. QVH has a range of internal assurance processes in place. An overview of Infection Prevention and Control activities in QVH are in place. The ICN's also works closely with the CCG ICN to provide reassurance on processes and practice within the trust. QVH has an overview of all relevant Infection Prevention and Control information and documents, which are systematically developed, reviewed and/or updated. QVH has local external regulation undertaken by the CCGs. Monitor ensures QVH are registered with the CQC. Local Infection Prevention and Control peer review and assurance processes are in place. IPACT are well supported by the Director of Nursing/ DIPC. QVH staff are guided and supported by the specialist Infection Prevention and Control clinicians. The QVH Infection Prevention and Control team present this report to provide assurance to the Board that the Infection Prevention and Control agenda is robustly overseen and managed within the trust and with partners. To conclude, the Infection Control Team believes this annual report accurately reflects the commitment and achievements of the infection prevention and control service in the trust. Looking forward to 2019/20, prevention of healthcare associated infections will remain a priority for the infection control team at QVH. The ICNs will continue to work to a robust annual programme of work to help ensure that a high standard of infection control service continues at the trust.

10.	Report approval and governance
	The Board is asked to consider the contents of this report and raise any issues of concern or outline any specific action they request.

11.	Appendices

APPENDIX A **Infection Prevention and Control Structure Chart 2017/2018**



Appendix B
Infection Control Annual Programme Objectives for 2019/20

Infection prevention and control continues to be a top priority at both National and local level. The IPACT, under the direction of the DIPC and with the full support of the Board of Directors and Governors, will continue to ensure that the highest possible standards in infection prevention and control are applied and achieved at the QVH.

This action plan contains new areas of activity and a number of on-going areas of particular importance. A large amount of activity is on-going and not included in the action plan.

Department	Section	Action	Frequency
Microbiology	Management	Continued review of pathology provider to ensure safe and efficient service delivered	On-going
Microbiology	Management	Continued review of pathology provider IT systems, e.g., the provision of electronic reporting in a useable, reliable format and request for regular list of blood cultures taken	On-going
Microbiology	Management	Continued review of antimicrobial prescribing	On-going
Microbiology	Management	Maintain input into Clinical Audit Meetings and Consultant mandatory training	Quarterly
Microbiology	Management	Maintain input into the review of any new Estates project from start to finish	On-going
IC	Management	Continue to review the Board Assurance Framework related to the Health and Social Care Act (2010)	Quarterly
IC	Management	Quarterly IPACT report for Board	Quarterly
IC	Management	Decontamination Lead to continue monitoring of decontamination of equipment in conjunction with the decontamination staff within Theatres	Ongoing
IC	Management	Review policies in line with DoH and NICE National guidance and Trust timescale	As required
IC	Management	Continued attendance at external meetings and Infection Prevention Society annual conference	On-going
IC	Surveillance	Continue mandatory surveillance and reporting in line with DH requirements including MRSA, MSSA, *C. difficile* and *E. Coli*	Monthly
IC	Surveillance	Enhanced surveillance (RCA/PIR) of *C. difficile*, MRSA, MSSA and *E. coli* bacteraemia	When new case identified
IC	Surveillance	Continue speciality specific surgical site infection audit	Annual
IC	Audit	Audit sharps policy compliance	Trust wide annual
IC	Audit	Continue hand hygiene audit and compliance	Monthly
IC	Audit	Continue to review external contracts e.g. laundry	As required
IC	Audit	Continue to implement the DH Saving Lives audit programme	On-going
IC	Audit	Continue PLACE inspections	Monthly
IC	Audit	Audit compliance with MRSA policy	Twice

		Audit compliance with MRSA screening	yearly Monthly
IC	Education	Updates for Clinical Practice Educators / Department Managers / departments	As required
IC	Education	Mandatory training: Clinical Non-clinical Induction Junior doctors Consultants	X2 month X1 month X1 month X6 year X2 year
IC	Education	Link person training	quarterly
IC	Education	Infection control awareness week	Annual
IC	Education	Hand hygiene roadshow	Annual
IC	Education	Hand hygiene training	On-going
IC	Education	Deliver training to staff on current issues and attend department meetings on request	As required
IC	Education	Relaunch the infection control team to promote compliance with infection control trust wide	As required
Estates	Management	Involvement in the Capital Programme	As required
Estates	Management	Review of estates policy and new guidance	As required
Estates	Management	Involvement in reviewing water sampling and ventilation results	As required
Estates	Management	Involvement in the prioritising of general refurbishment works within the Trust	As required
Estates	Management	Update for IPG	Quarterly
Estates	Audit	Waste facility	Annual
Decontamination	Management	Review of decontamination and disinfection policy	As required
Decontamination	Management	Update for ICC	Quarterly
Decontamination	Management	Formalise Decontamination structure and roles within the Trust	As required
Decontamination	Management	JAG audit	Twice a year
Decontamination	Audit	Synergy service	Annual

Appendix C

IC Policies Ratified April 2018 – March 2019

Reference	**Title**	**Lead Director**	**Ratifying Committee**	**Ratified Date**	Review Date
IC.7001.5	Introduction to Infection Prevention and Control	Director of Nursing	Infection Control Group	02/05/2018	**02/05/21**
IC.7002.6	Hand Hygiene	Director of Nursing	Infection Control Group	02/05/2018	**02/05/21**
IC.7007.5	Isolation policy	Director of Nursing	Infection Control Group	02/05/2018	**02/05/21**
IC.7010.6	Management of patients with clostridium difficile	Director of Nursing	Infection Control Group	02/05/2018	**02/05/21**
IC.7026.4	Management of staff with MRSA	Director of Nursing	Infection Control Group	02/05/2018	**02/05/21**
IC.7027.3	Guidelines for the control of Varicella zoster virus infection. (Chickenpox policy)	Director of Nursing	Infection Control Group	02/05/2018	**02/05/21**
IC.7021.4	Procedure for the collection of Microbiology specimens	Director of Nursing	Infection control group	02/08/18	**02/08/21**
IC.7019.4	Guidelines for the management of headlice	Director of Nursing	Infection Control Group	02/08/18	**02/08/21**
IC.7003.4	Personal Protective Equipment Policy	Director of Nursing	Infection Control Group	02/08/18	**02/08/21**
IC.7020.4	Guidelines for the management of scabies	Director of Nursing	Infection Control Group	02/08/18	**02/08/21**
IC.7009.5	Decontamination and disinfection policy	Director of Nursing	Infection Control Group	11/10/18	**11/10/21**
IC.7017.5	Surgical Site Infection: guidelines for the prevention of	Director of Nursing	Infection Control Group	11/10/18	**11/10/21**

	surgical site infections				
IC.7012.5	Procedure for the management of spillage of blood and bodily fluid	Director of Nursing	Infection control group	11/10/18	**11/10/21**
IC.7014.5	Policy for the Prevention of Healthcare Associated Infection in Peripheral Venous and Arterial Cannulae	Director of Nursing	Clinical Governance Group	11/02/19	**11/02/22**
IC.7013.4	Policy for the Insertion and care of Central venous Catheters	Director of Nursing	Clinical Governance group	11/02/19	**11/02/22**
IC.7024.9	Management of Outbreaks	Director of Nursing	Clinical Governance Group	11/02/19	**11/02/22**
IC.7015.5	Management Of Patients with Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSEs)	Director of Nursing	Clinical Governance Group	11/02/19	**11/02/22**
IC.7016.4	Management of patients with Tuberculosis	Director of Nursing	Clinical Governance Group	11/02/19	**11/02/22**
IC.7008.8	Policy for the screening of patients for Meticillin Resistant *Staphylococcus* Aureus (MRSA) and treatment and management of MRSA positive patients	Director of Nursing	Clinical Governance Group	11/02/19	**11/02/22**

References

British Medical Association. 2009. *Tackling healthcare associated infection through effective policy action.* Available from www.bma.org.uk

Control of Substances Hazardous to Health Regulations 2002.

Curran, E.T. 2014. Outbreak Column 13: Nosocomial Staphylococcus aureus outbreaks (part 2 – guidelines). *Journal of Infection Prevention*. 15 (2): 69-73.

Available from http://www.hse.gov.uk/coshh/

Department of Health. 2008a. Clean, safe care – reducing infections and saving lives. http://antibiotic-action.com/wp-content/uploads/2011/07/DH-Clean-safe-care-v2007.pdf

Department of Health. 2008b. *Board to Ward. – How to embed a culture of HCAI prevention in acute trusts.* Available from www.dh.gov.uk/publications

Department of Health. *Health and Social Care Act 2010.* Available from www.dh.gov.uk/publications

Department of Health. 2012. *Choice Framework for local policy and procedures 01-06 Decontamination of flexible endoscopes* (series)

Department of Health. 2012. *Choice framework for local policy and procedures 01-01 Management and decontamination of surgical instruments (medical devices) used in acute care. Part A: the formulation of local policy and choices manual. Version 1.0: England.*

Health & Safety at Work Act 1974.
Available from http://www.hse.gov.uk/legislation/hswa.htm

HTM 2030. 1997. Decontamination of surgical instruments.
Available from http://www.reverseosmosis.co.uk/Documents/HTM0105bookletv2.pdf

National Audit Office. 2009. *Reducing healthcare associated infection in hospitals in England.* Available from www.tsohop.co.uk

NHS England. 2015a. *Clostridium difficile* infection objectives for NHS organisations in 2015/16 and guidance on sanction implementation.

NHS England. 2015b. Quality improvement and clinical leadership; Clinical audit. Available from http://www.england.nhs.uk/ourwork/qual-clin-lead/clinaudit/

NHS Estates. 2001, revised 2003 and 2004 – *Revised Guidance on Contracting for Cleaning* as *The National Specifications for Cleanliness*.

Public Health England. 2015. Seasonal influenza vaccine uptake amongst frontline healthcare workers (HCWs) in England. February survey 2014/15.

World Health Organization, 2015. Health care-associated infections - FACT SHEET. Available from http://www.who.int/gpsc/country_work/gpsc_ccisc_fact_sheet_en.pdf

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**152-19**	
Report title:	**Patient Experience Annual Report 2018/19**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Nicolle Ferguson, Patient Experience Manager				
Appendices:	None				
Executive summary					
Purpose of report:	The Patient Experience Annual Report 2018/19 presents a rounded picture of patient experience at QVH utilising direct feedback, triangulation of quality metrics and social media to learn from positive practice and areas where experience could be improved.				
Summary of key issues	This report covers the period of April 2018- March 2019. QVH received 54 complaints during this time which is 2 more than the previous year. The report includes analysis of the complaints. Key themes from complaints remain communication attitude and behaviour examples of actions taken address these issues are included in the report. Including within the report are details of the annual Friends and Family Test scores, which have sustained qualitative scores and also QVH is one of the highest responders to this national programme. The trust has sustained and improved performance in the CQC 2018 National Inpatient Survey which shows that we are one of 8 top performing Trusts.				
Recommendation:	The Board is asked to approve The Patient Experience Annual Report 2018/19 which was reviewed and discussed at Q&GC in July and August 2019; following 2 minor amendments full assurance from the committee was noted and the report recommended for submission to the Board and be published on the QVH website.				
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:	Links to KSO1, KSO2, KSO3, KSO4, KSO5,				
Corporate risk register:	Links to workforce and access and performance risks on CRR				
Regulation:	The trust adheres to Regulation 18 of the The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, which requires NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public.				
Legal:	As above				
Resources:	No new resource requirements identified to compile this report				
Assurance route					
Previously considered by:	**Quality & Governance Committee**				
	Date:	24/07/19	Decision:	The report was received and full assurance has been given subject to 2 minor amendments, report updated and was represented at the August Q&GC.	
Next steps:	To QVH Board for approval prior to publishing on trust website.				

Holtye Rd,
East Grinstead
RH19 3DZ

Patient Experience Annual Report

Queen Victoria Hospital NHS Foundation Trust

Report covering the period from
April 2018 to March 2019

Document Control: Quality and Governance Committee

Executive sponsor: Jo Thomas, Director of Nursing

Authors: Nicolle Ferguson, Patient Experience Manager

Date: July 2019

Type: Annual Report
Version:
Pages: 17
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1. Executive Summary

As has been extensively reported in the media the NHS continues to experience significant demands of its services, both in primary and secondary care, and Queen Victoria Hospital NHS Foundation Trust is no exception to this. In these increasingly busy times, it is essential that we continue to listen to those we care for and their families, to help us understand what we do well and to learn lessons and make improvements in those areas where patients and families have found their care to be below the standard we aspire to deliver.

Our Trust is committed to listening and learning from our patients. During 2018/19 we received feedback from patients on their experience of being treated and cared for at the Trust, from a wide range of sources including Friends and Family Test[1] feedback, national and local patient surveys, Patient Advice Liaison Service (PALS) enquiries and complaints.

This feedback provides us with a rich picture of patient experience while also offering insight into what matters to patients. Importantly, it allows us to develop plans for patient and public engagement and quality improvements.

The Patient Experience Manager and the teams responsible for Risk and Patient Safety are committed to ensuring that all information the Trust received about its care and services is used in a coordinated way to safeguard the quality of care received by our patients and their families. The Trust cares for large numbers of patients locally, the South East Coast as well as nationally, the vast majority have a positive experience. We seek to improve how we listen to and encourage our patients to tell us how they felt about their experiences, so that we can continue to improve the quality of the care and services we provide.

2. Introduction

Queen Victoria Hospital NHS Foundation Trust has as its vision 'to be amongst the best performing NHS Trusts in the country', with high quality care and excellent patient experience at the heart of all we do. We aim to provide our patients and their carers' with the best possible experience whilst they are using our services. This combined patient experience, complaints and Patient Advice and Liaison Service (PALS) annual report demonstrates how the Trust measures progress towards the ambitions set out in the Trust Key Strategic Objectives (KSO), focusing on KSO1 Outstanding Patient Experience. The report includes a summary of patient and carer feedback and actions and initiatives to improve patient experience during 2019-20. The Trust's Patient Experience Group (PEG), a sub-group of the Quality and Governance Committee, provides the direction to deliver the strategy.

PEG is chaired by the Director of Nursing & Quality and includes representation from the and Deputy Director of Nursing, Patient Experience Manager, Facilities Manager, Healthwatch, Learning & Disabilities Lead, Dementia Lead, two hospital Governors and two patient representatives. The group meets on a quarterly basis and receives regular updates on the Trust's patient experience survey results and updates on patient experience action plans.

All feedback is shared with the relevant ward or department to enable teams to share positive feedback and consider suggestions for improvements made by patients and carers.

[1] Friends and Family Test is a national survey used to measure patient experience

Each ward/ department has a 'learning from your experience' poster which is updated monthly to share the actions that have been taken as a result of patient feedback. The Trust

Participates in the national mandatory patient experience surveys co-ordinated by the Care Quality Commission. This feedback is valuable as it enables the Trust to compare performance with other Trusts throughout the country. Last year the Trust received feedback from the national inpatient survey. A summary of results from this survey is included in the report

The Trust adheres to Regulation 18 of the The Local Authority Social Services and National Health Services Complaints (England) Regulations (2009)[2], which came into effect in April 2009. The regualtations require NHS bodies to provide an annual report on complaint handling and consideration, a copy of which must be available to the public.

3.	Friends and Family Test

The Friends and Family Test (FFT) gives patients the opportunity to provide feedback to the Trust by way of responding to one simple question, how likely are you on a scale ranging from extremely likely to extremely unlikely, they would recommend the service to their friends and family if they needed similar care or treatment. The information gathered, which when triangulated with other forms of feedback such as complaints, can be used across services to drive culture of change, learning and of recognising and sharing good practice. The results if the surveys are received on a monthly basis and are shared at directorate, divisional and Trust Board level in the form of divisional dashboards.

3.1	How likely are you to recommend our ward/department to family and friends?

The response rate to the Friends and Family Test question for In-Patients who are 'extremely likely/likely' to recommend us to a friend or family during that period from Margaret Duncombe ward, Ross Tilley ward, Burns ward and Peanut ward is 41% (the national response rate target to achieve is 40% for inpatient returns).

Between April 2018 and March 2019, we received 34,148 responses to the FFT, with over 28,564 comments given. The overall percentage of inpatients recommending (Extremely likely or likely) was 99%

As with previous years, the vast majority of our patients are more than satisfied with the high standards of care they receive, citing the friendliness, helpfulness, excellence, clinical outcomes, professionalism and overall very positive patient experience.

Where patients felt their visit could have been improved, cited communication and waiting times in clinic as their main concerns. Of the other suggested improvements, the majority concerned issues relating to their clinic experiences while waiting, such as the availability of refreshments, communication about waiting times and processes.

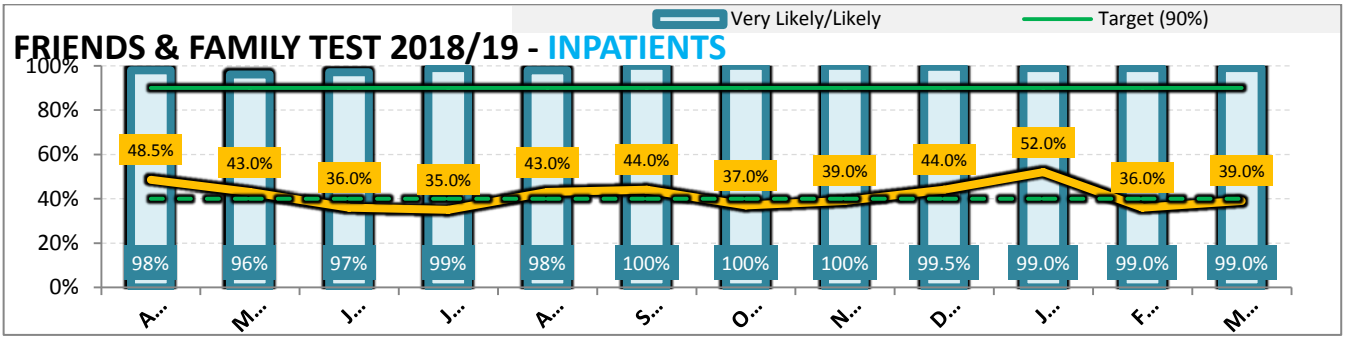
Other issues concerned parking, staff behaviour and appointments management. The Patient Experience Group will monitor improvements against the issues raised over the coming year.

[2] NHS England & Social Care England. The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009)

The following figures show the Friends and Family Test inpatient recommended rate:

Inpatients	2018/19	National average 2017/18
QVH recommended rate	99%	96%
QVH response rate	41%	24%

The following chart show the breakdown per month for patients admitted as inpatients:



4.	National Inpatient Survey 2018

The latest national NHS inpatient survey shows that QVH continued to achieve some of the best feedback from patients in the country. This year's survey carried out by the Care Quality Commission surveyed 76,668 people who received care at an NHS hospital in July 2018. The findings help the NHS to continually improve, enabling hospitals to see how they are doing year-on-year and how they compare with others.

Overall, QVH scored better than other trusts across all ten relevant sections of the survey – and we scored significantly better than other trusts for 48 of the 62 questions asked. Areas where QVH scored particularly highly were:

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, day case 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 (Johns Campaign is now fully embedded into everyday practice,

with carers able to stay with patients on the ward for as long as they wish, which has clearly had an impact).

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 being discharged
- Staff taking family/home situation into account when planning the discharge
- Written advice about medications
- Being asked about the quality of the care.

Improving discharge processes and patient's getting a choice of food continue to be priorities for the Trust. An action plan will be implemented and this will be monitored by the Patient Experience Group.

Eight acute trusts were classed as 'much better than expected' in 2018 including QVH as shown below:

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?'*.

5. Analysing the patient experience feedback

Analysis and triangulation of all forms of patient experience feedback, including complaints, results in the production of monthly detailed patient experience reports. These reports are then discussed at clinical governance group and quality and governance committee prior to public board. Exceptions are reviewed and actions taken, an example of this was targeting wards with lower inpatient feedback- discharge nurse and patient experience manager encouraged patients to provide feedback (which can be anonymous or named) and this was successful in improving response rates.

Developing an understanding of the patient experience by identifying and gaining knowledge of what people feel is crucial to the process of enabling the Trust to improve the experience of patients in our care. As a result of analysis, improving communication was chosen as a

patient experience initiative in 2018/19. To ensure that all patients/carers receive timely, clear and sufficient information that enables them to understand their condition and care, and make informed choices about proposed future treatment plans The Trust will continue to develop staff guidance on the importance of 'customer care' and excellent communication skills. A comprehensive cultural change programme is being developed and implemented to support our vision, values and behaviours. The principles of the programme will be integrated into existing programmes and incorporated into newly commissioned programmes.

5.1	Using the patient experience feedback

Receiving, analysing and presenting feedback and then involving users and staff in developing the solution completes the 'you said – we did' cycle.

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

Patient information: A patient told us that they needed more information within patient information leaflets having had a skin graft and who felt that the information they had been given was inadequate. The patient asked to see a copy of the leaflet that we send to patients regarding skin graft and has suggested that we might consider doing a leaflet about MoHs/bcc/skin graft.

The skin team in our plastic surgery department care currently reviewing all leaflets and the patients' suggestions and recommendations will be taken into consideration.

We offer a wide range of information to patients, relevant to their condition or treatment along with information about the Trust. We seek to consistently meet the Assessable Information Standard introduced by the CQC. Meeting this standard will improve the access to our services, how people experience our services, and the outcome that patients receive.

Patient information:
It was identified that there was no clear patient information boards on the wards. These are now in place on all wards, which detail our number of falls, infection control scores, FFT scores, 'you said – we did' etc.

The waiting times in clinic:
A full review of our outpatient services is currently being undertaken in an aim to achieve a streamlined process from point of receipt of referral through to admission for surgery.

6.	Patient Story at Board

The Patient Story at Board has been part of Trust Board agenda since September 2016. The main benefit is that it helps to ground discussions in the reality of patient care.

Patients are truly put at the heart of discussions as stories are powerful reminders of the context within which Board members are making decisions. Board members are able to see how their decisions impact on patients and carers, and help them to better understand the complexities of day to day life at an operational level.

The Patient Voice at Board is heard at the very start of most meetings before other items on the agenda. Board members have reflected that this is very valuable and reminds them of

the core business of putting patients, their carers and families at the centre of delivering high quality care.

It helps to highlight what the elements are of a good patient experience, directly from the patient/carer, and how we can replicate this across the Trust, but equally to address areas where there have been poor experiences and how the Trust can support staff with delivering improvements.

Over the last year, we have heard from a variety of patients, carers. From May 2018 to March 2019 there were four patients who came to board to tell their story in person.

7.	Patient Experience Group (PEG)

The group meet on a quarterly basis, chaired by the Director of Nursing and Quality, are the key vehicle for patient representation / participation, and the group is a formal, business/assurance group comprised mainly of Trust staff, patient representatives, dementia and learning disabilities leads and Healthwatch representatives. PEG is a sub-Committee of the Board's Quality & Governance Committee.

The role of PEG is to:

- Advise the Trust on issues of concern to patients
- Form patient/representative led working groups to help develop priorities for action and ensure regular feedback on outcomes of actions
- Help develop Trust strategies, appraise information for the public developed by the Trust and help determine priorities for patient engagement
- Consider service changes and participate in a range of schemes to gather patient/ carer intelligence on Trust services including surveys, walkabouts and ward visits
- Monitor trends in complaints and feedback
- Ensure the effective implementation of action plans arising from individual local and national surveys
- Share and promote good practice in connection with patient experience

PEG has continued to receive and comment on reports including complaints, feedback, patient experience reports and national surveys. The committee has received updates on key projects which impact on patient experience, including the outpatient improvement programme.

The group has also worked on cleaning audits and helped with the PLACE (patient led assessment of the care environment) initiative.

The outputs from PEG are discussed at the Quality and Governance Committee, a sub-committee of the Board. Also feeding the work of PEG are any care reviews or reports from Healthwatch West Sussex.

8. Complaints

In accordance with NHS Complaints Regulations (2009), this Annual Report provides detailed information about the nature and number of complaints Queen Victoria Hospital NHS Foundation Trust received, as well as feedback and concerns via the Patient Advice and Liaison Service (PALS). The Trust deals with complaints and concerns from patients and users, their relatives/carers, in accordance with its Complaints Policies and Procedures and the Care Quality Commission's (CQC) *Essential Standards of Quality and Safety.*

The Trust uses the following definitions:

- complaints are expressions of displeasure or dissatisfaction where the complainant wishes a formal investigation to be undertaken;

- concerns are issues that are of interest or importance affecting the person raising them, including displeasure or dissatisfaction and where the complainant is content for the issue to be dealt with via the PALS route;

- feedback is information/suggestions about care or services that we provide, which may be complimentary or critical;

- Compliments are expressions of thanks and praise.

The distinction between a 'concern' and a 'complaint' is challenging. Both indicate a level of dissatisfaction and require a response. It is important that concerns and complaints are handled in accordance with the needs of the individual, and investigated with an appropriate level of scrutiny.

Complaints are considered at a senior level in the Trust in recognition of their importance. The Chief Executive is the 'Responsible Person' under the 2009 Regulations and is signatory to all written responses, delegation in his absence is a member of the Executive team.

In order to ensure that complainants have access to appropriate support, as part of our complaints handling process, complainants are signposted to SEAP (Support Empower Advocate Promote) for help in making their complaint. All complainants are signposted to the Parliamentary and Health Service Ombudsman (PHSO) of the NHS complaints process in case they wish to take their complaint further.

The Trust has an integrated service – Complaints and PALS - to manage complaints, concerns and feedback in accordance with its Complaints Policy. This service is made up of one full time member of staff who manages the complaints, PALS and overall patient experience service. This member of staff also provides guidance, training and support to staff.

Being a single person service has some limitations on the service such as not always being able to meet the Trust standard of closing complaints in 30 working days or continuity of service during periods of leave(cover is provided by the director of Nursing's office during these times).

8.1	Standards for Complaints management and escalation

The Trust has standards for responding to complaints which comply with the statutory requirements for complaints handling published in the National Health Service Complaints Regulations (2009)1 and are based on the principles for good complaint handling as set out by the Parliamentary & Health Service Ombudsman (PHSO)[3] :

• Getting it right
• Being customer focused
• Being open and accountable
• Acting fairly and proportionately
• Putting things right
• Seeing continuous improvement

The Trust complaints response process builds from local acknowledgement, apology and resolution, through the Patient advice and liaison service (PALS) to the formal complaints process and response. The PAL Service aims to:

• Provide information and support to patients, their families and carers.
• Listen to concerns, queries, suggestions or views.
• Help to sort out problems on behalf of patients, their families and carers.
• Learn from experience about what the hospital gets right and where there is a need for improvement.

If resolution is not achieved by the service through the initial responses, or if the patient wishes to go straight to a formal complaint, the Patient Experience Manager will manage the complaint.

While the Trust aims to investigate and provide a response to any complaint within 30 working days, there are some complex complaints which can require much longer to provide a full response particularly if associated with a serious incident investigation or with multiple complex issues.

8.2	Complaints received

The time limit for making a complaint as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant.

All complaints are acknowledged within 3 working days. We aim to respond to all complaints within 30 working days in an honest, open and timely manner. If it is clear on receipt of the complaint or at any point during the investigation that the investigation cannot be completed on time, for example when a complaint is more complex or requires a joint response from services/organisations a new timeframe will be agreed with the complainant.

It again has been a challenge to achieve the 30 working day response timeframe particularly at times of increased clinical pressures and this has dropped slightly to 45% (previous year 50%). Many of the complaints closed outside of the agreed timescales were either complex ones which involved more than one service area or organisation, or those which raised

[3] PHSO Principles of good complaints handling (2009)

additional issues during the course of the investigation and complaint handling.

Improving the number of responses made within 30 working days will remain one of the top priorities for 2019/20 and was also a recommendation in 2019 CQC Inspection. This has been set as an objective for the Patient Experience Manager but will also require the prioritisation from staff assisting or cited in complaints investigations.

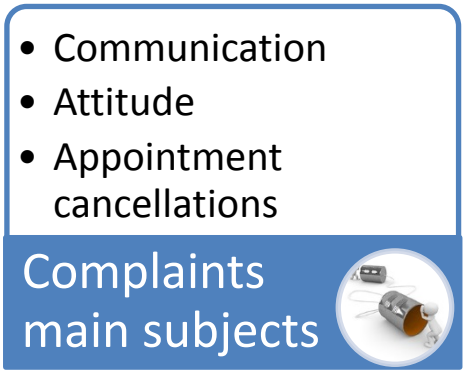
The Trust aims to remedy complaints locally through investigation and meetings if appropriate. However, if the complainant remains dissatisfied they have the right to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) as the final step of the complaints system.

The NHS complaints procedure is the statutorily based mechanism for dealing with complaints about NHS care and treatment and all NHS organisations in England are required to operate the procedure.

At Queen Victoria Hospital we aim to provide local resolution to complaints and take all complaints seriously. We listen carefully, we are open, honest and transparent in our responses and welcome the opportunity to do all we can to put things right. Our complaint system gives the opportunity for complainants to meet with managers/clinicians to discuss their concerns and we ensure that staff are made aware if concerns are raised about them and encourage them to look at ways they can change their practice or behaviours where appropriate.

Excellent liaison between the Patient Experience Manager with the Heads of Nursing and also maintains a close working relationship with consultants and matrons. This has enabled clinical staff to manage patient, family and carer concerns at an operational level and this is reflected in the reduction of informal concerns received. Concerns regarding communication have reduced and this is a reflection of work carried out by ward staff to include all required people in discussions regarding care and management plans.

During 2018/19 we received 54 formal complaints, which is 1 more than the previous year. To provide a context the 54 complaints represent 2.9 complaints per 1000 spells.



Under the NHS complaints regulations, the Trust is required to acknowledge receipt of complaints within 3 working days. Of the 54 complaints we investigated 50 complied with this requirement. The remaining 4 complaints were acknowledged as soon as possible, however, due to other complexities such as clarifying the address or gaining the necessary patient consent.

We take all negative feedback very seriously and our Chief Executive sees all complaints when they arrive and reviews all responses personally before they are sent. Complaints

handling and any trends or themes identified from them are shared and discussed regularly by the Executive Team and the Board of Directors.

8.3 Investigation outcomes

On completion of a complaint investigation we state whether a complaint is upheld, upheld in part or not upheld. Establishing if a complaint is upheld/not upheld can be complex, as often there are a number of concerns/allegations within an individual complaint, some of which may prove to be unfounded whilst other elements are.

Complaints received during 2018/19 included the following themes and whether the complaints was upheld, upheld in part or unsupported:

	Total number of complaints received	Complaints upheld	Complaints upheld in part	Complaints unsupported
Appointments/admission delay/cancellation	4	3	1	0
Access and waiting (waiting time in clinic/ward)	2	0	1	1
Admission/transfer/discharge arrangements	1	1	0	0
Attitude of staff	10	2	8	0
Communication/information to patients (written & oral)	6	3	3	0
Confidentiality	5	1	3	1
Consent to treatment	1	0	1	0
Discharge	1	1	0	0
Health records	1	1	0	0
Safe, High Quality Co-ordinated Care	1	0	1	0
Surgery treatment/procedure	9	1	4	4
Referral	1	1	0	0
Treatment (medical)	6	2	2	2
Treatment (nursing)	6	2	2	2
Total	**54**	**18**	**26**	**10**

- The eighteen complaints that were graded to be upheld included incidents relating to service failure. This is categorised for example as: appointment cancellations and communication.
- The twenty six upheld in part complaints were categorised as such because there were clear concerns about a patient's experience being poor. This included poor communication, certain aspects where care could be improved and expectations not being met.
- The ten complaints that were unsupported, as the investigation concluded that care and treatment provided was timely and appropriate.
- The assessment of the outcome of complaints as to status of upheld, not upheld or partially upheld continues to be developed.

8.4	Learning from complaints, concerns or feedback

In response to complaints raised, the Trust may take action to resolve the issue which may not result in improved systemic changes but would include, for example, the arrangement of a second opinion of a patient's diagnosis, a change of clinical team or consultant, issuing a formal apology if things have gone wrong or review of care plan and changes made where appropriate. The Patient Experience Manager raises individual learning points to staff directly or by attending and reporting to Clinical Governance Groups on a monthly basis.

Below are examples of actions and learning identified from complaints:

- Attitude of staff member; member of staff spoken to and communication skills training implemented
- Number of cancellations for clinic appointment; discussed with outpatient team importance of ensuring that cancellations discussed with consultant when patients appointments deferred as a consequence.
- Overall review and training in processing and monitoring urgent referrals
- Ensuring that a patients experience has been shared with a department
- Dementia awareness training attended by clinicians
- Staff reminded of guidance in relation to biopsy samples
- Process change in checking of x-rays in MIU

8.5	Further analysis of formal complaints

- None of the 54 patients who had raised a formal complaint, approached advocacy services to support them through the complaints process.
- The Trust received no requests for a complaint response in large print or brail.
- As in previous years, all formal complaints were received in the English language with no requests made by a complainant (or enquirer) for the assistance of the Trust's Interpreting Service.
- The Trust received no formal complaints where people stated that they had a learning disability nor did this become evident during any of the investigations.
- Of the 54 complaints, none of the complainants asked to meet with a senior member of staff on completion of the investigation.
- One external review of care was commissioned as part of the Trust investigation during 2018/2019.
- In line with the Duty of Candour (November 2014) the trust investigation responses have been scrutinised to ensure they are open and transparent. Where it has been established that errors occurred this was shared with the complainants and an apology given and lessons identified to enhance learning for the Trust.

8.6	Parliamentary and Health Service Ombudsman (PHSO)

The Ombudsman is the point of recourse for a complainant if they are not happy with the outcome of a complaint response or the way a complaint has been handled. The Ombudsman reviews Trust complaint files where there has been a referral and may make recommendations about future handling or taking additional steps. All complaint responses letters clearly advise complainant s of their right to refer their complaint to the Ombudsman and also provide the Ombudsman's contact details.

There was one referral to the Ombudsman in 2018/19 and at the time of writing this report this case was still under review by them.

9.	Patient Advice and Liaison Service (PALS)

PALS is part of our commitment to provide high standards of care, and to support patients, carers and the public, providing an informal way to resolve concerns of service users. The core functions of PALS are to manage concerns, comments and enquiries effectively, and to reduce the number of issues that may escalate to a complaint where appropriate, ensuring that lessons are learnt and that the patient's voice is at the heart of the service. There were a total of 80 enquiries received in PALS from April 18 to March 19. The majority of these enquiries were related to appointment cancellations and referrals, especially within the eye services. All of these enquiries were dealt with satisfactorily and no patients asked for their issues to be dealt with in accordance with the NHS complaints procedure.

Due to medical staffing shortages within our eye services this has resulted in cancellation of appointments and we envisage that this will continue to be a challenge for the forthcoming months. However we have been running additional nurse led visual field clinics as and when the nursing staff are available to so. We do aim to prioritise those patients who have Glaucoma appointments coming up.

All other concerns were either resolved with information/advice given or referred to a more appropriate department. Other enquiries received were appointment changes/cancellations, comments, guidance/information requests and non QVH related queries e.g. local GP's dental services.

In addition, we also deal with information, advice and support requests. Many service users will contact PALS for reasons other than complaints. This may be about:

- Care and treatment
- Services which the trust provides
- Signposting to other services
- Outpatient clinic appointments (patients may occasionally ask PALS to attend with them)
- Assisting families who arrive in East Grinstead with a patient but do not live locally and require local orientation and signposting, to further help about local finding somewhere to stay e.g. local hotels

The PALS telephone contact line is operated during working hours Monday to Friday. A voice mail service is available during 'out of hours' and calls are returned on the next working day. During out of hours the Site Practitioner is the contact for patients/relatives who have urgent issues that require action.

PALS are an invaluable service for enabling patient involvement and engagement, providing a rich source of effective feedback about the patient experience.

10. Website feedback

During the year, the Trust has been responding to feedback posted onto social media websites. This is an important source of feedback for us with 49 comments regarding the Trust being posted over the past 12 months on the two main patient feedback websites, NHS Choices and Care Opinion.

- We posted 262 times on Facebook – an average of 22 posts a month. Each comment received on the QVH page is acknowledged (liked or responded to)
- Our Facebook followers increased from 1,315 in April 2018, to 1,769 by the end of March 2019
- During that time we received 42 reviews on Facebook.

We don't actively push the review aspect of our page so these are always left by patients who want to genuinely feedback on their experience of our hospital. We thank each person that leaves a review and ask if we can share the feedback with staff to help us to continually improve our services.

- In the same period we posted 1,758 times on Twitter.
- On Twitter we have increased the people who like our page from 2,922 in April 2018 to 3,411 in March 2019.
- In that period the amount of impressions our tweets had (times they appeared on people's timelines) was an incredible 1,333,600.

All comments are viewed by all staff via the Trust's intranet website and passed to relevant staff across the Trust for action.

11. Key achievements

We understand that complaints are an important part of feedback and that they are a strong indicator of patient experience and have taken the following actions to support continued improvement;

- Friends and Family Test (FFT) - over 34,000 surveys were received by the Patient Experience Manager 2018-19, enabling our Trust to see top line patient feedback for divisions and wards
- Our Patient Experience Manager has developed the patient story tool within our Trust. Patient stories are heard at every bimonthly Trust Board meeting in order to drive home the power of patient experiences.
- A new children's play area has been created within our Outpatient area
- Patient Magnets - symbol magnets introduced to wards to enable easy identification of additional support needs for individual patients and maintain confidentiality
- New wayfinding and signage is now in place throughout the whole Trust

- We like to know what our patients and visitors think of their experience at QVH so we can continue improving in the future. We have placed 'You said we did' noticeboards in our wards with information about what patients have told us, and what we are doing as a result.

12. Future developments 2018/19

The aim of the Trust and its Patient Experience Manager is to increase the confidence of our patients by having a flexible approach to resolving concerns. There is extensive work being undertaken with the staff on the wards and in departments to help prevent complaints by listening to and responding when things can be put right. When further support is needed, the Trust aims to ensure that the complaints process is signposted locally so that patients know how or where to complain.

Improving access to information for patients on a range of patient experience initiatives, including complaints is a key focus for the Trust. The predominant method for making a complaint remains letter or email but by signposting other options such as the Trust's website, social media and patient opinion websites we ensure patients are given a choice. Where contact is initially made in person or by telephone, staff supports the complainant in registering their concerns formally with the Trust.

In order to improve the services provided to patients further, additional developments will be implemented.

- To reduce the number of open complaints we have. A reduction in open formal complaints will mean that we are responding in a timelier manner to patients.
- Make the best use of technology in our data capture methods, whilst being mindful of the General Data Protection Regulation
- Focus on celebrating excellence, both internally and externally
- Ensure patient experience feedback is fully used as part of the Trust's wider improvement plan

When experiences do not achieve the required standards we will commit to listening and acting on concerns raised and aspire to resolve concerns and complaints within the timeframes.

We will do this by:

- Continuing to be open and transparent in complaint responses
- Develop ownership with managerial and clinical leads that lessons learned from complaints are embedded into service delivery
- Improve the monitoring of complaint action plans post-investigation
- Improve the response timescales by aiming for 30 working day turnaround
- Review PEG and grow the membership of the group to include more representation from patients and carers with greater focus on involvement, not just experience
- Involve patients and carers more in the design and delivery of our services
- Continue to provide Patient Stories at Trust Board
- Continue to advise and support staff with tools and techniques with which to capture feedback, involve patients and carers and act on what they learn

- Continue to refine the patient experience reporting
- Continue to explore and refine our approach to gathering data on themes

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**153-19**	
Report title:	**Emergency Preparedness Resilience and Response (EPRR) and Business Continuity Annual Report 2018/19**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Nicky Reeves, Deputy Director of Nursing/EPRR Lead				
Appendices:	2				
Executive summary					
Purpose of report:	Annual report with 2018/19 and action plan to provide assurance to the Board that the trust is meeting essential EPRR requirements.				
Summary of key issues	The 2018/19 NHS England annual assurance review process undertaken in conjunction with our Clinical Commissioning Group placed our compliance with national standards as partial but meeting essential requirements; compliance with 10 of the 11 standards action plan to further improve compliance is in progress. The report identifies the assurance process, work plan and trust learning from incidents				
Recommendation:	The Board is requested to note the Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2018/19.				
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:	BAF reviewed when compiling this report				
Corporate risk register:	CRR reviewed when compiling this report				
Regulation:	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident Nationally. There are also local requirements from commissioners and the burns network QVH works in partnership with the Local Health Resilience Partnership Executive Group to achieve emergency preparedness, resilience and appropriate responsiveness in the event of a local, regional and national business continuity incident.				
Legal:	As above				
Resources:	No new resources have been allocated to achieving this work plan in 2018/19.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	24/07/19	Decision	Partial assurance given subject to the action plan being updated: report has been represented at August Q&GC with 2018 action plan. Further paper will be presented at October Q&GC detailing progress from annual self-assessment for further assurance.	
Next steps:	To QVH Board for information.				

Holtye Rd,
East Grinstead
RH19 3DZ

Emergency Preparedness Resilience and Response and Business Continuity Annual Report

Queen Victoria Hospital NHS Foundation Trust
Service Annual Report

Report covering the period from
April 2018 to March 2019

Document Control: Quality and Governance Committee
Executive sponsor: Jo Thomas

Author: Nicky Reeves

Date: June 2019

Type: Annual Report
Version:
Pages:
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

1.	Executive Summary
	The EPRR annual report highlights the significant events and activities during 2018/19. It also identifies the rationale behind the duties placed on the trust regarding emergency planning. The 2018/19 NHS England annual assurance review process undertaken in conjunction with our Clinical Commissioning Group assessed our compliance with national standards as **partial** (appendix 1). The action plan in appendix 2 identifies the work ongoing to further improve compliance in 2019/20

2.	Introduction
	The Civil Contingencies Act 2004 places a number of duties on responding agencies in the event of a Major Incident. QVH is categorised as a Category One responder which include the following responsibilities: • To carry out a risk assessment of our operational areas • To make emergency plans • To make business continuity plans • To warn and inform the public • To cooperate with other responders through a Local Resilience Forum • To share information with other responders During 2018/19, Emergency Preparedness Resilience and Response and Business Continuity Executive leadership within QVH was held by the Deputy Director of Nursing and Quality who represented the organisation at the Local Health Resilience Partnership Executive Group (LHRP). This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2018/19.

3.	Service aim, objectives and expected outcomes
	The requirements of being a category one responder for the basis of the service aims and objectives. The EPRR lead has co-ordinated activities which demonstrate the trust has met its responsibilities as a category one responder the key outcomes being: • Updated EPRR policy • Refreshed and tested plans related to emergency plans • Collaborative working with LHRF • Establishing QVH in the wider EPRR health economy and utilising expertise within this network • Resilience test of business continuity. Maintaining effective continuity of our business is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management (BCM).

4.	Activity analysis/ achievement
	Policy Emergency Preparedness policies are held centrally on the Trust intranet pages accessed via a “tile” within the Policies section; for ease they are divided into sections to reflect specific guidance. Policy review is ongoing; seasonal policies (Cold Weather and Heatwave) have been changed in line with national guidance and local action cards for major incident have also been revised. Work is carried out during the year to ensure the policies are up to date and all sections are currently in date.

	Incident Co-ordination Centre (ICC) The ICC is located in the Jubilee Meeting room. The equipment is tested on a bi monthly basis by the emergency planning lead. This process provides assurance that all necessary equipment is always in good working order including the fax machine; telephone lines; computer and television.

5.	Involvement & Engagement
	Assurance process *Internally:* Bi-monthly on-call manager meetings continue with all managers and directors who undertake on call duties being invited to the meeting. At these meetings the on-call logs and incidents are reviewed and learning is shared and actioned. In year there has been a review of the managers who undertake on call, inclusion of new managers within the rota has brought a new perspective to these meetings. New managers receive an induction session from the EPRR lead and to facilitate the transition into the element of their role. A buddy system for new on-call managers to 'test' decisions is offered for the first couple of on-call periods. There is also a system in place for non-clinic on-call managers without an operational remit to have the contact details of a manager with a clinical background to call for advice as required. EPRR updates have been Quality and Governance Committee and the annual report is presented for information at Board. These updates have been presented by the Director of Nursing or Deputy Director of Nursing during 2017/18. *Externally:* All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. We are considered a Category 1 responder. The Trust reviewed its compliance with the EPRR Core Standards and the Statement of Readiness as part of the LHRP process in September 2018. In 2018 there were 55 core standards applicable to QVH and we demonstrated full compliance in 44 of these. Ten standards were rated as partially compliant and one was non-compliant, (this specifically related to QVH being unable to send representation to both the executive meeting as well as the delivery group) This outcome was reported to Board in December 2018. The process will be repeated in autumn 2019. In 2018 the organisation again demonstrated **partial** compliance (appendix 1) following the review and the work plan to address these is contained within appendix 2. QVH has an ambition to achieve substantial assurance during the peer review process review in 2019

6.	Learning from Experience
	Practice Exercises and Live Events During 2018/19 QVH has tested its emergency planning resilience during a number of "live" incidents including generator issues, IT failures, and winter weather. In addition, during the preparation for "Brexit" QVH carried out a table top exercise to review our resilience in the event of a "no deal" and participated with several regional planning workshops and meetings. During the Brexit preparations, there was a requirement for daily situation reporting and this enabled QVH to test communication arrangements. The learning from these exercises and incidents was utilised to ensure the emergency plan remains up to date and is reviewed in the light of any

recommendations as a result of these scenarios. A standard operating procedure is being devised to address issues when the trust is running on the generator. Any changes to the emergency plans are approved via the Quality and Governance Committee. Other than general review of the plans, no significant changes have been made following incidents.

A national burns table top exercise was carried out in October 2018 to test the revised surge and escalation response and QVH participated with this. There is a further Burns exercise planned for October 2019.

Winter Planning

Snow
There was only minor snowfall in the winter of 2018/19 and the impact was minimal.

Flu
The 2018/19 flu vaccination programme concluded in March 2019 with all data submissions to IMMFORM uploaded successfully.

Final uptake for staff receiving the vaccination was 61.3%, an improvement on 59.2% for 2017/18. As in previous years, a CCG locally agreed variance to the CQUIN allowed us to include all staff officially "declining" the vaccination producing a final figure of 80.4%, exceeding the national target of 75%.

ImmForm Data Submission			% of staff group headcount
All Doctors	169	66	39.1% 6.7%
Qualified nurses	186	129	69.4% 13.0%
All other professional qualified	141	96	68.1% 9.7%
Support to clinical staff	493	315	63.9% 31.9%
ImmForm	**989**	**606**	**61.3%**
CCG	**989**	**795**	**80.4%**

Fit testing
Staff who may be involved in the care of pandemic flu patients are taught how to wear their protective equipment annually. This has taken place in all services throughout 2018/19 and is managed at a departmental level.

Training
Face to face training continues to be delivered at trust induction and also at clinical and non-clinical mandatory update sessions. Mandatory training for Non-clinical staff is delivered every 3 years. The content of the training has been reviewed in light of feedback following the 2018 peer review and is also updated following any learning from incidents, for example, there is now a specific section on Chemical, biological, radiological and nuclear incidents following the "Novichok" incident in Salisbury in March 2018.

Business Continuity
Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual

	improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of business continuity plans for core business activity. All business continuity plans can be accessed by the on call managers and site practitioner team via folders on the "N" drive and hard copies of the emergency plan area available in the incident control room in the event of a power or IT failure and all departmental leads have a copy of their individual plans. **Other activity undertaken over the year:** • Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme. • Bi monthly meeting for on-call managers, control personnel and bleep holders. • The Trust maintained its membership with the Sussex Resilience forum • Attendance at the LHRP executive Group • Attendance at "Brexit" table top and workshops

8.	**Future plans and targets**
	The EPRR lead has developed an action plan for 2018/19 to ensure the organisation has satisfactory arrangements in place to meet the requirements of the peer review.(appendix 2) A member of the exiting team will start to attend the emergency planning delivery group to increase compliance with this requirement

9.	**Conclusions and assurance**
	As reported to the Board in December 2018, the Trust currently has effective policy and systems in place for the effective management of expected and unexpected EPRR and business continuity incidents. It meets the requirements of the category one responder and demonstrates **partial** compliance to the national standards. (appendix1). Delivery of the work plan should ensure the organisation achieves **substantial** compliance in the 2019 review.

Appendices

Appendix 1

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix 2

Overall assessment:			Partially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Partially compliant	Requires additonal staffing respource or innovative ways of working to address and meet the need	EPO/AEO	Dec-19	Requires additonal staffing respource or innovative ways of working to address and meet the need
22	**Duty to maintair**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Policy being written	EPO and Clare Pirie	Oct-19	Policy being reviewed, planned to go to CGG September 2019
25	**Command and**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	• Process explicitly described within the EPRF	Partially compliant	Training needs analysis and idetification of relevant courses	All on call managers	Nov-19	Need commitment from on call managers to attend relevant external tactical or strategic training. Comptent regarding internal escalation of incidents. Staff booking on to SLC in September and October
28	**Training and ex**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	• Training records • Evidence of personal training and exercising portfolios for key staff	Partially compliant	Training needs analysis and idetification of relevant courses	All on call managers	Novmeber 2019	Need commitment from on call managers to attend relevant external tactical or strategic training. Comptent regarding internal escalation of incidents
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	• Documented processes for accessing and utilising loggists • Training records	Partially compliant		EPO	Dec-19	Challenge with maintiaing up to date loggists. Work around in place until formal traingin avaialble
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	• Minutes of meetings • Governance agreement if the organisation is represented	Partially compliant	To be addressed and delegated	EPO	Dec-19	Individual identified to attend. QVH pays in to the SRF as required
49	**Business Contin**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Partially compliant	All BIAs need review	EPO	Apr-20	
50	**Business Contin**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	Partially compliant	Working towards	IG lead	Sep-19	Email confirmation of pt assurance
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	Partially compliant	Awaiting external support	MIU and EPO	Dec-19	E mail from Louise Marchant, consider adding QVH CBRN response of MIU
66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Partially compliant	Collaboration with ambulacne trust to train MIU	MIU and EPO	Dec-19	As above
			Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-					

66	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Partially compliant	Collaboration with ambulacne trust to train MIU	MIU and EPO	Dec-19	As above
68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Partially compliant	Collaboration with ambulacne trust to train MIU	MIU and EPO	Dec-19	As above
5	**Command struc**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Partially compliant	Booking in to external training, particiapation in table top events and practices	On call managers	Nov-19	Training need for on call managers

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**154-19**	
Report title:	**Research & Development Annual Report 2018/19**				
Sponsor:	Ed Pickles, Medical Director				
Author:	Sarah Dawe, Research & Development Manager; Julian Giles, Clinical Lead for Research				
Appendices:	One (list of research projects)				
Executive summary					
Purpose of report:	An annual report of the work coordinated by the Clinical Research Department				
Summary of key issues	• QVH has had another exceptional year, with steep increases in activity. • There was s a **64%** increase in overall recruitment. • There was a **45%** increase in National Portfolio recruits. • Success has been due to a sustained focus on prioritizing CRN targets. • This excellent performance has been recognised by the CRN, who have increased our core funding by **143%**.				
Recommendation:	Quality & Governance Committee is requested to receive the annual report for 2018/19.				
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:	Research & Development contributes directly to the delivery of BAF KSO2.				
Corporate risk register:	No				
Regulation:	Compliance with The Research Governance Framework 2005 which outlines principles of good governance that apply to all research within the remit of the Secretary of State for Health.				
Legal:	As above and compliance with GDPR 2018 requirements				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	24/07/19	Decision:	The report has been received and partial assurance has been given with the request for a further paper for the October meeting regarding research governance.	
Next steps:	To QVH Board for information.				

Holtye Rd,
East Grinstead
RH19 3DZ

Queen Victoria Hospital NHS Foundation Trust
Research & Development Annual Report

Report covering the period from
April 2018 to March 2019

Document Control: Q&G Committee, R&D Governance Group
Executive sponsor: Ed Pickles

Authors: Sarah Dawe

Date: June 2019

Type: Annual Report
Version: 1
Pages: Number
Status: Public. Written and prepared for the Trust Board
Circulation: QVH Trust Board

Contents List

1.	Executive Summary
	• QVH has had another exceptional year, with steep increases in activity. • The CQC Inspection of February 2019 recognised research practice at the Trust as '**outstanding'**. • We have worked hard to make sure that as many patients as possible get the opportunity to take part in research, and in 2018-19 we recruited 887 participants. This is a **64%** increase in total activity over the previous year, which in itself had seen a 47% increase in activity. • Of these recruits, 640 participants were recruited into National Portfolio studies. This represents a **45%** increase over the previous year. • Progress has been achieved despite being short-staffed during the year. Success has been due to a sustained focus on prioritizing CRN targets. • This excellent performance has been recognised by the CRN, who have increased our core funding by **143%**. • In 2018-19 the Trust also had a major grant-funded study ongoing, to develop a new device to assist with the rehabilitation of facial palsy patients. This project was funded by the National Institute for Health Research (NIHR) Invention for Innovation (i4i), and Charles Nduka was the lead applicant. This was a collaborative effort with the University of Nottingham Trent and a commercial partner (Emteq). • We are proud that three of our clinicians are acting as Chief Investigators on National Portfolio research studies (Julian Giles, Charles Nduka and Raman Malhotra), and two are members of NIHR faculty (Julian Giles and Charles Nduka). This is a significant achievement for a small Trust. • We have built up a very productive relationship with the Brighton and Sussex Medical School to host a programme of undergraduate projects. This year we welcomed our ninth cohort of students, who spent nine months of their 4th year with us working on research/audit projects, supervised by QVH consultants.

2.	Introduction
	It gives me great pleasure to introduce the QVH Annual Research report for 2018/19. This year has seen further significant increases in research activity at the Trust. When I wrote the introduction to the Annual Report last year I was concerned that it would be difficult to equal the amazing successes of 2017/18. I am delighted to report that we have not only matched our activity in 2017/18 but considerably surpassed it. In excess of 800 patients and staff were recruited to be involved in clinical trials. Our activity has increased by 64%. This is a record for us. Our team of research nurses and managers have worked tirelessly to achieve this success. At the core of our vision for research is to ensure as many people at the QVH are given the opportunity to be involved in research. This allows us to develop and refine the excellent care we aim to provide to our patients. Publication of the results of formal research projects undertaken at the QVH allows us to shape and influence care provision both nationally and internationally. We have included some of the key publications coming from our hospital in this report. Our unprecedented success has been recognised by the National Institute of Health Research Clinical Research Network (CRN). They have substantially increased the funding they allocate to the QVH. This has allowed us to recruit two additional research nurses to join the team. We are grateful to the CRN for their continued faith and support. Jag Dhanda has continued to energise maxillofacial research. He has initiated several studies that we are jointly undertaking with the other leading head and neck cancer centres in the UK. DEFEND and JAWPRINT are now recruiting patients. Jag was appointed as the divisional lead for Kent Surrey and Sussex CRN. This has considerably lifted the profile of the QVH within our region. Charles Nduka continues to be successful in driving forward his pioneering work to improve the care of patients suffering from facial paralysis. He is nearing the end of the clinical phase of the FRAME study. This study was supported by a prestigious NIHR i4i grant. Plans are afoot for how the prototype devices

	developed through the study can best be deployed to improve care of patients suffering from facial palsy. We have also aimed to bolster the number of commercial studies undertaken at the QVH. Examples of this include our forthcoming participation in a series of ophthalmic studies with Allotex, a company developing novel solutions to sight loss. Samer Hamada is the clinician primarily responsible for this. We are also proud to be collaborating in commercially-funded studies that explore new dressings to improve healing in patients with burns and other difficult to heal wounds. Baljit Dheansa and Simon Booth have been heavily involved in this. I hope that broadening our range of partners can widen our portfolio of research interests and opportunities. Increasing our commercial work will reduce our reliance on funding from the Trust and the CRN. In the coming year I hope that we can work harder to embed a research culture that encompasses all the health care professionals at the QVH. At the moment there are pockets of activity but I would like to see more clinicians, nurses and allied professionals involved in research that underpins the excellent care that we all strive to deliver. Dr Julian Giles

3.	**Service aim, objectives and expected outcomes**
	Research & Development aims to improve outcomes for patients both at QVH and in the wider NHS. This is achieved through a programme which focuses on quality, transparency and value for money. R&D at QVH is performance-monitored by our local CRN. They closely monitor our research activity on a daily basis via an interactive online system (Edge), as well as via regular meetings and written reports. The key objective which we are set by the CRN is a Value For Money (VFM) measure. For the past three years, QVH has delivered one of the most efficient R&D programmes in Kent/Surrey/Sussex, with a low cost per patient recruited. The CRN also sets objectives for total recruitment; time to first recruit; time to local approval; and recruitment to time and target.

4.	**Activity analysis/ achievement**
	# Research Activity The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2018-19 that were recruited during that period to participate in research approved by a research Ethics Committee was **887**. This represents a **64%** increase in total activity over the previous year.

Participation in clinical research demonstrates QVH's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting **40** clinical research studies in 2018-19, as per the tables below.

Study ref in appendix	Study title	Start date	Principle Investigator	National Portfolio study	Recruitment in 2017-18
1	JaWPrinT	27/03/2019	Jag Dhanda	Yes	0
2	FFFAP Falls Audit Evaluation	18/10/2018	N/A	Yes	0
3	Allotex – a prospective multicentre clinical study to evaluate the safety and effectiveness of the Transform corneal allograft for the treatment of hyperopia (PRO12)	08/02/2019	Samer Hamada	Yes	0
4	Allotex - IntraStromal - (PRO10)	08/02/2019	Samer Hamada	Yes	0
5	Single Use PICO NPWT Post-Market Safety and Efficacy Study	21/01/2019	Simon Booth	Yes	6
6	ADAPT - HCP Training in Assistive Technology	26/07/2018	N/A	Yes	0
7	TEARS Grading scale: grading the clinical severity of epiphora	12/11/2018	Raman Malhotra	Yes	72
8	XEN45 in Angle Closure Glaucoma	22/10/2018	Gok Ratnarajan	Yes	2
9	Nail bed INJury Analysis (NINJA)	23/05/2018	Rob Pearl	Yes	43
10	DEFeND	11/12/2018	Jag Dhanda	Yes	2
11	Validating a quality of extubation scoring system in a specialist airway centre	17/04/2018	Chet Patel	No	100
12	Objective dynamic description of facial co-contractions and facial dominance in the general population	13/08/2018	Charles Nduka	Yes	99

13	DALES - Drug Allergy Labels in the Elective Surgical Population	01/05/2018	Julian Giles	Yes	109
14	Haemostatic markers in ECMO (HAE) study	25/01/2018	N/A	Yes	0
15	Smartmatrix SMA0217	10/09/2018	Baljit Dheansa	Yes	4
16	Carbapenem-resistant Enterobacteriaceae Screening Survey v1	02/01/2018	N/A	No	0
17	Patient experiences of adapting to life following orthognathic treatment for facial asymmetry	25/09/2018	Lindsay Winchester	Yes	2
18	Ambulatory measurement of facial expressions in health and disease - FRAME	12/11/2018	Charles Nduka	Yes	32
19	Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme (PQIP)	03/05/2017	Julian Giles	Yes	125
20	Ciclosporin 1mg/ml eye drop emulsion (Ikervis) for the treatment of severe keratitis in adult patients with dry eye disease, which has not improved despite treatment with tear substitutes	28/09/2017	Samer Hamada	Yes	8
21	Head & Neck 5000 Follow Up Study	01/02/2018	Brian Bisase	Yes	3
22	Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients	24/01/2018	Charles Nduka	Yes	0
23	Pharmacists' perceptions of patient medicines helplines.	08/02/2018	N/A	No	0
24	Lock & Key	08/06/2017	N/A	No	0
25	Lugol's Iodine in Surgical Treatment of Epithelial Dysplasia in the Oral Cavity and Oropharynx	21/11/2017	Paul Norris	No	9
26	MindSHINE 3	20/03/2017	N/A	Yes	0
27	A nationwide survey of prosthetic eye users: a	01/03/2017	Raman Malhotra /	No	92

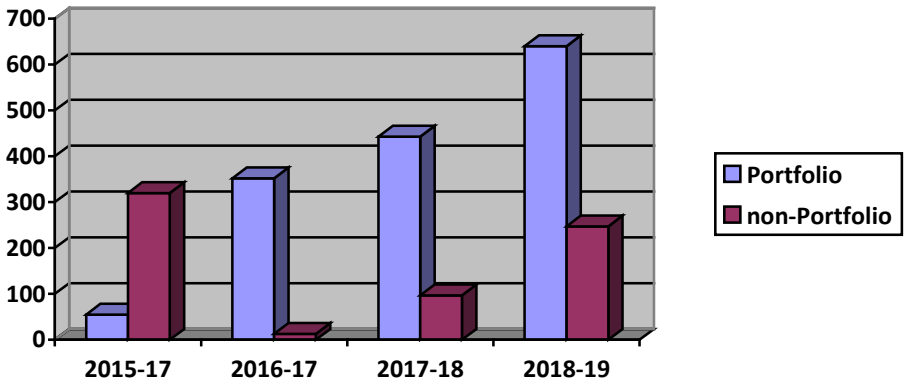
	collaborative study with all NHS ocular prosthetic service providers.		Emma Worrell		
28	Ex-vivo Infection Detection - EVIDEnT	20/10/2016	Simon Booth	Yes	6
29	Antibiotic Levels in Burn wound Infection (ABLE)	30/08/2016	Simon Booth	Yes	4
30	EuPatch	01/07/2016	Samer Hamada	Yes	0
31	Investigation of Potential Biomarkers in the Role of Scar Formation	16/03/2016	Baljit Dheansa	No	79
32	SUBMIT	21/09/2016	Asit Khandwala	Yes	2
33	A study to refine the CAR burns scales	03/11/2015	Simon Booth	Yes	3
34	Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases. (Dupuytrens patients)	30/11/2015	Loz Harry	Yes	85
35	Molecular Genetics of Adverse Drug Reactions	31/01/2012	Baljit Dheansa	Yes	0
36	The co-administration of multiple drugs in intensive care units	04/02/2019	N/A	No	0
37	Experiences of using NHS patient medicines helplines	21/05/2018	N/A	No	0
38	The anatomy of flexor tendon repair		Rob Pearl	No	0
39	S100 and CD31 in tongue cancer	12/05/2014	Bill Barrett	No	0
40	Molecular prediction of metastasis in oral tongue squamous cell carcinoma	19/07/2012	Bill Barrett	No	0

Involvement in NIHR Portfolio studies

Accruals for NIHR Portfolio studies are recorded and monitored via a national database, and the level of CRN funding received by the Trust is partly determined by these accrual figures. In the past three years, the number of Portfolio participants recruited has greatly exceeded the number of non-Portfolio recruits, reflecting a strategic push to increase the proportion of Portfolio studies we undertake.

QVH recruited **640** Portfolio participants in 2018-19. This represents a **45%** increase over the previous year.

Research Participant Recruitment 2015-2019



Maxillofacial research funded by QVH Charitable Funds

Jag Dhanda was very generously funded by the QVH Charitable Funds for 3PA/week to focus on research. Two new studies were opened in 2018-19: DeFEND (Determining the Effectiveness of Fibrin Sealants in Reducing Complications in Patients Undergoing Lateral Neck Dissection) (2 patients recruited in 2018-19), and JaWPrinT (Jaw reconstruction with printed or flexed titanium and free tissue transfer).

A third, SAVER (Sodium Valproate for Epigenetic Reprogramming in the Management of High Risk Oral Epithelial Dysplasia), is planned for 2019-20.

Successful EME grant funding was obtained for a studying looking at lymphatic mapping of oropharyngeal cancer. The study is two phases (n=75 each) with no/no go decision between the two. Stage one is imaging protocol development and feasibility with radiotracer injection and imaging in theatre (freehand SPECT with Surgiceye) during EUA/biopsy. Pending on the success of imaging and the contralateral drainage rate in the first stage, stage two will be surgical intervention with SNB of contralateral nodes. Stage 1 begins in 2019-20.

Grant funding was also obtained from CRUK/Imperial for a PhD student to combine iknife and robot technology.

In February, Jag Dhanda was appointed KSS CRN Oral & Dental Specialty Lead.

Funding

Grant funding

The Trust had two grant-funded studies ongoing in 2018-19. We are the proud holder of a prestigious NIHR i4i grant, for which Charles Nduka was the lead applicant. This was a collaborative effort with the University of Nottingham Trent and a commercial partner (Emteq), to develop a new device to assist with the rehabilitation of facial palsy patients. The grant is worth a total of **£846,000** across all three partners.

The Anaesthetics Department, led by Dr Julian Giles, was engaged in an NIHR RfPB grant-funded (**£79,688)** study looking at non-site-specific pain following breast surgery.

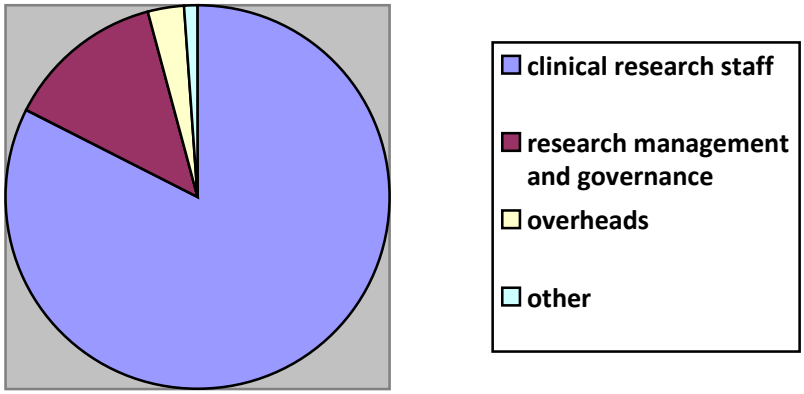
Core funding

The CRN awarded the Trust **£165,084** core funding in 2018-19, including £1500 Specialty Lead Funding. The CRN determines its level of funding using an algorithm based on the number of patients

recruited to Portfolio studies over the previous two years. This activity-based funding formula is a key driver for how research work is prioritized at QVH. The CRN undertook a financial audit of QVH in February 2019.

Funding was allocated according to CRN guidelines in the following way:

Resource	Staff	Name	Allocation
Lead Research Nurse	Gail	Pottinger	22,875
Research Nurse	Simon	Booth	54,131
Research Practitioner	Debbie	Weller	41,694
Research Nurse	Tracey	Shewan	12,246
Clinical Lead for R&D	Julian	Giles	5018
Clinical Trials Pharmacist	Judy	Busby	1728
Specialty Lead	Emma	Worrell	1500
R&D Manager	Sarah	Dawe	12,224
Research Governance Officer	Emma	Foulds	9710
Training			0
Travel			502
Overheads			5175



The Trust also received **£2,250** from the Brighton and Sussex Medical School to support the IRP students who undertake fourth-year research projects at the hospital.

Charitable Funding

The QVH Charitable Funds very generously supported a Maxillofacial Consultant to undertake research for 3PA/week. This is reported on under 'Research Activity' above.

The Scar Study has been kindly supported by the League of Friends, which funds 3 day/wk of a research technician. This study is investigating potential biomarkers in the role of scar formation.

Publications

We are proud to say that in 2018/19 QVH clinicians have continued to spread the results of their work extensively. There is little point in engaging in research if we do not effectively communicate the advances that we have made to the broader community. In the modern world there are a myriad of ways in which we aim to do this. Publishing articles in high impact, peer reviewed medical journals remains the traditional way to do this. QVH clinicians have contributed to over thirty such publications this year. Because of the breadth of collaborations coming up with an exhaustive list is difficult. We have listed a few of these below. We also encourage staff to 'spread the word' in other ways. Examples of this might include presentations at conferences, writing editorials, participating in teaching and engagement with patient groups. We have also been exploring the role of social media. I am delighted that publications are not confined to medical staff. We have been encouraging nurses and other members of the allied health care team to participate. Krissie Stiles and Simon Booth from the Burns team have been successful in publishing both research and educational articles. Listed below are a brief selection of research papers, editorials and educational pieces for 2018/19:

Quality of life and communication in orthognathic treatment. Susan L Catt, Sofia Ahmad, Jeremy Collyer, Lauren Hardwick, Nahush Shah & Lindsay Winchester; *Journal of Orthodontics*, 2018 45:2, 65-70. doi: 10.1080/14653125.2018.1458949

Effect of a punctal plug on ocular surface disease in patients using topical prostaglandin analogues: a randomized controlled trial. Sherwin JC, Ratnarajan G, Elahi B, Bilkiewicz-Pawelec A, Salmon JF. *Clin Exp Ophthalmol*. 2018 Apr 26. doi: 10.1111/ceo.13311.

Long-term outcome of flexible onabotulinum toxin: a treatment in facial dystonia. Bladen JC, Feldman I, Favor M, Dizon M, Litwin A, Malhotra R. *Eye (Lond)*. 2018 Sep 10. doi: 10.1038/s41433-018-0203-3.

The SILKIE (Skin GraftIng Low FriKtIon Environment) Study: A non-randomised proof-of-concept and feasibility study on the impact of low-friction nursing environment on skin grafting success rates in adult and paediatric burns. Hollén, Linda, Rosemary Greenwood, Rebecca Kandiyali, Jenny Ingram, Chris Foy, Susan George, Sandra Mulligan, Simon P Booth et al. *BMJ Open* 8, no. 6 (June 1, 2018): e021886. doi: org/10.1136/bmjopen-2018-021886.

Development of a high-throughput ex-vivo burn wound model using porcine skin, and its application to evaluate new approaches to control wound infection. Alves, Diana R., Simon P. Booth, Paola Scavone, Pascale Schellenberger, Jonathan Salvage, Cinzia Dedi, Naing-Tun Thet, A. Toby A. Jenkins, Ryan Waters, Keng W. Ng, Andrew D. J. Overall, Anthony D. Metcalfe, Jonathan Nzakizwanayo, and Brian V. Jones. 2018. *Frontiers in Cellular and Infection Microbiology* 8 (196). doi: 10.3389/fcimb.2018.00196

Objectively measuring pain using facial expression: is the technology finally ready? Dawes TR, Eden-Green B, Rosten C, Giles J, Governo R, Marcelline F, Nduka C. *Pain Management*. 2018 Mar;8(2):105-113.

Emergency management of burns: part 1. Stiles K. *Emergency Nurse*. 2018 May 10;26(1):36-42. doi: 10.7748/en.2018.e1815. Epub 2018 Apr 27.

Current trends in the medical management of osteoradionecrosis using triple therapy. Dhanda J, Rennie L, Shaw R. *Br J Oral Maxillofac Surg*. 2018 Jun;56(5):401-405. doi: 0.1016/j.bjoms.2018.03.009. Epub 2018 Apr 9.

5.	Involvement & Engagement

Patient and Public Involvement and Engagement

QVH continues to work to find meaningful ways to involve patients and members of the public in its research activity. We are fortunate to have on our R&D Governance Group two very involved patient representatives, who take an active role in advising on and monitoring the research activities of the Trust, and this year we also appointed a new Patient Research Ambassador. Patients are also often involved in the early stages of research projects via focus groups, who feed into protocol development. We have set up a Research Panel which has been established to suggest as well as review new research ideas for the QVH as they are being formulated. Work has also been undertaken on raising patient awareness of research via a publicity campaign, with features on local radio and television, and in newsletters. We have also used leaflets, posters and videos within the hospital to inform patients and the public of the research we do.

Comprehensive Research Network (CRN)

The Trust is a member of the Kent, Surrey, and Sussex Comprehensive Research Network (CRN). We work with the CRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CRN distributes R&D resources amongst its members according to an activity-based algorithm. The CEO sits on the CRN Partnership Board, and the R&D Manager and the Clinical Lead for Research regularly attend local finance and performance meetings, working closely with the CRN Link Manager and her team. Meeting CRN targets is a priority area for the Trust.

Staffing

Research Management and Governance

The R&D Department presently consists of one Clinical Lead for R&D, one R&D Manager (0.66WTE) one Research Governance Officer (13.8h/wk), and one Research Assistant (0.2WTE).

Funding was received from the Comprehensive Research Network (CRN) to help support the R&D Manager's post. Other income to support the R&D infrastructure comes from commercial studies, which in addition to paying general Trust overheads, contribute a fee for R&D Department services in handling their applications and setting up contracts.

Clinical Research Staff

In 2018-19, the Trust supported one Lead Research Nurse (0.5WTE), one Burns Research Nurse (1WTE), one Research Practitioner (1WTE), one Research Nurse (1WTE), and one Research Assistant (0.2WTE).

We have been fortunate to have the support of the QVH Charitable Funds, who have funded 3PA/year of a maxillofacial consultant's time for research (Jag Dhanda).

The Anaesthetics Dept has one Research Registrar (0.2WTE), funded out of its clinical budget. The Scar Study has been generously supported by the League of Friends, which funds 3 day/wk of a Research Technician.

Some clinical departments also each have their own arrangements for Research Fellows, which are funded by the departments themselves and which are not managed by the R&D

Department. In addition, some clinical areas have successfully identified nurses who have been trained up to support research in their own department.

Intellectual property and Innovation

The Trust engages the services of NHS Innovations South East to assist with commercializing and developing its intellectual property, and this year they have been managing royalties for a tracheostomy dressing device originally developed at QVH, as well as advising on a telemedicine referral image portal system (TRIPS).

Training and Development

Local Training
Individual support tailored to the individual is provided by the R&D Department to all new researchers who require guidance developing their protocols, navigating the approvals process and setting up their studies. We are fortunate to have the additional help of the University of Brighton, which has provided us with invaluable advice on study design, methodology and putting together grant applications.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by providing an onsite trainer, enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. One member of staff is a qualified GCP trainer, and also runs courses outside the Trust on behalf of the CRN. Commercial companies also regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

CRN training
The Trust also has access to training provided by the CRN for any studies which are accepted onto the National Portfolio. A wide range of courses are offered.

Our Research Governance Officer attended the national R&D Forum Local Capacity and Capability training in February 2019.

Departmental meetings
Individual departments run their own Audit & Research meetings, providing a forum to discuss new ideas and present completed studies.

Research Design Service
The NIHR Research Design Service South East provides a very good service in supporting staff in RfPB grant applications on a one-to-one basis.

NIHR faculty membership
Julian Giles has been made a member of the faculty of the National Institute for Health Research (NIHR), by virtue of his successful grant application to the NIHR RfPB funding stream. Charles Nduka is also a member of faculty, following his NIHR i4i award.

Governance Structure

R&D at the Trust is managed via a Research & Development Governance Group. Its members include: Clinical Lead for R&D, Chief Pharmacist/Clinical Trials Pharmacist, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead,

	Deputy Director of Nursing, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, R&D Manager, Finance Department Representative, Designated Individual with responsibility for Human Tissue Authority license, and External Academic Advisors from the University of Brighton. The Group also has two very active patient representatives who play a valuable role in advising on new projects. In February 2019, the Trust's R&D function was inspected by the CQC under its Well-Led section. The report is awaited. The R&D Governance Group reports to the Quality and Risk Committee. The Director of Nursing acts as the Trust's Nominated Consultee for research participants unable to consent. ***Trust policies which cover R&D*:** Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy. **R&D approvals and targets** QVH has effective, streamlined systems for managing R&D approvals in proportion to risk, and our turnaround times are swift. The R&D Dept provides guidance with using the national IRAS applications system, and works with the Health Research Authority (HRA) to approve studies and ensure they meet national guidelines. We use the Edge online system to manage and monitor research here at the Trust. There are national targets for the processing of R&D applications and for time to first recruit. QVH approval times for clinical trials and for commercial studies are also reported quarterly to the NIHR, and published on the QVH website. The median time for approval of new studies requiring formal Confirmation of Capacity and Capability in 2018-19 was **14 days** from date site selected, and the mean time was 28 days. This included 2 outliers of 95 days. The median time to first recruit from date site confirmed was **31 days** (this included one outlier of 149 days), and the mean time was 41 days. The proportion of new studies meeting the national HL04 target was **73%**. The proportion of new studies meeting the national HL05 target was **67%**. **Sponsorship status** Some research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent management of active projects. We currently have three Chief Investigators at the Trust who have initiated QVH-Sponsored National Portfolio studies, as well as several Chief Investigators on non-Portfolio studies. No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for the studies they initiate. QVH believes that it is right to support its researchers in developing new projects, and to encourage the spirit of intellectual enquiry, and so continues to provide Sponsorship status for all single-site non-CTIMPs plus phase IV CTIMPs. The Trust's capacity for R&D, and it's commitment to research, is clearly stated in its official RDOCS (R&D Operating Capability Statement), which is a publically available document endorsed by the Board and published on the QVH website, according to national guidelines.

6.	**Learning from Experience**

	QVH has made excellent progress in growing its National Portfolio research activity, and this has been recognised by significant extra funding from the CRN. Prioritizing CRN targets ahead of other research objectives has resulted in R&D funding now being on a more secure footing. This has given research a more stable foundation to build on in 2019-20.

7.	Recommendations
	Research activity at QVH has had three successive years of spectacular growth. In order to sustain this, consultant engagement needs to be developed.

8.	Future plans and targets
	Specific targets for 2019-20: • Meet CRN pledge for number of National Portfolio recruits • Meet national targets for commercial recruitment to time and target • Establish extra research nurse (funding already secured for this). • Develop PPIE (Patient and Public Involvement and Engagement) Progress towards these targets will be monitored by the R&D Governance Group.

9.	Conclusions and assurance
	Research at QVH has benefitted from three successive years of strong growth, despite a challenging understaffing situation. As a result of this activity, the CRN has awarded us considerably more core recurrent funding. This has enabled Research to make a positive contribution to the Trust's finances. Funding has been secured to address our staffing issues, but in order to sustain the current level of activity more consultant engagement needs to be developed.

10.	Appendices

Registered research projects (with HRA Approval) ongoing in 2018-19

1 JaWPrinT

JaW PrinT is a 'real-world' prospective observational pilot study, evaluating the clinical effectiveness, usability and economics of two approaches to mandibular reconstruction surgery (figure 1). Patient participants will be recruited prospectively over a minimum period of 18 months (with observation of at least 10 participants in each treatment pathway). The figures are based upon the historical clinical practice of the research site, with both techniques in equal use; choice depending on resources, surgical training requirements and surgeon's clinical preference.

As a purely observational study, treatment choice will be made in the normal clinical manner and will in no way be influenced by the study itself. Participants will be followed up at their routine outpatient clinics (6 weeks, 6 months and 1 year postoperatively) with prospective outcomes data collection

2 FFFAP Falls Audit Evaluation

Audit and feedback is widely used within quality improvement initiatives as a strategy to improve professional practice. However, the use in practice of these tools needs to be carefully designed and adapted to the specific local context to be effective.
Falls are the most frequent patient safety issue experienced by old patients during an acute hospital episode, resulting in over 2,000 hip fractures annually as well as considerably other injury, distress, and anxiety, plus increased healthcare expense.
This research will explore current use and opportunities of improvement of the National Audit of Inpatient Falls (NAIF), one of the work-streams of the Falls and Fragility Fracture Audit Programme (FFFAP), which is a national programme of quality improvement managed by the Royal College of Physicians (RCP) in the Clinical Effectiveness and Evaluation Unit (CEEU).

The purpose of this project is to provide a scientific evaluation to better understand the barriers and enablers to the use of the NAIF data by clinical services in their quality improvement work to reduce the incidence of inpatients falls. In particular in this research we aim to investigate technical, social and contextual factors, related to the audit and feedback process of the NAIF programme in order to explore how the audit data and reports from 2017 are perceived, received, and acted upon. The results of this research will be used to make recommendations as to how to improve the audit and wider programme 2018-2021 and more in general to inform future National Clinical Audits.

3 Allotex – a prospective multicentre clinical study to evaluate the safety and effectiveness of the Transform corneal allograft for the treatment of hyperopia (PRO12)

The purpose of this clinical research investigation is to evaluate the safety and effectiveness of implantation of the Allotex TransForm corneal allograft (TCA) for improving distance vision in hyperopic patients. The expected duration of the clinical investigation is 3 years, subject participation will last 2 years.

The Allotex TCA is a small piece of sterile human tissue designed to change the shape of the first layer of the eye known as the cornea (which is like the crystal on a watch), to adjust the point of focus of light at the back of your eye. The tissue source is specially treated human corneas from an eye bank in the United States.

Following topical anesthesia, the surgeon first creates a pancake-like flap of the cornea using

a laser. After the flap is created, your surgeon will place the TCA beneath the open flap and then complete the procedure by re positioning the corneal flap on the eye. When the flap is replaced, it lies on top of the TCA, causing the surface to change shape which will attempt to improve your distance vision and reduce your dependence on corrective lenses (spectacles and/or contact lenses). Up to 121 patients are being included in the clinical investigation.

4 Allotex - IntraStromal - (PRO10)

The objective of this clinical study is to evaluate the safety and effectiveness of intrastromal implantation of the Allotex TransForm corneal allograft (TCA) for improving near vision in presbyopic subjects.

The Allotex TCA is a piece of acellular cornea, sterilized with electron beam radiation and shaped to a particular shape using a laser. The availability of precise laser shaping systems and sterile corneas are the key factors that make the use of allogenic implants possible. One size of the TCA is available which has a +2.50 D power with a diameter of 2-3.5 mm and a central thickness of 15-25 microns. The TCA is applied to the surface of the cornea at the layer known as Bowman's membrane, which is just underneath the epithelium.
The goal is to enhance the visual performance of the patient with a material that is 100% biocompatible and precisely shaped for the individual's needs.

5 Single Use PICO NPWT Post-Market Safety and Efficacy Study

There is a significant amount of clinical evidence to show that NPWT may reduce oedema, increase healing and reduce chance of infection, through maintenance of pressure therapy, in closed incisions, but limited clinical evidence on skin grafts and flaps. In order to meet MDR regulation this study is being complete to assess performance efficacy and safety in skin grafts. In addition a minor modification has been made to the pump to reduce noise level. Evidence on a small number of abdominal and knee incisions are also being collected to assess that the pump works in the same way as previously on these indications. Subjects with abdominal incisions, skin grafts and knee incisions following knee surgery will be recruited to the study and receive NPWT for 7 days. Functional performance of the system will be assessed through the use of pressure data loggers and acceptability of the device as assessed by patient and clinician. Safety will be assessed with a 30 day follow up to assess complications and device related events.

6 ADAPT - HCP Training in Assistive Technology

This study asks Health Care Professionals in England and France to complete the online survey developed by the ADAPT team. The objective of the survey is to obtain feedback from those working with Assistive technologies, especially Health Care and Special Educational Needs Professionals on their:

- Knowledge and experience of training in assistive technologies
- Knowledge and experience working with assistive technologies
- Recommendations for training in the use of Assistive technologies and the support of those who use such technologies.

7 TEARS Grading scale: grading the clinical severity of epiphora

Epiphora (watery eye) is a common presentation to the ophthalmology clinic, with most patients being amenable to surgical (61-69%) or non-surgical treatment. Surgically-amenable epiphora affects an estimated 16/100 000 persons rising to 100/100 000 in 75-84 year olds. While in some, the epiphora represents no more than a tolerable nuisance, in others it significantly affects their quality of life. At the more severe end of the spectrum, some cases require repeat medical attendances and hospital admissions for systemic infection. With ever-increasing financial constraints on healthcare providers, there is a need for clinicians and healthcare commissioners to better prioritise patients for surgical intervention.

The 'TEARS scale' was developed through extensive literature review, patient focus groups and consultation with an expert panel of consultant ophthalmologists. Disease severity is graded based on 4 subscales: symptom frequency, the effects on patients and healthcare

providers, patients' functional status, and the compounding effect of ocular surface disease. This prospective study aims to validate the TEARS scale by recruiting adult patients presenting to oculoplastic clinics with epiphora. Two clinicians will complete the TEARS grading scale at the study entry point. Patients will complete two questionnaires: The Watery Eye Quality of Life score (WEQOL) and The Lacrimal Symptom Questionnaire (Lac-Q). In a subset of patients who have previously agreed with their clinician to undergo either surgical or non-surgical intervention, the TEARS scale will again be completed at their clinical review by two clinicians between 3 and 6 months after their initial visit. Patients will again complete the WEQOL and Lac-Q, as well as the Glasgow Benefit Inventory (a measure of change in quality of life).

The scale's reliability will be evaluated through statistical testing of inter-rater agreement. Construct validity will be assessed by the scale's correlation with patient-reported outcome measures and by evaluating its responsiveness to surgical intervention.

8 XEN45 in Angle Closure Glaucoma

Glaucoma is an eye condition where the optic nerve is damaged by the high pressure of the fluid in the eye (aqueous humour). Aqueous humour is produced by a ring of eye tissue called the ciliary body, located behind the iris (coloured part of the eye). It flows through the pupil and drains out through a spongy network of holes called the trabecular meshwork (which sits in the angle formed where the iris meets the cornea). In Angle Closure Glaucoma (ACG), the outer edge of the iris and cornea come in contact, closing the drainage angle. This prevents the aqueous humour from draining and causes the pressure in the eye to build up. Currently available treatment for ACG consists of procedures to reduce eye pressure, including laser treatment, lens extraction, eye pressure-lowering medications, and incisional surgeries. There are no minimally invasive glaucoma surgery options available for ACG. XEN45 Glaucoma Treatment System (referred to as XEN) potentially alleviates this unmet need. XEN comprises of the Gel Implant and the Injector. The Gel implant is a soft gelatinous implant, approximately 6 mm long and as wide as a human hair. After implantation in the eye, it acts as a conduit for the drainage of aqueous humour in the eye.

The current study, sponsored by Allergan, is a prospective, multicentre, single arm, open-label (the participants and study team will know which treatment the participant is assigned to) clinical trial in patients with ACG. Approximately 65 patients will be implanted with XEN in one eye and followed for 12 months to evaluate its safety and effectiveness. Participants will be enrolled at approximately 15 research sites in the Asia-Pacific and European regions.

9 Nail bed INJury Analysis (NINJA)

Nail bed injuries are the most common hand injury in children in the UK. Treatment usually involves surgical repair of a laceration located underneath the fingernail. To do this the fingernail is removed, the laceration repaired, and the fingernail can be replaced or discarded. Historically the nail was replaced routinely but recent evidence indicates not replacing the nail may reduce the incidence of infection and post operative complications. The NINJA trial is a multicentre, parallel group, randomised controlled trial comparing replacing the nail to the alternative practice of discarding (not-replacing) the nail as part of the surgical nail bed repair for the treatment of nail bed injuries. This study will be undertaken at multiple UK sites, identified through the Reconstuctive Surgery Trials Network (RSTN) over a 3 year period. Each patient will be followed up for 4 months.

10 DEFeND

A neck dissection is an operation to remove the glands in the neck either because they have cancer in them or they are at risk of cancer spreading to them. Complications after neck dissection are a significant problem for patients and may affect their quality of life. Research on understanding the feelings of patients who have had head and neck cancer, has shown that avoiding complications is very important to them.

We have found evidence that by giving patients a substance that copies the blood clotting process called Fibrin Sealant, we may be able to protect them from complications. This is because this substance can seal areas of bleeding and stick the raw surfaces of the wound

together. Unfortunately, there is no high quality research that has been able to answer whether Fibrin Sealants can prevent complications after neck dissection. Therefore we have designed a clinical trial to help us answer this important question. However, before this can be started we need to conduct a miniature version of the trial to make sure it has been designed in the best possible way.

11 Validating a quality of extubation scoring system in a specialist airway centre

A quality of extubation scoring system has previously been developed within a specialist airway centre (Queen Victoria Hospital). Extubation in this case refers specifically to the removal of an endotracheal tube ("breathing tube") in the immediate recovery period after surgery. This research aims to validate this scoring system by comparing objective scores assigned by two independent raters (anaesthetists of minimum ST5 registrar level experience or a recovery nurse trained to perform extubation independently) with a subjective assessment of the quality of the extubation process (as made by the extubating practitioner - i.e. usually an experienced recovery nurse, but may be another anaesthetist). The patients observed will not be subjected to any deviation from standard post-op care - the only variation is that their extubation will additionally be observed by the two professionals making their objective assessment of the process. No objective scoring system for the quality of extubation exists at present, despite it being well accepted that objective methods are superior to subjective assessment. Validation of this scoring system will therefore be useful for guiding future research comparing the effect of different anaesthetic techniques on quality of extubation, as well as for highlighting those factors that contribute most reliably to a safe, comfortable extubation (applicable for training).

12 Objective dynamic description of facial co-contractions and facial dominance in the general population

In the context of lack of research describing normal patterns of facial co-contractions, this project aims to elucidate this research question by measuring objective patterns in healthy subjects. This will allow a baseline to be defined for assessing patients with facial nerve pathology and subsequent treatments.

13 DALES - Drug Allergy Labels in the Elective Surgical Population

Self-reported drug allergies are common in the surgical population. Allergy labels are of particular concern for anaesthetists, whose patients are exposed to a wide range of drugs during the peri-operative period. Unfortunately, many of these labels are based on reactions not indicative of true allergy, but rather of side effects or other non-allergic phenomena. Allergy labels must be interpreted on the day of surgery, and may significantly influence peri-operative drug prescribing.

The avoidance of drugs due to an allergy label is potentially harmful, with important drugs unnecessarily avoided, and alternatives given which may be less effective and more toxic. A good example is the 'penicillin allergy' label. Around 10% of the population report penicillin allergy, but fewer than 5% of these will actually be allergic. Use of broad spectrum alternatives is detrimental to patients and healthcare services. Other examples relevant to anaesthesia include spurious allergy labels for opiates and non-steroidal pain killers; the impact of these has not been assessed previously.

We aim to define the prevalence of drug allergy labelling in the UK surgical population, and to determine the proportion of these labels which are likely to reflect true allergy. For a sub-set of allergy labels, we will study their impact on perioperative prescribing. We will also conduct an attitude and knowledge-based survey of anaesthetists, to explore understanding of drug allergies, the effect of allergy labels on prescribing habits, and ideas to help reduce the burden of inaccurate labelling in the future.

14 Haemostatic markers in ECMO (HAE) study

Multicentre, prospective cohort study of haemostatic activation markers and correlation with bleeding and thrombotic complications in patients receiving extracorporeal membrane

15 Smartmatrix SMA0217

This is a multi-centre, non-comparative, prospective study to demonstrate that the Smart Matrix dermal replacement scaffold has an acceptable safety profile and enables healing in full-thickness surgical wounds. Approximately 40 patients scheduled for elective surgical excision of suspected or histologically proven BCC or SCC lesions who meet the inclusion and exclusion criteria and provide written informed consent will be enrolled in the study.
The study will be conducted in 2 stages, with the first 12 patients (the safety cohort) reviewed by the Data Monitoring Committee (DMC) to assess the safety and performance of Smart Matrix.

When the safety cohort reaches the Week 6 post-operative time point, safety and the requirement for rescue therapy, in the opinion of the Investigator, will be assessed to decide if the study should continue to full enrolment.

16 Carbapenem-resistant Enterobacteriaceae Screening Survey v1

Enterobacteriaceae are bacteria commonly found in the human intestinal tract. Over the past decade these bacteria have become increasingly resistant to antibiotics known as carbapenems which are used to treat patients with severe infections. Such bacteria are called carbapenem-resistant Enterobacteriaceae or CRE. CRE pose a significant global threat to public health as they cause infections which are easily spread and are associated with high mortality rates. CRE infections are more common in countries where the use of antibiotics is not as regulated as it is in the UK.

The spread of CRE can be prevented by screening patients who have recently been in hospitals (in the UK or abroad) known to have problems with CRE. However, the European Centre for Disease Control also advises screening patients who have recently travelled to countries known for their high rates of CRE, even if they were not in contact with a healthcare institution.

This study aims to establish whether or not NHS Trusts are indeed screening all such high risk patients and if not why. The results will provide useful information for Infection Prevention and Control teams who are currently developing or reviewing their own CRE screening policies.

17 Patient experiences of adapting to life following orthognathic treatment for facial asymmetry

The aims of this study are to understand patient experiences of undergoing orthognathic surgery for facial asymmetry and adapting to everyday life after treatment. Orthognathic treatment involves the use of orthodontic appliances (braces) and jaw surgery to correct major skeletal discrepancies in a person's jaw. Facial asymmetry is a notable discrepancy between the left and right sides of the face which affects a person's facial appearance. Symmetrical and asymmetrical faces have particular social meanings. There is a need to better understand patient experiences of facial asymmetry and adapting to facial change post-treatment.

The research will use interviews and photos to explore patient experiences before, during and after treatment. Patients of different ages and genders who have undergone orthognathic treatment for facial asymmetry will be recruited to the project. Participants will be encouraged to talk about their experiences of facial asymmetry, undergoing orthognathic treatment and their experiences of adapting to life since surgery. They will be encouraged to provide photos to illustrate their experiences and talk about these in their interviews. This project will allow us to develop recommendations for orthodontists and jaw surgeons on meeting the needs of their patients with facial asymmetry.

18 Ambulatory measurement of facial expressions in health and disease – FRAME

Spontaneous facial expressions are part of daily interactions, but can be affected by a

number of health conditions. The aim of this project is to develop a sensor enabled glasses, that can detect facial expressions of the wearer to provide pervasive monitoring of treatment effects outside the clinic. Potential beneficiaries of this technology include service users with conditions that affect facial expressions such as those living with facial palsy, Parkinson's disease and depression. FRAME is being developed as a NIHR-funded project in partnership between the host, Queen Victoria Hospital NHS Foundation Trust, and Emteq Ltd, a technology company co-founded by the study PI, Charles Nduka.

In order to assess facial expressions in specific conditions, we need to understand the patterns of data created by non-clinical volunteers as well as service users. The pilot study consists of 2 parts. First, we will investigate facial expression of service users living with these conditions and of healthy participants in response to standardised video clips designed to provoke emotional responses (Samson, Kreibig, Soderstrom, Wade, & Gross, 2016). Whilst participants are watching these videos, we will assess facial muscle activity using (i) electromyography (EMG), (ii) the non-invasive sensor technology, FRAME, embedded in a pair of glasses and (iii) video recording. This will enable us to establish a baseline and highlight markers which can help enable the technology to distinguish between emotional facial expression responses. We will also ask participants to complete a series of self-assessments. The second part of the study will investigate the recruitment usability, and retention rates of participants wearing FRAME over an extended period of time. This study will enable us to evaluate how well we can monitor facial expressions “in the wild” by having service users use the glasses at home. Participants will be asked to wear the FRAME glasses, during weekdays for up to 4 weeks at home. In addition to these measures, participants will be asked to complete short condition-specific questionnaire 3 times a day.

The eventual outcome of this pilot project will be a technology that will enable objective, remote measurement of facial expression responses.

19 Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme (PQIP)

Over ten million operations take place in the UK NHS every year. The number of patients which are at high risk of adverse postoperative outcomes has grown substantially in recent years: this is attributable to a combination of an ageing population, the increased numbers of surgical options available for previously untreatable conditions, and the increasing numbers of patient presenting for surgery with multiple comorbidities. Estimates of inpatient mortality after non-cardiac surgery range between 1.5 and 3.6% depending on the type of surgery and patient related risks. Major or prolonged postoperative morbidity (for example, significant infections, respiratory or renal impairment) occur in up to 15% of patients, and is associated with reduced long-term survival and worse health-related quality of life; this signal has been consistently demonstrated across different types of surgery, patient and healthcare system.

Data from the US demonstrate wide variation in risk-adjusted mortality & morbidity rates between healthcare providers, suggesting that at least some complications after surgery could be avoidable if standards of care were improved. It is likely that the same is true in the UK; however, there is currently no unified national system for measuring complications or patient reported outcomes across different types of major surgery in the NHS. In order to address this gap, the National Institute for Academic Anaesthesia’s Health Services Research Centre (NIAA-HSRC) has launched the Perioperative Quality Improvement Programme (PQIP) for the UK. PQIP will measure risk-adjusted morbidity and mortality, as well as process and patient-reported outcome data in adult patients undergoing major surgery (eg lower GI resection, upper GI resection, liver resection, cystectomy, major head and neck reconstructive surgery, thoracic resection).

20 Ciclosporin 1mg/ml eye drop emulsion (Ikervis) for the treatment of severe keratitis in adult patients with dry eye disease, which has not improved despite treatment with tear substitutes

Dry eye disease (DED), also known as keratoconjunctivitis sicca, is a multifactorial, chronic and progressive ophthalmic disease causing inflammation and damage to the ocular

surface, caused in part by increased osmolarity of the tear film.

Treatment depends on disease severity. Currently available medical options include artificial tear products, lubricants, topical steroids and ciclosporin A (CsA). Lubricants are classified as 'health products', proof of their efficacy is not required by Health Authorities [15], and many are available over-the-counter. Mild to moderate DED can usually be treated symptomatically with tear substitutes, but few effective treatments exist for moderate to severe DED. Artificial tears provide short-term relief at best, and require frequent dosing.

The efficacy of Ikervis has been explored in trials however there is a lack of evidence from the real-world, observational setting. This non-interventional prospective study will evaluate the effectiveness, tolerability and safety of Ikervis in routine clinical practice. As such, the study will recruit a substantially more heterogeneous patient population than would be seen in a clinical trial.

21 Head & Neck 5000 Follow Up Study

Head & Neck 5000 is a large observational study of people with head and neck cancer from across the United Kingdom. The overall aim of the Head & Neck 5000 Follow-up Study is to describe the social, lifestyle and clinical outcomes in people with head and neck cancer and relate these to information gained from the original Head & Neck 5000 study. In order to achieve this, participants who have taken part in Head & Neck 5000 for at least three years will be sent an invitation to complete the Follow-up Study questionnaire. Data will be collected from the medical notes and through linkage to national databases for all participants who consented to this.

22 Validation of the MIRROR facial expression tracking application in healthy subjects and facial paralysis patients

Facial paralysis (FP) presents from either a peripheral nervous abnormality (most commonly Bell's Palsy) or a central nervous lesion (usually a cerebro-vascular accident (CVA)). Bell's Palsy accounts for 60% of cases of facial palsy, causing up to 24,800 new UK cases annually, leaving upwards of 100,000 people living with permanent disability. Of the 152,000 CVAs per year in the UK, many patients suffer resultant chronic facial movement problems. Current methods for tracking facial expression recovery include subjective measures, e.g. doctor-delivered grading systems, and objective measures, e.g. 2D / 3D imaging (photography and/or stereophotogrammetry) or videos of dynamic facial function. However, a consensus method for objectively measuring initial paralysis and monitoring progress towards normal facial expressions remains elusive. Gold standard treatment for FP includes daily rehabilitative exercises, but patients often fail to perform these regularly due to lack of feedback on exercise efficacy leading to demotivation and non-compliance with the prescribed physiotherapy. This in turn reduces patients' likelihood of recovery of normal facial function.

A new iPad-based non-invasive physiotherapeutic software application (MIRROR) has been developed, allowing FP patients to objectively track their paralysis / facial expressions in real-time via MIRROR's immediate feedback on exercise performance. To validate MIRROR, a study has been designed to analyse the facial movements of healthy and FP patients pre- and post-administration of Botulinum toxin (BT). Each subject's response to BT over the period of action of the injected BT will be assessed. Subjects will have their facial expressions quantitatively analysed via subjective grading scales validated for use in FP analysis, 2D / 3D imaging, via surface-electromyography (sEMG) and using MIRROR.

23 Pharmacists' perceptions of patient medicines helplines.

The aim of the study is to explore pharmacy professionals' perceptions of the benefits of patient medicines helplines, their limitations, and ways that they can be improved. Through learning about pharmacy professionals' experiences and perceptions of medicines helpline services, we aim to make suggestions to improve how helplines are operated so that they better meet the needs of service users and providers. This accords with the NHS agenda of seeking service providers' views and experiences to improve service quality.

24 Lock & Key

At any time, around 10% of people carry meningococcal bacteria in the nose and throat, which can cause meningitis, blood poisoning and other serious illnesses. Most people carry these bacteria and never become ill, yet a very small proportion go on to develop these illnesses which can result in life long disabilities or death. The mechanism by which this happens is poorly understood and has been studied in various ways, usually focussing on the bacteria or on the individual, but none has given a definitive answer. This study will be the first of its kind and will assess the interaction between the host and the bacteria at the genetic level, through genetic mapping, helping us to understand what makes some people susceptible to this infection.

The study will have minimal impact on individuals as we hope to use residual samples from those collected whilst they were in hospital or convalescing, though we will have the mechanism for collection of a new sample in the few cases where no residual is available. The study will include all cases recorded within a five year period regardless of age, and whether or not they survived. This is essential in gaining a breadth of information. The study will not affect the care pathway, which is explained in the information leaflet, but could contribute to the development of new treatments and vaccines, which it is anticipated would be of interest to anyone who has experienced this infection as those being invited to participate will either personally have done, or as the family of a case.

25 Lugol's Iodine in Surgical Treatment of Epithelial Dysplasia in the Oral Cavity and Oropharynx

When patients are referred with abnormal lining tissue (mucosa) in the mouth or throat which has been present for more than two weeks a sample of this tissue (a biopsy) is taken to assess the surface cells under the microscope. In these abnormal areas, there can be changes to the cells: this is called dysplasia. The cells can be slightly abnormal or very severely abnormal. If they are very severely abnormal, a cancer is more likely to develop from them in the future. This is why these changes are also referred to as precancerous changes. We know that removing these cells can reduce the risk of cancer developing. However it is often difficult for surgeons to see clearly where the abnormal tissue ends and normal tissue starts.

Lugol's iodine stain, which has been used as an antiseptic for many years, is used in some other parts of the body to help identify these precancerous cells. We think that this stain might help us to be more sure of removing all of the precancerous/abnormal cells and leaving behind the normal areas. There is evidence which suggests that if we do this, fewer patients will develop cancer after surgery and so more will be successfully treated.

26 MindSHINE 3

Stress, anxiety and depression are significant causes of sickness absence among NHS employees, and contribute to the NHS having higher rates of sickness absence than any other public sector organisation in the UK. The effects of psychological distress not only impact healthcare workers as individuals, but can also have negative consequences for their patients via a compromised quality of care.

The term mindfulness refers to a specific way of paying attention, non-judgmentally, to present moment experiences. The development of mindfulness skills is considered to lead to a number of therapeutic benefits including increased compassion for oneself and others, and reductions in negative emotional states. A wealth of empirical research supports the effectiveness of mindfulness-based interventions (MBIs) among both clinical and non-clinical populations. More specifically, recent research reports significant benefits of traditionally delivered, face-to-face MBIs among NHS employees, and mindfulness-based self-help (MBSH) among medical students. Especially when considering the limited number of qualified practitioners available to deliver face-to-face MBIs, and the 24/7 nature of NHS working hours, MBSH may offer particular potential among NHS employees in terms of flexibility, accessibility

and cost-effectiveness.

The proposed Randomised Controlled Trial (RCT) is primarily intended to investigate the effectiveness of smartphone-delivered MBSH intervention 'Headspace' in reducing stress among NHS staff. A large sample of NHS staff will be randomly allocated to receive either Headspace or an active control condition (NHS website for work-stress). The RCT will also aim to answer questions relating to the effectiveness of Headspace in improving other markers of psychological well-being and psychological distress, sickness absence, and compassion. Objective and subjective measures of engagement will be taken, and mediation and moderation analysis will be conducted in order to establish the processes and factors influencing MBSH engagement and outcomes.

27 A nationwide survey of prosthetic eye users: a collaborative study with all NHS ocular prosthetic service providers.

Patients who wear an ocular prosthesis often suffer with dry eye symptoms. Up to 90% will also complain of socket discharge, many on a daily basis. No literature exists on their quality of life post eye loss or adapting to monocular vision. Psychometric questions from the National Eye Institute Visual Functioning Questionnaire, investigate the patient's quality of life and how the loss of an eye has impacted on patients' well-being.

Participants receive a questionnaire covering aetiology, length of prosthetic eye use, length of eye wear, age of prosthesis, cleaning regime, lubricant use, inflammation, comfort and discharge. Lower scores relate to a better-tolerated prosthesis. Is there an association between deposit build up, frequency of ocular polish, to socket discharge and dry eye symptoms? A series of quality of life questions probe the effects of monocular vision on day-to-day activities, hobbies, driving and how each patient regards their own general health after the loss of an eye.

28. Ex-vivo Infection Detection - EVIDEnT

Burn wound infections are difficult to diagnose. Diagnosis involves removing dressings, which may slow the healing process. A new dressing (SmartwoundT) may help to diagnose infection without needing to remove dressings, and capsules within the dressing will change colour if the number of bacteria in the burn wound indicate that it is infected. Before it is used with patients, we need to check whether the capsules can identify when bacteria are, or are not, present in wounds. This study will use samples from patients with and without infected wounds to check whether the capsules change colour in the presence of bacteria that are causing a wound infection. The samples will come from burn wound fluid (exudate) taken from used wound dressings, and from swabs and gauze used during normal care of patients with burns. Both adults and children with and without infected burn wounds, who attend one of four participating Burns Services will be asked to participate. Participants will be asked to consent to have their dressings kept by the study team once they have been removed during the course of their normal treatment, and for swab samples to be taken. From these a sample of exudate will be tested. Information will be recorded from participants' notes about their health, care, suspected presence of infection and need for antibiotics. Participants will be followed-up within 21 days, either as part of normal scheduled clinic visits or by phone, and will be asked about their wound healing and health status. The Smartwound dressing's ability to detect infection will be measured using visual assessment of colour change. Bacteria from the swab will be tested separately to confirm presence of infection. Findings from this study will indicate whether capsules are effective in detection of infection prior to studies into the development of their use in dressings.

29. Antibiotic Levels in Burn wound Infection (ABLE)

Burn wounds have a high risk of developing infections. Oral or intravenous antibiotics are routinely given to manage such infection; however, the appropriate use of antibiotic therapy as a means of treating infection has become a topic of international debate due to rise in antimicrobial resistance (AMR). Several issues within the management of burn wound infection have led to the question of therapeutic levels being found in the burn wound. The

most common antibiotic used, Flucloxacillin, belongs to a family of antibiotic known as Beta-Lactam antibiotics. Unfortunately this group of antibiotics is known to bind to serum proteins in the blood, meaning a fraction of the original dose is available and active at treating infection. Secondly, the antibiotic needs to be transported to the area which needs treating. The body does this by transporting the drug through the blood; however, burn wounds have an impaired blood supply which would lead to the supposition that very low levels enter the wound. Furthermore, the wound environment may have an altered pH which may further prevent effective utilisation of the antibiotic as antimicrobials such as Flucloxacillin have a narrow band of acid/alkali that they can be effective in.

The main question that the study will answer will be whether we can find therapeutic levels of antibiotics in patients wounds, which are sufficient to treat the infection.
Participants will give consent to participate and then give a wound exudate swab and blood test to measure their levels of antibiotic. At each subsequent dressing change the wound swab and blood samples will be repeated until the participant finishes their course of antibiotics. This is likely to be up to a maximum of 4 blood samples and 4 additional wound swabs

The study population will be adults with burn injuries over and including 1% total body surface area who are being treated with antibiotics for suspected or confirmed infection.

30. EuPatch

Amblyopia (also called lazy eye) is the most common disease affecting vision in childhood. It affects between 2 to 5% of the population and 90% of visits to children's' eye clinics are for the purpose of treating amblyopia. Currently 30% of children treated for amblyopia do not reach normal vision after a year or more of treatment. Amblyopia is usually treated with glasses wearing and by patching the better eye.

There is controversy whether a long period of glasses wearing before patching, called refractive adaptation, helps in treating children with amblyopia. Refractive adaptation has not been tested in a randomised controlled trial, and currently we do not know how long children wear glasses each day.

The purpose of this study is to perform the first randomised controlled trial to test whether refractive adaptation before patching improves the number of successfully treated children with amblyopia. We will use electronic monitors to measure how much children wear their glasses and patches each day and will determine how this relates to their improvement in vision. We will also investigate whether different types of amblyopia respond better to different treatments.

31. Investigation of Potential Biomarkers in the Role of Scar Formation

The reason for the development of a scar is not clearly understood and the causes are multi-factorial. In simple terms, scarring may be a direct consequence of evolutionary changes that have lead to a rapid healing of the wound site in order to prevent infection. As a consequence of this speed of wound epidermal closure, the cells in the dermis of the skin are prone to produce inappropriate amounts of extracellular matrix molecules. It is this over production that leads to the formation of a scar.

The only example of scar-free healing is in utero. Surgery performed on a foetus in the third trimester (and these often save lives of unborn children) do not leave any traces of surgical intervention. A child is born without a scar. This amazing ability is lost shortly after birth and for the rest of adulthood, any post-traumatic event to the skin results in the production of a scar. The Queen Victoria Hospital (QVH) is a regional centre for burns and plastic surgery. The hospital treats patients with acute wounds and those undergoing surgical reconstruction or scar revision. As part of this treatment scar tissue will often be removed and disposed of as clinical waste. This redundant scar tissue offers the possibility of developing a clearer understanding of the mechanisms of scar formation.

32. SUBMIT

Metacarpal fractures are common, accounting for 40% of all hand injuries and many can be treated non-operatively. However, surgery is reserved for cases in which an adequate reduction of both angular and rotational deformity cannot be maintained or where an adjacent ray is damaged.

A variety of surgical strategies exist, including percutaneous kirschner wiring, intramedullary fixation, and fixation with plate and screw construction. A plate secured along the dorsal midline of the metacarpal has been shown to be the best biomechanical method of fixation, and allows early aggressive hand therapy post-operatively.

Traditionally, bicortical fixation is the standard practice, where both dorsal and palmar cortices of the metacarpal are drilled though. However, such practice is not without risk. In this method, the flexor tendons and neurovascular bundles at risk from over-zealous drilling through the palmar cortice. Correct screw size selection is also critical as overly long screws can irritate and cause rupture of flexor tendon. More recently, with the advent of a new generation of locking plates, unicortical fixation, where only the near cortex is drilled, has been used to treat fractures. Unicortical fixation is a surgically less complex operation, can theoretically cause less damage to surrounding soft tissues and avoids the complications associated with incorrectly sized screws.

This trial aims to compares the functional outcomes and complications of patients having unicortical versus bicortical fixation for diaphyseal metacarpal fractures.

33. A study to refine the CAR burns scales

A burn injury can greatly impact upon a person's quality of life. In order to provide the most useful support it is vital for health workers such as doctors, nurses, psychologists and physiotherapists to know what are the most important issues to patients affected by burns. Therefore in collaboration with burn patients themselves, a survey has been developed which explores adult's experiences of living with a burn injury. The plan is for all adults that are seen in hospital for a burn injury to complete this survey, so health professionals can identify their support needs and their treatment progress.

We are asking adults living with a burn to complete this survey to test out the questions. The results of this study will help us shorten and refine the survey, so it can be used in burn units throughout the UK to provide the best possible care and support for patients and their families.

34. Molecular mechanisms and pathways of chronic inflammatory and degenerative diseases

Using synovial tissue in explant cultures obtained from rheumatoid arthritic patients undergoing joint replacement surgery, the Kennedy Institute was the first research laboratory in the world to identify the pathogenic role of the inflammatory cytokine tumour necrosis factor alpha (TNF) in Rheumatoid Arthritis (RA). Biological therapies that block the function of TNF are now clinically proven and over one million people worldwide have been treated successfully with this drug. However, this is not a cure for RA, so current research activities at the Kennedy are aimed at understanding those events that trigger RA, and developing better therapies for this disease.

Patients scheduled to undergo a surgical procedure as a result of arthritis or other inflammatory diseases, will be given the option to take part in our study. In addition waste tissue will be obtained from an amputation as a result of a traumatic injury and adipose as a result of an abdominoplasty. A qualified clinician / GCP trained team member will take written, informed consent prior to surgery. Waste tissue from surgery is collected in a sample pot and couriered to the Kennedy Institute. This waste tissue includes joints (cartilage and bone), periarticular tissue, connective tissue (muscle and fascia) and other soft tissue such as skin.

The tissue will be processed ex vivo to liberate single cell suspensions, which will then be cultured for up to 5 days or long term lines will be derived. Cell supernatants will be analysed for cytokine, MMP and other inflammatory mediators by ELISA and cell phenotype determined by Flow cytometry. In addition mRNA will be harvested and gene expression determined by TaqMan

PCR. The histopathology of the tissue will also be looked at.

35. Molecular genetics of adverse drug reactions

Adverse drug reactions (ADR's) are a common cause of drug-related morbidity and may account for about 6.5% of all hospital admissions. A meta-analysis of studies performed in the USA has shown that ADRs may be the fourth commonest cause of death. ADRs are also a significant impediment to drug development, and a significant cause of drug withdrawal. The purpose of this research is to (a) identify patients with different types of adverse drug reactions; (b) using DNA obtained from blood or Saliva samples from these patients, identify genetic factors which predispose to adverse reactions. The net effect of our research will be the development of genetic tests which can help in predicting individual susceptibility to adverse reactions prior to the medication's administration. Patients with a pre-disposition to reacting adversely can be prescribed alternative medication of monitored more closely during their treatment. This will reduce the harm for patients and save valuable resources for the NHS.

We aim to recruit 250 cases for each reaction for a period of eight years throughout multiple sites in the UK. Specific adverse drug reactions we are looking at include:
- Statin induced myotoxicity, characterised by high CK
- Severe hypersensitivity reactions including Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis
- Anaphylaxis induced by NMBA anaesthetics
- ACE inhibitor or ARB induced angioedema
- Taxane hypersensitivity
- Chemotherapy induced peripheral neuropathy
- Bleomycin induced lung toxicity
- Clozipine induced agranulocytosis or neutropenia
- Bisphosphonate-related osteonecrosis of the jaw
- Tenofovir associated renal injury
- Serious bleeds induced by warfarin or other anticoagulants

36 The co-administration of multiple drugs in intensive care units

Critically ill patients, especially those admitted to intensive care units (ICUs) tend to receive numerous drugs intravenously (IV) which can sometimes outnumber the available sites on the body for IV administration. Therefore, multiple drugs are administered through the same line using a Y-site connector, which is a small device that can be connected to the lumen of a central or peripheral venous catheter, allowing drugs to be mixed together in the tubing of the lumen before entering the patients' bloodstream. Co-administration of drugs in this way increases the risk of combining drugs which may not be compatible with each other. Mixing of incompatible drugs can result in chemical or physical reactions that may reduce the efficacy of one or more of the drugs. This could lead to patient harm or prolonged treatment. It is therefore important that IV drug compatibility is known and can be determined by healthcare professionals before co-administration. Data on compatibility is fairly limited with nurses sometimes using alternative ways to administer medicines safely to patients. This study aims to understand the practice surrounding coadministration of multiple medicines and collate drug combinations nurses would like to have compatibility information on.

37 Experiences of using NHS patient medicines helplines

Research suggests that recently discharged hospital patients often lack information about their prescribed medicines. Patient medicines helplines enable discharged patients to speak to a hospital pharmacist for medicines information. Patients can also call about medicines errors, and studies suggest that between 19-39% of calls avoid harm to patients. However, studies also suggest that patient medicines helplines are not as widely used as they could be. On average, acute Trusts receive 8 calls per week, and only 52% of Trusts in England currently provide the service.

Service evaluation survey studies have been conducted to examine what patients think of

medicines helplines. However, such studies have limitations. For example, surveys include questions and answer options which are important to the researcher, rather than allowing participants to provide information that is important to them. Also, service evaluations may be prone to bias, since they are typically conducted by the service operators. We would like to know more about the benefits of medicines helplines, and ways that they could be improved. Establishing this may help to increase their availability and use. To achieve this, qualitative research methods would be preferable.

This study involves carrying out interviews with patients and carers within one month of them using a medicines helpline service. The aim of the study will be to explore service users' experiences of the service, and how things have been for them since. Interviews will enable participants to use their own words to describe their experiences. Through learning about service users' experiences of patient medicines helplines, we aim to make suggestions to improve how helplines are operated so that they better meet the needs of patients and carers. This accords with the NHS agenda of seeking patients' and carers' views and experiences to improve service quality.

38 The anatomy of flexor tendon repair

This study will be a joint project with the Department of Anatomy and Queen Victoria Hospital and look at different methods of tendon repair in cadaveric hands.

Specifically, the volume of the knot and suture material as a proportion of the cross sectional area of the tendon, the circumference of the tendon repair site and the degree of shortening will be measured in cadaveric hands for different types of tendon repair.

39. S100 & CD31 in tongue cancer (Perineural and vascular invasion in tongue cancer: is detection improved using markers for nerves and blood vessels?)

Microscopic invasion of nerves and blood vessels in oral cancer is an unfavourable prognostic indicator, but depends on the histopathologist sampling the tumour adequately and then identifying these features in tissue sections using routine haematoxylin and eosin (H&E) stains. There is evidence that suggests that staining the section for a marker of nerves (S100 protein) and the cells lining blood vessels and capillaries (CD31) increases the microscopic detection of perineural and vascular invasion by 52% and 12% respectively. Thus nerve and vascular invasion could be significantly underreported.

We are currently auditing the incidence of perineural and vascular invasion by cancers arising in subsites swithin the oral cavity, and aim to assess the degree of underreporting, if any, in a sample of 60 cancers of the tongue. Thirty of these were originally reported as showing nerve invasion in the excision specimen, thirty were reported as negative. Only two were reported as showing vascular invasion.

40. Molecular prediction of metastasis in oral tongue squamous cell carcinoma (external study)

A cDNA microarray study carried out in Utrecht (Netherlands) discovered genetic differences between primary squamous cell carcinomas of the oral cavity and oropharynx that spread to the neck and those that do not. This work leaves the door open to genetic analysis of a tumour of the tongue that has yet to spread to the neck. It may be possible to check the genetic makeup of the tumour, using a combination of antibodies to help surgeons decide how likely a tumour is to spread to the neck and to decide whether or not a neck dissection operation or radiation to the neck is necessary. This could avoid unnecessary morbidity and mortality. Patients with squamous cell carcinoma of the oral tongue are to be identified with at least 5 year follow up i.e. diagnosed before October 2004. Two groups are to be identified: those with spread to the neck, and those who did not develop spread to the neck. Case notes are to be reviewed and all clinical data and treatment, overall and event free survival are to be recorded. The histopathology slides and blocks of tumour archival material are to be identified will be used to make a tissue microarray. This is a research technique which allows for genetic analysis of samples to be done more quickly than routine techniques. No new samples

	collection or patient interventions are to be undertaken. The data will then be analysed to see which markers show differential expression between the two groups, or have relationship to overall and event free survival. These markers, used in combination, may be used in future prospective studies and in treatment planning. **Planned projects – studies which had not been given Approval as of 01/04/19, but which are expected to start in 2019-20** • Facial muscle responses with reported pain scores • SAVER • Allotex 3 • SPACE • IDose

11.	Report approval and governance
	This annual report has been reviewed by our R&D Governance Group, as well as by the Quality and Governance Committee.

Report cover-page					
References					
Meeting title:	**Trust Board**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**155-19**	
Report title:	Consultant revalidation annual report				
Sponsor:	Ed Pickles, Medical Director				
Author:	Ed Pickles, Medical Director Katie Ally, Medical Workforce Coordinator and Revalidation Administration Support				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Committee with assurance regarding the process of appraisal and revalidation for medical and dental staff.				
Summary of key issues	Note appraisal rate, statement of compliance, completed 2018/19 action plan, and 2019/20 actions.				
Recommendation:	Agree statement of compliance.				
Action required	Approval ✓	Information ✓	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *Outstanding patient experience*	KSO2: *World-class clinical services* ✓	KSO3: *Operational excellence*	KSO4: *Financial sustainability*	KSO5: *Organisational excellence*
Implications					
Board assurance framework:	BAF KSO 2				
Corporate risk register:	Not impact on the to the CRR				
Regulation:	The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'				
Legal:	As above				
Resources:	This annual report was produced using existing resources.				
Assurance route					
Previously considered by:	Quality and Governance Committee				
	Date:	24/07/19	Decision:	The report has been received and partial assurance has been given due to difficulties in securing all appraisals in year. Action: New deputy Medical Director role to support this process to achieve full assurance.	
Next steps:	To QVH Board for approval.				

A Framework of Quality Assurance for Responsible Officers and Revalidation – Queen Victoria Hospital Annual Board Report 1st April 2018 to 31 March 2019 and Statement of Compliance

1.0 Executive Summary

The medical revalidation and process is used to provide assurance to the General Medical Council (GMC) that a doctor has fulfilled the necessary criteria to continue their licence, based on the Good Medical Practice Framework published by the GMC.

All doctors are required to have a prescribed connection to a Designated Body. Designated Bodies include NHS Trust, Local Education and Training Boards, (LETB), Locum Agencies and other organisations. Each Designated Body has a Responsible Officer (RO), usually the Medical Director who is responsible for the appraisal and revalidation process.

Doctors on training rotations are connected to the Local Education and Training Board (LETB) with the relevant Dean as their Responsible Officer. All other doctors who perform the majority of their practice at Queen Victoria Hospital are connected directly to the Trust. Doctors connected to Queen Victoria Hospital fall under the responsibility of Dr Ed Pickles, Medical Director, as the Trust's Responsible Officer (RO).

As of 31 March 2019, 98 doctors had a prescribed connection with the RO.

2.0 Purpose of the Paper

The purpose of this report is to provide assurance to the Board that arrangements for Medical Appraisal and Revalidation have been operating effectively during the calendar year (1 April 2018- 31 March 2019). This report forms part of the Medical Director's duties as a Responsible Officer (RO).

Appraisal for the purposes of revalidation is made up of two elements:

- The appraisal element, which is the process by which a doctor is supported in their continuing professional development
- The revalidation element, whereby a doctor demonstrates that they remain up to date and fit to practice.

3.0 Background

Medical Revalidation was launched in 2012 to strengthen the way doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Trusts have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that Trusts will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- Confirming that feedback is sought from patients periodically, so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment checks (including pre-engagement of locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate for the work performed.

The Trust submits quarterly and annual confirmation of appraisal rates to South East and South West Regions Team (NHS England and NHS Improvement). The Annual Organisational Audit (AOA) has been simplified by NHS England with the removal of most non-numerical items. This

Annual Board Report and Statement of Compliance[1] is presented in a revised format and now includes the qualitative questions previously contained in the AOA and is offered to support QVH in reviewing its progress in the following key areas over time and combines the Statement of Compliance for efficiency and simplicity

- Annual Organisation Audit 2018-2020
- Effective Appraisal
- Recommendations to the GMC
- Medical Governance
- Employment Checks
- Summary of Comments and overall conclusion
- Statement of Compliance

The report is based on appraisal rates for those with a prescribed connection to the Trust as at 31 March 2019.

This report is to provide assurance to the Quality & Governance Committee that the appropriate processes are in place within Queen Victoria Hospital for the management of medical appraisals and revalidation, as well as providing an update on the recommendations for further improving process.

4.0 General

4.1 The Annual Organisational Audit (AOA) report 2018-19

A summary of figures was submitted to the South East and South West Regions Team (NHS England and NHS Improvement) on 5th June 2019 as part of the Annual Organisational Audit (AOA) report is shown below:

	Number of Prescribed Connections	Completed Appraisals	Approved Incomplete or Missed	Unapproved Incomplete or Missed
Consultants	64	60 (94%)	0	4 (6%)
SAS Doctors	8	6 (75%)	0	2 (25%)
Doctors on Performers List	0	0	0	0
Doctors with practising privileges	0	0	0	0
Temporary or short-term contract holders	25	24 (96%)	0	1 (4%)
Other doctors with a prescribed connection	1	0	0	1 (100%)
Total	98	90 (92%)	0	8 (8%)

Comments; Dr Pickles is standing down from the role of RO following a period of 3 years with effect from 30 September 2019. Mr Keith Altman, Consultant Maxillofacial Surgeon has been appointed as incoming Medical Director and RO with effect from 1 October 2019.

The 8 unapproved incomplete or missed appraisals consisted of factors doctors, appraisers and organisational.

Factors	Unapproved incomplete or missed appraisal
Doctor	6
Lack of Participation	4
Out of date prior to start	1
New Overseas Doctor	1
Appraiser	1
Administration or Management	1
Total	8

Action for next year; continued use of the TRAC recruitment system to identify at the start of every new employment the doctor's appraisal due date and to allocate a QVH appraiser on commencement of employment.

[1] Annex D – Annual Board Report and Statement of Compliance

4.2 The designated body provides sufficient funds, capacity and other resources for the RO to carry out the responsibilities of the role.

Dr Pickles acknowledges sufficient funds, capacity and resources are available to carry out the responsibilities of this role.

Comments: the incoming RO, Mr Keith Altman may wish to review funds, capacity and resources available for this role.

Action for next year will be deferred and reviewed by Mr Altman during Q3.

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The GMC Connect portal is utilised to ensure an accurate record of all doctors with prescribed connection is maintained. This is regularly monitored by the RO and Medical Workforce Office. A new doctor is added to the list and when a doctor leaves the Trust the doctor is removed from the list.

Comments: some newly appointed oversea doctors are not always fully aware of the GMC Connect process and their responsibility to connect to their new designated body.

Action for next year; continue with existing good practice plus improve communication and offer further guidance to newly appointed oversea doctors.

4.4 All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Trust has a published Medical Appraisal, Revalidation and Remediation Policy which aims to ensure doctors within its employment receive high quality appraisals which support their practice with a view to identifying development opportunities, provide greater assurance to patients and drive continuous improvement. It is expected that by engaging in the appraisal process, this will enable the RO to make a recommendation to the General Medical Council that the doctor can continue to practice. All Trust policies are reviewed every 3 years.

During early 2019 this policy was reviewed and was presented to the Appraisal & Revalidation Recommendation Panel (A&RRP) for comment on 10 June 2019.

Action for next year; the revised policy will be presented to the Local Negotiation Committee in July 2019 for discussion and ratification.

4.5 A peer review has been undertaken of this organisation's appraisal and revalidation processes.

An annual screening review was conducted in August 2018 by the Higher Level RO (HLRO) (South).

Comments; a following up meeting with the HLRO is due to take place during 2019, dates are yet to be confirmed by Higher Level RO (HLRO) (South).

Any actions for next year will be agreed following peer review.

4.6 A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

During the year; TRAC has continued to provide greater visibility of previous appraisals and revalidation needs of locum or short-term placement doctors new at QVH in the pre-employment checks stage. This enables increased accuracy of appraisal records and earlier engagement with the doctors thus maintaining continuity of revalidation and governance.

Comments: historically it has proven difficult to maintain accurate information for doctors employed on the Medical & Dental Bank who do not have a prescribed connection with QVH. Plans are in place to recruit Medical & Dental Bank doctors using TRAC to improve this issue.

Action for next year; a recruitment to the Medical & Dental Locum Bank will be via the TRAC.

5.0 Effective Appraisal

5.1 All doctors in this organisation have an annual appraisal that covers a doctor's whole scope practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

During the course of the year we have made available on request Appraisal and Revalidation Data Packs. These packs share with the doctor: complaints, incidents together with information relating to their statutory and mandatory training compliance. This allows for reflective practice from own experiences to improve ways of work and engage in a process of continuous learning and development. For those doctors whose scope of practice covers spoke sites Medical Practice Information Transfer (MPIT) Form are required.

Comments; the requirement to include an MPIT can on occasion be overlooked by doctors as part of the annual appraisal process however any omissions are identified and then provided before a revalidation recommendations.

Action for next year; Medical Workforce will improve guidance and communication regarding the necessity of MPITs as part of annual medical appraisal supporting documentation.

5.2 Where in 5.1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

During the year; there were 8 unapproved incomplete or missed appraisals due to doctors, appraisers and organisational factors.

Action for next year; review the communications and processes for the small minority who do not actively participate in annual appraisal within a 12 month period. Introduce early escalation to Clinical Directors and the RO ensuring participation in a meaningfully annual appraisal in accordance with GMC revalidation regulations.

5.3 There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

During early 2019 this policy was reviewed and presented to the Appraisal & Revalidation Recommendation Panel (A&RRP) for comment on 10 June 2019.

Comments; there has been no significant changes introduced with the exception of moving all appraisal dates to fall within the 1 April to 31 December. The objective is to complete all medical appraisals within a nine month period from 1 April to 31 December period, thus striving to improve the completed appraisal rate by 31 March 2020.

Action for next year; the revised policy will be presented to the Local Negotiation Committee in July 2019 for discussion and ratification.

5.4 The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

There are currently 20 trained appraisers.

Specialty	No. of Appraisers
Anaesthetics	5
Cornoe Plastics	4
Oral & Maxillofacial Surgery	1
Orthodontics	3
Plastic Surgery	6
Radiology	1
Total	20

During the year; 1 appraiser was reinstated having undergone recent training and 1 was recruited.

Action for next year; confirm appraisers wish to continue with the role and seek to recruit at 2 further appraiser from Oral & Maxillofacial Surgery.

5.5 Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

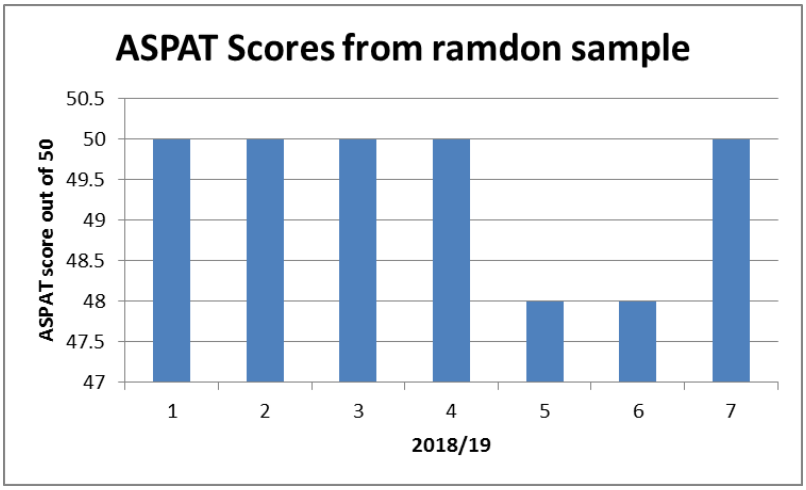
During the year we collaborated with East Sussex and Healthcare NHS Trust and Brighton & Sussex University Hospital Trusts to provide quality assured training for new appraisers to ensure quality and consistency.

Following an internal review by Mazar's in March 2018; agreed action was to ensure all appraisers at the Trust attended appraiser training, annual updates and participate in annual peer network sessions. During the year, these sessions have been incorporated into the Consultants' Statutory and Mandatory Update Sessions which take place in February and September annually. To date 84% of appraisers have attended these sessions.

Action for year; to increase attendance rate to 90%+

5.6 The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The Trust samples appraisal outputs using NHS England's Appraisal Summary and PDP Audit Tool (ASPAT)[3]. The data is anonymised and shared with appraisers and identifies future training needs for doctors and appraisers. Findings are shared with the Appraisal & Revalidation Recommendation Panel (A&RRP). The Panel is authorised by the Board of Directors to monitor the progress in implementing the Responsible Officer Regulations.



[2] https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/quality_assurance_medical_appraisers_main_document_v5.pdf
[3] https://www.england.nhs.uk/medical-revalidation/appraisers/aspat-notes/

Comments; the RO seeks to adopt greater evidence of reflective practice during appraisal discussions in order to improve the quality of care.

During the upcoming year; the ASPAT generic tool will be reviewed to include greater clarity on reflective practice.

6.0 Recommendations to the GMC

6.1 Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

During the year; there were 16 recommendations made on time with 0 late or missed recommendations, of which 0 were deferred.

Actions for next year; there are 25 recommendations due.

6.2 Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All upcoming recommendations are reviewed and discussed by the Appraisal & Revalidation Recommendation Panel (A&RRP) during its quarterly meetings. Any issues relating to the doctors revalidation portfolio are communicated to the doctor in a timely fashion by either the RO or Medical Workforce.

Comments: none

Action for next year; to maintain current process.

7.0 Medical governance

7.1 **This organisation creates an environment which delivers effective clinical governance for doctors.**

All doctors work within the clinical governance framework of the trust, which fulfils all CQC patient safety, risk and quality improvement requirements. Clinical incident reporting is monitored by the medical director and Quality and Governance committee to ensure any conduct and capability concerns are reported and acted on promptly. The introduction of data packs collates this information in a reportable format suitable for appraisal.

7.2 **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Conduct and performance concerns are reported via direct reports to the medical director, through patient and staff complaints, clinical governance, including audit and outcome measurement and incident reporting. The response monitored through annual appraisal and direct intervention by the RO where needed.

7.3 **There is a process established for responding to concerns about any licensed medical practitioner's1 fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns**.

The trust utilises a policy based on the national 'Maintaining High Professional Standards (MHPS)' and GMC guidance. This has been recently revised and will be ratified at Local Negotiating Committee in 2019/20.

7.4 **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.**

Responding to concerns is undertaken by the Medical Director, supported by the Director of Workforce, and discussed with the GMC Liaison Officer and NCAS / NHS Resolution as required. Any investigation conducted is overseen by a non-executive board member. Numbers and type of complaints are reported annually through this report.

7.5 **There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.**

This is managed by the Responsible Officer and the Appraisal and Medical Workforce Coordinator. Timely transfer of information from other organisations can be challenging at times.

We will make minor adjustments to the RO contact details, using a generic email address, monitored by the Medical Workforce team, to improve our own responsiveness to requests from other organisations. Information from within the QVH risk and complaints teams is readily available to support responses.

7.6 **Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

The Disciplinary policy for medical and dental staff has been revised in 2019, and continues to adhere to national MHPS and GMC / NHSE guidance on managing concerns. Concerns are managed by the RO and Medical Director, supported by The Director of Workforce and OD, and the HR team as required.

8.0 Employment Checks

8.1 A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties**.**

Since last year, QVH has fully adopted TRAC when recruiting medical staff which not only reduces the cost of recruitment, but makes recruitment processes faster and more robust. Using Trac has simplified the pre-employment checks, saved time by having all checks and documents stored in one place including a self-declaration relating to conduct issues or performance investigation by a previous employer. Weekly reports are reviewed by the Medical Workforce Manager in which any significant issues are identified and addressed during the recruitment stage prior to commencement of employment.

All new applicants are asked questions based on the Trust's values, in additional the standard clinically based questions at interview. The purpose of this is to assess organisational fitness and ensure that they are able to converse and understand medical terminology at an appropriate level in English. References follow a set format and must include past employer, most recent Responsible Officer declaration.

A similar although more extensive assessment process using Stakeholder Panels is part of the recruitment process for consultants and consideration will be given to the possible introduction for permanent non-consultants career grade staff.

Action of the current year; continue with good practice and scope changes to the current recruitment process for permanent non-consultants career grade staff.

9.0 Summary of comments, and overall conclusion

9.1 General review of last year's actions.

In addition to refreshing the terms of reference and structure of the revalidation panel, there has been a significant improvement in the annual refresher training of both appraisers and appraisees. This is reflected in the quality of the information supplied for appraisals, demonstrated through consistently high ASPAT scores. The embedding of providing trust 'data packs' for doctors has allowed for triangulation between trust derived data and that supplied by doctors to their appraisals.

9.2 Actions still outstanding

All previous actions were completed by 30 April 2019.

9.3 Current Issues

Since 1 April 2019 medical appraisal rates have fallen and action is required to address this decline. The movement of all appraisals into the 9 months April to December is expected to have positive impact, although will take 12 months to settle.

Through the regular training of appraisees and appraisers now instituted within the mandatory training programme, we seek some areas of quality improvement in appraisals, particularly greater written reflection, and more timely patient and colleague feedback. This will be included within the ASPAT scoring.

9.4 New Actions

Corrective Actions	Timescales
Increase overall medical appraisal rates to 90%	31 March 2020
Funds and resources to be reviewed by incoming RO	31 March 2020
Provide additional guidance to overseas doctors on GMC requirements	31 March 2020
Increase completion rate of medical appraisals feedback forms	31 March 2020
All medical & dental bank doctors to be recruited using TRAC	31 March 2020
Action finds from HLRO screening review	31 March 2020
Improve guidance/communication from doctors incorporating MPIT in annual appraisal supporting documents.	31 March 2020
Review of communication and escalation processes for those doctors who lack participation in the annual process.	31 March 2020
Revised Appraisal policy to be ratified and published	31 March 2020
Recruit additional appraiser from OMFS	31 March 2020
Revise ASPAT regarding reflective practice	31 March 2020

9.5 Overall conclusion

The processes for effective appraisal and revalidation are embedded and function well, and the QVH is compliant with all regulations pertaining to revalidation.

Areas for further development include qualitative improvement in appraisal content, ensuring adherence to a 12 month appraisal cycle, and strengthening the governance of transfers of information.

10.0 Statement of Compliance:

The Quality and Governance Executive Committee team of Queen Victoria Hospital NHS has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

KSO5 – Organisational Excellence

Risk Owner: Director of Workforce & OD
Date: 27 August 2019

Strategic Objective
We seek to be the best place to work by maintaining a well led organisation delivering safe, effective and compassionate care through an engaged and motivated workforce

Risk
- Staff lose confidence in the Trust as place to work due to a failure to offer: a good working environment; fairness and equality; training and development opportunities ; and a failure to act on feedback to managers and the findings of the annual staff survey.
- Insufficient focus on recruitment and retention across the Trust leading to an increase in bank and agency costs and having longer term issues for the quality of patient care

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

Rationale for risk current score
- National workforce shortages in key nursing areas particularly theatres, CCU
- Generational changes in workforce, 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
- SHCP (STP) case for change supported by a workforce strategy
- NHS Interim People Plan published, action plan awaited
- 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, five have completed the OSCE

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

Future risks
- An ageing workforce highlighting a significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility.
- Developing new health care roles -will change skill mix
- Consultant contract negotiations may resume in 2019 unknown financial impact
- Unknown impact of System case for change
- Pension changes impacting particularly on senior medical staff now wishing to reduce PA's and restrict WLI activity

Future Opportunities
- Closer partnership working with Sussex Health and Care Partnership. This includes through LWAB whole system leadership and talent management initiatives , best place to work programmes and collaborative resourcing

Controls / assurance
- Developing more robust workforce/pay 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, capacity of workforce team improved
- Engagement and Retention plan actions ongoing, improvements in some KPI's
- Overseas recruitment continues with nurses on site and some with PIN
- 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, now aligned for reporting purposes
- 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 CRR1125, 1094, 1077, 1035

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**05/09/2019**		**Agenda reference:**	**157019**	
Report title:	**Workforce Report – August report, July Data**				
Sponsor:	Geraldine Opreshko, Director of Workforce				
Author:	David Hurrell, Deputy Director of Workforce				
Appendices:	• Workforce Disability Equality Standard (WDES) first annual return • Workforce Race Equality Standard (WRES) annual return				
Executive summary					
Purpose of report:	The Workforce and OD report for August 2019 (July data) provides the Trust Board with a breakdown of key workforce indicators and information linked to performance.				
Summary of key issues	Some key improvements in workforce metrics and performance remains stable in most areas The report also includes the first Trust Workforce Disability Equality Standard which we are required to publish. As yet there is no benchmark data available. The annual WRES submission is also included and shows some improvements in key areas.				
Recommendation:	The committee is asked to note the report				
Action required *[highlight **one** only]*	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs): *[Tick which KSO(s) this recommendation aims to support]*	KSO1: *Outstanding patient experience* ✓	KSO2: *World-class clinical services*	KSO3: *Operational excellence* ✓	KSO4: *Financial sustainability* ✓	KSO5: *Organisational excellence* ✓
Implications					
Board assurance framework:	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:	21/07/19 and 24/08/19	Decision:	Noted	
Next steps:					

Queen Victoria Hospital
NHS Foundation Trust

Workforce & Organisational Development

Workforce Report – August 2019

Reporting Period - July 2019

KPI Summary

Trust Workforce KPIs	Workforce KPIs (RAG Rating) 2018-19 & 2019/20			Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Compared to Previous Month
Establishment WTE *Note 1				955.65	990.87	990.87	990.87	990.87	990.87	990.87	990.87	990.87	1000.54	1000.54	1000.54	1000.54	◄►
Staff In Post WTE				835.19	848.43	845.94	860.66	868.62	863.91	867.20	868.41	874.06	886.85	885.27	885.00	887.06	▲
Vacancies WTE				120.46	142.44	144.93	130.21	122.25	126.96	123.67	122.46	116.81	113.69	115.27	115.54	113.48	▼
Vacancies %	>12%	8%<>12%	<8%	12.61%	14.38%	14.63%	13.14%	12.34%	12.81%	12.48%	12.36%	11.79%	11.36%	11.52%	11.55%	11.34%	▼
Agency WTE				46.85	46.11	45.33	47.07	44.12	37.43	39.95	39.31	36.77	34.44	34.47	34.06	33.40	▼
Bank WTE *Note 2				63.37	59.28	58.49	61.13	65.64	51.69	61.66	63.57	70.70	63.85	67.29	69.22	74.90	▲
Trust rolling Annual Turnover % (Excluding Trainee Doctors)	>=12%	10%<>12%	<10%	18.17%	18.42%	19.88%	20.29%	19.52%	19.23%	18.73%	17.46%	17.67%	15.74%	15.67%	16.25%	16.38%	▲
Monthly Turnover				1.10%	1.58%	2.94%	1.56%	0.75%	1.48%	1.43%	0.64%	1.61%	0.66%	1.10%	1.28%	1.09%	▼
12 Month Rolling Stability % *Note 3	<70%	70%<>85%	>=85%	82.34%	82.07%	81.00%	80.36%	80.69%	81.17%	81.46%	81.86%	82.86%	83.76%	84.04%	81.12%	83.40%	▲
Sickness Absence %	>=4%	4%<>3%	<3%	3.29%	3.23%	2.42%	3.02%	3.16%	2.97%	3.24%	3.55%	3.30%	3.12%	2.55%	2.77%	*TBC*	▲
% staff appraisal compliant (Permanent & Fixed Term staff)	<80%	80%<>95%	>=95%	79.55%	78.71%	76.89%	81.18%	83.76%	85.94%	84.64%	84.91%	86.81%	86.69%	85.53%	88.19%	87.41%	▼
Statutory & Mandatory Training (Permanent & Fixed Term staff) *Note 4	<80%	80%<>90%	>=90%	89.70%	88.54%	87.70%	87.75%	88.31%	89.79%	90.68%	92.03%	91.96%	91.98%	92.23%	92.71%	92.88%	▲

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%	**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%**	**2019-20 Quarter 1: Of 126 responses: 97.62% : 1.59%**	Qtr 1 & Qtr 1 ▲Responses ▲ Likely ▲Unlikely
Friends & Family Test - Work Quarterly staff survey to indicate likelihood of recommending QVH to friends & family as a place of work	**Measure** Extremely likely / likely % : Extremely unlikely / unlikely%	**2018-19 Quarter 1: Of 205 responses: 51.22% : 20.48%** (**data**	**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%**	**2019-20 Quarter 1: Of 126 responses: 74.60% : 14.29%**	Qtr 2 & Qtr 2 ▲Responses ▲ Likely ▲Unlikely

*Note 1 - 2018/19 Establishment updated in Aug 18. 2019/20 Establishment Updated Jun19 backdated to April 19 Data from Finance Ledger
*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 - RAG rating updated in June 2019 for Statutory & Mandatory Training. Compliance changed from 95% to 90% however,induvial compliance remains at 100%

Goal 1: Engagement and Communication

The winners of the inaugural Junior Doctors' Forum awards were announced – the results were published in Connect. Best Place to Work have now drafted a report this week which will be shared during September with Board and HMT.
The OD & Learning team 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 month we have engaged with with Information Management & Technology, Estates & Facilities and Finance & Commerce departments.
The 2019 GMC Survey results show an impressive improvement on 2018, particularly in core surgical training. It is also pleasing to see the numbers of green flags in anaesthetics and oral and maxillofacial surgery. There is still some work to do in plastic surgery, although the trend compared to previous years shows that the majority of areas are moving in the right direction:

Programme Group	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Team Work	Handover	Supportive environment	Induction	Adequate Experience	Curriculum coverage	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Rota Design
Anaesthetics	GREEN				GREEN	LIGHT GREEN												GREEN
CST	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN		LIGHT GREEN		GREEN		GREEN						GREEN
OMFS						GREEN	GREEN	LIGHT GREEN						GREEN				
Plastic surgery		PINK	PINK											PINK				RED

Red	Strong negative outlier	**Pink**	Negative in comparison to the average but not quite a negative outlier.
Green	Strong positive outlier	**Light Green**	Positive in comparison to the average but not quite a positive outlier.
White	Within the range of the average	**Grey**	Less than three trainees
Yellow	No trainees responded to questions relating to this indicator		

The 2019 results show an impressive improvement on 2018, particularly in core surgical training. It is also pleasing to see the numbers of green flags in anaesthetics and oral and maxillofacial surgery.

There is clearly still some work to do in plastic surgery, although the figures in the trend analysis (see page 5) show that the majority of areas are moving in the right direction.

It is important to remember that the results are based on very small numbers of HEE appointed trainees. The significance of the results is therefore not always easy to interpret, with the responses of one trainee potentially accounting for large swings. This does not detract from the importance given to the results.

NB: in 2019 there were only two radiology trainees in post and therefore their responses were not counted for QVH's survey results.

Goal 2: Attraction and Retention

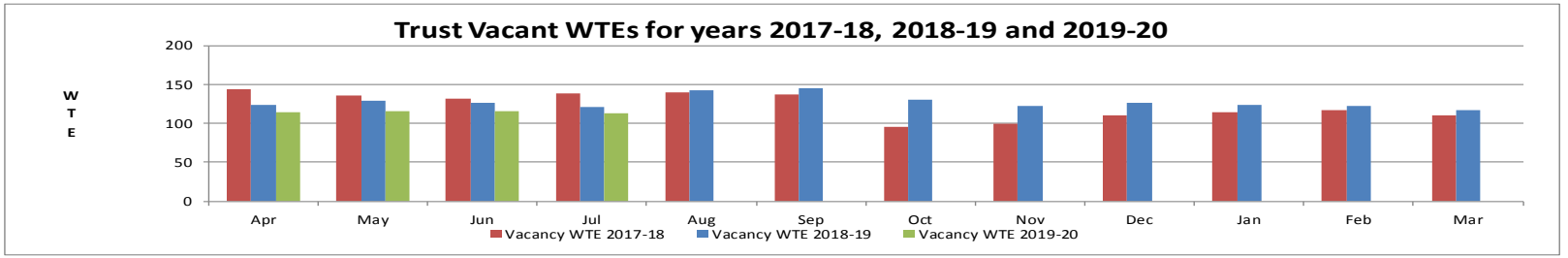
a) *Vacancies*

'Staff in Post' numbers have remained at the same level as the previous 4 months. July saw 13 substantive new starters (12.67wte) and 22 bank recruits (13 Admin, 8 HCA's and 1 Medical and Dental) including 2 wte overseas nurses 1wte within Theatres and 1 wte within Operational Nursing. Our vacancy levels remain stable at 11.34%.

VACANCY PERCENTAGES	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate	6.14%	12.28%	10.17%	▼
Eyes	12.02%	21.25%	25.90%	▲
Sleep	20.86%	28.60%	28.60%	◄►
Plastics	-0.98%	6.66%	5.81%	▼
Oral	5.58%	5.58%	7.56%	▲
Periop	18.76%	11.19%	11.77%	▲
Clinical Support	7.09%	11.14%	12.29%	▲
Access and Outpatients	10.16%	7.77%	3.79%	▼
Director of Nursing	2.43%	1.83%	1.83%	◄►
Operational Nursing	15.72%	13.64%	12.81%	▼
QVH Trust Total	10.66%	11.55%	11.34%	▼

NON-MEDICAL RECRUITMENT(WTE)	Posts advertised this month	Recruits in Pipeline
Corporate	2.00	8.00
Eyes	0.80	1.80
Sleep	2.75	1.00
Plastics	0.00	0.00
Oral	0.53	0.53
Periop	17.00	10.11
Clinical Support	5.80	4.00
Access and Outpatients	0.00	1.00
Director of Nursing	0.00	0.00
Operational Nursing	19.50	14.90
QVH Trust Total	48.38	41.34
of which Qual Nurses / Theatre Practs (external)	3.00	*16.11*
of which HCA's & Student/Asst Practs (external)	6.00	*9.00*

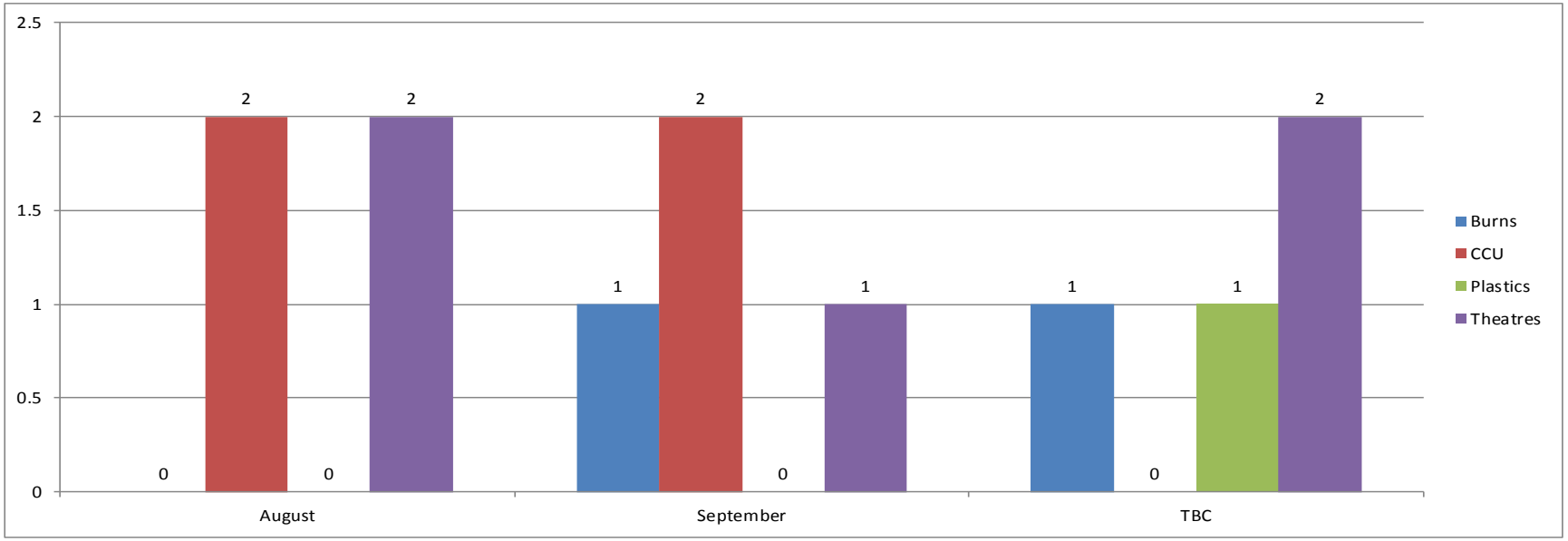
MEDICAL RECRUITMENT (WTE)	Posts advertised this month		Recruits in Pipeline
Clinical Support	1.00		2.10
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*		*2.10*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*1.00*		*0.00*
Plastics	0.00		17.00
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*		*17.00*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*0.00*		*0.00*
Eyes	3.00		1.00
of which are Deanery Trainees, Trust Registrars or Fellows	*3.00*		*1.00*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*0.00*		*0.00*
Sleep	0.00		0.00
Oral	3.20	#	3.20
of which are Deanery Trainees, Trust Registrars or Fellows	*2.20*		*2.20*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*1.00*		*1.00*
Periop	1.00		13.50
of which are Deanery Trainees, Trust Registrars or Fellows	*0.00*		*9.00*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*1.00*		*4.50*
QVH Trust Total	8.20		36.80
of which are Deanery Trainees, Trust Registrars or Fellows	*5.20*		*31.30*
of which are SAS doctors	*0.00*		*0.00*
of which are Consultants (including locums)	*3.00*		*5.50*



b) International Recruitment

International Recruitment	Started	Offered and Accepted (WTE) remaining*	Expected to start in the next month	Expected to start within 2-3 months	Expected to start within 4-6 months
Critical Care	1	4	2	2	0
Other Nurse	4	3	0	1	2
Theatres / Recovery	4	5	2	1	2
Total	9	12	4	4	4

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



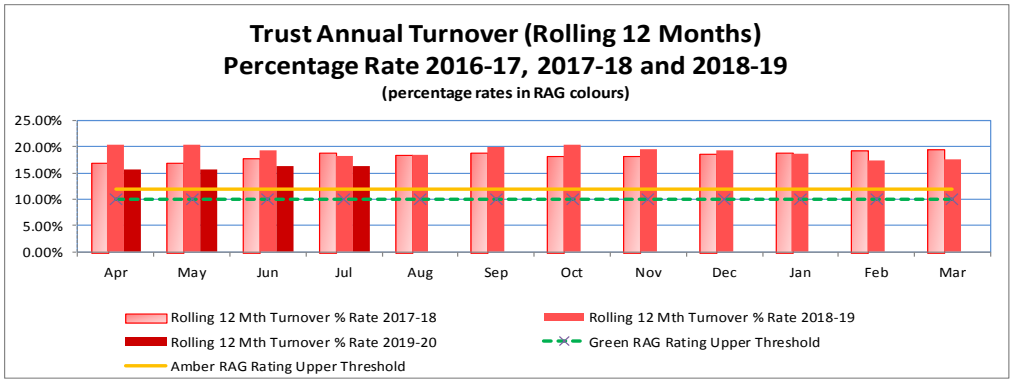
2 international nurses started in the month of July within the Canadian Wing and Theatres, who have commenced their orientation and preparation for OSCE exams.

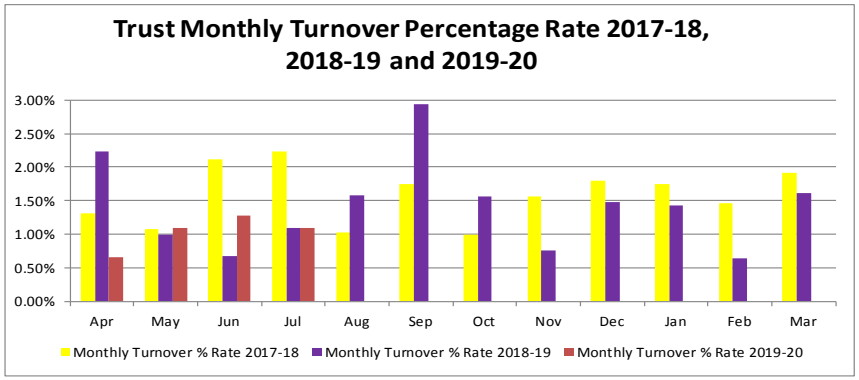
c) Turnover, New Hires and Leavers

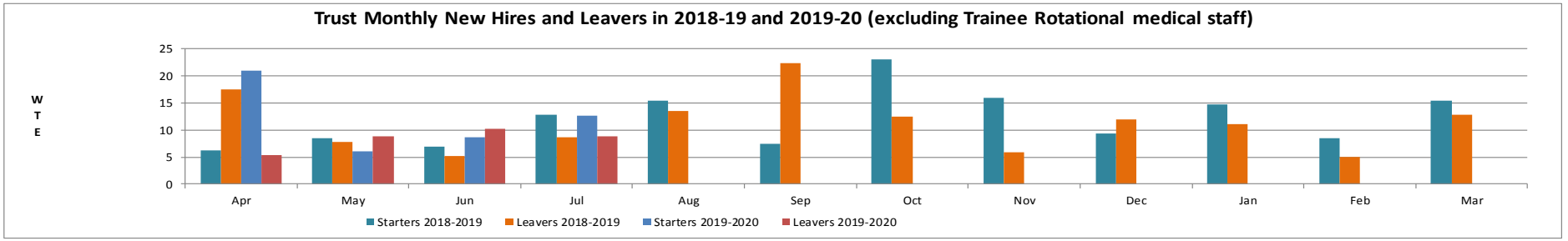
The monthly turnover position of 1.09% is within normal control limits for QVH. The annualised rolling turnover position has remained stable at 16.38%. This maintains a strong positive position compared to the last 3 years. There were 8.8wte leavers in month (9 headcount), including 1wte HCA in Canadian Wing, 1wte Theatre Practitioner and 1wte Qualified Nurse within ITU. The annualised stability index shows a increase in stability with (-2.28%) 16.60% of new starters leaving within their first year of employment (excluding doctors in training). 7 of the 10 leavers were voluntary resignations/retirement with no particular pattern.

ANNUAL TURNOVER ROLLING 12 MTHS excl. Trainee Doctors	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate %	15.29%	15.77%	14.97%	▼
Eyes %	34.95%	34.81%	40.88%	▲
Sleep %	21.37%	31.26%	23.56%	▼
Plastics %	17.35%	13.42%	13.32%	▼
Oral %	11.44%	10.20%	8.28%	▼
Peri Op %	12.43%	13.89%	14.00%	▲
Clinical Support %	14.25%	14.86%	16.78%	▲
Access and Outpatients %	18.07%	17.87%	17.60%	▼
Director of Nursing %	10.58%	10.49%	40.41%	▲
Operational Nursing %	16.85%	17.74%	18.30%	▲
QVH Trust Total %	15.67%	16.25%	16.38%	▲

MONTHLY TURNOVER excl. Trainee Doctors	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate %	1.80%	1.21%	0.00%	▼
Eyes %	5.54%	0.00%	9.77%	▲
Sleep %	0.00%	12.77%	0.00%	▼
Plastics %	0.00%	0.00%	0.00%	◄►
Oral %	0.00%	0.00%	0.00%	◄►
Peri Op %	1.37%	1.48%	0.68%	▼
Clinical Support %	1.30%	1.04%	2.41%	▲
Access and Outpatients %	0.00%	0.00%	0.00%	◄►
Director of Nursing %	1.94%	0.00%	0.00%	◄►
Operational Nursing %	0.00%	1.32%	1.31%	▼
QVH Trust Total %	1.10%	1.28%	1.09%	▼







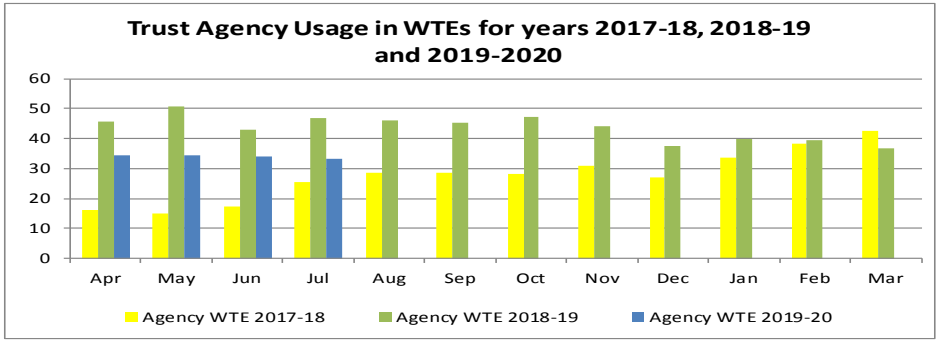
d) ***Temporary Workforce*** Temporary staffing usage in month remains high (108.30wte total), an increase of +5.02 WTE in month caused by the increased transparency of Additional Duty claims being processed electronically. This accounts for 5.47 wte increase in medical bank mostly within plastic surgery. Increases were also seen in Operational Nursing (+3.01%) and Corporate Services (+2.12%) . Agency usage remains consistent at 33.40wte in month, with a small reduction in all staff groups off-set by a small increase in Medical and Dental (+0.25%). There continues a trend of agency workers transferring on to the staff bank.

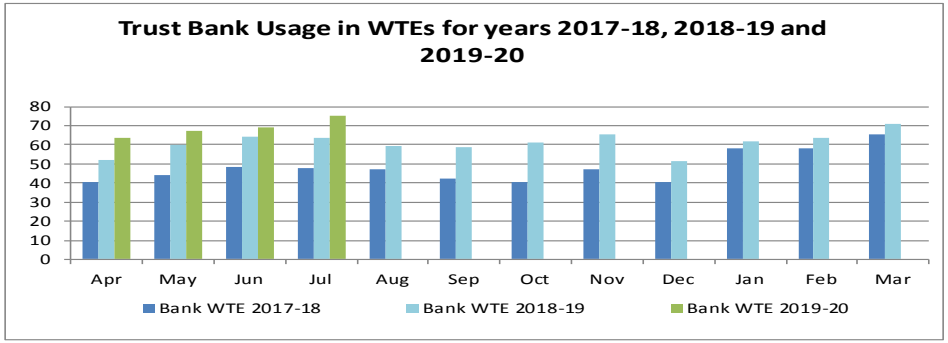
Agency				
BUSINESS UNIT (WTE)	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate	7.78	7.92	7.43	▼
Eyes	0.00	0.00	0.00	◄►
Sleep	0.00	0.00	0.00	◄►
Plastics	1.48	0.90	1.15	▲
Oral	0.00	0.00	0.00	◄►
Periop	14.40	15.06	15.37	▲
Clinical Support	3.46	2.74	2.39	▼
Access and Outpatients	0.00	0.00	0.00	◄►
Director of Nursing	0.00	0.00	0.00	◄►
Operational Nursing	7.35	7.45	7.06	▼
QVH Trust Total	34.47	34.06	33.40	▼

Bank				
BUSINESS UNIT (WTE)	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate	10.12	11.32	13.93	▲
Eyes	1.97	2.69	2.01	▼
Sleep	4.00	4.31	5.74	▲
Plastics	2.14	4.25	3.07	▼
Oral	1.64	1.91	2.94	▲
Periop	19.17	19.58	17.82	▼
Clinical Support	6.17	5.05	5.81	▲
Access and Outpatients	3.30	2.78	2.93	▲
Director of Nursing	0.32	0.36	0.27	▼
Operational Nursing	18.46	16.97	20.37	▲
QVH Trust Total	67.29	69.22	74.90	▲

Agency				
STAFF GROUP (WTE)	May-19	Jun-19	Jul-19	Compared to Previous Month
Qualified Nursing	21.75	22.51	22.43	▼
HCAs	0.00	0.00	0.00	◄►
Medical and Dental	0.79	0.90	1.15	▲
Other AHP's & ST&T	3.46	2.74	2.39	▼
Non-Clinical	8.47	7.92	7.43	▼
QVH Trust Total	34.47	34.06	33.40	▼

Bank				
STAFF GROUP (WTE)	May-19	Jun-19	Jul-19	Compared to Previous Month
Qualified Nursing	25.12	25.62	25.23	▼
HCAs	8.55	7.34	10.45	▲
Medical and Dental	1.17	5.50	5.47	▼
Other AHP's & ST&T	2.36	1.89	1.70	▼
Non-Clinical	30.08	28.87	32.06	▲
QVH Trust Total	67.29	69.22	74.90	▲





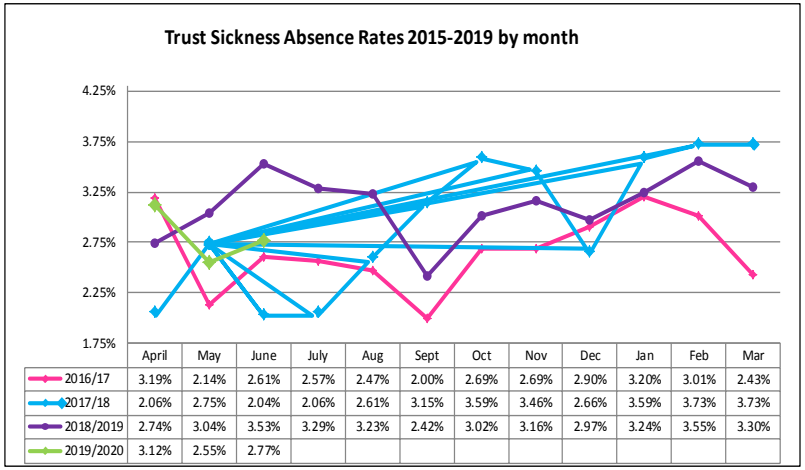
Goal 3: Health and Well-being

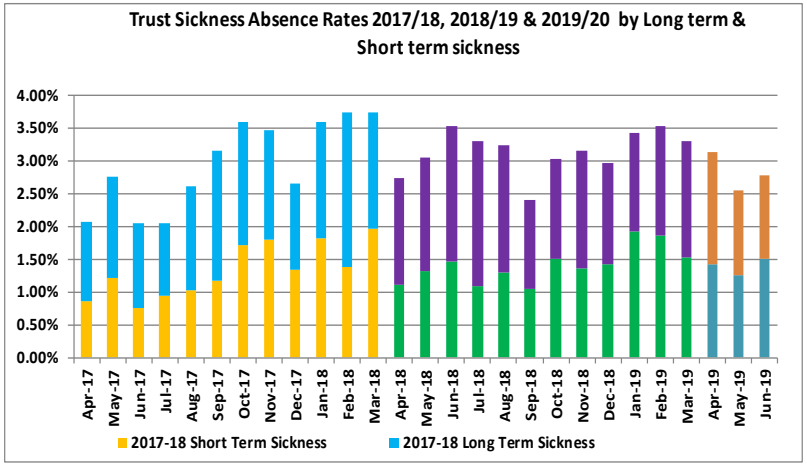
Confirmed sickness levels for June shows in month absence rate of 2.77%, a continued decrease from February's position of 3.55%. Highest 3 reasons based on occasions is gastrointestinal, cold cough flu and not Specified/Unknown; top 3 reasons based on total days lost are 'other musculoskeletal (non-back related), gastrointestinal and 'benign/malignant tumours, cancers'. Perioperative Care and Operational Nursing also have higher than Trust average rates. Whilst it is normal to have higher sickness levels in patient facing staff, Nursing, Theatre Practitioners and HCA's were at a position of 4.24%. Compared to the previous 12 months QVH remain at this level. All medical sickness is included in our trust figures and recorded in Healthroster.

SHORT TERM SICKNESS	Apr-19	May-19	Jun-19	Compared to Previous Month
Corporate	0.92%	0.99%	0.68%	▼
Clinical Support	1.45%	0.85%	0.96%	▲
Plastics	0.49%	0.73%	1.31%	▲
Eyes	0.24%	1.90%	2.22%	▲
Sleep	1.11%	0.21%	2.27%	▲
Oral	0.24%	0.03%	0.86%	▲
Periop	2.22%	2.25%	2.87%	▲
Access and Outpatients	0.93%	0.41%	1.21%	▲
Director of Nursing	0.91%	0.70%	0.53%	▼
Operational Nursing	2.57%	2.01%	1.86%	▼
QVH Trust Total	1.42%	1.26%	1.51%	▲

LONG TERM SICKNESS	Apr-19	May-19	Jun-19	Compared to Previous Month
Corporate	0.61%	0.47%	1.14%	▲
Clinical Support	1.39%	1.05%	0.70%	▼
Plastics	2.03%	0.00%	0.00%	◄►
Eyes	0.00%	0.00%	0.00%	◄►
Sleep	7.07%	3.88%	0.00%	▼
Oral	0.00%	0.41%	1.28%	▲
Periop	3.18%	3.06%	2.73%	▼
Access and Outpatients	0.80%	0.00%	0.00%	◄►
Director of Nursing	0.00%	0.00%	0.00%	◄►
Operational Nursing	2.16%	1.99%	2.00%	▲
QVH Trust Total	1.71%	1.29%	1.26%	▼

ALL SICKNESS (with RAG)	Apr-19	May-19	Jun-19	Compared to Previous Month
QVH Trust Total	3.12%	2.55%	2.77%	▲

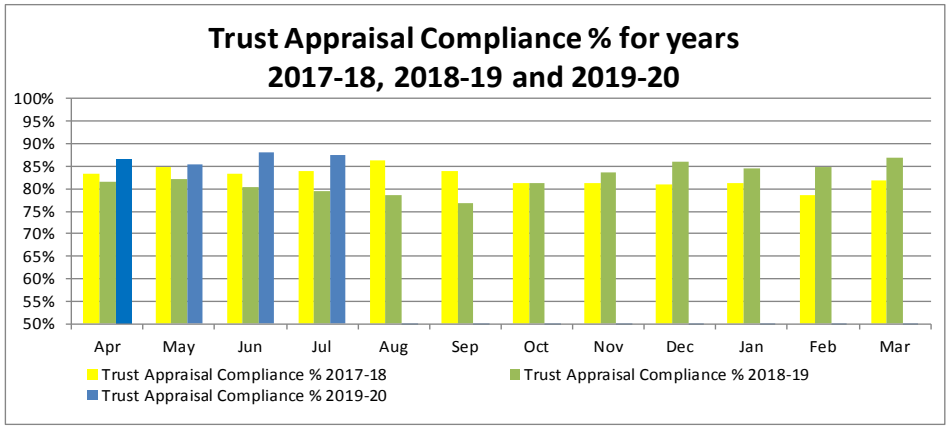




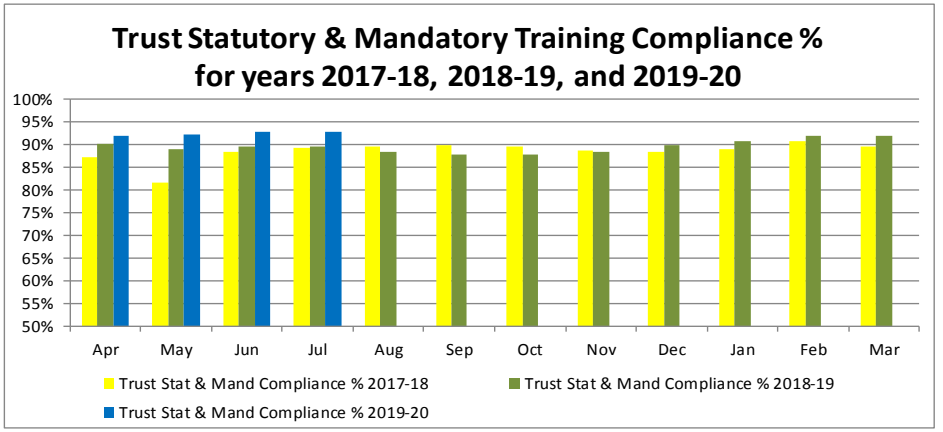
Goal 4: Learning and Education

Appraisal compliance figure decreased marginally from 88.19% to 87.41% (-0.78%). A positive increase was seen in Sleep directorate (+6.89%) and Corporate Services (was at 77.96% currently at 78.49%). However, Eyes compliance declined from 76.67% to 61.29% (-15.38%). In terms of staffing categories, appraisal rates for medical staff reduced (-4.42%) to in month position of 79.35% ; non-clinical staff reduced slightly (-1.22%) to 83.60% in month, with other clinical staff improving (+0.69%) to 92.49% in month. Mandatory and Statutory Training compliance figures increased marginally, from 92.71% to 92.88%. Business Units below the revised Trust-wide compliance rate of 90% are Plastics (currently at 86.11%), Perioperative Services (currently at 88.70%) and Eyes (currently at 89.26%). Clinical Support, Director of Nursing, Operational Nursing and Access & Outpatients all exceed 95%. Information Governance remains the only competency below 85%, with a slightly improved compliance rate of 83.48%.

APPRAISALS	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate	79.12%	77.96%	78.49%	▲
Eyes	76.67%	76.67%	61.29%	▼
Sleep	81.25%	86.21%	93.10%	▲
Plastics	87.80%	95.00%	90.36%	▼
Oral	86.84%	88.00%	81.08%	▼
Peri Op	82.95%	88.00%	89.27%	▲
Clinical Support	90.57%	91.77%	92.50%	▲
Access and Outpatients	82.22%	93.33%	91.30%	▼
Director of Nursing	94.87%	100.00%	100.00%	◄►
Operational Nursing	89.36%	91.10%	91.15%	▲
QVH Trust Total	85.53%	88.19%	87.41%	▼



MANDATORY AND STATUTORY TRAINING	May-19	Jun-19	Jul-19	Compared to Previous Month
Corporate	94.59%	95.65%	94.83%	▼
Eyes	90.03%	92.02%	89.26%	▼
Sleep	92.68%	93.85%	94.41%	▲
Plastics	85.02%	86.05%	86.11%	▲
Oral	90.62%	90.62%	91.16%	▲
Peri Op	87.47%	88.15%	88.70%	▲
Clinical Support	95.61%	95.68%	95.82%	▲
Access and Outpatients	97.39%	97.62%	98.14%	▲
Director of Nursing	95.12%	94.53%	96.09%	▲
Operational Nursing	94.93%	94.81%	95.38%	▲
QVH Trust Total	92.23%	92.71%	92.88%	▲



Goal 5: Talent and Leadership

Sussex Health and Care Partnership (STP) Leadership and Talent Group are in the early stages of scoping out a programme and range of interventions to be funded by HEE/LWAB/Leadership Academy. These will be aimed at middle managers across the health and social care system.

OD & L are developing further career pathways for sleep technicians and administration.

Leadership opportunities continue to be promoted across QVH including a system wide Foundation Coaching Programme and a refresher for existing coaches in stage 1 of the project.

The East Surrey and Sussex STP consortium for the nursing associate apprenticeship has supported 4 cohorts of nursing associate apprentices from across the STP to commence at University of Brighton. Using a similar model, the STP, chaired by a QVH lead is presently procuring for the operating department practitioner apprenticeship, which should be offered from autumn 2019.

To provide an apprenticeship pipeline, QVH has continued to offer functional skills (maths and English) and the care certificate to support staff to become apprenticeship ready. In 2018/19, 26 people successfully completed functional skills qualifications.

-ends-

Appendix 2

Workforce Disability Equality Standard (WDES)

The WDES is a set of ten specific measures (Metrics) that will enable NHS organisations to compare the career and workplace experiences of disabled and non-disabled staff.

First reports must be published by 1 August 2019 and based on the data from the 2018/19 financial year.

What is the purpose of the WDES?

- Results of the annual NHS staff survey show that Disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities. The purpose of the WDES is to improve the experience of Disabled staff working in, and seeking employment in, the NHS.
- The WDES mandates all NHS Trusts and Foundation Trusts to publish the results of their Metrics, together with an action plan, outlining the steps the organisation will take to improve the experiences of Disabled staff.

QVH will be reporting on its workforce disability standard using the national submission form. The evidence highlights that:

- 5.2% of the QVH workforce have disclosed a disability (n = 53), which is slightly lower than the national average of those in employment of around 7%. However, there are high numbers of staff with 'Unknown' or 'Non declared' disabilities totalling 16.3% of the overall workforce which greatly impacts on data quality and accuracy of the information.
- There are less staff disclosing a disability in Bands 8a and above. Consultants within the medical and dental staff group have over double the non-disclosure rate compared to other staff categories (34% non-disclosure)
- There is a variation in the number of disabled shortlisted applicants being appointed, with only a 2.18 comparative likelihood of disabled applicant being appointed. Approximately 1:4 non-disabled applicants are successful from being shortlisted to being offered the role, compared to 1:8 disabled applicants being appointed.
- From National Staff Survey findings:
    - The percentage of staff reporting perceptions of harassment, bullying or abuse from patients, relatives or the public in last 12 months has an almost equal score of 24.7% for disabled and 24.9% for non-disabled staff

- There is a negative variation regarding the perceptions of harassment, bullying or abuse from their manager / team leader or other colleague with 19.5% for disabled and 10.2% for non- disabled staff. Although the total number of disabled staff reporting at least one such incident is statistically small (n = 17), the Trust zero-tolerance approach to such instances means this is an area of concern, more so with the apparent disproportionality.
- There is a negative variation regarding the percentage of staff reporting perceptions of harassment, bullying or abuse from other colleagues in the last year with 24.1% (n = 21) for disabled and 16% for non-disabled staff (n = 63). With the Trust's zero-tolerance approach to such instances means this is an area of concern, more so with the apparent disproportionality.
- The percentage of staff believing that QVH provides equal opportunities for career progression or promotion has a gap of 4.9% (disabled staff declaring 85.5%, non-disabled 90.4%). This is based on a small cohort of staff that responded to the question (n=55) compared to non-disabled staff (n=271). This means statistical significance is questionable as the perception difference is based on 2-3 individuals.
- 77.4% of disabled staff has declared that their employee has made adequate adjustments to enable them to carry on their work, demonstrating there is considerable room for improvement

What we will do in 2019/20

The Trust is already a level 1 Disability Confident employer, and will continue work towards achieving level 2 status. To achieve this we will:

- Support proactive discussion around disabilities (both physical and mental health) to encourage improvement of disclosure rates to improve data quality
- Connect with local and national disabled people's organisations (DPO's) to access networks of disabled people to attract disabled people to apply for jobs at QVH
- Help managers build a wider understanding of the WDES metrics that are relevant to recruitment and retention, making sure people involved in the interviewing process understand the Disability Confident commitment and know how to offer and make reasonable adjustments
- Actively involving Trust board in providing clarity on their governance role and the NHS Workforce Disability Equality Standard. Sharing activities and approaches that can be adopted to demonstrate board effectiveness in overseeing the WDES implementation. Highlighting the personal contribution they can make as a leader/board member

Appendix 3

Workforce Race Equality Standard (WRES)

QVH is reporting on its workforce race equality standard using the national submission form for the 2018-19 financial year. It highlights that:

- The % of BME staff within the workforce has increased as a proportion of the total workforce from 14.2% to 14.8%. There has also been an increase in seniority of the BME workforce, with more senior managers at Band 8a and above from a diverse ethnic background
- There is a variation in the number of shortlisted applicants being appointed, with a 1.32 comparative likelihood (with 1 being an equal comparison). This is a decline from 1.17 in the previous year. This is based on a similar number of BME recruits as last year (n= 34 compared to 33 in 2017-18), but an increase in successful applicants from a white demographic (171 compared to 150 the previous year). Due to relatively low numbers, statistical significance is questionable
- No BME staff entered a formal disciplinary process within the reference period, compared to a relative likelihood of 2.94 the previous reference period and therefore an improvement. However with a small base (n=5 total cases, this remains statistically insignificant
- The relative likelihood of BME staff accessing non-mandatory training and CPD has changed significantly compared to last year (from variation of 1.03 to 0.65), showing those from a BME ethnicity are nearly twice as likely to access such training. More detailed analysis shows that 64% of the Trust's BME workforce have engaged with the 'Leading the Way' leadership and management develop course, twice the proportion of the rest of the workforce. This will be a significant enabler in facilitating the BME workforce to obtain more senior roles.
- 8.3% of the Trust Board is from a BME background, compared to 14.8% of the QVH workforce, the same as the previous year. This results from a small number (n=12) of Board members

From National Staff Survey findings:

  - The variation between white and BME staff experiences within the staff survey report continues to improve, with the gap shortening in all findings. In particular:

- the percentage of staff reporting perceptions of harassment, bullying or abuse from patients, relatives or the public in last 12 months is 24.58% of White staff and 27.59% of BME staff (3% gap). This has improved since the 2017 National Staff Survey where 30.36% of BME staff reported such experiences (and where the gap was 8%)
- BME staff continue to declare lower rates of experiencing harassment, bullying or abuse from staff in last 12 months – where 22.8% of BME staff reported such compared to 24.50% of White staff. However, the total numbers have worsened since the 2017 National Staff Survey where 17.85% of BME staff and 22.06% of White staff reported such experiences. Due to the statistically small number of such instances reported in the 2018 survey (10 BME staff), overall significance of the comparison is questionable. However the Trust's zero-tolerance approach to such instances means this is still an area of concern.
- The percentage of staff believing that QVH provides equal opportunities for career progression or promotion has declined for BME staff, so that 82.85% of BME staff agree compared to 90.17% compared to white staff. This is broadly comparable to the previous year's data. Only 35 BME staff answered this staff survey question, so the variation relates to 2 BME staff experiences; this is not statistically significant, but is a gap that we wish to reduce.
- The percentage of staff reporting perceptions of discrimination at work from their manager / team leader or other colleague improved compared to the previous year, so that 12.96% of BME staff believed such compared to 16.07% in 2017-18. This still compares poorly to the comparator White staff group reporting 4.11% in this year, so is an area for improvement.

What we will do in 2019/20

- Analyse staff perceptions of equal opportunities for career progression through the Clever Together platform to make targeted recommendations and an agreed plan
- Continue to support managers considering taking disciplinary action against all staff to ensure it is appropriate and justified in the circumstances
- Continue to offer management and leadership training to all staff, including a new route of qualification accredited by the Chartered Institute of Management, to ensure they understand the impact of management style and effective team management
- Continue to offer a 'challenging conversations' workshop, where managers are supported to have non-discriminatory conversations and understand the difference between assertiveness and inappropriate challenge
- Proactively promote advertising and recruitment to those from a BME background to increase the overall percentage of BME staff within the workforce