Agenda item: 22
Enclosure no: TB2018/066

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

Public Board
Wednesday 30th May, 2018

Details of the Paper

Title	Update on 2018/19 Budget Plan
Responsible Director	Director of Finance
Purpose of the paper	Notify Board of updates to the Budget Plan since last reported.
Action / decision required (e.g., approve, support, endorse)	Board is requested to note revised Budget Plan.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	***Financial Performance***	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*
ANNUAL OBJECTIVE					
Which Strategic Objective/s does this paper link to? Balanced Financial Plan					
Please summarise the potential benefit or value arising from this paper: Board informed that a balanced budget in place, but recognise risk associated with delivery.					

RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: A robust and sustainable financial plan is required to deliver continued high quality and safe care.
	Financial Risk: A balanced and sustainable budget is required to the satisfy regulatory regime.
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	*(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: James Drury, Director of Finance
Presenter of Paper: James Drury, Finance Director
Other committees / groups where this paper / item has been considered: N/A
Date of Paper: 22nd May, 2018

1. Introduction

The Trust submitted its Operating Plan to NHSI on 30th April 18. Aligned to this plan is an internal budgetary plan that aligns resources to the Trust governance structures, and enables the Trust Management Hierarchy to be held to account for delivery of the Annual Financial Plan.

The key assumptions to this plan were presented to Trust Board in April, along with a Month 1 Budget for approval in advance of full plan submission. The Plans are fully aligned to the nationally published guidance.

The overall budgetary plan has been agreed through the Executive Management Committee, and Quality Impact Assessments of underpinning decisions undertaken by the Medical Director and Chief Nurse.

The internal budgetary plan has been agreed at a Divisional and Departmental level, with formal sign off by Divisional Management Teams, Chief Executive and Finance Director diarised over the coming weeks as diaries allow.

The key points and summary Budgetary Plan follow:

2. Key Points

The base assumptions align to the nationally published ones as included in the planning guidance issued by the regulators.

Contract values are agreed with all commissioners, with the exception of Bedfordshire, and final contract details and documentation will be closed down over the coming fortnight.

Pay awards – it is assumed that any award above the 1% level currently funded in tariff will receive additional central funding.

STF – It is assumed in plans that the Trust receives its full allocation of STF - £11.9m. The delivery of Operational Targets is under pressure which puts receipt of full STF at risk.

The CIP requirement remains at £20m. This equates to approximately 5% of turnover and as such is high risk. Phasing is 45% H1 and 55% H2.

Plans include a workforce reduction overall of 30 w.t.e

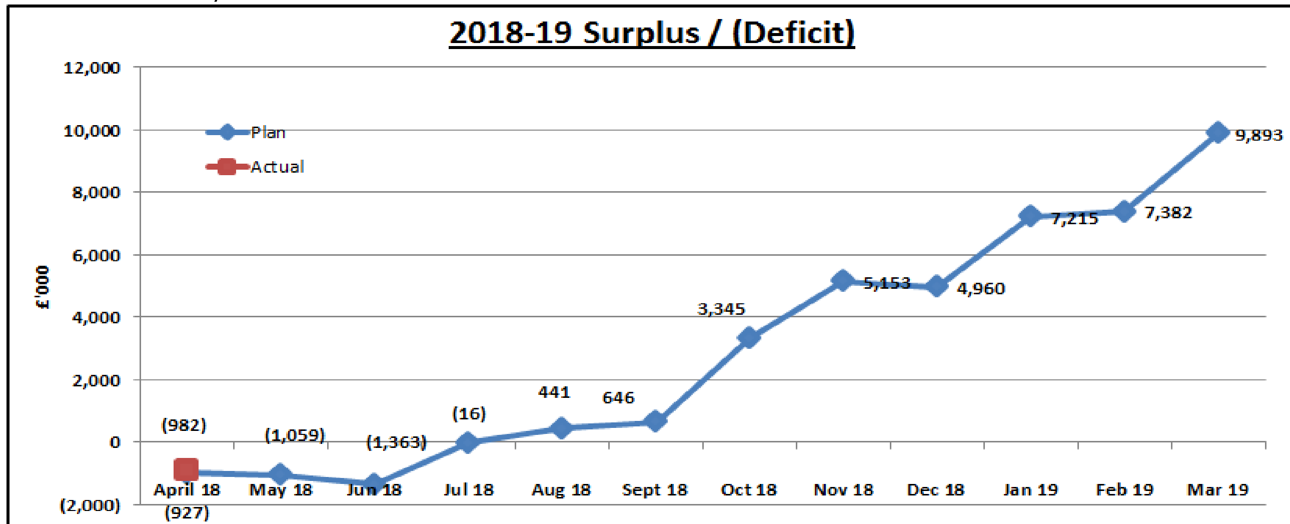
Clinical Income is phased by calendar days for non-elective work and working weekdays for elective work. The exception being for August and December where 90% of working days are assumed for slow down resulting from holidays. The plan has been adjusted for seasonality between Elective and Non-elective activity, with Elective being weighted in the first six months of the year and non-elective the last six months.

3. Budget Summary / Phasing

The Annual Budget Summary is as per the table below:

Expense Type	Forecast
Contract Income	382,566
Other Income From Activities	10,288
STF Funding	11,938
Other Operating Income	19,557
Donated Asset income	1,000
Income CIP Underplan	6,935
Total Income	**432,284**
Nursing	(107,180)
Medical Staff	(66,148)
Admin & Clerical	(36,366)
Professional & Tech	(40,687)
Other Staff	(6,320)
Exec & Non Exec Dirs	(1,021)
Pay CIP Underplan	6,572
Total Pay	**(251,149)**
Drugs	(39,630)
Clinical Supp Servs	(30,670)
Gen Supp & Servs	(981)
Establishment Exps	(4,284)
Premises & F Plant	(16,403)
Miscellaneous	(19,659)
PFI	(21,769)
CNST	(13,124)
Non Pay Reserves	(2,500)
Non Pay CIP Underplan	6,494
Total Non Pay	**(142,526)**
TOTAL EBITDA	**38,609**
Owned Depreciation	(11,058)
Donated Depreciation	(1,000)
Interest Paid And Pdc Div	(16,693)
Interest Receivable	35
Total Other	**(28,716)**
TOTAL	**9,893**

The monthly surplus / deficit phasing is as contained in the graph below:



4. Conclusion

The Trust has a balanced budget plan but delivery remains high risk as it depends upon £20m CIP delivery, receipt of £11.9m STF, and assumes overall other areas remain within budget.

5. Recommendation

Trust Board is requested to approve the Annual Budget Plan.

Agenda item: 23
Enclosure no: TB2018/067

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

TRUST BOARD IN PUBLIC
30 May 2018

Title	NHS Provider Licence Self-Certification for NHS Trusts				
Responsible Director	Director for Governance				
Purpose of the paper	The purpose of the paper is to seek Board approval for the NHS Provider licence self-certification as required by NHS Improvement for 2017/18 going into 18/19				
Action / decision required (e.g., approve, support, endorse)	Decision to Approve				
IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*
ANNUAL OBJECTIVE					
Which Strategic Objective/s does this paper link to? All objectives					
Please summarise the potential benefit or value arising from this paper: Good governance process					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here	*Non-Financial Risk*: Although the licence only applies to Foundation Trusts, most of the conditions within the licence apply as best practice in NHS Trusts and if we do not meet those conditions this could result in a negative impact on quality, people and money and potentially result in enforcement action from the Care Quality Commission.				
	Financial Risk: Potential for financial penalties where there are issues of compliance which are not being addressed.				
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY					
Which CQC standard/s does this paper relate to?	Well Led Domain; Regulation 15 Good Governance				
Author of paper: Liz Hollman					
Presenter of Paper: Liz Hollman					
Other committees / groups where this paper / item has been considered:					
Date of Paper: 22 May 2018					

UPDATE ON COMPLIANCE WITH REGULATION

1. PURPOSE

The purpose of the paper is to seek Board approval for the NHS Provider licence self-certification as required by NHS Improvement.

2. BACKGROUND

Although NHS trusts are exempt from needing the Monitor NHS provider licence, directions from the Secretary of State require the NHS Trust Development Authority (part of NHS Improvement) to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

To this end the Board is required to self-certify against the following NHS provider licence conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (**condition G6(3)**)
- The provider has complied with required governance arrangements (**Condition FT4 (8)**)

A summary of the range of obligations in the licence is shown in Appendix 1.

3. CONDITION G6

This condition requires NHS trusts to have processes and systems that identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring. Providers must annually review whether these processes and systems are effective.

The Board has been assured through the following mechanisms that Condition G6 is in place:

- Preparation and publication of an Annual Governance Statement which sets out mechanisms of control and risk management for the trust

- Head of Internal Audit opinion confirms that the organisation has an adequate and effective framework for risk management, governance and internal control. Further enhancements have been identified to ensure that it remains adequate and effective

- Performance reporting on a monthly basis through Board and Committees which includes monitoring of the requirements within the NHS Constitution and compliance with financial duties

- Board Assurance Framework updated on a quarterly basis, and Corporate Risk Register updated on a monthly basis and risk escalation processes in place

- Self-assessment using the Well-led Framework. The Board will be reviewing a self-review in July 2018 and this will be followed by an external review to be completed by the end of the calendar year. The Board considered the Well-led Framework in September 2017 and February 2018

- External reviews, including the annual Staff Survey and the annual National Inpatient Survey

- Achieving Level 2 in the Single Oversight Framework and bi-monthly monitoring by NHS Improvement

- Compliance with laws and regulation paper to Quality Committee and Board in March 2018

- Expected external audit opinion on financial accounts and quality accounts

The NHS Improvement sign off template for condition G6 is shown in Appendix 2.

4. CONDITION ST4

This condition requires the provider to comply with required governance arrangements. These are summarised below with reference to the sources of assurance which confirm compliance:

Statement	Sources of Assurance
The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Director for Governance and Director of Finance provide expertise on standards of governance as they apply to the NHS and advise the Board and organisation accordingly • Review of elements of governance by CQC, NHS Improvement, External Audit, Internal Audit • Declaration of Interests
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Board and relevant Committees are briefed on guidance issued by NHS Improvement in relation to governance. For example the grip and control spread sheet for financial management. This can be identified through meeting minutes
The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	• Board and Committees set up in line with Monitor's Code of Governance for Foundation Trusts as far as it applies to NHS Trusts • Standing Orders, Standing Financial Instructions and Committee Terms of Reference reviewed in year by the Board • Self-reflection on effectiveness evident in minutes of Board meetings and Committees • Review of effectiveness of Audit Committee and performance in each committee • Chair's observation of each Committee and feedback to each Committee Chair • Board development programme including Board self-review and process for 360 degree feedback • Organisational structure charts showing lines of accountability • Performance Management Framework
The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:	• Board and committee forward plans • Board agendas and minutes • Annual Governance Statement

Statement	Sources of Assurance
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	• Internal and External Audit • Local Counter Fraud Specialist Annual report • Auditor review of going concern declaration • Risk Management Strategy and Policy • Board Assurance Framework • Corporate risk Register • Comprehensive business planning process involved Board and Committee sign off • Emergency Planning, Resilience and Response compliance reported to Finance and Business Performance Committee • Information Governance Toolkit submission • Compliance with laws and regulations paper to the Board
The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients,	• Board development programme including Board self-review and process for 360 degree feedback • Quality Impact Assessment process • Leadership programme • Quality report to Board • Range of internal and external assurances to Quality and Clinical Governance Committee including clinical audit and other reviews • Monthly mortality reporting • Patient Experience Group • Programme of patient and public involvement reported to the Board • Feedback processes such as Friends and Family Test and complaints process • Range of patient stories to Board • Engagement with Healthwatch and the

Statement	Sources of Assurance
staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Health and Adult Health and Social Care Select Committee
The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	• Strategic Workforce Committee forward plan and meeting minutes • Workforce performance reports • Staff survey • CQC reports

The NHS Improvement sign off template for Condition FT4 is shown in Appendix 3.

5. CONCLUSION

The Board and Committees have received a range of assurance through 17/18 and into 18/19 which confirms compliance with the licence conditions relevant to NHS Trusts.

6. RECOMMENDATION

It is recommended that the Board approve the self-certification statements to confirm compliance with G6 and FT4 Conditions.

Liz Hollman
Director for Governance
22 May 2018

Appendix 1 Summary of Obligations in the NHS Provider Licence

- Provide information to regulators as required
- Publish information as required by regulation
- Fit and Proper persons as Directors
- Comply with NHS Acts
- Have regard to the NHS Constitution in providing health care services for the purposes of the NHS
- Systems and process to identify risks to compliance and guard against their occurrence and regular review of those processes and systems
- Register with the Care Quality Commission
- Set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner
- Continuity of Services
- Pricing: record information about cost; information systems in place; provide information to regulator as required; compliance with National Tariff; engage constructively with Commissioners
- Patient choice
- Competition oversight
- Provision of integrated care
- Provision of Commissioner Requested Services
- Maintain asset register and follow appropriate regulation for disposal of assets
- Adopt and apply systems and standards of corporate governance and financial management
- Risk pool levy

Agenda item: 23
Enclosure no: TB2018/067

Appendix 2 Sign off template G6

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Please Respond

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Agenda item: 23
Enclosure no: TB2018/067

Appendix 3 Sign off template FT4

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		[including where the Board is able to respond 'Confirmed']
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		[including where the Board is able to respond 'Confirmed']
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		[including where the Board is able to respond 'Confirmed']

4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		[including where the Board is able to respond 'Confirmed']

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		[including where the Board is able to respond 'Confirmed']
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
30 May 2018

Details of the Paper

Title	Quality Improvement Plan (QIP)
Responsible Director	Chief Nurse
Purpose of the paper	• To note 70% achievement 17/18 and areas requiring further focus /embedding in 2018/19 • To approve 18/19 approach
Action / decision required	Board approval

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	***Operational Performance***	***Strategy***	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*
ANNUAL OBJECTIVE					
Which Strategic Objective/s does this paper link to? Quality – specifically the provision of safe, effective quality care to the community we serve					
Please summarise the potential benefit or value arising from this paper: To demonstrate the commitment to continually improve the quality of care for patients, building on safe systems and processes and listening and responding to the patient voice					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: Risk to slippage in delivery should procurement processes of equipment be delayed *Financial Risk*:				
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY					
Which CQC standard/s does this paper relate to?	*Regulation 9 – Person Centred Care* *Regulation 10 – Dignity and Respect* *Regulation 12 – Safe Care and Treatment* *Regulation 14 – Meeting Nutritional and Hydration Needs* *Regulation 17 – Good Governance*				

Author of paper: Emily Montgomery, Deputy Chief Nurse
Presenter of Paper: Carolyn Morrice, Chief Nurse
Other committees / groups where this paper / item has been considered: **Divisional Governance Boards, Quality and Patient Safety Group, Quality and Clinical Governance Committee and Executive Management Committee**
Date of Paper: 22 May 2018

Quality improvement plan achievements 2017/18 and approach 2018/19

1. Quality improvement programme 2017/18

During 2017/18 there were forty one areas included within our quality improvement plan (QIP), each of these had an executive lead and delivery lead assigned to them; these leads were responsible for delivering their projects, supporting the staff involved and reporting on progress monthly to the executive board.
In quarter 4 an independent review of all the schemes was undertaken testing the assurance provided.

Results

70% of the outcomes of the QIP were delivered.
30% have not fully delivered or there is insufficient assurance that the improvement has been fully embedded. The decision was made therefore to roll over into 18/19. The exception table below indicates which will be part of the 18/19 QIP and which are improvement initiatives which are integral to our day to day improvement and organisational transformation (business as usual).

Exception Report Table

Expected Outcome	Result and Commentary	Roll Over to 2018/19
HSMR <90	Outcome a rolling 92.8% (Jan to Dec'17)	No business as usual **Quality and patient safety group**
Better supported care in people's homes and community settings	Transition period community hubs and clusters	No business as usual **Community transformation**
Zero incidents resulting in severe harm or death from medication errors (3)	Not achieved zero incidents	Yes
Medicines managed securely and safely	87% compliance	Yes
Implementation of electronic physiological vital sign system to improve the care of the Deteriorating Patient	Executive decision to delay – more comprehensive IT platform purchased by CCG with broader benefits for patients and staff.	Yes
The standard of record keeping is improved through regular audits and action taken for areas of non-compliance	Insufficient evidence of improvement to have full assurance	Yes
There will be a net increase in the number of filled qualified nursing staff posts with efficiencies delivered through skill mix and staffing reviews.	There is a national challenge in recruiting qualified nurses and use of temporary staffing remains a challenge. Successful band 4 work	No business as usual **SWFC Non medical transformation workforce 18/19 drive improvement**

Expected Outcome	Result and Commentary	Roll Over to 2018/19
All clinical areas have 100% compliance in participating in quality round submissions to evidence reducing variation in care	This is the Clinical Accreditation Programme that has been reignited in the 2018/19 QIP	Yes
Improved consent process and training in place	A consent policy and review group has been established to further drive improvements 2018/19	No business as usual **Quality and patient safety group**
To enhance the current system of handover to achieve a consistent and standardised approach throughout the organisation.	Further work needed to embed and sustain	No business as usual **Deteriorating patient group**
Having a single Trust wide IT platform that collects patient experience and outcomes data that can make a difference and engage clinical staff	To be in place by end quarter 1	No business as usual
Every patient at the end of life will have an accurately completed pain assessment that has been responded to	A pain assessment tool is now included within the newly designed care plans. Audit of compliance is underway. EOLC strategy approved at board which underpins continued improvement	No business as usual **Quality and patient safety group EOLC steering group**

2. Quality Improvement Plan 2018/19

The quality improvement plan is based on the three quality corporate objectives and has been shaped by the divisional teams, executive management committee and quality committee.

Enhance our culture of safety
Listen to our patient voice
Develop as a learning organisation

The quality improvement plan has been strengthened in terms of approach and ownership, monitoring and reporting. The approach is outlined below.

2.1 System to support monitoring of delivery

- Aspyre is the system platform being used to record, monitor and report against progress of each project area
- Training has been delivered by the programme management office (PMO) for the majority of staff requiring it, others will be supported as requested
- Technical support will be provided by the PMO

2.2 Ownership

- Corporate projects have been agreed with the Executive Medical Director, Executive Chief Nurse and Executive HR Director
- Divisional Clinical Chairs, Director of Operations and Chief Nurses have identified and agreed their projects
- There is a named Corporate/divisional lead and operational lead against each project
- Corporate and divisional leads are accountable for the recording, monitoring and reporting of progress and ensuring delivery against Key Performance Indicators.

2.3 Monitoring

- Monthly quality review executive management committee
- Quarterly report to the quality and patient safety group and a highlight report to the quality committee for the purpose of monitoring assurance
- Any project off track will be required to provide an exception report describing how they will get back on track with KPIs and any additional support required
- Divisions are expected to monitor their progress, address issues/risks and report into their governance boards on a monthly basis as a standardised agenda item
- The Deputy Chief Nurse will alert the Executive Chief Nurse to any projects that require executive intervention to ensure delivery

2.4 Reporting

- The Divisions will provide quarterly updates
- The Deputy Chief Nurse will provide quarterly updates by exception to the quality and patient safety group
- Assurance reports will be reported into the quality committee executive management committee and patient experience group on a quarterly basis in addition to a dashboard

**Divisions will be expected to plan their QIP 2019/20 in January 2019 ready for sign off by the executive board in March 2019. **