Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 30th April 2015

Session in public at 13.00
Session in private at 16.00

The Cranston Suite
East Court
College Lane
East Grinstead
West Sussex
RH19 3LT

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 30th April 2015

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	Lester Porter
Non-Executive Directors:	-	Ginny Colwell
	-	Ian Playford (apologies)
	-	John Thornton
Chief Executive:	-	Richard Tyler
Medical Director	-	Stephen Fenlon
Interim Director of Nursing and Quality	-	Joanne Thomas
Interim Director of Finance and Commerce	-	Dominic Tkaczyk

In full attendance (non-voting):

Director of Human Resources & OD	-	Graeme Armitage
Interim Director of Operations	-	Jane Morris
Head of Corporate Affairs & Company Secretary	-	Kathleen Dalby
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode

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Thursday 30 April 2015 at 13:00
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

Agenda: session held in public		
No.	**Item**	**Page**
Welcome		
84-15	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Patient story		
85-15	**Patient safety** *Jo Thomas, interim Director of Nursing and Quality*	-
Standing items		
86-15	**Draft minutes of the meeting session held in public on 26 March 2015 (for approval)** *Beryl Hobson, Chair*	1
87-15	**Matters arising and actions pending** *Beryl Hobson, Chair*	13
88-15	**Update from the Chief Executive** *Richard Tyler, Chief Executive*	16
Results and actions		
89-15	**Patients: safe staffing and quality of care** *Jo Thomas, interim Director of Nursing and Quality*	19
90-15	**Operational performance: targets, delivery and key performance indicators** *Jane Morris, Interim Director of Operations*	44
91-15	**Financial performance: 2014/15 draft outturn** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	50
92-15	**Contracts update** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	65
93-15	**Information governance toolkit submission results** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	70

94-15	**Workforce** *Graeme Armitage, Director of Human Resources and Organisational Development*	73
Strategic priorities		
95-15	**Key strategic objective three: operational excellence – quarterly update** *Jane Morris, interim Director of Operations*	88
96-15	**Annual plan 2015/16: submission to Monitor** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	93
Governance		
97-15	**Monitor declaration: Q4 2014/15** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	112
98-15	**Board governance review: progress report** *Beryl Hobson, Chair*	114
99-15	**Corporate risk register** *Jo Thomas, Interim Director of Nursing and Quality*	122
100-15	**Annual declarations by directors** *Kathleen Dalby, Head of Corporate Affairs and Company Secretary*	135
Reports from the chairs of the sub-committees to the board of directors		
101-15	**Clinical Cabinet** *Richard Tyler, Chief Executive*	140
102-15	**Audit Committee** *John Thornton, Committee Chair*	141
103-15	**Charitable Funds Advisory Committee** *Lester Porter, Committee Chair*	147
Next meeting agenda		
104-15	**Draft agenda for next month's meeting** *Kathleen Dalby, Company Secretary and Head of Corporate Affairs*	149
Stakeholder and staff engagement		
105-15	**Feedback from events and other engagement with staff and stakeholders** *All board members*	-
Members of the public		
106-15	**Observations from members of the public** *Beryl Hobson, Chair*	-

107-15	Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature. *Beryl Hobson, Chair*	-

Agenda: session held in private		
Commercial-in-confidence		
108-15	**Draft minutes of the meeting session held in private on 26 March 2015 (for approval)** *Beryl Hobson, Chair*	150
109-15	**Acquisition of the McIndoe Surgical Centre by a third party** *Richard Tyler, Chief Executive*	-
Any other business (by application to the Chair)		
110-15	*Beryl Hobson, Chair*	-

Date of the next meetings		
Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 21 May at 13:00	**Q & R:** 07 May 2015 at 09:00 **Audit**: 20 May 2015 at 14:00 03 June 2015 at 14:00 **CFAC:** 25 June 2015 at 09:00 **N & R:** 30 July 2015 at 09:00	**Public**: 09 July 2015 at 15.00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 26th March 2015, 13.00 – 16.00, The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT** *(For the sake of accuracy please note item 73-15 was taken ahead of 68-15)*	
Present:	Peter Griffiths (PAG)	Trust Chairman
	Beryl Hobson, (BH)	Non-Executive Director and Chair Designate
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Dominic Tkaczyk (DT)	Interim Director of Finance
	Jo Thomas (JMT)	Interim Director of Nursing & Quality
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources & Organisational Development
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Interim Director of Operations
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Kathleen Dalby (KD)	Head of Corporate Affairs & Co Sec

WELCOME	
59-15	**Welcome, apologies and declarations of interest** The Chairman welcomed one member of the public to today's meeting. Apologies had been received from Kathleen Dalby. There were no new Declarations of Interest.
PATIENT STORY	
60-15	**Patient Safety** It was agreed that this item would be deferred until next month.
STANDING ITEMS	
61-15	**Draft minutes of the meeting session held in public on 26th February 2015 for approval** Under item [038-15], a correction to the level of surplus was noted. Taking this amendment into account, the minutes of the meeting were **APPROVED** as a correct record.
62-15	**Matters Arising & Actions Pending** The board reviewed the current record of matters arising and actions pending, the update was received and **APPROVED**.
63-15	**Update from the Chief Executive** Several of the issues highlighted this month would be reported in greater depth later in the agenda. In the meantime, RT highlighted the following: • Challenges created by this year's budget setting process, to be presented for approval today, should not be underestimated. On the whole RT felt the budget was cautiously optimistic, mitigating risks on both expenditure and income. The board had now agreed to opt for the default tariff rollover (DTR) which on balance was

	more financially advantageous to the trust but not without risk. Under the DTR option Monitor is able to make in-year changes to the tariff. At present there was no indication of when this might happen but a contingency for a reduction in tariff was included in the budget. RT reminded the board that also under this option the trust was not eligible for CQUIN payments (up to 2.5% of the trust's budget) during 2015/16. It would be important to keep commissioners updated on the challenges the trust would face in maintaining quality improvement without additional funding. This would be debated further later in the agenda. It was also important to ensure stakeholders and governors were fully aware of the implications. RT would be explaining the consequences of the new tariff to governors at their meeting on 9th April. **[Action: RT]** • The trust continued to forecast full compliance in February within the Referral to Treatment (RTT18) target. • The trust had appointed successfully to the key posts of Director of Finance and Director of Operations. Both appointments will join the trust at the beginning of June. • The Monitor Q3 review confirmed that the trust remained rated green for governance, and retained its continuity of service rating of 4. Monitor had visited the trust earlier this week and provided positive feedback. PAG thanked RT for his monthly update, the contents of which were **NOTED** by the board.
RESULTS AND ACTIONS	
64-15	**Patients: safe staffing and quality of care** JMT presented this month's update. The main themes included: • Safe staffing levels: Whilst being achieved, this was becoming a daily operational challenge given the levels of vacancy and sickness on wards at present; • Vacancy rates: These continued to be an area of concern, resulting in an increased use of agency staff. It was brought to the board's notice that some members of QVH staff were working agency shifts in neighbouring trusts due to more favourable rates of pay. GA explained that contractually it was not possible to compel staff to work over and above their contracted hours. However, he and JMT were discussing ways in which to better incentivise staff. • Falls: Six patient falls occurred in February. Four of these occurred in clinical areas (two of which were recurrent). JMT assured the board that these incidents involved high risk patients who had been allocated additional support and therefore could not be attributed to inadequate staffing levels. (The remaining two falls did not relate to patients and took place within the hospital grounds). • CQUINS: 2015/16 National CQUINS applicable to QVH included Acute Kidney Injury, Mental Health, Dementia, and Sepsis. Locally negotiated CQUINS with Commissioners included Human Factors training and Mental Health support for trauma patients. JMT noted that whilst Human Factors training was essential, achieving Mental Health support targets would be slightly more challenging. The current Mental Health policy would be revised to see how best to support all patients. As the board was aware, under the DTR tariff, the trust would no longer be eligible for the

CQUIN scheme in 2015/16, resulting in a loss of £1.2m income. Nevertheless, these five CQUINs would remain important in order to maintain and improve quality. To avoid confusion these would in future be referred to as 'internal quality improvement initiatives'. Whilst no longer monitored by commissioners, the five initiatives would be reviewed by JMT and SF. They would then set achievable targets within the resources available. The board would be apprised of progress on a quarterly basis. In addition, despite absence of payment for CQUINS, the trust would still share progress against initiatives with commissioners, although not as part of formal contract monitoring.

The Board went on to discuss at length points of clarification about the financial implications and impact of the proposal. These included:

- The importance of quantifying additional costs incurred through maintaining quality;
- Proactive dialogue with commissioners should costs become unsustainable;
- Apprising the board of progress with regard to cost pressures; and
- The need to work closely with governors, stakeholders, commissioners and public to ensure these constraints were clearly understood.

- CQUINS 2014/15
  Dementia scores were on track, although there was concern at the level of Friends & Family Test (FFT) response rates. JMT advised that other trusts used bespoke systems to improve data collection. Whilst a provider had been appointed to support QVH, delays in implementation had occurred due to incompatibility of IT systems. JMT agreed to enquire as to what FFT rates other specialist trusts achieved. **[Action: JMT]** JMT would also ascertain the financial implications of not achieving this target and report back **[Action: JMT]**

- Care Quality Commission (CQC): JMT confirmed that QVH had not been identified in the next wave of inspections (April to June) although an internal self- assessment was underway to ensure the trust was well prepared for later in the year. A formal update would be presented to the board in May **[Action: JMT]**

- Patient Safety: There was one grade 2 pressure ulcer acquired at QVH during February. (This occurred during an 18 hour theatre case and a Root Cause Analysis was underway). In addition, one new Serious Incident was declared in February 2015, which was an Information Governance and Caldicott Guardian issue. A patient who had undergone surgery at QVH had received a copy of a letter with another patient clinical details printed on the reverse. Again a full investigation was taking place. (It was noted that item 17 of the report should read 'Serious Incident' and not 'Never Event').

- Infection Control: NHS England Guidance on Clostridium difficile infection objectives in 2015/16 has been released which advises that the RCA process should identify `lapses` in the quality of care. JMT reported that the QVH policy had been altered to reflect this. The CCG would continue to review cases. Whilst a case may still be attributable to the trust even if the CCG concluded there had been no 'lapse' in care, a sanction would be unlikely.

- Patient Experience: The results of the National Inpatient Survey (carried out by Picker Institute on behalf of QVH) were presented. This survey highlighted many positive aspects of patient experience. However, compared to 2013 the trust was significantly worse in the following areas:
  - *Could not always find staff member to discuss concerns with*. JMT agreed to investigate why this might have declined in the last year. **[Action: JMT]**
  - *Not offered a choice of food*. The board was already aware of this issue which was being addressed through the Key Strategic Objective 2 action plan.

  It was also noted the trust didn't score well in offering a choice of hospital, but as QVH is a specialist trust, the board agreed it had little scope to address this.

	• Patient Complaints: Four new complaints were opened in February 2015 and two were closed. LP queried the wording in respect of resolution of a complaint on Peanut Ward. JMT agreed to follow up and email a response **[Action JMT]** The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
65-15	**Operational performance: targets, delivery and key performance indicators** JM presented February's report, highlighting the following: • The Trust is compliant at an aggregate level for all three 18-week targets in February. It was also compliant in February for all three 18-week performance targets at specialty level except for Rheumatology. In addition, the trust was forecasting compliance for all three 18-week targets in March, (an update would be provided in the usual weekly report to the board). • Additional Saturday clinics were continuing in Orthodontics, in order to increase capacity. • No urgent operations were cancelled in February. One patient was cancelled on the day of admission in February but was rebooked within the 28 day NHS Guarantee. (JM asked the board to note that two patients had been cancelled this week due to safe staffing concerns). • The trust achieved all cancer waiting times in January. There were no breaches of 52 weeks. In addition the trust achieved the diagnostic target for February. • JM assured the board that whilst the exact MIU performance score for February was not available at the time of submitting this report, the trust was performing consistently above 95%. BG noted an inconsistency between the finance and operational reports. It was confirmed that income from patient activity was in fact above plan in Month 11. LP queried the lack of information with regard to off-site referrals but was advised this was a timing delay and would be resolved next month. The Chairman congratulated JM for her achievements and the board **NOTED** the contents of the report.
66-15	**Financial performance: monthly update** DT confirmed that work was currently underway in preparation to submit the annual accounts by 23rd April. In order to meet the deadline for laying these before Parliament, timescales were extremely tight. Highlights of this month's report included: • Despite February being a short month, activity was good. • DT would explain what was in place to mitigate a repeat of the 2014/15 overspend within the 2015/16 budget update later in the meeting. • Cash balances remained significantly above plan and were projected to remain at a high level to the year end. • Although capital expenditure was still below the phased plan, this was now closer to the budget's tolerance level. The board was reminded of the reasons why activity had fallen below plan, therefore impacting on income. These had been discussed in great detail over the last few months.

	SF asked the board to note that £240,000 of donated assets related to money donated by the League of Friends for new anaesthetic machines. He wished to publicly express his thanks to the League for its generous contribution. The Chair thanked DT for his update, the contents of which were **NOTED** by the board.
67-15	**Contract update** DT presented the monthly contract update drawing the board's attention to the following: • Commissioners had now confirmed that financial penalties for the 18-week breaches (from July to November) would not be applied, thanks to actions taken by the trust to reduce backlog; • DT commended the efforts of Elin Richardson in gaining commissioner agreement for the emergency rate threshold to be applied at trust level only; and • The trust's actual income and activity is higher than commissioner plans. However, over performance had been anticipated partly because commissioners had contracted below the 2013/14 outturn, and also because of the trust's growth plan. There was a risk this could be challenged. However, the trust would not be making provision in this respect and would expect to be paid for work undertaken. DT explained that a contingency had been built into the plan last year for the Marginal Rate Emergency Tariff (MRET) but this was not required for standard elective activity. The Chair thanked DT for his update, the contents of which were **NOTED** by the board.
68-15	**Workforce** The highlights of this month's workforce report were presented as follows: • Turnover had increased but this was as a result of the changeover of junior doctors in training and was anticipated. Of more concern was the rate of turnover within Canadian Wing. Whilst limited career progression had been cited as a reason for high turnover in the past, GA advised there were now plans to speak to staff on Canadian Wing to try to identify what was causing this. • Reported sickness had fallen again to 2.85% and was now at its lowest level for 8 months. The target rate for 2015/16 would remain at 2% and it was hoped this might be achieved by year end. Current figures included the anticipated impact of seasonal colds and flu and therefore indicated an encouraging trend towards improved sickness management. • As reported earlier, the recruitment day held in January had resulted in five appointments (a 10% conversion rate). However, recruitment continued to be a priority. An 'advertorial' featuring QVH would be run in the April edition of Nursing Times. A second recruitment event, specifically focused on qualified nurses, would be held in May. GC commended this proposal and suggested talks and presentations be incorporated into the day to attract more interest. GA reported that QVH was also now featured on the NHS jobs website. JT suggested there should be greater focus on retention as this appeared to be a cultural issue. The staff survey (discussed earlier) had highlighted a lack of support from immediate managers, and a drop in appraisal rates which would all contribute to staff turnover. GA explained that line management was being addressed through the Leadership Framework programme but noted that cultural issues would take longer to tackle.

	PAG reiterated concerns regarding turnover and recruitment and commended plans to take a 'deep dive' on Canadian Wing to ascertain what might be done to resolve the current situation. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
STRATEGIC PRIORITIES	
69-15	**Quarterly update on delivery of Key Strategic Objective (KSO) 1: Outstanding Patient Experience** JMT presented an update summarising changes which had taken place over the last quarter. The plan had been reviewed in February and circulated to all stakeholders for comment. In addition to the shorter term actions identified this year, this report also contained a timetable setting out longer term aims. Good progress was being made against priorities, with 20 actions now showing green (17 previously) and 18 now amber, (21 previously). There were no red areas. JMT advised that this programme was monitored through the trust's Patient Experience Group whose membership (in addition to trust staff) comprised governors, patient representatives and members of the public. The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
70-15	**Quarterly update on delivery of Key Strategic Objective (KSO) 2: World Class Clinical Services** The Medical Director presented his quarterly update highlighting the following: • **Clinical Strategy** Seven Day services: As set out in the Keogh report, non-elective care now requires changes to working practices. Our medium term aim was to increase the out of hours cover as much as possible within the Keogh objectives, whilst not increasing costs. Good progress had been made against the ten criteria. Some criteria would not apply within QVH but there remained 5 areas of compliance which the trust had submitted to the CCG for approval. SF reminded the board that no additional funding was available for this initiative and therefore a business case would be necessary before further progress could be made. • **Publication of Consultant Level Clinical Outcomes** SF reminded the board that the original target had been to deliver six outcome measures but this had proved challenging. To date the trust had managed to publish only three measures over the last 9 months. Nevertheless, SF was pleased with progress and commended the work undertaken by the scheme's project manager. • **Clinical Research and Development** SF reminded the board that it had recently received a positive report from the Research and Development team. In addition to success of the 14i bid, resulting in a joint award of £850k, additional contingency funding of £13k had been awarded by the NIHR in recognition of the trust's research activity in 2014. Several other grants had been submitted, and were still awaiting response. SF felt assured that the trust was starting to reap the benefits of being part of the research network. • **Education and Training** Whilst the trust was proceeding with a full business case for the new on-site education centre, plans for the temporary simulation suite were progressing well.

	Under the Leadership of Ed Pickles, Director of Medical Education and Helen Moore, Medical Education Manager, an action plan to address deanery concerns was underway. In order to address a shortfall in trainees, a recruitment day had been held recently. This had been very successful with over 50 plastic surgical trainees attending. A number of honorary contracts would be offered to successful candidates. The Chair thanked SF for his update, the contents of which were **NOTED** by the board.
71-15	**Strategic Priorities for 2015/16** RT reminded that board that it had considered an initial set of strategic priorities at its seminar on 17th February. It was agreed the number of priorities should be reduced to enable the trust to focus on those which aligned with the QVH 2020 strategy. The board considered a list of 11 themes which would take precedence in 2015/16. These would consolidate and progress work already undertaken in 2014/15, and form the basis of next year's work programme. RT felt it was important to maintain a balance between achieving targets and progressing with development. He noted the reduced list would enable tangible outcomes. The reporting mechanism would remain as at present with lead directors taking responsibility for individual projects, and associated milestones. GC sought and received assurance on improved tracking for next year. **[Action: RT]** JT asked how work already underway (eg, outcomes) would be maintained. RT agreed to ensure this was captured. **[Action: RT]** After due consideration, the board **AGREED** to support the priorities for 2015/16 as set out in the paper.
72-15	**2015/16 Budget** DT introduced the 2015/16 budget as the means by which the trust would support delivery of the priorities agreed under item 71-15. A high level draft plan was due for submission to Monitor on 7th April. The deadline for the final plan was 13th May. Unlike last year, there was no requirement for a 5-year plan. In view of the short deadlines imposed by Monitor for deciding which tariff to adopt, the board had discussed this between meetings. The board had agreed that the trust should adopt the Default Tariff Rollover (DTR) as this was more financially advantageous (even after taking into account the loss of CQUIN funding) The high level plan reviewed at the board meeting on 12th March included details of the Cost Improvement Programme, (CiP), cost pressures, level of provision and tariff change. Since this meeting, the Medical Director had reviewed the CiP and was satisfied it would not impact negatively on the quality of patient care. DT also reminded the board that cost improvements had been built up from budget holders rather than driven centrally. In addition to delays in setting the tariff, the trust was also experiencing delays in commissioning. Whilst contract proposals had been submitted, currently only one CCG had responded. This meant agreements wouldn't be in place for the start of 2015/16, although DT did not determine this to be a risk. The board was asked to note that, to date, no proposals had been sent out from NHS England. The income plan for 2015/16 was felt to be realistic but not over ambitious. A 2% general growth

had been built into the plan in line with 5-year plan. Specific growth was linked to strategic developments such as orthodontics and trauma. As discussed previously, activity levels had not been realised for 2014/15 but sufficient resource was now in place in 2015/16 to address this.

The 2015/16 financial plan showed an anticipated surplus of £1m. This was less than 2014/15 (and also of previous years). It was also less than that anticipated in 2015/16 in the trust's five-year forecast. However, DT reminded the board of some of the factors which would make achievement of surplus at previous levels more difficult, including:

- No CQUIN funding
- National pay awards of around 1%
- An increase in the employers pension contribution
- AfC incremental pay awards
- The impact of increased interest and depreciation charges on Theatres and other Medical and IT equipment.

DT had discussed the level of surplus with Monitor, explaining that the impact of the revised tariff would make it impractical to deliver £2.2m. He would support this assumption when preparing the operational plan.

Cost pressures of £1.23m had been kept to a minimum by the Directorates. These included:

- Additional Clinical and Clinical Support Staff;
- Take up of Macmillan initially funded posts;
- Continued rental of the OT6 building; and,
- Increased PDC & depreciation.

DT confirmed these cost pressures would be embedded from the start of the new financial year.

JT sought assurance that cost pressures were fully budgeted for. DT explained that the trust had the following set aside:

- Pay inflation reserve of £0.66m (although it was unlikely to need the full amount).
- General reserve of £0.3m. (Monitor recommend 0.5% contingency, although this could be topped up from the inflation reserve if necessary).

DT advised that this did not include provision which had been set aside for the predicted tariff increase, (anticipated to take effect mid-year or later). JT asked if the level of provision was sufficient. DT reminded the board how the figure of £350k had been calculated and felt assured this would be adequate.

In order to mitigate any overspend in 2015/16, DT advised that
. The Chair queried why this had not been the case last year. He was informed that whilst much work had been done to better engage with budget holders, a lack of both transparency and of financial management support had emerged throughout the year. However these had now been addressed.

Key schemes in the 2015/16 capital programme included Medical Devices, Estates and IT. A capital monitoring group would be established to oversee the programme. This would be chaired by the Director of Finance and include representatives from the key schemes. It would report directly into the new Finance & Performance sub-committee of the board.

DT was asked if there was a risk of slippage to the Medical Devices programme in view of the current vacancy for a medical devices manager. SF assured the board that whilst the trust had yet to appoint, this vacancy was on the risk register and would continue to be monitored.

LP sought and received assurance that there was sufficient project management provision built into the capital programme for delivery of the schemes.

	The Chairman thanked DT for his report and after due consideration, the board **approved** the revenue and capital budgets for 2015/16.
73-15	**Staff Survey Results** A summary report of the results was included in today's papers. GA advised that a more detailed report could be accessed by going online. Whilst results showed QVH to be one of the top performing trusts (based on staff feedback), GA noted there were still areas where results needed to improve. NHS results had deteriorated both nationally and at QVH in the following areas: • Staff recommending their Trust as a place to work; • Staff experiencing an increase in work pressures; and, • More staff saying they have suffered work related stress. Nationally there was also an increase in staff experiencing bullying, harassment and abuse from work colleagues. GA confirmed that bullying and harassment rates were within reasonable tolerance thresholds at QVH, but assured BH work would continue on improving these. GA noted the detrimental impact of reports such as Francis and Savile on staff morale. Whilst intended to improve patient care by developing a more open culture they had also caused a negative impact by continuously reminding staff of when things go wrong. A further external factor was three years of pay freeze. This had been addressed this year and should have a positive impact in 2015. GA would be developing an improvement action plan. However, in order to move ahead a more detailed review of survey results over the last five years was required. This would be presented to the board in May. BH queried the timescales and was advised this was necessary to be able to produce a robust plan. GA also confirmed that a communication strategy would be part of the action plan. **[Action: GA]** The bottom five ranking scores were: • Appraisals and their effectiveness, (although this was due to the impact of changes to mandatory training refresh rates. GA assured BH that he was expecting considerable progress in 2015); • Improvements in team working; • Health and Safety training (again due to changes to mandatory training refresh rates); • Managing work related stress. (Although sickness rates had dropped significantly in recent months, work pressure issues still needed addressing). GC asked if data was analysed via staff group and area. If so it would be useful to have targeted actions, combined with exit interview data to feed into the recruitment and retention strategy. GA agreed it may be possible but to maintain the survey's confidentiality, it was important to avoid identifying individuals. GA noted that whilst staff were happy to recommend friends and family to be treated at QVH, there had been a decline in the numbers who would recommend the trust as a good organisation at which to work. LP expressed disappointment in the results. Whilst acknowledging the current restructuring process would have had an impact, he felt the trust was not where it aspired to be.

	By contrast, RT felt assured that results had not deteriorated further, given internal and external issues previously highlighted. He did, however, concur that results were average and not where the trust aspired to be. Areas relating to process such as appraisal rates and health and safety training would be relatively easy to tackle, although cultural issues would take longer. PAG agreed that general disparaging of the NHS was taking its toll on staff morale. Nevertheless, he noted the board's dissatisfaction with the results. He also noted the importance of benchmarking against specialist acute trusts, instead of those within Kent, Surrey and Sussex in order to obtain a more accurate picture. He reminded the board that staff morale was equally as important as finance and patient experience. In order to improve board and corporate level focus he suggested this should be incorporated into the current governance review. BH agreed and confirmed she would take this forward. **[Action: BH]** The Chairman thanked GA for his report, the contents of which were **NOTED** by the board.
GOVERNANCE	
74-15	**Corporate Risk Register (CRR)** JMT presented the regular CRR update, noting there were no major changes this month. The board was asked to note that under 'ability to meet RTT18 targets' this should read 'risk reduced to 12' rather than 'risk escalated to 20'. The three remaining top risks included: • Breaching cancer targets. • Impact on the trust's decontamination services, due to relocation of core surgical services at Synergy healthcare. • Failure to maintain continuous Estates services due to staff shortages e.g. sickness and recruitment. RT responded that this was too high as plans were in place to mitigate the risk. He suggested he and DT should review **[Action: RT]** JT suggested that risks relating to staffing issues should also be captured on the BAF which would help monitor risks on an aggregate level. JMT agreed to review **[Action: JMT]** The Chairman thanked JMT for her update, the contents of which were **NOTED** by the board.
75-15	**Update in response to 'Savile NHS investigations: lessons learned' report'** JMT reminded the board that the Kate Lampard independent review had been undertaken to provide assurance of investigations undertaken at the four NHS Trusts relating to the late Jimmy Savile. This had resulted in 28 reports, plus a separate assurance report which included 14 recommendations. The trust had now undertaken an assessment of its current position against these 14 recommendations. Whilst amber and green ratings were scored against the actions, there was still some work to do. JMT confirmed that the action plan would be reviewed initially through the Quality and Risk Committee, although this could pass to Human Resources in time. LP advised recommendation 12 had been reviewed at today's Charitable Funds Advisory Committee meeting, and a policy was being drafted. It was also noted under recommendation 12 that the governance restructure timescale should be changed from May to October 2015 **[Action: JMT]**

	The Chairman thanked JMT for her update, the contents of which were **NOTED** by the board.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
76-15	**Clinical Cabinet** RT had nothing to add to his written report. There were no further questions and the board duly **NOTED** the contents of his report.
77-15	**Quality & Risk Committee** GC had nothing further to add to the written update, the contents of which were duly **NOTED** by the board.
NEXT MONTH'S AGENDA	
78-15	Next month's draft agenda was presented for comment. • It was agreed the Board Development Programme would be moved from the morning seminar to the public session of the board. • The Board Assurance Framework session would be scheduled from 10.00 to 12.00 • Finance reports would include 2014/15 draft outturn and annual operational plan for 2015/16 These changes were duly **NOTED** by the board.
STAKEHOLDER AND STAFF ENGAGEMENT	
79-15	**Feedback from events and other engagement with staff and stakeholders** SF had attended an NHS Providers stakeholder event. Highlights included: • The quality and content of keynote speeches; • The likelihood that safe medical staffing would be introduced within the next two years; A list of repeated behaviours to be found within successful organisations had been identified by visiting fellow of the King's Fund, Richard Bohmer. SF suggested this could be presented to the board at a future seminar. **[Action: SF]** BG reminded the board that interviews for a new NED had taken place earlier this week. A recommendation would be put to the Council for approval at its meeting on 9th April. BG had also taken part in a Compliance in Practice visit and received excellent feedback from patients. BH had attended an event whose keynote speakers had included the Chair of Monitor and the Chair of the Care Quality Commission. Notes and slides would be circulated to the board for information in due course. As reported earlier, Monitor had visited the trust this week, and it was felt by all involved that the meeting had been very positive.
ANY OTHER BUSINESS	
	BH reminded the board this was PAG's last meeting as Chairman of the trust. Whilst the board would be holding a farewell dinner in the Chairman's honour later in the evening, she wished to record formally the board's gratitude for his expert chairmanship over the last 10 years.
MEMBERS OF THE PUBLIC	
80-15	**Observations from members of the public** Dr Gulliver-Jones noted this meeting had been very useful. She commended the board for its

	open culture and the positive tone of the meeting.
81-15	Further to paragraph 39.1, and annex 6 of the Trust's Constitution, it was agreed that members of the public should be excluded from the remainder of the meeting in order to enable the board to discuss confidential information concerning the trust's finances and matters of a commercially sensitive nature

Chair …… Date ……

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	REF.	AGREED ACTION	OWNER	DUE	UPDATE	STATUS
March 2015 meeting						
	63-15	Governors to be updated on implications of 2015/16 tariff.	**RT**	April	Update presented at Council of Governors on 9th April.	**Complete**
	64-15	Board to be advised of FFT rates achieved within other specialist trusts.	**JMT**	April	Contained within Safe Staffing and Quality report	**Complete**
	64-15	Board to be advised of financial implications of not achieving FFT targets in Q4.	**JMT**	April	The FFT CQUIN has been achieved. The payment at risk of not achieving this was £71k.	**Complete**
	64-15	JMT to clarify response to complaint on Peanut Ward and email LP with update.	**JMT**	April	JMT updated LP following the March board meeting	**Complete**
	71-15	Improved tracking on progress against new and existing strategic priorities to be introduced.	**RT**			
	73-15	Action plan to be developed to tackle areas of concern highlighted in the Staff Survey.	**GA**	May	On board agenda for May 2015	**Pending**
	73-15	As part of the current governance review, the group to reconsider establishing a board workforce sub-committee in order to improve board and corporate level focus on staff wellbeing.	**BH**			
	74-15	Risk rating with regard to maintaining continuous Estates services to be reviewed as a result of actions in place to mitigate risks.	**RT**			
	74-15	Staffing issues captured on CRR to be incorporated into BAF to help monitor risks on an aggregate level.	**JMT**	April	GA has now reviewed this with the Head of Risk	**Complete**
	75-15	Governance restructure timescales (item 12 of the Savile Action Plan) to be amended from May to October 2015.	**JMT**	April	Done	**Complete**
	79-15	Board to receive presentation on 'Repeated behaviours to be found within successful organisations' identified by Richard Bonher, visiting fellow of the King's Fund.	**SF**			

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
February 2015 meeting						
	034-15	Whistleblowing policy to undergo further evaluation to incorporate new recommendations following *Freedom to Speak up* and returned to BoD for review in April.	**GA**	April	**21.04.2015** The changes incorporated following the Freedom to Speak up review need to be agreed at the Quality and Risk Committee before this policy returns to the Board for ratification. The next meeting of the Q&R committee is the 11th May 2015.	**Pending**
	035-15	Future Safe Staffing reporting to include quality matrix for Theatres	**JMT**	March	**26.03.2015** This will be included no later than May	**Pending**
	035-15	Greater level of detail, including context, to be provided in respect of cancelled operations in future reporting.	**JMT**	March	**26.03.2015** JMT confirmed that this information will be included as and when required	**Complete**
	035-15	Board to receive update on progress for CQC inspection once visit is confirmed.	**JMT**	TBA	**26.03.2015** This will be scheduled for May	**Pending**
	036-15	Board to receive further clarification in respect of Consent Before Day of Treatment (CBDOT)	**RT**	TBA		**TBA**
	037-15	Board to be apprised how best the trust might to achieve sustainable waiting lists in the long term.	**RT**	TBA		**TBA**
	038-15	Board to be apprised of reasons for recent fall in income, and whether this is due to changes in case mix.	**DT**	March	Board provided with an update at its February seminar	**Complete**
	040-15	Following January recruitment drive, information regarding 'conversion rate' of prospective candidates to be provided.	**GA**	TBA	**26.03.2015** Included in this month's workforce report	**Complete**
	042-15	Risk assessment to be undertaken in respect of conclusions following spoke site summary.	**JMT**	TBA	Risk assessment Undertaken at spoke sites annually. Of the 11 spoke sites, 4 have fully completed assessments, one is in progress. 6 awaiting booking.	**Complete**
	051-15	Recommendations following spoke site review to be implemented	**RT**	TBA		**TBA**
December 2014 meeting						
	331-14	Board to be apprised of criteria used when approving locations for off-site activity	**RT**	**TBA**	**TBA**	**TBA**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
	337-14	Explanation of how key high level risks are identified to be provided at a future board seminar.	**AP**	April 2015	Scheduled as part of April seminar programme	**On track**
	338-14	C-Wing Action plan to be returned to board for review in June 2015	**KD**	June 2015	Now incorporated into 2015/16 work programme	**On track**
July 2014 meeting						
	181-14	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**	~~Oct~~ ~~Dec~~ TBA	This will form part of the wider organisational review which will start in October 2014 **21.10.14:** Review has commenced, not expected to conclude until December **18.12.14** Review still underway	**Pending**
May 2014 meeting						
	136-14	Monitor's "Well-Led" assessment framework to be implemented as part of the governance review. LH to liaise with RT regarding next steps, and board to be updated accordingly.	~~**LH**~~ **KD**	~~Aug~~ ~~Oct~~ ~~Dec~~ Mar	**08.07.14:** Presentation to be made to October Nomination & Remuneration Committee **15.09.14:** Well Led Review template to be used as framework for Board self-assessment commencing at December away day. **21.10.14:** Current Governance Review led by Chair Designate to be based on Well –Led Framework **01 02 2015** As LH has now left the trust this will be picked up by KD	**Pending**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th April 2015
Agenda item reference no:	88-15
Author:	Richard Tyler, Chief Executive
Date of report:	21st April 2015

CHIEF EXECUTIVE'S REPORT APRIL 2015

1. Attached is the April which cover key issues of operational performance and external issues of interest to the Trust

2. The Board is asked to **NOTE** the report.

CHIEF EXECUTIVE'S REPORT
APRIL 2015

TRUST ISSUES

April has been a relatively quiet month. However I thought it was worth sharing my most recent staff message that was published in the 20th April edition of *Connect*.

> I am pleased to report that we finished 2014/15 in good shape. We achieved our planned surplus of just over £2m and have been compliant with our waiting list targets since December. On top of this we continue to achieve over 98% in the Friends and Family Test (the percentage of our patients who would recommend our services to their family and friends).
>
> However, the year wasn't without its challenges. As you will all be aware we needed to push really hard in November to get our waiting lists under control and we didn't achieve our planned levels of in-patient activity. We undertook a major structural review and it is a tribute to all involved that we have continued to provide such a good service in the middle of considerable change.
>
> Looking forward to 2015/16 we are making some major investments in IT to support the electronic patient record, aim to appoint to some new posts in orthodontics and corneo-plastics, and will complete our organisational restructuring. However the year ahead will be challenging. We all know that QVH is a unique organisation and that unlike many hospitals we continue to attract new work. This new work is crucial to our ongoing success but it is vital that we continue to manage our costs effectively so that this new work supports investment in our estate and other areas of the Trust.

NATIONAL & REGIONAL ISSUES

Federation of Specialist Hospitals (FSH) meeting with Simon Stevens.

I attended a recent meeting with Simon Stevens. The meeting was organised by FSH as an opportunity to brief Simon on the important role of specialist hospitals. I took the opportunity to brief Simon on the important role we play within trauma networks and the need for NHS England to avoid a 'one size fits all' approach to specialised commissioning.

Brighton & Sussex Medical School

I recently met Professor Malcolm Reid, Dean of the Medical School. He was visiting the Trust at the invitation of Dr Julian Giles and Mr Baljit Dheansa. Professor Reid was particularly interested in our growing research practice as well as the prospects for developing closer teaching ties with the Medical School.

Useful Publications

The Kings Fund have published an analysis of NHS performance under the coalition government
http://www.kingsfund.org.uk/publications/nhs-performance-under-coalition-government

NHS Providers have published a useful analysis of the main political parties NHS election pledges:
http://www.nhsproviders.org/resource-library/general-election-manifestos-april-2015/

Richard Tyler
21st April 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Reference number:	89-15
Report from:	Jo Thomas, interim Director of Nursing & Quality
Author:	Jo Thomas, interim Director of Nursing & Quality
Report date:	22 April 2015
Appendices:	Reports on 1:Safe Staffing 2:Patient experience, complaints & claims

Patients: safe staffing and quality of care

Key issues

1. This report provides information on;

- Safe staffing and whether safe staffing levels are being achieved as per national recommendations and information on how safe and well led each ward is. (Appendix 1).
- Quality and risk management with information provided on quality and safety metrics and incident management.
- Infection prevention and control issues and actions.
- Quality Account update
- Information on new and closed complaints, claims and patient experience feedback.

Safe Staffing

2. Safe staffing levels were achieved throughout March.
3. Areas of concern continue to be the vacancy rates on Canadian wing and increased use of agency staff (particularly in Burns ITU) required and this is reflected in incident returns made by wards on staff resource.

CQUIN

4. Dementia screening has dipped slightly in month but maintains an aggregate score about performance.
5. Significant improvement in FFT in-patient response in moth to achieve the CQUIN target at year end.
6. Quarter 4 reports on all CQUIN schemes currently being compiled; these will be presented to commissioners for review and agreement of CQUIN payments for 2014/15.

.

Quality and Risk Management

7. Two grade 2 QVH acquired pressure ulcer developed in March
8. Two serious incidents (SI) regarding information governance were reported to the Clinical Commissioning Group in March. A further SI will be added to February; investigation of an amber incident has led to this being upgraded to an information governance SI.
9. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.

Infection Control

10. One case of methicillin sensitive staphylococcus aureus (MSSA) was reported in March.

Complaints, Claims and Patient Experience

11. A summary of the results of the National Children's Inpatient Survey are presented within the Patient Experience report.
12. There were two new complaints received during March and these are under investigation. Three complaints were closed and one new claim opened.
13. The average FFT percentage for patients extremely likely/likely to recommend was 99%.

Implications of results reported

14. Additional agency and bank staff have been required as a result of vacancies on wards.
15. A pilot scheme to enhance rates of pay for nurses has been developed between nursing, operations and HR departments and commenced 13 April.

Action required

16. Recruitment and retention of substantive staff to reduce reliance on agency and bank staff.

Link to Key Strategic Objectives (delete those not applicable)

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

17. The issue raised can potentially adversely affect all of the trusts KSO's however many also support the KSO's and demonstrate that the trust is proactive in reporting and investigating incidents and complaints to improve care to patients.

Implications for BAF or Corporate Risk Register

18. The board assurance framework risk associated with the recruitment of staff remains at a rating of 12.

Regulatory impacts

19. Nothing within the report has an impact on our ability to comply our CQC authorisation nor our Monitor governance risk rating or our continuity of service risk rating. However both are aware of the never event and this has been formally discussed with Monitor.

Recommendation

20. The Board is recommended to note the contents of the report.

Patients: Safe Staffing and Quality of Care (March 2015 data)

Introduction

The attached report provides an update on the quality performance of the trust in respect of safety, effectiveness and patient experience. Key national, regional and local metrics are reported within the trust dashboard which is attached within relevant sections of the report along with the monthly complaints report that provides the detail around complaints raised. Performance is described on an exceptional basis with a RAG (red/amber/green) rating used for guidance to highlight areas of concern.

Safe Staffing

1. During March all areas were deemed to have safe staffing levels, where shifts were unfilled due to short notice sickness or in some instances failure of agency staff to attend staff were redistributed and the site practitioner and trauma co-coordinators utilised to ensure safe levels of staffing.

2. The reduction in night staff on Ross Tilley is due to the levels of activity not staff availability. If there are concerns over staffing this is escalated and acted upon appropriately, for example by DATIX and this can be triangulated within the safe care module of e-roster as well as senior professional judgement.

3. A pilot scheme to enhance rates of pay for nurses has been developed between nursing, operations and HR departments and commenced 13 April. Initial findings are shifts are being filled with bank more frequently with the enhanced rate of pay, with less agency use, all of which is promising.

4. Sickness reduced slightly on the Burns ward and ITU in March but increased on Canadian Wing and Peanut ward. Sickness is being managed using agreed HR processes.

5. Within the safe staffing metrics the board is directed to the vacancy rate within Canadian Wing which has slightly improved in March. Interviews for staff have taken place during April and 2 wte HCA posts and 4.5wte registered posts have been offered leaving 4 wte posts not filled.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
SAFE STAFFING - Percentage of staff actually on duty against those planned	Margaret Duncombe Registered staff Day shift			112%	103%	111%	103%	102%	100%	100%	108%	99%	102%	100%	98%
	Margaret Duncombe Support staff Day shift			115%	100%	94%	95%	97%	102%	98%	102%	91%	98%	98%	91%
	Margaret Duncombe Registered staff Night shift			101%	96%	100%	102%	98%	99%	98%	102%	100%	99%	100%	97%
	Margaret Duncombe Support staff Night shift			106%	97%	97%	100%	100%	100%	103%	94%	92%	100%	93%	106%
	Ross Tilley Registered staff Day shift			73%	97%	96%	103%	98%	101%	100%	96%	97%	99%	96%	97%
	Ross Tilley Support staff Day shift			69%	87%	90%	100%	101%	100%	98%	94%	102%	97%	100%	96%
	Ross Tilley Registered staff Night shift			79%	96%	94%	95%	98%	100%	99%	92%	99%	105%	93%	96%
	Ross Tilley Support staff Night shift			71%	97%	93%	93%	83%	100%	93%	89%	83%	94%	86%	87%
	Peanut Registered staff Day shift			100%	94%	101%	95%	93%	99%	100%	105%	100%	95%	99%	99%
	Peanut Support staff Day shift			106%	97%	100%	100%	103%	100%	100%	106%	89%	97%	100%	94%
	Peanut Registered staff Night shift			100%	98%	98%	98%	95%	98%	93%	97%	100%	100%	89%	95%
	Peanut Support staff Night shift			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Burns Registered staff Day shift			86%	93%	94%	99%	96%	100%	99%	100%	100%	95%	99%	97%
	Burns Support staff Day shift			113%	103%	108%	106%	91%	100%	94%	109%	100%	95%	97%	97%
	Burns Registered staff Night shift			97%	98%	103%	100%	92%	100%	98%	103%	97%	98%	96%	100%
	Burns Support staff Night shift			88%	93%	93%	106%	150%	100%	100%	100%	100%	100%	120%	100%
	ITU Registered staff Day shift			99%	93%	95%	98%	93%	98%	100%	100%	93%	97%	95%	98%
	ITU Support staff Day shift			128%	95%	94%	112%	100%	110%	100%	58%	125%	110%	100%	100%
	ITU Registered staff Night shift			90%	96%	87%	95%	99%	98%	92%	102%	94%	97%	92%	98%
	ITU Support staff Night shift			110%	100%	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%

Commissioning for Quality and Innovation (CQUIN)

6. CQUIN schemes continued to make strong progress. Dementia performance has decreased in month but continues to achieve the required aggregate performance of above 90%. Achieving the FFT required a response of 40% for inpatients completing the questionnaire. This was achieved in March, which was due to renewed effort by nursing teams and patient experience manager engaging with our patients. This means that the final FFT CQUIN milestone agreed with our commissioners has been met. The staff have been challenged to sustain this improved response

7. The patient experience manager contacted 2 other specialist hospitals during March to ascertain if there was any shared learning for QVH in improving the FFT response rates. There were no new ideas generated from these inquiries, however contacts were established during these calls which expand our networks on FFT and patient experience.

CQUIN	VTE prophylaxis	100%	>95%	100%	100%	100%	100%	100%	100%	100%	100%	97.4%	100%	100%	100%
	VTE in hospital/RCA undertaken	100%	0/100	0	0	0	0	0	0	0	0	0	0	0	0
	FFT Score acute in-patients extremely likely/likely	86%	>80	88	86	94	91	83	75	98%	97%	99%	100%	99%	99%
	FFT Score acute in-patients unlikely/extremely unlikely									1%	0%	0%	0%	0%	0%
	Number of responses	NEW	30%	72%	37%	47%	48%	35%	27%	28.6%	47%	60%	33%	27.6%	54%
	FFT Score MIU extremely likely/likely	85%	>80	76	77	77	75	86	62	86%	94%	94%	98%	93%	94%
	FFT Score MIU unlikely/extremely unlikely							1		5%	2%	4%	0%	3%	4%
	Number of responses	NEW	20%	21%	8%	45%	19%	44%	34.50%	35.3	29%	31%	24%	25%	19%
	FFT Staff Survey Recommend trust to friends and family / as a place to work	NEW	>4	79			69							.	
	Dementia >75 trauma asked indicative question	93%	90%	80%	100%	100%	100%	100%	100%	100%	71%	86%	100%	94%	85%
	Dementia >75 having diagnostic assessment	100%	90%	100%	100%	100%	100%	100%	100%	100%	71%	86%	100%	94%	85%
	Dementia > 75 referred for further diagnostic advice	89%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Dementia training for staff	—	65%	81%	77%	85%	85%	85%	86%	86%	89%	92%	92%	92%	92%
	Dementia clinical leads identified	—	NA	Informatiion submitted to CCG during June 2014											
	Dementia carers monthly audit	100%	NA	All Q1 carers of patient on the butterfly scheme have been contacted with the butterfly scheme evaluation tool			Q2 audit information collated and submitted to CCG			Q3 data received			Q4 data received		
	Safety thermometer data submission	100%	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Harm free care rate	100%	>95%	100%	98%	100%	95%	92%	100%	100%	95%	95%	96%	100%	95%
	No new harm rate (aquired at QVH)	100%	>95%	100%	100%	100%	100%	96%	100%	100%	95%	97%	100%	100%	98%
	Reducing cancelled operations	—	TBC	Baseline identified & reported			Q2 data collected, submitted to CCG			Reported 1/4ly			Reported 1/4ly		
	WHO Checklist compliance - Qualitative (100% compliance is CCG target)	100%	90% by end Q2 & >95% by end Q4	47%	90.50%	89%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		
	WHO Checklist compliance - Quantative (100% compliance is CCG CQUIN)	96%	>95%	96%	91%	96%	96%	98%	99%	96%	95%	98%	94%	98%	98%
	Assessment against Bronze food chartermark	NEW		Quarterly report submitted			Quarterly report submitted			Quarterly report submitted			Quarterly report submitted		
	Manchester Patient Safety Framework (MaPSaF) compliance	NEW		Quarterly report submitted			Quarterly report submitted			Quarterly report submitted			Quarterly report submitted		

Quality Account

8. The 2015/16 quality account priorities were shared with the Council of Governors on 9 April 2015.

9. In addition to the 2 national quality indicators for external audit the governors selected cancelled operations as the local indicator. KPMG have confirmed that this is a an acceptable local indicator and these indicators will part of the limited assurance opinion on the content of the Trusts 2014 /15 quality account.

10. **Patient Experience**

11. There were 2 new complaints opened in March 2015 both relating to communication and 3 complaints were closed. The full report can be seen at appendix 1.
12. There was 1 new claim opened in March 2015.
13. 300 children and parents completed national children's inpatient and day case survey 2014, giving QVH a response rate of 37% , 10% above the national average. Of the 59 questions which remained the same from the previous year we performed significantly better that average on 37 question and about average on 22 were not significantly worse than average in any of the questions. A more detailed summary is contained within the patient experience report in appendix 1.

Source	**Description** (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	**2013/14 total / average**	**Target**	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Patient Experience	Complaints per 1000 spells	4.7		3.4	2.9	6.9	6.6	2.5	6.7	4.9	3.9	4.5	4.5	3.4	1.3
	Claims per 1000 spells	1		1.4	0.0	2.7	1.2	0.6	1.3	1.2	0.6	0	1.2	2.7	0.6
	FFT Score acute in-patients: likely and very likely to recommend QVH	86%	>90%	99%	100%	99%	97%	100%	97%	98%	97%	99%	100%	99%	99%
	FFT score acute in-patients: unlikely and very unlikely to recommend QVH			started October						1%	0%	0%	0%	0%	0%
	FFT score MIU: likely and very likely to recommend QVH	85%	>90%	99%	97%	96%	96%	97%	92%	86%	94%	94%	98%	93%	94%
	FFT score MIU: unlikely and very unlikely to recommend QVH			started October						5%	2%	4%	0%	3%	4%
	FFT score OPD: likely and very likely to recommend QVH	82%	>90%	98%	98%	98%	98%	98%	97%	97	95%	97%	98%	98%	99%
	FFT score OPD: unlikely and very unlikely to recommend QVH			started October						1%	3%	1%	0%	1%	0%
	FFT score DSU: likely and very likely to recommend QVH	93%	>90%	0	98%	99%	99%	100%	99%	99	99%	95%	100%	100%	96%
	FFT score DSU: unlikely and very unlikely to recommend QVH			started October						0	0%	0%	0%	0%	0%
	FFT score Sleep disorder centre: likely and very likely to recommend QVH	76%	>90%	99%	97%	98%	98.0%	95%	98%	97	100%	95%	100%	98%	100%
	FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH			started October						0%	0%	0%	0%	0%	0%
	Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	—	>90%	92%	97%	99%	98%	98%	97%	98%	96%	97%	99%	98%	100%

Patient Safety

14. There were two grade 2 pressure ulcers acquired at QVH during March and root cause analyses is being undertaken on both cases.

15. There were four patient falls in March. Three falls occurred in clinical areas and one occurred in hospital grounds. Two of the falls resulted in minor harm including a superficial laceration and a graze.

16. There were 2 new serious incident was declared in March 2015. These were both information governance issues. A patient letter was sent to an old address and opened by new resident (patient says he told outpatient receptionist that he had changed address) and 2 patients who both required same treatment prior to admission were mixed up and sent each other's letters. It is too soon to say this is a trend, however feedback on both these cases and the case last month has taken place at clinical cabinet to highlight these breaches and to instruct all attendees to reflect on their own practice both on and off site and review systems in place for managing and communicating patients details with their teams. A full Root Cause Analysis is underway for both incidents and Monitor, CQC and commissioners have been informed.

17. There is also an amendment to the number of SIs in February: following investigation of an amber incident it has been found that there is another information governance breech. This involves the wrong patient sticker with confidential details being attached to a form and dent to another patient A full Root Cause Analysis is now underway for this incident and Monitor, CQC and commissioners have been informed.

Source	**Description** (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	**2013/14 total / average**	**Target**	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Patient Safety	Number of Pressure ulcer development Grade 2 or over acquired at QVH	8		0	0	0	0	1	3	0	0	1	3	1	2
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	NEW	>95%		100%	97%	100%	100%	100%	100%	100%	97%	100%	97%	100%
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	NEW	>95%		80%	83%	100%	100%	100%	100%	66%	100%	80%	100%	100%
	Patient Falls resulting in no or low harm	16	—	4	1	3	6	4	5	3	2	3	8	6	4
	Patient Falls resulting in moderate or severe harm or death	NEW	—	0	0	0	0	0	1	0	0	0	0	0	0
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	NEW	>95%	100%	73%	82%	85%	88%	80%	86%	92%	97%	100%	97%	95%
	Avoidable patient falls identified on the Safety Thermometer	—		0	0	0	0	0	0	0	0	0	0	0	0
	Serious Incidents	5		0	0	1	1	0	1	2	0	1	0	2*	2
	Never Events	NEW		0	1	0	0	1	0	0	0	0	0	0	0
	Total number of incidents involving drug / prescribing errors	NEW		13	10	19	16	17	20	19	31	20	14	16	15
	No & Low harm incidents involving drug / prescribing errors	NEW		13	10	18	16	17	20	19	31	20	14	16	15
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	NEW		0	0	1	0	0	0	0	0	0	0	0	0
	Medication administration errors per 1000 spells	1.3		0.7	3.6	2.7	1.2	0	2	2.4	5.6	2.7	0.7	2	3.2
	To take consent for elective surgery prior to the day of surgery (Total)	72.2%	75%	84.7%	69.6%	76.8%	77.1%	68.7%	74.5%	74.8%	74.3%	75.2%	69.2%	68.5%	#DIV/0!
	To take consent for elective surgery prior to the day of surgery (Max Fax)	60%		68.2%	69.7%	71.4%	77.8%	57.1%	51.6%	65.2%	72.7%	81.3%	65.4%	77.1%	#DIV/0!
	To take consent for elective surgery prior to the day of surgery (Plastics)	46%		84.3%	65.1%	72.9%	72.4%	69.4%	79.6%	72.2%	70.1%	69.4%	68.5%	65.8%	#DIV/0!
	To take consent for elective surgery prior to the day of surgery (Corneo)	81%		95.0%	88.5%	93.9%	87.8%	75.7%	75.3%	87.2%	87.5%	87.5%	80.0%	69.0%	#DIV/0!
	Number of outstanding CAS alerts	NEW		0	0	0	0	0	0	0	1	0	0	1	0
	Number of reported incidents relating to fraud, bribery and corruption	NEW		0	0	1	0	0	0	0	0	0	0	0	0

Staff Safety

18. The mandatory training figure is reported as 75% and the process of data cleansing continues.

19. Whilst the increase in staff needle stick injuries has decreased in the last 2 months this remains a high priority. These incidents will be presented at the infection prevention and control committee 23 April 2015 to see if there is any further learning from these incidents to minimise future needle stick injuries to staff.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Staff Safety	Staff incidents causing harm	58		9	8	6	10	9	8	13	5	5	11	7	5
	RIDDOR (Patients & Staff)	4		1	0	0	0	0	0	1	0	0	0	0	0
	Mandatory training attendance	71%	80%	82%	78%	82%	89%	79%	77%	74%	43%*	69%	75%	76%	75%
	Flu vaccine uptake	55%	60%	Not due till October						38.1%	49.70%	51.50%	53%	53%	n/a

Infection Control

20. There was 1 MSSA bacteraemia in the burns unit for March. A full RCA was undertaken and the unanimous decision of the panel was this was an unavoidable case. No additional measures or actions were identified following the RCA and the discussion of the case with clinical team, infection control team and consultant microbiologist. This has been reported to Health Protection Agency.

21. There has been a decrease in the compliance of completing saving lives audit forms from July 2014December 2014 which precludes any credible conclusions being drawn from this data. Once this issue was highlighted immediate action has been taken to resolve this issue, a solution has been proposed by the matrons and infection control team to collect the data in real time rather than a retrospective audit. This will be closely monitored at infection prevention and control committee until there is sustained evidence that this data collection issue is resolved.

22. Infection control risk assessments have been undertaken on 3 of the 5 spoke sites with no major concerns regarding infection control or decontamination practice.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	E-coli bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	MRSA screening - elective	96%	>95%	97%	97%	97%	95%	94%	96%	96%	94%	95%	99%	98%	98%
	MRSA screening - trauma	98%	>95%	95%	97%	97%	97%	93%	99%	96%	98%	98%	98%	96%	96%
	Trust hand hygiene compliance	95%	>95%	99%	100%	96%	99%	97%	99%	99%	97%	98%	99%	99%	99%

Care Quality Commission (CQC)

23. Inspections by the CQC are now being announced on a monthly basis giving Trusts a 20 week notice period. QVH does not have a date yet for inspection and dates for September are awaited.

24. The CQC self-assessment is underway. The deadline for completion of this initial assessment and return of actions plan is 27 April.

25. A revised CQC Hospital Intelligent Monitoring report is expected at the end of April; QVH is currently rated 6 with an overall risk score of 2.

26. Work has started on rolling out the CiP inspections to all areas of the Trust.

27. CiP inspection information is collated and feedback given to the Matrons who agree actions with ward and team leads. The table below shows the CiP FOR 2014/15. The average CiP score trust-wide currently stands at 92.1%.

CiP 2014/15	Burns	Corneoplastic OPD	Main Theatres	Margaret Duncombe	MIU	Outpatients	Peanut	Pre-assessment	Ross Tilley Ward	X-Ray
April	73		86	85		100	100		85	Cancelled
May	96		89	79		100	93		88	94
June	92		97	94		97	97		95	95
July	Cancelled		97	94		96	96		89	92
August	Cancelled		87	96		90	96		89	95
September	Cancelled		91	91		Cancelled	94		93	97
October	80		87	99		97	96		81	97
November	Cancelled	97	94	84	97			88	92	
December	96		100	90.7		89.2	92.7		89	Cancelled
January	96.8	92.1	92	89.4	91.9		Cancelled		91	
February	95.4	89.1	93.4	94.1			95.7		90.3	Cancelled
March	90			93.1	89.7	Cancelled		83.9	92.3	92.2
April			93.1	96.3		98.9	97.2		96	
Monthly Average (%)	**89.9**	**92.7**	**92.2**	**91.2**	**92.9**	**96.0**	**95.8**	**86.0**	**90.0**	**94.6**

SAFE STAFFING DATA – MARCH 2015

CANADIAN WING																
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies wte/hrs Est = 62.88	7.76 WTE 1288.7hrs	9.21 WTE 1480hrs	6.22 WTE 1033hrs	3.83WTE 636hrs	6.38WTE 1025.3hr	6.38WTE 1059.53	11.25WTE 1808hrs	12.41 WTE 1994hrs	12.69 wte 2107hrs	12.70wte 1905	12.2WTE 2026	<5%	19%				good response to advert interviews planned in April
Temporary staffing Exc RMN Bank / Agency hours	530.10 431.30	553.15 360.30	735.15 375.0	836.50 452.30	418.15 499.30	579.00 795.15	648.45 982.40	418.50 471.30	835.45 545.05	563.00 1419.20	761.40 855.00	<10% 235.8 + vacancy	-349hrs				increase in bank and reduction in agency hours in month
Sickness	2.4%	1.2%	1.0%	1.8%	1.5%	3.56%	5.29%	4.90%	4.53%	5.59%	6.36%	<2%	+4.36%				long term sickness continues
Shifts meeting Est Day RN Support	97.0%	98.0%	100.0%	99.0%	100% 101%	100% 98%	108% 102%	99% 91%	100.4% 101.9%	98.1% 99.2%	97.5% 93.5%	>95%					slightly under measure for non trained but safe staffing maintained
Shifts meeting Est RN day/night Support day/night					99% 100%	98.5% 98%	102% 94%	100% 92%	97.8% 96.9%	97% 90.1%	96.5% 96.8%	>95%					On track no action required
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	70.2%	70.3%	63.2%	61.6%	48.0%	64.80%	68.00%	65.00%	75.64%	70.60%	70.21%	>85%	-14.79				Action required below target
Appraisals	67.7%	70.5%	73.7%	68.9%	66.7%	61.29%	70.00%	76.00%	74.19%	64.91%	62.71%	>85%	-22.29%				Action required below target
Drug Assessments	96%	98%	100%	100%	100%	100%			100%	100%	100%	>95%	5%				On track no action required
Friends and Family Test Score MD / RT	89 85	94 94	87 91	83 82	73 75	97% 100%	98% 95%	99% 100%	100% 100%	100% 98%	98% 98%	>95%	+3 +2				Scoring methodology changes to percentage rating in October 2014
Staff Friends and Family Test Score		79 17															
Budget (K)	15	6	12.6	-24	-37	-22	-52	-80	-91			>0	-187.4				Over spend on nursing budget due to reliance on bank and agency to cover established posts

MARGARET DUNCOMBE	MAY	JUNE	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	1	0	0	0	0	1	0	1	0	0				RCA in progress re PU
Falls	0	1	2	1	4	1	0	0	3	3	0	0	0				On track no action required
Medication errors	5	2	1	0	2	2	2	1	0	2	Data unavail	0	1				No update avaialble due to sickness
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	88%	67%	100%	75%	100%	95%	0%				On track no action required
Nutrition assessment MUST/7 day review	100% 30%	94% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 50%	100% 100%	100% 100%	94% 100%	100% 100%	>95%	0%				On track no action required
Activity	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy (10am)		73%	67%	82%	67%	Data unavail	Data unavail	Data unavail	Data Unavail	Data unavail	Data unavail	<90%	-23%				Process being reviewed by information department
Bed utilisation	93%											<100%					On track no action required
Patient numbers	158	141	148	132	133	143	122	94	126	132	136						On track no action required
Average length of stay	32.8Hrs																
Average patient acuity numbers/day		0 = 12 1a = 1.7 1b = 7															Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE,

ROSS TILLEY	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	DN Rating					
Safe Care	No/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0	0	0	0	1	0	0	0	0				On track no action required
Falls	1	0	1	0	0	0	1	1	3	0	2	0	1				RCA in progress for both falls
Medication errors	0	15	0	0	1	4	6	1	Data unavail	1	Data unavail	0	0				no information available due to sickness
MRSA/Cdiff	0\0	0/0	0/0	0/0	0/0	0/1	0/0	0/0	0/0	0/0	0/0	0	0				One C Diff declared; unavoidable; within 72 hours of admission
VTE reassessment	91%	100%	100%	100%	100%	100%	78%	90%	100%	100%	80%	95%	5%				matron to identify additional actions to resolve
Nutrition assessment MUST / 7 day	100% 100%	100% 92%	100% 100%	100% 100%	100% 100%	100% 100%	100% 0%	94.4% N/A	100% N/A	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	No/%	No/%	No/%	No/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy		67%	64%	67%	59%	Data unavail	Data unavail	Data unavail	Data unavail	Data unavail	Data unavail	<90%	23%				Process being reviewed by infomrmation department
Bed utilisation	107%											<100%					On track no action required
Patient numbers	199	186	207	190	178	212	179	151	185	186	172						On track no action required
Average length of stay	34.9Hrs																
Average patient acuity numbers/day		0 = 14.3 1a = 0.86 1b = 1.5															Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE

BURNS UNIT																	
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 30.63	1.6 wte 266hrs	6.40 wte 1028hrs	7.40 wte 1229hrs	6.40 wte 1062.85	6.50wte 1044.6	6.53WTE 1084.44	6.53WTE 1044.64	6.50WTE 1044.64	5.50wte 913 hrs	5.07 760.50	1.75wte 290hrs	<5%	5.7%				Vacancy on establishment
Temporary staffing Exc RMN Bank / Agency	398.15 114	466.30 128.55	400.45 573.0	335.0 216.0	124.45 78.0	301.25 137.45	212.30 42.00	226.00 144.00	271.20 180.00	370.55 180.00	191.09 504.00	<10% 114.8hrs + vacancy	+258 hrs				significant increase in agenct spend
Sickness	4.1%	4.79%	2.42%	1.98%	0.75%	0.66%	2.05%	6.46%	3.72%	3.17%	3.68%	<2%	+1.68%				increase in sickness
Shifts meeting Est Day RN Support							100 103%	100% 100%	95% 95%	98.7% 96.6%	96.7% 97.2%						slight chnages in month no impact on safety
Shifts meeting Est Night RN Support	96%	99%	98%	92%	100%	98%	109 100%	97% 100%	98% 100%	96.2% 120%	100% 100%	>95%					on target
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	80.25%	83.60%	77.10%	75.91%	58.79%	74.17%	78.00%	70.00%	83.99%	77.69%	72.73%	>85%	-12.27%				Below target
Appraisals	58.82%	66.67%	86.21%	80.00%	79.31%	80.00%	80.00%	77.00%	70.97%	56.67%	54.55%	>85%	-30.45%				Below target
Drug Assessments	95%	97%	97%	94%	90%	90%			100%	100%	100%	>95%	-1%				Action required
Friends and Family Test Score	100	94	100	100	100	100%	100%	100%	100%	100%	100%	>95%	20				Scoring methodology changes to percentage rating
Staff Friends and Family Test Score		79 17															
Budget	3	15	-14.6	-90	-95	-99	-101	-124	-127				-632.6				Overspend is split between income and non pay

BURNS WARD	MAY	JUNE	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No%**	**No%**	**No%**	**No%**	**No%**	**No%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	1	0	0	0	0	0	0	0	0				On track no action required
Falls	0	2	3	0	0	0	1	1	0	1	0	0	0				Fall was due to patient trying mobilise independently and no harm was sustained
Medication errors	0	0	0	0	0	0	3	0	0	0	Data unavail	0	0				no data available due to sickness
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	83%	100%	100%	100%	80%	95%	5%				matron asked to identify what additional actions are required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 75%	100% N/A	100% 100%	>95%	5%				matron asked to review
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	78%	68%	77%	29%	39%	Data unavail	Data unavail	Data unavail	Data unavail	Data unavail	Data unavail	<95%	18%				process being reviewed by information department
Bed utilisation																	
Patient numbers	28	25	38	3	15	31	19	26	25	29	20						On track no action required
Average length of stay	36.5Hrs																
Average patient acuity numbers/day burns & ITU		0 = 1.2 1a = 0.23 1b = 3 2 = 0.29 3 = 0.1															Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE

ITU																	
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 6.16	2.40 WTE 386 hrs	0 WTE 0.0	.44wte 73.0	1.76 wte 292.28	2.76wte 443.5	2.76WTE 458.35	1.76WTE 282.85	1.76WTE 282.85	0.76 wte 122hrs	1.76wte 264	1.60wte 266	<5%	10.00%				staffed to activity actively recruiting
Temporary staffing Exc RMN	151.30	238.40	124.4	249.30	64.00	119.30	239.45		152.30	160.45		<10% 60.6hrs + vacancy	+393hrs				
Bank / Agency	280.20	112.30	426.0	414.00	184.00	444.00	600.50	95.20 100.20	234.00	235.25	464.15 84.00						impproved bank rate fill
Sickness	14.59%	7.01%	5.52%	2.30%	2.15%	2.09%	1.67%	13.46%	4.12%	1.94%	7.14%	<2%	+5.14%				Raised directly with manager and matron
Shifts meeting Est Day RN							100		97%	95%	97.6%						
Support	95%	91%	97%	96%	99%	96%	58%	93% 125%	110%	100%	100%	>95%	2%				on plan
Shifts meeting Est Night RN							102		97%	91%	97.7%						
Support							100	94% 100%	100%	100%	100%	>95%					on plan
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	79.17%	83.60%	76.00%	80.27%	56.42%	78.57%	78.00%	70.00%	78.85%	72.44%	63.64%	>85%	-21.36%				Raised directly with manager and matron
Appraisals	50.0%	46.67%	33.33%	37.71%	38.46%	53.85%	53.00%	62.00%	53.85%	53.85%	53.85%	>85%	-31.15%				Raised directly with manager and matron
Drug Assessments	95%	97%	97%	94%					100%	100%	100%	>95	-1%				on plan
Budget	-7	-25	-48	-62	-63	-47	-3	-22	-40			>0	-317				Pay oversepnd

ITU	MAY	JUNE	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No%**	**No%**	**No%**	**No%**	**No%**	**No%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0	0	1	1	1	1	0	0				On track no action required
Falls	0	0	0	0	0	0	0	0	0	0	0	0	0				On track no action required
Medication errors	0	0	0	0	1	2	2	0	Data Unavail	0	Data Unavail	0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 75%	100% N/A	100% 100%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy																	
Bed utilisation																	
Patient numbers																	
Average patient acuity numbers/day burns & ITU		1a = 0.23 1b = 3 2 = 0.29 3 = 0.1															Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE

Peanut																	
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 25.00	1.72wte 286hrs	2.2wte 365hrs	2.2wte 365hrs	.63wte 104.62	.63wte	1.0WTE 166.07	1.35WTE 216.96	1.99WTE 319.82	1.99 wte 330hrs	1.99wte 298.50	2.1 wte 349hrs	<5%	8.4%				out to advert
Temporary staffing Exc RMN Bank / Agency	160.15 23.45	289.20 0	328.05 7.30	331.0 35.0	196.45 20.00	212.45 0.00	230.10 25.00	166.00 35.30	179.55 82.30	246.30 28.00	240.00 71.30	<10% 93.75 + vacancy	-37.10hrs				no action required
Sickness	3.8%	4.36%	10.03%	8.43%	6.05%	6.42%	10.87%	4.93%	6.03%	8.90%	10.58%	<2%	+8.58%				update from kate required
Shifts meeting Est Day RN Support	96%	100%	97%	94%	99%	98%	105% 97%	100% 89%	95% 97%	98.7% 100%	98.9% 93.8%	>95%					no unsafe staffing incidents
Shifts meeting Est Night RN Support							106 100	100% 100%	100% 100%	89.3% 100%	94.9% 100%						no unsafe staffing incidents
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	81.3%	85.00%	67.20%	77.69%	58.54%	73.28%	69.00%	63.00%	80.96%	78.24%	78.38%	>85%	-6.62%				Action required
Appraisals	87.1%	96.77	84.38%	87.10%	87.88%	84.38%	78.00%	77.00%	73.33%	85.71%	80.00%	>85%	-5.00				Action required
Drug Assessments	100.0%	95.5%	88.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>95%	-8%				On track no action
Friends and Family Test Score	100	100	66	-100	100	88%	100%	100%	N/A	N/A	100%	>95%	-14				On track no action
Staff Friends and Family Test Score		79 17															
Budget	-6	-5	-6.6	-12	-17	-15	-18	-25	-25			>0	-129.6				This is asplit between pay, non pay and income

Peanut	MAY	JUNE	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	No/%	No%	No%	No%	No%	No%	No%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0				On track no action required
Falls	0	0	0	0	0	0	0	0	0	0	0	0	0				On track no action required
Medication errors	0	0	0	1	0	0	0	0	Data unavail	Data unavail	Data unavail	0	0				no data due to sickness
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
Activity	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy Taken at 10.00 daily excluding weekends	64%	67%	68%	67%	59%	Data unavail	Data unavail	Data unavail	Data unavail	Data unavail	Data unavail	<95%	27%				process being reviewed by information department
Bed utilisation																	
Patient numbers									6	9	12						
Average length of stay	5.5Hrs																
Average acuity																	

Queen Victoria Hospital NHS
NHS Foundation Trust

Monthly patient experience report

1 March 2015 – 31 March 2015

This report provides an overview of all activity during this period. During this period there were 2 new formal complaints receive and 1 new claim. The following is a summary of those new cases that were received.

Monthly patient experience report

1 March 2015 – 31 March 2015

Complaints

Open complaints: There were 2 complaints opened during this period. All Complaints received are acknowledged, investigated and responded to. Actions identified are monitored for completion by the monthly clinical governance group.

Main Theatres

1. **Reception/nursing – communication** – The patient arrived at 12:45pm and was taken through at 3:30pm. There was a lack of communication from the staff in relation to the delay and keeping the patient and the accompanying relative fully updated. I**nvestigating lead – Matron**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Possible**

   Comment/Action – It is acknowledged that there was a lack of communication and we are looking at ways that this can be improved upon within the theatre area. Meeting is being arranged with staff, Matron and Patient Experience Manager to discuss areas for improvement.

Plastic Surgery

2. **Medical – Access and waiting/communication** – The patient was initially diagnosed with melanoma on the ankle in 2013. As per protocol the patient was returning for 3 monthly check-ups. In October 2014, the patient mentioned to one of consultants (now retired) who was carrying out a procedure that the nodes in groin felt raised. Patient was told to mention this at his next appointment on 13 November 2014.

   At his appointment in November 2014 the patient says that he mentioned to clinician that nodes in groin appeared raised. However this was dismissed by him 'as not being important', which at the time brought relief to the patient.

   During a clinic visit to Pembury Hospital on 27 November, following a Hernia revision, he had an ultrasound scan to check a haematoma, which also found the an enlarged lymph node, which was noted as suspicious. They subsequently arranged a further ultrasound scan and fine needle aspiration in January on the lymph node.

   The patient recently underwent a groin dissection and has been referred for radiotherapy. The patient wishes to know why this wasn't noted and dealt with at his appointment on 13 November 2014.

   Initial risk grading: **Major**. Likelihood of recurrence as: **Possible.**

   Comment/Action – The patient has made reference within his letter that he has sought legal advice and has asked for a copy of the clinical entry made within his health records for 13 November 2014. Please note that there is no written entry within the health records and the typed letter to the GP makes no reference to the concerns of the patient of the raised node. The clinician who saw the patient in November 2014 is no longer at the trust.

Nicolle Tadman, Patient Experience Manager

Closed complaints: There were 3 complaints closed during this period. The Trust triages all complaints in line with the Department of Health guidance to ensure that proportionate investigations take place.

Canadian Wing

1. **Nursing - Safety -** Patient found on the floor by the toilet in one of the bathrooms on ward. Patient had walked out to the toilet on her own without pressing the call bell for assistance. Patient had hit her head, lump to forehead noted. Assisted by nursing staff to stand up and patient walked back to her bed. 'Patient informed son that she felt like she had been hit over the head by someone.' **Investigating lead – Matron**

   Initial risk grading: **Major.** Likelihood of recurrence as: **Very unlikely**

   Comment/Action - It is accepted that the patient fell in the bathroom but there is no evidence to indicate that she was pushed or hit. It is clinically felt that the patient sustained a mild heart attack which resulted in her falling and hitting her head against the sink. **Outcome – Unsupported.**

Maxillofacial

2. **Medical – Clinical Care -** During tooth extraction the patient sustained damage to the facial nerve. Patient has asked for a full explanation as to how this could have happened as they allege that they were not warned of this risk. **Investigating lead – Consultant and Clinical Lead**

   Initial risk grading: **Moderate** Likelihood of recurrence as**: Possible**

   Comment/Action - The patient did sustain nerve damage during surgery however the risk was fully explained (this is a rare but recognised risk of this type of surgery) and the consent form was signed by the patient. **Outcome – Upheld in part.**

Offsite – Medway (outpatient services)

3. **Maxillofacial - waiting time in clinic** – Patient had to wait over 1 hour to be seen at appointment. **Investigating lead – Team Leader (Medway) – General Manager**

   Initial risk grading: **Minor.** Likelihood of recurrence as: **Possible**

   Comment/Action – Apologies given to the patient for the delays incurred. A full review of the maxillofacial service provided by QVH at Medway is currently being undertaken. **Outcome – Upheld.**

Claims

Open claims: There was 1 new claim opened during this period. Overall there are 52 claims. A quarterly report is provided to the Quality and Risk Committee. Lessons learnt from claims are disseminated through the Joint Hospital Audit meeting each quarter.

Incident date	Claim date	Directorate	Specialty	Description
24/04/2012	24/03/2015	Plastic Surgery	Medical (Doctors)	It is alleged that we failed to act upon an 'urgent' referral and undertake a biopsy in relation to the diagnosis of cancer.

Closed claims: 1 claim was closed during this period.

Patient comments, surveys & Friends and Family Test

Patient feedback is actively sought by the trust through the friends and family test and patients can actively feedback to the trust through NHS Choices, PALS, twitter or email.

There were 5 new comments posted onto the NHS Choices/Patient Opinion websites.

The following is a link to the sites: Patient Opinion

National Children's inpatient and day case survey 2014

The results presented here are from the Inpatient Survey 2014, carried out by Picker Institute Europe on behalf of the Queen Victoria Hospital NHS Foundation Trust. This survey is part of a series of annual surveys required by the Care Quality Commission for all NHS Acute trusts in England. The Picker Institute was commissioned by 69 UK trusts and one private provider to undertake the Children's Inpatient & Day Case 2014 Survey. A sample of 300 paediatric inpatients and day case patients that were discharged between July and August was submitted.

A total of 300 patients from your Trust were sent a questionnaire. 297 were eligible for the survey, of which 111 returned a completed questionnaire, giving a response rate of 37% (average response rate 27%).

Key facts about the 111 who responded to the survey:

- 45% of returned questionnaires were the parent/carer version (0-7 years), 15% were the children's survey (8-11 years), and 40% were the young person's questionnaire (12-15 years).
- 38% of admissions were emergency whereas 62% of attendances were planned.
- 92% had an operation or procedure during their stay.
- 59% of young patients were male; 41% were female.
- 92% stated their ethnic background as White; 4% Mixed; 2% Asian/Asian British; 2% Black/Black British; 1% other ethnic group.

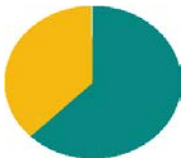
This survey has highlighted the many positive aspects of the patient experience.

Some key results:

- **Overall:** 98% of parents rated care 7 or more out of 10.
- **Overall:** 95% of children and young people rated care 7 or more out of 10.
- **Hospital ward:** 100% of parents felt their child (aged 0-7 years) was always safe on the ward, and 95% of children and young people (aged 8-15 years) always felt safe.
- **Hospital ward:** 94% of parents of children aged 0-7 years stated there were definitely appropriate things for their child to play with on the ward, whereas 48% of young people aged 12-15 years felt there was a lot for their age group to do.

- **Hospital staff:** 92% of children and young people (aged 8-15 years) stated that someone at the hospital spoke with them about their worries, and 92% felt that the people looking after them always listened to them.
- **Hospital staff:** 98% of parents always had confidence and trust in the members of staff treating their child (0-15 years)
- **Overall:** 100% of parents stated they were always treated with dignity and respect by the people looking after their child (0-7 years)

How do we compare to other trusts?



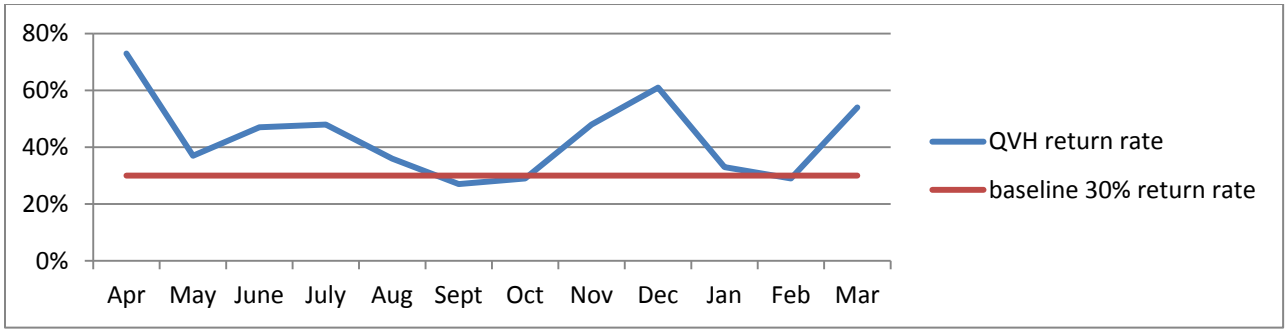
The survey showed that QVH Trust is:

- Significantly BETTER than average on 37 questions
- Significantly WORSE than average on 0 questions
- The scores were average on 22 questions

Friends and Family Test

The role out of FFT is a national CQUIN, currently the return rate is **30%** but in April 2014/15 we are required to achieve a return rate of 40% for inpatient returns and 20% for MIU.

The Trust wide FFT scores for in-patients in March was **99%** of our patients would recommend us. **179** inpatients out of a possible **329** inpatients completed the questionnaire which is a **response rate of 54.4%, which is vast improve from February which was 27.9%.** The following is a chart showing our response rate over the last financial year.



The following are the specific area/wards FFT score, % score for extremely likely/likely and return rate, which are considered to be very disappointing with the response rate scores for some areas:

Area	Total Responses	Total Eligible	Response rate	Percentage recommended	Percentage Not

									recommended	
Month	**Mar**	Feb	**Mar**	Feb	**Mar**	Feb	**Mar**	Feb	**Mar**	Feb
MD ward	**59**	41	**136**	132	**43.4%**	31.1%	**98%**	100%	**0%**	0%
RT ward	**101**	49	**172**	186	**58.7%**	26.3%	**98%**	98%	**0%**	0%
Peanut	**10**	0	**12**	9	**83.3%**	0%	**100%**	0%	**0%**	0%
Burns	**9**	9	**20**	29	**45%**	31%	**100%**	100%	**0%**	0%
Sleep	**81**	42	**136**	131	**59.6%**	32.1%	**100%**	98%	**0%**	0%
MIU	**192**	195	**1028**	769	**18.7%**	25.4%	**94%**	93%	**4%**	3%
Trauma	**205**	136	**620**	523	**33.1%**	26%	**92%**	90%	**2%**	4%
OPD	**452**	253	**11310**	10138	**4%**	2.5%	**99%**	98%	**0%**	1%
DSU	**50**	16	**731**	643	**6.8%**	2.5%	**96%**	100%	**0%**	0%

The following chart is a comparison of specialist hospitals and their FFT scores for February 2015 (please note that NHS England publishes their statistics 1 month behind).

Trust	Total Responses	Total Eligible	Response Rate	Percentage recommended	Percentage Not recommended
Moorfields Eye Hospital NHS Foundation Trust	56	86	65.12%	100%	0%
Papworth Hospital NHS Foundation Trust	536	952	56.30%	98%	0%
Queen Victoria Hospital NHS Foundation Trust	99	342	28.95%	99%	0%
The Royal Marsden NHS Foundation Trust	155	285	54.39%	99%	0%
Royal National Orthopaedic Hospital NHS Trust	299	557	53.68%	95%	2%
Stoke Mandeville Hospital	168	717	23.42%	98%	1%

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Reference number:	90-15
Report from:	Jane Morris, Interim Head of Operations
Author:	Jane Morris, Interim Head of Operations
Report date:	22 April 2015

Operational performance: targets, delivery and key performance indicators

Key performance indicators

1. Income from patient activity was on plan in month 12.

2. The trust is compliant at an aggregate level for all three 18 week's targets in March.

3. The trust was also compliant in March for all three 18 week performance targets at a speciality level except for rheumatology and oral surgery who were not complaint for non-admitted pathways. However it should be noted for rheumatology, as there are less than 20 patients, this is classed as deminimus and so will not be reportable as a speciality breach as per Monitor guidance.

4. The trust is currently forecasting a risk with compliance for the admitted 18 week aggregate target based on patients booked with non-compliance forecasted for both oral surgery and plastics. This position is being reviewed on a daily basis.

5. The trust is forecasting compliance for April with both non admitted and open pathways both at an aggregate and speciality level.

6. There was one patient whose pathway was closed over 52 weeks for March due to patient being unfit for surgery after accepting a reasonable offer. Please note as this was not a patient with an open pathway this is not reportable and so no fines will be applied.

7. The trust achieved all cancer waiting times in February except for the 62 day target.

8. There were no urgent operations cancelled in March.

9. There were no patients cancelled on the day of admission in March.

10. The exact trust MIU performance in March was not available at the time of writing this report however the trust has consistently been performing above 95%.

11. The trust achieved the diagnostic target for March.

Implications of results reported

18 weeks

12. The trust has continued to sustain the national and Monitor requirement to be compliant at an aggregate level for all three 18 week performance targets.

Actions being taken to achieve compliance

18 weeks

13. Key actions in place

- Operational control centre is now fully embedded and meets three times a week. This group focuses on providing targeted lists of patients to be booked by secretaries, waiting list progress as well as addressing immediate operational issues so that backlog continues to reduce as per trajectories
- Information provided to the above is now fully embedded to support the operational team.
- Weekly forecast update is being provided to the board
- Extra operating sessions are being organised as required ensure the trust continues to maintain compliance.
- The trust has opened a further orthodontic treatment room this month alongside the appointment of a locum consultant to support the achievement of sustainable waiting times within the department
- The trust is still also securing extra capacity at Centre for Sight, for the more complex corneal patients who cannot currently be treated at QVH as well as continuing with Saturday operating twice a month. An additional locum consultant ophthalmologist is being recruited to further improve the capacity within the speciality to meet demand
- Extra clinics are being held to reduce waiting times at off sites particularly for oral surgery.

Cancer

14. Main risks to achieving compliance with cancer waiting times are as follows:
    - The trust's cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at QVH, complex multi-organisational pathways and late secondary referrals.
    - Late referrals from off sites.
    - Administrative errors at QVH due to shortages of staff / incorrect listing as routine when added to waiting list.

15. Actions being taken to mitigate the risks include:
    - Liaising with management teams off site to improve processes.

- Training of admin teams and reinforcing to junior doctors about the correct listing of patients.
- Contacting individual trusts when an immediate breast breach has occurred due to unavailability of visiting consultant and asking them to review systems.
- An interim manager has completed a review and new data collection process surrounding cancer waiting times and COSD is being introduced in Jan with a new tracking system.

Link to key strategic objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

16. The performance in month contributes to the financial sustainability objective as no penalties have been applied.

17. More relevant is the adverse impact on patient experience and operational excellence of the 18 week and cancer breaches as well as urgent cancelled operations.

Implications for BAF or Corporate Risk Register

18. Risks associated with this paper have been reviewed and corporate risk register has been updated accordingly to reflect the sustained performance since December.

Regulatory impact

19. Currently the performance reported in this paper does not impact on our CQC authorisation or the current Monitor governance risk rating which remains as ‘Green’.

Recommendation

20. The Board is asked to **NOTE** the content of this report.

Queen Victoria Hospital NHS
NHS Foundation Trust

Operational performance update

1. **18 weeks**

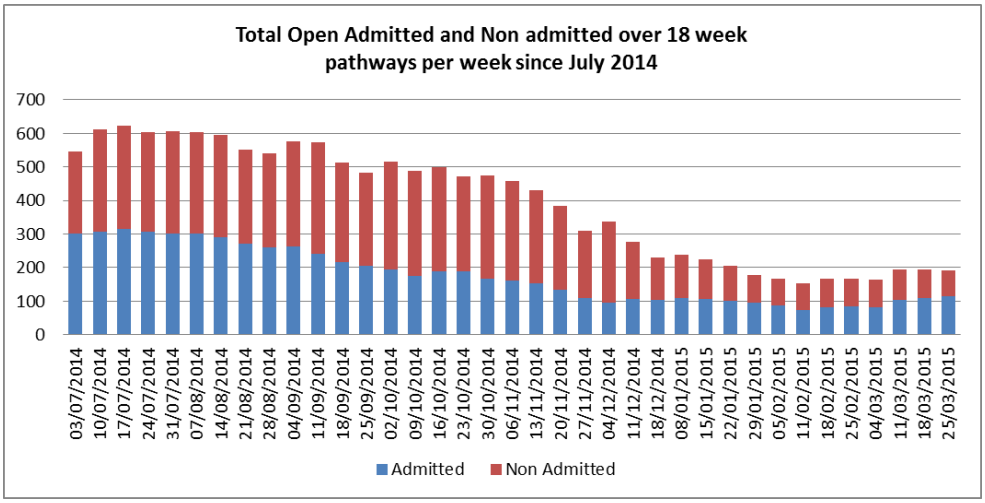
In March the trust achieved aggregate compliance with all three 18 week targets and with all specialities, except for rheumatology and oral surgery non admitted pathways as shown in the table below. However it should be noted for rheumatology, as there are less than 20 patients, this is classed as deminimus and so will not be reportable as a speciality breach as per Monitor guidance.

Speciality	Total Patients	Patients over 18 weeks	18 week % compliance
Ophthalmology	239	11	95.4%
Oral Surgery	236	23	90.25%
Plastic Surgery	649	51	92.14%
Other	97	0	100%
Admitted Total	1221	85	93.04%
Ophthalmology	135	4	97.04%
Oral Surgery	718	38	94.71%
Plastic Surgery	383	16	95.82%
Cardiology	24	1	95.83%
Rheumatology	16	1	93.75%
Other	157	1	99.36%
Non Admitted Total	1433	61	95.74%
Ophthalmology	799	25	96.87%
Oral Surgery	1881	53	97.18%
Plastic Surgery	1914	73	96.18%
Cardiology	61	4	93.44%
Rheumatology	23	1	95.65%
Other	498	2	99.59%
Open Pathway Total	5176	158	96.94%

The forecast for April based on the patients currently booked, shows that there is a risk for the Trust aggregate compliance for admitted patients, with non-compliance forecasted for both oral surgery and plastics. This position is being reviewed on a daily basis with validators ensuring all activity is being captured and all breaches are being rechecked.

Progress on reducing the overall numbers of patients waiting over 18 weeks is remaining stable providing assurance that the trust is progressing towards long term sustainable position.

Actions that are in place



- Operational control centre is now fully embedded and meets three times a week. This group focuses on:
  - providing targeted lists of surgical patients to be booked for admission by secretaries, review waiting list size, progress towards scheduling patients at least 3 weeks ahead as well as addressing immediate operational issues so that backlog continues to reduce as per trajectories.
  - Providing targeted lists for outpatients to ensure they are booked and/ or reviewed before breach date.
- Information provided to the above is now fully embedded to support the operational team.
- Weekly forecast update is being provided to the board.
- Extra operating sessions are being organised as required to ensure the trust continues to maintain compliance.
- The Trust has opened a further orthodontic treatment room this month alongside the appointment of a locum consultant to support the achievement of sustainable waiting times within the department.
- The trust is still also securing extra capacity at Centre for Sight, for the more complex corneal patients who cannot currently be treated at QVH as well as continuing with Saturday operating twice a month. An additional locum consultant ophthalmologist is being recruited to further improve the capacity within the speciality to meet demand.
- Extra clinics are being held to reduce waiting times at off sites particularly for oral surgery.
- Additional hours for validation put in place earlier this year have now been agreed to continue substantively as part of business planning. The dedicated analyst for 18 weeks also continues at present.
- Pooling of lists amongst consultants continues.

2. 52 week breaches

There was one patient whose pathway was closed over 52 weeks for March due to patient being unfit for surgery after accepting a reasonable offer. Please note as this was not a patient with an open pathway this is not reportable and so no fines will be applied. Therefore the Trust total of 8 patients reported waiting over 52 weeks within 14/15, due to breaches earlier this year, remains unchanged.

a. Cancer

Trust cancer waiting times for the first three quarters is shown in the table below.

	Q1	Q2	Q3	Jan	Feb	Mar
Cancer 2 ww rule (93%)	97.5%	97.3%	95.7%	94.2%	96.8%	
Cancer 31 FDT (96%)	94.8%	98.0%	97.9%	96.2%	97.7%	
Cancer 31 Subs (94%)	97.2%	97.3%	98.5%	100%	100%	
Cancer 62 day (85%)	89.9%	81.8%	95.2%	88.2%	75%	

QVH achieved all cancer standards for February except the 62 day target. All but one of the patients who breached this target (5 out of 6 patients) was shared with other organisations. Reasons for delay included complex pathway, late transfer to QVH for treatment and delays by other Trusts in booking follow up appointments.

The forecast position for cancer performance for March is not available at the time of writing this report. A verbal update will be provided at the trust board in April.

Main risks to achieving compliance with cancer waiting times are as follows:

- The trust's cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at QVH, complex multi-organisational pathways and late secondary referrals.
- Late referrals from off sites which may become more frequent due to the wider operational pressures other providers are facing.
- Administrative errors at QVH due to shortages of staff / incorrect listing as routine when added to waiting list.

Actions being taken to mitigate the risks include:

- Liaising with management teams off site to improve processes and understand reasons for delay
- Training of admin teams and reinforcing to junior doctors about the correct listing of patients
- An interim manager has been brought in to cover sickness and to undertake a review to streamline the data collection process surrounding cancer waiting times and COSD – good progress is being made.

b. Cancelled operations

There were no patient's cancelled on the day of surgery or urgent cases cancelled for a second time in March.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 April 2015
Reference number: 91-15
Report from: Dominic Tkaczyk, Director of Finance and Commerce
Author: Dominic Tkaczyk, Director of Finance and Commerce
Report date: 21 April 2015

Financial performance: month 12 2014/15, March 2015

Key issues

1. The financial performance report details the trust's financial performance for year ended 31 March 2015.

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	5,714	5,183	532	61,850	59,551	2,299
EBITDA	426	654	(229)	4,634	5,756	(1,122)
Surplus	133	358	(225)	2,253	2,203	51
Continuity of Service risk rating (CoSRR)	4	4	-	4	4	-

NB table subject to rounding differences.

2. The trust delivered a £2,253k surplus for the year, with increased income offset by increased costs, and after the beneficial impact from the revision of prior year estimates. In month the Trust made a surplus of £133k.

3. The trust maintained a continuity of service risk rating of 4.

Implications of results reported

4. The trust has achieved the surplus of £2,253k with the benefit of the revision of prior year estimates. However this is still an excellent result in a very difficult year, which has seen increasing deficits across the provider sector in the NHS.

Action required

5. Plans for 2015/16 include expansion of trauma and orthodontic services and an increase in elective services to bring activity levels back to 2014/15 planned levels. Delivery of the action plans to meet performance targets is critical, as is cost control; including the delivery of the cost improvement plans.

Link to Key Strategic Objectives

- Operational excellence

- Financial sustainability

6. The achievement of financial targets ensures financial stability and supports the other KSOs including operational excellence.

Implications for BAF or Corporate Risk Register

7. Nothing new to add.

Regulatory impacts

8. The financial performance keeps our Monitor continuity of service risk rating at 4 and does not have a negative impact on our governance rating.

Recommendation

9. The Board is asked to **NOTE** the content of this report.

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
March 2015
Month 12
30th April 2015

Executive Director: Dominic Tkaczyk

Contents

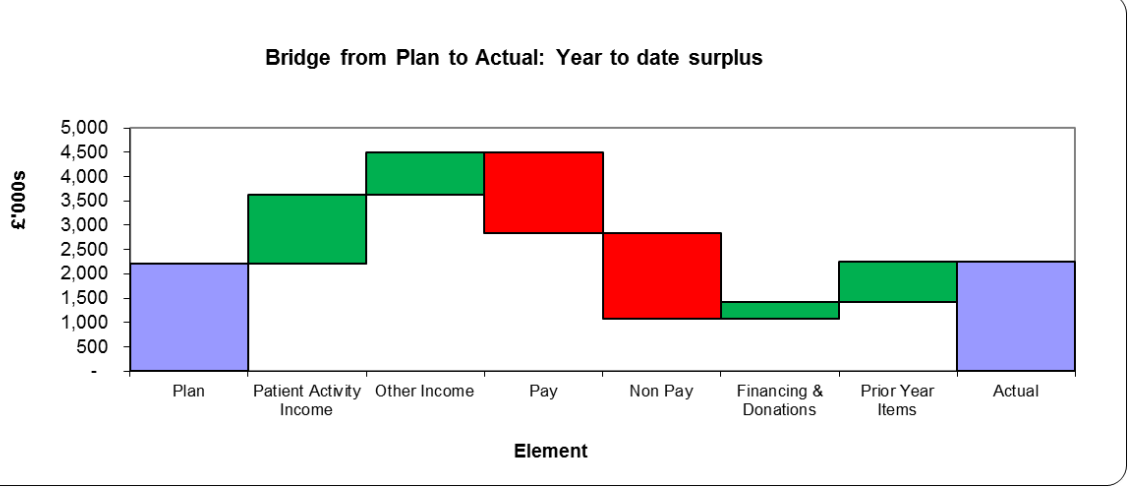
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M12 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance	2014-15	13-14	March 14-15			13-14	Year to Date 2014-15		
Income and Expenditure	Annual Plan £k	M12 13-14 CM Actual	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	M12 13-14 YTD Actual	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	55,788	*6,424*	5,138	4,869	270	*56,139*	57,208	55,788	1,420
Other Income	3,763	*847*	576	314	262	*4,459*	4,642	3,763	878
Pay	(38,401)	*(3,233)*	(3,589)	(3,215)	(374)	*(38,316)*	(40,064)	(38,401)	(1,663)
Non Pay	(15,394)	*(2,927)*	(1,593)	(1,313)	(280)	*(17,120)*	(17,152)	(15,394)	(1,758)
Operational EBITDA	**5,756**	***1,110***	**532**	**654**	**(123)**	***5,162***	**4,634**	**5,756**	**(1,122)**
as a %	*9.7*	*15.3*	*9.3*	*12.6*	*-3.3*	*8.5*	*7.5*	*9.7*	*-2.2*
Financing & Donations	(3,553)	*(2,189)*	(294)	(296)	3	***(5,633)***	(3,203)	(3,553)	351
Current Year Surplus / (Deficit)	**2,203**	***(1,080)***	**238**	**358**	**(120)**	***(471)***	**1,431**	**2,203**	**(772)**
Prior Year Items	-		(106)	-	(106)	*533*	823	-	823
Total Surplus / (Deficit)	**2,203**	***(1,080)***	**133**	**358**	**(226)**	***62***	**2,253**	**2,203**	**51**
Surplus (Deficit) %	3.7%	*-14.8%*	2.3%	6.9%	-4.6%	*0.1%*	3.6%	3.7%	-0.1%

Note: Financing costs consist mainly of depreciation, dividends, theatre loan interest, donations and any impairments to assets.



Summary

- The surplus for the year is £2,253k, against the plan of £2,203k.
- The underlying position is one of increased income more than offset by additional costs.

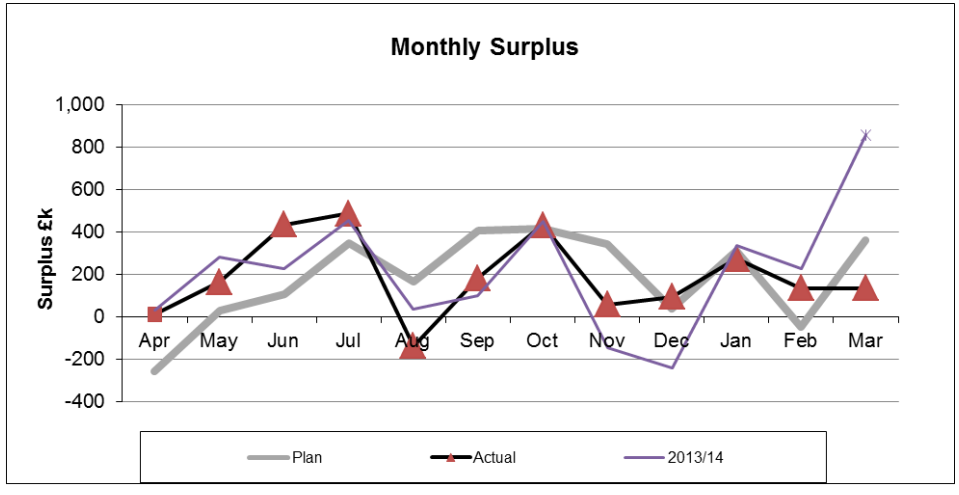
Issues

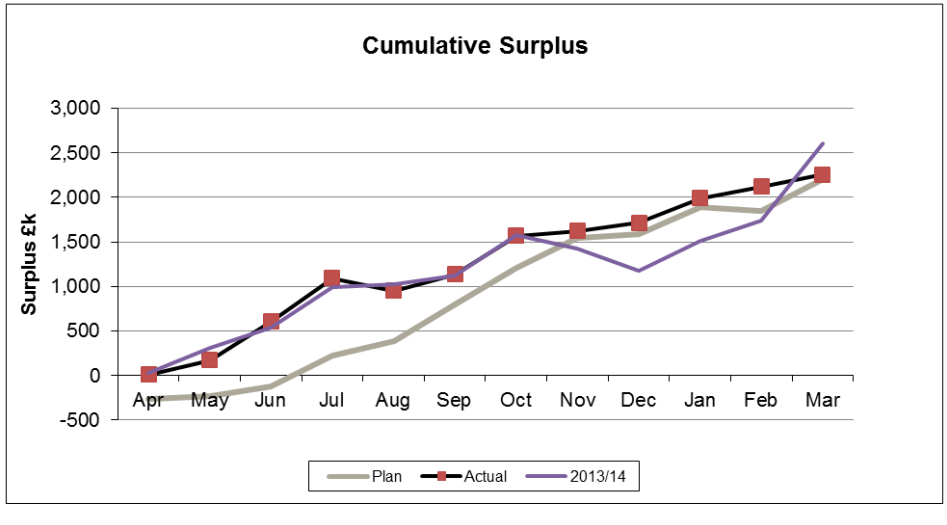
- Income includes the recognition of 100% of CQUIN.
- Income reflects estimated penalties of £311k, which is at a similar level to 2013/14.
- Pay costs include additional interim agency costs covering vacancies and initiatives.
- The Continuity of service risk rating is 4, as planned.

Continuity of Service Risk Rating	Metric	Level 4 threshold	Score	Weighted Score	
Liquidity days	45	0	4	50%	2
Debt Service Cover	2.9	2.5x	4	50%	2
Combined Score (1 to 4)					**4**

Summary Trend Position – M12 2014/15

Queen Victoria Hospital
NHS Foundation Trust





Summary

- The cumulative surplus is marginally ahead of plan.

Divisional Performance Summary – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Patient Income		Other Income		Pay		Non Pay		Financing		Prior Year			Total Current Month			Total Year To Date		
Direct Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Anaesthetics and Surgery																			
Plastics	(39)	(450)	63	118	(118)	(310)	(30)	56	-	-	-	-	24,362	2,051	2,176	(125)	23,776	24,362	(586)
Oral	58	(256)	13	56	(7)	(157)	(37)	(114)	-	-	-	-	6,987	642	615	27	6,516	6,987	(472)
Ophthalmology	(21)	596	(3)	7	(37)	(135)	(11)	(160)	-	-	-	-	2,583	150	222	(72)	2,891	2,583	308
Sleep	13	411	0	12	(6)	(93)	(70)	(355)	-	-	-	-	1,852	97	160	(62)	1,828	1,852	(24)
Theatres	-	-	(2)	(26)	(18)	(92)	(23)	(107)	-	-	-	-	(6,637)	(605)	(562)	(43)	(6,862)	(6,637)	(225)
Anaesthetics	-	-	23	19	5	10	(10)	(60)	-	-	-	-	(3,335)	(261)	(279)	18	(3,367)	(3,335)	(32)
Administration	3	66	(0)	(1)	0	(35)	6	14	-	-	-	-	(630)	(45)	(54)	9	(586)	(630)	44
Anaesthetics and Surgery Total	**14**	**367**	**94**	**186**	**(181)**	**(812)**	**(175)**	**(726)**	**-**	**-**	**-**	**-**	**25,182**	**2,030**	**2,278**	**(249)**	**24,197**	**25,182**	**(986)**
Clinical Support																			
Radiology	14	142	20	69	(5)	(94)	(25)	(57)	-	-	-	-	117	10	7	3	177	117	59
Pathology	-	-	-	-	-	-	15	39	-	-	-	-	(653)	(42)	(57)	15	(614)	(653)	39
Histopathology	-	-	8	12	22	63	3	(26)	-	-	-	-	(981)	(49)	(82)	33	(931)	(981)	50
Pharmacy	(0)	32	3	9	(0)	8	2	(27)	-	-	-	-	(64)	(1)	(4)	4	(41)	(64)	23
Surgical Appliances	(0)	5	-	-	0	0	(1)	(11)	-	-	-	-	8	(1)	1	(1)	3	8	(5)
Prosthetics	(13)	(92)	2	20	5	123	(1)	7	-	-	-	-	(315)	(33)	(25)	(8)	(257)	(315)	58
Medical Photography	-	-	1	(2)	(2)	(8)	(0)	(0)	-	-	-	-	(136)	(12)	(11)	(1)	(146)	(136)	(10)
Therapies	14	95	9	32	(2)	1	(5)	(13)	-	-	-	-	(543)	(26)	(43)	17	(429)	(543)	115
Psychotherapy	2	(1)	(0)	(0)	(0)	16	(0)	7	-	-	-	-	(125)	(9)	(10)	2	(103)	(125)	21
Clean room	-	-	(1)	56	2	14	(2)	(49)	-	-	-	-	(183)	(17)	(16)	(2)	(162)	(183)	21
General Specialities	0	(33)	-	-	(6)	(56)	7	43	-	-	-	-	218	21	19	2	172	218	(46)
Clinical Support Total	**17**	**148**	**41**	**197**	**13**	**68**	**(7)**	**(86)**	**-**	**-**	**-**	**-**	**(2,657)**	**(159)**	**(222)**	**64**	**(2,331)**	**(2,657)**	**326**
Nursing																			
MIU	13	126	-	-	2	(10)	(0)	(15)	-	-	-	-	539	62	47	15	641	539	102
Inpatient	(9)	(40)	8	21	(64)	(223)	(38)	(161)	-	-	-	-	(5,661)	(573)	(471)	(102)	(6,064)	(5,661)	(403)
Outpatient	-	-	(8)	(2)	(3)	(5)	(27)	(92)	-	-	-	-	(2,238)	(226)	(188)	(39)	(2,337)	(2,238)	(98)
Audit and Risk	-	-	51	164	15	103	(27)	(56)	-	-	-	-	(1,608)	(95)	(134)	39	(1,398)	(1,608)	211
Research	-	-	9	78	(5)	(64)	(11)	(13)	-	-	-	-	(74)	(13)	(6)	(7)	(73)	(74)	1
Nursing Total	**5**	**87**	**60**	**262**	**(55)**	**(199)**	**(103)**	**(338)**	**-**	**-**	**-**	**-**	**(9,043)**	**(846)**	**(752)**	**(94)**	**(9,231)**	**(9,043)**	**(188)**
Sub-total Operational Services	**35**	**601**	**194**	**644**	**(223)**	**(943)**	**(286)**	**(1,150)**	**-**	**-**	**-**	**-**	**13,482**	**1,025**	**1,304**	**(279)**	**12,634**	**13,482**	**(848)**
Estates and Hotel Services																			
Estates	-	-	(1)	(15)	(16)	(9)	45	(364)	-	-	-	-	(1,989)	(143)	(171)	28	(2,376)	(1,989)	(387)
Hotel Services	-	-	4	(8)	(2)	(44)	(19)	(103)	-	-	-	-	(1,659)	(157)	(140)	(18)	(1,815)	(1,659)	(156)
Estates and Hotel Services Total	**-**	**-**	**3**	**(23)**	**(18)**	**(53)**	**26**	**(467)**	**-**	**-**	**-**	**-**	**(3,648)**	**(300)**	**(310)**	**10**	**(4,191)**	**(3,648)**	**(543)**
Human Resources	-	-	4	84	(0)	6	(9)	(44)	-	-	-	-	(746)	(67)	(63)	(5)	(700)	(746)	46
Human Resources Total	**-**	**-**	**4**	**84**	**(0)**	**6**	**(9)**	**(44)**	**-**	**-**	**-**	**-**	**(746)**	**(67)**	**(63)**	**(5)**	**(700)**	**(746)**	**46**
Finance																			
Finance Commerce IT	-	-	0	23	(31)	81	(33)	28	-	-	-	-	(2,328)	(258)	(194)	(64)	(2,196)	(2,328)	132
Finance Other	234	818	43	88	(0)	(0)	29	(39)	3	351	(84)	915	(3,054)	(28)	(254)	225	(921)	(3,054)	2,133
Finance Total	**234**	**818**	**43**	**110**	**(31)**	**81**	**(4)**	**(11)**	**3**	**351**	**(84)**	**915**	**(5,382)**	**(286)**	**(448)**	**162**	**(3,117)**	**(5,382)**	**2,265**
Corporate	-	-	17	63	(102)	(754)	(7)	(86)	-	-	(22)	(93)	(1,504)	(239)	(125)	(114)	(2,373)	(1,504)	(869)
Corporate Total	**-**	**-**	**17**	**63**	**(102)**	**(754)**	**(7)**	**(86)**	**-**	**-**	**(22)**	**(93)**	**(1,504)**	**(239)**	**(125)**	**(114)**	**(2,373)**	**(1,504)**	**(869)**
Grand Total	**270**	**1,420**	**262**	**878**	**(374)**	**(1,663)**	**(280)**	**(1,758)**	**3**	**351**	**(106)**	**823**	**2,203**	**133**	**358**	**(226)**	**2,253**	**2,203**	**51**

Summary

- This analysis shows financial performance by division.

Issues

- Anaesthetics and Surgery and Nursing Divisions are showing adverse variances on patient income, pay and non-pay.
- The Clinical Support Division has delivered a surplus for the year, with Therapies showing a strong performance on patient income.
- Estates and Hotel Services have an adverse variance due to increased costs from the continued rental of the OT 6 unit.
- Human Resources are benefiting from higher than expected training income.
- Finance patient income reflects the central CQUIN and penalties position.
- Finance also includes the recognition of benefits from release of prior year income and debt provisions, and other underspends partially offset the increased costs in Corporate that reflect interim pay costs.

NB All values are £k, CMV is Current Month Variance and YTDV is Year to Date Variance.

Income by Point of Delivery – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust

POD Month 12	Current Month Actual £K	Current Month Plan £K	Current Month Variance £k	Year to Date Actual £k	Year to Date Plan £k	Year to Date Variance £k
Day Case	974	1,001	(27)	11,909	11,128	780
Elective	683	936	(253)	8,971	10,675	(1,704)
Non Elective	974	956	18	11,165	10,940	225
Exclusions	294	259	35	3,362	3,040	322
Outpatient First Attendance	517	440	78	5,100	5,102	(2)
Outpatient Follow Up	937	794	143	9,788	9,244	544
Outpatient Procedure	367	340	27	4,233	3,981	252
Minor Injuries	68	71	(3)	790	830	(41)
Radiology	117	102	14	1,337	1,188	149
Critical Care	128	65	63	864	758	105
Sub total	**5,059**	**4,964**	**95**	**57,518**	**56,888**	**631**
CQUIN reduction	-	-	-	-	-	-
Penalties	118	-	118	(190)	-	(190)
ERT deduction	(9)	(96)	87	(121)	(1,100)	979
Total Penalties Provision	**109**	**(96)**	**205**	**(311)**	**(1,100)**	**789**
Patient Activity Income	**5,168**	**4,868**	**300**	**57,207**	**55,788**	**1,420**

Summary

- Patient income by point of delivery (POD) is £95k ahead of plan (before performance adjustments) with elective inpatients showing a significant adverse variance.
- The reduction in the penalties is taken from the additional risks provision as performance improves.

Issues

- Income by POD is at the full rate, i.e. it assumes 100% CQUIN, no penalties and no reduction for ERT. These are accounted for separately.
- CQUIN has been accrued at 100% achievement. 100% CQUIN was achieved in 2013/14.
- The penalties relate to 18 week breaches and other contractual penalties; these remain subject to final commissioner agreement.
- ERT was prudently assumed to be suffered at 100% in the budget but contracts reflected an improved position. The financial provision assumes ERT is incurred at a provider not CCG level.

Penalties: Issues / Risks

- Within income there is an accrual of £311k for penalties and challenges (activity data is still to be finalised and any penalties are to be agreed with commissioners).

Provision for Income Performance Penalties 2014/15	M1 £	M2 £	M3 £	M4 £	M5 £	M6 £	M7 £	M8 £	M9 £	M10 £	M11 £	M12 £	Year to Date
RTT18 Admitted	2,400	2,400	10,800									-800	**14,800**
RTT18 Non-Admitted	600	0	2,000									100	**2,700**
RTT18 Open pathways	7,200	5,200	8,200										**20,600**
Sub total RTT18	**10,200**	**7,600**	**21,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**-700**	**38,100**
52 week waiters (estimate)	0	5,000	15,000	10,000	0	5,000	5,000	0	0			-10,000	**30,000**
Diagnostic 6-weeks												800	**800**
Cancer Waits												17,000	**17,000**
Urgent operation cancelled for 2nd time	0	10,000	10,000	5,000	0	0	0	0	0			-25,000	**0**
Never Events (estimate)	0	1,000	2,000	1,000	1,000	0	0	0	0			-3,962	**1,038**
Excess Bed Days												3,331	**3,331**
Data Challenges (estimate)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000			11,000	**20,000**
Outpatient Follow Up Ratios								85,600	11,200		-96,800		**0**
Diagnostic Unbundling Risk Share									69,000			-59,630	**9,370**
Best Practice Tariff Penalty									24,220			45,780	**70,000**
Additional Risks													**0**
Sub total non RTT penalties	**1,000**	**17,000**	**28,000**	**17,000**	**2,000**	**6,000**	**6,000**	**86,600**	**105,420**	**0**	**-96,800**	**-20,681**	**151,539**
Total Penalties	**11,200**	**24,600**	**49,000**	**17,000**	**2,000**	**6,000**	**6,000**	**86,600**	**105,420**	**0**	**-96,800**	**-21,381**	**189,639**
Emergency Rate Threshold reductions	22,506	1,853	34,973	6,609	61,482	82,293	5,365	-33,109	-56,000		-13,857	9,247	**121,361**
CQUIN reduced achievement provision													**0**
Grand Total	**33,706**	**26,453**	**83,973**	**23,609**	**63,482**	**88,293**	**11,365**	**53,490**	**49,420**	**0**	**-110,657**	**-12,134**	**311,000**

- CQUIN to March is now recognised at 100%.
- The level of penalties is estimated and still subject to agreement with commissioners.
- Last year total penalties and challenges were £307k.

Cost Improvement Analysis – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes built into budgets 2014-2015	Annual Plan £000's	Month 12 Plan	Achieved £000's	Achieved %	Shortfall
Pay	337	337	314	93%	22
Clinical Supplies	233	233	174	75%	59
Non Clinical Supplies	142	142	28	20%	114
Other non operating expenses	170	170	170	100%	-
Total Cost Improvement Programmes	**882**	**882**	**686**	**78%**	**195**

Summary

- At M12 the trust achieved 78% of the cost improvement plan.

Issues

- Pay - the key adverse variance was in the Programme Office.
- Clinical supplies - sleep devices are the key adverse variance and the procurement for this has now been completed with an approximate annual saving of £60k.
- Non clinical supplies includes the cost of leasing Operating Theatre 6. The decision to dispose has now been made but there will be no rental savings until next year.

Actions

- Conclusion of the disposal of leased building.

Balance Sheet – YTD M12 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet for: Month 12 2014/15	2013/14 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,211	37,705	36,407
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	37,705	36,407
Current Assets			
Inventories	415	420	421
Trade and Other Receivables	8,939	8,458	8,093
Cash and Cash Equivalents	3,655	6,548	6,983
Current Liabilities	(6,574)	(7,945)	(6,851)
Sub Total Net Current Assets	6,436	7,481	8,646
Total Assets less Current Liabilities	43,647	45,186	45,053
Non-Current Liabilities			
Provisions for Liabilities and Charges	(554)	(616)	(616)
Non-Current Liabilities >1 Year	(8,933)	(8,156)	(8,156)
Total Assets Employed	**34,159**	**36,414**	**36,281**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	18,013	17,890
Revaluation Reserve	6,173	6,164	6,154
Total Tax Payers Equity	**34,159**	**36,414**	**36,281**

NB Analysis is subject to rounding differences

Summary

- Net assets improve with the generation of the surplus.

Issues

- Debtor balances have improved in-year from the previous year-end balance.
- Non-current liabilities have reduced in year due to the theatre loan repayments made in June and December.
- Cash balances rely on prompt payment by commissioners. The position has improved but the trust is affected by financial pressures within the health economy.

Capital – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	2014/15 Plan £000s	2014/15 Total Spend £000s
Estates projects		
13/14 Projects:		
Jubilee/Burns heating	450	257
Other projects	92	50
14/15 Projects:		
Corneoplastic electrical upgrade	100	28
Fire compartmentalisation	160	-
A Wing repairs	100	-
Meeting rooms	50	-
Carbon reduction	50	-
Wet rooms	24	21
Canadian Wing waiting area	-	10
Other projects	374	166
Medical Equipment	550	1,663
IT Equipment	1,400	597
Grand Total	**3,350**	**2,791**

Summary

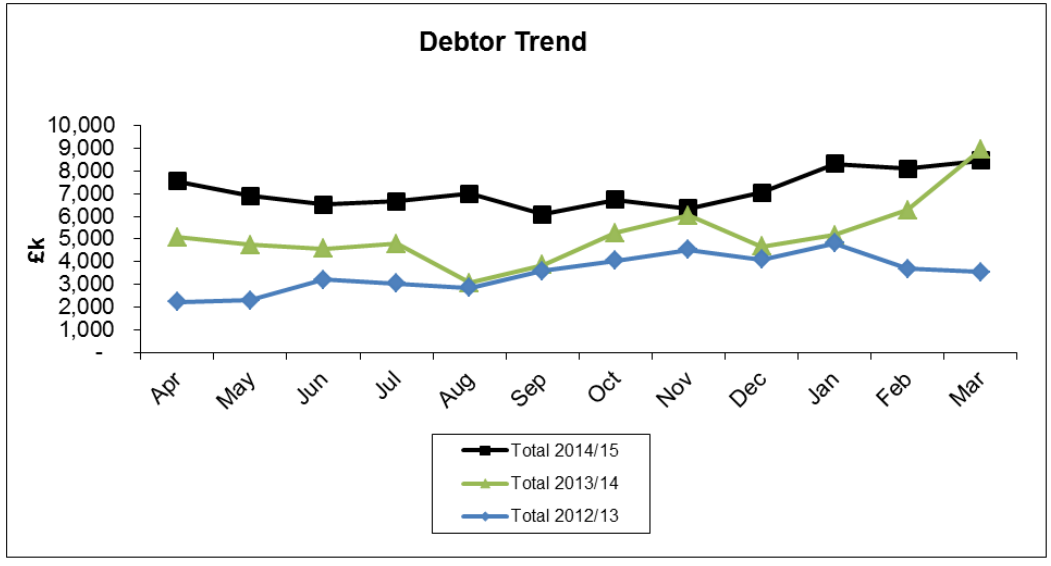
- Capital expenditure is significantly below the phased plan because of the delayed start of the IT network replacement project and the reconsideration of the Estates programme, offset by increased expenditure on Medical Equipment.

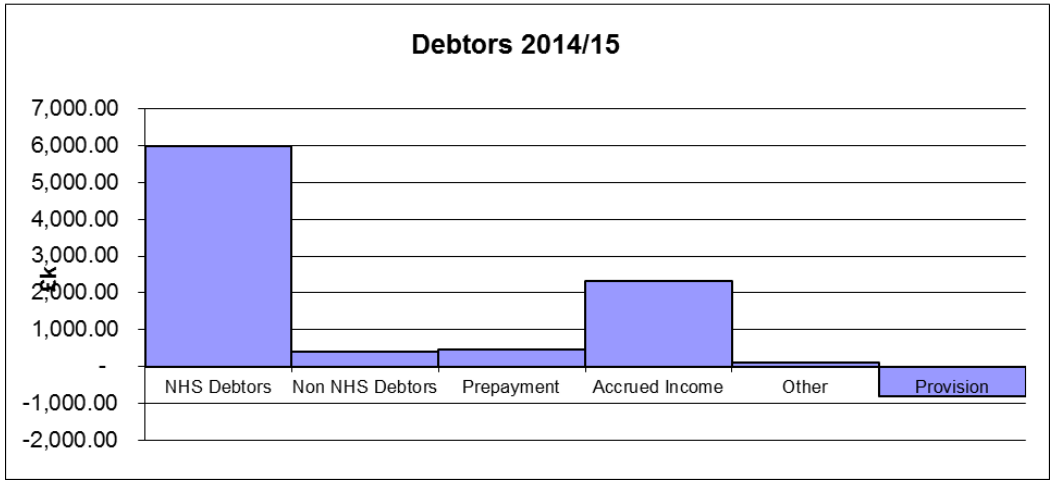
Risks

- Sufficient project management is key to the delivery of capital projects so this is being built into future delivery plans.

Debtors – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust





Summary

- Debtor balances continue to be below the prior year end balance.

Issues

- Debtor balances are at high levels because of some delayed payments and the delay caused by high levels of over-performance. Work continues with commissioners to reduce outstanding balances.
- Accrued income includes income over-performance that is to be agreed and then invoiced.
- The bad debt provision is subject to monthly review and has been reduced down to reasonable expected levels.

Risks

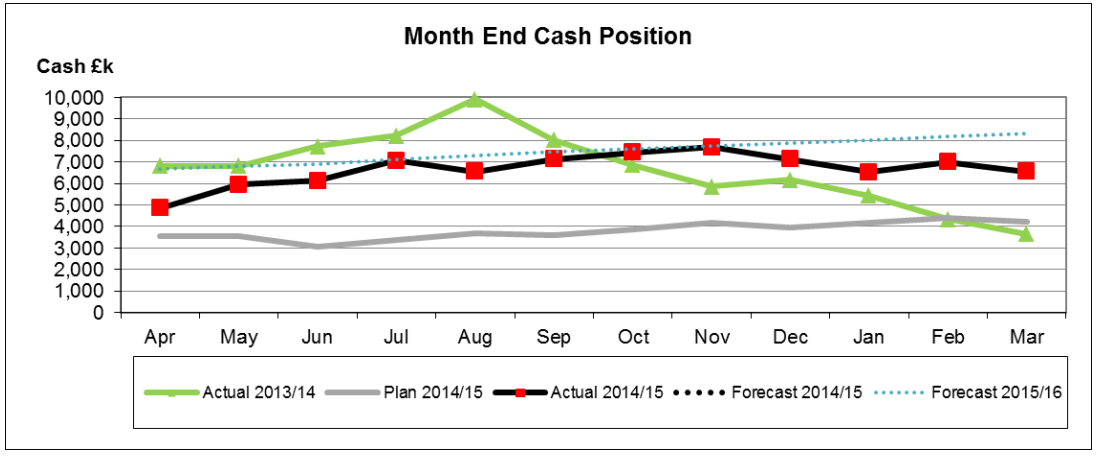
- Debt arising from over performance against income plans is slower to be paid.

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust



Summary

- Cash balances are significantly above plan because of recovery of prior year debts, reduced debtor balances and delays to capital expenditure.

Risks

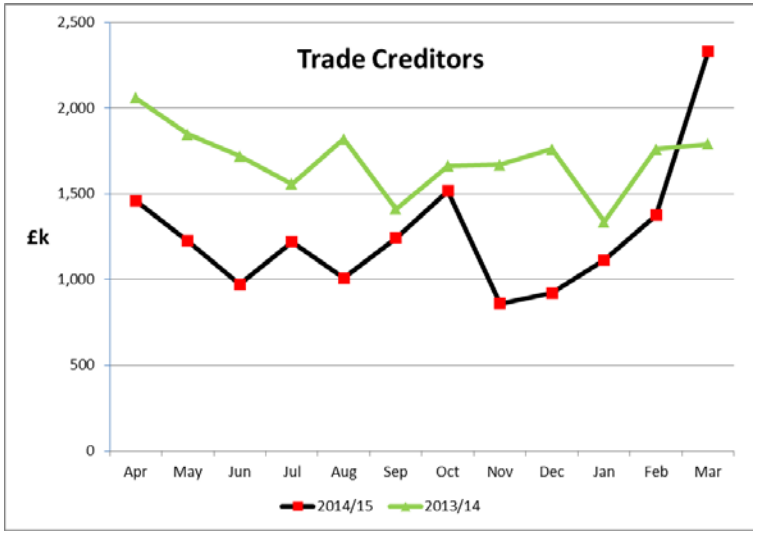
- Cash balances are sensitive to the level of surplus, payment performance of commissioners and the level of capital spend so these are risk areas.

Actions

- Continued liaison with commissioners to ensure prompt payment.
- Robust management of capital planning and associated schemes.

Creditors – M12 2014/15

Queen Victoria Hospital NHS Foundation Trust



Summary

- Trade creditors have risen above 2013/14 levels in month 12 as a result of capital expenditure on medical devices.

Issues

- Payment performance YTD against the 30 day target is improving overall, but is still below target.
- Daily monitoring of invoices on hold is helping to ensure payment but is focusing on payment of older invoices which impacts on reported performance.

Risks

- Working capital levels are such that prompt payment of suppliers does not pose a liquidity problem for the trust.

Actions

- Continued action to speed payment times with a view to paying 90% of suppliers within 30 days by the end of the cial year.

Better Payment Practice Code March 2015	2013/14 Outturn # Inv's	2013/14 Outturn £k	Current Month # Inv's	Current Month £k	YTD # Inv's	YTD £k
Total **Non-NHS** trade invoices paid	15,071	21,255	1,450	1,692	15,882	16,661
Total **Non NHS** trade invoices paid within target	9,386	15,087	1,137	1,334	10,806	11,312
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**78%**	**79%**	**68%**	**68%**
Total **NHS** trade invoices paid	1,082	4,544	62	470	933	5,241
Total **NHS** trade invoices paid within target	624	2,858	52	355	505	3,037
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**84%**	**76%**	**54%**	**58%**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Reference number:	92-15
Report from:	Dominic Tkaczyk, Interim Director of Finance and Commerce
Author:	Elin Richardson, Head of Commerce
Report date:	Wednesday 15th April 2015

Contracts update

Key issues

1. This paper provides an update on activity and income performance against the signed contracts with the commissioners for the year 2014/15.
2. Trust actual income and activity is higher than the external commissioner plans at Month 12 reflecting the position reported over the course of this year.
3. Over performance is predominantly in day cases.
4. An update on emergency rate threshold is provided.
5. A brief update on the 15/16 contract round is provided.

Implications of results reported

6. Over performance against the external commissioner plans was anticipated both because commissioners commissioned below 13/14 outturn and because of the Trust growth plan.

Action required

7. At this stage the key action is ensuring the year end process to agree activity outturn is undertaken.

Link to Key Strategic Objectives (delete those not applicable)

- Financial sustainability

8. Minimising the risks outlined will contribute positively to the financial sustainability KSO.

Implications for BAF or Corporate Risk Register

9. The risks in this paper are covered by the BAF.

Regulatory impacts

10. Currently the information reported in this paper does not impact on either our CQC authorisation or our Monitor continuity of services rating.

Recommendation

11. The Board is recommended to **NOTE** the contents of the report.

Queen Victoria Hospital NHS
NHS Foundation Trust

2014/15 Contract Report

Prepared for the Board of Directors

Elin Richardson, Head of Commerce

1.0 Executive summary

The trust ended the financial year with over performance against external contracts with CCGs and NHS England.

Over performance remains predominantly due to:

- Actions to reduce 18 week backlogs;
- Under commissioning by NHS England; and
- Extension of the provision of musculo-skeletal services (MSK) which had been removed from commissioner plans.

2.0 Overall contract performance

Table 1 below shows the year-to-date performance against all contract and non-contract activity before the removal of any penalties / adjustments. This shows that the trust has over performed against these plans by £4.4m at Month 12 (up from from £4m at Month 11).

The greatest over performance remains in areas where signed contracts are in place i.e. General Acute (CCG contracts remained 8% over at the end of the year), and dental and specialised (NHS England contracts 6% and 17% over at year end).

Table 1: Trust performance against contract and non-contract activity

Contract Group	YTD M12 Plan £	YTD M12 Actual £	Variance £
General Acute	£31,783,569	£34,379,411	£2,595,842
Dental	£11,441,290	£12,155,406	£714,115
Specialised	£6,122,209	£7,203,257	£1,081,047
NCA	£1,575,845	£1,423,727	-£152,118
AQPNOUS	£0	£156,690	£156,690
SMSKP	£76,707	£139,168	£62,460
non-England NCA	£76,707	£87,572	£10,865
Private Patients	£63,240	£35,050	-£28,190
Overseas	£37,364	£21,618	-£15,746
Offenders	£3,578	£8,347	£4,769
Military	£4,714	£7,152	£2,438
WHSSC	£0	£935	£935
Grand Total	**£51,185,225**	**£55,618,332**	**£4,433,108**

3.0 CCG contracts for acute care

Table 2 below shows the year-to-date over performance against the general acute contracts – these are signed CCG contracts.

Table 2: Performance against general acute care contracts

CCG	YTD M12 Plan	YTD M12 Actual	Variance
NHS HORSHAM AND MID SUSSEX CCG	£4,590,322	£5,409,192	£818,870
NHS WEST KENT CCG	£4,343,047	£4,948,804	£605,757
NHS HIGH WEALD LEWES HAVENS CCG	£3,069,814	£3,326,141	£256,328
NHS EAST SURREY CCG	£2,323,125	£2,581,187	£258,062
NHS MEDWAY CCG	£2,208,396	£2,399,157	£190,761
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG	£2,363,883	£2,357,622	-£6,262
NHS COASTAL WEST SUSSEX CCG	£1,895,746	£2,004,573	£108,828
NHS HASTINGS AND ROTHER CCG	£1,636,142	£1,684,704	£48,562
NHS CRAWLEY CCG	£1,488,461	£1,582,777	£94,316
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	£734,723	£1,042,528	£307,805
NHS BRIGHTON AND HOVE CCG	£1,265,866	£1,009,664	-£256,202
NHS SWALE CCG	£973,569	£953,780	-£19,789
NHS SURREY DOWNS CCG	£567,458	£768,475	£201,017
NHS SOUTH KENT COAST CCG	£710,782	£749,492	£38,710
NHS CANTERBURY AND COASTAL CCG	£626,470	£679,166	£52,697
NHS BROMLEY CCG	£656,574	£580,033	-£76,541
NHS BEXLEY CCG	£613,996	£561,623	-£52,373
NHS ASHFORD CCG	£376,177	£540,454	£164,277
NHS THANET CCG	£528,258	£465,823	-£62,435
NHS GUILDFORD AND WAVERLEY CCG	£430,701	£427,542	-£3,160
NHS CROYDON CCG	£380,059	£306,674	-£73,385
Grand Total	**£31,783,569**	**£34,379,411**	**£2,595,842**

At month 12 the trust had over performed by £2.6m against these contracts. Continuing the trend from previous months the greatest over performance (in value) is with our host commissioner Horsham and Mid Sussex CCG.

The over performance for this CCG is mainly in first and follow up outpatients as well as day cases. As noted previously this will be a combination of the removal, from plan, of MSK work as well as the increased activity from 18 weeks.

The trust continues to under-perform against the Brighton and Hove CCG contract predominantly in plastic surgery day cases and electives.

Table 3 below breaks the general acute performance down to point of delivery (POD) level.

Table 3: General acute care split by point of delivery (POD)

Point of Delivery (POD)	YTD M12 Plan £	YTD M12 Actual £	Variance £	YTD M12 Activity Plan	YTD M12 Actual Activity	Variance
Non elective	£7,079,852	£7,221,640	£141,788	3,266	3,142	-124
Day case	£6,825,084	£8,139,184	£1,314,101	5,863	7,417	1,554
Elective inpatient	£5,922,247	£5,605,749	-£316,498	2,749	2,622	-127
Outpatient First Attendance	£2,525,340	£2,622,350	£97,010	24,001	23,842	-159
Outpatient Follow Up	£5,474,484	£6,148,206	£673,722	85,841	92,931	7,090
Exclusions	£1,144,492	£1,677,291	£532,799	0	0	0
Outpatient Procedures	£954,250	£961,485	£7,235	5,747	6,447	700
MIU attendances	£717,872	£739,765	£21,893	11,044	11,381	337
Radiology	£867,733	£1,112,676	£244,944	21,251	27,419	6,168
Other	£155,135	£151,065	-£4,070	513	433	-80
Grand Total	**£31,666,488**	**£34,379,411**	**£2,712,923**	**160,275**	**175,634**	**15,359**

Day cases continue to over perform significantly representing half of the overall over performance. This reflects reasons previously reported

- the additional work under taken in month 8 for the 18 weeks initiative;
- the underlying level of over performance particularly in ophthalmology; and
- the extension of the MSK services at QVH.

4.0 NHS England contract for specialised care and dental services

Table 4 below shows the year-to-date over performance for the NHS England contract covering specialised services and dental. This shows over performance of £1.7m at month 12 up from £1.5m at month 11. This is again before the application of any penalties.

Table 4: Performance against the NHS England contract

Contract Name	YTD M12 Plan £	YTD M12 Actual £	Variance £
NHS England Specialised	£6,122,209	£7,203,257	£1,081,047
NHS England Dental	£11,441,290	£12,155,406	£714,115
Grand Total	**£17,563,499**	**£19,358,662**	**£1,795,163**

The over performance on the specialised element of the contract is in all PODs with the exception of 'other' and is shown in table 5 below. Day case over performance has been predominantly in specialised ophthalmology.

The over performance on critical care bed days is offset by an under performance in dental critical care bed days.

Similarly the over performance in the dental contract is in all PODS (with the exception of 'other' and critical care noted above.

Table 5: Performance against the NHS England specialised element of contract at point of delivery level (POD)

Point of Delivery (POD)	YTD M12 Plan £	YTD M12 Actual £	Variance £	YTD M12 Activity Plan	YTD M12 Actual Activity	Variance
Elective inpatients inc. day cases	£2,011,988	£2,385,566	£373,578	982	1188	206
Non elective inpatients	£1,639,673	£1,913,884	£274,211	658	760	102
First outpatients	£293,816	£370,851	£77,035	1,139	1,441	302
Follow up outpatients	£1,329,012	£1,489,148	£160,136	5,173	5,792	619
Critical care bed days	£380,836	£619,083	£238,247	154	339	185
Other	£475,177	£440,224	-£34,953	467	185	-282
Grand Total	**£6,130,502**	**£7,218,756**	**£1,088,254**	**8,574**	**9,705**	**1,131**

Table 6: Performance against the NHS England dental element of contract at point of delivery level (POD)

Point of Delivery (POD)	YTD M12 Plan £	YTD M12 Actual £	Variance £	YTD M12 Activity Plan	YTD M12 Actual Activity	Variance
Elective inpatients inc. day cases	£3,188,245	£3,460,684	£272,440	2,780	3,116	336
Non elective inpatients	£1,221,592	£1,256,265	£34,672	699	652	-47
First outpatients	£1,682,832	£1,843,894	£161,062	11,855	13,106	1,251
Follow up outpatients	£1,400,163	£1,505,658	£105,495	15,999	17,179	1,180
Outpatient procedures	£2,637,131	£3,083,810	£446,679	16,958	19,434	2,476
Critical care bed days	£334,596	£135,175	-£199,422	301	126	-175
Other	£976,732	£869,920	-£106,812	131	152	21
Grand Total	**£11,441,290**	**£12,155,406**	**£714,115**	**48,724**	**53,765**	**5,041**

5.0 Emergency rate threshold (ERT) update

A proposal to reinvest the ERT monies will be taken to the QVH Programme Board in May 2015.

6.0 15/16 Contract Negotiations

Contract negotiations are nearly complete with commissioners and a brief update per contract is provided below. Items for arbitration had to be notified by 17 April 2015 and the trust does not require arbitration with any commissioner.

6.1 CCG Acute Contracts

Activity and income offers have been received from 20 of the 21 CCG signatories to the contract. These generally are close to outturn performance with some reduction for the CCGs' quality, innovation, productivity and prevention (QIPP) schemes as well as a full year effect of the MSK contract transfer. The majority of the supporting contract documentation has been agreed.

6.2 NHS England contract

Activity and income offers for specialised services and dental services have been received. As above, these reflect outturn less QIPP schemes that are largely driven at moving some day cases to outpatient procedures which will be reviewed with the relevant clinicians.

Sussex MSK partnership contract (Mid Sussex)

Sussex MSK partnership activity have extended the existing contract until 31 May 2015. An activity and income offer has been received again, largely on the basis of outturn. Unlike the other commissioned contracts this is a sub contract and there are significant reporting burdens within this contract alongside a requirement to operate the enhanced tariff option (ETO) (as opposed to the Default Tariff Rollover) which require further review. With this contract operating at ETO, CQUIN will be included and this is being discussed with the team.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 April 2015
Reference number: 93-15
Report from: Dominic Tkaczyk, Interim Director of Finance
Author: Dominic Bailey, Information Governance Lead
Report date: 22 April 2015

Information governance (IG)toolkit submission results

Key issues

1. The information governance toolkit is a self-assessment of compliance against information governance requirements. The requirements are broadly defined as:

    - Management structures and responsibilities
    - Confidentiality and data protection
    - Information security

2. All health and social care service providers, commissioners and suppliers must have regard to the information governance toolkit, and it remains Department of Health policy that all bodies that process NHS patient information provide assurance via the IG toolkit.

3. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

4. Where partial or non-compliance is revealed, the trust must take appropriate measures, (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

Implications of results reported

5. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

6. Where partial or non-compliance is revealed, the trust must take appropriate measures, (e.g. assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

7. The trust provided evidence to record satisfactory scores in all 45 requirements of the toolkit. An overall score of 82% matched that of the previous year.

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

8. None.

Regulatory impact

9. Final publication assessment scores reported by the trust are used by the Care Quality Commission to risk assess outcome 21, which is – '*records (and other standards as appropriate) of Essential standards of quality and safety'*. It also forms part of the trust quality accounts.

Recommendation

10. The Board is asked to **NOTE** the content of the report.

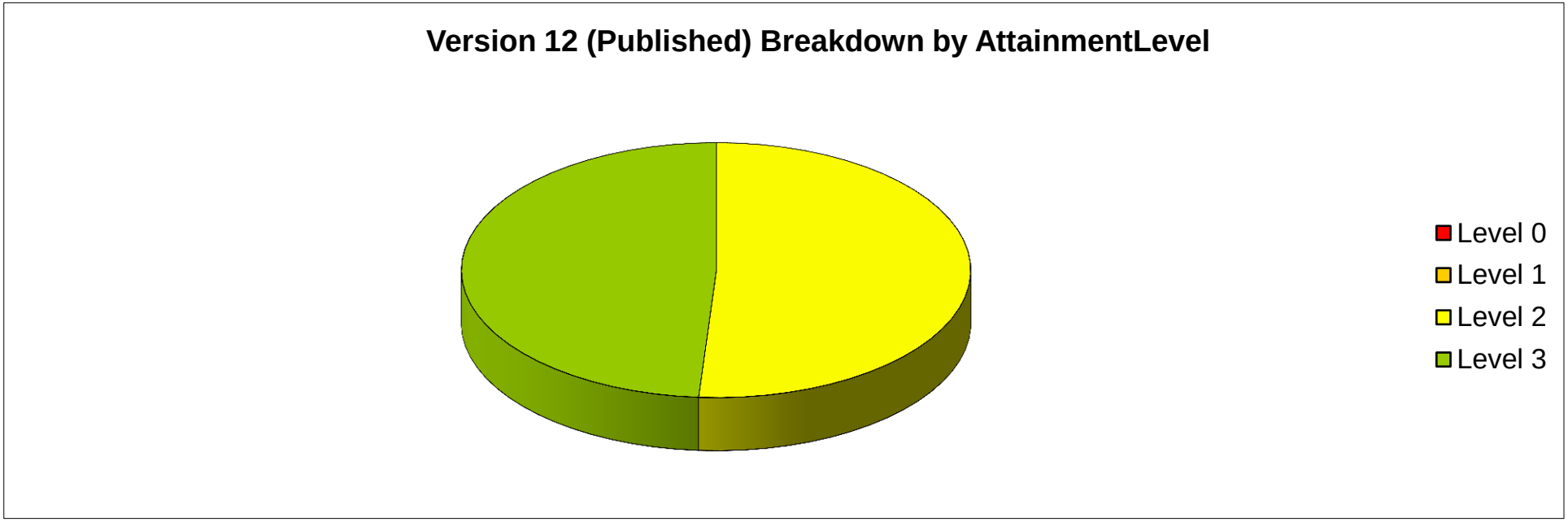
IG Toolkit Assessment Summary Report

THE QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

(Acute Trust)

Prepared on 22/04/2015

Assessment	Stage	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score	Self-assessed Grade
Version 12 (2014-2015)	Published	0	0	23	22	45	82%	Satisfactory
Version 11 (2013-2014)	Published	0	0	24	21	45	82%	Satisfactory



Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Reference number:	94-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	20 April 2015

Workforce report: April 2015

Key issues

1. This report provides the board with an update on the workforce key performance indicators and highlighted below are the main themes emerging during March 2015.

2. Turnover/vacancies: Turnover remains above the trust target of 11% as has been the case for the last 18 months. The trend has stabilised however and measures are in place to support an overall reduction in turnover through 2015/16. These include more detailed analysis of the reasons staff leave the organisation, improvements in pay for bank work where appropriate and more development opportunities for staff. Aside from this, stability remains high at 98% and therefore recruitment initiatives will continue to be focussed on those areas where turnover has been highest in 2014/15. During April, C Wing has had a significant improvement in reducing the number of vacancies and all current vacant posts being recruited to. A second recruitment day is being planned to take place in June 2015.

3. Pay, bank and agency: Overall pay is in line with expectations and the trust financial planning with a reduction of 2% on overall pay. Bank and agency showed some increases in those areas where they have been carrying a number of vacancies i.e. mainly within the inpatient services. As a consequence of low fill rates for bank following a number of trust staff opting to work agency shifts elsewhere, we have introduced a 3 month pilot to pay staff overtime for bank shifts. This offers staff the opportunity to earn more pay, help stem the flow of trust staff working for external agencies and provide a greater consistency of care for patients. The pilot will be closely monitored to see the impact on pay and fill rates. We will also be able to monitor more closely additional hours worked to ensure this is compliant with the European working time directive.

4. Sickness absence: March sickness levels remained below 3%. This was the 3rd month in a row and provides a firm basis for further improvements through 2015/16. As reported earlier in this quarter, the focus has moved to short term sickness cases which are largely reported as coughs, colds and flu and is common at this time of year. We expect this to improve with the spring and summer months and therefore can anticipate a further reduction in sickness during Q1. However the HR team will continue to monitor short-term absences with managers to see where further improvement can be achieved.

5. Statutory and mandatory training: The compliance rates continue to improve across all aspects of statutory and mandatory training; there are no ‘red’ highlighted areas in the report. Compliance stands at 75% including those who are booked to attend courses but more importantly the figure for those staff who are compliant in line with their profession is now at 72% the highest this has been since formal reporting began.

6. Included in this months report is the Q3 staff friends and family test score which shows positive scores about our staff’s views of the trust as both an employer and a place to receive treatment. We are already aware of the need to engage with our staff more to ensure we provide the environment for them to perform well; this is being addressed through the staff survey action plan. Equality and diversity information is also included in this report to highlight our profile in relation to our population. It is worth noting that the age profile does raise a number of issues for the medium term, which we will need to address through improved workforce planning.

Implications of results reported

7. The report provides the board with assurance against the workforce elements of the trust strategy.

8. The information contained within the report will be available to our commissioners and the general public.

Action required

9. Management and progress of the areas outlined in this report is the responsibility of the Director of HR/OD. Consequently, day to day delivery is addressed through the HR and learning and development teams as part of their individual and team objectives. A system of monthly update meetings has been introduced to monitor progress closely.

10. In addition to the above progress within the trust is monitored by Clinical Cabinet and quarterly updates to the board.

Link to Key Strategic Objectives

- Outstanding patient experience
- World Class Clinical Services
- Operational Excellence
- Financial sustainability

Implications for BAF or Corporate Risk Register

11. The issues raised at paragraphs 1 – 6 above are not so serious as to merit inclusion on the corporate risk register or board assurance framework at this stage, although the potential for matters to escalate will be monitored and recommendations will be made if appropriate.

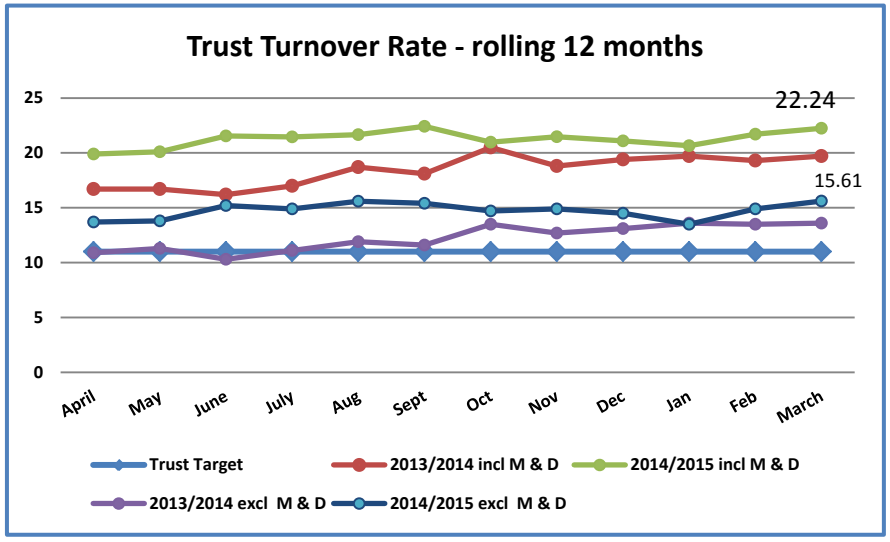
Regulatory impacts

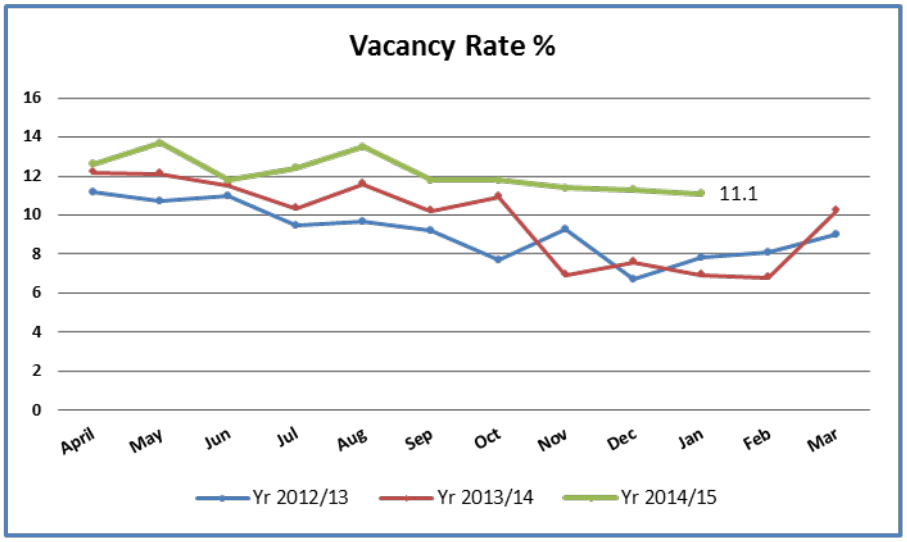
12. Progress to date is sufficient to assure the board that good progress is being made in all areas and there is unlikely to be any adverse implications for the trust's delivery of high quality patient care. Consequently there is no adverse impact for regulatory compliance.

Recommendation

13. The Board is asked to **NOTE** the content of the report.

HEADLINE HR KPIs April 2015





Staff Movements

	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb15	Mar 15
Headcount	971	966	966	967	965	957	961	965	966	965	973	965	979
WTE in Post	823.78	816.86	816.07	816.78	816.79	816.79	812.47	816.49	818.86	818.48	825.73	820.25	832.99
WTE Funded Establishment	867.99	897.51	897.51	897.51	897.51	897.51	897.51	897.18	897.14	897.14	897.14	897.14	897.14
New Hires	7	10	7	19	10	23	24	23	12	8	15	26	16
Leavers	15	9	9	21	12	44	17	17	12	12	7	33	19
Maternity Leave	19	19	20	17	16	19	20	18	16	16	13	13	12
Vacancy Rate	10.2%	12.6%	13.7%	11.8%	12.4%	13.5%	11.8%	11.8%	11.4%	11.3%	11.1%	N/A	N/A
Turnover Rate Headcount	1.55%	1.04%	1.04%	2.18%	1.35%	4.62%	1.77%	1.76%	1.24%	1.24%	0.72%	3.42%	1.94%
Turnover Rate (FTE)	1.65%	0.93%	0.93%	2.07%	1.24%	4.49%	1.69%	1.66%	1.14%	1.15%	0.66%	3.60%	1.96%

Rolling 12 Monthly Turnover Figures

	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov14	Dec14	Jan 15	Feb 15	Mar 15
12 Month Turnover (including Medical & Dental)	19.74%	19.94%	20.15%	21.55%	21.45%	21.66%	21.61%	20.97%	21.47%	21.09%	21.70%	21.84%	22.24%
12 Month Turnover (Excluding Medical & Dental)	13.62%	13.67%	13.79%	15.19%	14.93%	15.57%	14.87%	14.74%	14.96%	14.50%	14.95%	15.15%	15.61%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Staff turnover in the Trust for the last 12 month rolling period ending March 2015 (excluding Medical and Dental) has increased slightly from 15.15% to 15.61%. Staff turnover has seen an increase of 2.0% when compared with the 12 months ending March 2014.

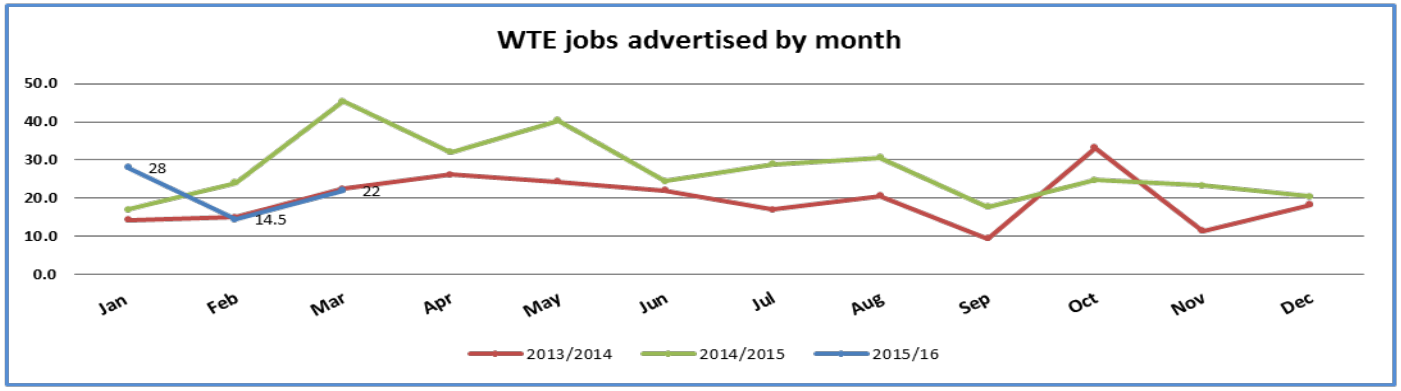
There were 19 leavers (16.35 FTE) in March 2015, a monthly turnover rate of 1.96% representing a fall of 1.62% compared to February 2015. The majority of Leavers for March were from the Admin and Clerical staff group i.e. 8 leavers, 2 of which retired, 2 end of fixed term contracts, 2 left due to lack of opportunities and incompatible working conditions, 1 promotion in another Trust and 1 leaving reason unknown.

Nursing had 2 leavers, 1 of which left due to promotion to another Trust and 1 left to go abroad.

Medical and Dental had 5 leavers for March, 3 of which left due to end of fixed term contracts and a further 2 due to relocation.

To address the high levels of turnover, all leavers will now be asked to either complete an online leavers survey, or as an alternative have an interview with HR or a designated manager. HR will analyse the feedback to address concerns raised and share with managers where appropriate. It is anticipated that the choice given to leavers will result in higher numbers of staff providing valuable feedback.
Over the next 12 months HR&OD will be focusing on employee engagement and will include strategies for rewarding staff for their commitment and performance.

It is worth noting that although turnover is higher target (11%), staffing stability is currently at 98.99%.



RAG Rating

HEADLINE HR KPIs

Vacancies/Recruitment (figures 2 months in arrears)

There were 28.7 WTE vacant positions advertised in March 2015 which included, 20.0 WTE Nursing posts 2.0 Admin and Clerical posts and 5.0 WTE Medical and Dental posts.

There were 12 job offers of employment made in March, this includes 1 internal promotion in Medical Photography.

The Plastics Registrar vacancy was not appointed due to the poor quality of applicants and this post is still currently open. Outlined below are further recruitment details:

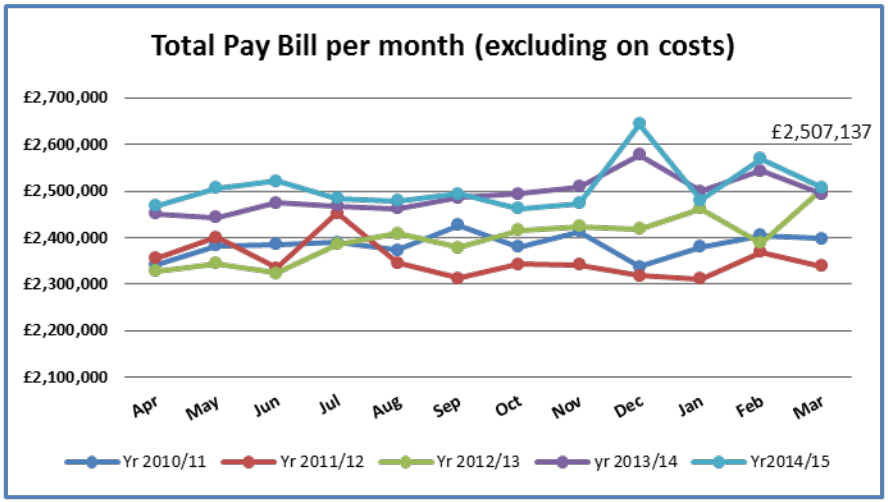
- Eye Bank Technician - No suitable candidates on first advertisement. However, this post was successfully filled by an internal candidate
- Corneo Nursing – currently has a 5.0 WTE shortfall that continues to be a pressure.
- ***Canadian Wing – there is an ongoing advertisement on NHS Jobs. The Trust has successfully offered 2.92 WTE Staff Nurse posts in March and following further interviews in April the nursing team are now fully appointed to. Retention of staff will be monitored closely.***
- ITU – are currently re-advertising for 4.0WTE

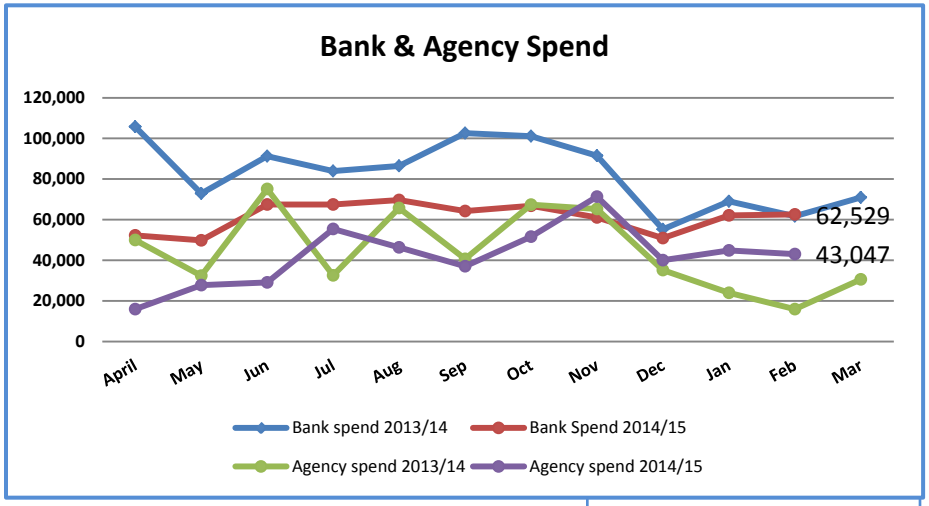
The recruitment team operate a 5 week target to complete pre-employment checks after the offer of employment has been made. Through March 2015 there has been one breach of recruitment targets this was due to a candidate failing to supply accurate reference information.

Actions

- The Trust is planning a Nursing Open Recruitment Day in June 2015 – this will involve conducting interviews so that the Trust is in a position to offer employment to successful candidates
- The Recruitment team are now considering a range of social media to advertise vacant positions such as Facebook, Twitter and LinkedIn. Recent research shows that organisations from all sectors are increasingly using social media to advertise jobs and are receiving higher calibre candidates
- Reviewing the implementation of Return to Practice as an incentive to attract ex- nurses, as well as enhancing the roles of Band 5 nurses within the Trust

HEADLINE HR KPIs





Pay Bill – (1 months in arrears) reported pay does not include on costs.

Pay for March decreased by 2.4% to £2,507,137, this follows the trend for March 2014.

Payroll

All staff were paid on time and in accordance with the agreed timetable and pay advices were all distributed on time. All payments were made to correct bank accounts and employees. Payroll accuracy remains at 99.98% month on month.

There were 2 new overpayments , the volume remaining the same level from February, with the amount decreasing from £8824.25 to £4429.72. The overpayment was due to Incorrect calculation of Tax and National Insurance and set up error for a new starter. A recovery plan is in place for one of the overpayments, we are still to receive notification of a plan for the other.

Interim payments increased from 1 to 2 and payroll errors decreased from 1 to 0.

RAG Rating

HEADLINE HR KPIs

RAG Rating

Bank and Agency usage – (figures are 1 month in arrears)
Bank expenditure for February increased very slightly by 0.7% to £62,529, this is a similar trend as that seen in quarter 4 in 2014. Agency expenditure (excluding RMN) has increased by 4% to £43,047, this is significantly higher than the same period last year (March 2014). The increase in agency expenditure is due to establishment vacancies and high patient acuity. It is also in line with the vacancy factor rates. It is anticipated that bank and agency expenditure is due to increase in March 15 based on the number of bank fill rates to date.

The Bank fill rate for February 15 is at 83.6%, and in total 9349 hours were requested, 5648 hours were filled by bank and 2164 were filled by agency.

In order to reduce agency costs it has been agreed for a temporary 3 month pilot whereby nursing staff in our inpatient areas will be offered overtime pay for carrying out bank shifts (with effect from 13th April 2015). The 3 month period will enable Operations management to monitor the staffing situation to see if this has any impact on the amount of agency expenditure we incur and also the number of shifts we are able to fill. The trial period will also allow us to review alternative payments which can be introduced again to improve our internal temporary staffing levels.

If the pilot proves successful we will be proposing a fixed payment for all nursing staff to provide additional work which although will not be the same as agency rates will provide an incentive and therefore contribute to a longer term solution.

The top three highest users of bank and agency expenditure for March 2015 were:

•Canadian Wing which saw a slight fall in expenditure for bank staff, however agency expenditure increased, with a combined amount of £29,776. Increased use of bank and agency usage was due to establishment vacancies and high patient activity.

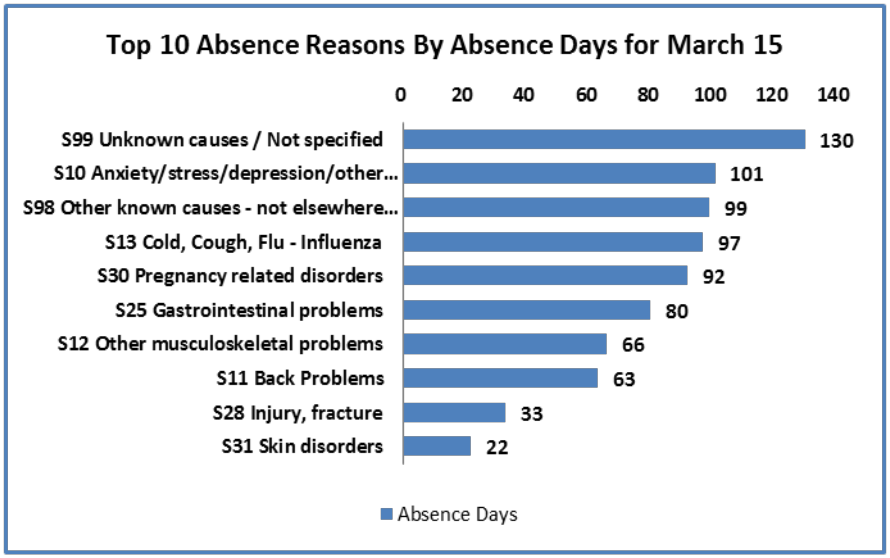
•Corneo nursing saw a slight increase in bank expenditure but this was balanced with the decrease in agency usage, with a combined expenditure of £14.638. The increased use of bank and agency staff was due to establishment vacancies and high patient activity.

•ITU bank and agency expenditure remained the same as last month, with a combined amount of £11,344. The increased use of bank and agency was due to high patient activity.

Actions

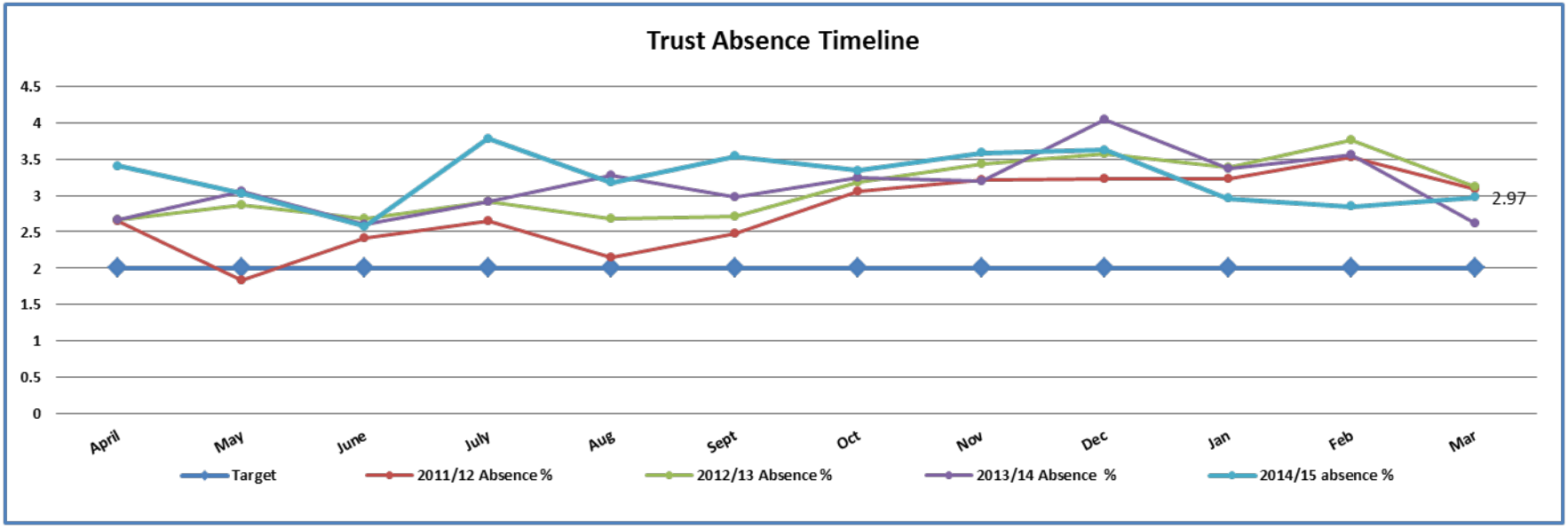
•Monitor controls put in place and review in month by month.
•Senior managers to sign off before any bank or agency agreed to avoid unnecessary use of bank/agency workers.
•Tighter financial controls on departments budgeted establishment

HEADLINE HR KPIs



Absence Estimated Cost & Absence Days Lost (March broken down into staff groups)

Staff Group	Absence days lost	Estimated Cost
Add Prof Scientific and Technical	109.13	£8,930
Additional Clinical Services	122.72	£7,797
Administrative and Clerical	100.02	£7,251
Allied Health Professionals	34.60	£3,741
Estates and Ancillary	98.55	£5,161
Healthcare Scientists	0	0.0
Medical and Dental	65.50	£8,282
Nursing and Midwifery Registered	229.50	£22,030
Total	760.04	£63,192



HEADLINE HR KPIs

Sickness/Absence

Sickness absence within the Trust has seen a slight rise in March to 2.97%. The last 3 months has seen sickness below 3% this is similar to the sickness levels for Q4 2014. The majority of reported sickness is now short-term related and over the last couple of months the main reasons recorded were cough, colds and flu. Now that the summer months are approaching we anticipate sickness rates to fall closer to the Trust target of 2%.

March saw 148 episodes of short-term sickness, with the highest number of short-term sickness cases for the second month running being Cough, Cold and Flu, of which 97 calendar days were lost equating to 65% of all short-term sickness reported. Gastrointestinal problems being the second highest level of short-term sickness, equating to 59 days lost and 39.9% of all short-term sickness recorded.

Long-term sickness cases which are continuous absence of 28 days or more have increased from 10 to 16 for March. However 10 of those long term sickness cases are due to return to work this month and 1 due to be dismissed under the Capability Procedure due to ill health. Whilst long-term sickness remained high for the first two quarters of 2014/15 subsequent training and support to managers has seen long-term sickness decline over the last four months, however March has seen as slight rise again with the main cause being Stress, Anxiety and Depression. The work with managers and additional training will need to continue and the impact closely monitored.

There were 855 absence days lost (760.04 WTE) due to sickness. The average WTE days lost to sickness for March was 6.50 days with a cost to the Trust of £63,192. Monday was the highest first day absent for a continuing month, a recurring trend for the Trust – work is being undertaken to identify any individuals who take sickness absence on a Monday.

There are no reported sickness cases this month due to disciplinary or capability procedures.

Nursing Absence

Nursing had the highest sickness absence in March with 45 occurrences of sickness, 7 x long-term cases and 38 short-term sickness cases relating to Cough, Cold and Flu and Gastrointestinal problems. The highest reported sickness within nursing were;

•Paediatrics – 10.58**%** with a total of 7 occurrences totalling 74 days, the main cause of sickness was gastrointestinal problems.

•ITU – 7.14% with a total of 9 occurrences of sickness totalling 35days. There were no main cause of sickness, all various illnesses.

•Canadian Wing – 6.36% with a total of 18 occurrences of sickness totalling 102 days. The main cause of sickness was gastrointestinal problems.

RAG Rating

HEADLINE HR KPIs

Sickness Absence continued

Admin and Clerical

Had the second highest sickness absence levels in March with 38 occurrences of sickness of which 2 are long-term cases and 36 short-term sickness cases, relating to Cough, Cold and Flu and Gastrointestinal problems. The highest reported sickness within admin and clerical were;

•Plastics - Skin – 12.98% with a total of 2 occurrences totalling 79 days, one of which is a long-term sickness. The main cause of sickness was due to Cough, Cold.

•Plastics - Breast– 8.63% with a total of 6 occurrences totalling 119 days, two of which are long-term sickness cases. The main cause of sickness was due to Gastrointestinal problems and Back problems.

•Admissions and Appointments – 5.43% with a total of 4 occurrences totalling 33 days. The main cause of sickness was due to Cough, Cold and Flu and Stress and Anxiety (non work related).

Additional Clinical Services

Has the third highest sickness for March with 32 occurrences of sickness, 2 x long-term sickness and 30 short-term sickness cases relating to Cough, Cold and Flu and Gastrointestinal problems.

•Theatres (Healthcare Assistants) – 13 occurrences of sickness totalling 90 days. The main cause of sickness was Unknown Causes – Not Elsewhere Specified and Gastrointestinal problems.

•Paediatrics (Nursing Auxiliaries) – 4 occurrences of sickness totalling 117 days, two of which are long-term sickness cases. The main cause of sickness is Fracture and Gastrointestinal problems.

Medical Workforce Sickness

A Deanery higher trainee is on long term sickness absence , and is being managed in line with the Trainee in Difficulty policy in conjunction with the Deanery. The Trust is obliged to extend the trainee's contract for a further 3 months as the individual is anticipated to return to work in early May. However, this will not be to QVH, and the Deanery are currently looking at another placement on a part time basis for the trainee. In view of this the Trust is looking to recruit a Locum Accredited for Service to this post. It is anticipated that a final resolution to this matter will be apparent in May.

Actions

The Managing Sickness Absence Policy and Procedures is currently been reviewed, and it is proposed that the procedures a much more robust approach to managing sickness absence

The HR Advisors are working with managers and occupational health to manage long /short-term sickness in line with Trust policy and procedures. Sickness Absence Policy has been revised and new triggers are proposed to help manage short term absence.

RAG Rating

HEADLINE HR KPIs

Employee Relations – General

Formal Conduct - 2 cases of formal conduct currently being investigated relating to allegations of inappropriate behaviour. One is concluded and will progress to a disciplinary hearing and the other investigation will conclude in April.

Capability - 2 nursing staff, one on Burns and the other on C-Wing and 1 Domestic.

Probation – Sleep Disorder Centre has one on-going case under the probation policy and this will be concluded in April.

Suspension / Redeployment - One member of the Appointments Team is currently redeployed whilst investigation into alleged inappropriate behaviour is carried out by Nicky Reeves and HR.

Employee Relations – Medical Workforce

•**Capability** - Trust Registrar on fixed term contract until end of October 2015. Remains supervised as part of an a performance plan.

•**Formal Conduct** – Consultant investigation being undertaken relating to communication with colleagues, and time management.

Case Type	Number of cases
Conduct (formal)	3 (Hotel Services & Appointments & Medical Workforce)
Conduct (informal)	3
Bullying & Harassment	0
Capability	4 (formal) 2 (informal)
Long-term sickness	7
Short-term sickness (formal)	12
Change Management	0
Grievance	0
Whistleblowing	0
Probationary	1
Appeals	0
Suspension / Redeployment	1
Flexible Working	0
Dismissals	0
Total cases	**32**

RAG Rating

Statutory and Mandatory Permanent Staff Training – 1.4.15

Competency Name	EXPIRED	Expired but Booked	Match	Grand Total	Trust Overall (Expired+Match)
CSTF Equality, Diversity and Human Rights - 3 Years	35.43%	3.89%	60.69%	100.00%	64.57%
CSTF Health, Safety and Welfare - 3 Years	21.94%	4.12%	73.94%	100.00%	78.06%
CSTF Infection Prevention and Control - Level 1 - 1 Year	39.73%	0.00%	60.27%	100.00%	60.27%
CSTF Infection Prevention and Control - Level 1 - 3 Years	11.33%	1.74%	86.93%	100.00%	88.67%
CSTF Infection Prevention and Control - Level 2 - 1 Year	15.61%	5.75%	78.64%	100.00%	84.39%
CSTF Information Governance - 1 Year	30.86%	1.14%	68.00%	100.00%	69.14%
CSTF Moving and Handling - Level 1 - 3 Years	17.71%	4.75%	77.54%	100.00%	82.29%
CSTF Moving and Handling - Level 2 - 1 Year	30.40%	7.33%	62.27%	100.00%	69.60%
CSTF NHS Conflict Resolution (England) - 3 Years	29.94%	3.65%	66.41%	100.00%	70.06%
CSTF Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	19.93%	10.24%	69.83%	100.00%	80.07%
CSTF Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	21.27%	10.73%	68.00%	100.00%	78.73%
CSTF Safeguarding Adults - Level 1 - 3 Years	18.86%	3.09%	78.06%	100.00%	81.14%
CSTF Safeguarding Children - Level 1 - 3 Years	14.17%	2.51%	83.31%	100.00%	85.83%
CSTF Safeguarding Children - Level 2 - 3 Years	27.47%	1.81%	70.72%	100.00%	72.53%
CSTF Safeguarding Children - Level 3 - 3 Years	33.33%	0.00%	66.67%	100.00%	66.67%
LOCAL Emergency Planning - Non-Clinical - 3 Yearly	13.50%	2.20%	84.30%	100.00%	86.50%
LOCAL Emergency Planning: annual	18.47%	5.50%	76.03%	100.00%	81.53%
LOCAL PDR - annual	39.77%	0.00%	60.23%	100.00%	60.23%
Grand Total	**24.18%**	**3.91%**	**71.90%**	**100.00%**	75.82%

Statutory & Mandatory Training

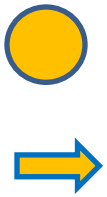
The matched Trust figure of statutory and mandatory training matching requirements has increased slightly from 71.70% to 71.90% although the Expired but Booked figures has dropped this month from 4.12% to 3.91%. The Trust Overall Figure has remained the same at 75.82%.

Ten of the competencies have seen their Trust Overall figure increase slightly this month, the Expired but Booked figure is lower this month which impacts upon the overall percentage completion. However we continue to increase completion overall.

Exceptions

Equality, Diversity & Human Rights. Has continued to make steady progress and moved from Red to Amber (59.86% last month to 64.57% this month).

RAG Rating



HEADLINE HR KPIs

Staff Friends & Family Test

The requirement to undertake a Staff friends and Family Test (FFT) commenced in April 2014. A proportion of staff have the opportunity to respond to Staff FFT in three of the quarters with all staff having the opportunity once a year, as a minimum requirement. Staff FFT wording is nationally mandated on research, it seeks to give an overview through use of two recommendation questions.

1. Would you recommend as a place to work?

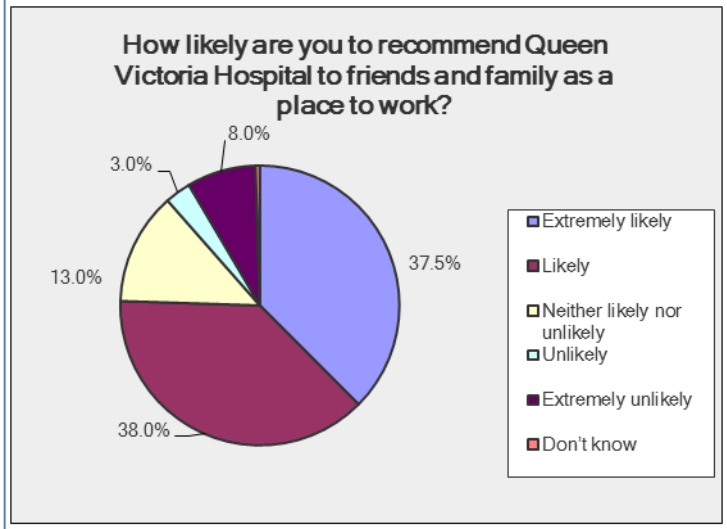
2. Would you recommend as a place to receive treatment?

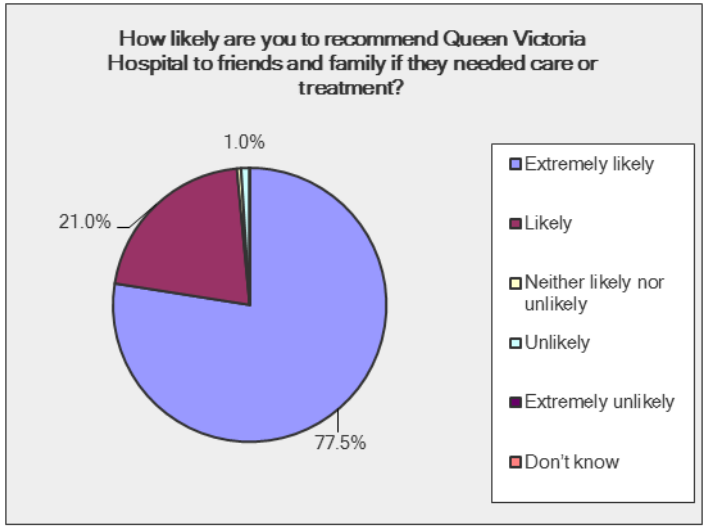
This is because willingness to recommend or be an advocate for your employer appears to be a good overall indicator of both engagement and quality. The overall aims of the staff FFT are to:

•Identify trends in staff opinion on a more frequent basis than the annual NHS staff survey, thereby allowing action at an earlier stage

•Provide a further way in which staff can put forward ideas for improvement.

There were 200 respondents to the test in Q3 which compared to 188 in quarter 2 and 201 in quarter 1, bringing the total year to date response to 589. It is recognised that quarter 1 and quarter 2 was a paper based questionnaire and quarter 4 was an online only questionnaire. Further work needs to be done in improving response rates.



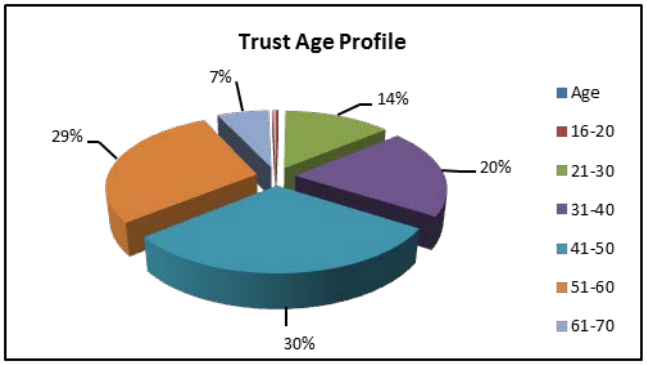


In quarter 3, 75.5% of respondents stated they were either 'extremely likely or likely' to recommend the Trust as a place to work, compared to 3.0% 'unlikely' or 8.0% 'extremely unlikely' to recommend.

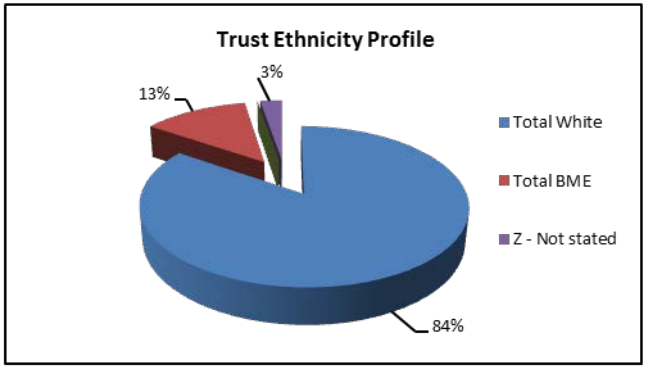
In quarter 3, 98.5% of respondents stated that they were either 'extremely' likely or 'likely' to recommend the Trust as a place to receive treatment, compared to 1.0% saying they were 'extremely unlikely'.

RAG Rating

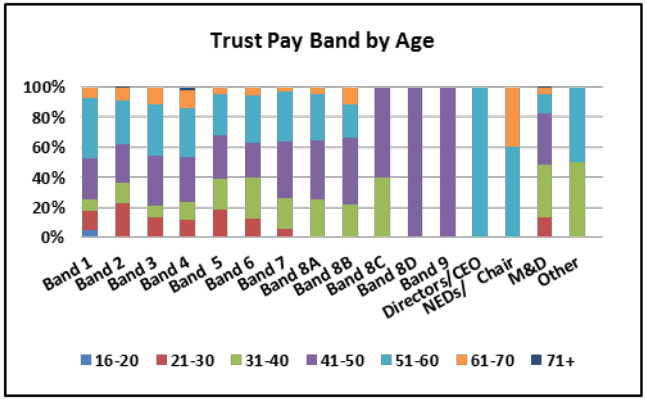
Equality & Diversity



There has been no significant changes in the staff age ranges employed by the trust from the previous year. The majority of Trust employees are aged 41-50 , this reflects the Sussex population. There is a high percentage of staff (36%) aged 51+, which indicates that the Trust has an ageing workforce and it is important that this is addressed through workforce planning, and talent management to ensure that key skills are transferred to younger workers. The Trust is underrepresented by young people (aged 15 – 30) and the trust intends to address this by re-launching its Apprenticeship Scheme, which is specifically aimed at attracting young people aged 16 – 24 into the workplace. Provided the apprentices complete their qualification and work programme successfully they have the opportunity of gaining permanent employment.



The Trusts workforce profile shows that the number of BME staff employed by the Trust is in line with the population of Mid-Sussex. The percentage of BME staff employed by the trust is higher than the population of Sussex which is 5%, whilst the percentage of staff at the trust is 13%, showing a 1% increase from the previous year. The number of staff who have not stated their ethnicity is low in comparison to previous years. However, the trust will continue to encourage staff and new starters to provide this information.



The Trusts workforce profile shows the Trust AFC pay band split by age for all permanent and fixed term staff. The pay and gender split show no significant change in the distribution pattern for gender between 2013/14.

There remains an under representation of male staff in the bands 2 – 8A and 8C, however there is a higher representation of males in senior roles 8D and above, including Medical and Dental.

It is clear that staff in the Trust continue to be predominantly female, this is line with the majority of NHS organisations.

RAG Rating

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Reference number:	95-15
Report from:	Jane Morris, Interim Director of Operations
Author:	Jane Morris, Interim Director of Operations
Report date:	21 April 2015
Appendices:	A: QVH 2020 KS03
	B : KSO3 Road Map 2014 to 2020 - updated April 2015

Quarterly update on delivery of Key Strategic Objective 3: Operational Excellence

Background

1. The attached document summarises the progress against actions in respect of delivery of key strategic objective (KSO) 3 – operational excellence.

2. This is a key strand of QVH 2020 and identifies the actions that support organisational delivery of streamlined services that ensure our patients are offered choice and are treated in timely manner. Operational excellence will be about everything we do.

3. This involves embracing the use of technology, implementing lean systems, reducing duplication, striving to be paperless by 2018, standardising processes, reducing waste, co-locating departments to improve efficiency and reviewing structures to ensure fit for purpose.

Process

4. Operational excellence QVH 2020 programme has been prioritised and incorporated into a 'roadmap' for implementation over the next 5 years.

5. The following groups are meeting regularly and are being used to ensure operational excellence is delivered over the next five years:
    - Electronic patient record steering group
    - Out-patient redesign group
    - Pre-assessment group
    - Theatre user group
    - Trauma management group
    - In-patient redesign.

6. The actions that were identified for achievement during 2014/15 are shown in appendix A and have been updated to reflect progress to date.

7. The attached document is shared with the Clinical Cabinet and is updated following discussions at the groups mentioned overleaf, using their action plans to support the achievement of delivering operational excellence as part of QVH 2020 programme.

8. An updated version of the 'roadmap' for of organisational excellence implementation over the next 5 years as part of the QVH 2020 programme is also attached (see appendix B.

Key issues

9. The main focus of the actions to date relate to the key areas of focus of KS03 in 2014/15: pathway redesign, capacity review and delivery of the annual operational plan.

10. Delivery of the objectives sits across the operational team, with the Interim Head of Operations coordinating progress through the key transformation groups that are supporting QVH 2020 as part of the wider operational excellence action plan.

11. Progress has already been made against a number of the objectives. The main areas of challenge are;
    - Continued focus of operational team on prioritising compliance with operational performance standards for 18 weeks and cancer - which has meant that some developments have had to be delayed. These will now be reviewed and allocated to individuals to coincide with when the new operational structure takes effect.
    - Introduction of the new national e-referral system replacing Choose and Book being postponed until June 2015 and lack of electronic document management storage space on Patient Centre meant we were not able to move towards implementing using electronic referrals within the trust during 14/15 as we had planned.
    - Problems with pre-assessment IT system which has resulted in significant delays to this project.

12. It is recognised that this document provides evidence of progress against the short term plan for KSO 3. Detailed plans regarding the longer term goals for operational excellence have been developed with the relevant teams and are being updated regularly.

13. Under the new operational structure the groups set up to support this KSO will in the future fall under the Head of Clinical Infrastructure.

Link to Key Strategic Objectives

14. The above information relates to the key strategic objective – Operational excellence.

Implications for Board Assurance Framework or Corporate Risk Register

15. Risks to achieving this objective are included within the current corporate risk register and board assurance framework. No new risks have been identified.

Regulatory impact

16. Nothing within the paper attached indicates that the organisation is not fully compliant with the Care Quality Commission's requirement for the trust to be safe, effective, caring, well led and responsive.

17. There is no impact on the trust's Monitor governance risk rating or continuity of service risk rating as a result of this paper.

Recommendation

18. The Board is asked to **NOTE** the content of the report.

KEY STRATEGIC OBJECTIVE 3 Operational Excellence

Improving Productivity and reducing costs – through pathway redesign, delivery of operational plan and stakeholder engagement

	KEY ACTIONS 2014/15	Owner	Measure	Due	Progress	RAG
	Pathway redesign					
1	Implement pre-assessment IT system	JM + AN/TV/JD	Pre-assessment steering group minutes. Synopsis project update reports	Oct-14	Pilot of system has now been delayed further until 1st of July due to problems with testing. Several meetings have taken place with company during Q4 to get the project back on track.	R
2	Introduce electronic referrals	JM	No paper referrals being used within trust to book OPD appointments	Dec-14	Software solutions were put in place to scan referrals electronically into Patient centre. However storage issues have been highlighted. Alternative solutions being sought. Single point of receipt of referral put into place from July and referrers encouraged to send electronically rather than paper copies. Upgrade of Patient Centre now taken place. New national e-referral system now been delayed until Spring 2015	
3	Introduce dedicated LA DC / See and Do unit	JM / GM for Surgery & Anaesthetics	Opening of Theatre 11	Jul-14	Theatre 11 is now seeing 80% sessions utilised. Further see and do sessions are planned to come on line during Q4	G
			Movement of activity from main theatres	By Sept 2014	Plans in place to facilitate these lists once theatre 11 open as theatre staff ill be available	G
			Reduction in waiting list backlog	From July 2014	Backlog clearance has begun. Trajectories in place to monitor progress and weekly patient access meeting set up to focus team on booking patients without TCI's waiting over 13 weeks	G
4	Review and implement revised theatre scheduling systems	JM/PS/SJ	Pilot to be completed and reviewed by theatre user group	Pilot completed by October 2014	Push on reducing 18 week waiting times and seeking replacement theatre scheduling system has meant that pilot has been put on hold. However in the meantime generla improvements to scheduling are being implemented and nearly 60% of patients now have TCI booked over 3 weeks notice. Teams are striving to meet 80% by the end of March 2015	G
5	Introduce internal service improvement training modules	JM/AN	Training proposal for service improvmenet to be devised	Sep-14	Unfortuantely the Trust was not successfully selected to participate in a national training programme so that we could deliver Organising for Quality programme in house. Strategy for continous improvement training will now need to be reviewed in light of new operational structure.	R
			Programme to be launched	October 2014 onwards		
	Delivery of annual operational plan					
6	Delivery of annual operational targets as agreed by Trust board for clinical spoeciality areas	JM		Monthly	Weekly Operations and patient access meetings put into place	
			a. 18 weeks standard, inc. 28 day guarantee		Proactive validation of admitted 18 week pathways adopted	
			b. Service lines performance		Ops restructure to taken place in May 2014, and will be fully established from Aug 14	
			c. Mandatory training and ADR compliance		Detailed action plan devised in response to IST visit in April and now being implemented	G
7	Delivery of streamlined pathways of care for cancer patients particularly off site	JM	Average waiting time for cancer patients off site to be reduced	Monthly	Trend analysis to be undertaken	
			Compliance with cancer waiting time targets		Process map of delays in off site planned	
			COSD completion rates		COSD action plan to be reviewed for progress	
					Agreed will use Infoflex for Trust cancer database which will help streamline data sources for CWT, DAHNO, COSD	G
8	Capacity versus demand review to be undertaken quarterly	JM	IST Demand and capacity tools to be completed for each Speciality quarterly	Quarterly	Q1 models completed and trajectories developed	G

	Delivery of increased productivity					
9	Introduce Productive OPD series	Service Manangers and Matrons	Start and finish times Throughput per OPD clinic	Monthly	Monthly dashboard has been devised. Zero tolerence to late starts introduced from Nov, audit undertaken in Dec and results being analysed. Action plan will then be implemented and supported by OPD redesign group. Clinics start and finish times have improved. Increased productivity of OPD clinics and reduction in new to FU ratios will be priority for new Business Managers	A
10	Internal review of theatre productivity and introduce productive theatre series methodology	Service Manangers and Matrons	Implement recommendations from recent theatre review	Monthly	Metrics has been agreed by Theatre user group and dashboard now in place. Three theatre productivity pilots now underway and progress monitored by Theatre User group. Theatre manager has been appointed who with Head of Clinical infrastructure will implement action plan in response to external review of Theatres undertaken in Q3 14/15.	A
11	80% of elective operating lists to be scheduled at least 3 weeks in advance of operating list, excluding cancer and those requiring donor tissue (QA)	JM /GM Surgical and Anaes Directorate	% of elective operating lists booked on ORSOS upto 3 weeks in advance of date Number of elective surgical cases cancelled and rebooked before admission for the convenience of QVH i.e. non clinical hospital cancellations rather than at the request of the patient or for clinical reasons.	Monthly	Metrics devised and reported regularly Q2 - from data specific areas will be targetted who are booking patients less than 3 weeks notice (excluding cancer) and processes used by secretaries will be reviewed Version 4.3 Patient Centre to be introduced in Q3 Cancellation process – policy in final draft and to be agreed by the end of July	G G G G
12	Review of clinic templates for all clinical services and implement alternatives to FU's to release capacity	JM + GM's + SM's	New to FU ratio's to decrease from current levels Capacity for OPFA to increase Waiting times for OPD to be at 6 weeks for all specialities	Monthly	Audit into N:FU ratio for Corneo has been undertaken and actions being progressed by GM for Surgery and Anaesthetics . Reducing N:FU ratios is being discussed as part of business planning with all specialities.	A
13	Off site spoke review (cross reference with clinical strategy)	JM/ER	Development of clear strategy for off sites	Quarterly	Review of existing sites in terms of activity, income, costs, referral catchment areas is being incorporated into the wider QVH Clinical Strategy work being co-ordinated by E Richardson	G
14	Introduce one stop services for trauma	JM	Number of patients who are treated on the same day as initial assessment Reduction in the number of visits to QVH for NEL patients	Quarterly	Q1 Proposal put forward to Clinical Cabinet for discussion and was in principle approved in May 2014. Options appraisal presented to Clincal Cabinet in Sept 14 with plans for increasing trauma capacity to facilitate improvement for these measures. Futher update provided in Oct 14 highlighting staffing requirements, costs and estate needed. Final paper due to be presented in Dec for implementation in 2015	G
15	Review options around centralized referrals / appointments/scheduling function	JM/PS	Proposal for options for centralized a) Referrals b) Appointments c) Scheduling function put forward for consideration by Clinical Cabinet Implementation of recommended option for the above	Quarterly	Due to operational focus on 18 weeks administrative review and options appraisal for discussion will now take place after the Operational restructure has been completed. In the meantime three times a week Operational scheduling meeting is taking place to ensure complaince with waiting times and maximise theatre utilisation	A
16	Review and implement colocation of departments to reduce duplicaton or delay in process	JM + GM's	Proposal for colocation put forward following a review Implementation of proposal within exisiting estate with minimal capital costs	By March 2015	Work on this objective will beginning once the outcome of the above review of admin teams is known	G
17	Implementation of key IT projects which enhance the Trust's ability to operate more efficient and cost-effective systems that result in improved patient experience, eg outsourced mailing, self check-in, smart scheduling (OPD), patient portal, electronic patient records, as well as maximising use of ORSOS and electronic theatre boards.	JM and service improvement team	Outsourced mailing to be used for 80% of end user letters from Patient centre 80% of patients to use Self check-in kiosks Procurement of OPD smart scheduling system Procurement of electronic patient record system	Monthly Monthly By March 2015	Existing letters been updatd and currently now sending out 77% of letters using outsourced mailing . Project plan being devised to extend system to Sleep and Orthodontics in order to achieve 80% Most recent metrics show improvement each month. Trust wide we have now achieved 75.42% from 54% in July 2013. Team leader for appointments team is asking staff to encourage patients to use the system where possible. OPD Smart scheduling system specification and tender document is being finalised with aim to go out to procurement before Sept 14 QVH staff involved with collaborative in SaCP process. Demonstration and evaluation completed. FBC now being finalised including benefits realisation	G A G
18	Ensure operational teams are able to respond to key strategic service	JM	5 day trauma cover implemented at BSUH Medway ENT all day list from	Jul-14 Oct-14	Q1 Plastic Lower leg consultant in post from June July. Medway ENT post recruited and due to start in Oct. Theatre capacity being facilitated	G
19	Development of QVH 2020 programme management office	JM / QVH 2020 Programme manager and other QVH2020 leads	Programme office established with progress reports tracking key milestones	From July 2014	Q1 Programme manager appointed and office set up. Met with all Leads and devising detailed action plans to establish current progress	G

Operational Excellence Road Map - Key Projects Priorities 2014-2020

	14/15	15/16	16/17	17/18	18/19	19/20
Development of single outpatient facility						X
Providing the same day assessment and treatment of trauma		X				
Outpatient smart scheduling system	X	X	X			
Electronic patient record		X	X	X	X	X
Extend use of self-check in and patient calling systems	X					
Patient portal			X	X		
Electronic clinic outcome forms			X	X		
Theatre smart scheduling system		X	X			
E-referrals	X	X				
Development of trauma unit					X	
Development of a dedicated discharge lounge	X					
Increase in hours trauma theatre capacity		X				
Live electronic bed state		X				
Electronic waiting list forms			X			
Telephone / telemedicine FU		X	X			
Electronic ordering of blood tests	X	X				
Live operating lists	X	X				
E prescribing		X	X			
Introduce See and Do clinics 5 days a week	X	X				
Pre-operative assessment IT system	X	X				
Extended use of automated mailing systems	X	X				
Extended patient and relative text/ buzzer alert system	X					
Paperless operating theatres		X	X			

Queen Victoria Hospital NHS
NHS Foundation Trust

Meeting date: 30 April 2015
Reference number: 96-15
Report from: Dominic Tkaczyk, Interim Director of Finance
Author: Dominic Tkaczyk, Interim Director of Finance
Report date: 22 April 2015

Annual plan 2015/16: submission to Monitor

Background

1. The trust must submit its annual operating plan to Monitor by 14 May 2015. The operating plan that is submitted will include the financial templates, however for the meeting today only the draft narrative is presented.

Key issues

2. The board approved the budgets for 2015/16 at its meeting on 26 March. The plan includes a number of key service developments and a cost improvement programme of 2.7%.

3. The operational plan sets out in more detail how the trust intends to deliver the plan, the risks to achievement and the mitigating factors. Further work will include activity plans.

Link to Key Strategic Objectives

- Operational excellence
- Financial sustainability

4. The achievement of financial targets ensures financial stability and supports the other KSOs including operational excellence.

Implications for BAF or Corporate Risk Register

5. Nothing new to add.

Regulatory impacts

6. None.

Recommendation

7. The board is asked to note the draft narrative for the annual operating plan. The Chair will be asked to give final approval to the plan before submission to Monitor.

MONITOR OPERATIONAL PLAN

Executive Summary

1. Queen Victoria Hospital NHS Foundation Trust (QVH) is a specialist NHS hospital providing life-changing reconstructive surgery, burns care and rehabilitation services for people across the South of England.
2. Our world-leading clinical teams also treat common conditions of the hands, eyes, skin and teeth for the people of East Grinstead and the surrounding area. In addition we provide a minor injuries unit, expert therapies and a sleep service.
3. We are a centre of excellence, with an international reputation for pioneering advanced techniques and treatments.
4. Everything we do is informed by our passion for providing the highest quality care, the best clinical outcomes and a safe and positive patient experience.
5. QVH has a successful record of both financial management and service quality. In 2014/15 we continued to provide our patients with great experiences of care; 99% of our in-patients would recommend QVH to Friends and Family and the 2014 Care Quality Commission's (CQC) national NHS inpatient survey showed that we were significantly better than average on 48 of the 60 questions for how well patients rate their experience of care and in hospital. There are no quality concerns from Monitor or the CQC for 2014/15. Monitor rate QVH as green for quality and the CQC intelligent monitoring system rates us at 6 (which is the lowest risk) for priority inspection.
6. QVH provides both regional specialist expertise and local services for local residents. It therefore has an array of core services which need to be supported across the full range of complexity. In common with other NHS providers, QVH faces challenges from continued efficiency requirements and new commissioning strategies. We are working closely with commissioners to ensure that we are able to play a full role in supporting the Sussex health economy.
7. The Trust continues to work closely with the local health economy to agree the future shape of services. However the nature of the Trust's activity means that although host commissioner Horsham and Mid Sussex CCG takes the lead for contractual matters, the Trust has regular dealings with over 25 CCGs across the south east, as well with the NHS England team dealing with specialist services and secondary care dental services.
8. The Trust's service portfolio means it is less affected by the Better Care Fund changes than local District General Hospitals, but continues to support the delivery of wider economy savings. However commissioners in the south east are beginning to tender for services which impact on QVH. For example the Musculo Skeletal (MSK) services have been tendered across Sussex, which could impact on the Hand surgery and Therapy services provided by QVH.

9. In common with many NHS organisations the identification of annual cost savings continues to be challenging. However 2015/16 is also challenging due to the uncertainty of the tariff. In line with other specialist trusts, QVH has opted for the Default Tariff Rollover (DTR) option which protects the Trust against the downwards direction of the tariff against the loss of CQUIN funding. The Trust Board of Directors debated both options before deciding on the DTR option. Provision has been built into the plan should the final tariff be announced during the year.

10. In summary, QVH expects financial performance in 2015/16 (compared with the provisional outturn for 2014/15) to be:

£m	2014/15 outturn	2015/16
Turnover	61.7	62.0
Surplus (for FRR purposes)	2.2	1.0
Cash	7.8	4.2
Continuity of Services rating	4	4

Establishing the Strategic Context

QVH 2020 – The Strategic Plan 2014/15 – 2018/19

12. The Strategic Plan 2014/15 – 2018/19 submitted to Monitor in June 2014 remains relevant to QVH, to our local population and to our wider catchment area regionally, nationally and internationally.

13. A summary of the key clinical elements of that strategic plan are below.

QVH 2020

Queen Victoria Hospital NHS
NHS Foundation Trust

Service Area	A future where
Specialist Surgery, Burns and Rehabilitation	▪ We retain our position as the major provider of specialist reconstructive surgery, burns and rehabilitation for SE England ▪ Our major base for burns and trauma is co-located with a Major Emergency Centre in SE England with planned surgery in East Grinstead and satellite unit(s) in [locations tbc] ▪ Through our strategic partnership swith Kings, MTW & BSUH we have strengthened our services and have fit for purpose facilities with the required clinical support on site ▪ We have been able to further extend our reach into Surrey and Kent
Routine Elective Surgery	▪ We have significantly grown our market share in hand, breast, skin, cornea and max-fax surgery ▪ Our outreach services all add value to our business and are strategically located to provide excellent patient access and ensure patient flows into QVH ▪ We have a significant private business alongside our NHS business which has increased our flexibility and value, and we work in partnership with consultants to grow both businesses to our mutual benefit
Community Facing Services	▪ We work in partnership with other local services to jointly provide integrated primary and community care on our site and in the local community. This may incorporate general practice, community nursing and rehab services, rapid access to diagnostics, geriatricians and an urgent care centre ▪ These services contribute to avoiding unnecessary admissions and enabling earlier discharge from hospital for East Grinstead patients

www.qvh.nhs.uk

14. There have been no significant variations to those strategic goals although there has been some refinement over the year.

Specialist Surgery, Burns and Rehabilitation

15. QVH continues to work with specialist commissioners and local partners to ensure the sustainable delivery of a specialist burns service to the population of South East England. Services at QVH are supported by the Operational Delivery Network for Burns in this area.

16. QVH continues to work with commissioners and partner organisations to ensure the continued delivery of high quality plastic surgery support to major trauma centres and head and neck reconstructive surgical support to the head and neck cancer networks.

Routine elective surgery

17. A review of the Trust's spoke services was completed in year and a site by site action plan is progressing through to implementation stage.

Community Facing Services

18. Our early strategy in this area reflects the strategic direction subsequently published in the Five Year Forward View to see far more care delivered locally but with services in specialist centres organised to support people with multiple health conditions, not just single diseases. In this area has strategy has been refined in year with significant engagement from our local GPs.

19. Appendix 1 sets out the strategic priorities for 2015/16 as agreed by the Board.

External environment

20. There has not been a significant change to the external environment over and above that which was anticipated. Local commissioning assumptions for the Trust have taken into account the change in lead accountable provider for musculo skeletal services (MSK) and the Trust is adjusting to being a sub contractual relationship in order to continue the delivery of those services. It does present increased transactional costs through to the Trust through increased and fragmented reporting and therefore may present an affordability problem longer term if more services are commissioned in this way.

Five Year Forward View

21. Our CCG has embedded the strategic direction of the Five Year Forward View within its commissioning plan for 2015/16 and QVH have been working with the CCG, local GPs, the local Community Trust and other third sector partners to scope the feasibility of a Multi-Specialty Community Provider. Horsham and Mid Sussex CCG have consulted widely across the areas they serve in the development of their 5 communities plan which QVH has committed to support.

Operational Plan

The short term challenge

22. The Trust has focussed on developing its specialist services in recent years and has

ceased to provide some services that did not fit with the organisation's core strengths. The Trust has generally performed well both financially and operationally and has received strong ratings in quality measures such as the Friends and Family test. However in common with all NHS organisations, there are significant pressures on the Trust.

23. The demand for QVH services remains high and much of the work undertaken at the Trust is not the type of activity that commissioners are seeking to move to alternative providers or settings. Therefore the Trust needs to ensure that the patients referred to us for expert care can be seen quickly but also that all work can be done in a cost effective way.

24. The Trust undertook a strategic review of its services, entitled QVH2020, and further details of this were included in the Strategic Plan submitted to Monitor in June 2014. The review has identified the priorities for 2014 to 2016 to be

- Creating capacity for profitable growth, further improving our productivity & pathways
- Reducing waiting times through targeted activity growth
- Delivering the opportunities we have identified to grow our services and market share

25. Progress has been made in delivering these priorities with the most notable being the delivery of a sustainable 18 week position from the beginning of December 2014. A key priority in 2015/16 will the continuation and embedding of the theatre efficiency programme to ensure capacity for the both the elective and emergency care pathways.

QVH's Quality goals

26. The QVH2020 Strategy- Delivering Excellence forms the basis of our quality aspirations. Within the strategy quality, in its three basic components, safety, clinical effectiveness and patient experience remains paramount in everything we do. Our staff and their engagement in the quality plans for 2015/16 are crucial to improving quality of care and services for patients and we recognise that staff satisfaction and recognition translates into better care for our patients. The strategy is focussed on five key strategic objectives, each with a lead director responsible these are;

Outstanding patient experience
- Superior care and outcomes
- Exceptional environment
- Outstanding personal service

World class clinical services
- Clinical strategy
- Clinical outcomes
- Research and development

Operational excellence (Outstanding patient care)
- Pathway redesign
- Capacity review
- Delivery of annual operational plan

Financial sustainability
- Delivery of annual financial plan

- Cost improvement programmes
- Business development programme

Organisational excellence

- Leadership development
- Performance management
- Innovation and learning

Quality Priorities for 2015/16

27. Priorities for 2015/16 have been influenced by our progress on our 2014/15 priorities, the trust's governors, our lead clinical commissioning group and staff from across the organisation through their contributions to QVH 2020, our long-term strategic plan. In addition, information was considered from national reports, our results from national inpatient and cancer surveys, in-house patient experience reviews, NHS friends and family test feedback, clinical incident reporting, complaints, patient safety reviews and clinical audit.

28. Three priorities were identified, covering patients' experience, patient safety and operational excellence. Having monitored and reviewed last year's priorities, we have decided that we will continue the work associated with priority 2, scheduling of elective surgery.

29. The three priorities proposed for QVH for 2015/16 are:

    - **Scheduling of elective surgery**
    - **Expand trauma capacity**
    - **Improving patient experience of QVH food**

Priority 1: Scheduling of elective surgery

30. At QVH we understand that having advance notice of proposed surgery dates are important to patients as it allows them to plan their personal commitments accordingly. The national guidance on managing waiting lists states that all patients having planned surgery should ideally be offered a date for surgery that provides at least three weeks' notice. This does not apply to cancer patients for whom organisations are required to meet shorter timescales or complex patients who for example may require donor tissue. Delivery of this priority will enhance our patients' experience as they will have earlier confirmation/notice of surgery date.

31. By the end of 2014/15 QVH aimed to schedule 80% of elective surgical patients with at least three weeks' notice of their planned operation date. A number of actions were taken during 2014/15 however these did not impact on the amount of notice we give, as much as we would have liked. Therefore our objective for 2015/16 will be to continue the work started the year before, with some further targeted work with specific teams to improve providing earlier notice/confirmation to patients of their surgery date, with an aim that the percentage of patients booked with at least 3 weeks' notice increases in a phased manner during Q2 and Q3 in order to reach and sustain 80% by the end of 2015/16.

32. Current baseline: Month 1-10; average 57.8%

33. Target for patients knowing their surgery date 3 weeks in advance: Q1 60% Q2 70% Q3 80% Q4 80%.

34. Monitoring and reporting will continue monthly and presented to the management team and included within the board papers. The metrics included will be percentage of patients scheduled with 3 weeks' notice, number of elective cases cancelled and rebooked for non-clinical reasons (i.e. for convenience of QVH rather than at the request of the patient or a clinical reason).

Priority 2: Expand trauma capacity to reduce waiting time for trauma patients

35. QVH prides itself on providing a good patient experience for all our services, whilst continuing to look at services to see where further improvements can be made. QVH trauma service has reached a maximum capacity and is on average turning away up to 4 referrals a week. There have also been occasions where elective patients have been cancelled, or some trauma cases have to wait long lengths of time to be treated and some are being operated on out of hours all of which are not seen to be in line with best practice. Creating additional theatre capacity will improve trauma services at QVH by decreasing the associated risk of operating out of hours and improving patient experience. This will also enable the organisation to reduce waiting times following injury by offering one stop treatment services as well as provide increased access and support to lower leg trauma within the region.

36. For 2015/16 we plan to increase available theatre capacity for trauma patients by June. This will ensure that QVH can provide a service that enables 90% of cases to be treated within 24 hours of admission and almost eradicate the need to operate on cases out of hours between 10pm – 1am. In addition to these two measures we will monitor the overall patient's waits for treatment, number of attendances and length of stay.

37. Our current baseline for percentage of patients treated within 24hours of admission is 88%. By Q3 we will ensure 90% of all patients are treated within 24 hours and aim to achieve 92% by the end of Q4. We also plan to reduce by 50% the number of patients operated on out of hours (after 10pm).

38. Monitoring and reporting will continue monthly and presented to the management team and included within the board papers.

Priority 3: Improving patient experience of QVH food

39. The challenge to provide appetising, nutritious food to a wide range of patients at varying levels of recovery in hospital is always going to be a difficult one. However, we must listen and learn from the feedback of our patients and strive to improve the way we produce, choose and serve meals to our patients. Responses to some of the food questions from the 2014 Picker Institute inpatient survey showed QVH scores to be significantly worse than the previous survey. The aggregate score for Friends and Family (FFT) food scores by patients who rated their food as fair or poor in Quarter 3 was 34% compared with 56% of patients rating their food as very good or good for the same period.

40. For 2015/16 we plan to engage with patients during Q1 to find out what changes our patients would like to QVH food, focusing on some patients with swallowing difficulties or

burns, and utilise this information to review menus, and patient choice to decrease in the number of fair and poor ratings in our FFT.

41. Current baseline Q3 2014/15: 'Fair' and 'Poor' rating 34% and of this 11% rated as 'Poor'.

42. Target for improvement, Q1 Engagement exercise and fair and poor ratings <30 %, Q2 fair or poor ratings <25 %, Q3fair or poor rating<20%, Q4 sustain fair or poor ratings at <20% with poor ratings not above 5%.

43. Progress on our achievements will be monitored at the patient experience group and reported quarterly in the patient experience report presented to the management team and included in the board report.

CQUIN 2015/16

44. For 2015/16, QVH had agreed National and local CQUIN with our Commissioners. However due to the DTR specifications there will be no CQUIN payments for 2015/16. The three National and two local schemes remain important to QVH as is the intention to drive quality improvements in all of these areas. There were three National CQUINs applicable to QVH: Acute Kidney Injury, Dementia and Sepsis.

    Locally negotiated CQUINS with Commissioners were:

    - Human Factors training to enhance clinical performance and patient experience through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings.

    - Mental Health support for trauma patients by improving mental health assessments and referrals through the implementation of the Safeguarding Managing Risk Tool (SMART) and training for staff using this tool.

45. The Medical Director and the Director of Nursing will review the five quality schemes and reset achievable milestones within the resources available reporting quarterly to the board. We will share progress against these quality initiatives with the commissioners but no as part of formal contract monitoring.

Progress on quality priorities in 2014/15

46. For 2014/15 we agreed four quality account priorities, national and four local CQUINs with our commissioners. With the exception of one (elective scheduling of theatre with three weeks' notice) all of the priorities have made good progress and achieved the agreed milestones. We anticipate full payment of the 2014/15 CQUIN scheme.

Key quality risks to plan

47. A working group is currently examining board governance structures with reference to Monitors Well-Led framework for governance reviews 2014 and the Francis inquiry findings, an interim report has been presented to the board alongside a list of initial recommendations a final report will be presented to board in June 2015 with final recommendations being implemented by October 2015. Plans to minimise risks to organisation during this change period will be part of the recommendations.

48. Other key risks associated with delivery of the quality plan are ensuring that we have the resources to deliver on areas we have identified for action. These resources include physical areas to meet the capacity demand related to delivering activity to meet targets such as RTT18 and trauma services, retaining and recruiting staff that support the delivery of activity, ensuring robust infrastructures such as IT to enable timely rather than manually intensive reporting processes and not reducing focus on our excellent reported patient experience.

49. Meeting of RTT18 time frame has been challenging during the latter part of 2014/15, plans to address this are covered within the operational requirements of this plan, however we have improved and demonstrated compliance since December 2014.

50. Recruitment and retention within the trust has a high profile and there is collaborative working between HR and nursing to tailor strategy to specific need. Work is also in progress to assess the impact of NMC nursing revalidation form January 2016.

51. How we communicate with patients affects our reputation, we were disappointed that our responses to a specific question in the national inpatient survey, “could not always find staff member to discuss concerns with” has worsened from our previous position. We are currently working with staff and stakeholders to achieve this.

52. We undertook a major structural review during 2014/15 and the interim structure will move to the new structure at the end of quarter 1. We acknowledged the higher risks of operating our services during this transition period to our staff and have been vigilant about looking for early warning signs whilst continuing to deliver safe high quality services.

53. Ensuring strong clinical leadership and project support for development and implementation of electronic patient record during 2015/16.

How the Board seeks assurance around safety and quality of services

54. QVH continues to have systems and processes in place through quarterly directorate reviews conducted by the chief executive to assure itself regularly on the quality of the service provided to patients. At these meetings, the safety of care is monitored through governance reports on incidents, infection control and identified risks. Where there are concerns, action plans are put in place and reviewed at monthly operational meetings of the directorates.

55. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, and clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints and feedback questionnaires including the Friends and Family test. A summary quality dashboard is presented monthly to the clinical cabinet and board of directors.

56. The audit committee routinely review the framework of control in respect of quality and reports back regularly to the board of directors.

57. The Trust has assessed the recommendations from the Francis, Berwick, Keogh and Cavendish reports and has an action plan in place that is monitored through the Quality and Risk Committee. Many of these actions support the QVH 2020 Delivering Excellence Strategy.

58. Where the executive team or a directorate identifies a significant concern they will instigate actions that are documented and regularly reviewed. Significant incidents are reported through to the trust board and followed up through the quality and risk committee.

59. QVH has systems in place which provide transparent and accurate information on the safety and quality of our services monthly to our Commissioners, Monitor and CQC. There are no quality concerns from Monitor or the CQC for 2014/15. We continue to plan for our CQC inspection anticipated in 2015/16.

60. All of these are areas of quality that QVH has identified within its own review of quality and supports feedback from patients through complaints, the Friends and Family test feedback and our own observations of quality and care. To date in 2014/15 all milestones have been achieved for the National and local CQUINs.

61. For 2015/16 QVH had agreed National and local CQUIN with our Commissioners. However due to the DTR specifications there will be no CQUIN contract for 2015/16. The three National and two local schemes remain important to QVH as is the intention to drive quality improvements in all of these areas. There were three National CQUINs applicable to QVH: Acute Kidney Injury, Dementia and Sepsis. Locally negotiated CQUINS with Commissioners were:

    - Human Factors training to enhance clinical performance and patient experience through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings.

    - Mental Health support for trauma patients by improving mental health assessments and referrals through the implementation of the Safeguarding Managing Risk Tool (SMART) and training for staff using this tool.

62. The Medical Director and the Director of Nursing will review the five quality schemes and reset achievable milestones within the resources available and quarterly reporting of the schemes. We will share progress against the initiatives with the Commissioners but not as part of formal contract monitoring.

Existing quality concerns

63. Through current activity on reviewing the quality of care, development of the trusts strategy QVH 2020 Delivering Excellence, safety incidents, patient feedback in the form of complaints, the national surveys and Friends and Family test feedback we would recognise that areas where quality standards could be improved include;

    - Meeting of RTT 18 time frames for patients care has been challenging during the latter part of 2013/14 due to increased referrals, plans to address this are covered within the operational requirements.

    - Consistent use of the WHO safer surgery checklist, while this is actively promoted and recognised as good practice it has not been undertaken consistently and we are aware of incidents that could have been prevented had one or all of the three aspects of the checks been undertaken. We also recognise that this is about all staff engaging in the process rather than just some staff, for this reason we support the inclusion of

quality and quantitative auditing of this as a CQUIN during 2014/15.

- The documentation of surgical consent prior to the day of surgery has been a focus for the last two years and we have seen a steady increase over this time. Our focus for the next year will be to work with our largest surgical speciality group – plastic surgery to further improve their documentation in this area.

- How we communicate with patients; this in the main is related to how some staff attitude is perceived by patients and by changes to appointment times that mean patients are required to change plans they have already made.

64. Actions to address these areas have been incorporated into activity and quality plans for QVH during 2014/15.

Key quality risks

65. The key risk associated with delivery of the quality plan is ensuring that we have the resources to deliver on areas we have identified for action. These resources include physical areas to meet the capacity demand related to delivering activity to meet targets such as RTT18, retaining and recruiting staff that support the delivery of activity and ensuring robust infrastructures such as IT to enable timely rather than manually intensive reporting processes.

How the Board seeks assurance around safety and quality of services

66. QVH continues to have systems and processes in place through quarterly directorate reviews conducted by the chief executive to assure itself regularly on the quality of the service provided to patients. At these meetings, the safety of care is monitored through governance reports on incidents, infection control and identified risks. Where there are concerns, action plans are put in place and reviewed at monthly operational meetings of the directorates.

67. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints and feedback questionnaires including the Friends and Family test. A summary quality dashboard is presented monthly to the clinical cabinet and board of directors.

68. The audit committee routinely review the framework of control in respect of quality and reports back regularly to the board of directors.

69. Where the executive team or a directorate identifies a significant concern they will instigate actions that are documented and regularly reviewed. Significant incidents are reported through to the trust board and followed up through the quality and risk committee.

Sharing information about the safety and quality of our services with Regulators and Commissioners

70. QVH has systems in place which provide transparent and accurate information on the safety and quality of our services monthly to our Commissioners, Monitor and CQC. There are no quality concerns from Monitor or the CQC for 2014/15.

What the quality plan means for the workforce

71. Staff engagement in the quality plans for 2014/15 is crucial; their enthusiasm in

improving the quality of care and services for patients will support the ability to delivery on all of the actions we have identified. It is recognised that staff who are satisfied and recognised within their roles delivery better care to patients. Within our QVH 2020 Delivering Excellence there is recognition that to delivery outstanding care we require outstanding people and therefore our plans include leadership development, performance management and innovation and learning actions to support staff development.

The Trust's response to Francis, Berwick and Keogh

72. The Trust has assessed the recommendations from the Francis, Berwick, Keogh and Cavendish reports and has an action plan in place that is monitored through the Quality and Risk Committee. Many of these actions support the QVH 2020 Delivering Excellence Strategy.

Risks to delivery of the plan

73. The main risk to delivery of the plan is that current proposals to restructure governance arrangements may take focus away from delivering on plans, however it is anticipated that the planned activities will benefit any new reporting structure that is introduced. Should the management not support the post identified to support delivery of QVH 2020 Delivering Excellence there would be a risk that robust reporting and oversight of the plan may not occur and individual activity occurs in isolation.

Working with Health Economy Partners

74. QVH have been working with our LHE partners to consider how we can support delivery of high quality services over the next two years. These plans include;

75. Supporting trauma management locally with LHE partners and providing specialist lower leg plastic surgery input to major trauma centres within the region

76. Providing cancer services to support patients with head and neck, skin and breast oncology. This includes providing joint appointments of ENT consultants, delivery of a regional Moh's service and providing immediate breast reconstructions for patients across Surrey, Sussex and Kent.

77. Developing our sleep disorder unit to provide care more locally particularly for NIV patients

78. Providing local community services including MIU, diagnostic and community therapy services so QVH support care more widely than just the specialist functions.

79. These discussions are being built into our latest strategic review QVH2020 Delivering Excellence that supports QVH's aspiration to have outstanding care delivered by outstanding people.

80. QVH recognises that ensuring the quality of care for their patients requires the organisation to work effectively with its LHE partners. In order to ensure we deliver the highest quality of care to patients we work with our partners to secure support in our delivery of expert paediatric, psychiatric, intensive care and microbiology services.

Operational requirements and capacity

81. As part of business planning QVH has carried out a detailed demand and capacity analysis to assess the inputs required to deliver the organisation plan for 2015/16. This

analysis included the following:

- expected activity levels anticipated including impact of any service change / development
- identifying the capacity to achieve sustainable waiting times to meet current demand and incorporating the above anticipated activity levels
- identifying any gaps in current capacity compared with the analysis for outpatients, theatres and beds
- implications of this analysis for workforce and estate

82. This analysis has led to QVH devising a number of plans to respond and these will be outlined in turn within the following section.

Outpatients

83. Capacity analysis undertaken as part of business planning has shown that demand on outpatients remains generally steady across all specialities with some growth in specific service lines. Previously a number of short term measures have been used to meet demand and respond to the changes in demand. The Trust is continuing to review its overall outpatient capacity, both on and off site, with planned increases to respond to growth for specific service lines.

84. The plans to increase OPD capacity in 15/16 include appointing a number of new consultants in Orthodontics, Ophthalmology, Maxillofacial Surgery and Sleep as well as a speciality doctor for Oral Surgery. In addition as part of 2020 strategy QVH will continue to focus on improved scheduling of outpatients as reductions in new to follow up ratio, implementing alternatives to consultant led services like nurse led / therapy led clinics etc.

Operating theatres

85. Capacity analysis undertaken as part of business planning has shown that demand on theatres has continued to grow, due to a number of factors including sustaining waiting times, change in case mix towards day case procedures and growth in demand within a number of service lines.

86. In response to this in 14/15 the Trust increased the number of operating sessions[1] per week. This included opening an additional theatre for local anaesthetic day cases which will offer a one stop service for outpatients to have treatment on the same day reducing unnecessary visits. This proposal freed up capacity with some Saturday sessions that enabled the Trust to sustainably meet the 18 week performance standards from the end of Q3. The Trust also increased the surgical input from ENT to our major Head and Neck services by a joint consultant appointment in December 2014. This provided new activity to QVH and is a significant service development in response to specialist commissioning. Further increases in this service are being explored for 15/16.

87. For 15/16 the Trust plans to further increase the capacity for local anaesthetic cases as well as create additional operating sessions for trauma. This will enable QVH to offer one-stop service regional trauma service for minor cases even at weekends, whilst freeing up capacity for more complex cases through our dedicated CEPOD sessions.

[1] Each session = 4hrs

This in turn will enable more patients to be treated locally in the region and help to reduce pressure on neighbouring emergency departments for these patients.

88. Additional staff will be required to support this development including nursing staff and two trauma registrars in plastics.

89. Combined these proposals will enable the Trust to continue to sustain access waiting times within 15/16 and provide additional capacity for QVH regional trauma service. However it is also recognised that alongside these developments QVH also plans that the organisation will continue to implement 'Productive Theatre' methodology to ensure that maximum efficiency and productivity is maintained.

Beds

90. Currently QVH has an ITU/Critical care unit, one children's ward (9 beds) and two dedicated adult wards which incorporates a step down unit (total of 46 beds). Capacity analysis undertaken showed that the current beds are sufficient to meet the demand and achieve sustainable waiting times over the next two years. However it has been recognised that in order to maintain 85% bed occupancy QVH will need to continue to reduce length of stay. At the end of 14/15 the Enhanced Recovery After Surgery (ERAS) was successfully introduced for Breast patients and plans are to extend this programme throughout 15/16 to other specialties including Head and Neck. In addition closer working between critical care and step down departments is being explored to further improve skill mix and maintain safe staffing levels to support increasing number of complex cases following the increase in ENT and appointment of a 5th Head and Neck Consultant.

Information Technology

91. In 15/16 the Trust is committing to two main investments in technology i.e. Electronic Patient Record and upgrade to the organisations IT network. These are two significant programmes that the Trust is implementing to ensure that QVH is able to become a paper light organisation. Project teams are being appointed to support these two key projects. In addition to these other clinical IT systems are also planned to be introduced this year. These include stock control system for Sleep, introduction of Blood hound to monitor blood product usage and upgrades for a number of systems including medical photography storage, PACs for radiology and Histopathology reporting.

Analysis of key risks

92. As part of the assessment of the operational plan the following key risks have been identified and the mitigating actions proposed to reduce their potential impact over the next two years.

	Risk	Likelihood	Impact	Mitigating actions
1	Unexpected decrease / Increase in referral demand	Low	High	• Work closely with commissioners, other providers to secure services • Ensure that the organisation reviews tenders for services and places bids where relevant • Constantly review demand and capacity to ensure service can respond • Advertise services provided to patients, GP's using websites such as NHS Choices • Ensure waiting times and Friends and Family

				scores are maintained to encourage patients to choose QVH.
2	Reduction in Junior Doctor posts funded by Deanery	Medium	High	• Liaise with Deanery regularly • Support junior doctors on site to ensure they have access to training and good experience whilst at QVH • Review rotas regularly • Consider increasing number of trust employed CT2 and SPR grades • Increase consultant led service provision • Expand use of other clinical professionals within Trust to take on more junior doctor roles
3	Lack of engagement of Consultants	Medium	High	• Hold regular consultant meetings with CEO and Medical Director to involve them in strategic and business decisions • Review and Increase accountability of Clinical Directors
4	Changes to services specified by commissioners including Burns / MSK	Medium	High	• Work closely with CCG's, NHS England and LAT representatives • Work with prime providers to see how QVH could work collaboratively with them • Work with partner acute Trusts around provision of burns care that meets specialised commissioning specification within an agreed timeframe
5	Increase in competition	Medium	High	• Work closely with CCG's and LAT representatives • Work with prime providers to see how QVH could work collaboratively with them • Work with partner acute Trusts around provision of burns care that meets specialised commissioning specification within an agreed timeframe
6	Shortage of key members of staff (hard to replace/ recruit)	Medium	High	• Work with departments to regularly review workforce plans • Streamline recruitment process to reduce delays • To work with local universities to support in house training programmes • Consider recruitment and retention premiums for specific staff groups
7	Age of estate	High	High	• Agree capital programme for immediate maintenance • Develop a long term investment programme to align with strategic objectives and clinical priorities
8	Ensuring productivity is maintained	Medium	High	• Regular monitoring of KPI's • Weekly review at Operations meeting to escalate issues to be addressed • Regular demand and capacity review during the year • Implementation of lean thinking and service

				improvement as part of QVH 2020 strategy to deliver operational excellence
9	Slippage of IT projects	Medium	High	• Prioritise investment in Network infrastructure • Monitor progress of key projects against milestones – escalate issues early via the appropriate Trust structure
10	Reliance on partner organisations for support	Medium	Medium	• Work and meet with partner acute Trusts regularly around provision of services and how we both organisations can work collaboratively for the benefit of patients

Budget setting 2015/16

93. The budget setting process for 2015/16 has been particularly challenging. The Board are aware that the original 2015/16 tariff proposals were suspended following objections during the consultation process. The subsequent options of a default tariff rollover (DTR) or enhanced tariff option (ETO) were discussed at the February Board meeting and, following further clarification from NHS England, the Board opted for the default tariff rollover. It is worth noting that this decision puts the Trust in a minority position.

94. Over 80% of NHS Trusts have opted for the enhanced tariff option largely on the basis that it includes an improvement in the marginal rate emergency tariff (MRET) from 30% in 2014/15 to 70% in 2015/16. For Trusts with busy A&E departments and high levels of emergency activity this represents a considerable improvement on the current MRET system. However it should also be noted that the Shelford Group, which represents ten leading NHS teaching and academic healthcare organisations, has rejected both proposals, as have the majority of hospitals represented by the Federation of Specialist Hospitals. Under the current arrangements any trust that rejects both proposals is by default placed on the default tariff rollover.

95. On balance DTR was more financially advantageous to the Trust although not without risk. Under the DTR option the Trust is not eligible for CQUIN payments during 2015/16. CQUIN payments of up to 2.5% of the Trust's budget (£1.4m) are available on delivery of agreed quality improvements. Whilst the payment is not guaranteed the Trust has achieved 100% in previous years. In addition under the DTR option Monitor is able to make in-year changes to the tariff. At present there is no indication of when this might happen but as part of budget setting it has been prudent to include a contingency for a reduction in tariff, and therefore income, at some point during the year.

96. It is against this backdrop that we have set the budget for 2015/16. However the headlines are as follows:

- We have increased our cash releasing cost improvement programme (CIP) from 1.5% to 2.7%. This brings us in line with most other acute trusts. It is important to note that the CIP programme has not been centrally imposed but developed by the individual services. It is also important to note that the individual proposals have been reviewed by the Trust's Medical Director to ensure that they do not have a detrimental impact on patient safety.

- We have made strategic investments of c. £800k. These include; new consultant appointments in corneo-plastics and ophthalmology to meet growing service

demands and waiting times; investment in trauma capacity to reduce out of hours operating and delayed admissions; and investments in our management structure to ensure we have the right capacity and capability to support our longer-term sustainability.

- We have created a £350k contingency to allow for in-year tariff changes as per the DTR option outlined above and we are planning for a 2% increase in activity in line with our 5-year planning assumptions.

97. The combination of CIP, investment and activity will generate a net surplus of just over £1m. This is obviously a reduction from the planned surplus of £2.3m in 2014/15 and is largely the result of the absence of any CQUIN income. However, it needs to be noted that this figure is net of the investments and contingency outlined above and still represents a surplus of 1.5%.

98. Our budget strategy is not without risk. The Board is aware we have underperformed on elective in-patient activity during 2014/15. Our analysis indicates that this was largely the result of short-term capacity constraints rather than longer-term changes in demand. However we will be setting out proposals for risk mitigation as part of setting the board assurance framework (BAF) for 2015/16.

99. Similarly we have experienced in-year pressures on both pay and non-pay over the last two years that have reduced the net benefits of additional activity. The budget setting process for 2015/16 has been more robust than 2014/15 with greater ownership from service managers and increased support from the finance team. However, as with the income, we will include proposals for risk mitigation as part of the 2015/16 BAF process.

100. The surpluses in previous years have been achieved by growth in activity at low marginal costs and CIPs. However the tariff changes for 2015/16 announced in the Monitor consultation would have meant income reductions of 3.5% (circa £1.9m). This was a combination of the efficiency requirement and tariff price reductions in service areas the Trust specialises in – major skin procedures as one example. Dealing with the tariff reduction would be challenging and not something that can have been expected when the five year plan was prepared last year.

101. There are other factors to bear in mind in 2015/16 which would make the achievement of a surplus at previous levels more difficult; these include:

    - National tariff-loss of CQUIN in 2015/16
    - National pay awards expected at 1%
    - Additional employers pension contributions 0.3%
    - Further incremental pay awards under Agenda for Change
    - Increased interest and depreciation charges on Theatres and other Medical and IT equipment

102. However in 2015/16 the Trust plans to spend £2.1m of its accumulated surplus for strategic investment in IT and the estate. Furthermore the Trust has accumulated surpluses over a number of years so that cash balances currently stand at over £8m which is considerably in excess of its cash requirements.

103. We have assessed the potential impact on the Continuity of Service Risk Ratings

(CoSRR) and the forecast is that the rating would remain at 4.

Income

104. Contract negotiations with CCGs, NHS England and Sussex MSK Partnership are nearly concluded. There is a gap of about £0.5m between our income expectations and the CCG offers but we would expect this to be closed once negotiations are finalised.

Appendix 1

QVH 2020 15/16 Priority List			
THEME	**PRIORITY AREA**	**BRIEF DESCRIPTION**	**EXECUTIVE LEAD**
Organisational culture	Board to Ward engagement	Increase staff engagement at all levels across QVH	Chief Executive
Major role in trauma networks	Burns derogation – paediatrics	Sustainable future for burns @ QVH	Operations
'Hub & Spoke 'delivery model	'Super Spoke' model	Feasibility study/business case	Chief Executive
Community facing provision	Primary care development	Decision on future location of EG GPs	Chief Executive
New Markets & Relationships	Alternative income streams	Develop private/international offering	Chief Executive
Productive advantage	Theatre productivity	Evaluate and roll out productivity pilots	Nursing
	CIP programme	Robust programme for 16/17 & beyond	Finance
	IT infrastructure	Commission and implement new infrastructure	Finance
	EPR	Initiate implementation project	Operations
	Site – development	Develop OBC on basis of agreed strategic framework	Finance
Operational Excellence	Access & activity	Deliver in-year access and activity targets	Operations
Organisational Excellence	Non-clinical infrastructure	Sustainable staffing solutions for estates, facilities & IT	Finance
	Non-consultant grade doctors	Sustainable staffing solutions for non-consultant grades	Medical Director
	Leadership development	Programme for middle managers & clinical leaders	HR & OD
Financial sustainability	Income & expenditure	Deliver in-year income & expenditure targets	Finance
World class clinical services	Improving patient safety	Introduce human factor training into theatres	Medical Director
Outstanding patient experience	Catering	Catering improvement & sustainability plan	DN

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Reference number:	97-15
Report from:	Dominic Tkaczyk, interim Director of Finance & Commerce
Author:	Keith Mansfield, interim Deputy Director of Finance & Commerce
Report date:	21 April 2015

Monitor Declaration: Quarter 4 2014/15

Key issues

1. The trust is required to submit its quarter 4 (Q4) monitoring return by the end of April.

2. The paper confirms the in-year governance statement contained in the Q4 return.

3. For finance the declaration that "the board anticipates that the trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months" is **confirmed.**

   In Q3 the COSRR is submitted as 4: No evident financial concerns.

   In the annual plans submitted to Monitor the planned rating from Q4 onward is 4 and the forecast remains at 4.

4. For governance the declaration that "the board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in appendix A of the risk assessment framework; and a commitment to comply with all known targets going forwards" is **confirmed**.

   For Q4 the trust is expecting to meet the 18 week targets. The forecast is compliance in Q4 for 18 weeks as we expect to meet the standards.

5. The governance rating for Q2 was Green: No evident concerns.

6. For the declaration "the board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the risk assessment framework page22, diagram 6) which have not already been reported" is **confirmed**.

7. For consolidated subsidiaries the response is **nil** to the question the "number of subsidiaries included in the finances of this return".

Implications for BAF or Corporate Risk Register

8. Nothing new to add.

Regulatory impacts

9. Implications for continuity of service risk rating and governance rating noted in the report.

Recommendation

10. The Board is asked to **NOTE** the contents of this report and **APPROVE** that the above declarations be made to Monitor.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Agenda item reference no:	98-15
Author:	Kathleen Dalby, Company Secretary on behalf of the Governance Review Group
Date of report:	22 April 2015

Board governance review: progress report

1. In 2014 the QVH board of directors charged the chair (then non-executive director and chair designate) with undertaking a review of existing board governance structures.

2. A small working group was established to lead the review on behalf of the board of directors. It reported its progress and initial recommendations to the board of directors in January 2015.

3. The following paper provides a general update on further progress and the work of the governance review group since January 2015.

4. The board is asked to consider the report, provide feedback and approve the following recommendations:

   - To establish the non-executive and executive membership of the new financial and operational performance committee, the governor representative and secretariat roles and the meeting logistics as proposed in appendix 1.

   - To appoint Lester Porter, Senior Independent Director, to chair the audit committee from 1 June 2015.

   - To change the name of the charitable funds advisory committee to ‘charity committee’.

Link to key strategic objectives (KSOs)

5. Ensuring that the trust’s board governance arrangements are refined and robust supports the delivery of all KSOs, and in particular, KSO 5 – organisational excellence.

Implications for the Board Assurance Framework or Corporate Risk Register

6. None at present or anticipated.

Regulatory impact

7. The aim of the governance review is to strengthen the trust’s board governance arrangements and to maintain the trust’s regulatory ratings for governance.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Agenda item reference no:	98-15
Author:	Kathleen Dalby, Company Secretary on behalf of the Governance Review Group
Date of report:	22 April 2015

Board governance review: update

Background

1. In 2014 the QVH board of directors charged the chair (then non-executive director and chair designate) with undertaking a review of existing board governance structures.

2. Terms of reference for the review were established and agreed with the board of directors and a small working group was established to lead the review on behalf of the board of directors. The group comprises:
    - The chair
    - The chief executive
    - The senior independent director
    - The governor representative to the board of directors
    - The company secretary.

3. In January 2015 the governance review group reported its progress to the board of directors and made initial recommendations. These were agreed in principle and the board of directors asked the governance review group to develop further proposals regarding the board and committee meetings schedule to include information about meeting frequency, membership, timing and secretariat support.

4. This paper aims to respond to this request and to provide a general update on the progress of the review and the work of the governance review group since January 2015.

Further context and assurance

Meeting with Monitor

5. In March 2015 the board of directors met with representatives of the trust's regulator – Monitor – for a routine meeting. At this meeting the trust chair designate informed Monitor of the trust's governance review and sought advice on two principle matters associate with it:

    - *Frequency of formal meetings of the board of directors*
      The governance review group had recommended that the frequency of formal meetings of the board be reduced to every two months if its other recommendations regarding the sub-committee structure were implemented.

Monitor confirmed that it would not prescribe the frequency of formal meetings of the board of directors of a foundation trust and that the recommended pattern would not, in isolation, raise governance concerns for the regulator.

- *Requirement to use independent reviewers for governance review processes*
  The chair designate also sought advice from Monitor regarding its guidance on the well-led framework for governance reviews which sets an expectation that foundation trusts should use independent reviewers to ensure objectivity.

  The chair designate explained that the trust intends to commission an independent review of governance in 2017 (within the required three-year timeline) after its own internal review is complete and the recommendations are fully implemented and given time to embed.

  Monitor confirmed that this approach would be acceptable to the regulator and seemed appropriate in the circumstances. Monitor also confirmed that trusts are expected to appoint whichever independent reviewer it sees fit to meet the scope of the review and its own needs. There is no formal requirement upon foundation trusts to appoint a "big four" firm of reviewers.

Salisbury NHS Foundation Trust

6. In March 2015 the company secretary approached Salisbury NHS Foundation Trust which is known to operate a similar board governance structure. The company secretary held an informal discussion with her counterpart at the trust and has arranged for Beryl Hobson to do the same with the chair at Salisbury.

7. Salisbury NHS Foundation Trust runs a district general hospital and provides a range of specialist services across three counties, including plastics. Its turnover is in excess of £180m. It was authorised as a foundation trust in 2006 and currently has the same Monitor ratings as QVH. It appointed a new chair in 2014 and its previous chair served for 9 years.

8. The Salisbury board of directors meets monthly. Meetings alternate between formal business meetings and seminars or away-days. It has a sub-committee responsible for finance and performance which meets monthly and a clinical quality sub-committee that meets 10 times per year. It recently disbanded a 'workforce' sub-committee.

9. The Salisbury board feels that its governance structure works well for the organisation but advised us to:
   - Be particularly vigilant about managing formal and informal agendas and making and recording decision in the appropriate forum.
   - Think carefully about feedback mechanisms from sub-committees to the board to avoid potentially long intervals between board meetings and reliance on approved minutes.
   - Be aware that the structure is unlikely to eradicate the need for occasional extraordinary meetings or a sense that the board still needs more 'free-style' discussion time.

Appointment of a non-executive director

10. At its meeting on 9 April, the council of governors approved a recommendation to appoint Ian Playford as a non-executive director to the board of directors. The

appointment replaces Beryl Hobson as a non-executive director when she assumed the role of trust chair on 1 April 2015.

11. Ian's appointment re-establishes the required non-executive majority on the board of directors and provides additional skills to the overall capabilities of the board.

    Ian's appointment has allowed the governance review group to recommend allocations of non-executive resources to the proposed board governance structure (see appendix 1).

Clinical governance

12. In parallel with the board governance review, the medical director has initiated a review of clinical governance and hosted a summit meeting on the topic on 20 April.

13. The summit meeting was attended by a range of relevant senior individuals from across the trust, by the chair, chief executive and company secretary on behalf of the governance review group and by the chair of the quality and risk committee (Q&R) on behalf of the committee.

14. The agenda focused on high-level principles of clinical governance as a concept and as a system and began to consider specific issues of safety, quality and risk for QVH. It was acknowledged that culture, standard operating procedures, communications and engagement and committee structures are all issues to be addressed and summit attendees agreed to meet again to begin to work through them systematically.

15. It is likely that this forum will initiate changes to the governance structure that sits beneath Q&R as a sub-committee of the board of directors. In turn, these changes may have wider implications for board level governance.

Progress on implementation of initial recommendations

16. The diagram at appendix 2 summarises the proposed governance structure at board and executive level following implementation.

Quality and risk (Q&R)

17. Q&R will move to monthly meetings from October 2015, subject to final approval of the governance review by the board of directors at its meeting in September 2015.

18. Non-executive and executive membership of the committee, governor representative and secretariat roles and meeting logistics are proposed in appendix 1.

Financial and operational performance (F&P)

19. F&P will be established from June 2015 and operate in 'shadow' form until final approval of the governance review by the board of directors at its meeting in September 2015.

20. The absence of this committee was considered by the governance review group to be the most pressing need of the board's current governance arrangement.

21. Establishing and operating the committee in shadow form will, we believe, address this need sooner than might otherwise be possible and allow a phased approach to implementing the most significant changes to the sub-committee structure.

22. The timing of the establishment of the committee is to coincide with new directors of finance and operations joining the trust at the beginning of June.

23. Non-executive and executive membership of the committee, governor representative and secretariat roles and meeting logistics are proposed in appendix 1. The board of directors is asked to **APPROVE** these arrangements.

24. The board of directors is also asked to **NOTE** the recommendation that public governor Chris Orman assumes the role of governor representative to the F&P committee until September 2015. As this is a new committee Chris, as vice-chairman of the council of governors, has been invited by the trust chair to assume this role on a temporary basis. This arrangement will hold until the next round of elections amongst the council of governors which assigns governor representative roles.

25. The governance review group is developing draft terms of reference to be shared with the proposed F&P chair and then the full board in due course.

26. The chair of the committee will be invited to join meetings of the governance review group from July 2015 to feedback on progress and inform the final stages of development of the new governance structure.

Human resources and organisational development (HR&OD)

27. The governance review group initially recommended the establishment of an executive level HR&OD sub-committee of the F&P committee.

28. Since making that recommendation, and in the light of discussions about staff survey results at meeting of the board of directors held in March 2015, the governance review group has considered other variations that might meet the need to ensure an appropriate profile for HR&OD matters in the trust.

29. The group would like to give further consideration to this matter before reporting again to the board of directors at its meeting in June 2015.

Audit committee

30. No fundamental changes are proposed to this statutory sub-committee of the board of directors.

31. However, it is proposed that the chair of the committee should change from June 2015 in order that the current chair might chair the new F&P committee.

32. The board of directors is, therefore, asked to **APPROVE** the appointment of Lester Porter, Senior Independent Director, to chair the audit committee from 1 June 2015.

Nomination and remuneration committee

33. No fundamental changes are proposed at this stage to this statutory sub-committee of the board of directors (subject to paragraph 27 above).

Charitable funds advisory committee

34. No fundamental changes are proposed to this sub-committee of the board of directors in its capacity as corporate trustee of the QVH charity.

35. However, it is proposed that the name of the committee might be changed to better reflect the charity's revised name and avoid misconceptions that it has only advisory functions.

36. The board of directors is asked to **APPROVE** changing the name of this committee to 'charity committee'.

Summary of next steps

37. The governance review group will meet monthly until at least three months after implementation of the full review recommendations when it will provide a final report to the board of directors.

38. The secretariat leads will begin to make diary arrangements to hold F&P meetings from June and change Q&R and board of directors meetings from October 2015.

39. The governance review group will consider new templates for agendas, minutes and standard reports for and between the various components of the governance structure.

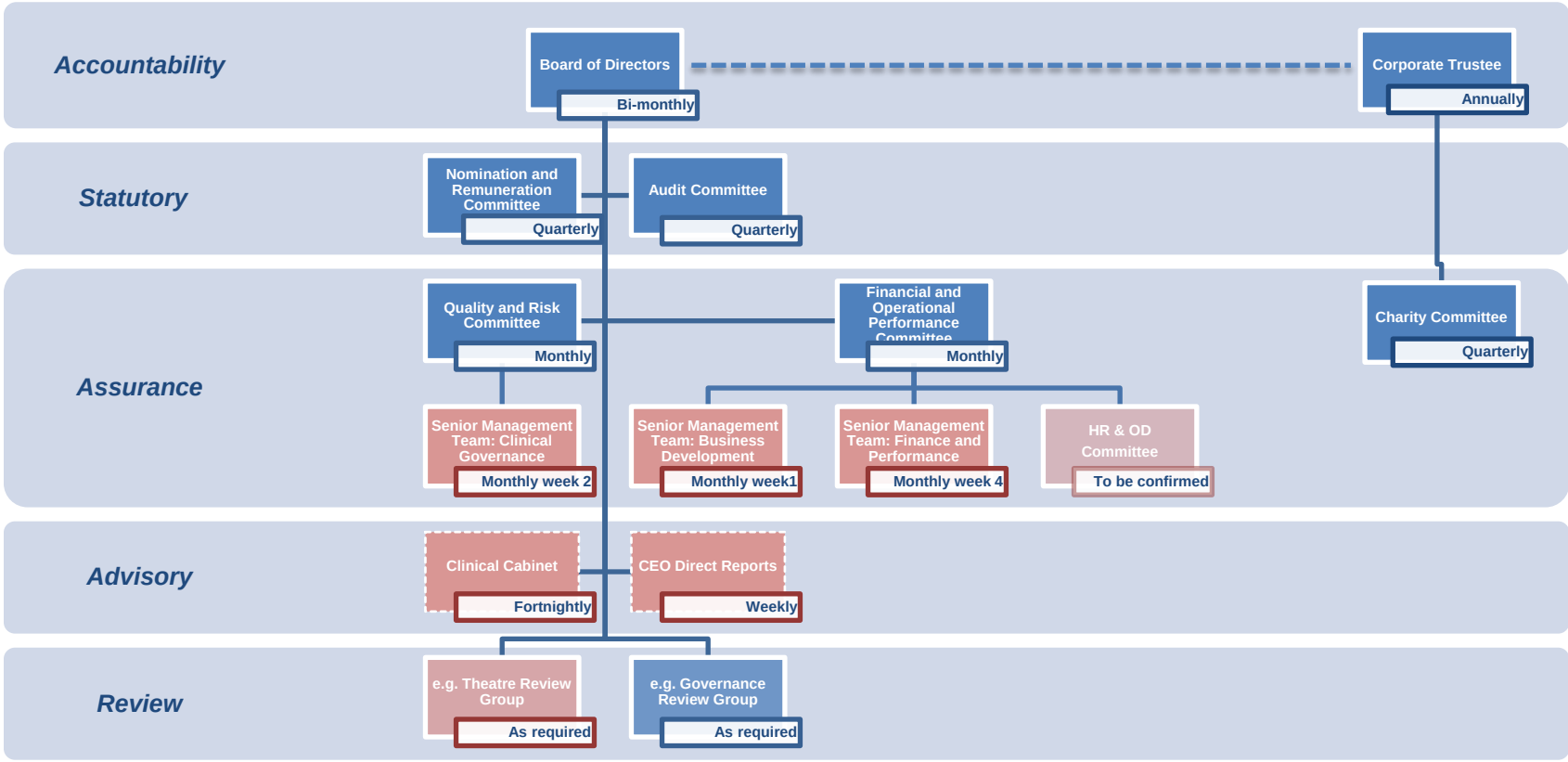
40. The governance review group will also review all relevant terms of reference.

41. The company secretary will draft new rules of engagement and role specifications to better inform governor representatives to the board and its sub-committees.

42. The next update report will be provided to the board of directors at its meeting in June 2015 and the board will be asked to provide final approval of changes arising from the governance review at its meeting in September 2015.

	Board of Directors	Audit Committee	Nomination & Remuneration Committee	Quality & Risk Committee	Financial and Operational Performance Committee	Charity Committee
Chair	B. Hobson	L. Porter (SID)	B. Hobson	G. Colwell	J. Thornton	L. Porter
NED members	G. Colwell I. Playford L. Porter J. Thornton	G. Colwell J. Thornton	G. Colwell I. Playford L. Porter J. Thornton	L. Porter	B. Hobson I. Playford	B. Hobson
ED members	Chief Executive Medical Director Director of Finance Director of Nursing	-	Chief Executive Medical Director	Chief Executive Medical Director Director of Finance Director of Nursing	Chief Executive Director of Finance Director of Nursing	Director of Finance Medical Director
Other board attendees	Director of Operations Director of HR	Chief Executive Director of Finance Director of Nursing	Director of HR	Director of Operations Director of HR	Director of Operations Director of HR	-
Governor representative	Brian Goode	None – statutory committee	None – statutory committee	Tony Martin	Chris Orman (to September 2015)	Brian Beesley (public) Shona Smith (staff)
Secretariat	Company Secretary and Deputy Company Secretary	Deputy Company Secretary	Company Secretary	Executive Assistant to the Director of Nursing	Executive Assistant to the Director of Finance	Charity Coordinator
Meeting frequency	Monthly, alternating formal and seminar/ away-day	Quarterly	Quarterly	Monthly	Monthly	Quarterly
Time	1 day per month, 11 months per year	½ day per quarter	¼ day per quarter	¼ day per month	¼ day per month	¼ day per quarter

Board and executive governance structure



Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th April 2015
Reference number:	99-15
Report from:	Jo Thomas, Director of Nursing
Author:	Alison Vizulis, Head of Risk
Report date:	22nd April 2015
Appendices:	Corporate Risk Register

Corporate Risk Register

Key issues

1. The trusts top two risks are, risk of;
   - failing to maintain continuous Estates services due to staff shortages e.g. sickness and recruitment.
   - impact on the Trusts decontamination services due to relocation of core surgical services at Synergy healthcare.

2. One new risk was rated as a 12 - Failure to meet the Trusts Medical Education Strategy.

3. No risks were closed.

4. Changed risk score (1 identified) to reflect action taken to increase current controls to reduce risk of adverse patient outcome as a result of the relocation of core surgical services at Synergy healthcare.

5. The corporate risk register was reviewed at the monthly Clinical Governance Group and Clinical Cabinet in March.

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 by owners.
2. No specific group/individual with a protected characteristic are affected issues 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 Monitor.

Action required

4. Continuous review of existing risks and identification of new or altering risks through existing processes.

Link to Key Strategic Objectives (delete those not applicable)

- 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 trusts KSO's.

Implications for BAF or Corporate Risk Register

6. Significant corporate risks have been cross referenced with the Trusts 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 our CQC authorisation and does not indicate that the Trust is not:
   - Safe
   - Effective
   - Caring
   - Well led
   - Responsive

8. The attached risk register does not impact on our Monitor governance risk rating or our continuity of service risk rating.

Recommendation

9. The Board is recommended to note the contents of the report

Clinical Cabinet and Trust Board
Summary of Risk Register Overview (Risks scoring 12 and above) - March 2015
Report excludes all Board Assurance Framework risks

February 2015 data (01/03/2015 – 31/03/2015)

For the period of 01/03/2015 – 31/03/2015 there were 41 open risks scoring 12 and above.

The Trusts top risks are given below (these were reviewed in March 2015):

- Estates services - Risk ID 670 - Failure to maintain estates service due to continued staff shortages (Score 15)
- Decontamination provider relocation - Risk ID 756 - Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilisation unit (Score 12)*

**It is proposed to continue monitoring of this risk for a further month in this section of the risk summary, and then de-escalate if appropriate. This risk will then be monitored routinely within the standardised risk reporting process unless it is identified as featuring within the Trusts top risks.*

New Risks added between 01/03/2015 and 31/03/2015 – One new risk was added scoring 12 and above during January 2015.

Risk register	Risk Score (C/L)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
Corp	3x4=12	789	Failure to meet Trusts Medical Education Strategy	Part of March 2015 BAF review with Medical Director

Risks Closed between 01/03/2015 and 31/03/2015 – No risks were closed scoring 12 and above during March 2015.

Changes to Risk Scores for March 2015 – One risk scoring 12 or above was given a reduction in risk score:

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
Corp	756	Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilisation unit. Possible delays/cancelations to patient care Damage to QVH reputation Financial impact	3x5=15	3x4=12 ↓	Reflects quarterly Synergy /QVH contract review meetings and progress	TUG – March 2015

Committee Key:

- TB – Trust Board
- AC – Audit Committee
- Q&RC – Quality and Risk Committee
- MDC – Medical Devices Committee
- PDC - Patient Documentation Committee
- HNE – Head, Neck & Eye Clinical Directorate
- TUG – Theatre User Group
- CSS – Clinical Support Services Committee

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
602	10/02/2013	Business continuity risk to the organisation due to failure of IT network infrastructure	1: Inability for the organisation to function and provide services 2: Delay/inability to provide patient care 3: Financial loss and reputational damage	1: Failure of organisational IT network infrastructure 2: Lack of access to data/patient information i.e PACs, Clinical and business systems. 3: Lack of immediate replacement/back-up hardware/system	1: Available support from an external company to repair if failure occurs. 2: Limited support available on-site 3. A full network review has been carried out and awaiting budget approval. Funding approved for new infrastructure - Budget approved	Dominic Tkaczyk	Nasir Rafiq	Information Governance	12	8	Looking to procure new network (by 31/03/2016) IT Capital bids programme for 2014/15 monitored at Information Management and Governance Committee IT annual plan for 2014/15 in place to monitor progress on IT renewal Purchase and install 2nd core switch which is connected to all edges and other core switch New equipment to be rolled out within 12 months covered by life time warranties	03/02/2015
604	26/03/2013	Breach of information security due to use of unsecure email accounts to transfer person identifiable data (patient and staff)	1: Breach of data protection act 2: Loss/accidental disclosure of patient identifiable data 3: Reputational damage to the organisation 4: Information Commissioner's Office (ICO) investigation and fines 5: Complaints and litigation	1: Failure to follow Trust policy, legislation and confidentiality 2: Lack of responsibility from staff to adhere to IG standards 3: Potential for private email accounts to be subject to hacking 4. Emails containing patient identifiable data sent to non secure address	1: Mandatory information governance training available for all staff and compliance rates increased. 2: Datix incident reporting and investigation procedure in place. 3: Trust information governance manager to oversee and advise regarding information governance standards. 4: The following solutions are in place for accessing and transferring information securely. 4.1 NHS mail 4.2 Good e-mail app 4.3 Remote access 4.5 encrypted memory sticks 5 IT & IG lead to review new security restrictions (soft ware applications) 6. Compatibility review in preparation for Windows 7	Dominic Tkaczyk	Nasir Rafiq	Information Governance	12	6	Monitoring of compliance with IG Toolkit Implement data leakage prevention software Data test to be completed using Data leakage prevention software by 31/03/2015 Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	02/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
159	29/11/2006	Ability to operationally meet 18 week target for all directorates	Failure to meet referral to treatment time of 18 weeks (RTT18)for a second month could result in reduced Monitor rating and a financial loss of 1.2 million. This could be for the trust aggregate failing to meet target which could be more than two specialties failing in one month.	1. Failure to update booking system on changes during pathway - administration errors 2. Failure to update system on patients declining treatment dates 3. Increased number of patients requiring treatment 4. Inadequate number of surgeons or Consultant absence 5. Lack of theatre space (capacity) 6. Poor validation of data.	1. RTT18 PTL established and now circulated daily. 2. Weekly escalation process now established via clinical specialties managers, OPG meeting twice a week to ensure all capacity is fully utilised. 3. 18 week steering group, each specialty highlighting capacity issues in issues log. 4. RTT 18 action plan being reviewed at steering group. 5. Additional theatre lists provided on Saturdays 5. RTT18 clinical outcome recorded on PAS 6. Additional data analyst post to provide cover for DH returns. 7. Clinical outcome forms revised for each specialty. 8. Develop reports to monitor specialty performance, planned w/l with expected TCI, backlog and open pathways monthly. 9. Validation of PTL lists weekly including admitted, non admitted and open pathways. 10. Amended policy incorporates new guidance re planned cases. 11. Training and guidance issued. 12. Monthly review of planned cases without date for attendance at QVH. 13. Develop early warning systems to track increased demand and mismatch with future capacity 14. Proactively discuss W/L each week at OPG for patients 10 weeks plus who do not have TCI date to avoid breach in each speciality 15. Review and validate all pending TCI's for Apr, May, June to ensure patients booked within 18 weeks 16. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably 17. Introduce new LA DC facility by July to increase capacity in main theatres for more complex work	Dominic Tkaczyk	Jane Morris	Compliance (Targets / Assessments / Standards)	12	8	Centralise all referrals through one access point - Completed Plans and agreements in place until the end of November 2014 to enable compliance from December 2014 Restructure of appointments and admissions teams to achieve consistent Trust wide approach to management of elective pathway bookings Training and guidance to be issued to all relevant staff - Completed Review to take place in January 2011. - Completed 3. Ensure all Planned cases have estimated TCI's when placed on list - Ongoing Implement daily ptl - completed Ensure all future TCI's are validated in relation to 18 weeks- completed 6. Introduce a new automated 6 month administrative WL validation - Completed Agree business case for increasing capacity in sleep studies - completed Explore locum for Ocular plastics - completed 1. Expediate Medway hub 2. Develop matrix of planned cases seen at QVH - Completed Policy being redrafted, to launch May, with associated training package. - completed Clinic outcome forms being revised within specialities - Completed 5. Clinical pathways for top 3 procedures within specialities with clock stops being devised with CD's - agreed, being put into	06/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
474	10/03/2011	Cancer target breaches	Breach in any quarter for an Oncology treatment targets for 31 and 62 day pathways resulting in delay to patient care and reduction in Monitor rating. This could also result in financial loss to Trust.	1.Administration Staff for plastics and maxfacs failing to follow alerts on potential breaches identified by cancer data coordinator. 2.Lack of theatre capacity. 3. Lack of outpatient capacity. 4. Delays in recieving referals from other trusts. 5. Patient choice to wait longer for surgery however the clock continues to run. Small numbers at QVH cause this to be an issue.	1 - Cancer Data Co-coordinator issues reviewed monthly by Directorate Manager 2 - Patient tracking list for the specialties in place and produced twice a week. 3 - Cancer Data Co-coordinator communicates with staff on potential breaches. 4 - Secretaries respond to requests to bring patients forward wherever possible. 5 - Off site team leader in place to contribute and reconcile breaches. 6 - Appointments team allocate 2 week wait referrals to avoid delay. 7 - All breaches reviewed weekly by Directorate Manager. 8 - Project team established to integrate the cancer pathway. 9 - Action plan for skin cancer performance devised and implemented including process mapping sessions 10 - Cancer Outcomes Dataset report reviewed on a monthly basis by cancer team	Dominic Tkaczyk	Jane Morris	Compliance (Targets / Assessments / Standards)	12	8	Introduce and use cancer network databases within QVH for all MDT's.- Completed Streamline current referral pathwaysfor all types of cancer Establish Cancer Group and Cancer Data Management/MDT team for QVH. Proposals in development - Completed Setting up of 2 week skin cancer clinic - Completed Setting up of central referral management - No longer required Implementation of infoflex and Somerset cancer databases on site - completed Introduce same day see and do LOPA slots - Completed Expand use of infoflex system across Trust Establish business continuity cover in the absence of the data co-ordinator - completed - restructure being agreed and implemented from 22nd April - Completed Create local access policy for the Trust- completed Establish project team to integrate the cancer pathway- Completed Process mapping of skin cancer pathway and cancer data - Completed Action plan specifically focused on skin cancer performance to be devised and implemented including process mapping sessions. - Completed Set up QVH cancer improvement steering group - completed Review COSD data completeness and agree	06/03/2015
733	12/08/2014	restricted access to blood fridge/cross infection from staff movement	due to the recent restrictive access status of the burns unit there is a potential for delay for both obtaining units of blood and blood gas analysis	delays to treatment for patient burns staff diverted from patient care to manage theatre requests cross infection between burns and theatres	controlled access by burns staff who retrieve blood units and process blood gas cost and introduce a seperate blood fridge and blood gas anaylsis machine for theatres	Dr Ken Sim	Jo Davis	Patient Safety	12	2	Idneitifation of funding for additional blood fridge in Theatres Review of Blood Fridge arrangements to be undertaken-to include exploration of the purchase of an additional fridge	09/03/2015
779	21/01/2015	Inadequate emergency alarm system (sirens and lights) to direct staff to where the emergencies are occurring.	Inadequate emergency alarm system (sirens and lights) in place to direct staff to where the emergencies are occurring.		Ward grade system currently in place (incorrect level of alert given). Staff attend as required (where available) Admission/Discharge Nurses test the alarms every day at 08:00hrs	Dr Ken Sim	Jo Davis	Patient Safety	12	8	Full Estates review and replacement of system Emergency alert drill to be developed and put in place Estates Dept reviewed current system - Completed - increased level of sirens (slightly)	09/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
629	19/07/2013	Inadequate health records storage	1. Staff injury from increased moving and handling for staff 2. Staff injury from slip,trip / fall over notes/boxes 3. Lack of storage space for paper records for Trust 4. Delay to obtain health record 5. Lack on budgetary allocation for ongoing storage costs from mid June 2014	1. Kings House near capacity 2. Delay in procurement of electronic patient record system 3. Failure for departments to follow archiving and storage proccess 4. Destruction of records less than 10% of new records created 5. Departments following different storage methods 6. Existihg tender for transport and storage requires renewal	1. Health records policy includes process for managing records off site 2. Bags used for transporting notes changed to fit within boxes therefore reducing handling 3. Regular destruction of notes in place. 4. Increased racking in place in Commonwealth house 5. Missing notes procedure in place Paper to Clinical Cabinet with costs of more packaging and moving records to free additional space 6. Regular transport runs between Kings House and QVH 7. Tracking system for notes in place 8. Outsourcing scanning of 10000 sets of notes to increase capacity completed 9. Tender renewal process underway. 10.Regular meetings between Head of Procurement, Head of RM, HR Manager and Matron (commenced 09/04/2014)to monitor progress 11. Action plan developed and monitored at above meetings	Jane Morris	Sally Joselyn	Patient Safety	12	3	new group in place to monitor the progress of finding suitable a location and renewal of contract Paper to April Clinical Cabinet summarising the costs associated with packaging,moving and storage of medical records as space limited to mid June 2014 Transport tender renewal to include transport and storage of medical records (est costs of transport 2.5-3k) Continue collaborative procurement for EDN Review in 3 months whether further permanent notes need to be scanned to release more space Review on site storage and archive to ensure space utlilised appropriately Develop report showing audits and monitoring of compliance to discuss at Patient Documentation Committee Implement 5 S's lean approach to keeping Health records tidy and that trip hazards are kept to a minimum Provide training sessions for staff to raise awareness of correct filing system - Completed Review staffing on a regular basis to ensure all processing kept up to date including destruction as per policy	03/02/2015
639	10/10/2013	Support and access from supplier to ORSOS will cease 03/16 leaving Trust without electronic theatre record	Unable to record data for operations. - impact on scheduling - effect on live theatre management - ORSOS reporting including management reports.	Source company withdrawn support.	Discussed at ICAG monthly and theatre user group. Paper back up	Jane Morris	Mr Mark Savage	Information Governance	12	4	Agree on the preferred solution before sourcing the new supplier Source the new supplier Demo of ORSOS completed in Sept 2014 Specification being drawn up to procure new/replacement system ICAG reviewing progress of replacement each month; also Theatre User Group	03/02/2015
742	12/09/2014	Limited ability to disseminate information on criminal sanctions	Non-Compliance to NHS Protect Security Standards due to ilimited ability to disseminate information on successful convictions due to infrequent occurrences	No criminal sanctions brought to date to demnstrate compliance	Head of Risk added reference to disseminating information on successful convictions to the Draft Comms Strategy in Sept 2014. Use of newletters e.g. Connect, and new Risk newsletter. Induction, mandatory training and other traingin sessions Dissemination of LSMS leaflets and information	Jo Thomas	Alison Vizulis	Compliance (Targets / Assessments / Standards)	12	12	NHS Protect approached for advice on utilising a historic case to demonstrate compliance with processes - Completed Discussed with the LSMS - Completed Identification of a local case/incident that may be relevant - completed	08/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
743	09/09/2014	Reputational damage to the Trust as a result of the occurrence of Never Events	Reputation damage to the Trust as a result of the occurrence of Never Events		Risk Management and Incident Reporting Policy Completion of RCAs Never Event reporting and notification process that includes internal and external notifications Internal incident reviews and analysis undertaken via meetings/committees etc Monitoring via dashboards External publishing of Never Event occurrence via NHS England	Jo Thomas	Alison Vizulis	Compliance (Targets / Assessments / Standards)	12	8	Revisions scheduled for CQC regulations in 2015 Governance reporting review underway	08/12/2014
623	19/07/2013	Failure to meet CQUIN requirements for 2014/15 therefore incurring a loss of CQUIN funds £1.4M	1. Financial penalty and loss of CQUIN funds	1. Failure to meet CQUIN requirements set for 2013/14	1. VTE risk assessments within each patient drug chart - VTE policy in place 2.Dementia - process in place to identify trauma patients >75 years of age.Clinical lead identified. 3. Dementia training in place 4. Patient experience group in place reviewing and ensuring actions implemented and linked to OPD experience. Family and friends test score. 4.NHS safety thermometer completion is linked within deputy director of nursing job role and harm score reported to the Board. 5. Organisational performance against CQUIN measures are monitored and reported to Trust board on a monthly basis. 6. High impact intervention CQUINS reports produced each quarter and reviewed by Q&R Committee.	Jo Thomas	Jo Thomas	Compliance (Targets / Assessments / Standards)	12	3	Risk to be updated for 2014/15 CQUINS and 2014/15 BAF Ongoing audit reports to demonstrate CQUIN compliance e.g. WHO checklist and MaPSaF Provide Q3 update to quality and Risk Committee and Board	08/12/2014
756	02/12/2014	potential impact on core service delivery	Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilsation unit. Possible delays/cancelations to patient care Damage to QVH reputation Financial impact	Trustwide disruption to the processing of sterile equipment during the relocation of the sterile service facility	Contingency plans in service contract to provide an on going service Quarterly Synergy contract meetings in place to include discussions on these areas.	Jo Thomas	Jo Davis	Finance	12	6	Peripoperative Matron to meet with the Synergy regional Operational Manager in @ 2 wks potential impact on QVH Change to risk score to reflect quarterly meetings - March 2015	01/03/2015
753	27/11/2014	Inaccurate search results for specimens	V number searches do not always highlight the results; searches required both on V number and names. Not all results on Winpath are on ICE (and vice versa).		1. Two searches carried out. 2. Staff reminded to accurately complete request forms.	Jo Thomas	Emma Kerr	Compliance (Targets / Assessments / Standards)	12	2	BSUH to devise new electronic reporting system for ICNs - ongoing issue	30/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
27	07/01/2005	Infection risk to individual patients due to poor systems and practice of control	Increased risk of patient(s) contracting a HCAI such as MRSA, C.diff, MRAB or Norovirus.	1. Unknown infection to patients admitted to hospital. 2. Infected patients not isolated on admission. 3. Poor hand hygiene / environmental cleaning.	1. Mandatory training of all staff and awareness raising sessions. 2. Implementation of trust policies - isolation, screening, treatment including root cause analysis for all C Diff / MSSA/Ecoli bacteraemia cases and PIR review for all MRSA bacteraemia. 3. Routine audit of practice, and monthly PLACE inspections. 4. Cleaning strategy implemented including deep clean arrangements 5. Monitoring of trajectory targets for MRSA bacteraemia, MSSA, E Coli and C.diff. 6. Monthly monitoring and Board reports from DIPC to inform organisation of acquisition of infection 7. Failure to achieve 90% or more in any staff group for hand hygiene leads to action plan and matron auditing. 8. Decant arrangements include wider involvement of matrons regarding single room use, with advice from IPACT. 9. Specific interventions depends on risk identified i.e. staff undertake an MRSA protocol treatment 10: Training completed for IPAC Team re: access to BSUH IT System. Awaiting ICNet. 11. Review of investigation processes completed 12. Follow up actions from current infections completed 13. Infection control nurses have direct IT access to BSUH Microbiology system 14. Antibiotic policy reviewed to ensure best practice use and reduce risk of C.diff 15. Departmental training provided as and when required	Jo Thomas	Emma Kerr	Patient Safety	12	6	Awaiting ICNet computer system access 5. Provide direct IT access to BSUH Microbiology system - complete 3. Follow up actions from current infections - Completed 4. Review of anti-biotic policy to ensure best practice use and reduce risk of C.diff - completed 2. Review of investigation process - Completed 7. Complete actions from RCA/PIR investigations as required. Complete actions from MRAB SI report 6. Monitor microbiologist attendance on site to ensure antibiotic prescribing reviewed	30/03/2015
513	04/01/2012	Potential failure to act on infection concerns due to unavailability of Microbiologist	1. Delay in updating policies 2. Reduced patient care due to review not conducted by microbiologist on site 3. Delay in reporting on specimens 4. Reduced attendance on site by Microbiologist	1. Problems recruiting consultants at BSUH 2. No regular microbiology consultant cover on-site 3. Failure for BSUH to fulfil contract requirements	1.Daily lab sheet of positive specimen results however, not all positive specimen are listed on this sheet. 2. Presence of microbiologist during week back to 2 days/wk, remainder of cover provided via telephone (24/7) 3. Trust policies and procedures. 4. Staff mandatory training 5. Access to ICE system winpath for ICNs to review organism resistances 6. Daily visits to wards by ICNs.	Jo Thomas	Emma Kerr	Patient Safety	12	6	QVH to review BSUH contract to ensure appropriate microbiolgy service and consultant cover is available on site - BSUH issued with performance notice regarding the microbiology service provided to the QVH. Identify BSUH ability to deliver increased on site attendance Waiting feedback from BSUH	30/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
648	06/11/2013	Cross infection resulting in an outbreak and closure of services	1. Infection to patients causing harm and delay in recovery. 2. Closure of department resulting in loss of activity 3. Potential for this bacteria to spread to other patients 4. Following deep clean, decant area, Rycroft has again been used for unauthorised storage.	1.Spread of Multi Resistant Infections to burns patients 2.Unable to contain bacteria/outbreak	- Hand hygiene (failure to achieve 90% compliance in any staff group leads to action plan/ matron audit) - Robust implementation of gowning procedure - Strict universal precautions - Review of patients requiring admission on individual basis with consultant microbiologist and clinician - Regular outbreak review meetings to discuss other actions required. - Monitoring via Datix reporting - Internal inspections undertaken e.g. PLACE inspections and Hotel Services cleaning audits - Reporting of outbreaks as required e.g. Health Protection Agency, CCG, PHE. - Mandatory training of all staff and awareness raising sessions. - Implementation of trust policies.	Jo Thomas	Emma Kerr	Patient Safety	12	4	Dept training as required Abx review by microbiologist Complete RCA / PIR / outbreak report / SUI Specific interventions depend on risk identified. Rycroft to be prepared ass possible decant area (for transfer in, not enough equipment to be set up as additional ward)	30/03/2015
728	29/07/2014	Risk of non-compliance with best practice and regulatory requirements at spoke sites	Risk of compliance with regulatory and best practice requirements e.g. CQC, HSE, CiP assessments and audit etc at spoke sites offering QVH services		Annual H&S assessments programme (monitored by quarterly H&SC) Annual infection control/decontamination reviews CQC/HSE notifications of queries relating to service provision	Jo Thomas	Alison Vizulis	Patient Safety	12	8	Annual CiP assessments to continue at spoke sites revised programme of infection control and decontamination annual assessments in pklace for 2015/16 Ongoing monitoring via KPIs Feedback to DoNs at sites	07/04/2015
727	21/07/2014	Limited on site Physician cover and non compliance with NCEPOD standards	Limited on site Physician cover and non compliance with NCEPOD standards		Cover arrangements managed by Consultant Plastic Surgeon Onsite cover available on Monday, Wednesday and Thursdays (Part BSUH, part agency locum) Telephone cover provided as part of SLA with Brighton. Geriatrics Clinic covered by Locum Geriatrician from SASH Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Mr Asit Khandwala	Paul Gable	Patient Safety	12	6	Explore GPSI option and cover from London Trusts SLA proposal from East Surrey Hospital Arrangements agreed in principal with ESH Meeting between QVH Medical Director and Head of Geriatrics at ESH	09/12/2014
748	03/10/2014	Field safety notice FSN83000189 patient data may not be updated when exporting to 3rd party devices using the auto export featur	Patient identifiable information on x-rays may not be updated in the VNA (vendor neutral archive. Studies pulled back from the VNA or pushed into a new PACS will potentially contain incorrect patient demographics.	Philips Healthcare released an FSN regarding their implementation of a PACS/Ris solution dated 27/07/2014 stating that when a study requires patient informaion be updated the updated informaion is not always passed to the VNA. There is no fix for for our current version of PACS but there is a solution in the next release of software (Kona). However the release of Kona has been delayed due to desktop intergration issues.	We await the following from Philips: -An explanation as to what workflow causes this miss match in patient data between PACS and VNA. -A description of a workflow to reduce/remove the risk of miss- matched patient data between the PACS and VNA -Implement Kona across Surrey and Sussex to correct this error -Identify studies that have miss-matched data -Produce and implement a fix for the identified miss-matached data	Paul Gable	Paul Gable	Information Governance	12	6	Range of information awaited from Phillips (as per controls column)	03/02/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
670	17/12/2013	Failure to maintain estates service due to continued staff shortages.	Failure to maintain estates service due to continued staff shortages. Continued staff shortages due to un planned absences and long term vacancies which we have been unable to find suitable candidates and annual leave entitlement, has put pressure on the service.	•Unable to maintain a full on call cover 24/7 •Increased stress in the work place leading to potential sickness absences. •Insufficient staff to cover annual leave. •Potential breeches in compliance work being carried out. •Loss of reputation. •Loss of business.	•Recruitment to temporary staff authorised by CEO •Staff volunteering for additional on call duties. •Use of external contractors and agency staff to cover staff shortfalls e.g. lighting, storm damage and electrical failure Use of external contractors for March 2014 to provide additional cover. 24/02/2015: Review recommended: * Upskilling existing workforce * Undertaking more works in-house * Expand Workforce	PRODIR	John Trinick	Estates Infrastructure & Environment	15	6	24/02/2015: HoE to explore the possibilities of a Restructure "HoE to explore the possibilities of a Restructure - Draft paper to be prepared Up-skilling of existing staff (Currently B3s On-Call), Undertake more works in-house (Reduce costs of outsourcing), Expand Workforce (funded by above) Estates review action completed June 2014-Company commissioned to undertake a review of the Estates Service - Draft Report due end of September 2014	31/03/2015
689	25/04/2014	Potential to adversely affect statutory and mandatory training due to increasing number of vacancies (3mths and over)	Risk to patient safety if staff are not up to date with their statutory and mandatory training.	Staff would be unaware of latest updates relating to key clinical and non-clinical areas including infection control, M&H, risk management and governance arrangements.	1. Statutory and mandatory training reviewed monthly and reported to Board. 2. Departmental feedback from above. 3. Utilisation of bank and agency staff to release others to attend training. 4. Risk monitored as part of BAF risk 766 & 749	Richard Tyler	Graeme Armitage	Compliance (Targets / Assessments / Standards)	12	6	Training frequency under review to ensure match with NHS education passport Continue with utilisation of agency/bank staff to release others for training Review being completed of training matrix and adjustment of profiles as part of KSF skills passport Implementation of more elearning options Overseas recruitment initiative being taken forward Erostering review being undertaken to utilise staff efficiency/availability	04/03/2015
732	11/08/2014	Use of Long Term Model Box Store for Maxfacs	Identification of alternative storage for Maxillofacial models on a long term basis		Existing model storage can be accessed by authorised staff using appropriate PPE Risk assessment in place for use of existing location Email sent to owners of materials found in area asking for clearance to enable resiting of model boxes	Stephanie Joice	Alison Vizulis	Staff Safety	12	6	HoR to meet with new Records Manager (SJ) and Matron for Elective Services to agree action plan for documentation belonging to Department that is retained there to be reviewed as per retention guidelines	08/12/2014
745	09/09/2014	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources From Risk ID 744 (Closed 02/12/2014 to combine with Risk ID 745): Recent vacancy of Head of Radiology and RPS have led to there being a vacant RPS post within Radiology.		Provision of an additional day included in the BSUH Radiology SLA. Radiation Protection Committee reporting and governance structures and reporting Positive outcome of 2014 IRMER inspection From Risk ID 744 (Closed 02/12/2014 to combine with Risk ID 745): Nominated RPC in place Extended SLA with MTW physics for on-site presence and support on half day a month RPS role is written into the job description of the new band 6 role. Until this person is in post the service manager, operational lead and existing band 6 will share this role. Physics to provide a course for these staff members.	Steve Fenlon	Kirsty Humphry	Patient Safety	12	8	New staff member commenced in post April 2015	10/01/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
627	19/07/2013	Failure to embed safer surgery checklist process due to lack of engagement	1. Patient harm due to incorrect procedure 2. Lititigation 3. damage to reputation	1. Key safety checks not undertaken for each individual patient such as correct patient, operation site and side and procedure. 2, Not all staff engaged in process so vital members could be missing	1. 1st stage consent by experienced surgeon in out patients. 2. 2nd stage consent on admission (check with patient) 3. Surgical safety checklist-sign in and time out stages. 4. Patient marking policy changed, presentations to all medical staff and directorates by MD. 5. Consent working group set up to improve consent before day of operation. 6. Pre list brief in place and effective prior to full list starting 7. Safer surgery checklist in place - (WHO Checklist) 8. Information and awareness sent to all theatre staff and clinicians 9. Audit of checklist quality in place 10. operating surgeon is now responsible for timeout 11. training in place for all staff 12. patient safety forum in place to review practice. 13. Addition of WHO checklist compliance as a 2014/15 CQUIN - Q1 & Q" audit reports submitted. 14. WHO checklist audit developed for 2014/15 CQUIN and reporting commenced 15. WHO checklist audits x 2 reviewed at monthly Theatre User Group and Patient Safety Forum.	Steve Fenlon	Jo Davis	Patient Safety	12	4	Ongoing monitoring at Patients Safety Forum and reporting as an indicator on the Quality Metrics dashboard - Completed Audit tool amended following pilot to improve robustness - Completed WHO CQUIN audit reports fro Q3 & Q4 to be submitted Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting - Completed and ongoing	30/01/2015
711	30/05/2014	Reliability of Theatre Doors	Defective doors to theatre areas are affecting entry for both staff and patients - Please note this affects ALL automatic doors	Musculoskeletal injury to staff Restricts high levels of privacy and dignity for patients Inconsistency across a range of Theatre doors could lead to staff applying inappropraite pressure when opening doors	Risk Assessment completed and Risk added to the Theatre Risk Register on staff musculoskeletal injury. Two year "Willmott Dixon" agreement for repair of new build includes Theatre Doors Regular meetings to monitor situation takingplace Doors currently being reset by Estates and Theatre staff when faults occur Willmott Dixon visit on 5th and 6th July to fully service all doors Work schedule to upgrqde the doors to correct standard has been agreed with Wilmott Dixon and a financial framework has also been agreed. Timetable to be agreed. Works to commence 21 March 2015 by Gilgen Doors.	Steve Fenlon	John Trinick	Staff Safety	12	6	Affected staff to use alternative access to Theatres one Theatre door to be replaced to "test" if issue could be resolved by replacing the door - Completed Ongoing updates at Theatre User Group Meeting regarding this risk Willmott Dixon agreed to replace doors - Date to be agreed Work schedule to upgrqde the doors to correct standard has been agreed with Wilmott Dixon and a financial framework has also been agreed. Timetable to be agreed. Trial of replacement door-motors on doors on Theatre 1 and Theatre 4 Increased follow-up with Estates & Willmott Dixon Notices to be put up in Theatres to alert staff of defective doors - Completed Staff utilised to retain privacy and dignity - in affecetd areas - Completed Raise staff awareness at team meetings - completed	09/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
750	12/12/2014	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national gu	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national guidance includes additional recruitment to post of Head & Neck Oncology Consultant.	Single consultant surgeon operating	Clinical audits undertaken on key outcome data on a monthly basis Data submission to DAHNO Consultant Outcomes Publication (COP) database Local review undertaken to identify options for resolution e.g. appointment of a second surgeon and review of job planning. Major Oncology H&N cases to only be run with 2 x surgeons from Jan 2015	Steve Fenlon	Nicola Reeves	Patient Safety	12	8	Actions identified from completed review Major Oncology H&N cases to only be run with 2 x surgeons from Jan 2015 - Completed Major cases moved to Monday for joint sessions	10/03/2015
681	13/02/2014	Failure of cleanroom air handling unit due to wear and tear and age of unit - ongoing issues	Repeated failure of the cleanroom air handling unit is occuring due to the age of the plant equipment leading to cancelled internal and external grafts, loss of income and harm to reputation (unit was installed in 2004 and it has a life expectancy of 10 years)	cancelled internal and external grafts, loss of income and harm to reputation	Ad hoc repairs. Unit on quarterly maintenance contract (as recommended) Company last attended site on 13/02/2014 to fix the bearings Reporting of breakdowns on Datix (on 13/02/2014 ID 11705, On 28/03/2014 ID11878, and on 03/06/2014 ID12119).	Steve Fenlon	Nigel Jordan	Estates Infrastructure & Environment	12	8	28/10/2014: Head of Estates to recommend to Finance Director that a 'reduced scheme' be agreed to the value of £30K as per Clinical Scientists submission. Case to the Estates & Facilitaties Steering Group on 08/09/2014 with quotes for decision 24/02/2015: Orders Raised to enable repair to existing system as per Business Plan by Eyebank Manager and Interim General Manager - Clinical Support Services (works to commence subject to agreement with Eyebank Manager) 24/02/2015: Consideration for relocation of Cleanroom and combining with Hispopatologay proposals Business Case/options appraisal being drafted by General Manager for 3 Options	31/03/2015
786	23/02/2015	Impact arising from the vacancy for the role of Medical Devices Liaison Officer	Impact of the vacancy for the role of Medical Devices Liaison Officer. Remit being covered by the remainder of the Risk Management Department. Potential impact upon medical device purchase applications and recording of medical device training/competencies.		1. Risk Management and Procurement Depts covering remit of role on an interim basis. 2. No change to CAS alert receipt and dissemination procedures 3. MHRA notified of vacancy and curent arrangements	Steve Fenlon	Alison Vizulis	Patient Safety	12	8	Assistance provided by redeployed staff Bank staff member recuited to assist on an interim basis- Completed Areas identified for new EME contract provider to undertake	07/04/2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 April 2015
Agenda item reference no:	100-15
Author:	Kathleen Dalby, Company Secretary on behalf of the Governance Review Group
Date of report:	22 April 2015

Annual declarations by directors

Declarations of interest

1. Executive and non-executive directors of the trust are required by its constitution to make annual declarations of interest for inclusion in the register of interests maintained by the company secretary and made available for inspection upon request.

2. Declarations are sought from directors at the beginning of each financial year or on appointment to the board of directors using a standard pro-forma. A signed copy of the completed pro-forma is kept on file and the details from it are entered into the register.

3. All directors are required to complete the form including those who will make a nil return.

4. Directors' declarations of interest for the 2015/16 register are now due.

Fit and proper person test

5. In 2014, in response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, a new regulation was imposed on health service bodies.

6. Known as the "fit and proper person test", the regulation aims to ensure that all board level appointments of NHS foundation trusts, NHS trusts and special health authorities are fit and proper individuals to carry out their roles.

7. The duty extends to executive directors, non-executive directors, interims and associate positions regardless of voting rights. It does not apply to governors except where a governor has a place on the board.

8. It is the ultimate responsibility of the chair of the NHS body to discharge the requirement placed on the provider to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

9. As part of its new inspection approach, the Care Quality Commission (CQC) will check and monitor the extent to which a provider meets the fit and proper person regulation.

10. Following the introduction of the regulation, QVH directors were asked to confirm that none of the "unfit" criteria applied to them. All directors in post at that time confirmed and this was reported formally to the board of directors in December 2014.

11. The confirmation process was carried out by email and allowed for a degree of informality and variation of the way in which confirmation was expressed.

Recommendation

12. In anticipation of the trust's next inspection by the CQC, and for the board to be assured of good governance processes with regard to declarations, it is recommended that:

    - The trust's current declaration of interests pro-forma for directors is expanded to incorporate a more formal fit and proper person declaration.

      An amended pro-forma is included at appendix A and the board is asked to **APPROVE** it for immediate use by all directors.

    - The Company Secretary and Director of HR/OD work together to develop an integrated procedural document that describes the steps the trust takes to assure itself that its directors are fit and proper persons.

      This document will form part of the evidence required by the CQC to demonstrate that the trust meets the requirements of regulation 5: fit and proper persons: directors.

      A draft of the document will be submitted to the board at its meeting in June 2015.

    - The guidance documentation for directors on making both declarations are amalgamated to better support the annual declarations process in future.

      In the meantime, directors will be asked to complete the amended pro-forma for 2015/16 with reference to the current separate guidance notes which will be re-circulated by email.

Link to key strategic objectives (KSOs)

13. Ensuring that all directors are fit and proper persons and have complied with the trust's constitution supports the delivery of all KSOs, and in particular, KSO 5 – organisational excellence.

Implications for the Board Assurance Framework or Corporate Risk Register

14. None at present or anticipated.

15. However, all declarations will be reviewed in due course by the company secretary and trust chair and any implications will be reported to the board of directors.

Regulatory impact

16. None at present or anticipated.

17. However, Monitor and the CQC require all foundation trusts to demonstrate that they are well-led. Failure to comply with the trust's constitution, regulation 5 or general good governance practice could lead to the trust being considered in breach of its authorisation as a foundation trust and/or its licence as a provider. Associated regulatory measures would follow in either case.

Queen Victoria Hospital NHS
NHS Foundation Trust

Annual declarations by directors

Declaration of interest

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 the following 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.

All declarations of interest and nil returns are kept on file by the trust and recorded in the register of interests of the director which is maintained by the company secretary and made available for inspection on request.

By completing and signing this declaration you confirm your awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust.

Relevant and material interests	**Details of interest(s)**	**Nil return**
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.		□

Fit and proper person declaration

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 this declaration you confirm your awareness of any facts or circumstances which prevent you from holding office as a director of QVH NHS Foundation Trust.

Categories of person prevented from holding office	**Applicable**	**Not applicable**
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.	□	□

Declaration

Name:

Title:

Signature:

Date:

Review and approval:

Chair	**Chief Executive**	**Company Secretary**
Name:	Name:	Name:
Signature:	Signature:	Signature:
Date:	Date:	Date:
Comments:		

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th April 2015
Reference number:	101-15
Report from:	Clinical Cabinet
Author:	Richard Tyler
Report date:	21st April 2015
Appendices:	None

Report from meetings of the Clinical Cabinet held on 16th March & 20th April 2015

Key issues and Actions

Cabinet **endorsed** the following;

1. Emergency Plan: Cabinet ratified update to the Trust Emergency Plan relating to bomb threats and suspected terrorism action.
2. Serious Untoward Incident: Cabinet signed off the root cause analysis (RCA) arising from the recent information governance incident.

Cabinet received **updates** on the following;

1. 15/16 tariff proposals
2. Monthly quality & risk report
3. Monthly operations report
4. Key Strategic Objective 1 – Outstanding Patient Experience
5. Key Strategic Objective 2 – World Class Clinical Services
6. IT Strategy

Link to Key Strategic Objectives
Links to all five strategic objectives.

Implications for BAF or Corporate Risk Register
None

Regulatory impacts
Issues reported do not have an immediate impact on either CQC or Monitor risk ratings.

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 April 2015
Reference number: 102-15
Report from: John Thornton
Committee meeting date: 18 March 2015

Report of the Chair of Audit Committee

Key issues discussed

1. Whistle blowing policy

It was confirmed that the responsibility for signing off the policy would rest with Quality and risk committee not Audit Committee. Q&R would also be responsible for regular monitoring of incidents and reporting any issues to the Board.

Audit Committee would be responsible for providing assurance that the whistle blowing 'process' was fit for purpose and working effectively as required by the Board.

2. Audit Committee Terms of Reference

The terms of reference were reviewed and amended to reflect this change of responsibility for Whistle blowing and some other minor changes were proposed.

Proposed Terms of Reference with marked changes are attached for consideration and approval.

3. External Audit

The interim Audit was well underway and everything was on track. The auditors had nothing significant to report at this stage.

The requirement for a new 'long form audit report' has been introduced this year. KPMG explained the main differences and the new requirements. These will not cause QVH any issues but KPMG will walk us carefully through the process as this is the first year.

4. Internal Audit

<u>Stock Management Arrangements</u>

An audit had been completed in Theatres and Sleep Studies departments. A positive report with full assurance. comments made that new management had significantly improved controls in this area of performance.

<u>Main Accounting Systems</u>

The annual review of controls had been completed. Some areas for improvement were identified but overall the report showed a major improvement on last year.

5. Counter Fraud

<u>Review of compliance with NHS Protect standards</u>

The Trust underwent a three day inspection in March 2014 which identified a number of major issues. A follow up assessment in December 2014 showed good progress on a number of issues but all standards relating to the FIRST case reporting system were still red. The cause of this is timing of uploading the information which must be done within ten days. It is not practical for the CF team to do this without increasing visits and costs.

The problem was acknowledged but a solution needs to be found and this would be passed to Mazars in the handover.

Corporate Credit (Procurement) Cards

A review in 2013 had identified a number of significant issues and weaknesses in systems. A follow up report had shown that four of the six main recommendations at that time had not been addressed. These were now being resolved but concerns were raised as to why these actions had not been taken by management and how they should have been tracked. It was agreed that CF actions need to be monitored alongside the actions from internal audit reviews as discussed below.

6. Monitoring of internal audit actions

The regular review of progress against agreed internal audit action plans was presented by the Finance team. Following requests at previous Audit Committees the format had been changed to provide more detail. But the Committee still did not feel that the report provided enough clarity on the accountability for these actions and the progress made.

The following was agreed:

- Responsibility for monitoring and tracking progress against agreed actions would pass to the internal audit team, who would report to audit committee.
- Responsibility for delivering on the agreed actions clearly lines with the relevant management teams. Committee considered that progress should be reviewed regularly at Senior Management meetings.
- Where appropriate executives should attend Audit Committee to review progress against the actions for which they were responsible.

7. Implications for BAF or Corporate Risk Register

There were not considered to be any implications for the BAF of Corporate Risk Register.

8. Recommendation

The Board is recommended to **NOTE** the Committee's actions and findings.

TERMS OF REFERENCE

AUDIT COMMITTEE of the Board of Directors

Purpose

The prime purpose of the Audit Committee is the scrutiny of the establishment and maintenance of an effective system of governance, risk management and internal control. This should include financial, clinical, operational and compliance controls and risk management systems. The Committee will also oversee financial performance and the actions to address any issues arising. The Committee is also responsible for maintaining an appropriate relationship with the trust's auditors.

Responsibilities

1. Governance, risk management and internal control

The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across all of the Trust's activities (both clinical and non-clinical) that support the achievement of its objectives.

a) The Committee will review the adequacy and effectiveness of:
   i. all risk and control related disclosure statements (in particular the Annual Governance Statement) together with any accompanying head of internal audit statement, external audit opinion or other appropriate independent assurances
   ~~i.~~ii. the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
   ~~i.~~iii. the process for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification

b) On behalf of the board the Committee will review the operation of, and proposed changes to, standing orders, standing financial instructions, codes and standards of conduct.

~~b)~~c) The Committee will maintain vigilance regarding the key financial, operational and strategic risks facing the business, including regular review of the board assurance framework and corporate risk register.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited in this regard. It will also seek reports and assurances from other officers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's scrutiny and use of an effective Board Assurance Framework to guide its work and the audit and assurance functions that report to it.

2. Financial reporting

The Committee will:

a) ensure that systems for financial reporting to the board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.
~~a)~~b) monitor the integrity of the financial statements, and any formal announcements relating to the trust's financial performance
~~a)~~c) review the annual report and financial statements before submission to the board, focusing particularly on:

   i. the wording in the statement of internal control and other disclosures relevant to the terms of reference of the Committee

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~~i.~~ii. changes in, and compliance with, accounting policies, practices and estimation techniques Unadjusted mis-statements in the financial statements

~~i.~~iii. significant adjustments resulting from the audit

~~i.~~iv. the letter(s) of representation

~~i.~~v. qualitative aspects of financial reporting

d) receive regular reports regarding losses, overpayments, compensation payments and tender waivers.

3. Internal audit

The Committee will ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the audit Committee and chief executive. This will be achieved by:

a) consideration of the provision, cost and quality of the internal audit service and any questions of resignation or dismissal

~~a)~~b) review and approval of the internal audit strategy, operational (risk based) plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the board assurance framework

~~a)~~c) considering the major findings of internal audit work (and the management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources

~~a)~~d) ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

~~a)~~e) an annual review of the effectiveness of internal audit

4. External audit

The Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

a) consideration of the performance of the external auditors

~~a)~~b) discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy

~~a)~~c) discussion with the external auditors of their evaluation of audit risks and assessment of the trust and associated impact on the audit fee

~~a)~~d) review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

5. Whistle blowing and counter fraud

The Committee will

a) review all incidents of whistle blowing that have ~~-~~occurred since the previous meeting and management's response to those incidents, together with any outstanding actions from previously reported incidents. Consider any implications for wider internal audit or counter fraud planning.~~the adequacy of the arrangements by which trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters, or any other matters of concern including patient care and safety~~

~~a)~~b) review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service

~~a)~~c) approve and monitor progress against the operational counter fraud plan

~~a)~~d) receive regular reports and ensure that appropriate action is taken in significant matters of fraudulent conduct and financial irregularity

~~a)~~e) monitor progress on the implementation of recommendations in support of counter fraud

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~~a)~~f) receive the annual report of the local counter fraud specialist

6. Other assurance functions

The Committee will

a) review the work of the other committees within the organisation whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular it will consider the work of the clinical performance committee ?? and the Quality and Risk Committee in assessing the outcome of care, patient safety, and user experience.
    a. In reviewing the work of the clinical performance committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and other sources of evidence about the overall quality of care provided.
    ~~a.~~b. The Committee will wish to assure itself of the systems, processes and controls which underlay the reporting of the trust's quality data. It will rely mainly on the internal audit program and the annual external audit review of quality accounts to provide this assurance.
b) receive exception reports from the risk, governance and regulation Committee in relation to implementation of recommendations made by external bodies and inspections.
~~b)~~c) request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may request reports from individual functions within the organisation.

7. Other duties

The Committee will

a) self-assess performance annually, and draw up and implement a plan for improvement as required
~~a)~~b) prepare an annual report commenting on the fitness for purpose of the assurance framework, risk management arrangements, integration of governance arrangements, the process undertaken to meet Care Quality Commission compliance and registration and the robustness of the processes behind the Quality Accounts
~~a)~~c) adopt processes that ensure that no Monitor authorisation condition for which it is the lead is breached. The Committee is responsible for authorisation conditions 2 (general duty), 21 (audit committee), 22 (audit), and 23 (public interest reporting).
~~a)~~d) report annually to the Board and the Council of Governors. The report will include the performance of the external auditors and recommend whether or not to re-appoint them.

Level of Authority

Statutory ~~ub~~ Committee of the Board

The Committee is authorised by the board to seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Membership

Up to three non-executive directors.

Attendees

Director of Finance & Commerce
Representative from Internal Audit
Representative from External Audit
Representative from Local Counter Fraud Service
Director of Nursing & Quality (as lead for risk)
Deputy Director of Finance

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Deputy Company Secretary (secretariat) Other executive directors and senior managers may be asked to attend to provide assurance to the Committee.
Quorum Two non-executive directors
Frequency of Meetings Meetings will be held quarterly, plus a meeting prior to the May Board to approve accounts. The Chair of the Audit Committee may convene additional meetings as deemed necessary.
Access The head of internal audit and representative of external audit will have free and confidential access to the Chair of the Audit Committee. A private session will be available for the non-executives to meet the head of internal audit and a representative of external audit before each Audit Committee meeting.
Reporting Arrangements The Committee will report to the Board of Directors. The ~~minutes of the~~ Audit Committee will provide a ~~to be~~ report~~ed~~ to the Board after each meeting. The Audit Committee will provide an Annual report to the Board.
ToR Review: Annual These Terms of Reference revised A~~ug~~pril~~ust~~ 201~~4~~5 to be reviewed ~~June~~September 2015 following completion of Board Governance Review.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 April 2015
Reference number: 103-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: 26 March 2015

Report of the Chair of the Charitable Fund Advisory Committee

Key issues discussed

1. Proposed restructure of the charity

   a. A discussion paper on a restructured approach to managing the charitable funds, including replacing the current £10k directorate funds, was presented.
   b. The proposal is to split the funds into four: patient fund, staff fund and paediatric fund plus a general fund for unspecified use donations.
   c. It was emphasized that, with the new tracking system now in place for donations, it was possible to ensure that donations with specific requests attached could be allocated for that particular purpose.
   d. It was also agreed that where income is generated from courses run by consultants this would be allocated directly to the budget holder revenue line.
   e. The proposal was agreed with a request that the communication process with consultants and staff generally be carefully managed.

2. Internal audit report

   There were a number of outstanding items in the internal audit report; these are now dependent on the implementation of the restructured funds arrangements.

3. Funding applications

   The Committee approved applications for funding for two tono pens for corneoplastics, and for two sleep studies technicians to attend a conference in Seattle. An application for an additional 'sky ceiling' in theatres was declined.

Items to be referred to the Board of Directors

4. Confoscan and endoscope equipment for corneoplastics

   a. These two items were originally approved by the CFAC in 2013 but were not purchased due to a planned external fund raising campaign. The campaign was not subsequently implemented.
   b. In view of the amounts involved these items now need to be submitted to the board of directors as corporate trustee of the charity for approval.
   c. However the committee felt that a significantly more detailed application, describing the benefits and explaining why this is not a priority for the trust's medical equipment budget, should be provided to the corporate trustee.

Additional information or assurance sought

5. None

Implications for BAF or Corporate Risk Register

6. There were no items identified which should be added to the corporate risk register or the board assurance framework.

Recommendation

7. The Board is asked to **NOTE** the Committee's actions and findings.

Queen Victoria Hospital NHS
NHS Foundation Trust

Proposed Schedule May Board of Directors

Thursday 21st May 2015

The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

BOARD SUB-COMMITTEE		
09.00 – 10.00	**None**	
INFORMAL SEMINAR		
10.00 – 11.00		
11.00 – 12.00		
12.00 – 12.30		
13:00	**FORMAL BOARD AGENDA**	
	PATIENT STORY	
	Experience	Interim Director of Nursing & Quality
	RESULTS AND ACTIONS	
	Patients	Interim Director of Nursing & Quality
	Operational Performance	Interim Head of Operations
	Financial Performance	Interim Director of Finance & Commerce
	Contract update	Interim Director of Finance & Commerce
	Workforce	Director of HR & OD
	Staff Survey Action Plan update	Director of HR & OD
	STRATEGIC PRIORITIES	
	Quarterly update on delivery of KSO5: Organisational Excellence	Director of HR & OD
	Quarterly update on strategy & sustainability (private session)	Interim Director of Finance & Commerce
	Board Development programme	Director of HR & OD
	GOVERNANCE	
	Corporate Risk Register	Interim Director of Nursing & Quality
	Board Assurance Framework	Interim Director of Nursing & Quality
	Annual Report and Accounts	Interim Director of Finance & Commerce
	CQC inspection update	Interim Director of Nursing & Quality
	SUB-COMMITTEE REPORTING	
	Nominations & Remuneration	Chair
	Clinical Cabinet	Chief Executive

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in private)** **Thursday 26th March 2015, 16.00, The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT**	
Present:	Peter Griffiths (PAG)	Trust Chairman
	Beryl Hobson, (BH)	Non-Executive Director and Chair Designate
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Dominic Tkaczyk (DT)	Interim Director of Finance
	Jo Thomas (JMT)	Interim Director of Nursing & Quality
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources & Organisational Development
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Interim Director of Operations
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Kathleen Dalby (KD)	Head of Corporate Affairs & Co Sec

COMMERCIAL-IN-CONFIDENCE

82-15	**Draft minutes of the meeting sessions held in private on 26th February 2015 and 12th March for approval** The minutes of the meetings were **APPROVED** as a correct record.

ANY OTHER BUSINESS

83-15	There was no other business and the meeting was closed at 4.40pm

Chair …… 26th March 2015