Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 28 August 2014

Session in public at 13.00
Session in private at 16.00

Council Chamber,
East Court,
College Lane,
East Grinstead,
West Sussex RH19 3LT

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: AUGUST 2014

Members (voting):

Chairman:	-	Peter Griffiths
Non-Executive Directors:	-	Ginny Colwell
	-	Beryl Hobson
	-	Lester Porter
	-	John Thornton
Chief Executive:	-	Richard Tyler (apologies)
Medical Director:	-	Stephen Fenlon (apologies)
Director of Nursing and Quality:	-	Amanda Parker
Interim Director of Finance and Commerce	-	Stuart Butt

In full attendance (non-voting):

Head of Human Resources	-	Graeme Armitage
Interim Head of Operations	-	Jane Morris
Interim Company Secretary	-	Lois Howell
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode

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NHS Foundation Trust

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PUBLIC AGENDA			
No.	**Item**	**Time**	**Page no**
WELCOME			
199-14	**Welcome, apologies and declarations of interest** Peter Griffiths, Chairman	13:00	-
PATIENT STORY			
200-14	**Patient Experience** Amanda Parker, Director of Nursing and Quality	13.02	-
STANDING ITEMS			
201-14	**Draft minutes of the meeting session held in public on 31 July 2014 for approval** Peter Griffiths, Chairman	13.10	1
202-14	**Matters arising and actions pending** Peter Griffiths, Chairman	13.15	10
203-14	**Update on behalf of Chief Executive** Amanda Parker, Director of Nursing	13.20	-
RESULTS AND ACTIONS			
204-14	**Patients: safe staffing and quality of care** Amanda Parker, Director of Nursing and Quality	13.35	14
205-14	**Operational performance: targets, delivery and key performance indicators** Jane Morris, Interim Head of Operations	13.45	63
206-14	**Financial performance: monthly update** Stuart Butt, Interim Director of Finance & Commerce	13.55	77
207-14	**Workforce** Graeme Armitage, Head of Human Resources and Organisational Development	14.05	100
STRATEGIC PRIORITIES			
208-14	**Quarterly update on delivery of Key Strategic Objective 5: Organisational Excellence** Graeme Armitage, Head of Human Resources and Organisational Development	14.15	113

GOVERNANCE			
209-14	**Corporate Risk Register** Amanda Parker, Director of Nursing and Quality	14.40	128
210-14	**Annual Seal Register Report** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	14.55	148
211-14	**Statutory Duties of Co-operation / Stakeholder Engagement** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	15.00	150
212-14	**Audit Committee Terms of Reference and Work Plan** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	15.15	156
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD (AND COUNCIL OF GOVERNORS)			
213-14	**Clinical Cabinet** Amanda Parker, Director of Nursing (on behalf of Richard Tyler)	15.30	165
214-14	**Nominations & Remuneration Committee** Lester Porter, Committee Chair	15.35	167
STAKEHOLDER AND STAFF ENGAGEMENT			
215-14	**Feedback from events and other engagement with staff and stakeholders** All board members	15.40	-
GOVERNOR REPRESENTATIVE AND NON-EXECUTIVE DIRECTORS			
216-14	**Observations from the Chairman, Non-Executive Directors & Governor Representative** Peter Griffiths, Chairman	15.45	-
MEMBERS OF THE PUBLIC			
217-14	**Observations from members of the public** Peter Griffiths, Chairman	15.50	-
218-14	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. Peter Griffiths, Chairman	15.55	-

PRIVATE AGENDA			
COMMERCIAL-IN-CONFIDENCE			
219-14	**Draft minutes of the meeting session held in private on 31 July 2014 for approval** Peter Griffiths, Chairman	16.00	169
220-14	**Capital Plans** Stuart Butt, Interim Director of Finance & Commerce	16.05	172
221-14	**Contract Update** Stuart Butt, Interim Director of Finance & Commerce	16.15	177
222-14	**Operational Performance** Jane Morris, Interim Head of Operations	16.25	182
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIRMAN)			
223-14	Peter Griffiths, Chairman	16.30	-
NEXT MONTH'S AGENDA			
224-14	**Draft agenda for next month's meeting** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	16.35	185

DATES OF THE NEXT MEETINGS

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 25 September 2014 at 13:00	**Q&R:** 4 September 2014 at 09:00 **Audit:** 17 September 2014 at 14:00 **CFAC:** 25 September 2014 at 09:00 **N&R:** 30 October 2014 at 09:00	**Public**: 11 September 2014 at 16:00

Document:	**Minutes (draft & unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 31 July 2014, 13:00 – 16:00, Council Chamber, East Court, College Lane, East Grinstead, West Sussex RH19 3LT**	
Present:	Peter Griffiths (PAG)	Chairman
	Stuart Butt (SB)	Interim Director of Finance
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Beryl Hobson (BH)	Non-Executive Director and Chair Designate
	Amanda Parker (AP)	Director of Nursing & Quality
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Head of Human Resources & Organisational Development
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Interim Head of Operations
	Lois Howell (LH)	Interim Head of Corporate Affairs & Co Sec
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	None	
Public gallery:	Two members of public (including one staff governor)	

WELCOME

169-14 **Welcome, apologies and declarations of interest**

The Chairman opened the public session and welcomed BH to her first meeting as non-executive director and Chair Designate. He also welcome two members of the public (one of whom was a staff governor).

There were no apologies and no declarations of interest.

PATIENT STORY

170-14 SF presented details of a Serious Incident reported in June which related to a late diagnosis of malignancy. At this stage it was unclear whether failure had been systemic or due to an individual however, a root cause analysis (RCA) was underway and the board would be kept apprised of the situation.

In the meantime, SF drew the board's attention to those members of staff who had exceeded expectations in managing this incident. RT also asked the board to note the time and effort which SF had dedicated to ensuring this case was handled swiftly and sensitively.

The Chairman thanked SF for his report and the board **NOTED** its contents.

STANDING ITEMS

171-14 **Draft minutes of the meeting session held in public on 26 June 2014 for approval**

Subject to the following changes, the minutes were **APPROVED** as a correct record.

- Item 150-14 to be amended to show that SF would be making a formal application to the QVH Charity for additional funding in due course;
- Item 151-14 to read 'JT confirmed that the Board Assurance Framework (BAF) could be presented to the board without a requirement for it to go through the Audit Committee first'

172-14	**Matters Arising & Actions Pending** The board reviewed the current record of Matters Arising and Actions Pending and the document was updated as appropriate.
173-14	**Update from the Chief Executive** • RT advised he was continuing to meet with specialist commissioners, and the Chief Executives of Brighton and Sussex University Hospital NHS Trust (BSUH), Maidstone and Tunbridge Wells NHS Trust (MTW) and Surrey and Sussex Healthcare NHS Trust (SaSH), as part of developing the trust's service provision, • RT updated the board on a local GPs' meeting he had attended recently to gain a better understanding of how the trust might work in partnership with the local community; • Work with the sub-committee of the Foundation Trust Network (FTN), established to consider long term sustainability of small trusts), was continuing; • Financial performance was broadly positive this month; SB would provide greater detail under agenda item 177-14; • The trust was still experiencing difficulties in meeting the 18-week target, and a full update would be provided under agenda item 176-14. • New governance arrangements in respect of the Senior Management Team (SMT) structure were continuing to bed-in, with weekly meetings focussing alternately on current performance and long term strategy; • New plastic surgeon Adam Blackburn, had been appointed to replace Phil Gilbert (due to retire shortly); RT stressed this was a key appointment in developing breast and burns services. The Chairman thanked RT and the board **NOTED** the contents of his update.
174-14	**Update from the Medical Director** SF chose this month to draw the board's attention to the 7-day services agenda. He explained this had originated following a Dr Foster report citing statistical evidence of higher mortality rates at weekends, perceived to be due to a lack of consultants. The Keogh report had followed, which included ten recommendations around service provision. SF described the two separate definitions of 7-day services; one for non-elective and one for elective care. The trust's focus was currently on the non-elective model; however, SF asked the board to note that at this stage there was no additional funding, and that the agenda was driven by quality not safety concerns. A gap analysis and associated action plan in respect of non-elective care were in draft form and would be circulated to the board in due course. The Chairman thanked SF and the board **NOTED** the contents of the update.
RESULTS AND ACTIONS	
175-14	**Patients: safe staffing and quality of care** AP presented this month's report on safe staffing which included information on safety, outcomes, experience and ward management; this was supported by data on planned and actual staffing of the wards, and a review of nursing establishments. AP reminded the board that, in line with the National Quality Board requirements, a review of nursing establishment figures has been routinely undertaken every six months for the last two years and was last received by the Board in March 2014. As evidenced under the Safe Staffing report, whilst there was sufficient staffing at present, some posts remain vacant. AP assured the board that she was working closely with GA and the Human Resources team to find more innovative ways to recruit.

	The board sought assurance that lower levels of staffing were not in any way responsible for increases in MRSA on the burns ward. AP did not believe there was a link but agreed to review occupancy and staffing levels to ensure there was no direct correlation. **[Action: AP]** AP provided an update on the current position regarding the MRSA outbreak in the Burns Unit and the unit's associated closure. She advised that a Public Health England investigation was now underway to determine why the trust was not notified about the MRSA status of the index patient prior to admission. The Chairman asked about re-opening the ward, and was assured that a 'lessons-learned' exercise would be undertaken in advance. AP summarised the quality dashboard, covering patient and staff safety, patient experience, quality account metrics, Commissioning for Quality and Innovation Payments (CQUINs), and infection control metrics. AP asked the board to note the contents of final report into the alleged role Jimmy Savile had played at the trust, and also of the Serious Incident, details of which had been disclosed previously under agenda item 170-14. BG sought, and was given, assurance that a complaint reported under patient experience did not relate to the competency of the surgeon. The Chairman highlighted concerns which had been raised in respect of Infection Control this month. AP noted that whilst there were still concerns regarding the onsite presence of microbiologists, support received during recent incidents on the burns ward had been exemplary. A second concern related to the current vacancy level within the Hotel Services team which was impacting on the team's ability to keep the organisation clean, and represented a very real risk. GA assured the board that the trust was actively recruiting to the vacant posts, however, RT noted a longer term review was planned to address the underlying issues. The Chairman thanked AP and the board **NOTED** the contents of this month's report.
176-14	**Operational performance: targets, delivery and key performance indicators** RT reported that the trust had failed to achieve its 18-week target in Ophthalmology, Maxillo-facial (MaxFacs) and Plastics this month. As this was the third time it had failed to meet targets in three consecutive months, the trust's Monitor governance risk rating would change from 'green' to 'under review'. There would also be financial penalties applied by commissioners, and a detrimental impact to the trust's reputation. RT apprised the board that in ensuring the trust was taking all necessary action to address the situation he had focused on several key areas. These included: • Did the trust understand the issues and why it was breaching? Although it had taken longer to establish the key issues, RT was confident that there is now a clear understanding of the reasons. • Did the plan reflect the actions required to address these issues? In the case of Plastics, RT was assured the additional capacity already planned would result in the desired outcome. However, whilst MaxFacs had sufficient capacity, the methodology around prioritising patients on the waiting list would need to be improved. In the case of Ophthalmology, RT was clear that there was currently insufficient capacity and consequently that waiting lists were too long. • Would the plan have the desired impact? RT was assured that the desired outcome for Plastics and Maxfacs would be apparent by early October but it would not be possible to

	address Ophthalmology waiting lists in this time and accordingly JM was implementing plans to address this. JM reiterated the current waiting list size for Ophthalmology was not sustainable in terms of 18-week compliance unless significantly reduced, an issue which had been highlighted by the NHS England Intensive Support Team modelling tools; plans to reduce the waiting lists with the support of the Ophthalmology consultants currently showed compliance being achieved in February, however the team was at present exploring a number of further operating sessions to expedite the reduction in waiting list size for the speciality. JM would provide a progress update at the August board. RT reminded the board that the trust had already predicted failure in Quarter 2 and was currently working with the NHS England Local Area Team (LAT), Clinical Commissioning Group (CCG) and IST on revising trajectories following performance in June, which were noted to be lower than predicted partly due to delays in opening Theatre 11. In addition to the above, RT assured the board that the 18-week position was reviewed on a weekly basis and also at monthly finance and performance meetings. Whilst Monitor's response at this stage was unclear, RT felt confident that there was now a robust plan in place. BG questioned why QVH was missing targets but still ahead on finance. RT explained that there was no direct correlation between the activity which was generating money and that relating to current waiting lists. SB concurred that the 18-week activity was only a very small part of the operational and financial picture but noted the need to make this information clearer in the monthly board reports. As part of the monthly update, JM reported that two urgent operations had been cancelled for a second time in June, explaining that on both occasions these had been cancelled due to a more urgent cases taking precedence. The trust had also failed the 31-day first definitive treatment (FDT) target for cancer patients in May. RT additionally reported that he had now written directly, CEO to CEO, to relevant trusts with which QVH has a contractual arrangement for the provision of specialist surgeons to support immediate reconstruction surgery, as failure of these arrangements had contributed to some surgical delays. JM was in contact with other provider Operations Directors as required on the same theme. Early responses appeared positive. In summary, the Chairman observed that whilst there appeared to be systematic problems with the 18-week target nationally, this was not a satisfactory level of performance and a sustainable solution would be required. He thanked both RT and JM and the board **NOTED** the contents of the report and the associated action plan.
177-14	**Financial performance: monthly update** SB reported that the trust was currently in a very strong position and significantly ahead on plan, with a current surplus of £606k; this was predicated on a strong income position (up by £800k), only marginally offset by increased costs. SB advised the board he was also assured on the position in respect of pay and non-pay. SB drew the board's attention to the forecast assumptions. Whilst the downside was a surplus of £1.8k, the upside was projected at £4.5k. He suggested that, although it was too early at this stage to discuss potential utilisation of benefits, he recommended the board should informally start to consider ways in which increased cash reserves could be used. Cash balances for June were significantly above plan due to a reduction in debtor balances and delays to capital expenditure. LP sought clarification regarding the capital programme

	and SB explained this encompassed a suite of projects. One of the key projects related to Information Management and Technology (IM&T) and a business case would be submitted to the board in October. SB was currently reviewing the projects sitting within the Estates Department; and additional project management support was being invested to ensure their delivery. The Chairman thanked SB and the board **NOTED** the contents of the update.
178-14	**Workforce** GA reported a further improvement in the level of sickness absence which was now currently at 3%; however, he predicted there was likely to be an increase between September and December which the trust should be prepared to manage. Bank and agency levels remain low, whilst vacancies and overall pay have increased. Statutory and Mandatory training rates have stayed around the 80% level for the last three months with the number of bookings (for conversion to compliance) also increasing. GA asked the board to note that there were no separate appraisal figures this month as these were now incorporated into quarterly reporting, but he could advise the level was around 60%. GA highlighted that turnover had increased to 14% but said that he did not believe any overall trend was emerging, with core stability of the organisation still very good. BH asked if there was any correlation between levels of stress and high turnover rates which would indicate staff workload was increasing to manage the vacancies; GA responded that exit interview data did not suggest this to be the case. BH also queried the low levels of compliance in respect of Child Protection competencies; AP assured her that, as reported at previous board meetings, this was as a result of inappropriate categorisation and work was underway to correct this. GC reminded the board that its members were also required to undergo safeguarding training. AP agreed to arrange this at a future board seminar workshop. **[Action: AP]** The Chairman thanked GA for his update, however, he requested additional information regarding safeguarding, and stress and anxiety be brought to the board next month**. [Action: GA]**
STRATEGIC PRIORITIES	
179-14	**Quarterly update on delivery of Key Strategic Objective (KSO) 3: Operational Excellence** JM presented a quarterly update on the delivery of KSO3 , explaining this was a key strand of the QVH2020 strategy which identified actions supporting organisational delivery of streamlined services to ensure patients would be offered choice and treated in a timely manner. A 'road-map' setting out the timeline of the programme had been produced and steering groups established to support delivery of programme outputs. JM noted that implementation of the pre-assessment IT system was a significant piece of work and, providing the procurement process went to plan, she would hope to bring a business case to the board for approval in September.

	JT commended JM on the clear and concise way in which the update had been presented. The Chairman thanked JM for her report and the board **NOTED** its contents.
180-14	**Quarterly update on delivery of Key Strategic Objective (KSO) 4: Financial Sustainability** SB provided background to the key headings for each of the core components of financial sustainability, which linked in to the Board Assurance Framework (BAF); these included financial planning, scope and provision of clinical services, financial control, infrastructure and investment and performance and standards. The Chairman thanked SB and the board **NOTED** the contents of the update.
GOVERNANCE	
181-14	**Corporate Risk Register (CRR)** The Chairman sought clarification as to why the Corporate Risk Register currently sat within the Nursing and Quality Directorate. In light of earlier discussions regarding executive workload, RT concurred he would reflect on where this should sit as part of the wider review. **[Action: RT]** AP asked the board to note key risks currently rated at 12 or above as these posed the most significant risk to the trust. Details of controls in place to mitigate the risk were provided, together with outstanding actions required. AP assured the board that the risk rated as 16 (regarding potential failure of the Clean Room), was currently being addressed through an options appraisal report; SB noted that short, medium and long term strategies would be required and this would be managed within the Estates and Facilities Group. The Chairman asked why the CRR was presented to both the Quality and Risk and Audit sub-committees of the board; AP advised that both the CRR and the Board Assurance Framework (BAF) were reviewed by the Audit Committee to alert it to areas where a greater level of scrutiny might be required. Highlighting a discussion during the earlier Nomination and Remuneration Committee, the Chairman reiterated the board's need for clearer direction in respective of its sub-committees, with consensus on appropriate levels of scrutiny. The board **NOTED** the contents of the report.
182-14	**Board Assurance Framework (BAF)** AP outlined the robust process under which the BAF had been devised which ensured risks associated with the trust's KSOs and the QVH2020 strategy had been captured. RT confirmed that executive leads had been identified for each KSO, and its associated risks, to ensure these were regularly calibrated; however, he stressed the board should note this process was in its early stages and further honing of certain risk descriptions was still required. GC suggested this document should contain more aspiration, and less scrutiny and governance; however, RT reminded her that BAF was a list of risks to delivery of those aspirations listed elsewhere within the KSOs. LP raised concerns that this was a particularly difficult document to navigate and suggested it should be condensed to an easier format for the board to manage; AP reminded board

	members that, in its current format, the document met requirements of both external and internal auditors. RT concurred he was assured by the risks identified but reiterated that further work was to be done on presentation. The Chairman again raised the question of scrutiny by the Audit Committee, noting that whilst part of the board's remit is to review the work of the sub-committees, at present the board met more frequently than the sub-committees. He tasked the executive team with identifying the best way to summarise the current risks in a more helpful format, and also noted the board's need to be mindful of the balance between development and scrutiny at its meetings. The board **NOTED** the contents of the report and associated actions.
183-14	**Consultant Revalidation Annual update** SF reminded the board that Revalidation was a process by which doctors are required to demonstrate to the General Medical Council (GMC) that they are compliant with relevant processional standards, that they had up to date skills and competencies, and that they are fit to practice. SF presented an initial formal report setting out the role and responsibilities of the Responsible Officer (RO) detailing how the revalidation team at QVH had delivered, documented and assured the process had been undertaken in accordance with national requirements. SF highlighted some areas where improvement was required, particularly in relation to quality assurance of appraisals, and the mechanisms for appraisers to quality assure their practice. He advised the board that the appraisal audit was now available and would be happy to circulate as required. GC asked how consultants at QVH had responded to this process; SF felt assured that this was a valuable exercise, and no-one at QVH had refused to engage with it to date. However, resources required at organisational level to support the process were greater than originally anticipated; it therefore fell to the organisation itself to provide these, an issue which had been highlighted at national level. Moreover, feedback from bi-monthly RO meetings suggested there was a need to provide robust systems to manage those doctors with capability or conduct issues which would also left to the organisation to address. The Chairman noted the continued need for the Trust to define explicitly the responsibilities and accountabilities of doctors. The board **APPROVED** the approach put forward by SF, noting that the contents of the report and audit would be shared with the High Level Responsible Officer. The board also **APPROVED** the statement of compliance confirming it believed the trust to be compliant with the regulations. The Chairman thanked SF for his report.
184-14	**Monitor Quarterly Return (Q1)** SB reminded the board that the trust was required to submit its Quarter 1 (Q1) monitoring return by the end of July. A paper confirming the proposed Board governance statement was included, together with the updated self-certification framework providing the board with evidence for its declaration. JM reported that, in respect of Governance, it would not be possible to confirm the declaration that "The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets and a commitment to comply with all known targets going forwards". This was because in Q2 the trust was not expecting to meet the aggregate

	admitted or non- admitted 18 week targets. However, JM reminded the board that the IST had now concluded its review of systems and trajectories and the trust was working to a detailed action plan which should achieve aggregate compliance with all 18 week targets from Q3. However, the trajectory for speciality compliance for Ophthalmology was currently not predicted to be achieved until Q4. With regard to Finance, it was confirmed the board would declare, "The board anticipates that the trust will continue to maintain a Continuity of Service risk rating (COSRR) of at least 3 over the next 12 months" and accordingly a COSRR of 4, 'no evident financial concerns', would be submitted. SB reminded the board that in the annual plans submitted to Monitor, the planned rating from Q2 onward remained at 4. For Otherwise, 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 page 22, Diagram 6" was made. Under Consolidated subsidiaries the "Number of subsidiaries included in the finances of this return" is 'nil'. The Board **NOTED** the contents of the schedules and **APPROVED** that the above declarations should be made to Monitor.
185-14	**Board Governance Assurance Framework (BGAF) Action Plan update** LH presented an update on the BGAF action plan. It was noted that whilst a number of actions were overdue, revised dates for completion would be achievable. The board **NOTED** progress made to date, the contents of the report, and **AGREED** the proposed changes to deadlines.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
186-14	**Clinical Cabinet** In presenting his monthly update, RT reported that in the twelve months since he had been in post, the Clinical Cabinet was now more widely attended, with members better focussed; SB concurred, and observed it was rewarding to see such a high level of engagement with clinicians addressing challenges in a positive way. The board **NOTED** contents of the update
187-14	**Council of Governors** A report on the two Council of Governors' meetings held in June had been prepared and circulated. JT asked the board to note under item 5 that Council had agreed to extend only the internal auditors' contract for a further year. The board **NOTED** this amendment and the contents of the update
188-14	**Board Outcomes Group** LP presented his report and noted that the recent appointment to manage this project had been very effective. There were no further comments and the board **NOTED** the contents of the report.

189-14	**Charitable Funds Advisory Committee** LP presented his quarterly update. There were no further questions and the board **NOTED** the contents of the report.
STAKEHOLDER AND STAFF ENGAGEMENT	
190-14	**Feedback from events and other engagement with staff and stakeholders** Board members highlighted events in which they had been involved in the last month; these included: • RT had received feedback from patients recently indicating that, in addition to researching ways of improvement it was equally important to continue to maintain current high levels of performance; • JT reported that both he and LP had undertaken a Compliance in Practice session in July; in addition, both JT and GC had attended two Foundation Trust Network (FTN) events and had gained greater insight in cultural change and the importance of high quality management and leadership; • AP had spent time in theatres this month and was assured by high levels of both policy compliance and compassion shown to patients in the operating theatre. In addition she had also attended a conference of the Federation of Specialist Hospitals; • SB had visited theatres to investigate current problems relating to the new theatre doors and whilst there he was apprised of issues relating to the discharge waiting areas. • The Chairman reported on his recent visits to theatres and outpatients; he too had been apprised of dissatisfaction in respect of the patient discharge area, and also of the limited staff facilities within theatres. The board **NOTED** contents of the verbal updates.
GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
191-14	**Report from the Governor Representative** BG reported that the new governor induction programme took place last week; it was noted that one of the newly appointed staff governors had joined the public gallery today.
192-14	**Observations from the Chairman and Non-Executive Directors and observers** BH expressed her thanks to everyone for the warm welcome she had received since joining the trust at the beginning of the month.
MOTION TO EXCLUDE THE PRESS AND MEMBERS OF THE PUBLIC	
193-14	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

Chairman…… Date…….....

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
July 2014 meeting						
1	**175-14**	Occupancy and staffing levels to be reviewed to ensure no direct correlation with recent infection issues on Burns Ward.	**AP**	**Oct**	**Update 07 08 2014** Review to be undertaken on conclusion of current outbreak and completion of action plan and Root Cause Analysis	**On track**
2	**178-14**	Board to attend Safeguarding training	**AP**	**Sept** **Oct**	**Update 07 08 2014** Board to receive Annual Safeguarding Report **Update 07 08 2014** Safeguarding training to be included as part of October board seminar	**On track** **On track**
3	**178-14**	Additional information regarding safeguarding, and stress and anxiety to be brought to August board.	**GA**	**Aug**	To be included as part of the August Workforce Report	**On track**
4	**181-14**	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**			
June 2014 meeting						
5	**143-14**	Presentation made by Secretary of State as part of FTN review into sustainability of small hospitals to be circulated to board members.	**RT**	**July**	**Update 31 07 2014** RT confirmed this had been done	**Complete**
6	**144-14**	Details of organisational restructure within Estates Department to be provided to board.	**RT**	**Sept**	Pending outcome of Green & Kassab review into Estates function **Update 31 07 2014** This will be incorporated into the next quarterly update on KSO4 following review to be undertaken by RT and SB (see items 082-14 & 157-14)	**Pending**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
7	**145-14**	CEO to lead on discussions with Medical Director and Director of Nursing & Quality to determine if there are underlying concerns regarding current level of SUIs and 'Never Events'.	**RT**	**Sept**	**Update 31 07 2014** Initial discussion scheduled for 4 August; feedback to be provided to September board. (See 157-14 & 082-14)	**On track**
8	**146-14**	JM to raise concerns with Programme Board in respect of allocation of accountabilities for breaches.	**JM**	**Sept**	**Update 14 07 2014** Initial concerns raised by QVH at Programme Board beginning of July. Issue will be on-going over the next few months as part of the wider work relating to 18-weeks. JM to provide update after the next Programme Board in September.	**On track**
9	**148-14**	GA to review data to establish if there are any untoward trends relating to staff turnover	**GA**	**July**	**Update 31 07 2014** Contained within July Workforce report	**Complete**
10	**150-14**	Overarching aspirational statement relating to each Key Strategic Objective (KSO) to be developed to enable board to ascertain context and monitor progress.	**RT**	**Sept**	**Update 31 07 2014** On agenda for September board	**Complete**
11	**150-14**	Key headings and RAG status to be incorporated into future KSO quarterly reporting.	**SF**	**Sept**	Next quarterly report on KSO2 due September 2014	**On track**
12	**151-14**	Board Assurance Framework (BAF) to be presented to the board, (without requirement for prior review by Audit Committee)	**AP**	**July**	On July board agenda	**Complete**
13	**155-14**	As part of the BGAF action plan and in order to improve governor involvement in current NED appraisal process, NEDs to consider adopting a feedback form, similar to that used in Chairman appraisals; feedback to be provided to Interim Co Sec and Head of Corporate Affairs	**All NEDs**		**Update 31 07 2014** PAG confirmed NEDs in agreement for Governors will be asked by Chair to feedback on their performance. This will now be included as part of the process in the next round of appraisals and documented in Nomination & Remuneration meetings.	**Complete**
14	**155-14**	The Chairman and Chief Executive to meet to discuss NED feedback on the Executive team.	**PAG**	**July**	**Update 16 07 2014** PAG to provide verbal update at July board meeting.	**Complete**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
15	**157-14**	As a result of concerns raised by KPMG in its report into trust's capital projects and processes, final report to be circulated to board at its meeting in July.	**SB**	**~~July~~ Sept**	**Update 31 07 2014** This will be incorporated into the next quarterly update on KSO4 following review to be undertaken by RT and SB (see 145-14 & 082-14)	**Pending**
16	**158-14**	In order to satisfy criteria laid down within the Board Governance Assurance Framework (BGAF) board members will be asked to provide examples of how they are engaging with staff and stakeholders. Monthly updates to be provided with effect from July 2014.	**ALL**	**July**	To be included as a monthly agenda item with effect from July 2014.	**Complete**
17	**159-14**	Further to request made by Governor Representative, RT to provide updates to full Council of Governors regarding the QVH 2020 strategy and the Estate strategy.	**RT**	**Sept**	On agenda for September meeting of the full Council of Governors	**On track**
May 2014 meeting						
18	**114-14**	MIU to be invited to present at future board seminar.	**LH**	**~~June~~ Aug**	**Update 26.06.2014** MIU to attend board seminar in August to make a presentation on the work of the department	**Pending**
19	**117-14**	Deputy Director of Nursing to attend future board seminar to provide update on Leadership Development.	**LH**	**~~June~~ Oct**	**Update: 26.06.2014** Dep DoN to attend Board seminar session in October to provide update	**Pending**
20	**126-14**	Board lead for Sustainable Development agenda to be identified	**RT**	**~~July~~ Aug**	**Update 18 06 2014:** RT to circulate to Board members requesting expressions of interest	**Overdue**
21	**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**	**~~Aug~~ Oct**	**Update: 08.07.2014** Presentation to be made to October Nomination & Remuneration Committee	**Pending**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
April 2014 meeting						
22	**082-14**	Detailed breakdown of capital expenditure to be circulated to board.	**RT**	**~~May~~** **~~June~~** **~~July~~** **Sept** **Oct**	The estates programme to be considered at June audit committee as part of the wider response to the KPMG capital projects audit. Chair of Audit Committee to update June BoD **Update 31 07 2014** Now to be considered as part of KSO2 update at September board (see 144-14 & 157-14). **Update 19.06.2014:** Detailed business case in respect of proposed IT expenditure to be submitted to board in October 2014	**Pending** **On track**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28 August 2014**
Reference number:	**204-14**
Report from:	**Director of Nursing & Quality**
Author:	**Director of Nursing & Quality**
Report date:	**19 August 2014**
Appendices:	**A:Safe Staffing**
	B:Quality and Risk
	C:Infection Prevention and Control
	D: 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 A).
    - Quality and risk management with information provided on quality and safety metrics and incident management (Appendix B).
    - Infection prevention and control issues and actions (Appendix C).
    - Information on new and closed complaints, claims and patient experience feedback. (Appendix D).

Safe Staffing (p1)

2. Safe staffing levels were achieved throughout July.
3. Areas of concern are vacancy rates within the Burns ward, long term sickness of two staff within the burns ward and ITU and the low appraisal rate within ITU (p1). These matters have been raised with HR who are reviewing recruitment opportunities and the ward manager for ITU who will be completing appraisals.

Quality and Risk Management (p13)

4. Summary reports from a never event and serious incident are provided (pages 27 and 30). Both incidents have undergone a full investigation, have identified learning points and actions identified to reduce the risk of reoccurrence. These have been disseminated to staff and to the patients and their family who were involved throughout.
5. An executive review of the recent never events and serious incidents was undertaken as these are all linked to medical staff. Identified actions were; Medical Director to write to all medical staff informing them of the trusts expectations of them, inclusion of medical staff in the Manchester patient safety framework programme and QVH to join the sign up to ‘safety campaign’.

6. A serious incident was declared in July following an outbreak of hospital acquired multi resistant MRSA. Full precautions have been taken to protect patients and external advice sought from PHE, and expert in MRSA and out microbiologist. Further information is available within the infection prevention control report (p33)
7. Complaints have increased during July these are currently being investigated and responded to detail is contained within the patient experience report (p39).
8. Quality metrics that have not achieved their target have been addressed with the relevant staff groups; nursing and theatre personnel involved in the WHO checklist.

Infection Control (p33)

9. Infection control concerns being addressed are;
    - A period of increased incidence of healthcare associated infection (HCAI) MRSA has been managed we are now implementing the maintenance and decontamination programme prior to reopening. This is anticipated to be in early September.
    - Spoke site compliance visits have recommenced following new staff starting and an informal concern raised by the CQC. Processes have been amended to ensure the Health and Safety committee is informed of overdue visits.
    - Vacancies within the hotel services team continue to affect the capacity to clean, HR are involved in supporting recruitment and an external company will be used to decontaminate the burns unit.

Complaints, Claims and Patient Experience (p39)

10. There were eleven complaints acknowledged during July these are under investigation and progress is reviewed monthly by the chief executive and director of nursing. For all closed complaints letters have been sent to complaints that are signed by either the chief executive or director of nursing.
11. All actions identified as the result of a complaint are monitored through the monthly clinical governance group.
12. Patient feedback is good with a good response rate to the friends and family test (FFT). An action plan has been developed to meet the newly released guidance on further roll out. This will be monitored by the patient experience group though investment will be required to support data collection.

Implications of results reported

13. Additional agency and bank staff have been required as a result of vacancies on wards and due to managing the infection control outbreak with ITU located within two areas until mid-August.
14. Closure of the burns unit to adult admissions has meant that to date approximately 3 patients have had to be admitted to alternative burns units.
15. Non pay costs within the burns unit have increased due to the use of additional items to prevent the spread of infection.
16. Failure to further improve WHO checklist compliance for sign out and recovery hand over may impact on the related CQUIN.

17. Investment will be required to support additional staff or technology to collect FFT data.

Action required

18. Recruitment of staff within the burns unit.
19. Completion of appraisals within ITU.
20. Maintenance and decontamination completion within the Burns unit.
21. Increased compliance with patient risk assessment and WHO checklist by nurses and theatre personnel.
22. Roll out of additional FFT areas for completion by end march 2015.

Link to Key Strategic Objectives (delete those not applicable)

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

23. 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

24. The corporate risk associated with the recruitment of staff has been raised following a meeting on 18 August.
25. The corporate risk on hospital acquired infection has been raised from 12 to 16 (p33).

Regulatory impacts

26. 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.

Recommendation

27. Options include
    - The Board is recommended to note the contents of the report.

SAFE STAFFING
Monthly Report – July 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- National recommendations are followed and that wards are provided with sufficient staff to provide safe care.
- The report contains key information on;
    - day by day and shift by shift staffing information
    - safety and quality metrics by ward
    - information to indicate how well led a ward is

Key Points:

The key priority that the board need to be aware of for this month are ;

1. Safe staffing levels were provided throughout the month of July, this achieved while segregating staffing to manage patients due to infection outbreak.

2. Burns ward and ITU are rated as amber by the director of nursing for the following reasons:
    - Vacancy rate > 24% burns ward
    - Sickness – 2 long term sickness 1 each area
    - Appraisal - ITU

   Recruitment concerns have been raised with HR in respect of recruitment and a variety of recruitment approaches are currently under consideration. Sickness is being actively managed and the ward manager has been approached by the DN about completion of appraisals.

Implications:

- Corporate risk (27) has been raised from 12 to 16 due to infection outbreak and this is impacting on burns ward non pay budget and ITU temporary staffing use.
- Recruitment has been identified as a risk and the rating increased – this i=has been since the production of the risk register.

Recommendations:

The board is asked to note the actions currently being taken and the raised risk related to recruitment.

Safe Staffing Levels Summary - July 2014

During July there was a staffing requirement for a total of 13719 hours. QVH were able to provide 13611 hours of nursing care achieving a percentage of 99.2% over the month.

Margaret Duncombe Ward all shifts had the expected staffing levels during the month (62/62 green days)

Ross Tilley Ward; 60/62 shifts were established as planned for the 2 shifts where staffing did not meet the plan staff were provided on one day and on the other there were fewer patients and care was deemed safe.

Peanut Ward; 54/62 shifts met the planned staffing establishment. On the days this was not achieved staffing was deemed safe either due to low numbers of patients or a variety of measure used to ensure sufficient staff; moving staff from one area to another or restricting admissions.

Burns Ward; 61/62 shifts met the planned staffing establishment on the one shift that did not there were additional RMN staff to support care.

Burns ITU; 60/62 shifts met the planned requirement. The two shifts that did not were supported by anaesthetic and additional nursing staff as per our escalation plan.

MARGARET DUNCOMBE	MAY	JUNE	July	DN Rating					
Safe Care	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0				On track no action required
Falls	0	1	2	0	1				For discussion at ward meeting no harm patient slipped on wet flooring
Medication errors	5	2	1	0	0				Paracetamol administered against a prescription with no dose specified
MRSA/Cdiff	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	95%	0%				On track no action required
Nutrition assessment MUST/7 day review	100% 30%	94% 100%	100% 100%	>95%	-1%				On track no action required
Activity	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy (10am)		73%	67%	<90%	-23%				On track no action required
Bed utilisation	93%			<100%					On track no action required
Patient numbers	158	141	148						On track no action required
Average length of stay	32.8Hrs								
Average patient acuity numbers/day		0 = 12 1a = 1.7 1b = 7							the level of nurisng required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE
CANADIAN WING									
Staff utilisation	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	<5%	9.9%				Action required under established adverts out to recruit
Temporary staffing Exc RMN Bank / Agency hours	530.10 431.30	553.15 360.30	735.15 375.0	<10% 235.8 + vacancy	-158.65				Action required above target
Sickness	2.4%	1.2%	1.0%	<2%	-1.0%				On track no action required
Shifts meeting Est	97.0%	98.0%	100.0%	>95%	3%				On track no action required
Training / Appraisal	No/%			Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	70.2%	70.3%	63.2%	>85%	-23.49%				Action rquired below target
Appraisals	67.7%	70.5%	73.7%	>85%	-11.30%				Action rquired below target
Drug Assessments	96%	98%	100%	>95%	+3%				On track no action required
Friends and Family Test Score **MD / RT**	89 85	94 94	87 91	>80	+4 +4				On track no action required
Staff Friends and Family Test Score									
Budget (K)	15	6	12.6	>0	+6				Undersepnd on nursing budget

WARD	MARGARET DUNCOMBE				
GREEN		Staffing meets planned requirement			
AMBER		Staffing does not meet planned requirement but care is safe			
RED		Staffing does not meet planned reqirement and the senior nurse has been informed			
MONTH	JULY	When amber or red rationale to be provided below			

		1	2			
		3	4			
		5	6			
7	8	9		11	12	
13	14	15	16	17	18	
19	20	21	22	23	24	
		25	26			
		27	28			
		29	30	31		

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	4	3	5	2	
2	3	2	3	2	
3	4	2	4	2	
4	5	2	5	2	
5	5	1	5	1	
6	2	2	2	2	11 patients
7	4	2	4	2	
8	4	3	4	3	
9	3	2	3	2	
10	3	2	3	2	
11	4	2	4	2	
12	5	2	5	2	
13	3	2	3	2	
14	3	2	3	2	
15	3	1	3	1	
16	3	2	3	2	
17	6	2	7	2	5 pts in SDU
18	5	1	5	1	2 pts in SDU
19	4	2	4	2	4 pts in SDU
20	2	2	2	2	2 pts in SDU
21	4	2	4	1	help from RTW organised
22	4	2	6	2	
23	3	2	3	2	
24	4	3	5	2	rn to assist rtw
25	4	2	4	2	
26	5	2	5	2	
27	3	2	2	2	1 x staff on A/L (low pt no's)
28	5	2	5	2	
29	4	2	4	2	4 pts in SDU
30	5	2	5	2	
31	5	2	5	2	
MD DAY	121	62	125	59	
HOURS	1391.5	713	1437.5	678.5	

WARD	MARGARET DUNCOMBE				
GREEN		Staffing meets planned requirement			
AMBER		Staffing does not meet planned requirement but care is safe			
RED		Staffing does not meet planned reqirement and the senior nurse has been informed			
MONTH	JULY	When amber or red rationale to be provided below			

		1	2			
		3	4			
		5	6			
7	8	9			12	
13	14	15	16	17	18	
19	20	21	22	23	24	
		25	26			
		27	28			
		29	30	31		

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	4	1	4	1	
2	3	1	3	1	
3	3	1	3	1	
4	3	1	3	1	
5	2	1	2	1	
6	2	0	2	0	
7	3	1	3	1	
8	3	1	3	2	2 patients needing specialing
9	3	1	4	1	5 pt in SDU
10	3	1	4	1	3 pts in SDU
11	4	1	4	1	3 in sdu
12	2	1	2	1	7 patients
13	2	1	2	0	4pts HCA moved to burns
14	2	1	2	1	no patients in step down
15	2	1	2	1	14 patients
16	2	1	2	1	12 patients
17	2	1	2	1	
18	2	1	2	1	13 PTS AND 4 SDU
19	3	2	3	2	
20	2	1	2	1	
21	2	1	2	1	
22	4	1	4	1	
23	2	1	2	1	
24	3	1	3	1	
25	4	1	4	1	
26	3	1	3	1	
27	3	1	3	1	
28	2	1	2	1	
29	4	1	4	1	4 pts in SDU
30	2	1	2	1	
31	5	1	5	1	3 nurses in step down
MD NT	86	31	88	31	
HOURS	989	356.5	1012	356.5	

ROSS TILLEY	MAY	JUNE	JULY	DN Rating					
Safe Care	No/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0				On track no action required
Falls	1	0	1	0	1				For discussion at dept meeting - no harm to patient
Medication errors	0	15	0	0					On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0					On track no action required
VTE reassessment	91%	100%	100%	95%					1 patient not reassessed in 24 hours
Nutrition assessment MUST / 7 day	100% 100%	100% 92%	100% 100%	>95%					On 1 patient had not had their nutrion assessment repeated at 7 days
Activity	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy		67%	64%	<90%	26%				On track no action required
Bed utilisation	107%			<100%					On track no action required
Patient numbers	199	186	207						On track no action required
Average length of stay	34.9Hrs								
Average patient acuity numbers/day		0 = 14.5 1a = 0.66 1b = 1.5							Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.32WTE, 1b 1.72 WTE

WARD	ROSS TILLEY
GREEN	Staffing meets planned requirement
AMBER	Staffing does not meet planned requirement but care is safe
RED	Staffing does not meet planned reqirement and the senior nurse has been informed

MONTH JULY — When amber or red rationale to be provided below

1	2				
3	4				
5	6				
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	4	3	4	3	
2	4	3	4	3	
3	4	3	4	3	
4	3	1	3	1	
5	3	1	3	1	
6	3	2	3	2	
7	4	3	4	3	
8	4	2	4	2	
9	4	3	4	3	
10	4	3	4	3	
11	2	2	2	2	11 patients
12	2	2	2	2	
13	3	1	3	1	
14	3	2	3	2	
15	3	2	3	2	
16	4	2	4	2	
17	4	3	5	3	
18	5	2	5	2	
19	3	2	3	2	
20	4	2	3	2	agency cancelled
21	4	3	7	3	
22	4	3	6	3	
23	4	3	4	3	
24	4	3	3	3	mdw to provide help
25	4	3	3	3	low pt numbers
26	4	1	4	1	
27	2	2	2	2	
28	3	3	3	3	
29	3	3	3	3	
30	3	3	3	3	
31	4	3	4	3	
RT DAY	109	74	112	74	
HOURS	1253.5	851	1288	851	

WARD	ROSS TILLEY
GREEN	Staffing meets planned requirement
AMBER	Staffing does not meet planned requirement but care is safe
RED	Staffing does not meet planned reqirement and the senior nurse has been informed

MONTH JULY — When amber or red rationale to be provided below

1	2				
3	4				
5	6				
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	1	3	0	only 15 pts
2	3	1	3	1	
3	3	1	3	1	
4	3	1	3	1	
5	2	1	2	1	
6	2	1	2	1	
7	3	1	3	1	
8	3	1	3	0	only 11 patients
9	3	1	3	1	
10	3	1	2	1	only 10 pts
11	3	1	3	1	
12	2	0	2	0	11 patients MD helping
13	3	0	3	0	
14	2	1	2	1	
15	3	1	3	1	
16	3	1	3	1	
17	3	1	3	1	
18	3	0	3	0	
19	3	1	2	1	reduced - cancelled agency as low patient acuity
20	3	1	3	1	
21	3	1	3	1	
22	2	1	2	1	
23	3	1	2	1	only 11 ptt- staff moved to SDU
24	3	1	3	1	
25	3	0	3	0	only 6 pts
26	2	1	2	1	
27	2	1	1	1	7 pts - 4 of them pre-op
28	2	1	2	1	
29	3	1	3	1	
30	2	1	2	1	
31	3	1	3	1	
RT NT	84	27	80	25	
HOURS	966	310.5	920	287.5	

Peanut	MAY	JUNE	July	DN Rating					
Safe Care	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0				On track no action required
Falls	0	0	0	0	0				On track no action required
Medication errors	0	0	0	0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0	0	0				On track no action required
Activity	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy Taken at 10.00 daily excluding weekends	64%	67%	68%	<95%	27%				
Bed utilisation									
Patient numbers									
Average length of stay	5.5Hrs								
Average acuity									
Peanut									
Staff utilisation	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Vacancies Est = 25.00	1.72wte 286hrs	2.2wte 365hrs	2.2wte 365hrs	<5%	9%				No action required
Temporary staffing Exc RMN Bank / Agency	160.15 23.45	289.20 0	328.05 7.30	<10% 93.75 + vacancy	- 123.40				
Sickness	3.8%	4.36%	10.03%	<2%	+8.03				Sickness increased,carrying 1 long-term sickness case from 16.06.14. Other sickness in the department relating to stress Anxiety, Back problems
Shifts meeting Est	96%	100%	97%	>95%	2%				No action required
Training / Appraisal	No/%	No/%	No/%	Target		RAG	Change	Trend	Improvement Plan / Actions
Stat and Mand compliance	81.3%	85.00%	67.20%	>85%	-3.40%				On track no action
Appraisals	87.1%	96.77	84.38%	>85%	- 0.62%				On track no action
Drug Assessments	100.0%	95.5%	88.0%	>95%	-8%				All assessments booked to be completed by end Aug
Friends and Family Test Score	100	100	66	>80	-14				Score reflect 2 pateints stating very likely and 1 patient stating likely. Only children over 16 currently feedback into FFT
Staff Friends and Family Test Score									
Budget	6	5	6.6	>0	-6.6				No extra spend on non pay however income on activity is down during July

WARD	PEANUT	
GREEN		Staffing meets planned requirement
AMBER		Staffing does not meet planned requirement but care is safe
RED		Staffing does not meet planned reqirement and the senior nurse has been informed

MONTH JULY — When amber or red rationale to be provided below

		1	2		
		3	4		
		5	6		
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	1	2	1	rn sick - hca moved from burns.
2	2	1	1	1	only x1 patient
3	3	1	2	1	
4	3	1	3	1	
5	2	2	2	2	
6	2	1	2	1	4 patients
7	3	2	4	3	
8	3	2	3	2	
9	3	1	3	1	
10	3	1	3	1	
11	3	1	3	1	
12	2	2	2	2	
13	2	0	2	0	
14	3	1	3	1	
15	3	2	3	2	
16	3	1	3	1	1 Tr helping in PAU to cover sickness
17	3	1	3	1	
18	3	1	3	1	REDUCED TO 2+1 PM as ward empty
19	2	1	2	0	REDUCED AS 2 PATIENTS ONLY
20	2	1	2	1	only 3 elective patients
21	3	1	3	1	
22	3	1	3	1	
23	3	1	3	1	
24	3	1	2	1	pau to provide help when needed
25	3	1	2	1	pau to help
26	2	1	2	1	
27	2	1	2	1	
28	4	0	4	0	
29	3	1	3	1	
30	3	1	3	1	
31	3	1	3	1	
PN DAY	85	34	81	34	
HOURS	1020	408	972	408	

WARD	PEANUT	
GREEN		Staffing meets planned requirement
AMBER		Staffing does not meet planned requirement but care is safe
RED		Staffing does not meet planned reqirement and the senior nurse has been informed

MONTH JULY — When amber or red rationale to be provided below

		1	2		
		3	4		
		5	6		
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	2	0	2	0	
2	2	0	2	0	
3	2	0	2	0	
4	2	0	2	0	
5	2	0	2	0	
6	2	0	2	0	
7	2	0	2	0	
8	2	0	2	0	
9	2	0	2	0	
10	2	0	2	0	
11	2	0	2	0	
12	2	0	2	0	
13	2	0	2	0	
14	2	0	2	0	
15	2	0	2	0	
16	2	0	2	0	
17	2	0	2	0	
18	2	0	2	0	no patients
19	2	0	2	0	
20	2	0	2	0	
21	2	0	2	0	
22	2	0	2	0	
23	2	0	1	0	Kate Sanders aware, no burns adm
24	2	0	2	0	
25	2	0	2	0	
26	2	0	2	0	
27	2	0	2	0	
28	2	0	2	0	
29	2	0	2	0	
30	2	0	2	0	
31	2	0	2	0	
PN NT	62	0	61	0	
HOURS	744	0	732	0	

BURNS WARD	MAY	JUNE	July	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0				On track no action required
Falls	0	2	3	0	3				No patient was harmed as aresult of their fall
Medication errors	0	0	0	0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	78%	68%	77%	<95%	18%				On track no action required
Bed utilisation									
Patient numbers	28	25	38						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 nurisng required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE
BURNS UNIT									
Staff utilisation	**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	<5%	24.16%				Vacancy on estatblishment
Temporary staffing Exc RMN Bank / Agency	398.15 114	466.30 128.55	400.45 573.0	<10% 114.8hrs + vacancy	-370.35				No action required
Sickness	4.1%	4.79%	2.42%	<2%	+ 0.42%				Carrying 1 long-term sickness case due to Anxiety & Stress
Shifts meeting Est	96%	99%	98%	>95%					Saffing identified as safe due to acuity of patients
Training / Appraisal	**No/%**	**No/%**	**No/%**	**Target**		**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	80.25%	83.60%	77.10%	>85%	-6.79%				Below target
Appraisals	58.82%	66.67%	86.21%	>85%	+ 1.21%				Action required
Drug Assessments	95%	97%		>95%					
Friends and Family Test Score	100	94	100	>80					
Staff Friends and Family Test Score									
Budget	3	15	-14.6	>0	-14.6				Non pay remains overspent some of which will be due to increased requiremtns due to infection outbreak plus acitivy income has not been achieved. An underspend in nursing equates to non pay overspend.

WARD	BURNS UNIT
GREEN	Staffing meets planned requirement
AMBER	Staffing does not meet planned requirement but care is safe
RED	Staffing does not meet planned reqirement and the senior nurse has been informed

MONTH JULY — When amber or red rationale to be provided below

		1			
		3	4		
		5	6		
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	2	3	2	hca moved to peanut to help out
2	3	1	3	1	
3	3	1	3	1	
4	3	1	3	1	
5	2	0	2	0	
6	2	1	2	1	
7	3	1	3	2	
8	3	1	3	1	
9	3	2	3	2	
10	3	2	3	2	
11	3	1	3	1	
12	4	2	4	2	
13	3	1	3	1	
14	3	1	3	1	
15	3	2	3	2	
16	3	1	3	2	
17	2	2	2	2	1 RMN
18	3	1	2	1	1 RMN
19	3	1	3	1	plus 1 RMN
20	3	1	3	1	plus 1 RMN
21	3	2	3	2	
22	3	2	3	2	
23	3	2	3	2	
24	3	1	3	1	
25	3	1	4	1	
26	2	0	2	0	1 RMN
27	3	2	2	2	1 x RMN extra staffing for itu move
28	3	0	3	0	1 RMN
29	3	0	3	0	1 RMN
30	2	0	2	0	1 RMN
31	2	0	2	0	I RMN
BC DAY	88	35	87	37	
HOURS	1056	420	1044	444	

WARD	BURNS UNIT
GREEN	Staffing meets planned requirement
AMBER	Staffing does not meet planned requirement but care is safe
RED	Staffing does not meet planned reqirement and the senior nurse has been informed

MONTH JULY — When amber or red rationale to be provided below

		1	2		
		3	4		
		5	6		
7	8	9	10	11	12
13	14	15	16	17	18
19	20	21	22	23	24
		25	26		
		27	28		
		29	30	31	

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	2	0	2	0	
2	2	1	2	1	
3	2	1	2	1	
4	2	1	2	1	
5	0	0	0	0	3 itu staff working ward
6	2	0	2	0	
7	2	0	2	0	
8	2	1	2	1	
9	2	1	2	1	
10	2	1	3	1	6 patients
11	2	0	2	0	
12	2	1	2	1	
13	2	1	2	2	6 pts & 1 rehab 1 HCA from Cwing
14	3	0	3	0	
15	3	0	3	0	
16	3	1	3	1	
17	2	1	1	1	1 RMN - 3PTS +1 FLATS
18	2	1	2	1	
19	2	1	2	1	4 pts + I on weekend leave
20	2	0	2	0	Plus 1 RMN
21	2	0	2	0	Plus 1 RMN
22	2	0	2	0	Plus 1 RMN
23	2	0	3	0	1:1 for BS
24	2	1	2	1	
25	2	1	2	1	
26	2	1	2	1	1 RMN
27	2	1	1	1	1 RMN
28	2	0	2	0	1 rmn
29	2	0	2	0	1 RMN
30	2	1	2	1	1 rMN
31	2	1	2	1	1 RMN
BC NT	63	18	63	19	
HOURS	756	216	756	228	

ITU	MAY	JUNE	July	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0					On track no action required
Falls	0	0	0	0					On track no action required
Medication errors	0	0	0	0					On track no action required
MRSA/Cdiff	0	0	0	0					On track no action required
VTE reassessment	100%	100%	100%	>95%					On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%						On track no action required
Activity	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy									
Bed utilisation									
Patient numbers									
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 nurisng required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE
ITU									
Staff utilisation	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies Est = 16.16	2.40 WTE 386 hrs	0 WTE 0.0	.44wte 73.0	<5%	3%				No action required
Temporary staffing Exc RMN Bank / Agency	151.30 280.20	238.40 112.30	124.4 426.0	<10% 60.6hrs + vacancy	+ 416.8 hrs				Action required, over usage of bank and agency. ITU have been required to cover two areas due to infection control transfer
Sickness	14.59%	7.01%	5.52%	<2%	+3.52%				Sickness improved over last month, still carrying 1x injury/fractue
Shifts meeting Est	95%	91%	97%	>95%	2%				
Training / Appraisal	**No/%**			**Target**		**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	79.17%	83.60%	76.00%	>85%	-13.57%				Fallen slightly below target, action required
Appraisals	50.0%	46.67%	33.33%	>85%	-51.67%				Action required below Trust target for the last four months
Drug Assessments	95%	97%		>95					
Budget	7	25	48	>0	-25				Activity income is underplan in respect of ITU H&N patients

WARD	BURNS ITU											
GREEN		Staffing meets planned requirement										
AMBER		Staffing does not meet planned requirement but care is safe										
RED		Staffing does not meet planned reqirement and the senior nurse has been informed										
MONTH	JULY	When amber or red rationale to be provided below										
		1	2									
		3	4									
		5	6									
7	8	9	10	11	12							
13	14	15	16	17	18							
19	20	21	22	23	24							
		25	26									
		27	28									
		29	30	31								

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	2	0	2	0	
2	2	0	2	0	
3	3	0	3	0	
4	2	1	2	1	no ITU pts, helping in EBAC & ward
5	2	0	2	0	no ITU patients helping burns unit and canadian wing
6	3	0	3	0	
7	2	1	2	1	
8	4	1	4	1	
9	4	0	4	0	
10	3	0	3	0	
11	3	0	3	0	
12	3	0	3	0	
13	3	1	3	1	
14	3	0	3	0	
15	2	0	2	0	
16	2	0	2	0	
17	2	0	2	0	
18	2	1	2	1	
19	2	0	2	0	
20	2	0	2	0	1 o/c
21	3	0	3	0	
22	3	0	3	0	
23	2	0	2	0	
24	3	0	3	0	
25	3	0	3	0	
26	3	0	3	0	
27	4	1	4	1	extra staffing for itu move
28	3	1	3	1	icu now in two areas
29	4	0	3	1	icu now in two areas
30	4	1	3	1	icu now in two areas
31	5	0	5	0	icu now in two areas
ITU DAY	88	8	86	9	
HOURS	1056	96	1032	108	

WARD	BURNS ITU											
GREEN		Staffing meets planned requirement										
AMBER		Staffing does not meet planned requirement but care is safe										
RED		Staffing does not meet planned reqirement and the senior nurse has been informed										
MONTH	JULY	When amber or red rationale to be provided below										
		1	2									
		3	4									
		5	6									
7	8	9	10	11	12							
13	14	15	16	17	18							
19	20	21	22	23	24							
		25	26									
		27	28									
		29	30	31								

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	0	3	0	
2	3	0	2	0	1 pt HDU
3	3	0	1	0	1 on call ITU to cover
4	2	0	1	0	1 on call
5	3	0	3	0	All 3 working on the ward.
6	2	0	2	0	
7	3	0	3	0	
8	3	0	3	0	
9	3	0	3	0	
10	2	0	3	0	2 ITU patients
11	3	0	3	0	
12	3	0	3	0	
13	3	0	3	0	
14	3	0	3	0	
15	3	0	3	0	
16	2	0	2	0	1 patient
17	2	0	2	0	1 patient
18	3	0	3	0	
19	3	0	2	0	Agency cancelled as only 1 patient
20	3	0	3	0	
21	3	0	3	0	
22	3	0	2	0	Agency cancelled as only 1 patient
23	3	0	3	0	
24	3	0	3	0	
25	3	0	3	0	
26	2	0	2	0	
27	2	0	2	0	
28	5	0	5	0	icu in two areas
29	4	0	4	0	icu in two areas
30	4	1	4	1	icu in two areas
31	4	1	4	1	
ITU NT	91	2	86	2	
HOURS	1092	24	1032	24	

QUALITY &RISK MANAGEMENT REPORT
Monthly Report – July 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- Areas of concern related to patient and staff safety have been identified, assessed and the risks are being prioritised and managed with the lessons learnt disseminated to the organisation.
- The report contains key information on;
  - quality metrics
  - safety metrics
  - incident management
  - policy updates

Key Points:

The key priority that the board need to be aware of for this month are ;

1. During May a never event was declared following the extraction of the wrong teeth.
   - A full investigation has been completed (summary attached p27).
   - The root cause was identified as human error by one individual.
   - The patient and their family have been involved throughout the investigation.
   - The full report was submitted to the CCG for closure.
   - As this was a further incident declared as a never event involving medical staff the executive team met to discuss and consider whether there were any cultural aspects that required investigating further. As a result the following actions will occur;
     - Medical Director to write to all medical staff informing them of the trusts expectations of them.
     - The Manchester Patient Safety Framework programme to include medical staff. This is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture.
     - QVH will join the Sign up to safety campaign launched in July 2014.

2. During June a serious incident was declared after the abnormal result from a specimen sent for a second opinion was not provided to the surgeon for further management of the patient.
   - A full investigation has been completed (summary attached p 30).
   - Actions are in place to prevent reoccurrence.
   - Feedback to the department involved has been provided.
   - The patient and their family have been involved throughout the investigation.
   - The full report has been submitted to the CCG and is awaiting closure.

3. A serious incident was declared in July following the outbreak of MRSA colonisation in the burns unit. Further information is available within the infection control report (p 33)

4. Information on trends is discussed at relevant department meetings and at Clinical Cabinet each month.

5. Within the quality and safety metrics;
   - An increase in complaints is expanded on within the patient experience, complaints and claims report (p 39).
   - Ward nurses have been reminded about their responsibilities in ensuring that all patient risk assessments are completed within 24 hours.

- Theatre staff have improved compliance with the WHO checklist and this remains a focus of attention with the sign out and recovery handover the areas of current focus at they are not achieving 100%.

Implications:

- Failure to improve the overall WHO checklist compliance score is identified as a risk to gaining the full CQUIN funding.

Recommendations:

The board is asked to note the actions currently being taken.

Clinical Cabinet & Trust Board
Quality & Risk Management Report

August 2014 (July 2014 Incidents)

Quality Metrics

1. **Quality Metrics data (monthly metrics for Clinical Cabinet only, Board receive quarterly Metrics)**
   This includes monthly & quarterly (where appropriate) Quality Metrics data

2. **Patient Safety Data**

Incidents

3. **Incidents open and closed**
   Chart showing the number of complete and incomplete investigations by month

4. **Incident Trend Analysis**
   This series of charts aims to identify unusual reporting activity therefore highlighting possible trends. The focus is on total incidents reported, patient falls and incidents by their severity plus any identified trend / increase in reporting category.

5. **Incidents of concern for <u>June 2014</u>**
   Red (severe) and amber (moderate) incidents - highlighted as potential areas of concern by the risk management team. The content of data has not been changed apart from names removed wherever possible. Please treat as confidential.

Policies

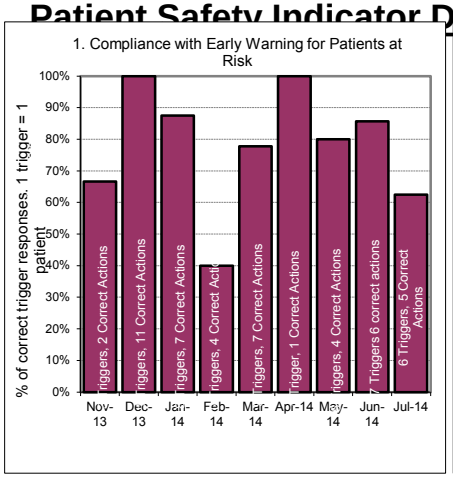
6. **Policies uploaded during the month**

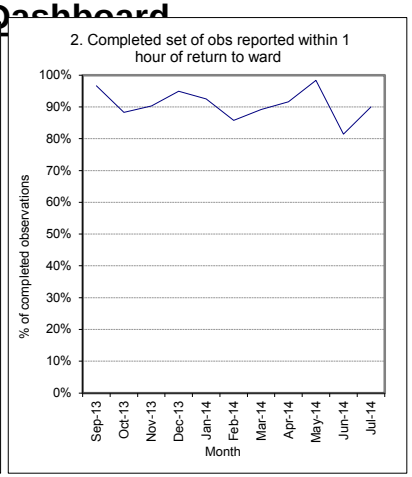
Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
CQUIN	VTE prophylaxis	100%	>95%	100%	100%	100%	100%									100%
	VTE in hospital/RCA undertaken	100%	0/100	0	0	0	0									
	FFT Score acute in-patients	86%	>80	88	86	94	91									90
	Number of responses	NEW	30%	72%	37%	47%	48%									
	FFT score MIU	85%	>80	76	77	77	75									
	Number of responses	NEW	20%	21%	8%	45%	19%									23%
	FFT Annual Staff Survey	NEW	>4	Annual Score												#DIV/0!
	Dementia >75 trauma asked indicative question	93%	90%	80%	100%	100%	100%									95%
	Dementia >75 having diagnostic assessment	100%	90%	100%	100%	100%	100%									
	Dementia > 75 referred for further diagnostic advice	89%	90%	100%	100%	100%	100%									
	Dementia training for staff	—	65%	81%	77%	85%	85%									
	Dementia clinical leads identified	—	NA	Informatiion sum=bmitted to CCG during June 2014						Reported twice yearly						
	Dementia carers monthly audit	100%	NA	All Q1 carers of patient on the butterfly scheme have been contacted with the butterfly scheme evaluation tool												
	Safety thermometer data submission	100%	Y/N	Y	Y	Y	Y									
	Harm free care rate	100%	>95%	100%	98%	100%	95%									
	No new harm rate (aquired at QVH)	100%	>95%	100%	100%	100%	100%									
	Reducing cancelled operations	—	TBC	Reported 1/4ly			Reported 1/4ly			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%									#DIV/0!
	Assessment against Bronze food chartermark	NEW		Quarterly report submission			Quarterly report submission			Quarterly report submission			Quarterly report submission			
	Manchester Patient Safety Framework (MaPSaF) compliance	NEW		Quarterly report submission			Quarterly report submission			Quarterly report submission			Quarterly report submission			
Quality Account 2014	Scheduling of elective surgery with 3weeks notice	NEW	80%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Number of elective patients receiving treatment on the day of their outpatient appointment	NEW	50% incr from Q1	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Introduction of safer care module to eroster	NEW	Commence reporting	Quarterly report submission			Quarterly report submission			Quarterly report submission			Quarterly report submission			
Clinical Indicators (Clinical outcomes reported annually in Quality Account)	Unplanned patient return to theatre within 24 hours (ORSOS Data)			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Unplanned patient return to theatre within 7 days (ORSOS Data)			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Surgical mortality (excludes Burns)			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Burns mortality			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			#DIV/0!
	Unplanned transfers out (HES Data)			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			#DIV/0!
	Unplanned re - admission (HES Data) *final figure (includes end of month crossover cases).			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			#DIV/0!

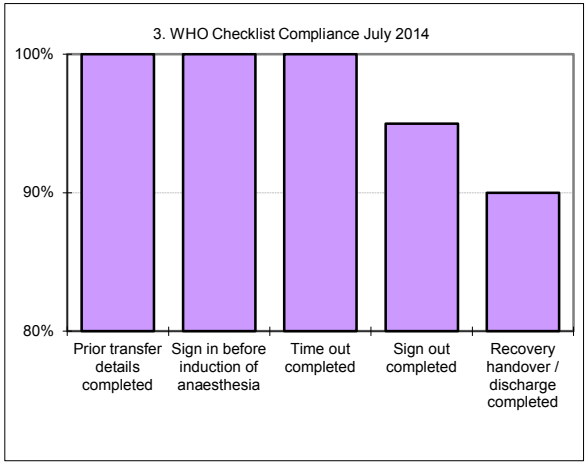
Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Experience	Complaints per 1000 spells	4.7		3.4	2.9	6.9	6.6									1
	Claims per 1000 spells	1		1.4	0.0	2.7	1.2									
	FFT Score acute in-patients	86%	>80	88	86	94	91									1
	% score for likely and very likely to recommend QVH		>90%	99%	100%	99%	97%									
	FFT score MIU	85%	>80	76	77	77	75									
	% score for likely and very likely to recommend QVH		>90%	99%	97%	96%	96%									
	FFT score OPD	82%	>80	82	81	80	82									1
	% score for likely and very likely to recommend QVH		>90%	98%	98%	98%	98%									
	FFT score DSU	93%	>80	-100	90	88	83									
	% score for likely and very likely to recommend QVH		>90%	0	98%	99%	99%									77
	FFT score Sleep disorder centre	76%	>80	78	74	76	78									98%
	% score for likely and very likely to recommend QVH		>90%	99%	97%	98%	98.0%									#DIV/0!
	FFT score Therapy	NEW														
	Mixed Sex accommodation breach	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%									
Patient Safety	Number of Pressure ulcer development Grade 2 or over acquired at QVH	8		0	0	0	0									
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	NEW	>95%		100%	97%	100%									
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	NEW	>95%		80%	83%	100%									
	Patient Falls resulting in no or low harm	16	—	4	1	3	6									
	Patient Falls resulting in moderate or severe harm or death	NEW	—	0	0	0	0									0.9
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	NEW	>95%	100%	73%	82%	85%									
	Avoidable patient falls identified on the Safety Thermometer	—		0	0	0	0									
	Serious Incidents (including Never Events)	5		0	1	1	1									
	Total number of incidents involving drug / prescribing errors	NEW		13	10	19	16									
	No & Low harm incidents involving drug / prescribing errors	NEW		13	10	18	16									0.5
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	NEW		0	0	1	1									
	Medication administration errors per 1000 spells	1.3		0.7	3.6	2.7	1.2									
	To take consent for elective surgery prior to the day of surgery (Total)	72.2%	75%	84.7%	69.6%	76.8%	77.1%									
	To take consent for elective surgery prior to the day of surgery (Max Fax)	60%		68.2%	69.7%	71.4%	77.8%									
	To take consent for elective surgery prior to the day of surgery (Plastics)	46%		84.3%	65.1%	72.9%	72.4%									1
	To take consent for elective surgery prior to the day of surgery (Corneo)	81%		95.0%	88.5%	93.9%	87.8%									
	Number of outstanding CAS alerts	NEW		0	0	0	0									25%
	Number of reported incidents relating to fraud, bribery and corruption	NEW		0	0	1	0									

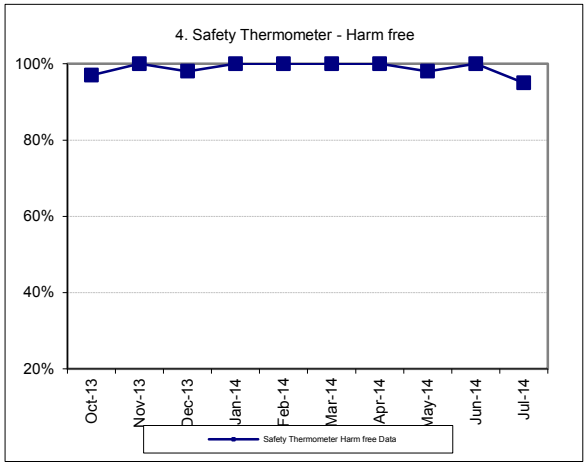
Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Staff Safety	Staff incidents causing harm	58		9	8	6	10									
	RIDDOR (Patients & Staff)	4		1	0	0	0									0
	Mandatory training attendance	71%	80%	82%	78%	82%	89%									0
	Flu vaccine uptake	55%	60%	Not due till October												0
																0
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0									0%
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0									0%
	E-coli bacteraemia	0	0	0	0	0	0									0%
	MSSA bacteraemia	0	0	0	0	0	0									
	MRSA screening - elective	96%	>95%	97%	97%	97%	95%									
	MRSA screening - trauma	98%	>95%	95%	97%	97%	97%									
	Trust hand hygiene compliance	95%	>95%	99%	100%	96%	99%									

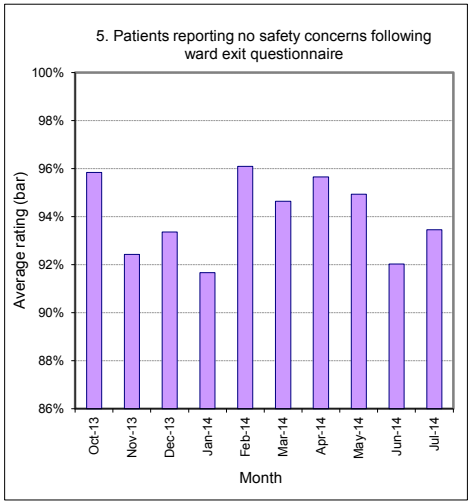
Patient Safety Indicator Dashboard

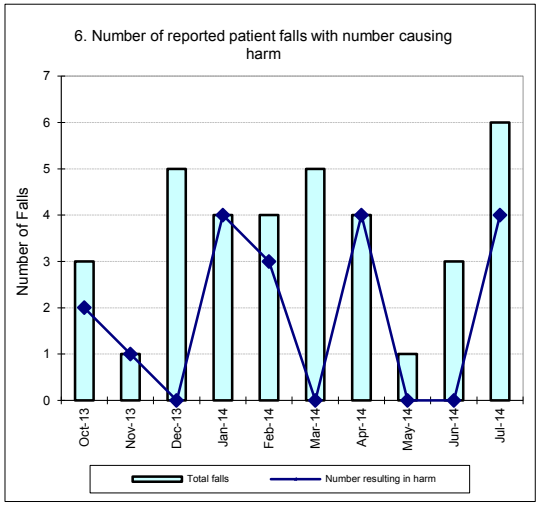


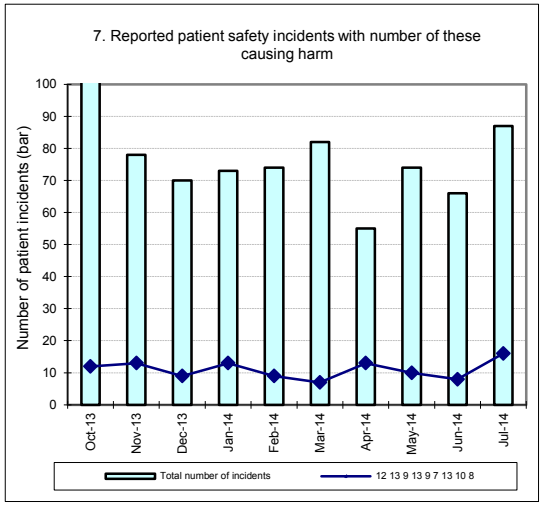


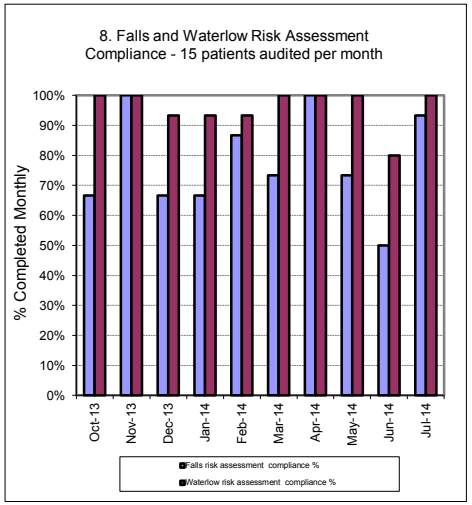












Incidents Open and Closed Data 2014/15

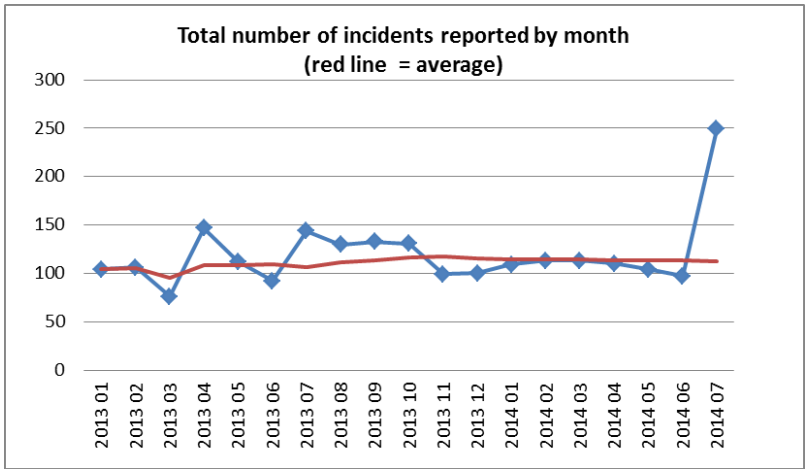
Overview/Summary

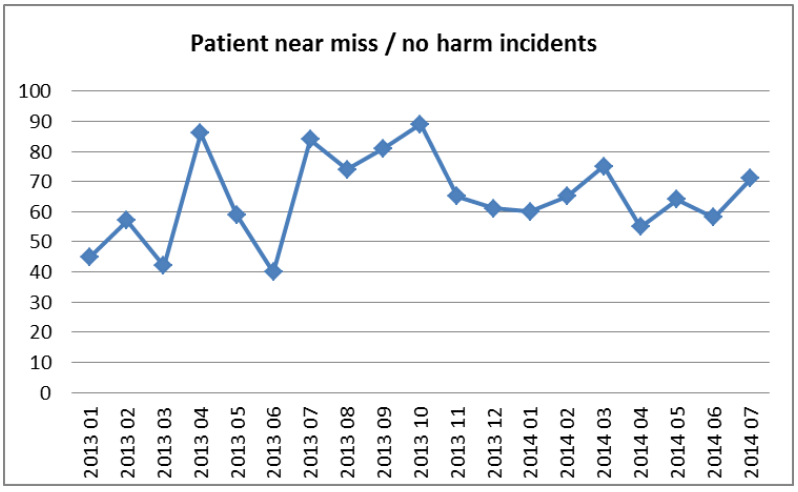
The number of incidents reported for the Trust for 01/07/2014 – 31/07/2014 was 249, with 109 of these being associated with a revised admistration process. The 140 other incidents that were reported is an increase of 44% when compared to the 97 incidents that were reported for June 2014.

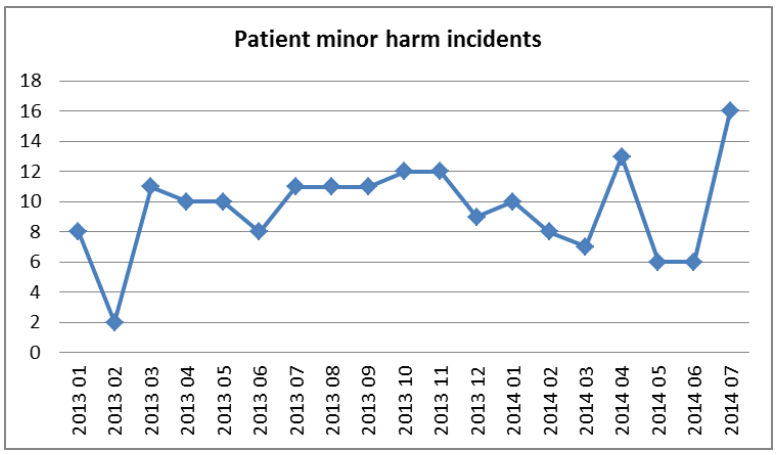
176 incidents were closed during the month of July, compared to 87 for the month of June 2014.

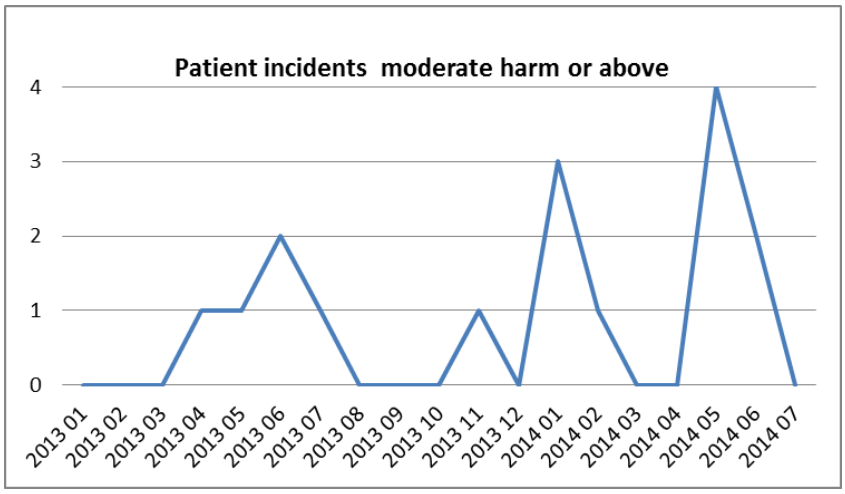
There were 2 “red” internal incidents and 2 “amber” internal incidents for July 2014, compared to 1 “red” internal incident, and 2 “amber” internal incidents for June 2014. Root Cause Analysis (RCA) reports are routinely completed for this category of incident.

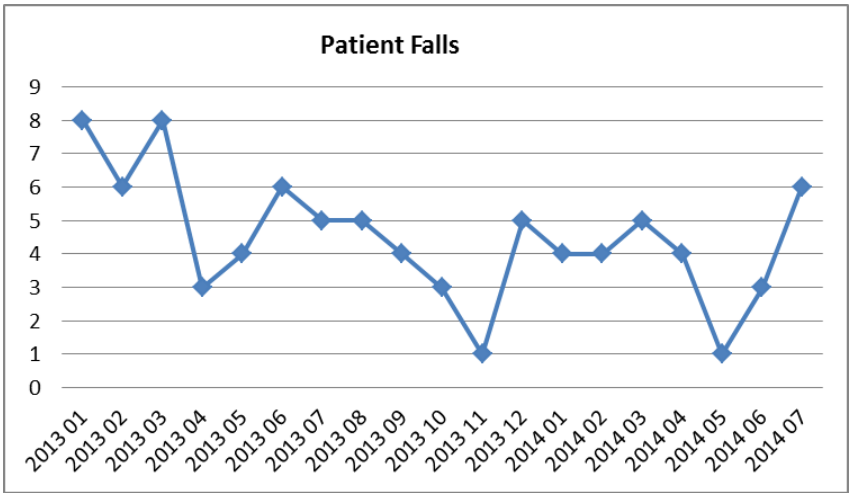
Incident Trend Analysis











Trends / issues following incidents reported in July 2014

Administration issues (n=109)

On 14 July 2014 the referral system to the hospital changed in order to centralise the system. Referrals were to be made via health records, and not to be sent to individual departments and/or consultants. A letter had been sent to all referrers with details but in order to audit those who did not use the new system, those who received referrals incorrectly were asked to record this via the Trust incident reporting system (DATIX) and send the referrer a standard letter.

From 14th to 31st July 2014, 109 delays were reported (some for more than one referrer). These have been included in all incident reports for the month but such a large number of extra incidents distorts the figures and should be borne in mind.

All drug errors (n=14)

The majority of the drug error incidents reported in July 2014, related to Prescribing Errors (n=11). Source clinicians, time of day and medications were reviewed for any patterns and no trends could be identified aside from five of them occurring between 15:30 and 17:30 (spread across specialties), and five incidents of the eleven taking place on Margaret Duncombe Ward.

Common errors related to the omission of information or inaccurate recording of medications on the drug chart. The drug charts are reviewed by the Pharmacists in the inpatient areas, and they also provide support and advice to medical staff in relation to medication queries.

The Head of Risk and Medication Safety Officer have put in place a new mechanism to meet with the Lead Consultants for Plastics and Maxillofacial surgery on a 4-6 weekly basis to review all incidents (with a special focus on medication related errors). This mechanism has been commenced to complement the incident and risk review process undertaken at the Monthly Directorate Review Meetings.

One of the medication errors reported has been categorised as an internal "amber" – Further information is given at the appropriate section of this report.

Caldicott / Information Governance (n=14)

The commonest type of Caldicott/Information Governance incident reported during July 2014 involved parties receiving information not intended for them (n=6). A breakdown is given below:

- Three occurrences of incorrect patients receiving information not intended for them occurred and the investigations for these remain ongoing.
- A GP Surgery received a letter for an unrelated patient (with a similar name). This was corrected and no documentation was sent to an incorrect patient in error.
- Two Burns staff members received letters intended for other staff members. The Human Resources Department have investigated these incidents and an improved review of staff lists and addresses will be undertaken to reduce discrepancies between the ESR and Mailshot systems.

Two incidents were also reported in relation to information that had been left in the Quiet Study Area. Medical staff have been reminded to ensure that documentation is removed when they leave the room.

No further trends were identified.

Delay in Performing Operation / Procedures (n=12)

Plastics experienced the majority of delays in Performing Operations/Procedures in July (n=9), and no trends were identified. List overruns accounted for two delays, with a further two being due to queries with patient notes. The remaining two incidents were ad hoc issues.

Maintenance / Building Issues (n=9)

6 of the 9 reported incidents for July 2014 related to excessively hot rooms during the hot weather conditions in the month. 2 of the 6 incidents were in off-site clinics. Reminders have been given by the Risk Management Department and Matrons to take precautionary measures to reduce heat such as drawing blinds and turning lights off (where appropriate). Staff were also aksed to record temperatures in affected areas.

New internal "red/amber" incidents and SI's – 1 SI (also categorised as a Red incident) and 1 x Red Incident,

1 x Serious Incident (ID 12261) was reported on STEIS for July 2014 (reference: 2014/22647). The investigation and completion of the Root Cause Analysis (RCA) report is underway.

7 patients were identified as having a hospital acquired MRSA with no apparent links other than the location that they were treated. All patients were negative on admission. All cases were identified in the Burns Unit. It is suspected that the index cases was transferred from an external organisation. RCAs have been completed on all patients and a timeline produced which is ongoing.

Immediate actions taken included:

- Routine HCAI procedures activated.
- Individual room/areas deep cleaned following positive patient discharges
- All beds blocked (as unit closed to admissions) until MRSA screening results have been received.
- Strict barrier nursing commenced for each patient the day that a positive result was known.
- All patients barrier nursed, even if negative, from 11/07/2014.
- Relatives of confirmed patients have been asked to take precautionary measures e.g. wearing gowns and washing hands.
- Staff will be asked to use the Decontamination Protocol and approach the Occupational Health Department for MRSA screening.
- A review meeting was held with hospital managers and a plan developed for patient, staff and environment management.

The unit was closed to all Burns admissions on 23/07/2014, following a meeting between the Medical Director, Director of Nursing and the Clinical Director for the Burns Unit, and Microbiologist advice, and a new intensive care area was set up for major head and neck cases in the main Theatre Recovery area.

1 x additional internal "Red" incident was reported (ID 12408)
A patient scheduled for an elective Swanson Arthroplasy to DIPJ Left index and middle fingers. The patient received a local block to two fingers before it was identified that only one implant was available for fitting. The size required was not highlighted in advance or at the time out. The theatre staff attempted to get another implant from other sources unsuccessfully.

The patient was asked if they wished to proceed with the procedure for one finger, but decided to have the surgery for both rescheduled. The patient had received an unnecessary local anaesthetic block.

2 x internal "Amber" incidents ID 12452 & ID12469 were reported

ID 12452
The patient attended for a right wrist radiograph at the request of MIU following presentation and trauma/injury that occurred to the patient on 15th May 2014 whilst they were playing golf. An Xray was undertaken and reported as normal. A fracture was not apparent from the images that were available.

A Cone beam CT was requested on 30/05/2014, as per Trust policy. The outcome (read by Ian Francis, Clinical Director for Radiology) showed evidence of an impacted comminuted fracture of the distal radius.

The Cone beam study results were entered into the departmental discrepancy process (for shared learning).

The investigation for this incident has been commenced and an RCA is underway.

ID	Risk	Incident date	Directorate	Service	Incident Summary	Investigation Summary	Category
12148	Red	04/06/2014	Plastics	Histopathology	Second opinion sought by Histopathologist with no record made; patient discharged with no further treatment (May 2013). Second opinion contained significant difference of opinion but report was not added to records. The surgeon did not receive the second opinion report. In March 2014, the Histopathologist wrote a letter to the surgeon about the patient with no explanation re the delay. The existence of the second opinion is mentioned but not that this represented a significant difference of opinion nor the possibility of malignancy.	04/06/2014 Incident initially discussed between the DoN and the Medical Director and the Head of Risk. Awaiting full details. 10/06/2014 DoN, MD and Head of Risk agreed to report as an SI. CCG, Monitor and CQC informed. STEIS Ref: 2014/18872 20/06/2014 - Full explanation of events and an apology given by telephone (as the patient is in Brisbane) by the Medical Director to the patient for the long delay in this coming to light. Immediate priorities identified. Medical Director has arranged for copies of documentation to be sent to a specialist. 20/06/2014 Notification received from the third opinion that this is a confirmed melanoma, and a referral letter has gone to a Surgeon in Brisbane and apopintments arranged. 24/06/2014 - MD has reported this incident to the GMC. The Consultant concerned has revoked her licence to practice. Additional Consultant in Brisbane identified for surgery and forwarded case information as initial Consultant on A/L. 24/06/14 Trust to offer £5k ex gratia payment to cover any financial losses, also linked in the Claims module of Datix. 07/07/2014 Letter to Medical Director from Australian Consultant confirming the update position and progress of treatment (letter attached in Datix) RCA updated regularly to reflect events. Copy to July 2014 Trust Board for discussion as a patient story	Delay in investigation, treatment, diagnosis or results

ID	Risk	Incident date	Directorate	Service	Incident Summary	Investigation Summary	Category
12192	Amber	20/06/2014	Plastics	Theatre Services	Dermatome did not take split skin graft as expected. Skin taken intermittently and not the full width. Synergy contacted requesting decontamination of dermatome, to enable investigation of faulty functioning dermatome.	Investigation showed no fault with device. Dermatome issues on risk register and HoR undertaking a review of age of equipment	Equipment failure / misuse
12141	Amber	06/06/2014	Plastics	Nursing	Patient attended MIU with finger injury. Extent of injury not confirmed as dressing not removed. Arranged for morning admission for surgery, possibly amputation. TRIPS showed on first photo a female hand with an injured RIF. However, 3 further photos were of a male hand with injury to middle finger. The SHO had booked her surgey on the basis of the severity of all the photos. The patient had been told that she may lose her finger. Patient attended in morning for re-assessment.	Unknown if error in uploading images at QVH or elsewhere. RCA to be undertaken. Investigation to also focus upon the failure to reduce the dressing and examine the injured digits at MIU. as clinical assessment should inform the correct medical management. A failure to reduce the dressing was a significant error in this case.	Lack of Pre-op / procedure preparation

Policies Uploaded in July 2014

The following policies were uploaded to the intranet during July 2014:

- Sugammeadex Guidelines – Medicines Management – MMC
- Nurse-led plasma bleed clinic protocol – Departmental for Corneo Plastics
- Measles Immunisation Policy – HR – Clinical Governance Group
- Methotrexate Policy – Medicines Management – MMC.

Root Cause Analysis Investigation Report

EXECUTIVE SUMMARY

Incident

A patient was harmed through the incorrect extraction of two additional teeth. The error has been attributed to human error, although it was perpetuated by documentation errors such as; a full review of the accompanying paperwork not being completed (letters, notes, radiographs), and an inaccurate undated entry in the patient notes. Consent had been taken for the extraction of four first premolars (not two as originally prescribed) and correctly an upper midline supernumerary due to the error.

The main learning points identified were that all documentation should be checked and cross referenced prior to consent and listing, entries must be dated, and that any discrepancies should be reviewed by the referring clinician prior to surgery.

Root causes

1) **Human error –** the basic root cause of this mistake is human error. It is essential that clinicians read the referral letter/s and clinical notes carefully and then cross-reference all information, letters, notes and radiographs, together with the patient's expectations of treatment, before confirming the consent and listing the patient for the procedure.

2) **Perpetuation of the error-**
   - At the time of surgery neither the clerking of the patient or double checking of the consent identified the error.
   - The error was further confused by the undated entry that was interpreted as a change to the treatment plan by the operating surgeon.
   - The countersignature of the Waiting List Form by the Lead Maxillofacial Consultant gave a false confirmation to the operating surgeon, who believed that there had been a change to the treatment plan. However this is not the purpose of the form, the Lead Maxillofacial Consultant has confirmed that this was only to confirm the time required for surgery and the grade of operator.

Arrangements for shared learning

Results of RCA to be shared with the clinical team via the Head and Neck directorate meetings and hospital audit meeting.

Distribution list

- Patient/family involved in care episode
- Horsham and Mid Sussex Clinical Commissioning Group
- Care Quality Commission
- Internal Committees
- Team involved in incident

Action Plan

Action Description (Specific)	Success Criteria (measurable)	Plan (Achievable and Realistic)	Timescale (Time-limited)	Lead (Specific)	Date Completed
Email reminder sent to all maxillofacial surgeons reminding them of importance of annotating teeth correctly for extractions and to check all records/ correspondence fully at time of consent and surgery	Clinical staff reminded of the importance of correct annotation and checking of patient records (measured via ongoing monitoring of this type of incident)	Email to all clinical staff	31/5/14	Lead clinician Maxfacs	Completed
Reminder to all clinical staff that all correspondence/ records should be checked and cross referenced before consenting a patient for treatment	Clinical staff awareness	a) Discussion at the Head and Neck Directorate meeting b) Discussion at the Head and Neck/MaxFacs M&M meeting **c)** Discussion at the Joint Clinical Audit Session	a) 31/08/2014 b) 31/08/2014 c) 31/08/2014	a) Lead clinician Maxfacs bConsultant Max Facs/ Lead Consultant Orthodontist c) Medical Director	a) b) c)

Remind all clinical staff that entries must be dated in the notes	a) Staff awareness raised b) Documentation audit report	a) Discussion at the Joint Clinical Audit Session b) Included in the Trust quarterly documentation audit	a) 31/08/2014 b) 31/08/2014	Medical Director	
Any discrepancies between referral letters/ correspondence and the planned procedure/ consent must be investigated with reference to the referring practitioner before proceeding with surgery.	a) Staff awareness raised b) Ad-hoc audit to be undertaken (report as evidence)	a) Discussion at the Head and Neck/MaxFacs M&M meeting b) Discussion at the Joint Clinical Audit Session	a) 31/08/2014 b) 31/08/2014	Medical Director	
Awareness to be raised with Consultants that countersignature of the Trust Waiting List (yellow) Forms will be deemed that patient notes/patients have been reviewed as part of the process of applicability for Theatre lists.	Clinical staff reminded of the importance of correct annotation and checking of patient records (measured via ongoing monitoring of this type of incident)	Discussion at the Joint Clinical Audit Session	31/08/2014	Medical Director	
Explore the role of Clinic Nurses in Outpatient Depts	Review documentation and any identified changes	Review to be undertaken of the role of nursing staff in all Outpatient Clinics and their involvement with clinic appointments	31/10/2014	Director of Nursing	
Implement the learning from this incident	Clinical staff aware of the learning	Discussion at the Head and Neck Directorate meeting and at the Joint Clinical Audit Session	31/08/2014	Medical Director	

Root Cause Analysis Investigation Report

EXECUTIVE SUMMARY

Incident

An incident has been reported on STEIS (reference number of 2014/18872). It refers to a delay that occurred between a histopathology case that was originally reported in May 2013 by a QVH Consultant Histopathologist of a narrowly but completely-excised benign lesion. A second opinion from an external expert was sought on 23/05/2013 and this request was omitted from the records. The patient was discharged without further treatment.

The second opinion report was received containing a significant difference of opinion (issued on 10/06/2013). This was not added to Winpath and the paper copy was not filed in the patients laboratory file. The plastic surgeon was not offered a copy of the second opinion report. Therefore both the patient and the Consultant Plastic Surgeon were unaware of the difference of opinion.

The surgeon received a letter from the QVH Consultant Histopathologist suggesting that the patient undergo a wider excision, and this alerted the Surgeon to the possibility of a change in diagnosis. The Clinical Director, Medical Director, Director of Nursing and Head of Risk were informed on 04/06/2014, and this has generated an investigation and an RCA.

Root causes

These are the most fundamental underlying factors contributing to the incident that can be addressed. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient.

- Failure by the Consultant Histopathologist to communicate the interim nature of the diagnosis in May 2013 and the existence of a contrary clinically more serious diagnosis in the opinion of an external expert.

Lessons learned

Key safety and practice issues identified which may not have contributed to this incident but from which others can learn.

- Working practices which are not in keeping with best practice should be addressed to protect patients
- Histological reporting in line with SOP needs to provide accurate, clear unambiguous opinion in the majority of cases. If this is not possible, an interim report must be issued, outlining the diagnostic dilemma and listing the actions (including second opinions) to resolve this.
- Supplementary reports should be added to include verbatim Histopathology external expert opinions.

- A Histopathology departmental failsafe mechanism needs to be established to ensure external opinion cases are followed up.
- Cases of clinicopathological non-correlation should be reviewed histologically and discussed at the multi-disciplinary meeting.
- A culture of sharing of difficult cases among the Consultant Histopathologists and timely resolution of diagnostic dilemmas should be encouraged.

Arrangements for shared learning

Discussed at 15th September 2014 Clinical Cabinet, 4th September Quality and Risk Committee, and 8th September Clinical Governance Group. Incident also reported as an SI on STEI. RCA shared with CCG.

Distribution list

- Discussed with Clinicians and Departmental Managers via the Clinical Cabinet, Quality and Risk Committee and Clinical Governance Group.
- Learning to be disseminated at monthly meetings via leads in attendance at the above meetings.
- Thursday 31st July 2014: Incident shared as *Patients Story* at the start of Board of Directors Meeting to the Executive and Non-Executive members present. The Incident, Actions and Good Practice were presented and assurance given that steps are already in place to prevent a recurrence

Recommendations and Action Plan

Action Description (Specific)	Success Criteria (measurable)	Plan (Achievable and Realistic)	Timescale (Time-limited)	Lead (Specific)	Date Completed
Open discussion of incident and clarification of expected working practices	Systems implemented, re-audit of external opinion cases to show compliance with best practice	Discuss at Histopathology Department, Clinical Governance and Management meeting	17/06/2014	Clinical Director for Pathology	17/06/2014
Audit of Consultant Histopathologist's cases sent for external opinion	Outcome Report completed to demonstrate that all cases have appropriate Histopathology supplementary reports and patient management	Comparison of external opinion with QVH Pathology report issued since 1st April 2010	30/09/2014	Clinical Director for Pathology	
Introduction of a failsafe mechanism for external opinion cases	Re-audit of external opinion cases to show compliance with best practice	Maintaining a log on the shared drive of external opinion cases, backed up by a visible whiteboard listing outstanding cases	31/10/2014	Histopathology Laboratory Manager	
Introduction of slide review for cases discussed at multi-disciplinary meeting	Review opinions documented on all Multi-disciplinary meeting (MDM) cases	Increased notice of MDM list prior to MDM to allow slide review	30/09/2015	Medical Director/ Clinical Director for Pathology	
Review of incidents reported on the DATIX system relating to Histopathology cases back to 1st April 2010	Report of cases compiled and any learning identified and disseminated	Datix report to be compiled and analysed for any trends	30/09/2014	Head of Risk	

INFECTION PREVENTION & CONTROL
Monthly Report – July 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- Areas of concern related to infection prevention and control have been identified, assessed and the risk are being prioritised and managed.
- The report contains key information on;
  - detail of outbreaks or significant infections
  - surveillance and audit information
  - infection control or prevention risks and mitigation

Key Points:

The key priority that the board need to be aware of for this month are ;

1. Last month the board was verbally updated about the closure of the burns unit to adult admissions due to declaration of an outbreak after a number of patients became colonised with MRSA while in patients within the unit. Currently the burns unit remains closed to adult admissions however arrangements have been made to ensure the trust can safely treat out patients, day cases and admit minor burns requiring inpatient care. To date the consultant burns surgeon has stated that no major burn have been admitted elsewhere that would have been admitted to QVH.
   - We have sought external advice from PHE and our microbiology provider and are taking all appropriate action.
   - There is a plan that will require continued closure of the unit to allow for decontamination.
   - Throughout this outbreak access to information and support from consultant microbiologists from BSUH has been excellent
   - The closure has required the relocation of ITU into our recovery area. All action is being taken to reduce the risk to patients.
   - Monitor, the local area team, Horsham and Mid Sussex clinical commissioning group and the care quality commission have all been kept updated.

2. Anonymous concerns were raised to the DIPC by the Care Quality Commission about care at Darent Valley within clinics involving QVH patients.
   - A full health and safety and infection control inspection was undertaken and the report provided to the Chief Nurse at Darent Valley and the CQC.
   - To provide assurance that QVH inspections at spokes have been completed these have been added to the health and safety report on annual inspections.

3. The ability to recruit into the domestic services team is anecdotally related to the time taken to gain DBS and reference checks. This has been raised with HR who are working with the hotel services team to ensure recruitment is as prompt as possible.

Implications:

- Corporate risk (27) has been raised from 12 to 16.

Recommendations:

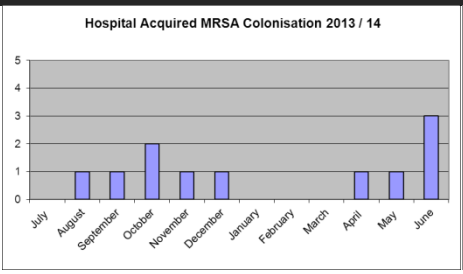
The board is asked to note the actions currently being taken and the raised risk related to hospital acquired infection.

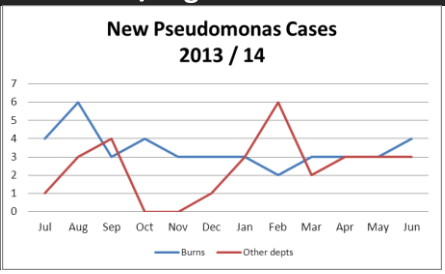
INFECTION PREVENTION & CONTROL
Monthly Report – July 2014

Areas of Concern

- Period of increased incidence HCAI MRSA colonisation on the Burns unit. The number of patients involved has increased to seven. Currently only one remains an inpatient (13 August). An outbreak has been declared and the Unit has been closed to adult admissions. With a plan devised to protect all patients and to address cleaning the unit once all affected patients have been discharged.
- Antimicrobial prescribing and the potential for over prescribing – A review of the guidelines has occurred, annual audit occurs and reminders are given to staff at clinical mandatory training to discuss antibiotic use with the Microbiologist. Patients are reviewed by the Consultant Microbiologist twice a week, when they are able to meet their contracted hours on site.
- Ability of BSUH to provide electronic reporting in usable format to the infection control team – This is been raised as a risk on the risk register and the DIPC is liaising with BSUH for a new format. Progress is monitored at the Pathology contract meeting.
- Inaccurate or missing results from the daily lab sheet provided by BSUH (MRSA positive results and streptococci)– Datix completed. This has been reported to the DIPC and discussed at the pathology contract meeting (August). BSUH looking into possibility of providing a new format for the ICNs.
- Lack of onsite Consultant Microbiology cover – This has been because BSUH have been short of microbiologists so have been unable to meet their onsite commitments at QVH. The risk is recognised on the risk register and is mitigated by the 24 hour telephone cover provided. It is anticipated that in September BSUH will be able to meet their contract commitments as they have employed a locum and a new Consultant Microbiologist and are awaiting commencement of employment.
- Only one Sterinis machine in working order – A business case submitted and new equipment has now been ordered (August). During the outbreak we have mitigated the risk by use of a loan machine.
- Hotel services team understaffed, this along with additional cleaning required due to the outbreak has reduced their ability to deliver a full cleaning service across the trust – The lead has met with the infection control team agreement reached on prioritisation of clinical areas. Staff in non-clinical areas have been informed of interim arrangements for cleaning prioritisation. Bank staff requested as short term measure whilst recruitment of permanent staff occurs.

Outbreaks / Significant Infection:





An outbreak was declared on the Burns Unit 7th July and the unit closed to adult admissions on 25th July. Currently there are two in-patients. A variety of measures have been implemented including: decolonisation/screening of staff, deep cleaning, review of scrub guidance, management of ITU patients moved to an alternative area, burns outpatients (EBAC) process reviewed, screening of patients, management of burns day case patients, cohorting of staff providing care and minimising those attending the Unit. PHE have been informed. Weekly outbreak meetings are being held.

One patient was diagnosed with a Group A Streptococcal infection following a dog bite. The patient went to theatre for a debridement and washout and was treated with antibiotics. PHE contacted QVH for information to enable contact tracing. Confirmed by the Microbiologist no further action required from QVH and there were no secondary cases.

Risk Register		
Risk	Number	Current situation
Lack of hand wash basins	442 (rated 6)	Portable sinks in situ where risk identified

Carpets in clinical areas	475 (6)	Replacement programme ongoing
Pseudomonas	556 (6)	Testing programme in place.
BSUH microbiology	513 (12)	Not currently providing 5 PA's on site. Telephone cover available. Infection control nurse hours increased.
Portable aircon units	631 (6)	Only for use at heatwave level 3 or where room temperatures exceed an acceptable level. Use in clinical areas is done in conjunction with an IPACT discussion.
Pre Sterinis cleaning	630 (3)	Use soap and water prior rather than Chlorclean prior to use of Sterinis (except in Burns)
Sterinis machines broken	688 (6)	Quotes being obtained urgently.

Surveillance

	New this month	Year to date (target)	IC mandatory training	Overall attendance at 6.8.14: 84.2% (incl booked)	
E.coli bacteraemia	0	0	**Trustwide Quarterly Results – Q1**		
MRSA positive blood cultures	0	0 (0)	MRSA Screening:	Elective: 96.7%	Overall 96.5%
VRE/GRE positive blood cultures	0	0		Trauma: 95.8%	
C.difficile	0	0 (0)	Hand Hygiene / BBE:	Hands: 98.8%	
MSSA positive blood cultures	0	0		BBE: 97.8%	

	All Theatres	Burns/EBAC	Corneo	MD/Stepdown	Maxfax/Ortho	MIU	OPD x2	PAC	Peanut	Recovery	Rehab	RT	Sleep	Therapies	X-ray
Screening – elective	95	90		96								100	92		
Screening – trauma	96	100		98								98	n/a		
Total new MRSA: 10	1	4		1				3					1		
Pos on admission: 8	*1*	*2*		*1*				*3*					*1*		
Previously positive: 0															
Hospital acquired: 2		*2*													
Unknown: 0															
Hand hygiene	100	100	100	100	100	96	100	100		100	100	94	100	100	
BBE	100	100	100	100	100	100	100	100		100	100	93	100	100	

Trust Cleanliness

The Trust has to comply with the PLACE standards. The domestic supervisor undertakes 12-15 cleanliness audits on a weekly basis. Areas must score above 80% to be considered compliant. The results are fed back to the Ward/Dept Manager. If an area scores below 80% the Matron for the area will be informed. Areas achieving cleanliness scores under 80 % in July were zero.
Three quotes have been received for purchasing of the new Sterinis (Hydrogen peroxide) cleaning machines. Discussion on preferred machine has taken place asap and machine is now on order (August).

Training

The infection control nurse specialist met with the Housekeepers on C-wing and the ward manager to review the processes for the C-Wing equipment cupboard and storage of equipment on Rycroft. Roles & responsibilities discussed and paperwork reviewed. IPACT to monitor standards.
Training delivered to Peanut staff on the Management of MRSA patients and hand hygiene
Training delivered to Therapy staff on the correct wearing of PPE, disposal of waste in the community and hand hygiene.

Policies

No policies updated during the month

Complaints

Paediatric patient attended the hospital for a dressing following a tendon repair. Nurse observed applying gloves without washing their hands and ran the gauze swab under the tap using the `hand washing only` sink and proceeded to clean the wound. IPACT reviewed and responded to the Patient Experience Manager who is investigating. Teaching delivered to Peanut staff (see above).

Patient treated in 2012 for a severed tendon in the finger under local anaesthetic. During the procedure an unannounced person asked the surgeon to remove the light cover which was over the patients head. The patient had an infection post-operatively. Antibiotics were prescribed. C.difficile infection was diagnosed. Discussed with the Microbiologist who states there is would be a minimal risk to the patient when the cover was removed. Advised the Perioperative Matron investigate during the response to the Patient Experience Manager.

The Care Quality Commission (CQC) raised a concern in respect of infection control practices for QVH patients at Darent Valley Hospital. QVH provide consultant cover only for QVH patients at Darent Valley so the head of risk, infection control nurse specialist and decontamination lead visited a QVH clinic at Darent Valley hospital in July to undertake a review of infection control and health and safety aspects related to QVH patients and staff. The finding have been communicated back to Darent Valley and the CQC and their Chief Nurse will be providing an action plan to QVH to provide assurance that concerns raised have been addressed. This will include actions for QVH to fulfil.

Audit Results

PLACE inspections – Clinical – Burns, Governor tour on Peanut. Non-clinical – Switch board, Public Toilets Unannounced visit from the Environmental Health Officer in the main kitchens. The Trust achieved a 5 rating - the top score.

Legionella and Pseudomonas Surveillance and Management

New Theatres – One toilet has a second positive count for legionella (immediate samples and samples taken after 10 minutes running: 400cfu/l Legionella non pneumophila). It has been confirmed that the pipework is designed and installed in compliance with latest regulations. The UV water treatment system for the theatre complex was checked and it is thought likely that low use of the outlet has caused the issue. Water is safe to use. Estates and night cleaners have commenced flushing regime. Repeat testing to be undertaken. Estates lead to arrange a meeting with the Consultant Microbiologist to review processes and confirm best practice is being followed.

Legionella Water safety sampling & response
<100.00cfu/l non detectable level (no further action required)
>100.00 - <1000.00 (Instigate flushing regime, investigate possible source, instigate rectification works)
>1000.00cfu/l (Arrange for 2 & 10 minute samples to be taken, investigate possible source, instigate rectification works)

Estates Issues

Area	Issue	Action
Dental lab	Carpet to be replaced with more suitable flooring to allow for cleaning	Requisition raised and awaiting date of installation
Prosthetics	Lack of hot water	Work progressing well and aiming to finish in September
Jubilee	Heating not functioning	Work progressing well and aiming to finish in September
Carpets	Carpeted area for replacement in areas in trust	Estates following the replacement programme prioritised by IPACT. New flooring approved.
OPD waiting areas	Increased temperature in clinic areas during hot weather	Agreement for portable air handling units in non-clinical areas only. Supplies Dept aware of pre- approved type.

Disposal of waste in pts homes	New guidance states clinical waste created in patient's homes should be returned to QVH for safe disposal	Policy updated. Training delivered. Awaiting delivery of equipment to ensure safe transportation of waste.
C-Wing	Wards need general repair, painting, holes filled, bumpers on walls added vents and radiators cleaned.	Date for works to be negotiated with Matron. Potential to decant to Rycroft.
Trust wide	Ventilation grills and radiators require cleaning.	On regular cleaning programme but Estates and Hotel Services to increase frequency. Waiver for easily removed radiator covers approved for Burns. Installation to be co-ordinated with deep cleaning.
PAC	Examination room 11 has a leak	Work under review by Estates
Public Toilets	All require refurbishment	Female toilet outside of RDU to have full refurbishment. Trust wide review of all public toilets and repair as required.
Burns	Possibility of installing permanent hand wash basins in the corridors	Estates to present costings to ICC in August.
Burns	Following Peter Hoffman (PHE report) requirement to check if the side rooms are delivering positive or negative pressure ventilation	Estates to urgently obtain quotes for validation by commissioning engineering company.
Burns	Heating not functioning	Works to begin in August. Dimplex heaters pre-approved for use in the theatres as required. Ventilation and hot water supply will function as normal.
Burns Theatre	Doors damaged	Partial repair. Costings for new doors requested.
Theatre Corridor	Flooring damaged	Willmott Dixon contacted, Estates Dept to organise a date for repair. All corridor flooring to be painted annually.
Prosthetics & Pharmacy	Require allocated hand washing facilities.	Estates to look into installation of sinks or refurbishment of current sink.

General Information

Agreement by the Microbiologist for minor OPD procedures to be undertaken in Rowntree as required.

Abbreviations

Abx	Antibiotics	ICC	Infection Control Committee
BBE	Bare below the elbows	ICNS	Infection Control Nurse Specialist
BSUH	Brighton & Sussex University Hospital	IPACT	Infection Prevention & Control Team
CAUTI	Catheter associated urinary tract infection	ITU	Intensive Therapy Unit
C.difficile/C.diff	Clostridium difficile	MDR	Multi drug resistant
CQC	Care Quality Commission	MSSA	Meticillin sensitive Staphylococcus aureus
C-Wing	Canadian Wing	MRSA	Meticillin resistant Staphylococcus aureus
DH	Department of Health	OPD	Out Patients Department
DIPC	Director of Infection Prevention & Control	PAC	Pre Assessment Clinic
E.Coli	Escherichia Coli	PHE	Public Health England
GRE / VRE enterococci	Glyptopeptide / Vancomycin resistant	PLACE environment	Patient led assessment of the care
HCAI	Healthcare associated infection	PPE	Personal protective equipment
HPA	Health Protection Agency	RCA	Root cause analysis
IC	Infection control	Strep A	Group A Streptococcus

Queen Victoria Hospital NHS
NHS Foundation Trust

COMPLAINTS, CLAIMS & PATIENT EXPEREINCE REPORT

Monthly Report July 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- Patient experience, complaints and claims have been acknowledged and issues identified, assessed and acted on with any risk identified prioritised and managed.
- The report contains key information on;
    - complaints received and complaints closed
    - claims received
    - patient feedback

Key Points:

The key priority that the board need to be aware of for this month are ;

1. Eleven new complaints were received and three complaints closed.
    - New complaints are under investigation with lead personnel identified.
    - Where identified immediate action was taken following a new complaint.
    - Investigations result in actions and a decision on whether the complaint is upheld

2. Two new claims were received.
    - All claims are opened and investigated.
    - Claim information is summarised quarterly and provided to the Quality and Risk Committee.

3. Patient feedback is sought through a variety of methods.
    - Feedback is provided to individuals.
    - Information is passed on to relevant departments for action.
    - Comparison is made against like organisations
    - There is an action plan to address the implementation changes to the FFT patient experience measurement.
    - We are on target to achieved the CQUIN return rate.

Implications:

- Investment in an alternative data collection methodology or in staff resource to load FFT feedback will be required by April 2015.

Recommendations:

The board is asked to note the actions currently being taken.

Monthly complaints, claims and patient experience report

1 July 2014 – 31 July 2014

This report provides an overview of all activity during this period. During this period there were 11 formal complaints received. This is an increase of the previous month (9). The following is a summary of the complaints that were received during this period:

Nicolle Tadman, Patient Experience Manager

Monthly complaints, claims and patient experience report

1 July 2014 – 31 July 2014

Complaints

Complaints received.

All Complaints received are acknowledged, investigated and responded to. Actions identified are monitored for completion by the monthly clinical governance group.

Peanut

1. **Nursing** - Infection control concerns raised regarding cleansing of wound. Nurse failed to wash hands and cleaned wound with tap water. When questioned, nurse informed that 'this is how we do it here.' **Investigating lead – Ward manager/Infection control nurse specialist**

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

   Comment/Action – Infection control attended ward meeting where the importance of hand hygiene was discussed.

Canadian Wing

2. **Nursing –** Level of care that complainants husband was given. Family upset that they were not present when patient passed away. **Investigating lead – Matron/Specialist nurse**

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

   Comment/Action – Infection control attended ward meeting where the importance of hand hygiene was discussed.

Plastics

3. **Medics -** Length of time that patient had to wait in main theatres for surgery. Arrived at 8am and not taken down until 14:10pm. Issues about whether patients should all be brought in at the same time (irrespective of where they are on the list) or staggered. **Investigating lead – Medical Director**

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

Comment/Action – review current policy. CEO and DoN to discuss this issue with the Exec team for a decision.

4. **Medics -** Alleges that consultant pointed finger at patient and shouted 'I don't want to see this woman any more'. **Investigating lead – Clinical Lead**

   Initial risk grading: **Low** Likelihood of recurrence as: **Rare** – Cannot believe that this will ever happen again.

   Comment/Action – discussion held with clinician who has no recollection of the events described or that he would act in this manner. Does clearly recall that patient was not happy that he would not sign them off work for longer.

5. **Medics** – Alleged that surgery carried out incorrectly. Patient's wounds should have been left to heal open rather than being sutured. Patient will have to undergo further surgery. **Investigating lead – Consultant**

   Initial risk grading: **Moderate** Likelihood of recurrence as: **Possible** – May recur occasionally.

   Comment/Action – From initial investigations it would appear that operating surgeon failed to read patients health records accurately resulting in further surgery being necessary.

Macmillan Information Centre

6. **Admin** - Patient received a cancer pack from Macmillan when she hadn't been diagnosed with cancer and had been assured by Cons that lesion was not cancer. Patient extremely distraught by this. **Investigating lead – Patient experience manager/Specialist nurse**

   Initial risk grading: **Minor** Likelihood of recurrence as: **Unlikely** – Do not expect it happen again but it is possible.

   Comment/Action: All confirmed melanoma patients to be referred to skin cancer nurse specialists so that they can send appropriate written patient information. All confirmed squamous cell carcinoma patients to be referred to the cancer information team who will dispatch the relevant information. Only confirmed diagnosed patients will be referred to Macmillan Information Centre and that manager will countercheck any information that is sent out to patients.

Theatres

7. **Theatre staff -** Delay in surgery on sixteen year old patient. Unable to admit patient via Peanut ward as had previously occurred for patient. Patient sent straight to Main Theatres. Staffs failed to adequate communicate with patient and mother. When patient asked if she could see her mother prior to surgery this was denied. **Investigating lead Consultant/Matron**

Initial risk grading: **Minor** Likelihood of recurrence as: **Unlikely** – Do not expect it happen again but it is possible.

Comment/Action: Still under investigation.

8. **Theatre staff** - Patient underwent surgery to finger in Sept 2012 during which the surgeon asked a theatre nurse to remove the light above operating table. Post-operatively patient became unwell and feels that infection may be due to involvement of theatre nurse and the unhygienic way in which the staff member replaced the light cover. **Investigating lead Matron/Infection control nurse specialist**

Initial risk grading: **Minor** Likelihood of recurrence as**: Rare –** Cannot believe that this will ever happen again.

Comment/Action: Still under investigation.

MIU

9. **Nursing -** Patient attended with sunburn to MIU and was told that he would be seen within an hour. Several other patients seen before treatment given. Patient waiting 3 hrs and when father they left the unit without treatment. Did not like way spoken to or attitude of staff in unit. **Investigating lead Department manager**

Initial risk grading: **Minor** Likelihood of recurrence as**: Unlikely –** Do not expect it to happen again but is possible.

Comment/Action: Still under investigation.

Offsite clinic – Darent Valley Hospital (DVH)

10. Overall experience at offsite clinic. Unfriendly attitude of clinician, phlebotomist, appointment administrator and secretary. **Investigating lead – Queen Victoria Hospital staff based at DVH**

Initial risk grading: **Very low** Likelihood of recurrence as**: Possible** – May recur occasionally.

Comment/Action: Still under investigation.

Policy and commissioning

11. **NHS policy:** patient had implants fitted 10 years ago. Implant has ruptured and funding for replacement has been refused by CCG. Patient informed by implant company that should have received a warranty form which was not given to her by surgeon. Patient feels that this has resulted in her not having the benefits that the warranty provides and covers.

Initial risk grading: **Minor** Likelihood of recurrence as**: Likely –** Will probably recur, but is not a persistent issue.

Comment/Action: Still under investigation.

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. As part of the investigation the investigating managers are required to make a decision, after consideration of the evidence, whether or not a complaint should be upheld (supported), partially upheld (supported in part), or not upheld (unsupported). Actions are monitored for completion through the monthly clinical governance group.

Paediatrics

1. **Nursing** - Referral to social services which parents feel was totally inappropriate. **Investigating lead – Ward manager/Safeguarding lead nurse**

   Outcome – Apologies made as although appropriate to make referral the parents should have been made aware. **Action completed:** 28.05.14 Lead for Child Protection e-mailed all staff on unit reminding them of policy in that when making a referral to SS parents MUST be made aware. Also matter stressed at trust induction. **Upheld**

MIU/Trauma/Theatres

2. **Medical -** Patient attended with laceration to finger injury on Monday and scheduled by clinician for surgery for Wednesday. When patient arrived informed that was not on theatre list and that we were unable to schedule him for surgery until following day.

   Outcome - Data inputted error. Registrar failed to save the details of the patient that she had scheduled for surgery. Apologies given and will ensure in future that she saves all theatre listings on the database. **Action complete:** Training to be undertaken at Induction re: trauma pathway training by Consultant. **Upheld**

3. **Medical** - Delay to surgery to remove large non-cancerous growth from nasal area on face.

   Outcome - This growth had been progressively growing for past 4 years prior to the patient seeking treatment. There was a slight delay in surgery being performed however patient was referred to Chelsea and Westminster Hospital for surgery due to the complex nature and size of the vascular growth that was on patients lip. Apologies given for this delay. **Unsupported.**

Claims

There were 2 new claims opened during this period. Overall there are 45 claims. A quarterly report is provided to the Quality and Risk Committee on claims paid, lessons from claims are disseminated through the Joint Hospital Audit meeting each quarter.

1. **Medics**: Alleged substandard management and treatment of sleep apnoea resulting in subsequent heart condition.

2. Vague information although patient under care of hand team. Alleged failure by clinicians at QVH and GP to carry out investigations, procedure with reasonable skill and care.

Patient comments & FFT

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. During July NHS England wrote to trusts announcing planned changes to the FFT patient experience measurement process and to issue new implementation guidance. This guidance has been developed into an action plan and will be monitored by the patient experience group. Already identified is that there will need to be either a change in our data collection methodology to make collection more automated or investment in staff to upload data.

NHS Choices

There was 1 new comments posted onto the NHS Choices website.

Physiotherapy Department

'I unfortunately broke my ankle and after six weeks in a plaster cast and air walking boot I was referred by my Consultant for physiotherapy.

My GP wrote a letter to the physiotherapy department at the Queen Vic and within 24 hours I received a phone call and was booked in to see a Physiotherapist from the Queen Victoria Hospital at my local Doctors surgery.

I cannot fault the service I received. Everyone I spoke to on the phone was pleasant and helpful and to be seen within a week of referral is fantastic. They were understanding of my wishes to be seen at my village surgery and not have to drive into town to the hospital.

*Please pass on my thanks to everyone as there does not seem to be a Physio department from the drop down box in section four. Off now to do my exercises as I don't want to be told off at my next appointment! (*Visited in July 2014. Posted on 15 July 2014)

Minor Injuries <u> Please see complaint No.9.**</u>**

'I have just been to minor injuries in East Grinstead QVH ,after a 3 hour wait and indifference by the staff on duty i left without treatment and will now have to seek treatment advice elsewhere .
*Strange that the Burns unit of England failed to see a burns victim.' (*Visited in July 2014. Posted on 15 July 2014)

Friends and Family Test

The role out of FFT is a national CQUIN by the end of 2014/15 we are required to achieve a return rate of 30% for inpatient returns and 20% for MIU.

The FFT scores for **July is +91** with a 47.7% response rate with the % score for extremely likely/likely **97%.**

Specific area/wards FFT score and % score for extremely likely/likely are:

Area	Net promoter score	Percentage score	% Return rate
MD ward	+87	97%	41.2%
RT ward	+91	97%	47.8%
Peanut ward	+66	100%	30.0%
Burns ward	+100	100%	15.8%
Sleep disorder centre	+78	98%	58.5%
MIU	+75	96%	18.5%
Trauma	+73	95%	19.5%
OPD	+82	98%	5.4%
DSU	+83	99%	21.6%

The following chart is a comparison of specialist hospitals and their FFT scores for June 2014 (please note that NHS England publish their statistics 1 month behind.

Trust	Total Responses	Total Eligible	Response Rate	Friends and Family Test Score
MOORFIELDS	57	79	72.15%	98
PAPWORTH	667	1040	64.13%	78
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	167	354	47.18%	93
ROYAL MARSDEN	229	533	42.96%	95
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	277	457	60.61%	75
STOKE MANDEVILLE HOSPITAL	225	956	23.54%	88

Report to:	**Board of Directors**
Meeting date:	**28th Aug 2014**
Reference number:	**205-14**
Report from:	**Jane Morris, Interim Head of Operations**
Author:	**Jane Morris, Interim Head of Operations**
Report date:	**19th Aug 2014**
Appendices:	**A: Performance Report**
	B: Exception Reports (RTT18 & Cancer Waiting times)

Operational performance: targets, delivery and key performance indicators

Key issues

1. Trust income from patient activity was above plan in Month 4.

2. Demand in the form of referrals and the numbers of first outpatients seen has remained static. New to follow up ratios for outpatients have fallen but are still higher than the contracted level for 2014/15.

3. All three aggregate 18 week targets were not met in month.
    a. The Trust failed to achieve the admitted target in three specialities – Ophthalmology, Oral Surgery and Plastics.
    b. The Trust failed to achieve the non-admitted target in three specialities – Oral Surgery, Plastics and Cardiology.
    c. The Trust failed to achieve the open pathway target in three specialities – Oral Surgery, Plastics and Ophthalmology.

4. There were two patients with closed pathways in July who waited over 52 weeks.

5. The Trust failed the 31 day first definitive treatment and 62 day wait for cancer patients in June.

6. The Trust failed the 31 day first definitive treatment for Q1.

7. There were no urgent operations cancelled for a second time in July.

8. There were three operations cancelled on the day of admission but none of these resulted in a breach of the 28 day guarantee.

Implications of results reported

9. Focus on clearing backlog of long waiting patients and complete validation of open pathways as planned has resulted in failure of 18 week Trust aggregate targets for July.

10. The adverse performance against the 18 week operational standard in the previous three consecutive quarters has impacted on the Trust's Monitor rating (as set out in regulatory section overleaf) and there will be financial penalties applied by commissioners for the current month.

11. Department of Health has tasked all providers to have plans in place to return to Trust aggregate compliance for 18 weeks by the end of September as part of operational resilience. QVH was unsuccessful in securing any additional national funding to support 18 weeks which was allocated to CCGs.

12. For Q2 the Trust is expecting not to meet the aggregate admitted or non-admitted 18 week targets. The Trust does expect to meet the open pathway aggregate target during this quarter. The Trust is introducing additional waiting list management systems alongside extra capacity to reduce the backlog and the Trust expects to achieve aggregate compliance with all 18 week targets from Q3. QVH continues working with commissioners and IST in monitoring trajectories to achieve Trust aggregate compliance by the end of September.

13. The trajectory for speciality compliance for Ophthalmology is currently predicted to be achieved by Q4. However the speciality continues to reassess the situation as it is in the process of securing more capacity during August and September to expedite compliance.

Action required

14. Further detail on the operational standards failed is provided within the exception report (Appendix B).

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

15. The income performance in Month contributes positively to the financial sustainability objective, noting that there will be the application of penalties for the failure of some operational standards.

16. 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

17. Risks associated with this paper are already included within the Corporate Risk Register.

Regulatory impacts

18. Currently the performance reported in this paper does not impact on our CQC authorisation.

19. The non-compliance with 18 week performance standards for three consecutive quarters, means our Monitor governance risk rating has now moved to ‘under review’.

Recommendation

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

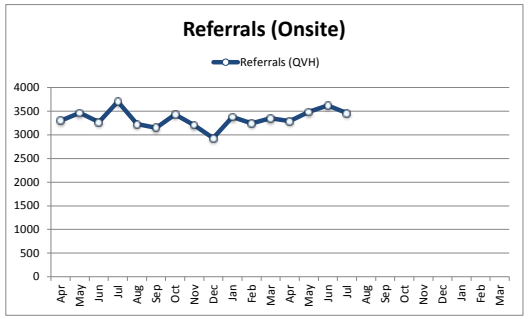
Queen Victoria Hospital NHS
NHS Foundation Trust

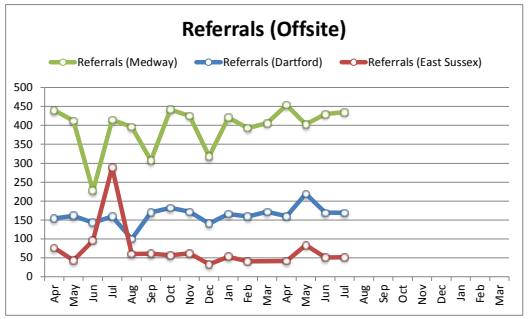
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Stuart Butt

Trust Level Report (All Services)

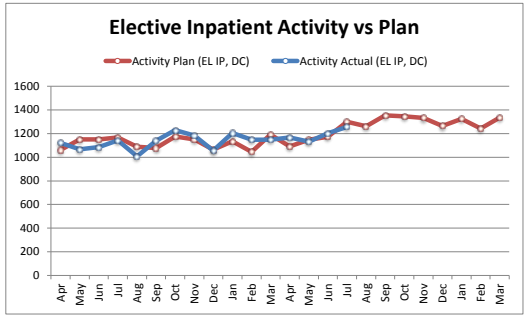
Period : 2014-15 Month 04 (July)

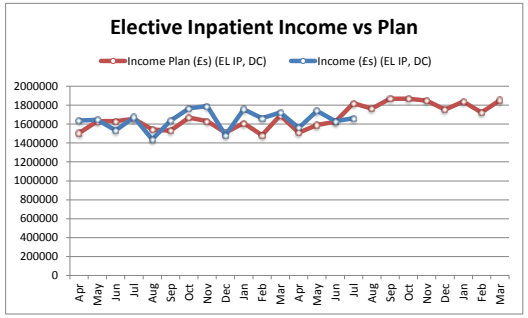
DEMAND



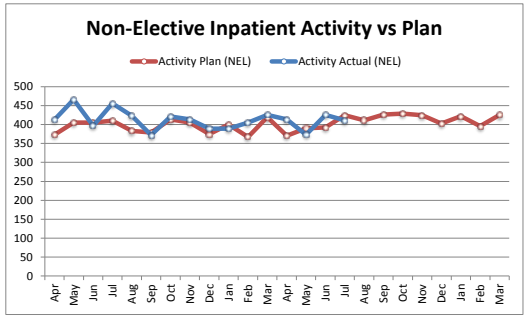


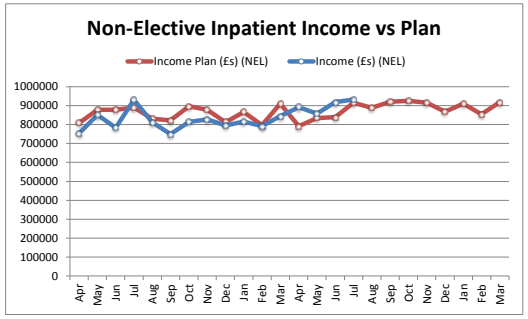
Elective Inpatients



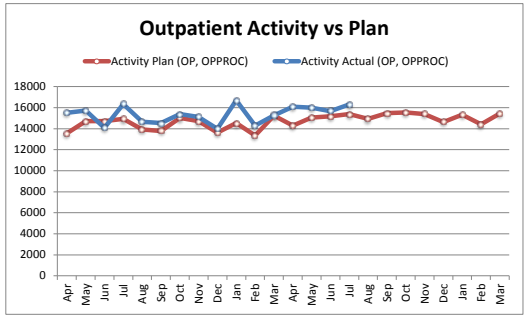


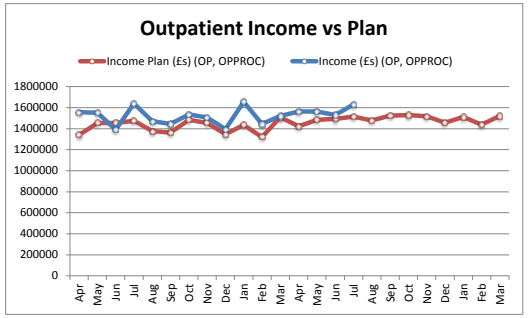
Non-Elective Inpatients

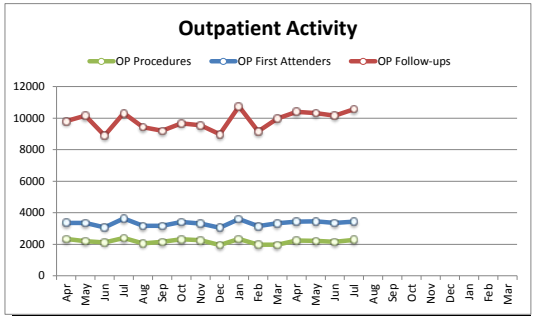




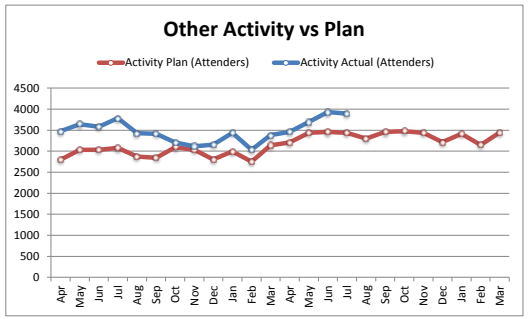
Outpatients

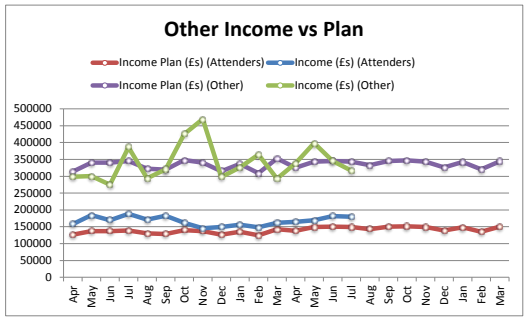




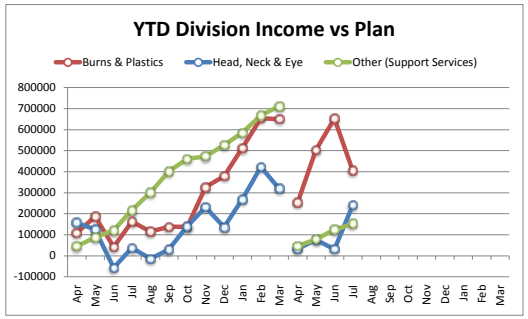


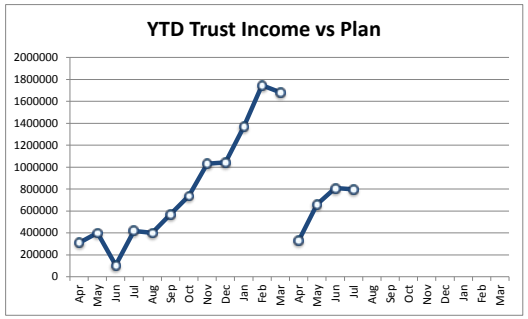
Other Activity/Income



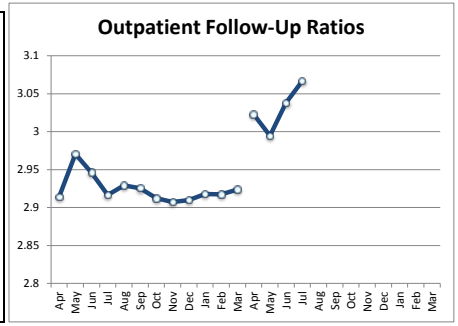


Income vs Plan





Follow-up Ratios



KPIs in-Month

N.B. Where scores are not marked "FINAL" these are estimates based on latest available data

Ref	Operational Standards	Threshold	Score	FINAL?	Consequence of breach	Timing
CB_B1	Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral	90%	85.0%	FINAL	£400 per breach	Monthly
CB_B2	Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	95%	94.0%	FINAL	£100 per breach	Monthly
CB_B3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92%	91.3%	FINAL	£100 per breach	Monthly
CB_B4	Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	99%	100.0%	FINAL	£200 per breach	Monthly
CB_B5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	99.8%	FINAL	£200 per breach. Capped at 8% over target	Monthly
CB_B6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93%	TBC		£200 per breach	Quarterly
CB_B7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	93%	TBC		£200 per breach	Quarterly
CB_B8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%	TBC		£1,000 per breach	Quarterly
CB_B9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94%	TBC		£1,000 per breach	Quarterly
CB_B12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%	TBC		£1,000 per breach	Quarterly
CB_B13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	90%	TBC		£1,000 per breach	Quarterly
CB_B14	Percentage of Service Users waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of the Service User (all cancers)	85%	TBC		2% of revenue derived from the provision of the locally defined servi	Quarterly
CB_B18	Operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons not offered another binding date within 28 days (QMCO)	0	TBC		Non-payment of costs - cancellation and re-scheduled episode	Monthly
CB_A15	Zero tolerance MRSA	0	0	FINAL	£10,000 in respect of each incidence in the relevant month	Monthly
CB_A16	Minimise rates of Clostridium Difficile	0	0	FINAL	£10,000 per case	Monthly
CB_S6	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0		£5,000 per Service User (incomplete RTT pathway waiting over 52 w	Monthly
DQ1A	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (APC)	99%	TBC		£10 per breach	Monthly
DQ1B	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (OP)	99%	TBC		£10 per breach	Monthly
DQ2	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	95%	TBC		£10 per breach	Monthly
CB_S10	No urgent operation should be cancelled for a second time (Monthly SITREPs)	0	0	FINAL	£5,000 per incidence in the relevant month	Monthly
VTE	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95%	100.0%	FINAL	£200 per breach	Monthly
FORM	Publication of Formulary	TRUE	TRUE	FINAL	Withholding of up to 1% of the Actual Monthly Value per month unt	Monthly
NEVER	Never Events	0	1		Cost of Episode	Monthly

KPIs Progression

	Ref	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
90%	CB_B1	92.8%	92.0%	91.9%	91.4%	91.7%	91.6%	92.0%	88.8%	90.9%	89.1%	86.6%	87.6%	90.5%	90.8%	88.0%	85.0%								
95%	CB_B2	96.4%	97.4%	95.9%	96.4%	97.1%	95.9%	96.4%	95.6%	95.6%	95.3%	95.0%	95.5%	95.1%	96.6%	94.1%	94.0%								
92%	CB_B3	95.6%	95.3%	95.9%	94.3%	95.5%	93.5%	93.8%	92.5%	92.8%	92.6%	90.8%	92.8%	93.3%	92.4%	91.5%	91.3%								
99%	CB_B4	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								
95%	CB_B5	99.7%	99.4%	100.0%	100.0%	99.4%	99.4%	98.5%	99.8%	99.5%	100.0%	99.9%	99.5%	99.5%	99.5%	99.3%	99.8%								
93%	CB_B6	96.6%	100.0%	96.4%	94.7%	96.1%	97.2%	94.6%	99.2%	98.2%	93.0%	98.4%	98.3%	96.6%	96.9%	99.3%	TBC								
93%	CB_B7	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	TBC	TBC								
96%	CB_B8	96.0%	93.6%	97.8%	97.2%	100.0%	95.8%	96.1%	98.4%	97.2%	98.0%	96.2%	91.7%	97.9%	95.6%	94.5%	TBC								
94%	CB_B9	100.0%	98.1%	100.0%	98.0%	97.2%	97.9%	97.8%	94.7%	96.3%	98.1%	98.0%	97.7%	97.6%	95.2%	98.0%	TBC								
85%	CB_B12	83.3%	96.4%	95.0%	78.3%	92.5%	92.9%	90.2%	84.6%	100.0%	94.9%	81.0%	75.9%	92.3%	87.5%	84.6%	TBC								
90%	CB_B13	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	66.7%	0.0%	0.0%	TBC	deminimis 5 cases in quarter - we've had 3.5 countable cases in Q1							
85%	CB_B14	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	TBC	no cases in June							
0	CB_B18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	TBC								
0	CB_A15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0								
0	CB_A16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0								
0	CB_S6	0	0	0	0	0	0	0	0	0	0	0	0	0	1	3	0								
99%	DQ1A	99.2%	99.3%	99.4%	99.4%	99.4%	99.4%	99.5%	99.5%	99.5%	99.6%	99.6%	99.6%	99.2%	99.3%	99.5%	TBC								
99%	DQ1B	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.7%	99.6%	99.6%	99.6%	TBC								
95%	DQ2	98.0%	98.5%	98.4%	98.1%	98.1%	98.2%	98.1%	98.2%	98.2%	98.3%	98.3%	98.4%	99.4%	99.0%	98.7%	TBC								
0	CB_S10	0	0	0	0	0	0	5	5	0	0	0	0	0	2	2	0								
95%	VTE	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								
TRUE	FORM	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE								
0	NEVER	2	0	0	0	0	1*	2	0	0	0***	0	0	0	1	1	1								

14/15 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	QUARTER 1			QUARTER 2			QUARTER 3			QUARTER 4			
				Perf	Achieved	Scoring	Perf	Achieved	Scoring	Perf	Achieved	Scoring	Perf	Achieved	Scoring	
M1C	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	88.0%	Not met		93.5%			0.0%			0.0%			
M2C	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	94.1%	Not met		94.0%			0.0%			0.0%			
M3C	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	91.5%	Not met	2	91.3%		0	0.0%		0	0.0%		0	
M4D	A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	99.5%	Achieved	0	100.0%		0	#DIV/0!		0	#DIV/0!		0	
M5E	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	89.7%	Achieved		#DIV/0!			#DIV/0!			#DIV/0!			de minimis <5 cases per Quarter
M6E	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	1.0	50.0%	Not relevant	0			0			0			0	de minimis <5 cases per Quarter
M7F	Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	96.4%	Achieved		#DIV/0!			#DIV/0!			#DIV/0!			
M8F	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0		Not relevant											
M9F	Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0		Not relevant	0			0			0			0	
M10G	Cancer 31 day wait from diagnosis to first treatment	96%	1.0	96.7%	Achieved	0	#DIV/0!		0	#DIV/0!		0	#DIV/0!		0	
M11H	Cancer 2 week (all cancers)	93%	1.0	96.8%	Achieved		#DIV/0!			#DIV/0!			#DIV/0!			de minimis <5 cases per Quarter
M12H	Cancer 2 week (breast symptoms)	93%	1.0	#N/A	Not relevant	0			0			0			0	de minimis <5 cases per Quarter
M20M	Clostridium Difficile -meeting the CDiff objective	0	1.0	0	Achieved	0	0		0	0		0	0		0	
M21	MRSA - meeting the MRSA objective	0	N/A	-	Achieved		-			-			-			
						2			0			0			0	

13/14 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	QUARTER 1			QUARTER 2			QUARTER 3			QUARTER 4			
				Perf	Achieved	Scoring	Perf	Achieved	Scoring	Perf	Achieved	Scoring	Perf	Achieved	Scoring	
M1C	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	92.2%	Achieved		91.5%	Achieved		88.8%	Not met		86.6%	Not met		
M2C	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	96.6%	Achieved		96.5%	Achieved		95.9%	Achieved		95.3%	Achieved		
M3C	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	95.6%	Achieved	0	94.4%	Achieved	0	93.0%	Achieved	1	90.8%	Not met	2	
M4D	A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	99.7%	Achieved	0	99.6%	Achieved	0	99.2%	Achieved	0	99.8%	Achieved	0	
M5E	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	91.6%	Achieved		87.9%	Achieved		91.6%	Achieved		85.9%	Achieved		de minimis <5 cases per Quarter
M6E	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	1.0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	de minimis <5 cases per Quarter
M7F	Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	99.4%	Achieved		97.7%	Achieved		96.3%	Achieved		97.9%	Achieved		
M8F	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0		Not relevant			Not relevant			Not relevant			Not relevant		
M9F	Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0		Not relevant	0		Not relevant	0		Not relevant	0		Not relevant	0	
M10G	Cancer 31 day wait from diagnosis to first treatment	96%	1.0	95.8%	Not met	1	97.7%	Achieved	0	97.2%	Achieved	0	95.3%	Not met	1	
M11H	Cancer 2 week (all cancers)	93%	1.0	97.7%	Achieved		96.0%	Achieved		97.3%	Achieved		96.6%	Achieved		de minimis <5 cases per Quarter
M12H	Cancer 2 week (breast symptoms) *<5 cases in quarter de minimis*	93%	1.0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	de minimis <5 cases per Quarter
M20M	Clostridium Difficile -meeting the CDiff objective	0	1.0	0	Achieved	0	0	Achieved	0	0	Achieved	0	0	Achieved	0	
M21	MRSA - meeting the MRSA objective	0	N/A	-	Achieved		-			-			-			
						1			0			1			3	

Queen Victoria Hospital NHS
NHS Foundation Trust

Cancer waiting times – Board exception report 18/8/2014

Performance Exception Report			
Month	June 2014 + Q1	**Executive Director:**	Richard Tyler
		Prepared By:	Jane Morris
Indicator	Cancer waiting times - 2 week wait = 93% Cancer waiting times – 31 day First Definitive Treatment (31FDT) = 96% Cancer waiting times - 31 day First Subsequent Treatment (31FST) = 94% Cancer waiting times – 62 Day wait = 85% Cancer waiting times – 62 Day Upgrade (no standard set) Cancer waiting times – 62 day Breast screening = 90% Cancer waiting times – 62 breast symptoms = 93%		
Variation from plan 	**June 2014** – The Trust failed to meet the following Cancer Waiting times standards 31 day First Definitive Treatment (31FDT) = **94.5%** against a standard of 96% (3 breaches out of 55 patients) 62 day wait = **84.6%** against a standard of 85% (2 breaches out of 13 patients) 62 day Breast screening = **0%*** against a standard of 90% **Low patient volume so not reportable as numbers below deminimus level* **Q1 2014/15** – The Trust failed to meet the following cancer waiting times standards 31 day First Definitive Treatment (31FDT) = **94.8%** against a standard of 96% (8 breaches out of 153 patients) 62 day Breast screening = **28.6%*** against a standard of 90%. **Low patient volume so not reportable as numbers below deminimus level*		
Reason for Variation	**June 2014** *31 day First Definitive Treatment (31FDT)* Reasons for breaching standard are • 1 x patient breached due to visiting surgeon unavailability for immediate breast reconstruction • 1 x patient breached due to lack of theatre capacity after patient declined one date for surgery • 1 x patient breached due to incorrectly being scheduled as routine rather than urgent case by team		

	62 day wait Reasons for breaching standard are • 1 x patient breached due to complex diagnostic tests required before surgery (1 x 0.5 shared breach) • 1 x patient breached due to lack of theatre capacity at QVH (0.5 shared breach) • 2 x patient breached due to incorrectly being scheduled as routine rather than urgent case by team (2 x 0.5 shared breaches) **Q1 2014/15** *31 day First Definitive Treatment (31FDT)* Reasons for breaching standard are (including patients in June) • 1 x patient breached due to visiting surgeon unavailability for immediate breast reconstruction • 1 x patient breached due to lack of theatre capacity after patient declined one date for surgery • 1 x patient breached due to lack of theatre capacity at QVH • 2 x patient breached due to incorrectly being scheduled as routine rather than urgent case by team • 2 x patients breached off site due to theatre overrun • 1 x patient breached due to delays in being scheduled due to administrative staffing shortages
Impact	**Patient Outcomes / Experience** Longer patient waits **Financial Position** Financial penalty applied by CCGs is to be confirmed **Monitor Targets / Contractual Requirements** The QVH cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at the Trust, complex multi-organisational pathways and late secondary referrals. The Trust seeks to manage these risks through effective internal monitoring and close working relationships with referring secondary organisations.
Actions to be taken to address variation and ensure Trust continues to maintain performance	The following actions are being taken • All Trusts have been contacted regarding reviewing their systems to ensure provision of a visiting surgeon for immediate breast surgery. Interim Head of Operations is working with the Director of Operations in the respective organisations. • Recruitment of administrative teams within Trust is on-going and all new staff will be trained about the importance of scheduling correctly. • Administrative and clinical staff are continually being briefed on the importance of ensuring that they choose the correct category of prioritisation on booking form to reduce any delays. • Cancer manager is working closely with the Health Records team following the

	introduction of the central receipt referral system to ensure potential cancer patients are identified and put onto the Cancer PTL early to improve tracking. • A bi-monthly performance report against cancer waiting time standards has been implemented in addition to weekly cancer PTL. The latter is now also being discussed at weekly access meeting to ensure patients are escalated accordingly. Medium to longer term actions • Increase number of skin cancer patients who are seen and treated on the same day as outpatient clinics with introduction of new theatre from Sept 2014.
Forecast	A verbal update will be provided at the Board for the latest forecast position for July as submission date for the final position is due on the 7th September. It does need to be stressed that throughout the year an element of risk remains with compliance with Cancer targets for the reasons given under the 'impact' section. However, the Trust is committed to reducing the likelihood of multiple breaches within any given period by continuing to deliver our action plans.
Monitoring	Clinical Cabinet (bi-monthly) and Senior Management Team (weekly)
Recommendation	The Board is requested to note and endorse the action being taken to improve performance in this area.

Queen Victoria Hospital NHS
NHS Foundation Trust

RTT18 Update
Board report – 18th Aug 2014

Performance Exception Report			
Month	July 2014	**Executive Director:**	Richard Tyler
		Prepared By:	Jane Morris
Indicator	Referral to Treatment < 18 weeks for Inpatients – Trust level aggregate 90% Referral to Treatment < 18 weeks for Outpatients – Trust level aggregate 95% Referral to Treatment < 18 weeks for Incomplete Pathways – Trust level aggregate 92% Referral to Treatment < 18 weeks for Inpatients for every speciality 90% Referral to Treatment < 18 weeks for outpatients for every speciality 95% Incomplete RTT pathway waiting over 52 weeks at the end of the relevant month = 0		
Variation from plan 	July In patient aggregate = **84.97%** against target of 90% Specialities failed: • Corneo (42 out of 214 =80.37%) • Oral Surgery (40 out of 185 = 78.38%) • Plastics (70 out of 546 = 87.18%) July out-patient aggregate = **94.03%** against target of 95% Specialities failed: • Oral Surgery (53 out of 658 = 91.95%) • Plastics (22 out of 418 = 94.74%) • Cardiology (2 out of 29 = 93.10%) July- Incomplete Pathways aggregate = **91.30%** against target of 92% Specialties failed • Corneo (85 out of 999 = 91.49%) • Oral Surgery (227 out of 2322 = 90.22%) • Plastics (223 out of 2268 = 90.17%) RTT pathway waiting over 52 weeks at the end of the relevant month = **2** (1 x Orthodontics + 1 x Plastics)		
Reason for Variation	The main reason for variation is due to focusing on reducing the backlog in each of the specialities and the completion of the one off validation exercise on all open pathways during the month of July. However in oral surgery further shortages in the Associate specialist grade in Max Fac continues to impact on clinics and minor dental surgery which has resulted in longer waiting times for treatment.		

	In July two patients had waited over 52 weeks for the following reasons • Orthodontics – This patient was originally referred in June and seen in Sept 2013 and added to waiting list for treatment. The department tried to contact the patient to offer a date for treatment before 52 weeks but was unable to reach patient. Therefore an appointment was arranged and letter sent for the end of June which was just over 52 weeks. Patient did not attend the appointment and so was sent a letter in accordance with our policy advising that they were now being discharged and would be sent back to original referrer. Patient contacted the department to say that they never received appointment letter. Therefore appointment was made and patient has attended for treatment at 53 weeks and 1 day. • Plastics – Patient was originally referred to us from an off-site clinic. Patient was placed on the waiting list for a complex hand joint replacement for consultant to do. Patient was booked for surgery at 51 weeks 1 day but was unfortunately cancelled on the day as the equipment required for the joint replacement was not available. Patient was rebooked and operated on at 53 weeks and 4 days.
Impact	**Patient Outcomes / Experience**
	Longer patient waits
	Financial Position
	Financial penalty applied by CCGs is forecast to be circa £ 45K
	Monitor Targets / Contractual Requirements
	Exception report submitted to CCG and Monitor Impact on Monitor risk rating – As reported in June current risk rating is 'under review' after failing three consecutive quarters
Actions to be taken to address variation and ensure all specialities continue to maintain performance	**Corneo** • A total of 18 extra all day operating sessions have now been organised between Aug to October allowing for an additional 204 patients to be treated from the backlog. Saturday sessions are likely to continue fortnightly for the rest of 2014/15. • Extra sessions for complex corneo cases continue at Centre for Sight for these particular procedures and have been secured until the end of Dec. • Continuing to review 'consultant only to do cases' and pooling where clinically appropriate. **Plastics** • Extra Saturday operating for Plastic Surgery is planned between April and October and likely to continue for the rest of 2014/15 due to delays in opening Theatre 11. • Th 11 DC LA capacity o Plans are in place to open this facility on the 8th Sept, however due to further delays in recruitment and gaps in registrar rotas it will not be possible to open all 7 sessions as planned immediately. Despite this the team is exploring all options to ensure backlog reductions continue in line with trajectories. • New Senior Hand fellow started in August which will lead to further increases in theatre capacity for this sub specialty once the vacant registrar posts are completely filled. • Review of Hand cases being undertaken by consultants continues to see if any can be passed onto registrars / fellows or onto another consultant. • Breast cases continue to be pooled within Plastics to reduce waiting times of other breast consultants.

- Replacement for retiring Burns Consultant has been appointed and job plan includes theatre time to undertake breast cases.

Oral Surgery

- Extra operating sessions have been organised between April through to October on Saturdays (once a month) and likely to continue for 6 months.
- From Sept (depending on recruitment of additional staff in Theatres) Trust plans to create one extra MOS list per fortnight.
- Significant capacity issues with middle and junior doctor grades - Trust is exploring appointment of another locum to further minimize reduction in clinic capacity.
- Increasing Orthodontic capacity through clinic template changes and extra nursing hours to support additional clinic in place from July. Interviewing at the end of this month for an additional locum Specialist Orthodontic post x 1 day a week to further reduce waiting times.
- Longer term increase in capacity – business case being prepared for additional consultant and clinical space needed to support this proposal.

Intensive Support Team (IST)

IST recommendations have now been prioritised into a detailed action plan. A summary of the key actions and progress against these is outlined in the table below

	Summary of Key action	Timescale
1	Review of access policy - IST has recommended a number of changes which are being incorporated to tighten up process	Final draft completed with support of IST. Due to go to CPC for approval asap – key changes will then be communicated to staff and training provided where required
2	Central referral point has been recommended	Completed In place from 14th July 2014
3	Increase engagement with commissioners to gain support with other providers who cause delays in patient pathways before referring to QVH	Discussions have already taken place and further actions to be agreed between programme board meetings over the summer CEO to CEO letter regarding immediate reconstructions has already been sent and JM speaking to other provider Director of Ops as required
4	Further refine and improve patient tracking especially within OPD and diagnostics to proactively reduce waiting times	Daily tracking tool has been refined with the help of the IST and will be ready for launch in September
5	Review demand and capacity using IST developed tools with their support	All specialties have been completed for admitted patients using this tool including compliance modeling which is being used to monitor progress against trajectories weekly. Outpatient tool will be used to extend this

		modeling in September once additional analyst support is put into place.
6	Implement process for booking pre-assessment and surgery date at same time (with 3 weeks apart)	Discussed at pre-assessment meeting on the 19th June and agreed in principle. Detailed action plan to support implementation being devised
7	Trust to ensure PAS is primary source for scheduling and should to discontinue medical secretaries using spreadsheets	Dependent on upgrade to Patient Centre which is due in the Autumn
8	Review overall booking processes to ensure consistency and correct application of rules by all secretaries involved in scheduling	New system for offering dates for new OPD patients is to being put in place from September. Weekly access meeting in place to ensure patients are booked according to clinical priority and to reduce waiting times, as well as escalate issues that need to be addressed
9	Trust to introduce partial booking for follow up appointments – will need to purchase software to make this possible	Tender specification being devised ready for procurement to be commenced – part funded by Safer Hospital, Safe Wards Technology funding

General actions for all areas

- Validation – One off validation exercise of all open pathways completed by the end of July resulting in an overall reduction of 400 patients from the waiting list. In addition Trust has substantively increased hours for pro-active validation which has almost now been fully recruited to.
- Ensure clinics are coded as patient attended more promptly and accurately, particularly with regard to off-sites.
- Weekly Patient Access group has been set up to ensure patients are being booked and issues raised quickly so that backlog continues to reduce as per trajectories.
- Reinforce with off-site secretaries to send information about additions to waiting list for surgery at QVH within 24 hours.
- Continue training of staff on 18 weeks and validation.
- Early warning tracking system being used to monitor peaks in referrals and conversion rates to assist capacity planning.
- Working with CCGs and LAT to respond to the Department of Health's requirement for Operational resilience capacity planning for Elective care.

Forecast position and return to plan	The Directorates are continuing to proactively manage waiting lists through weekly operational meetings and increasing capacity to reduce waiting times where possible. The Trust predicts for Q2 that QVH will fail the inpatient and outpatient aggregate as backlog clearance is expedited to coincide with longer term plans in order to achieve a long term sustainable 18 week position from Q3. There is a risk that Ophthalmology will continue to be non-compliant during Q3 whilst a sustainable waiting list size is achieved. It should also be noted any further delay to LA DC theatre operating sessions and or increase in referral demand could impact on

	this forecast and will be monitored carefully. The modelling of this has been done in conjunction with the support of the IST and is being used for monitoring progress on a weekly basis and reported through Clinical Cabinet and Senior Management Team meetings. The trajectories are being recalculated on a weekly basis for Q3 based on the extra capacity secured and a verbal update will be available at the board.
Forecast outturn	Forecast for end of year incorporating YTD 2014 figures are also being recalculated regularly based on the progress with backlog clearance to achieve a sustainable waiting list size, Theatre 11 opening, implementing longer term capacity plans where required and Trust wide aggregate compliance.
Monitoring	Clinical Cabinet (bi-monthly) and Senior Management Team (weekly)
Recommendation	The Board is requested to note and endorse the action being taken to improve performance in this area.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: **Board of Directors**
Meeting date: **28 August 2014**
Reference number: **206-14**
Report from: **Stuart Butt, Director of Finance and Commerce**
Author: **Stuart Butt, Director of Finance and Commerce**
Report date: **15 August 2014**
Appendices: **Financial Performance Report**

Finance Report M4 July 2014

Key issues

1. The financial performance report details the trust's financial performance for July 2014.

	Plan YTD (£k)	Actual YTD (£k)	Variance to Plan
Turnover	19,165	20,181	1,016
EBITDA	1,407	2,207	799
Surplus	223	1,093	870
Continuity of service risk rating (CoSRR)	4	4	-

NB table subject to rounding differences.

2. The trust is significantly ahead of the surplus plan for the year with increased income only marginally offset by increased costs.
3. The Trust is maintaining a Continuity of service risk rating of 4.

Implications of results reported

4. Achieving the enhanced surplus of £1,093k for the first 4 months gives reassurance that the planned surplus of £2,203k for the year is achievable.

Action required

5. As future plans rely on growth the additional capacity due from theatre 11 is being developed. The need to maintain cost control continues. Delivery of the action plans to meet performance targets is also critical.

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 contents of this report.

Queen Victoria Hospital
NHS Foundation Trust

Finance Report – Public
July 2014
Month 4

18th August 2014

Executive Director: Stuart Butt

Contents

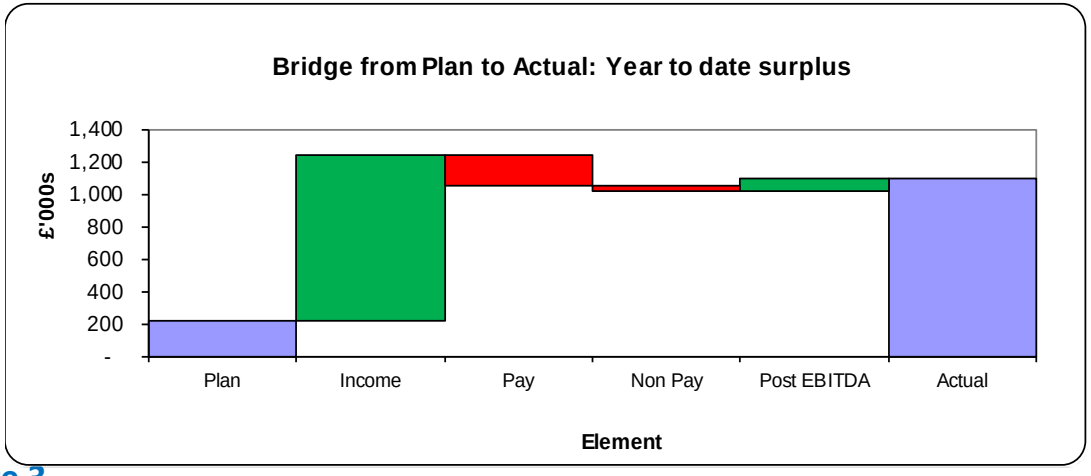
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure	CM 13-14	Current Month-July			YTD 13-14	Year to Date		
	Actual £k	Actual £k	Budget £k	Variance £k	Actual £k	Actual £k	Budget £k	Variance £k
Income	*5,257*	5,308	5,134	173	*19,333*	20,181	19,165	1,016
Pay	*(3,118)*	(3,261)	(3,198)	(63)	*(12,316)*	(12,901)	(12,721)	(180)
Non Pay	*(1,405)*	(1,284)	(1,294)	10	*(4,956)*	(5,074)	(5,037)	(37)
EBITDA	*733*	763	643	120	*2,062*	2,207	1,407	799
EBITDA %	*13.9*	*14.4*	*12.5*	*1.9*	*10.7*	***10.9***	*7.3*	*3.6*
Post EBITDA	*(279)*	(277)	(296)	19	*(1,074)*	(1,114)	(1,184)	71
Donated assets		-	-	-		-	-	-
Surplus (Deficit)	***454***	**486**	**347**	**139**	***988***	**1,093**	**223**	**870**

Continuity of Service Risk Rating	Metric	Level 4 threshold	Score	Weighted score	
Liquidity days	48	0	4	50%	2
Debt Service Cover	4.3	2.5x	4	50%	2
Combined Score			1 2 3		**4**



Summary

- The trust remains significantly ahead of the surplus plan for the year, with additional income only marginally offset by additional costs.

Issues

- The surplus of £1,093k is 49.6% of the annual plan target of £2,203k - continued performance at this level would exceed the annual plan.
- Income is above the current plan and above that achieved last year.
- July income includes the recognition of 100% of CQUIN for the first quarter, a positive impact of £157k in the month. CQUIN for July is assumed at 50% at this stage.
- Pay and non-pay variances reflect activity and non-recurrent costs. Pay costs are under pressure this month for a number of reasons including agency cover and sickness.
- Post EBITDA costs reflect the phasing of the opening of the new theatres.
- The Continuity of Service Risk Rating is 4, as planned.

Risks.

- Key risks are to the achievement of the higher activity plans in future months, sustained cost control and the ability to minimise level of contractual penalties.

Actions

- Action plans to deliver additional activity and to meet performance targets (to reduce penalties and achieve incentives).
- Budgetary control through revised accountability agreements and reporting arrangements.

Summary Actual Position – YTD M4 2014/15

Queen Victoria Hospital NHS Foundation Trust

£k	Annual Budget	Current Month Actual	Current Month Budget	Current Month Variance	YTD Actual	YTD Budget	YTD Variance
Patient Activity Income	55,788	4,870	4,821	49	18,702	17,911	791
Other Income	3,763	435	314	121	1,446	1,254	191
Pay	(38,401)	(3,242)	(3,198)	(44)	(12,831)	(12,721)	(110)
Non Pay	(15,394)	(1,295)	(1,294)	(1)	(5,201)	(5,037)	(164)
Prior Year Items	-	(5)	-	(5)	92	-	92
Financing	(3,553)	(277)	(296)	19	(1,114)	(1,184)	71
Grand Total	**2,203**	**486**	**347**	**139**	**1,093**	**223**	**870**

Note: Financing costs consist mainly of depreciation, dividends and theatre loan interest.

Summary

- The impact of prior year items is shown separately in the above analysis. In month the negative impact is £5k and year to date it is a positive £92k.
- Patient income is consistently above plan in most areas, with only elective and critical care showing adverse variances.

Issues

- The prior year items are costs that match to prior year activity and income from prior year activity, that were not recognised at the time and arise from the revision of previous estimates.
- The largest positive variance is £80k from the agreement of the 2013-14 Emergency Rate Threshold tariff with some commissioners.
- These items have been split out to ensure there is a clear understanding of the 'in year' position and the underlying financial performance.

Risks.

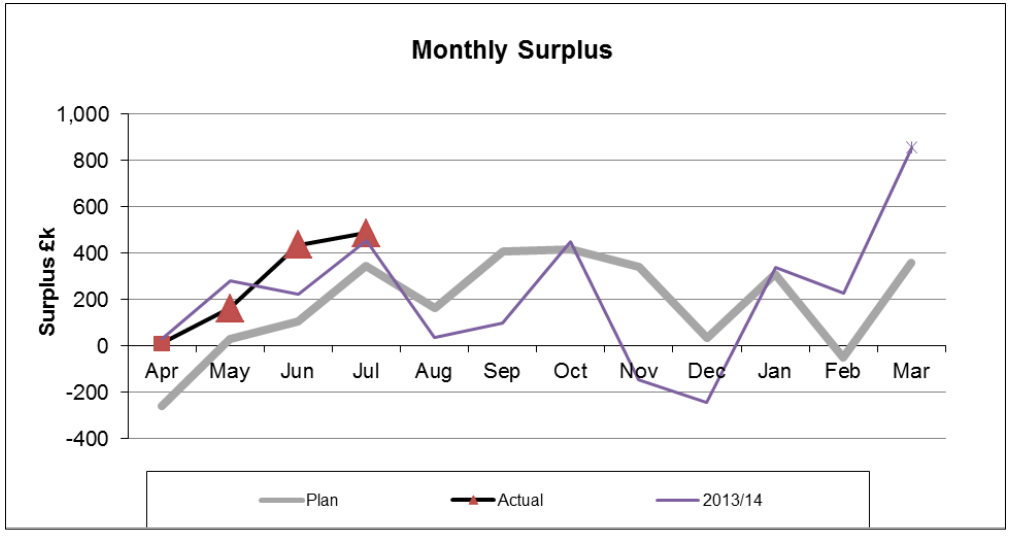
- The impact of the prior year is expected to remain positive as final agreement is reached with commissioners on the 2013/14 income which will reduce outstanding debts. The potential upside being an reduction in the bad debt provision of between £200k and £400k.

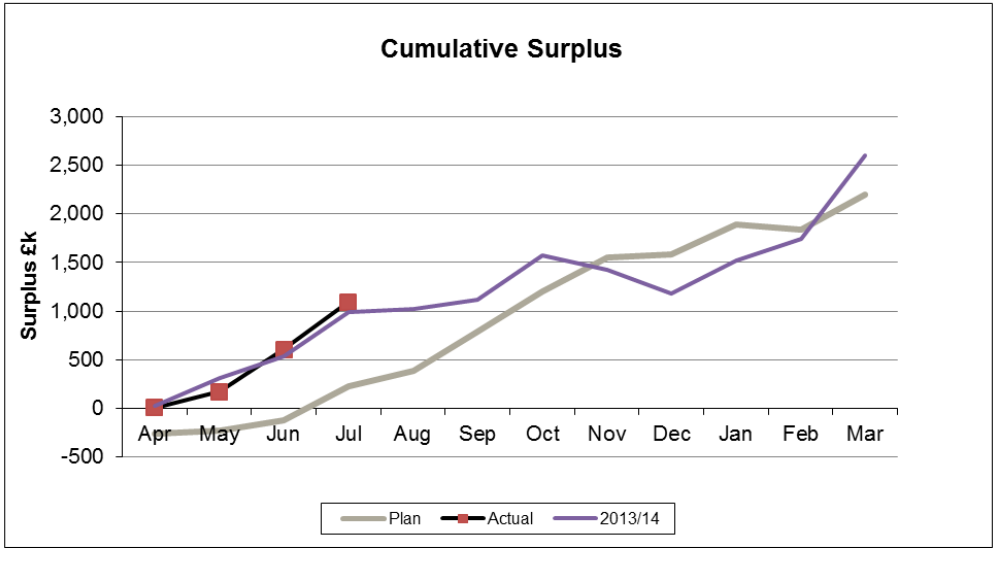
Actions

- Agreement of 2013/14 outturn with commissioners, robust collection of debt and discussion about potential use of funds.

Summary Trend Position – M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust





Summary

- Surplus performance is above the current plan and the surplus achieved last year.

Issues

- The plans from July onward start to include the effect of increasing activity plans associated with the opening of theatre 11.
- The plans for August and September are above those achieved last summer – the commissioning of the new theatres last summer led to a planned reduction in activity and surplus.
- The financial plans for the remainder of the year reflect the phasing of activity rather than any specific service changes

Risks

- The trust surplus remains sensitive to the achievement of activity plans.
- Cost control at a time of increasing activity and pressure to deliver improved waiting times remains critical.

Actions

- Monitoring of forecast levels of activity, and taking remedial action where necessary, is undertaken at a senior management level at the Weekly Operations Meeting. This meeting considers pay and non-pay costs and can escalate issues through to the monthly Senior Management Team meeting.

Forecast – M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Forecast at M4 2014-15	Plan £k	Downside	Downside £k	Upside	Upside £k	Midpoint £k
Income	59,581	Growth at actual levels	60,543	Increased activity to plan plus growth continues	62,629	61,586
Pay	38,431	Actual levels plus overspends	38,971	Increased activity and cost control.	39,088	39,030
Non-Pay	15,414	Historic overspending continues.	15,865	Increased activity and cost control.	15,635	15,750
ITDA	3,533		3,533		3,425	3,479
Surplus	2,203		2,174		4,481	3,328

Summary

- The downside forecast is for a surplus of £2,174k with an upside forecast of £4,481k, giving a midpoint of £3,328k. The planned surplus budget of £2,203k is consistent with the downside and provides for a strong financial forecast.

Issues

- The downside forecast assumes that activity continues at current levels but that there is no further growth above this level. The cost assumptions are increased pay costs from additional activity, and increased non-pay costs, reflecting additional activity and the potential for historical overspends.
- The upside forecast is that the current overachievement on income continues and that the planned income growth is achieved. The planned income growth is from additional capacity. The cost assumptions are increases in pay and non-pay to reflect additional activity.
- The phasing of income this year is unusual, with additional growth from extra capacity from quarter 2. In previous years activity and the surplus have been profiled evenly across the quarters and an actual surplus of £1,093k, year to date, is consistent with achieving the planned surplus of £2,203k.

Risks

- The trust surplus is sensitive to the achievement of an increasing activity plan and the ability to address any commissioner challenges / concerns.
- The operational pressures around staffing means that cost control remains critical.
- Penalties are assumed at year to date levels so the financial position would deteriorate if penalties increased or continued at month 4 levels.

Actions

- Monitoring of forecast levels of activity, and taking remedial action where necessary, is undertaken at a senior management level at the Weekly Operations Meeting.

Income – M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

POD. Month 4 Year to date :	Actual £k	Plan £k	Variance £k
Day Case	3,618	3,380	238
Elective	3,205	3,399	-194
Non Elective	3,704	3,497	207
Exclusions	1,109	1,020	89
Outpatient First Attendance	1,737	1,675	62
Outpatient Follow Up	3,286	3,059	227
Outpatient Procedure	1,419	1,327	92
Minor Injuries	297	278	19
Radiology	417	376	41
Critical Care	228	253	-25
Sub total	**19,020**	**18,264**	**756**
CQUIN reduction (50% M4)	-58		-58
Penalties	-159	0	-159
ERT deduction	-101	-353	252
Total Income	**18,702**	**17,911**	**791**

Summary

- Patient income by point of delivery (POD) is consistently above plan in most areas, with only elective and critical care showing adverse variances.
- The assumptions around CQUIN, penalties and Emergency Rate Threshold (ERT) are considered to be prudent at this stage and will be firmed up as each quarter is agreed with commissioners.
- 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.

Issues

- Income is above plan, before the additional capacity from theatre 11 is in place.
- CQUIN has been planned at 100% achievement. Q1 CQUIN is now reflected at 100% based on internal calculations and M4 at 50%.
- There is no specific budget for penalties and the £159k cost relates to penalties for 18 week breaches and other contractual penalties.
- ERT was prudently assumed to be suffered at 100% in budget setting but subsequent agreements have mitigated the risk.

Risks

- Performance in future months may deteriorate if access targets are missed.
- Future income plans rely on additional capacity being utilised effectively.

Actions

- Activity, CQUIN, penalties and ERT are routinely monitored.

Income – YTD M4 2014/15

Queen Victoria Hospital NHS Foundation Trust

Penalties: Issues / Risks

- Within income there is an accrual of £159k for penalties and challenges.

Penalties Accrual 2014/15	M1 £k	M2 £k	M3 £k	M4 £k	Total £k
RTT18 Admitted	2	3	11	28	**44**
RTT18 Non-Admitted	1	0	2	2	**5**
RTT18 Open pathways	7	5	8	25	**45**
	10	8	21	55	**94**
52 week waiters	0	5	15	10	**30**
Urgent operation cancelled for second time	0	10	10	**10**	**30**
Never Events (estimate)	0	1	2	**0**	**3**
Data Challenges (estimate)	1	1	0	**0**	**2**
	11	**25**	**48**	**75**	**159**

- 18 week penalties constitute the majority of the accrual but there are significant sums for other penalties too.
- The forecasts assume the continuation of penalties at this average level, £40k a month, for the remainder of the year.
- Last year total penalties and challenges were £307k.

Actions

- Operational plans and actions are being progressed to meet the access targets and reduce the level of penalties in future periods.

Directorate Performance – YTD M4 2014/15

Queen Victoria Hospital NHS Foundation Trust

Financial Performance	2014-15	July 2014			Year to Date 2014-15		
by Directorate	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	24,976	2,222	2,226	(4)	8,364	7,743	622
Clinical Support	(2,657)	(219)	(212)	(7)	(902)	(847)	(55)
Nursing	(8,837)	(742)	(735)	(7)	(2,780)	(2,936)	155
Estates and Hotel Services	(3,648)	(302)	(297)	(5)	(1,236)	(1,195)	(42)
Human Resources	(746)	(39)	(61)	22	(207)	(244)	37
Finance	(5,382)	(323)	(448)	124	(1,531)	(1,797)	266
Corporate	(1,504)	(110)	(125)	15	(615)	(501)	(113)
Grand Total	**2,203**	**486**	**347**	**139**	**1,093**	**223**	**870**

Summary

- Directorate performance reflects trust performance overall, increased income only partially offset by pay and non pay adverse variances.

Issues / Actions

- Page 10 gives greater detail of the performance by Directorate.
- Maintaining income levels, controlling costs and meeting performance targets are key financial challenges for the remainder of the year.

Actions

- Delivering additional capacity through theatre 11 opening which is now due in September 2014.
- Maintain control over costs through tighter budgetary control.
- Delivery of the action plans to meet performance targets.

Directorate Performance – YTD M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance by type		2014-15	July 2014			Year to Date 2014-15		
Directorate	Type	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	SLAM Income	49,958	4,300	4,324	(24)	16,666	15,962	704
	Other Income	1,390	129	116	13	502	463	39
	Pay	(18,766)	(1,609)	(1,567)	(42)	(6,295)	(6,201)	(94)
	Non Pay	(7,606)	(597)	(647)	50	(2,509)	(2,482)	(27)
Anaesthetics and Surgery Total		**24,976**	**2,222**	**2,226**	**(4)**	**8,364**	**7,743**	**622**
Clinical Support	SLAM Income	3,721	344	317	27	1,267	1,246	21
	Other Income	567	57	47	10	202	189	12
	Pay	(4,937)	(392)	(406)	14	(1,597)	(1,626)	29
	Non Pay	(2,008)	(228)	(170)	(58)	(774)	(657)	(117)
Clinical Support Total		**(2,657)**	**(219)**	**(212)**	**(7)**	**(902)**	**(847)**	**(55)**
Nursing	SLAM Income	1,873	100	160	(60)	643	627	16
	Other Income	1,046	158	87	71	457	349	108
	Pay	(9,452)	(811)	(788)	(23)	(3,119)	(3,151)	32
	Non Pay	(2,305)	(189)	(194)	5	(761)	(761)	(0)
Nursing Total		**(8,837)**	**(742)**	**(735)**	**(7)**	**(2,780)**	**(2,936)**	**155**
Estates and Hotel Services	Other Income	294	25	25	1	91	98	(7)
	Pay	(1,657)	(147)	(138)	(9)	(582)	(552)	(29)
	Non Pay	(2,286)	(181)	(184)	3	(746)	(740)	(6)
Estates and Hotel Services Total		**(3,648)**	**(302)**	**(297)**	**(5)**	**(1,236)**	**(1,195)**	**(42)**
Human Resources	Other Income	170	35	14	21	83	57	27
	Pay	(714)	(59)	(59)	(0)	(222)	(233)	11
	Non Pay	(202)	(15)	(17)	2	(69)	(67)	(1)
	ITDA	-	-	-	-	-	-	-
Human Resources Total		**(746)**	**(39)**	**(61)**	**22**	**(207)**	**(244)**	**37**
Finance	SLAM Income	236	127	20	106	126	76	50
	Other Income	345	18	29	(10)	109	115	(5)
	Pay	(1,605)	(126)	(134)	8	(513)	(535)	22
	Non Pay	(805)	(68)	(67)	(1)	(275)	(268)	(7)
	ITDA	(3,553)	(277)	(296)	19	(1,114)	(1,184)	71
	Other - Cross Year	-	3	-	3	136	-	136
Finance Total		**(5,382)**	**(323)**	**(448)**	**124**	**(1,531)**	**(1,797)**	**266**
Corporate	SLAM Income	-	-	-	-	-	-	-
	Other Income	(50)	13	(4)	17	-	(17)	17
	Pay	(1,270)	(98)	(106)	8	(504)	(423)	(80)
	Non Pay	(184)	(17)	(15)	(2)	(67)	(61)	(5)
	Other - Cross Year	-	(8)	-	(8)	(44)	-	(44)
Corporate Total		**(1,504)**	**(110)**	**(125)**	**15**	**(615)**	**(501)**	**(113)**
Grand Total		**2,203**	**486**	**347**	**139**	**1,093**	**223**	**870**

Summary

- The in month £139k positive surplus variance largely reflects full recognition of CQUIN for Q1 and this shows under Finance. In month the operational departments are marginally behind plan although they remain significantly over plan year to date.

Issues

- Anaesthetics and Surgery – M4 income adverse variance relates to Hands but the significant positive YTD variance remains. Pay variance is for additional clinical time and additional theatres costs due to sickness and vacancies.
- Clinical Support is showing an overspend on Non Pay mainly due to outsourcing Histopathology tests.
- Nursing – M4 income low for MIU (adjustment to prior month), burns and ITU. M4 pay reflects bank and agency pay across a number of areas.
- Estates and Hotel Services M4 pay is cover for absence.
- Finance SLAM income records the adjustments to patient income – CQUIN, Emergency Rate Threshold tariff adjustments and penalties and challenges. Finance Other Income is Road Traffic Accident (RTA) income. Finance Non Pay includes trust wide losses and compensation payments. Finance includes an element of upside from the prior year.
- The Corporate pay overspend will reverse as reserves are released to match costs brought forward.

Actions

- Delivering additional capacity through theatre 11 opening.
- Maintain control over costs through budgetary control.
- Delivery of the action plans to meet performance targets.

Pay Analysis – M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Directorate Positions	2014-15	July 2014			Year to Date 2014-15		
Pay Costs	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	(18,766)	(1,609)	(1,567)	(42)	(6,295)	(6,201)	(94)
Clinical Support	(4,937)	(392)	(406)	14	(1,597)	(1,626)	29
Nursing	(9,452)	(811)	(788)	(23)	(3,119)	(3,151)	32
Estates and Hotel Services	(1,657)	(147)	(138)	(9)	(582)	(552)	(29)
Human Resources	(714)	(59)	(59)	(0)	(222)	(233)	11
Finance	(1,605)	(126)	(134)	8	(513)	(535)	22
Corporate	(1,270)	(98)	(106)	8	(504)	(423)	(80)
Grand Total	**(38,401)**	**(3,242)**	**(3,198)**	**(44)**	**(12,831)**	**(12,721)**	**(110)**

Summary

- Pay costs are above plan in month and year to date reflecting the operational challenges faced by the trust.

Issues

- Shortfall on cost improvements represents £29k of the adverse variance although this will improve – see page 16.
- Anaesthetics and Surgery adverse variance is payment for additional sessions and agency cover in theatres due to sickness and vacancies.
- Nursing adverse variance is due to agency covering vacancies.
- Estates costs reflect Programme Office changes; the effect of this will be neutral by year end.
- Finance saving is for vacancies that will are being advertised.
- Corporate variance in month reflects funding of costs from the pay reserve. The adverse variance will become a nil variance by year end as the reserve is released.

Risks

- Pay costs reflect the operational challenges facing the trust – scheduling of activity, sickness, recruitment, retention and the need to safely maintain capacity to meet performance targets and objectives.

Actions

- Improve budget holder accountability through change in reporting structure, accountability agreements and lower level controls.

Pay Costs – YTD M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Pay Variances by Directorate and Staff Group	Anaesthetics and Surgery		Clinical Support		Nursing		Estates and Hotel Services		Human Resources		Finance		Corporate		Total	Total
July 2014	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV
CONSULTANTS	(15)	(18)	(12)	0	(3)	(16)	-	-	-	-	-	-	2	6	(29)	(28)
JUNIOR MEDICAL	12	(58)	-	-	(0)	(1)	-	-	-	-	-	-	-	-	11	(60)
AGENCY JUNIOR MEDICAL	(10)	(14)	(1)	(6)	(2)	(4)	-	-	-	-	-	-	-	-	(13)	(24)
NURSING, MIDWIFERY & HEALTH VISITORS	33	101	(1)	(1)	25	140	-	-	(0)	(0)	-	(0)	-	-	57	240
AGENCY NURSING, MIDWIFERY & HEALTH VISITORS	(26)	(26)	-	-	(43)	(101)	-	-	-	-	-	-	-	-	(69)	(127)
SCIENTIFIC, THERAPEUTIC & TECHNICAL	(24)	(77)	30	75	(6)	(23)	-	-	-	-	-	-	-	-	(0)	(26)
AGENCY SCIENTIFIC, THERAPEUTIC & TECHNICAL	-	-	(2)	(34)	-	-	-	-	-	-	-	-	-	-	(2)	(34)
OTHER CLINICAL STAFF	6	13	(0)	(2)	11	34	-	-	-	-	-	-	-	-	16	45
AGENCY OTHER CLINICAL STAFF	-	-	-	-	-	(0)	-	-	-	-	-	-	-	-	-	(0)
NON CLINICAL STAFF	(18)	(15)	1	(3)	(1)	2	(6)	(26)	(0)	11	8	28	28	(26)	13	(28)
AGENCY NON CLINICAL STAFF	-	-	(0)	(1)	(4)	3	(3)	(3)	-	-	(0)	(5)	(21)	(61)	(29)	(67)
Grand Total	**(42)**	**(94)**	**14**	**29**	**(23)**	**32**	**(9)**	**(29)**	**(0)**	**11**	**8**	**22**	**8**	**(80)**	**(44)**	**(110)**

Key: CMV-Current month variance; YTDV- Year to date variances to budget; in £k's; (red) is adverse.

Summary

- Pay costs reflect the operational challenges facing the trust with overspends in month and year to date.
- The challenges include scheduling, sickness, recruitment, retention and the need to safely maintain capacity to meet performance targets and objectives.

Issues / Risks

- The key variances are explained on page 13.
- The Corporate overspend will reduce to zero as reserves are released to cover costs incurred early.
- The other overspends are a continuing risk given the operational challenges.

Actions

- Enhanced budgetary control and an increased scrutiny of pay expenditure will help all budget holders to better understand variances and the necessary actions required to bring pay back in line with the financial plan.

Pay Costs – YTD M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Key Variances

- Anaesthetics and Surgery
  - Consultants costs are high in month with payments for additional sessions.
  - Scientific and therapeutic staffing costs are theatre staff covering sickness and absence.
  - Non clinical staff is additional support in Max Facs, theatres and health records.
- Clinical Support
  - Consultant cost are high in Radiology with additional cover.
  - Scientific and therapeutic underspend relates to vacancies that will be filled, particularly in the Prosthetics Lab.
- Nursing
  - Agency cover is driving the in month overspend and is covering vacancies / workload.
- Estates and Hotel Services
  - The overspend relates to the bringing forward of Programme Office costs, this overspend will reduce by year end.
- Corporate
  - The overspend relates to costs that are covered by reserves and the overspend will reduce to zero as reserves are released during the year.

Non Pay Analysis – M4 2014/15

Queen Victoria Hospital NHS Foundation Trust

Directorate Positions	2014-15	July 2014			Year to Date 2014-15		
Non Pay Costs	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	(7,606)	(597)	(647)	50	(2,509)	(2,482)	(27)
Clinical Support	(2,008)	(228)	(170)	(58)	(774)	(657)	(117)
Nursing	(2,305)	(189)	(194)	5	(761)	(761)	(0)
Estates and Hotel Services	(2,286)	(181)	(184)	3	(746)	(740)	(6)
Human Resources	(202)	(15)	(17)	2	(69)	(67)	(1)
Finance	(805)	(68)	(67)	(1)	(275)	(268)	(7)
Corporate	(184)	(17)	(15)	(2)	(67)	(61)	(5)
Grand Total	**(15,394)**	**(1,295)**	**(1,294)**	**(1)**	**(5,201)**	**(5,037)**	**(164)**

Summary

- Non pay costs are marginally over in month.

Issues

- Shortfall on cost improvements represents £63k of the adverse variance although this will improve – see page 16.
- Anaesthetics and surgery includes in month theatre savings that are not expected to continue as activity grows.
- Clinical Support relates primarily to histopathology tests being outsourced due to a consultant vacancy and capacity constraints.

Risks

- Overspends not linked to activity and shortfalls on cost improvement plans are risks.

Actions

- Improved budget holder accountability through change in reporting structure, accountability agreements and lower level controls.
- A review of the histopathology over spending is being progressed.

Non Pay Costs – YTD M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Non Pay Variances by Directorate and Group	Anaesthetics and Surgery		Clinical Support		Nursing		Estates and Hotel Services		Human Resources		Finance		Corporate		Total	Total
July 2014	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV
CLINICAL SUPPLIES & SERVICES EXPENSES	52	53	(15)	(18)	(6)	(38)	0	1	-	(0)	0	(2)	-	-	31	(5)
DRUG EXPENSES	(5)	(3)	(20)	(64)	15	48	-	-	(0)	0	-	(4)	-	-	(10)	(22)
ESTABLISHMENT EXPENDITURE	(5)	(41)	(6)	(13)	(1)	0	(3)	(6)	4	5	(2)	7	1	14	(13)	(34)
GENERAL SUPPLIES & SERVICES	(2)	(5)	1	(3)	(4)	(13)	6	6	0	(0)	(0)	(0)	-	-	1	(15)
OTHER NON PAY EXPENSES	10	(34)	(0)	(3)	0	(3)	0	0	0	0	0	(1)	(3)	(19)	7	(59)
PREMISES AND FIXED PLANT	(0)	3	(16)	(17)	1	(0)	1	(6)	(2)	(7)	0	(7)	(0)	(0)	(17)	(34)
RESEARCH AND DEVELOPMENT	-	-	-	-	-	5	-	-	-	-	-	-	-	-	-	5
Grand Total	**50**	**(27)**	**(58)**	**(117)**	**5**	**(0)**	**3**	**(6)**	**2**	**(1)**	**(1)**	**(7)**	**(2)**	**(5)**	**(1)**	**(164)**

Key: CMV-Current month variance; YTDV- Year to date variances to budget; in £k's; (red) is adverse.

Summary

- Non-pay costs are £1k above budget in month and £164k over year to date, but this includes non-recurrent and activity related costs.

Issues / Risks

- Non Pay costs may increase as the trust seeks to meet performance targets through additional activity.
- Anaesthetics and Surgery - Costs are favourable in July mainly due to underspends in theatres although underspends are not expected to continue as activity grows.
- Clinical Support - The in month overspend mainly relates to histopathology where the costs are for external tests.

Actions

- Enhanced budgetary control would contribute to the maintenance of non-pay costs either within budget or justified by increases in activity.

Cost Improvement Analysis – M4 2014/15

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes built into budgets 2014-2015	Annual Plan £000's	M04 Plan	Achieved £000's	Achieved %	Shortfall
Pay	337	112	83	74%	29
Clinical Supplies	233	78	56	72%	22
Non Clinical Supplies	142	47	7	14%	41
Other non operating expenses	170	57	48	85%	8
Total Cost Improvement Programmes	**882**	**294**	**195**	**66%**	**99**

Summary

- At M4 the trust is achieving 66% of the cost improvement plan however this is expected to improve.

Issues

- Pay - the key adverse variance is in the Programme Office where costs have been brought forward. The adverse variance will reverse and the £100k planned saving will be achieved.
- Clinical supplies - sleep devices are the key adverse variance and the procurement process is underway.
- Non clinical supplies include the proposal to purchase or dispose of the lease on Operating Theatre 6. The decision has been deferred and a business case is being prepared.
- Additional procurement savings are in development to help to achieve the full plan. .

Risks

- A 34% shortfall on plan is a risk of £300k.

Actions

- To prepare the business case for an Education Centre, original plans sought the use of old Theatre 6 with savings arising from the purchase of the building.
- Additional procurement savings.

Balance Sheet – YTD M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet	2013/14 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,211	36,703	36,764
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	36,703	36,764
Current Assets			
Inventories	415	418	413
Trade and Other Receivables	8,939	6,658	6,505
Cash and Cash Equivalents	3,655	7,065	6,120
Current Liabilities	(6,574)	(6,464)	(5,909)
Sub Total Net Current Assets	6,436	7,676	7,129
Total Assets less Current Liabilities	43,647	44,379	43,893
Non-Current Liabilities			
Provisions for Liabilities and Charges	(554)	(582)	(582)
Non-Current Liabilities >1 Year	(8,933)	(8,545)	(8,545)
Total Assets Employed	**34,159**	**35,253**	**34,767**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	16,843	16,357
Revaluation Reserve	6,173	6,173	6,173
Total Tax Payers Equity	**34,159**	**35,253**	**34,767**

NB Analysis is subject to rounding differences

Summary

- Net assets continue to improve with the generation of surpluses.

Issues

- Fixed assets are reducing as depreciation exceeds additions, although this is not expected to continue as capital plans are re phased and actioned.
- Debtor balances have improved significantly since the year end as commissioners reduce outstanding balances. This improvement brings debtor levels closer to those seen historically; further improvement is being sought.
- Non-current liabilities have reduced with the loan repayment made in June. The next repayment will be made in December.

Risks

- Cash balances rely on prompt payment by commissioners. The position has improved but the trust may be affected by financial pressures within the health economy.

Actions

- Reforecasting of the capital expenditure plan with a commitment to achieve the phased plan.
- Continued focus on reducing debtor balances.

Capital – M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Capital Programme	2014/15 Plan £000s	YTD Spend £000s	Committed £000s	Forecast £000s	2014/15 Total Spend £000s
Estates projects					
13/14 Projects:					
Jubilee/Burns heating	450	112	142	195	450
Other projects	85	-	19	66	85
14/15 Projects:					
Corneoplastic electrical upgrade	200	-	-	200	200
Fire compartmentalisation	160	-	-	160	160
A Wing repairs	100	-	-	100	100
Meeting rooms	50	-	-	50	50
Carbon reduction	50	-	-	50	50
Other projects	305	18	-	287	305
Medical Equipment	550	81	123	346	550
IT Equipment	1,400	59	7	1,334	1,400
Grand Total	3,350	270	291	2,789	3,350

Summary

- Capital expenditure is significantly below the phased plan and the original plan is being subjected to a more detailed review.

Issues

- The key project within IT is a replacement network to support more advanced clinical systems and this is expected to start in Q4.
- Estates costs include the £372k lease purchase that is subject to a business case that is being commissioned to consider other options.

Risks

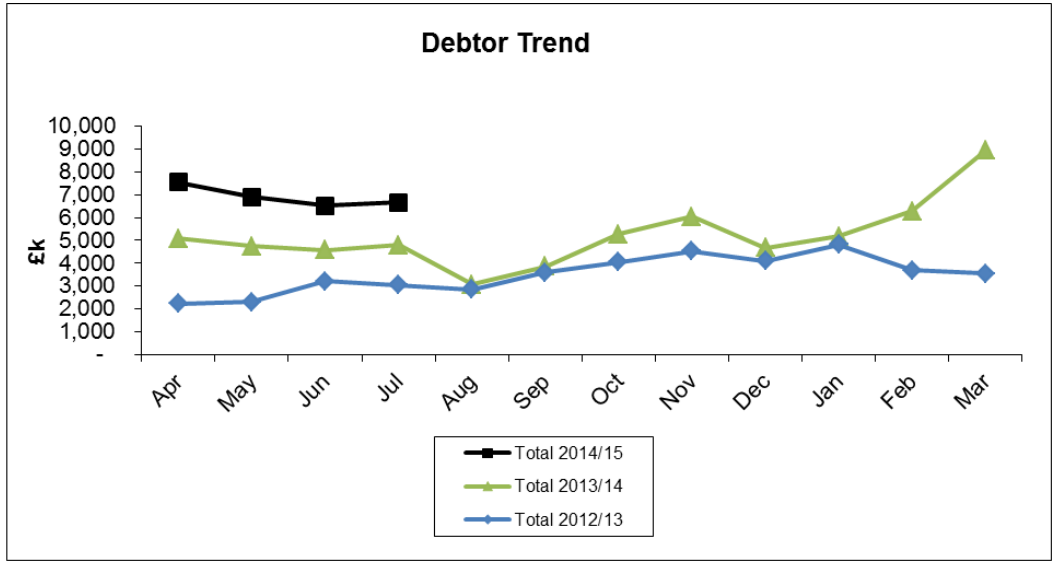
- Sufficient project management is key to the delivery of capital projects so this is being built into delivery plans.

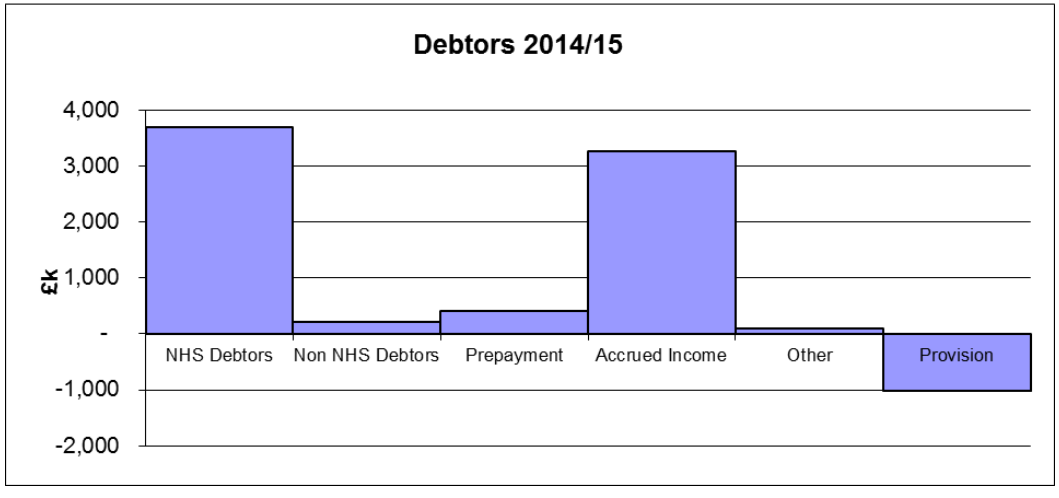
Actions

- Deliver planned projects.

Debtors – M4 2014/15

Queen Victoria Hospital NHS Foundation Trust





Summary

- Debtor balances have declined with commissioners reducing outstanding balances.

Issues

- Debtor balances are at historically high levels because of delayed payments. 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. Given the current value of debt, its age, and the pattern of cash receipts the provision may reduce by between £200k and £400k by year end.

Risks

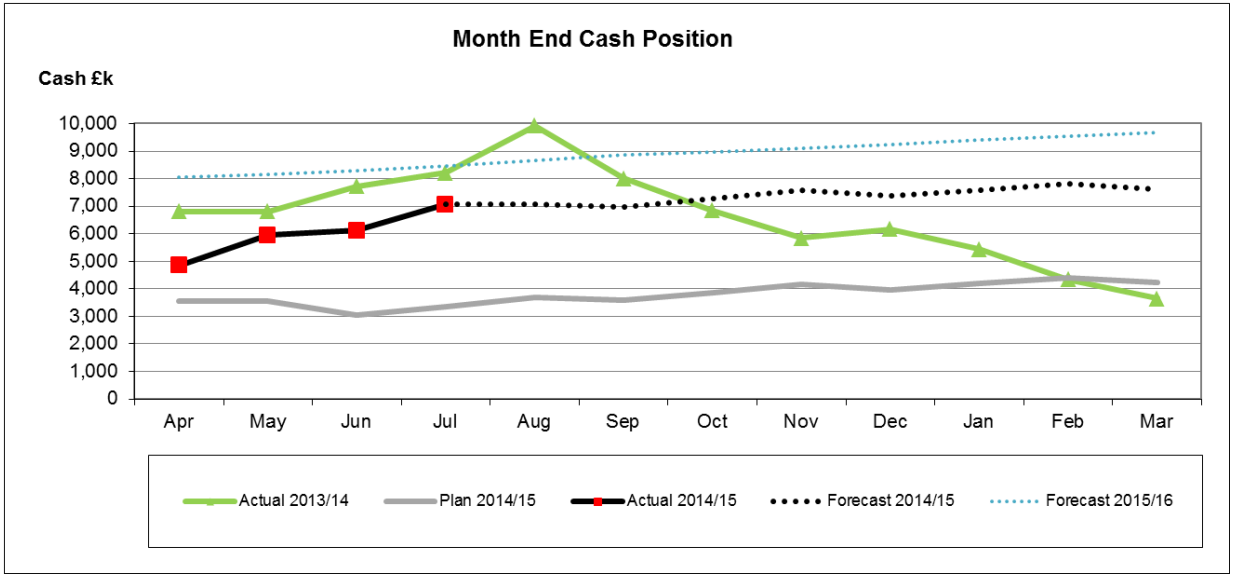
- Debt arising from over performance against income plans is slower to be paid.

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M4 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust



Summary

- Cash balances are significantly above plan because of reduced debtor balances and delays to capital expenditure.

Issues

- Cash balances peaked in 2013/14 and declined with delivery of the £4m internally funded theatres project. Increased debtor balances toward year end contributed to the reduction in cash .
- Cash balances are projected to increase through to the end of 2015/16 reflecting surpluses, continued reduction in debtor balances and an increase in capital spend to get back on plan.

Risks

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

Actions

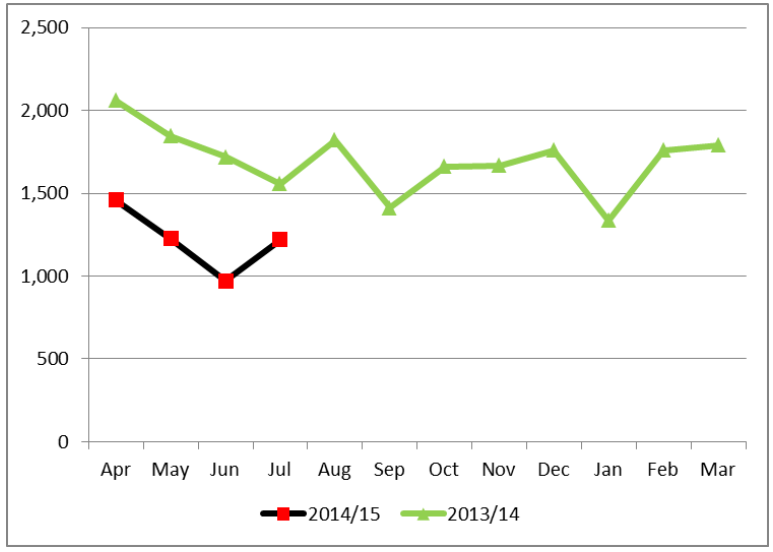
- Continued liaison with commissioners to ensure prompt payment.
- Management of capital schemes.

Creditors – M4 2014/15

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors

£k



Summary

- Current liabilities have shown a steady decrease this year.

Issues

- The trade creditors element of creditors has fallen through prompter payment and the reduction in capital spend.
- Payment performance against the 30 day target is below target, but not because of serious delays to payments.

Risks

- Internal delays in the authorisation and processing of invoices.

Actions

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

Better Payment Practice Code July 2014	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	1,140	1,240	4,819	5,141
Total Non NHS trade invoices paid within target	9,386	15,087	776	676	3,107	3,293
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**68%**	**55%**	**64%**	**64%**
Total NHS trade invoices paid	1,082	4,544	95	327	350	1,634
Total NHS trade invoices paid within target	624	2,858	57	191	160	838
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**60%**	**58%**	**46%**	**51%**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28 August 2014**
Reference number:	**207-14**
Report from:	**Graeme Armitage, Head of HR & Operational Development**
Author:	**Karol Goldsmith, Senior HR Advisor**
Report date:	**19 July 2014**
Appendices:	**A: Workforce Performance Report**

Workforce update - August 2014

Key issues

1. Sickness absence in the Trust rose in July however stress/anxiety related episodes remain the same.
2. Bank and agency levels remain lower than in previous years whilst vacancies and overall pay have increased from last year.
3. Turnover has increased to 16% however there is no overall trend emerging. June saw a very large number of leavers however the numbers for July were back to more normal figures.
4. Statutory and Mandatory training performance remains over 70% with a slight decrease in July to 72.43%.

Implications of results reported

5. The workforce metrics within this report have an impact on the quality of patient care and so robust management of those remain a priority.
6. The Trust has a duty to make reasonable adjustments to those covered by the Equality Act 2010 and this is taken into account when managing sickness absence.
7. Workforce data is shared with NHS England and may be used by commissioners.
8. The efficient use of resources is essential to being a well-run organisation and therefore the introduction of productivity measures supports managers to effective decision making.

Action required

9. Although there are no obvious trends in the high levels of turnover this needs to be monitored closely and reduced towards the Trust target of 11%. Therefore a continued focus by the Workforce Information Team on vacancy levels, reasons for leaving and improvements in exit interview process are in train.
10. Continue with the controls for agency and bank usage which require senior management approval for non-clinical and over-establishment cover.
11. Continue to manage sickness absence proactively through collaboration between line managers, Human Resources and Occupational Health.
12. Further review of workforce metrics including breakdown of average staff costs in comparable services, e-rostering performance, recruitment timescales and staff development.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability

- Organisational excellence

13. Vacancies, sickness absence and bank and agency usage have an impact on the quality of patient care, cost more to the organisation and affect the wellbeing of staff who are at work.

Implications for BAF or Corporate Risk Register

14. The issues raised at paragraphs 1 – 5 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.
    Although Anxiety and Depression are our main cause of sickness absence, we report on these issues at the Health and Safety and Risk Committee meetings – there is nothing additional in this report which needs to be escalated to the Corporate Risk Register or BAF outside that process.

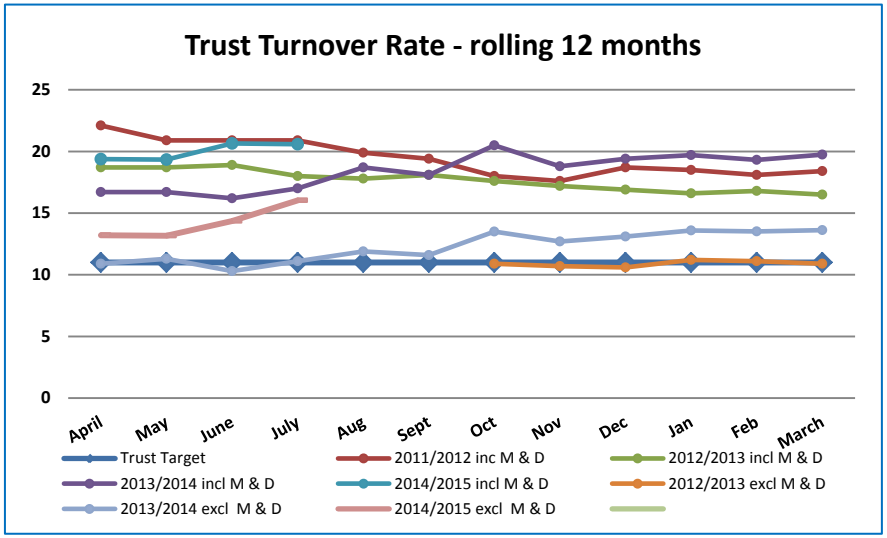
Regulatory impacts

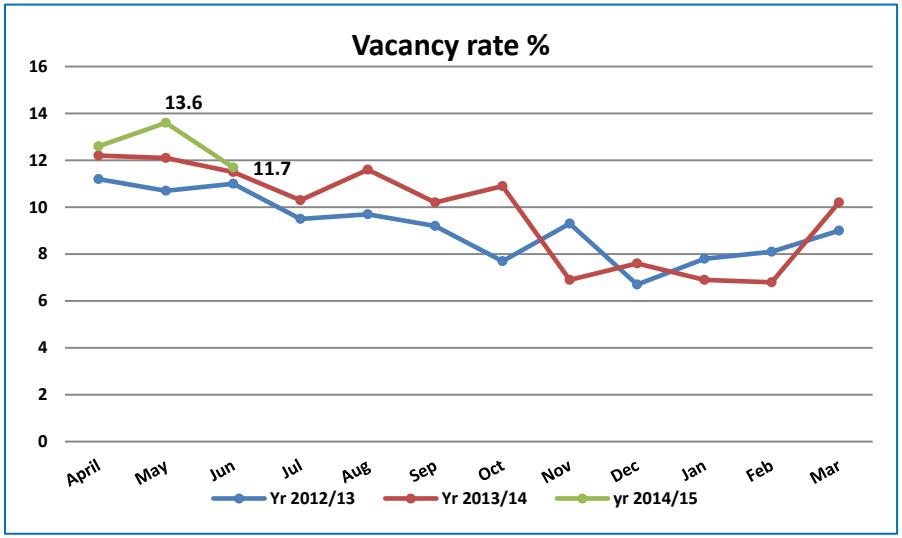
15. Although there is always a potential for high turnover and staff sickness to compromise quality of care and have a detrimental impact on the experience of other staff, it is not felt that the level of turnover and staff sickness prevailing currently is a genuine threat to regulatory compliance. Safety is maintained through use of temporary staff and the report shows that bank and agency use is low and recruitment to vacancies is improving.

Recommendation

16. Options include
    - The Board is recommended to note the contents of the report.

HEADLINE HR KPIs August 2014





	Staff Movements											
	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14
Headcount	930	938	942	960	959	967	971	971	966	966	967	965
WTE in Post	788	789	807	819	820	825	823.78	823.78	816.86	816.07	816.78	816.79
WTE Funded Establishment	867.99	867.99	867.99	867.99	867.99	867.99	867.99	867.99	897.51	897.51	897.51	897.51
New Hires	37	21	33	12	6	16	29	7	10	7	19	10
Leavers	43	12	24	6	14	11	22	15	9	9	21	12
Maternity Leave	15	18	18	19	21	16	17	19	19	20	17	16
Vacancy Rate	11.6%	10.2%	10.9%	6.9%	7.6%	6.9%	6.8%	10.2%	12.6%	13.6%	11.7%	N/A
Turnover Rate	4.62%	1.27%	2.51%	0.73%	1.46%	1.14%	2.05%	1.65%	0.93%	0.93%	2.07%	1.24%

	Rolling 12 Monthly Turnover Figures											
	Aug 13	Sep 13	Oct13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14
12 Month Turnover (including Medical & Dental)	18.7%	18.1%	20.5%	18.8%	19.4%	19.70%	19.32%	19.74%	19.38%	19.34%	20.65%	20.59%
12 Month Turnover (Excluding Medical & Dental)	11.9%	11.6%	13.5%	12.7%	13.1%	13.59%	13.51%	13.62%	13.21%	13.17%	14.36%	16.03%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 31st July 2014 decreased very slightly by 0.06% to 20.59% (including medical and dental) and increased by 1.67 % to 16.03% (excluding medical and dental).

During July there were 10 new starters and 12 leavers (10.20 FTE) with a monthly turnover rate for July of 1.24 % (1.25% FTE). Staffing stability is at 96.23%, this indicates that the organisational staffing core is stable.

Registered nurse staff group represents the highest number of leavers with 7.71WTE leaving within quarter 1. Research done by NHS Employers has shown that other trusts are facing recruitment shortages within the registered nurse staff group and that a high number of organisations have already considered the use of international recruitment to fill gaps. The Trust is looking at this and other options to incentivise nurses to join us.

Vacancies Rates (figures 2 month in arrears)

Vacancy rate for June was at 11.7 % of which 24.5 WTE (of total of 80WTE vacant) were actively being recruited to. Bank and agency are being used to cover establishment vacancies, increase in patient activity, long-term sickness and maternity leave to a total 52.89 WTE, currently 16 employees are on maternity leave and 20 employees with sick leave of 4 weeks or more)

Vacancies

Activity levels for July currently have 28.9 WTE of active vacancies, of which 6.4 WTE are nursing posts and 8 WTE are for medical and dental. Recruitment to nursing remains a priority and new innovative approaches are being sought to encourage interest in posts. Areas experiencing difficulties in recruiting nurses are Corneo, Theatres, ITU and Canadian Wing.

Average recruitment timescales remain at 5 weeks, from advert to conditional offer letter, this will improve with the implementation of on-line DBS clearance and electronic OH clearance.

Exceptions

The Trust continues to experience the highest level of vacancies within the Nursing Workforce, where a centrally co-ordinated recruitment campaign is in progress to address both current vacancies & future workforce developments concerning the Trust.

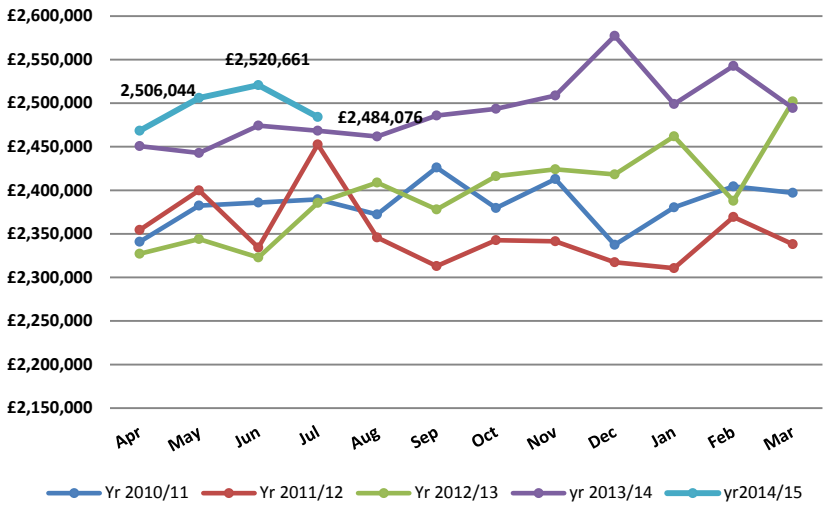
Actions

- Maintain relationships with universities to continue to employ nurses and build stronger links.
- Expand our talent pool so that the Trust can successfully recruit to our nursing posts.
- Look to recruit from with in Europe.

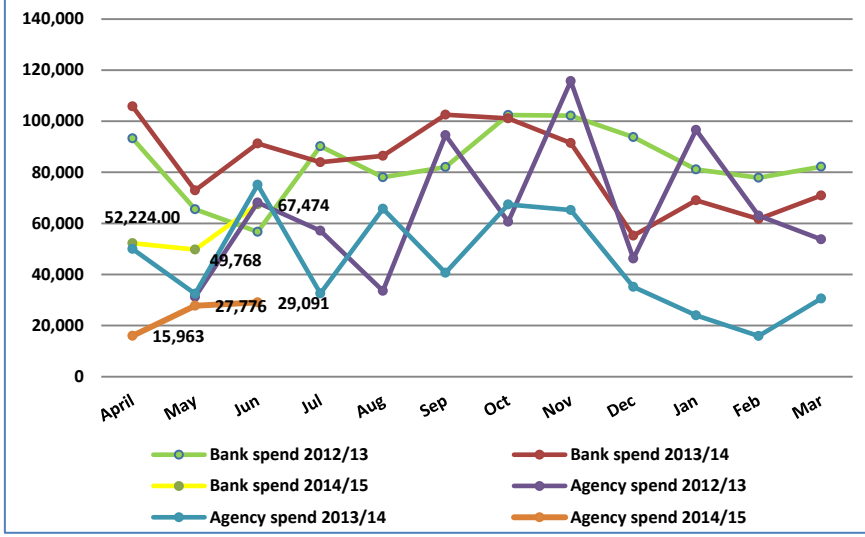
RAG Rating

HEADLINE HR KPIs

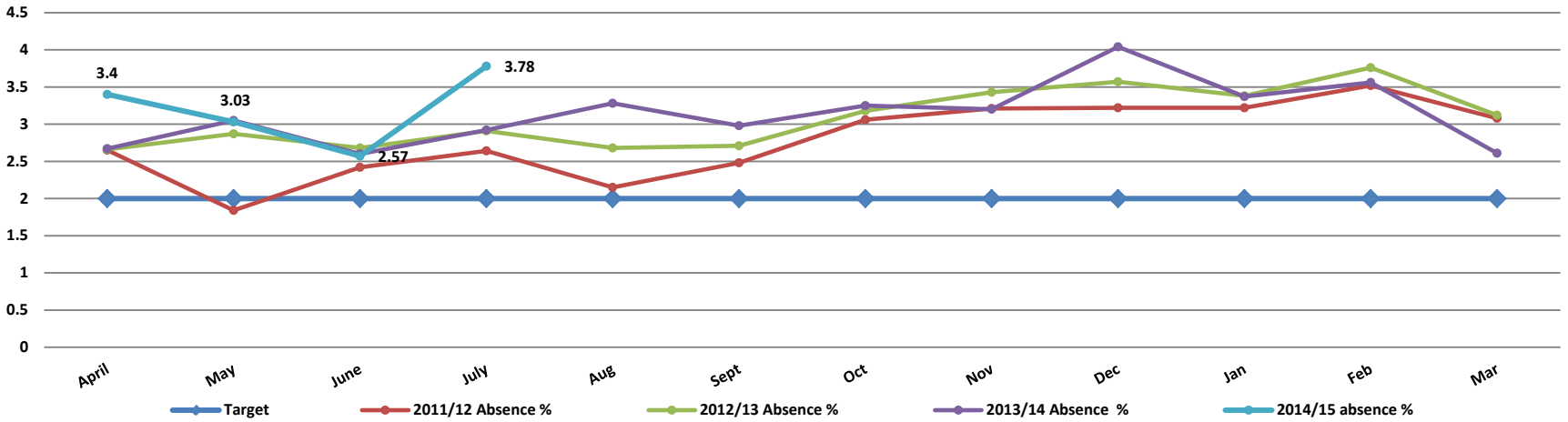
Total Pay Bill per month (excluding on costs)



Bank & Agency Spend



Trust Absence Timeline



HEADLINE HR KPIs

Pay Bill – (1 month in arrears) reported pay does not include on costs.
Pay for July decreased very slightly to £2,484,076 due to tighter monitoring of budgets and robust controls in place for the use of bank and agency workers.

A breakdown of the split between total staff paid WTE and bank/agency and overtime is reported in arrears and for June 14, shows WTE staff in post was 816.74, total WTE paid 871.76 (inclusive of 32.64 WTE Bank, 20.25 WTE Agency and 2.13 WTE over-time). There has been a steady decline over the last 6 months in bank expenditure due to tighter budget constraints.

Bank and Agency usage – (figures are 2 month in arrears)
Bank expenditure for June increased by 26% to £67,474 from last month, while agency expenditure rose slightly to £29,091 an increase of 4.5% over last month, this was due to additional workload, establishment vacancies and high patient activity.

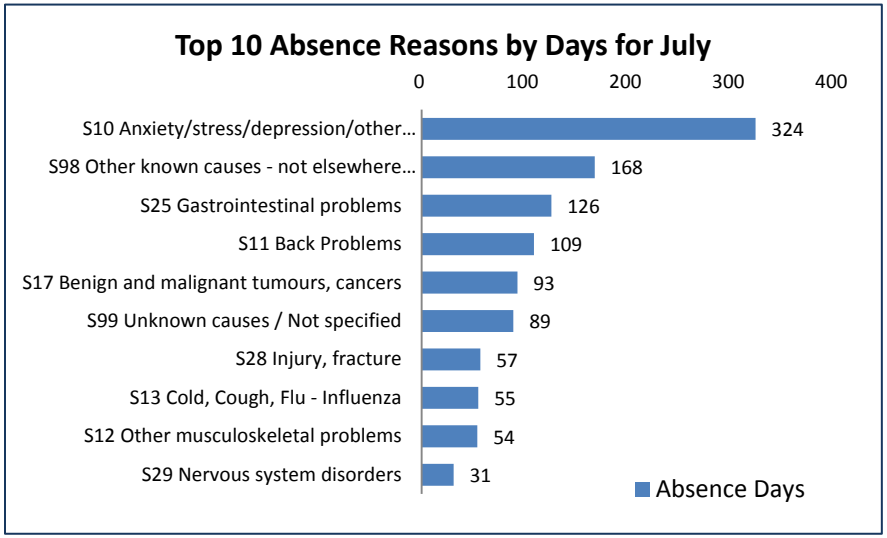
The Bank/agency combined fill rate for June was 77.2% a decrease of 8% over last month. In total 6207 hours (63.61%)were filled by bank and 1330 hours (13.63%)were filled by agency. Canadian Wing were the highest users of bank and agency at 913.45 hours (split 553.15 bank and 360.30 agency), this was due to establishment vacancies and patient demand. Burns Ward used 594.85 hours (split 466.30 bank and 128.55 agency) due to establishment vacancies.

Actions

- Monitor controls put in place and review in August as to whether further steps need to be instigated.
- 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

RAG Rating

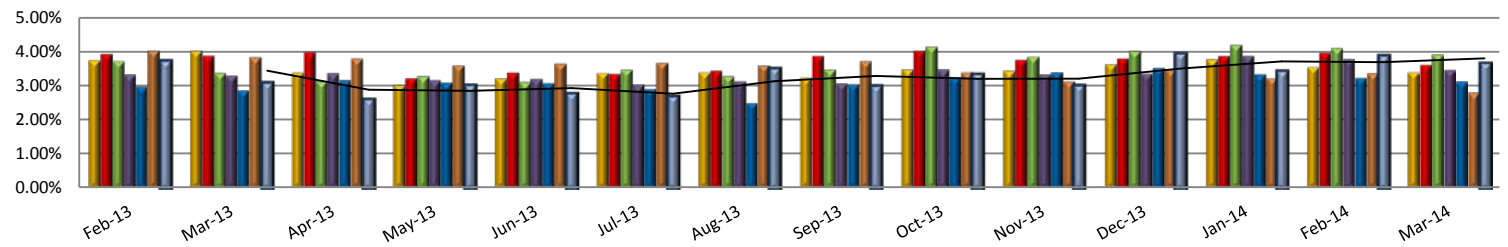
HEADLINE HR KPIs



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

Staff Group	Estimated Cost	FTE Days Lost
Add Prof Scientific and Technic	£13,584	121.50
Additional Clinical Services	£12,280	250.79
Administrative and Clerical	£19,124	302.69
Allied Health Professionals	£1,861	17.05
Estates and Ancillary	£7,015	111.80
Healthcare Scientists	0	0
Medical and Dental	£7,268	43.43
Nursing and Midwifery Registered	£15,326	131.90
Grand Total	£76,459	979.16

The graph below shows sickness absence rates for the Surrey and Sussex region for the last 12 months of available data on IView. The data shows throughout the period that Royal Surrey and QVH generally have the lowest rates in comparison.



	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Brighton and Sussex	3.76%	4.03%	3.39%	3.01%	3.22%	3.38%	3.40%	3.24%	3.49%	3.44%	3.64%	3.78%	3.55%	3.40%
Maidstone and Tunbridge Wells	3.96%	3.91%	4.01%	3.24%	3.41%	3.37%	3.47%	3.90%	4.05%	3.78%	3.82%	3.90%	4.00%	3.64%
East Kent Hospitals	3.74%	3.39%	3.14%	3.29%	3.12%	3.49%	3.30%	3.49%	4.17%	3.87%	4.03%	4.22%	4.13%	3.94%
Medway NHS Foundation Trust	3.33%	3.30%	3.37%	3.16%	3.20%	3.04%	3.12%	3.07%	3.48%	3.33%	3.36%	3.88%	3.78%	3.46%
Royal Surrey County	2.98%	2.86%	3.16%	3.09%	3.08%	2.91%	2.49%	3.04%	3.25%	3.39%	3.52%	3.33%	3.23%	3.12%
Surrey and Sussex	4.03%	3.84%	3.80%	3.60%	3.65%	3.68%	3.60%	3.73%	3.40%	3.13%	3.47%	3.23%	3.37%	2.80%
QVH	3.76%	3.12%	2.64%	3.05%	2.80%	2.72%	3.54%	3.03%	3.37%	3.04%	3.97%	3.46%	3.92%	3.69%

HEADLINE HR KPIs

Sickness/Absence

There has been a significant increase in sickness absence levels for the month of July to 3.78%. This is the highest level of absence since December 2013, however overall sickness absence for quarter 1 was lower by 0.54% compared to quarter 4. The cost of sickness absence in quarter 1 was £185,000.

Admin and Clerical represent the highest number of sickness absence this month with 284 FTE days lost to sickness, of which 20% were off with anxiety/stress. Efforts to maintain smarter control of absence is being coordinated between HR and OH, with monthly meetings with managers and case reviews in place. It has also been agreed to trial Mindfulness in the Trust to support those experience anxiety.

Exceptions

The main affected areas are Clinical Audit at 39.89%, a small department with 1 long-term sickness , Psychotherapy at 22.58% 1 long-term sickness case, SLR Breast at 17.37%, 2 long-term sickness cases both off with work related stress, Corporate Affairs at 17.01% a small department with 1 long-term sickness case, Catering at 10.86% 1 long-term due to surgery and 3 short-term sickness cases, Admissions at 10.30% 3 short term cases, Site Practitioners 10.14% 1 long-term and 2 short-term sickness cases

All cases are being managed through Occupational Health. Case management meetings with Occupational Health are taking place where necessary to determine individual's capability to continue in their role.,35 employees have hit trigger points and all are being managed in line with the Trust Sickness Absence Policy.,5 people are on formal stage 1 of the policy and 2 at formal stage 2.

Actions

- A new HR session has been also been added entitled 'Managing Work Related Stress' which is designed to support managers more specifically in understanding and recognising the signs of stress in the workplace and how to make improvements e.g. ensuring staff have their breaks on time.
- Mindfulness will be trialed in the Trust as part of our Wellbeing strategy and to address absence due to anxiety.

RAG Rating

HEADLINE HR KPIs

•Payroll

All staff were paid on time, there were 5 overpayments with an increase in amount from £818.25 to £6095.45. The overpayments were due to 3 x late notification of change of hours, 1 x late notification of termination and 1 x late notification of absence by managers.

•Interim payments made in July decreased in volume from 9 to 5, due to managers error when finalising shifts on HealthRoster. Payroll errors decreased from 3 to 2.

•Employee Relations

In July fewer cases were opened continuing a downward trend. The overall open cases is 33, a drop in last month from 37. Main case types continue to be capability (on health grounds) and Capability (poor performance)

Case Type — Number of cases

- Disciplinary – 0
- Bullying & Harassment - 0
- Conduct – 1
- Capability – 8 (this includes sickness capability cases)
- Long-term sickness - 20
- Change Management – 2
- Grievance - 0
- Whistleblowing - 0
- Probationary – 1
- Appeals – 1

Total 33

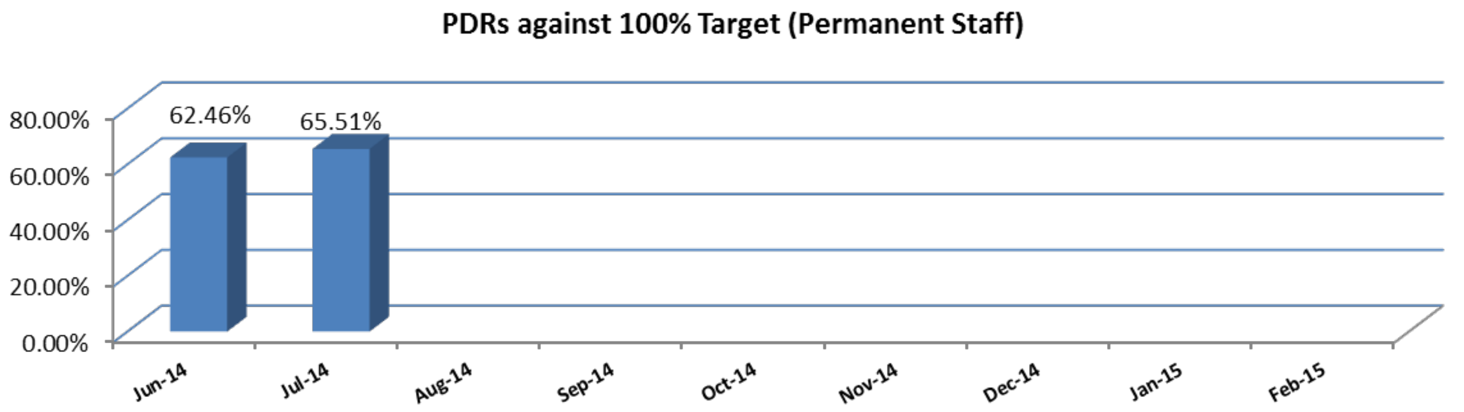
The number of health capability cases underlines the focus on managing sickness absence.

•Actions

- Continue to focus on areas above 2% absence rates. Meetings being held regularly with ward managers/matrons/line managers to discuss cases and develop action plans.
- Monitor the short term absence providing monthly reports to managers on staff who have hit trigger points that require intervention.

RAG Rating

PDR's by Directorate as at 6.8.14



Directorates - PDR Achieved against 100% (excluding Medical & Dental)

Directorate	Jul-14		Aug-14		Sep-14		Oct-14		Nov-14		Dec-14		Jan-15		Feb-15										
Anaesthetics & Surgery Dir)	41.60%																								125
Clinical Support Services (Dir)	72.97%																								111
Corporate (Dir)	47.62%																								21
Estates & Hotel Services (Dir)	60.29%																								68
Finance (Dir)	42.11%																								38
Human Resources(Dir)	80.77%																								26
Nursing (Dir)	73.87%																								398

Medical & Dental - PDR Achieved against 100%

Directorate	Jul-14		Aug-14		Sep-14		Oct-14		Nov-14		Dec-14		Jan-15		Feb-15										
Anaesthetics & Surgery (Dir)	68.12%																								69
Clinical Support Services (Dir)	40.00%																								5

HR KPIs as at 6.8.14

PDRs

Appraisal rates for the Trust overall have improved slightly for the month of July from 62.46% to 65.51%.

Due to the changes within the organisation directorates it is not possible to do a like for like comparison from last month to this month as some of the departments within the directorates have merged i.e. 12 departments into 7.

Exceptions

Areas of under performance are Anaesthetics & Surgery – 41.60%, Corporate – 47.62% and Finance – 42.11%.

Actions

Appraisal completion continues to remain a high priority and all the directorates have plans in place to ensure their teams will be compliant with regards PDR completion. Since last month we have had some areas being made aware to send their completed PDR paperwork to HR rather than L&D so this has helped with the completion rates.

RAG Rating

Statutory and Mandatory Training

Competence Name	Non Compliance	Expired but Booked	Compliant	Grand Total	Trust Overall (Expired + Meets Req)
Adult & Paediatric BLS - annual	9.03%	8.55%	82.42%	100.00%	90.97%
Child Protection Level 1 - 3 yearly	20.18%	1.59%	78.23%	100.00%	79.82%
Child Protection: Level 2 - 3 yearly	32.79%	2.85%	64.36%	100.00%	67.21%
Child Protection: Level 3 - 3 yearly	69.23%	0.00%	30.77%	100.00%	30.77%
Conflict Resolution - 3 yearly	30.82%	9.28%	59.89%	100.00%	69.18%
Emergency Planning: annual	16.55%	4.42%	79.02%	100.00%	83.45%
Equality, Diversity & Human Rights - 3 yearly	90.59%	3.97%	5.44%	100.00%	9.41%
Infection Control: annual	15.76%	5.10%	79.14%	100.00%	84.24%
Information Governance - annual	18.82%	0.68%	80.50%	100.00%	81.18%
Manual Handling - Clinical - annual	29.79%	6.62%	63.59%	100.00%	70.21%
Manual Handling - Non-clinical - 3 yearly	18.77%	0.28%	80.95%	100.00%	81.23%
Risk: annual	15.19%	4.76%	80.05%	100.00%	84.81%
Safeguarding Adults - 3 yearly	19.16%	2.04%	78.80%	100.00%	80.84%
Grand Total	27.57%	3.89%	68.54%	100.00%	72.43%

Statutory & Mandatory Training

Statutory and mandatory training Trust overall figure has dropped slightly from 76.57% to 72.43% (from 71.48% to 68.54% excluding those who are booked onto a course) but course completions are remaining steady and individually the majority of competencies have improved from last month. Whilst performance still remains below the 80% target improvements within the L&D team with regards Statutory & Mandatory training and aligning with the National passport is impacting positively.

The non-compliance figures are dropping as we are being more specific with our course targeting and reporting.

Exceptions

Equality, Diversity & Human Rights – this has changed from a once only to a 3 yearly renewal. Therefore we are showing as red for the 3 yearly compliance but as of last month we had a compliance rate of 76.48% for the once only E, D & HR. Some of these will be amended to 3 yearly competencies and over the next few months this will reflect in the data as we continue to update and data cleanse to align with the CSTF National Passport competencies.

Child Protection – Level 1 and 3 dropped slightly from last month.

Actions

L&D are continuing to cleanse data whilst aligning competencies to the National Passport. This also allows us to target those individuals who do not have the relevant competencies and be more specific with course enrolment targeting.

RAG Rating

Mandatory & Statutory Training by Directorate (Permanent Staff only)
As at 6.8.14

Activity	Trust	Corporate	Clinical Specialities	Clinical Support Services	Activity	Trust	Corporate	Clinical Specialities	Clinical Support Services
Adult & Paediatric BLS	82.04%	82.37%	77.94%	85.71%	E, D & H Rights - ONCE	76.31%	81.09%	67.98%	77.33%
Staff	412	295	68	49	Staff	895	201	178	516
Trained	338	243	53	42	Trained	683	163	121	399
Booked					Booked				
Gap	74	52	15	7	Gap	212	38	57	117
Child Protection Level 1	78.28%	76.77%	74.23%	92.24%	Infection Control	78.86%	80.22%	76.80%	75.86%
Staff	861	551	194	116	Staff	861	551	194	116
Trained	674	423	144	107	Trained	679	442	149	88
Booked					Booked				
Gap	187	128	50	9	Gap	182	109	45	28
Child Protection Level 2	64.86%	61.22%	66.67%	81.82%	Information Governance	80.49%	83.48%	66.49%	89.66%
Staff	481	343	72	66	Staff	861	551	194	116
Trained	312	210	48	54	Trained	693	460	129	104
Booked					Booked				
Gap	169	133	24	12	Gap	168	91	65	12
Child Protection Level 3	30.65%	28.57%	NA	50.00%	Manual Handling - Clinical	63.68%	60.33%	71.21%	74.47%
Staff	62	56	0	6	Staff	413	300	66	47
Trained	19	16	0	3	Trained	263	181	47	35
Booked					Booked				
Gap	43	40	0	3	Gap	150	119	19	12
Conflict Resolution	64.94%	66.57%	52.63%	74.42%	Manual Handling - Non Clinical	81.20%	83.07%	81.13%	75.00%
Staff	559	359	114	86	Staff	351	189	106	56
Trained	363	239	60	64	Trained	285	157	86	42
Booked					Booked				
Gap	196	120	54	22	Gap	66	32	20	14
Emergency Planning	78.86%	80.04%	75.77%	78.45%	Risk	79.91%	80.76%	78.35%	78.45%
Staff	861	551	194	116	Staff	861	551	194	116
Trained	679	441	147	91	Trained	688	445	152	91
Booked					Booked				
Gap	182	110	47	25	Gap	173	106	42	25
E, D & H Rights - 3 yearly	5.34%	4.17%	6.19%	9.48%	Safeguarding Adults	78.63%	77.31%	77.84%	86.21%
Staff	861	551	194	116	Staff	861	551	194	116
Trained	46	23	12	11	Trained	677	426	151	100
Booked					Booked				
Gap	815	528	182	105	Gap	184	125	43	16

Notes:
Activity - each subject area of statutory training without showing individual course types
Staff - Number of staff required to do Activity
Trained - Number of staff with current Activity competence
Gap - Those currently out of date with current Activity
Booked - We are not able to currently give figures for those that have the Activity booked

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28th August 2014**
Reference number:	**208-14**
Report from:	**Graeme Armitage, Head of HR & Operational Development**
Author:	**Graeme Armitage, Head of HR & Operational Development**
Report date:	**24 July 2014**
Appendices:	**A: Key Strategic Objectives Update – KSO 5 Organisational Excellence**

KSO 5 Organisational Excellence

Key issues

1. The report provides the Board with an update against the objectives / actions associated with KSO 5 Organisational Excellence.

2. Whilst the main focus of the report is to provide an outline of the progress in year, some of the objectives have a longer time span and therefore where this is the case the appropriate year has been indicated.

3. The report details the main objectives with progress to date but also links these actions to the overall aims associated with QVH 2020 : Delivering Excellence and the developing Workforce Strategy.

Implications of results reported

4. The report provides the Board with assurance against the workforce elements of the Trust strategy (mainly FY 2014/15). These are designed to provide the pathway for achieving the Trust's aims of continuous performance improvement and long-term sustainability.

5. The information contained within the report will be available to our Commissioners and the general public.

Action required

6. Management and progress of the objectives and actions outlined in this report is the responsibility of the Head 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.

7. 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

8. The issues raised at paragraphs 1 – 3 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

9. Progress to date is sufficient to assure the Board that good progress is being made in all areas. The slippage associated with the implementation of 3 year workforce plans and the implementation of the e-rostering system is unlikely to compromise the Trusts delivery of high quality patient care and sufficiently robust plans are in place to ensure these objectives are delivered. Consequently there is no adverse impact for regulatory compliance.

Recommendation

10. Options include
    - The Board is recommended to note the contents of the report.

Queen Victoria Hospital NHS
NHS Foundation Trust

HR Key Strategic Objectives 2014 - 2020

Graeme Armitage – Head of HR/OD

QVH 2020 : Delivering Excellence - Vision

Queen Victoria Hospital NHS
NHS Foundation Trust

Our aims and ambitions

Through our strategy the Trust will:

- be a modern and well led organisation
- have patient safety and quality of care at the heart of everything we do
- continue to be innovative in the delivery of care
- develop the estate to provide an excellent environment for our patients and staff
- develop a culture of continuous improvement
- become community focused as well as leading edge in our surgical specialties
- have a well trained, flexible and motivated workforce
- provide our staff with 21st century working arrangements which benefit the organisation and themselves

This vision for QVH led to work on developing our strategy (QVH 2020: Delivering Excellence)

Once our vision and aims had been established it was then possible to develop the Key Strategic Objectives (KSO) to ensure we achieve a sustainable future for the organisation

QVH

QVH Key Strategic Objectives

Queen Victoria Hospital NHS
NHS Foundation Trust

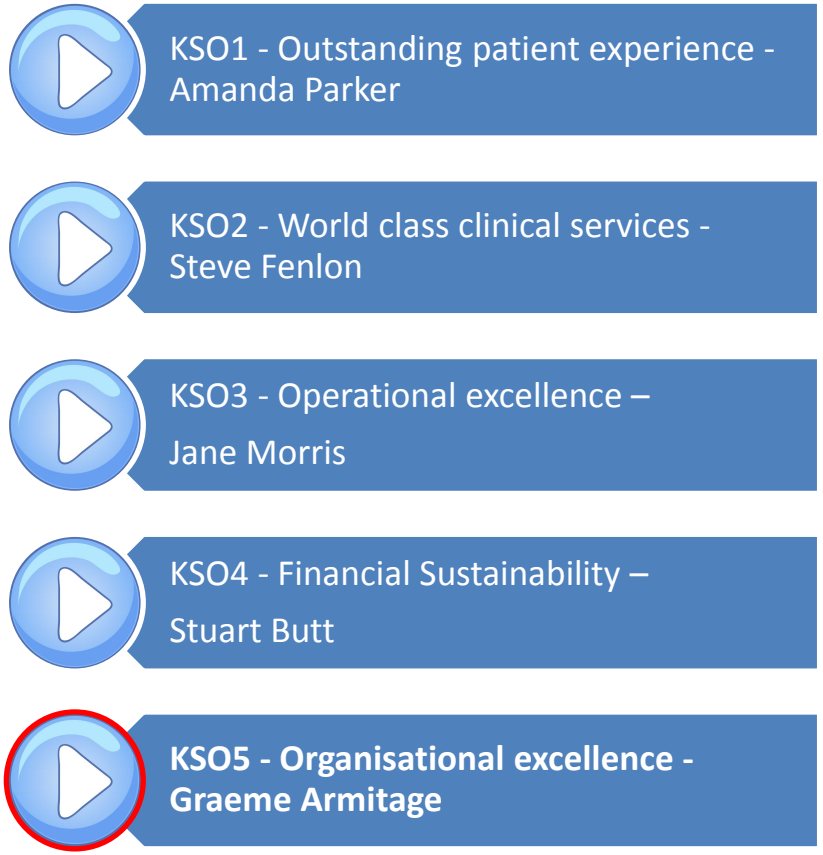
QVH 2020: Delivering Excellence

•Since the autumn of last year we have been developing the Trust's strategic direction i.e. ***Delivering Excellence: QVH 2020*.**

•The aim of our strategy is to provide leadership and direction for the Trust over the next 5-10 years and is based on the straightforward belief that delivering excellence is the most effective way of securing the Trust's long term future as a specialist surgical centre.

•In the work we have been taking forward over the last few months we have defined what 'Excellence' looks like and have broken this down into 5 domains.

•These in turn have now been turned into our Key Strategic Objectives (KSOs) which forms the work programme for the next few years. Each of the 5 KSOs have more details actions associated with them but in summary they are:

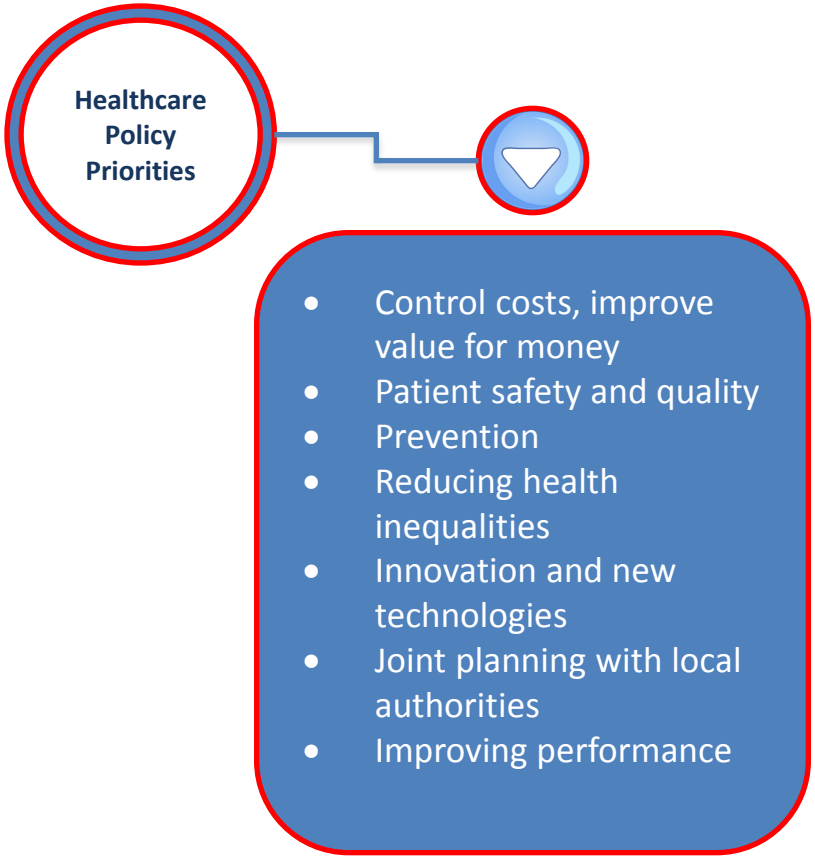


National and local drivers

- One of the strengths of QVH is in our workforce and our future success will depend greatly on our ability to provide the right environment for staff to work to the highest levels of quality and efficiency.

- Therefore, focussing on **KSO5**, the workforce strategy is being developed to underpin ***QVH 2020*** and therefore the work associated with KSO5 provides the back drop for our workforce strategy.

- To make the strategy workable a local perspective has been brought to bear to look at ways in which our staff will be supported and developed in the next 5 years. In addition, as part of the workforce strategy development, account has also been taken of the national healthcare priorities which are:



Workforce Strategy and the KSOs

Queen Victoria Hospital NHS
NHS Foundation Trust

- In this context and with the likelihood of no additional funding being provided to the NHS nationally, the workforce strategy is being designed around 6 themes which will support the organisation to transform the way we provide services and creates a culture for continuous improvement.
- Staff will be provided with the training and support they need to carry out their work to the high standards we are setting as part of ***QVH 2020***.
- Staff will also be involved in shaping our future along with helping us to become more innovative in the way services are delivered.
- The 6 themes and how they link to ***QVH 2020*** are outlined here and now form the focus for the workforce strategy over the next 5 years:

NB: Click the arrow to see the themes more easily

Developing our staff – improving flexibility of the workforce
- Flexible skills development which enable the Trust to be agile and responsive to change
- Improving learning opportunities for all staff
- Promoting healthy working and staff support

KSO 1,3 & 5

Improving our business – driving up quality and value for money
- Better patient experience with increased productivity
- Strengthening support to managers and staff from Human Resources
- Removing duplications and tightening administration processes

KSO 1,2,4 & 5

Being accountable – strengthening our leadership capability
- New Management / leadership framework to develop capability
- Talent management and succession planning
- Management modelling of Trust values

KSO 1,3 & 5

Sharing the journey – engaging with staff, patients and their carers
- Feedback to staff on performance against key objectives
- Widening opportunities for staff, patients and carers to become involved
- Annual review of QVH 2020 and progress towards our vision

KSO 1,2,3 & 5

Managing the change – workforce planning and effective change management
- 3 year workforce plans aligned to clinical strategy
- Improved HR systems e.g. e-rostering
- Developing new reward initiatives

KSO 1,4 & 5

Designing our future - working with staff / external stakeholders on the future delivery of services
- Design in technology for innovative service delivery
- Developing new healthcare roles
- Patient focussed with front line staff engagement

KSO 1,2,3 & 5

KSOs to Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

QVH 2020: Key Strategic Objectives

- KSO1 - Outstanding patient experience - Amanda Parker
- KSO2 - World class clinical services - Steve Fenlon
- KSO3 - Operational excellence - Jane Morris
- KSO4 - Financial Sustainability - Stuart Butt
- KSO5 - Organisational excellence - Graeme Armitage

QVH 2020: Workforce Strategy

KSO5 – Organisational Excellence

KSO 5 – Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

1. Leadership Development

Click arrow for progress

- Organisational re-structure
  - Senior management changes
  - Estates review
  - Management of Clinical Directors and Matrons
- Talent Management
- Leadership and Management Development
  - New programme
  - Basics of management
  - Management development / 360 Appraisal
- Values based recruitment
- Commerce and marketing

KSO 5 – Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

2. Performance Management

Click arrow for progress

- **Review existing performance management system**
- **Effective 3 year workforce plans**
- **Future Reward Strategy**
- **Vacancy management / Exit interviews**
- **Board reporting / HR metrics**
- **Early warning system / flash reporting**
- **e-Rostering – Safer Care module**

KSO 5 – Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

3. Innovation

Click arrow for progress

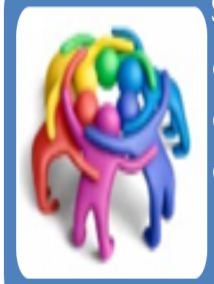
- Education Centre
  - Learning and Development
  - Medical Education
  - Library Services
  - Simulation Suite *R and D
- Marketing and brand development
  - Video conferencing
  - World Class services
- Tele-medicine
  - Technology changing delivery of care
  - New healthcare roles

QVH Workforce Strategy

Queen Victoria Hospital NHS
NHS Foundation Trust

Developing our staff – improving flexibility of the workforce

- Flexible skills development which enable the Trust to be agile and responsive to change
- Improving learning opportunities for all staff
- Promoting healthy working and staff support



Sharing the journey – engaging with staff, patients and their carers

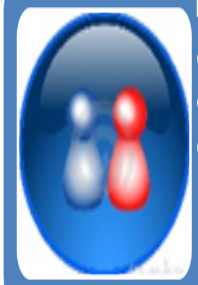
- Feedback to staff on performance against key objectives
- Widening opportunities for staff, patients and carers to become involved
- Annual review of QVH 2020 and progress towards our vision

Improving our business – driving up quality and value for money

- Better patient experience with increased productivity
- Strengthening support to managers and staff from Human Resources
- Removing duplications and tightening administration processes

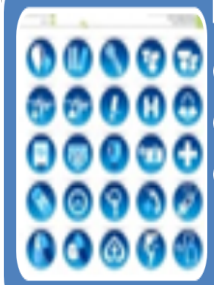
Managing the change – workforce planning and effective change management

- 3 year workforce plans aligned to clinical strategy
- Improved HR systems e.g. e-rostering
- Developing new reward initiatives



Being accountable – strengthening our leadership capability

- New Management / leadership framework to develop capability
- Talent management and succession planning
- Management modelling of Trust values



Designing our future - working with staff / external stakeholders on the future delivery of services

- Design in technology for innovative service delivery
- Developing new healthcare roles
- Patient focussed with front line staff engagement

KSO 5 – Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

1. Leadership Development

return

Progress to date

- Organisational re-structure
  - Senior management changes
  - Estates review
  - Management of Clinical Directors and Matrons

- Interim structure implemented from April 2014
- CEO led Executive Team review and revision to current management structure July/August 2014 – Proposals to Board in September 2014
- Medical Director and Director of Nursing reviewing CD and Matron management in light of organisational changes

- Talent Management

- Linked to objective below and aligned to NHS Leadership Framework. Board discussion planned for November 2014

- Leadership and Management Development
  - New programme

- New leadership framework drafted and to be agreed at the L&D Strategy Group in September. Based of NHS Leadership model. Launch planned for October 2014

  - Basics of management

- HR have introduced additional basic management sessions e.g. Managing stress and have agreed pilot sessions on Mindfulness supporting staff/managers to recognise and address signs of stress and anxiety

  - Management development / 360 Appraisal

- Targeted programme for new managers appointed to new structure and available from April 2015

- Values based recruitment
- Commerce and marketing

- Implemented

- Will be developed from implementation of new structure and will be a module of the management development programme in 2015/16

On track | Delay less than 2 months | Delay more than 2 months | Planned to start 2015/16

KSO 5 – Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

2. Performance Management

return

Progress to date

• **Review existing performance management system**	• System revised and changes implemented in 2013/14. 1 year transition to new process completed in October 2014. Review current system in light of Leadership programme and talent management process and annual training needs analysis
• **Effective 3 year workforce plans**	• Aligned to business planning process for 1st year but insufficient detail to produce 2nd and 3rd years. Forms part of the Workforce Strategy and new simple process implemented for 2015/16
• **Future Reward Strategy**	• Opened initial discussion with staff side who are willing to participate. Scoping exercise and project group to be established by November 2014 with initial discussion document for Board seminar in early 2015.
• **Vacancy management / Exit interviews**	• Reviewing recruitment process and difficult to fill vacancies August/Sept 2014 and agreeing with services need for oversees recruitment, local initiatives and use of other media. Options and costs to Clinical cabinet in October 2014. Short term needs met through use of bank and agency.
• **Board reporting / HR metrics**	• New HR metrics more complimentary to effective decision making and used within accountability agreements. Included over next 6 months; average staff costs, productivity measure, training, sickness % and cost, time to recruit, stability, turnover, paid wte against budgeted wte
• **Early warning system / flash reporting**	• Using existing information systems to provide managers with and early warning of potential workforce problems. Linked to HR metrics and trend analysis. HR team may need to be strengthened to achieve this aim.
• **e-Rostering – Safer Care module**	• Additional module to e-rostering and provides more detailed analysis on safe staffing. Software purchased, team review taken place and external resource engaged to support implementation.

KSO 5 – Organisational Excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

3. Innovation

return

	Progress to date
• Education Centre	• Incorporates Simulation Suite (Alison Chambers), Learning and Development, Library Services and Medical Education. Initial location for Simulation Suite identified (2014)and Estates strategy identifies development of SDC as location for Education Centre (2015)
• Marketing and brand development	• Utilising the Education to raise the Trust profile through video conferencing, clinical practice seminars multidisciplinary education opportunities. Linking to Trust marketing strategy and promotion of our world class / leading edge surgery. Development 2015/16
• Changes to skill mix	• Releasing specialist qualified staff time. Introducing band 4 development **(Dir of Nursing 2014)** Training Needs Analysis to determine staff development and recruitment for future roles – review of existing TNA completed in 2014 revised and TNA established for 2015
• Delivering 7/7 services	• Project led by Medical Director supported by Head of HR and Medical Workforce Manager. Delivery 2015/16
• Changes to the medical workforce	• Project led by Medical Director supported by Head of HR and Medical Workforce Manager. Includes Non-consultant grades and changes to PAs Delivery 2015/16, 2016/17
• Impact of telemedicine and technology	• Service changes being led by the Head of Operations to ensure that HR/OD are supporting the transformation and impact for staff i.e. additional training, new skills development and changes to working practice Delivery 2015/16, 2016/17.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28 August 2014**
Reference number:	**209-14**
Report from:	**Director of Nursing & Quality**
Author:	**Director of Nursing & Quality**
Report date:	**16 July 2014**
Appendices:	**Corporate Risk Register**

Corporate Risk Register

Key issues

1. Two new risks rated above 12 have been identified, mitigating actions have been taken and further actions that will further reduce the risk have been identified.
2. Changed risk scores reflect action taken to increase current controls to reduce risk and identification of an increasing risk and the implementation of additional actions and controls to mitigate the risk.
3. The full risk register was reviewed at the monthly clinical governance group in July and August.

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 which will be presented to the next Audit Committee.

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. Options include
   - The Board is recommended to note the contents of the report

Clinical Cabinet & Trust Board
Risk Register Overview (Risks scoring 12 and above)

This risk overview report contains information on the Trust risks scoring 12+ for the period of 09/07/2014 – 10/08/2014 (n=23), and highlights any amendments including rescoring, and additions.

1. New Risks scoring 12 and above

One new risk was added meeting this threshold between 09/07/2014 and 10/08/2014 (CxL scoring):

- ID728 - Risk of compliance with best practice and regulatory requirements at spoke sites (risk score = 4x3=12)
- ID732 - Use of Long Term Model Box Store (Maxillofacial) (risk score = 3x4=12)

2. Closed risks scoring 12 and above

One risk scoring 12 or over was closed between 09/07/2014 – 10/08/2014

Risk ID	Risk Description	Date of closure and rationale	Risk Score
723	Impact on patient management due to faulty Theatre doors	21/07/2014 • Risk closed and incorporated in to Risk ID 711 as a duplicate	3 x 4 = 12

3. Changes to Risk Scores – Two changes to risk scores between 09/07/2014 and 10/08/2014

Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
27	Infection risk to patients due to poor compliance with systems and practice of control	12 (4 x 3)	↑ 16 (4 x 4)	Score increase Agreed with Infection Control Nurse Specialist and Director of Nursing SI declaration on MRSA Outbreak Additional actions and controls added to risk
725	Reduced Radiologist cover over weekend for undertaking ultrasound procedures	16 (4x4)	↓ 12 (4x3)	09/07/2014 Score decrease Agreed with Clinical Director for Radiology (additional controls added)

4. Risk Reviews

The number of risk reviews that have taken place as per the Risk Management and Incident Reporting Policy are given below:

- June 2014 - 6
- July 2014 – 14
- August 2014 - 3

4.1 Summary of changes to 14 risks reviewed in July 2014

ID and Description	Risk score	Amendment(s) if applicable or action undertaken
27 - Infection risk to patients due to poor compliance with systems and practice of control	16	Rescored to a 4 x 4 =16 (from a 4 x 3 =12) and additional actions added
681 - Failure of cleanroom air handling unit due to wear and tear and age of unit. Latest failure in July 2014 - ongoing issues	16	Additions to actions/ controls
159 - Ability to operationally meet 18 week target for all directorates	15	Risk reviewed – No changes
629 - Inadequate health records storage and processing and lack of budgetary allocation for ongoing storage costs from mid June 2014	15	Additions to actions/ controls
728 - Risk of compliance with best practice and regulatory requirements at spoke sites	12	New risk added (as in Section 1)
639 - Support and access from supplier to ORSOS will cease 03/16 leaving Trust without electronic theatre record	12	Additions to actions/ controls
474 - Cancer target breaches	12	Risk reviewed – No changes
710 - Increasing bed occupancy on MD ward restricting the trusts ability to deliver care	12	Risk reviewed – No changes
711 - Reliability of Theatre Doors	12	Additions to actions/ controls
620 - Potential loss of referrals due to commissioners moving work to centralised centres	12	Risk reviewed – No changes
725 - Reduced Radiologist cover over weekend for undertaking ultrasound procedures	12	Risk reviewed – No changes
513 - Potential failure to act on infection concerns due to unavailability of Microbiologist	12	Additions to actions/ controls
689 – Potential to adversely affect statutory and mandatory training due to increasing number of vacancies (3mths and over)	12	Risk reviewed – No changes
627 - Failure to embed safer surgery checklist process due to lack of engagement	12	Risk reviewed – No changes
623 - Failure to meet CQUIN requirements for 2014/15 therefore incurring a loss of CQUIN funds £1.4M	12	Risk changed to suit 2014/15 requirements

4.2 Summary of changes to 3 risks reviewed in August 2014

27 - Infection risk to patients due to poor compliance with systems and practice of control
Rescored to a 4 x 4 =16 (from a 4 x 3 =12) and additional actions added

676 - Fire doors at back of clinic been opened by public with force
Rescored to a 4 x 3 =12 (from a 4 x 4 =16) and actions reviewed.

732 - Use of Long Term Model Box Store for Maxfacs
New risk (as in Section 1).

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
27	07/01/2005	Infection risk to patients due to poor systems and practice of control	1. Spread of infection of MRSA, CDiff, MRAB & Norovirus.	1. Unknown infection to patients admitted to hospital. 2. Infected patients not isolated on admission.	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 greater in any staff group for hand hygiene leads to 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 QVH IPACT 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 provided with direct IT access to BSUH Microbiology system 14. Anti-biotic policy reviewed to ensure best practice use and reduce risk of C.diff 15. Departmental training provided as and	Amanda Parker	Amanda Parker	Patient Safety	16	6	Awaiting ICNet computer system access 7. Complete actions from the MRSA RCA report 5. Provide infection control nurses with direct IT access to BSUH Microbiology system 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 proactive response to recognition of outbreaks to include meetings that continue post discharge of patients to ensure additional preventative measures identified 2. Review of investigation process - Completed Complete actions from MRAB SI report 6. Monitor microbiologist attendance on site to ensure antibiotic prescribing reviewed	06/08/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
681	13/02/2014	Failure of cleanroom air handling unit due to wear and tear and age of unit. Latest failure in July 2014 - 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	16	8	Business Case/options appraisal being drafted by General Manager for 3 Options	18/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	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	Stuart Butt	Jane Morris	Compliance (Targets / Assessments / Standards)	15	8	Centralise all referrals through one access point - Completed 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	29/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
629	19/07/2013	Inadequate health records storage and processing and lack of budgetary allocation for ongoing storage costs from mid June 2014	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	Nicola Reeves	Patient Safety	15	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	29/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
710	22/05/2014	Increasing bed occupancy on MD ward restricting the trusts ability to deliver care	Patient care compromised, suboptimal quality and safe care not provided Staff exposure to increased stress and anxiety Safe and effective patient discharge Increase in bank and agency use Increase in major cases requiring higher level care - SDU Increase in complaints Increase in drug adminstraion errors CQUIN targets compromised Adequate cover from surgical/ medical team Trust inability to admit referred trauma patients/ elective	Increased occupancy places strain upon the service/ nursing care provided to patients/ carers/ relatives Staff resources are stretched due to the increased demands upon them Patients readmission/ return to theatre may increase Potential catastrophic patient outcome due to drug prescription/ administration errors Increase in litigation Loss of License to operate Loss of reputation	Staffing monitored in accordance with patient acuity Safer Staffing levels in place, reviewed actively twice daily Staff encouraged to report concerns regarding patient care, quality of care provided, etc Staff to ensure "red" tabard is worn when administering medications to avoid interruption Staff encouraged to report incidents via Matron/ Manager and by using DATIX system Matron to attend weekly OPG meeting to monitor occupancy levels Monthly reprots on occupancy and utilisation and length of stay provided	Amanda Parker	Kathy Brasier	Compliance (Targets / Assessments / Standards)	15	8	Recruitment of Band 5 staff to meet vacancies Reduction in the use of agency and bank staff Recruitment drives to colleges and schools	23/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	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.	PRODIR	John Trinick	Estates Infrastructure & Environment	15	6	June 2014-Company commissioned to undertake a review of the Estates Service - Report due in September 2014	27/06/2014
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	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	11/08/2014
676	23/01/2014	Fire doors at back of clinic been opened by public with force	The fire escape doors at the back of the clinic has been opened by force by the genral public from the outside, looking for the discharge lounge. On investigation, it was noticed that the doors itself is not that secure, hence it been opened easily using force. This occurs mainly late afternoons, when it is dark.	Potential safety risk of staff and patients alike, Loss of equipment in event of theft i.e. computers.	Issue has been escalated to estates and previously put on datix, still happening.Staff informed to be vigilant about anyone using force to open doors and to report it	Jane Morris	Chris Dann	Estates Infrastructure & Environment	12	4		11/08/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
728	29/07/2014	Risk of 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 	Amanda Parker	Alison Vizulis	Patient Safety	12	8	Implementation of annual CiP assessments at spoke sites revised programme of infection control and decontamination annual assessments	29/07/2014
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.	Jane Morris	Mr Mark Savage	Information Governance	12	4	Agree on the preferred solution before sourcing the new supplier Source the new supplier Specification being drawn up to procure new/replacement system ICAG reviewing progress of replacement each month; also Theatre User Group	29/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	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	Stuart Butt	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	29/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
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 Theatres 1 and 8	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	Steve Fenlon	Mike Sexton	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 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	21/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
620	17/07/2013	Potential loss of referrals due to commissioners moving work to centralised centres	1. Loss of income affecting financial viability of the organisation 2. Loss of activity	1. Commissioners set up central services such as muscular skeletal services reducing hand services at QVH. 2. Increased number of community based providers established 3. Reduction in national tarrif makes routine work non viable financially	1. Quality of work and reputation of QVH provides a strong position. 2. Identified areas of opportunity - Head and Neck services and breast surgery from other trusts 3. Development of core reconstructive services 4. Contract monitoring meetings, 5. Programme Board overview 6. Review of Service Line reporting 7. Weekly Business meetings reviews of operational issues and referrals 8. Continued dialogue with Health Service Priorities Unit. 9. Business model adapted to cover lost procedures. 10. Engagement with GP's 11. Compliance with low priority procedure policy 12. Education and engagement with CCG leads 13. Engagement with the any qualified provider scheme. 14. 2013/14 reflects potential loss of income	Stuart Butt	Bill Stronach	Finance	12	6	Risk being reviewed and transferred to 2014/15 BAF Divest Gynaecology service - Completed Develop relocation of head and neck surgery from Brighton to QVH Develop provision of breast reconstruction surgery to Worthing and Brighton areas - Completed Develop hand surgery services for Surrey residents Develop new maxillo-facial clinics in Horsham - Completed Extend plastic-surgery service into East Kent Review non core services to ensure sustainability Develop referral base through business development plan - Completed annually Develop business intelligence capability	10/07/2014
725	09/07/2014	Reduced Radiologist cover over weekend for undertaking ultrasound procedures	Reduced Radiologist cover for undertaking ultrasound procedures over weekends (OOH) which could lead to delayed diagnosis		1. Scheduling of cases managed in such a way that there is minimal requirements from radiology 2. Hours are covered by Radiologist until 31/08/2014 3. Arrangements in place until 31/08/2014	Steve Fenlon	Kirsty Humphry	Patient Safety	12	8	referral pathway to be developed with Partnew Trust U/S - First morning slot available for any overnight cases Develop cover arrangements with BSUH/PRH	09/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
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. 7. Locum Microbiologist employed from Sept 2014 2. Presence of microbiologist during week on site has reduced, 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.	Amanda Parker	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	08/07/2014
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.	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	08/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	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 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 Audit tool amended following pilot to improve robustness Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting - Completed and ongoing	02/07/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
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.	Amanda Parker	Amanda Parker	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	01/07/2014
584	23/11/2012	Potential harm from medical devices due to inadequate training	1: Harm to patient from incorrect use of medical devices 2: Financial loss due to litigation 3: Reputational damage from complaints	1: Staff operating devices without training	1. Training and competencies for high risk devices 2. Meetings with medical device co-ordinators to develop action plans for above. 3. Training compliance monitored by medical device officer quarterly. 4. Junior doctors familiarisation session incorporated into induction. 5. Speciality training assessment forms available for ad hoc junior doctor starters. 6. Incident reports used to identify and monitor trends that would highlight training as an issue	Steve Fenlon	Alison Vizulis	Patient Safety	12	6	Elearning options being utilised e.g. dermatomes Medical Devices Officer to review all medical device related incidents from 01/09/2014 High risk and moderate risk competencies to be completed by Medical devices Officer Risk rescoring amended to reflect Education Committee output	24/06/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
715	11/06/2014	Patient notes not filed correctly	Incorrectly filed patient notes causing increase in waiting times, looking for proper notes □ mislaid information and not properly filed according to speciality□ Loose notes easily lost□ Delay in filing operation notes in time for out patients appointments.□ Fat files- patient current episodes missing from current files as might be misfiled in older notes not always available□ Incorrect patient information found in another patients notes.	delay in treatment□ Mis diagnosis□ incorrect prescibing of treatment and test□ Financial loss for trust□ Data protection and patient confidentiality	Staff vigilant about handling notes and information ensuring filed properly, which is time consuming for nursing staff.□ Ward clerk filing notes appropriately□ Filing instructions sent to relevant departments from CPU□ Datix all mislaid information or incorrectly filed	Mr Raman Malhotra	Sally Joselyn	Patient Safety	12	6		11/06/2014
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	Stuart Butt	Nasir Rafiq	Information Governance	12	8	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 Looking to procure new network (by 31/03/2016) 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	11/06/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	CRR	RRR	Actions	Date Reviewed
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	Stuart Butt	Nasir Rafiq	Information Governance	12	6	Implement data leakage prevention software Monitoring of compliance with IG Toolkit Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	11/06/2014
624	17/07/2013	Failure to invest in IT, estates and medical equipment due to insuficient funds or poor allocation	1. Failure to improve services 2. increased maintenance costs for equipment and estate	1. Lack of system in place for capital funding 2. No review process for capital funds for the 3 key areas estates, IT and medical equipment	1. IT strategy and site development strategy 2. Estates capital programme for 2013/14 3. Medical device committee and procurement process 4. Procurement software and process to ensure good procurement practice. 5. Allocation for capital funding between medical devices, estates and Information Technology to be prioritised on a needs basis rather than the previous process of set amount for each area.	Stuart Butt	Stuart Butt	Estates Infrastructure & Environment	12	4	Continued monitoring at the Information Management and Governance Committee Complete capital bid / review process - Completed Develop wireless and mobile technology Extend self check in and patient calling system - Completed Implement digital dictation and voice recognition - Completed Progress joint procurement of electronic document management and clinical portal	11/06/2014

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28 August 2014**
Reference number:	**210-14**
Report from:	**Lois Howell, Interim Company Secretary & HoCA**
Author:	**Hilary Saunders, Deputy Company Secretary**
Report date:	**20 August 2014**
Appendices:	**Extract from Trust Board Standing Orders**

QVH Trust Seal Register Annual Report 2014

Key issues

1. The Trust Standing Orders require an entry of every sealing to be made consecutively in a book provided for that purpose, which should be signed both by those who have approved and authorised the document, and those who verified the seal.
2. It is also a requirement of these Standing Orders that a report of all sealings is made to the Board of Directors at least annually. The report must contain details of the seal number, the description of the document and date of sealing.
3. A resolution to apply the trust seal was last brought to the board in September 2012
4. There have been no further requests to apply the trust seal since that time

Action required

5. There is no further action required

6. This report supports the achievement of:
   - Operational excellence
   - Financial sustainability

Implications for BAF or Corporate Risk Register

7. There is nothing in this report that should be recorded on either the Corporate Risk Register or Board Assurance Framework

Regulatory impacts

8. This report does not have any adverse impact on our ability to comply with our CQC authorisation.

9. This report does not have any impact on either our Monitor Governance risk rating, or our Continuity of Service risk rating.

Recommendation

10. The Board is recommended to **note** the contents of the report

8 CUSTODY OF SEAL AND SEALING DOCUMENTS

8.1 **Custody of Seal:** The Common Seal of the Trust shall be kept by the Chief Executive or Head of Corporate Affairs in a secure place.

8.2 **Sealing of Documents:** The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its powers.

8.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an executive nominated by him/her) and authorised and countersigned by the Chief Executive (or an executive nominated by him/her who shall not be within the originating directorate).

8.4 **Register of Sealing:** An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least yearly. (The report shall contain details of the seal number, the description of the document and date of sealing).

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board**
Meeting date:	**28 August 2014**
Reference number:	**211-14**
Report from:	**Interim Head of Corporate Affairs / Company Secretary**
Author:	**Interim Head of Corporate Affairs / Company Secretary**
Report date:	**14 August 2014**
Appendices:	**Schedule of statutory duties**

Statutory duties of cooperation

Background

1. As Board members will recall, during the self-assessment against the Board Governance Assurance Framework model conducted earlier this year, it was noted that there was no definitive statement in the Trust of how its various statutory duties of cooperation are fulfilled. As a result the action plan to address issues raised by the self-assessment includes a commitment to receive a Board report setting out the duties and details of the ways in which the Trust fulfils them. This report provides assurance to the Board that the duties are understood and appropriately met.

Regulatory requirements and statutory provisions

2. Monitor's Code of Governance sets out the regulator's requirements in respect of cooperation:

> "E.2 Co-operation with third parties with roles in relation to NHS foundation trusts
>
> Main principle
>
> E.2.a The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.
>
> Supporting principle
>
> E.2.b The board of directors should enter a dialogue at an appropriate level with a range of third party stakeholders and other interested organisations with roles in relation to NHS foundation trusts based on the mutual understanding of objectives.
>
> Code provisions
>
> E.2.1. The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.
>
> E.2.2. The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these

processes and relationships annually and, where necessary, take proactive steps to improve them."

3. The National Health Service Act 2006 sets out the legal duties:

> "s72 Co-operation between NHS bodies
> It is the duty of NHS bodies to co-operate with each other in exercising their functions."
>
> "s82 Co-operation between NHS bodies and local authorities
> In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales."

4. For the purposes of the 2006 Act, "NHS Bodies" and "local authorities" includes all those organisations listed in the attached appendix, together with details of how the Trust fulfils its obligations of cooperation.

Key issues

5. The information set out in the appendix demonstrates that the trust engages with all of those bodies with which it is statutorily obliged to cooperate. There are no known complaints about the extent to which the trust cooperates with its stakeholders and strategic partners, and the trust has fulfilled all of the specific requests made of it by the identified health bodies and local authorities. As a result, the board is invited to accept that it is fulfilling its statutory duties of cooperation on a routine basis.
6. Compliance with statutory duties of cooperation does not cause any significant detrimental impact on trust performance or finances, its ability to comply with human rights and equalities legislation, or its relationship with its regulators and stakeholders; the cooperation described tends instead to support and in many cases enhance the trust's own ability to operate effectively and within the law.

Link to Key Strategic Objectives (delete those not applicable)

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

7. Cooperation with other health bodies and relevant local authorities underpins our overarching objective of long term sustainability, and also, specifically:
   - KSO1 – Outstanding patient experience – cooperation with Healthwatch and the CCG contributes to delivery of outstanding patient experience
   - KSO 2 – World class clinical services – cooperation with Health Education England and the Health Research Authority particularly support this objective
   - KSO 3 – Operational excellence – cooperation with the CCG helps to ensure that our services are streamlined and efficient

Implications for Board Assurance Framework or Corporate Risk Register

8. Nothing in the information set out in the appendix suggests indicates that the Trust is exposed to any operational or strategic risk not already noted on the Risk Register or Board Assurance Framework.

Regulatory impacts

9. Cooperation of the kind described in the appendix supports, rather than compromises, the trust's ability to comply with its CQC authorisation and maintain its governance risk rating and continuity of service risk rating.

Recommendation

10. The Board is recommended to note the contents of the report and accept the assurance contained therein.

Appendix 2: Statutory duties of co-operation

Relevant body	Form of co-operation
Clinical Commissioning Groups CCG's commission the majority of acute and secondary care	The Board received a presentation at its June meeting from the lead CCG with which it does business. Apart from the contractual relationship which exists between the CCG and the Trust, cooperation occurs in the form of shared membership of a number of key strategic partnerships (including Safeguarding Panels and emergency planning arrangements). The health of the relationship between the Trust and the CCG is principally maintained via the Programme Management Board
HealthWatch England Statutory committee of the Care Quality Commission, which funds it. Local HealthWatch groups exist around the country, usually hosted by county / unitary councils. Local Healthwatch is comprised of volunteers who monitor local conditions, raise concerns with HealthWatch England and work with Health and Wellbeing Boards and Clinical Commissioning Groups.	Interaction with Healthwatch has been relatively limited to date – as required a Healthwatch opinion was sought in respect of the Quality account in April this year. The local Healthwatch representative was identified to the Trust in February this year, and is now is on the trust's patient experience group. The Director of Nursing and Quality attended the launch event of the local Healthwatch in Horsham in October 2013.
Health Education England Health Education England [HEE] oversees the provision of national leadership for workforce planning, education and training and support for local organisations in delivering education and training. HEE has responsibility for providing funding and monitoring outcomes from training and education providers.	The trust collaborates with HEE in sending out HEE's annual trainees survey and cooperates with HEE in addressing issues of concern raised in the responses. A trust representative attends quarterly meetings with HEE and submits routine data, as well as information about safety issues or performance concerns regarding trainee doctors
Health Research Authority The Health Research Authority is the regulatory authority for health care research. Its aim is to rationalise and streamline the governance of research and speed up the approval process for research projects.	The HRA is newly established and has yet to develop extensive links with the trust. The Lead for Research Dr Giles confirms that the trust is currently fully comply with all HRA requirements and will work with the HRA to establish better, more streamlined systems for managing research in the NHS.
Health and Wellbeing Boards Health and Wellbeing Boards are intended to integrate approaches to health care in local authority areas, combining representatives of NHS bodies (NHS Commissioning Board, Clinical Commissioning Groups, HealthWatch) and other local services providers.	Health and Wellbeing Boards are committees of the local authority (the County Council or Unitary authority in relevant areas). Providers are not generally members of the committee, but are required to assist with data collection and to contribute, as required, to assessing health care needs and planning provision to meet them (Joint Strategic Needs Assessments / JSNAs). All services commissioned in the area must then take account of the outcome of the JSNA. QVH collaborates with the Health & Wellbeing Board of West Sussex County Council as required and the Chairman and CEO meet occasionally with its Chair.

Appendix 2: Statutory duties of co-operation

NHS Clinical Networks and Clinical Senates ▪ Clinical Senates and networks are hosted by the NHS Commissioning Board and provide advice to the NHS Commissioning Board and Clinical Commissioning Groups. ▪ Clinical Senates aim to bring together a range of experts, professionals and others from across different health and social care professions for a specific geographic area and are intended to provide an overview of all services. ▪ Clinical networks are intended to focus on specific conditions and patient groups. Clinical networks currently exist in areas such as cancer, diabetes, stroke, coronary heart disease, maternity services, neonatal care and emergency care.	There is limited requirement for the trust to cooperate with Clinical Networks and Senates as their principle involvement is with commissioners. However, the trust supports participation in Network and Senate activity by its clinicians in furtherance of the objects of those bodies.
NHS England Commissioner of primary care services and specific acute and tertiary services; regulator of CCGs.	The trust participates regularly in contract monitoring / management and service development meetings with NHS England. The trust also ensures that NHS England is kept apprised of serious incidents and other actual or perceived serious risks.
NHS Trust Development Authority The NHS TDA provides oversight of NHS Trusts applying for Foundation Trust status and deals with the making of appointments to NHS bodies.	QVH NHS FT has little contact with the TDA and has not so far been required to collaborate or cooperate with the authority. However, partnerships between aspirant and authorised trust are sometimes seen as a solution to NHS Trusts' inability to obtain FT authorisation in their own right, and QVH would be obliged to consider any proposal for collaboration or more formal action submitted to it by the TDA.
Public Health England Public Health England is an executive agency of the Department of Health. PHE was created by the merger of the National Treatment Agency [NTA], Health Protection Agency [HPA], Public Health Observatories [PHOs] and caner registries.	The trust provides information on reportable disease etc and other data requests
Local Authorities ▪ Unitary councils (such as Brighton & Hove City Council and London Borough Councils) ▪ District councils (some of which are known as borough councils) ▪ County councils ▪ Parish or community councils (some of which are known as town councils)	Key areas for cooperation between QVH NHS FT and relevant local authorities include: • Public health functions exercised by county and unitary authorities – health promotion and protection. In the case of an acute trust such as QVH this would principally cover outbreak control lead by West Sussex County Council, and data provision to a range of Public Health teams at all of the local authorities in the areas from which patients attend at the trust. • Emergency planning – led by Mid-Sussex District Council in East Grinstead for local emergencies and by West Sussex County Council in connection with wider emergencies. The board received

Appendix 2: Statutory duties of co-operation

	an annual report on the Trust's emergency planning function participation at its June meeting. • Scrutiny – health scrutiny is the remit of county and unitary authorities and the trust could technically be obliged to attend at a meeting of the Health Scrutiny Committee of any local authority from whose area patients attend at QVH. In reality, however, it is only likely to be West Sussex County Council which requires attendance, although Brighton & Hove City Council, Kent County Council, East Sussex County Council and Medway Council could do so given the geographical reach of the trust's services. Health scrutiny is essentially intended to preview planned changes in health care provision and review existing services to ensure that the local community receives effective services. The Chief Executive meets regularly with the Chair of the West Sussex County Council Health Scrutiny Committee and attends as required.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28 August 2014**
Reference number:	**212-14**
Report from:	**Interim Head of Corporate Affairs**
Author:	**Interim Head of Corporate Affairs**
Report date:	**15 August 2014**
Appendices:	**(1) Draft revised terms of reference**
	(2) Draft work plan

Audit Committee terms of reference and work plan

Background

1. The Committee's terms of reference were last reviewed in December 2013, but the exercise was a relatively 'light touch' review.

2. At the instigation of the new committee chairman a more comprehensive review has been undertaken, and examples of good practice found elsewhere used as a basis for the revisions proposed. The draft revised terms of reference are set out at Appendix 1.

Key issues

3. A key feature of the revised document is a more explicit explanation of the purpose and function of the committee. The statement of the committee's responsibilities is more detailed and includes details of the processes and mechanisms to be employed to achieve the committee's purpose. The proposed terms of reference emphasise that the committee's function is to seek assurance, on behalf of the board, that the principal systems of financial, corporate and clinical governance, risk management and internal control are reliable and effective, both in principle and in practice.

4. The terms of reference identify five main work areas for the committee:

    - Governance, risk management and internal control
    - Financial reporting
    - Internal audit
    - External audit
    - Whistleblowing and counter fraud

    but provide also for the committee to review the effectiveness of other committees and systems around the trust, using internal or external sources of assurance as appropriate.

5. The assurances to be sought by the committee are intended to enable the board to ensure that the trust remains compliant with its legal, regulatory, contractual and moral obligations to its stakeholders, and achieves its corporate objectives. The Audit Committee plays a vital part in every aspect of the trust's existence as a service provider, employer, partner and custodian of public resources. To this end, the work programme for the committee has also been reviewed and made more comprehensive. The revised work programme is attached at Appendix 2.

Development process

6. The draft terms of reference and work plan have been developed in conjunction with the Chairman of the Audit Committee and the Director of Finance. Both documents draw

upon best practice examples provided by the Healthcare Financial Management Association.

Link to Key Strategic Objectives

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

7. The effective operation of the Audit Committee will support the delivery of all key strategic objectives by providing a resource for the review of the function of trust processes and systems, without which achievement of the KSOs could be compromised.

Implications for BAF or Corporate Risk Register

8. Nothing identified in the course of developing the work plan or reviewing the terms of reference represents a risk that should be fed through to either the corporate risk register or board assurance framework. Implementation and regular review of the plan should help to identify and manage risks associated with failure to assess the effectiveness of trust systems and processes, including those for risk management itself.

Regulatory impacts

9. As indicated above, implementation of the plan and compliance with the revised terms of reference should help to identify and manage risks to compliance with the trust's significant regulatory obligations, ie, its Care Quality Commission authorisation and its Monitor licence.

Recommendation

10. The Board is recommended to adopt the revised terms of reference and work programme for the Audit Committee.

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
   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
   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.

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.

Comment [HL1]:

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.
b) monitor the integrity of the financial statements, and any formal announcements relating to the trust's financial performance
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
   ii. changes in, and compliance with, accounting policies, practices and estimation techniques Unadjusted mis-statements in the financial statements

iii. significant adjustments resulting from the audit
iv. the letter(s) of representation
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
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
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
d) ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
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
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
c) discussion with the external auditors of their evaluation of audit risks and assessment of the trust and associated impact on the audit fee
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 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
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
c) approve and monitor progress against the operational counter fraud plan
d) receive regular reports and ensure that appropriate action is taken in significant matters of fraudulent conduct and financial irregularity
e) monitor progress on the implementation of recommendations in support of counter fraud
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.
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.
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
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
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).
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

Sub-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
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 (from 2015 April, July, October and January), 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 to be reported 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 December 2013 to be reviewed December 2014

Queen Victoria Hospital NHS
NHS Foundation Trust

Audit committee work programme
2014-15

Committee papers are to be despatched no later than five clear working days before each meeting

Ref	Agenda item/ Issue	May	Jun	Sept	Dec	Mar	Paper to be provided by
Governance							
1.	Review of CQC compliance and Quality Accounts		x	x	x	x	Director of Nursing & Quality
2.	Board sub-committee minutes: Quality and Risk		x	x	x	x	Director of Nursing & Quality
3.	NHS Litigation Authority Assessment		X	X	X	X	Director of Nursing & Quality
4.	Review Board Assurance Framework		x	x	x	x	Director of Nursing & Quality
5.	Review Annual Governance Statement	x					Chief Executive
6.	Review trust annual report and annual accounts	x					Director of Finance
7.	Review quality account	x					Director of Nursing & Quality
8.	Review changes to policies, e.g. SFI			x		x	Director of Finance
9.	Receive other sources of assurance as appropriate		x	x	x	x	As determined by Chair of Audit Committee
10.	Receive "quality of care" reports (including a report annually on the clinical audit process)		x	x	x	x	Director of Nursing & Quality
11.	Information Governance Annual Report				x		Director of Finance
12.	Incidents of whistleblowing		x	x	x	x	Director of Nursing & Quality
13.	Approval of policies as required (eg. Whistleblowing)			x			Audit Committee and Director of Nursing & Quality
14.	Presentation of the Annual Report and Accounts, and external audit report on accounts to council of governors			**x**			Director of Finance & Commerce
Financial							
15.	Agreement of final accounts timetable and plans, including changes to accounting standard and/or				x		Director of finance

Ref	Agenda item/ Issue	May	Jun	Sept	Dec	Mar	Paper to be provided by
	policies						
16.	Review audited annual accounts and annual report	x					Director of Finance
17.	Review losses and special payments	x	x	x	x	x	Director of Finance
Internal audit							
18.	Market testing for appointment of Internal Auditors				x		
19.	Review and approve the annual plan					x	Head of Internal Audit
20.	Review internal audit progress report, final reports and update against recommendations	x	x	x	x	x	Head of Internal Audit
21.	Receive annual report and Head of Internal Audit Opinion					x	Head of Internal Audit
22.	Review internal audit effectiveness			x			Audit Committee
23.							
External audit							
24.	Market testing for appointment of External Auditors			x	x		Audit Committee
25.	Agreement of external audit plans			x			External Audit
26.	Review effectiveness of external audit			x			Audit Committee
27.	Review external audit report to those charged with governance	x					External Audit
28.	Review progress reports		x	x	x	x	External Audit
29.	Receive (draft) audit report on the annual accounts and quality report	x					External Audit
30.	Submit annual report to council of governors on external audit effectiveness			x			
31.	Annual seminar to the governors on the external audit plan			x			
Counter fraud							
32.	Review and approve annual counter fraud plan					x	Local counter fraud officer
33.	Review progress report, final reports and update	x	x	x	x	x	Local counter fraud officer

Ref	Agenda item/ Issue	May	Jun	Sept	Dec	Mar	Paper to be provided by
	against recommendations						
34.	Receive LCFS annual report	x					Local counter fraud officer
35.	Review effectiveness of LCFS			x			Audit committee and management
Asset management							
36.	Review effectiveness of the in-house security management services as appropriate.			x			Audit committee with Director of Nursing & Quality
Audit Committee							
37.	Self-assessment of committee effectiveness	x					Audit committee with Head of Corporate Affairs
38.	Review annual Audit Committee report to board and council of governors			x			Audit committee with Head of Corporate Affairs
39.	Private discussions with internal audit and external audit and local counter fraud officer	x	x	x	x	x	Head of Internal Audit External Auditors
40.	To review terms of reference		x				Head of Corporate Affairs
Tendering							
41.	Review tender waivers >£30k	x	x	x	x	x	Director of Finance
42.	To receive report on all items which subsequently breach threshold after original approval	x	x	x	x	x	Director of Finance
Standing orders							
43.	To review every decision to suspend standing orders, where applicable	x	x	x	x	x	Director of Finance
44.	To receive / approve the trust's scheme of delegation		x				Director of Finance
45.	To receive / approve the trust's standing financial instructions		x				Director of Finance

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Trust Board**
Meeting date:	**28 August 2014**
Reference number:	**213-14**
Report from:	**Clinical Cabinet**
Author:	**Richard Tyler**
Report date:	**August 2014**
Appendices:	**None**

Report from meetings of the Clinical Cabinet held on 4th & 18th August

Key issues and Actions

1. Performance: 18 weeks: Agreed change of policy on 'dear doctor' letters to ensure individual waiting times taken into account when distributing letters.
2. Performance: 18 weeks: Agreed maximise internal ophthalmology capacity before using external sources.
3. Finance: M4: Noted apparent £70k in-month deterioration in histo-pathology expenditure. FD to investigate with CD & GM.
4. Finance: 15/16 CIP programme: Initial 'long-list' to be discussed at Cabinet on 15th September.
5. Estates: Education Centre: Reaffirmed commitment to education centre. Agreed to undertake options appraisal to determine options for location with findings for discussion at 5th October Cabinet. Agreed to find short-term location for simulation suite pending longer term decision. Report back scheduled for 5th October.
6. Quality & Risk:SIs: Cabinet signed off two serious incidents; wrong tooth extraction and histo-pathology late reporting.
7. Quality & Risk: Never Event: Cabinet was advised of a 'never event' relating to wrong tooth extraction (14th August).
8. Quality & Risk: Schwartz Rounds: Cabinet was advised of a successful bid to support the development of Schwartz rounds (www.theschwartzcenter.org)
9. Quality & Risk: Burns Unit: Cabinet was updated on MRSA situation. Agreed to engage external company to undertake deep clean of the unit.
10. Key Strategic Objectives: Cabinet were updated on progress against KSOs 3 & 4.

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

11. None

Regulatory impacts

12. Issues reported do not have an immediate impact on either CQC or Monitor risk ratings. However it should be noted that the Trust has failed the aggregate in-patient waiting list target for three consecutive quarters. This will be the subject of discussion with Monitor at the Q1 review scheduled for 18th August and Cabinet and the Board will be updated in due course.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**28 August 2014**
Reference number:	**214-14**
Report from:	**Lester Porter, Chair of N & R Committee**
Committee meeting date:	**31 July 2014**

Report of the Chair of the Nomination & Remuneration Committee

Key issues discussed

1. Which matters on the Committee agenda were of most interest / importance to the Committee?

   a) Annual Appraisal process
   It was confirmed that the NED and CEO appraisal process for the current fiscal year would operate in a broadly similar way to the 2013/14 process used for the Chair, and would include feedback from Governors and the Executive team. RT also confirmed that the appraisal process for the Executive team in respect of 2013/14 was currently underway and a summary would be provided by the CEO to the next Nomination & Remuneration meeting.

   b) Human Resources sub-committee proposal
   GA submitted a proposal on behalf of the executive team for a new sub-committee of the Board which would monitor the organisation's sustainability and workforce performance. After discussion it was agreed to defer any decision pending the planned review by PG/BH/RT of the balance of workload through the Board and its sub committees across both strategy and operational matters which is being carried out during the autumn.

   c) Draft Work Plan for N & R committee
   GA presented a draft work plan reflecting all the key responsibilities of the committee defined in its terms of reference, including Board development, talent management and succession planning. Whilst the work plan was broadly supported, it was agreed that it should be considered whether it was appropriate within the forthcoming Board/sub-committee structure review highlighted in Section 1B.

   d) Appointment of Director of Finance and Head of Operations
   It was agreed to proceed with the recruitment of these two key roles after the holiday period with a view to the vacancies being filled by April 2015 at the latest.

2. Which matters require referral from the Committee to the Board?

   None at this stage

Additional information or assurance sought

3. Did the Committee ask Officers to provide additional information?

   As described.

4. Was the Committee dissatisfied with assurance offered on any matter?

   No

5. What action is to be taken as a result (in particular, what are the timescales?)

   As described.

Implications for BAF or Corporate Risk Register

6. Should anything in the data reported be fed through to the Corporate Risk Register or Board Assurance Framework

   No

Recommendation

The Board is recommended to note the Committee's actions and findings