Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 26 June 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

MEETINGS OF THE BOARD OF DIRECTORS: JUNE 2014

Members (voting):

Chairman:	-	Peter Griffiths
Non-Executive Directors:	-	Ginny Colwell
	-	Lester Porter
	-	John Thornton
Chief Executive:	-	Richard Tyler
Medical Director:	-	Stephen Fenlon
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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Thursday 26 June 2014 at 13:00
Council Chamber, East Court, College Lane, East Grinstead, West Sussex RH19 3LT

PUBLIC AGENDA			
No.	**Item**	**Time**	**Papers**
WELCOME			
139-14	**Welcome, apologies and declarations of interest** Peter Griffiths, Chairman	13:00	-
PATIENT STORY			
140-14	**Patient experience story** Amanda Parker, Director of Nursing and Quality	13.02	-
STANDING ITEMS			
141-14	**Draft minutes of the meeting session held in public on 22 May 2014 for approval** Peter Griffiths, Chairman	13.10	1
142-14	**Matters arising and actions pending** Peter Griffiths, Chairman	13.15	2
143-14	**Update from the Chief Executive** Richard Tyler, Chief Executive	13.20	-
144-14	**Update from the Medical Director** Steve Fenlon, Medical Director	13.30	-
RESULTS AND ACTIONS			
145-14	**Patients: safe staffing and quality of care** Amanda Parker, Director of Nursing and Quality	13.35	3
146-14	**Operational performance: targets, delivery and key performance indicators** Jane Morris, Directorate Manager, Clinical Specialties	13.45	4
147-14	**Financial performance: monthly update** Stuart Butt, Interim Director of Finance & Commerce	13.55	5
148-14	**Workforce** Graeme Armitage, Head of Human Resources and Organisational Development	14.05	6

STRATEGIC PRIORITIES			
149-14	**Quarterly update on delivery of Key Strategic Objective 1 – Outstanding patient experience** Amanda Parker, Director of Nursing and Quality	14.15	7
150-14	**Quarterly update on delivery of Key Strategic Objective 2 – World class clinical services** Steve Fenlon, Medical Director	14.25	8
GOVERNANCE			
151-14	**Corporate Risk Register** Amanda Parker, Director of Nursing and Quality	14.35	9
152-14	**Research and Development Annual Report 2013-14** Steve Fenlon, Medical Director , and Julian Giles, Clinical Lead for Research and Development	14.45	10
153-14	**Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2013-2014** Amanda Parker, Director of Nursing and Quality	14.55	11
154-14	**C-Wing Action Plan update** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	15.00	12
155-14	**BGAF Action Plan – Governor involvement in NED appraisals** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	15.05	-
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD (AND COUNCIL OF GOVERNORS)			
156-14	**Clinical Cabinet** Richard Tyler, Chief Executive	15.10	13
157-14	**Audit Committee** John Thornton, Non-Executive Director	15.15	14
STAKEHOLDER AND STAFF ENGAGEMENT			
158-14	**Feedback from events and other engagement with staff and stakeholders** All board members	15.20	-
GOVERNOR REPRESENTATIVE AND NON-EXECUTIVE DIRECTORS			
159-14	**Report from the Governor Representative** Brian Goode, Public Governor	15.25	-
160-14	**Observations from the Chairman and Non-Executive Directors** Peter Griffiths, Chairman	15.30	-

QUESTIONS FROM OBSERVERS			
161-14	Peter Griffiths, Chairman	15.35	-
162-14	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 confidential information concerning the trust's finances and issues of a commercially sensitive nature. Peter Griffiths, Chairman	15.40	-
PRIVATE AGENDA			
COMMERCIAL-IN-CONFIDENCE			
163-14	**Draft minutes of the meeting session held in private on 22 May 2014 for approval** Peter Griffiths, Chairman	15.42	15
164-14	**Financial Service Line & Operational Performance reports** Stuart Butt, Interim Director of Finance & Commerce	15.45	16
165-14	**2014/15 Contract Report** Stuart Butt, Interim Director of Finance & Commerce	15.55	17
166-14	**Approval of Monitor 5-Year plan** Richard Tyler, Chief Executive	16.00	presentation
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIRMAN)			
167-14	Peter Griffiths, Chairman	16.15	-
NEXT MONTH'S AGENDA			
168-14	**Draft agenda for next month's meeting** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	16.20	18

DATES OF THE NEXT MEETINGS

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 31 July 2014 at 13:00	**Audit:** 17 September 2014 at 14:00 **CFAC:** 26 June 2014 at 09:00 **N&R:** 31 July 2014 at 09:00 **Q&R:** 4 September 2014 at 09:00	**Public**: 11 September 2014 at 16:00

Document:	**Minutes (draft & unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 22 May 2014, 13:00 – 16:00, Jubilee Community Centre, Charlwoods Road, Grinstead, West Sussex RH19 2HN**	
Present:	Peter Griffiths (PAG)	Chairman
	Stuart Butt (SB)	Interim Director of Finance
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	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 &OD [item: 118-14]
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Directorate Manager: Clinical Specialities [item: 119-14]
	Lois Howell (LH)	Interim Head of Corporate Affairs & Co Sec
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
	Ali Strowman (AS)	Deputy Director of Nursing
Apologies:	None	
Public gallery:	One member of the public	

WELCOME

109-14 **Welcome, apologies and declarations of interest**

The Chairman opened the public session and welcomed SB to his first meeting as Interim Director of Finance and Commerce; he also welcomed one member of the public who was in attendance today.

There were no declarations of interest

STANDING ITEMS

110-14 **Draft minutes of the meeting session held in public on 24 April 2014 for approval**

The draft minutes were **APPROVED** as a correct record.

111-14 **Matters Arising & Actions Pending**

The board reviewed the current record of Matters Arising and Actions Pending;

1. (082-14) LP sought clarification from RT regarding breakdown of capital expenditure;
2. (085-14) JT asked RT to explain which additional hours would have been advertised internally;
3. (086-14) The Chairman thanked AP for providing additional analysis of the recent National Inpatient Survey results which was more relevant to QVH and other specialist hospitals.

112-14 **Update from the Chief Executive**

- The Trust had received a letter from Monitor asking it to consider whether it needed to resubmit its financial plan for 2015/16 as, in the current financial climate, the Regulator was concerned trusts were being overly optimistic. RT noted that whilst Monitor had not raised the issue during the quarterly telephone call with the trust, he would review with SB before responding;
- RT reported that following Mike Bennett's departure at the end of May, he would be implementing a number of interim changes to the management structure, (pending

	a more wide ranging review). Jane Morris would be taking on a new role as Head of Operations, supported by two general manager posts, (Nicky Reeves would cover the Anaesthetic and Surgical Directorate and Paul Gable would cover Clinical Support Services). Amanda Parker will assume line management of the matrons. In addition, the review of the Estates function was imminent. • On a lighter note, RT reported he had undertaken his first 'back to the floor' initiative by undertaking a domestic shift the previous day. The board **NOTED** the contents of the update
113-14	**Update from the Medical Director** • The League of Friends had agreed to provide £50k towards the costs of providing an education centre, (to be based in the existing T6 building); SF noted the importance of providing a resource to recruit and retain medical staff in the future. • The first set of Outcome Measures, relating to Orthognathic treatment, were due to be published to the website. RT suggested this should be publicised once website capability was assured. Thanks were expressed to Consultant Jeremy Collyer for his efforts in developing these outcomes. • The Clinical Cabinet was considering how best to address trauma capacity issues and a review of the pathway was underway; • SF and Elin Richardson were developing 7-day elective and non-elective plans for the trust and would bring these to the board for information following submission to NHS England. The Chairman thanked SF and the board **NOTED** the contents of the update
SAFETY & QUALITY	
114-14	**Quality & Risk Exception Report** AS was attending today's meeting to present the Safety and Quality reports this month. The Chairman welcomed her and thanked her for organising the recent visit by the Chief Nursing Officer to QVH which had been a great success. AS opened her update by reminding the board that this report provided information on an exceptional basis, against national and local targets. Highlights included the following: • Due to the reduced number of domestic staff at present, a risk had been raised in connection with ability to maintain cleanliness around the site. • AS asked the board to note that a number of additional safety metrics planned for 2014/15 reporting were missing from this month's dashboard. This was to allow for data collection processes to be refined to ensure accuracy; • Four falls had been identified as causing harm, two of which had concerned the same patient, due to the patient being confused. AS confirmed that all appropriate measures had been taken to assess the risk of falls and to reduce the likelihood of patients falling, and assured the board that all injuries sustained were minor. GC asked for assurance that the trust was managing patients correctly and was advised that this issue was considered in great detail at the quarterly Quality & Risk Committee meetings. • Although there was continued improvement in the number of patients being consented prior to the day of surgery, concern had been raised at the low level of consent obtained by MaxFacs in April. The Medical Director was reviewing and would report back as part of his quarterly consent update to the board • During March there were two amber incidents that required investigation. One involved a patient who had acquired a grade 2 pressure ulcer. The patient had a history of pressure ulcers but inadequate care was provided at QVH to prevent a recurrence of this. The second incident involved a patient with an anterolateral thigh (free flap). Care

	administered overnight by both the nursing and medical staff was inadequate and resulted in the failure of the flap. In both of the stated incidents a full root cause analysis has been undertaken in order to identify lessons to be learnt and disseminated. • The board was apprised of all risks rated 12 or above, but was reminded that the risk register was a live document which was continually updated. The risk of not meeting Statutory and Mandatory training rates was raised by AP who reported that there were still inaccuracies in respect of HCA Mandatory training requirements within C-Wing; • Patient Experience: Poor scores in respect of the Day Surgery Unit Friends & Family Test data indicated that although surveys had been given out, responses had not been returned in a timely manner; AS reported that the DSU team had been reminded of the importance of returning data by month end; The F&FT score for Minor Injuries Unit (MIU) had fallen short this month; as an side, the Chairman asked if a presentation to the board by MIU could be arranged for the future **[Action: LH]** • LP sought assurance from RT in respect of a complaint about Corneo Admin which had not been upheld; • The level of safeguarding concerns raised was seen as a positive sign that staff felt enabled to act and report on instances. AP advised that the Practice Development Co-ordinator had been identified as being qualified to teach Child Protection Level 3 which would address some of the concerns raised in respect of compliance rates. • Commissioning for Quality and Innovation payments (CQUINS) for 2014/15 have been agreed with commissioners. Confirmation of the Q4 payment for 2013/14 was still awaited but the trust had met all targets. The board **NOTED** the contents of the update
115-14	**Patient Experience Annual Report** AS had circulated both the Q4 and the annual patient experience reports to the board, but noted that information contained within Q4 was also within the annual report. She advised that the annual patient experience report is required to support information in the quality account 2013/14 and the Department of Health KO41 data reporting on complaints. AS , asked the board to note that due to the changes in meeting cycles this month, this report had not been to Quality and Risk Committee prior to being presented to the board. AS outlined the remit of the Patient Experience Group and drew the board's attention to a series of outcomes as a result of the work undertaken by the group. 51 of the 80 formal complaints received during 2013/14, had been upheld. There were a large number of complaints in relation to communication with patients and staff attitude. As a means of addressing this issue, the staff induction programme now included specific training on Care and Compassion together with a session of Customer Care. Customer Care training is now also provided to both clinical and non-clinical front line staff to demonstrate how to communicate effectively and deal with service users both face to face and over the telephone. GC suggested the trust should provide a benchmark as to how it rates against other organisations and include a section on the duty of candour in the training. Referring to the live Tweeting which had taken place during the recent CNO visit, the Chairman observed there was currently no method for capturing the rich variety of patient experience feedback via social media and incorporating it into the Patient Experience data. The Chairman asked if the trend in increases in complaints was a cause for concern; AP noted this was only a very slight increase and suggested a metric reporting the actual number of complaints upheld against those which were not would be a more useful

	indicator. The Chairman thanked AS and the board **NOTED** the contents of her update.
	Safe Staffing (monthly update) Following publication of the 'Hard Truths' report, AP reminded the board it was now required to review information on staffing levels by ward and shift. To this effect, she had prepared a report to enable the board to judge the effectiveness of care. It was, however, the first of its type and it should be seen as developmental. SB suggested triangulating this data with the financial plan to mirror acuity requirements. He also queried whether RMN figures were reflected in this report; AP explained the reasons they weren't, but agreed to provide a separate weekly report to his team **[Action: AP]** RT commended the report, noting that it provided evidence of outstanding care. However, he reiterated concerns regarding occupancy and acuity and suggested focus should remain on how these are managed and aligned to safe staffing levels. AP was asked if utilisation of eRostering would facilitate this process; she responded that it would be difficult currently, but was hopeful it could improve in time with the introduction of new eRostering software. The Chairman concurred that the report was an excellent work in progress, although it had highlighted issues in recruitment of nursing staff. AP agreed this was an ongoing problem but advised that HR were aware of difficulties and continuing to provide advice and support. In the interim, RAF nurses were providing additional support on a rolling programme. The second area of concern related to the high levels of bed occupancy on C-Wing. AP was hopeful that provision of a discharge lounge would help in the long term. In the meantime, Matron Kathy Brasier was reviewing with the risk team and an action plan would be included in the next report **[Action: AP]**
117-14	**Board Assurance Framework 2013/14** Following on from detailed discussions during the earlier board seminar, the board **NOTED** the content of the report. The Chairman thanked AS for her input and suggested she provided an update on the Leadership Development programme at a future board seminar **[Action: LH/AS]**
BUSINESS PERFORMANCE & DELIVERY	
118-14	**Workforce Performance Report (monthly update)** The Chairman welcomed GA who was attending to provide the monthly Workforce Performance report. GA reported that sickness absence had risen in April, which was disappointing as it was against a previous 3 months downward trend. The HR team was working with managers to help them to manage their staff absence more effectively. Steady progress had been achieved in respect of statutory and mandatory training performance, with compliance rates now close to the Trust target of 80%. Additional training sessions were being provided in June for those staff who were non-compliant. . GA reminded the board that managers were responsible for reviewing reports (which now included data for staff who did not attend, those who were about to become non-compliant

	in the next 3 months, and those who had been non-compliant for more than 3 months), and to take action accordingly. In addressing the Chairman's previous concerns, GA confirmed that he would be reviewing action taken in respect of staff non-compliant for more than 3 months, and if necessary disciplinary action would be taken. Progress on reducing bank and agency expenditure continued, and further improvements should be achieved through eRostering. A decrease in the number of Performance and Development Reviews (PDRs) undertaken was reported this month, although GA assured the board this was anticipated as a result of the transition to the new appraisal cycle and would settle over the course of the next 12 months. Recruitment timescales had significantly improved now averaging around 5 weeks. This was important step in supporting operations to improve and reduce vacancies. JT queried the 20% rate of turnover which appeared high, but was assured this related to the bi-annual intake of medical staff, and the actual trend was around 13%; GA suggested an average of 10% would be about right. AP noted that the size of the trust limited opportunities to progress internally; GA concurred but assured the board that exit interviews were monitored carefully. JT also queried the rise in sickness absence rates. GA responded that staff survey results had indicated that morale was low due to stress and anxiety and reminded the board of some of the initiatives being introduced to assist with work related stress. SF observed that sickness levels often rise in cases where staff were subject to performance review. The Chairman thanked GA and the board **NOTED** the contents of the report.
119-14	**Operational Performance Report (monthly update)** JM joined the meeting to present this month's operational performance report. In addition to the standard report, JM advised were also two executive reports, one relating to cancer waiting times and the second an update on the Referral to Treatment (RTT) 18-week wait target. JM reported that the trust had failed to meet cancer waiting time standards in Q4, explaining the reasons for the breaches. In certain cases, numbers were so small it was difficult to determine a trend. However, two patients had breached under the 31-day First Definitive Treatment (FDT) due to lack of availability of a visiting surgeon required to perform mastectomy prior to breast reconstruction. Until targets were adjusted in line with NICE guidance, JM warned that such joint procedures would be inherently liable to cause breaches. The board considered what approach it might take to address this. The Chairman remarked that the best solution should combine the best interests of the patient whilst protecting the trust's reputation; however, it was agreed that a joint appointment whilst difficult to manage would also change the referral pathway. Following a visit by the Department of Health Intensive Support Team during April and May, JM advised it had now provided a series of recommendations for consideration by the trust. JT sought clarification in respect of Quarter 2. RT explained that in order to expedite backlog clearance, the trust was planning to fail its inpatient aggregate target for Q2, thus achieving a long term sustainable 18-week position. He assured the board that he had

	been working closely with Monitor in this process. The Chairman thanked JM for her presentation and the board **NOTED** the contents of the report.
120-14	**Financial Performance Report (monthly update)** SB introduced this month's report, noting that recent transitional changes in the department, coupled with the logistics of adhering to the 2013-14 annual reporting timetables, had resulted in a headline summary only for month 1. Having only joined the trust very recently, SB would have preferred more time to interrogate this month's report, but on face value, he suggested there was a favourable income variance of £10k above plan. Pay and non-pay costs were also both below plan although he cautioned the board to reserve judgement until he was fully cognisant of the plan. Increased cash balances in April reflected receipt of part of a legacy debt during the month. It was anticipated that the trust would maintain its Monitor Continuity of Services Rating (COSRR) of 4 throughout the year, with the exception of Q1 where it would drop to 3 as a result of phasing of the surplus (predicated on liquidity and the trust's ability to service its debt). The trust is anticipating generating a small surplus for 2014/15, and predicting a Monitor rating of 4. RT noted that whilst the operational plan assumed 100% achievement of CQUIN, actual income assumed only 50% and queried the logic in planning for less than 100% LP stressed to SB the importance of including year on year figures in finance reporting to enable an accurate comparison. The Chairman thanked SB and the board **NOTED** the contents of his update.
GOVERNANCE	
121-14	**Annual Report, Quality Account and Finance Accounts 2013/14** LH introduced the Annual Report, Quality Account and Finance Accounts for 2013/14. She asked the board to note that the format for these reports was heavily prescribed, and highlighted the restrictive timescales in which the team was obliged to operate. LP suggested it might be helpful to develop a financial calendar for the board; RT confirmed this would form part of a larger discussion around board scheduling in the future. JT advised these reports had been presented to the Audit Committee the previous day. Recognising the late distribution of papers, he had requested those presenting them to highlight key issues to the committee. He was aware there would be subsequent minor changes and agreed these on the basis that any material changes were brought to the attention of the Audit Committee via the Chairman. JT confirmed the Head of Internal Audit had offered a Significant Assurance Opinion for controls systems audited, during 2013/ 2014. External auditors KPMG intended to issue an unqualified audit opinion. It had sought further assurance in respect of severance pay packages and the recoverability of debts

from NHS England, and had requested clarification regarding a change in the reported position (due to the recalculation of bad debt and Emergency Rate Tariff (ERT) penalty provisions), JT provided details of a key recommendation from the external auditors relating to the trust's fixed asset register, which was now raised as high priority.

Being satisfied with the recommendation of the Audit Committee, the Board **AGREED** the contents of the Management Representations letter in connection with the audit of the Trust's financial statements for the year ended 31 March 2014,

JT reminded the board that reporting deadlines had precluded the Quality Account being approved by the Quality and Risk Committee (Q&RC) prior to today's meeting. Whilst it was noted that that the Chair of Q&RC was also a member of the Audit Committee and fully cognisant of the report, he wished the board to note this inconsistency. He confirmed that KPMG had provided a limited assurance opinion on the content of the Quality Account and on the mandated performance indicators (62 days from urgent GP referral to first definitive treatment, and Emergency Re-admissions within 28 days of discharge from hospital). In respect of local indicator (18-week referral to treatment), JT advised that KPMG had identified areas for improvement but at the same time had noted the likelihood of this being the same for the majority of trusts nationally.

Auditors had raised one recommendation relating to mandated indicator one (maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers) which was to consider moving towards an automated system for capturing and recording cancer pathways, accessible by all offsite centres.

Satisfied with the recommendation of the Audit Committee, the Board **AGREED** the contents of the Management Representations letter in connection to the audit of the Trust's Quality Account for the year ended 31 March 2014,

Given the criteria and evidence described within the 'Going Concern' report prepared by the Deputy Director of Finance, the board endorsed the 'Going Concern' assessment as reasonable and **AGREED** the following statement

"After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts."

SB explained the end of year adjustment resulting in a final report position of £2.6m before impairments, leaving a small surplus of £61k. The change was due to the recalculation of the bad debt and ERT penalty provisions using the information available at the finalisation of the accounts. The key change was the receipt of £723k of legacy debt on May 15th. LP sought clarification regarding impairments and SB advised that these largely reflected changes to the estate as a consequence of the theatre phase 1 and phase 2 developments. The A Wing complex had also reduced in value due to the change in use, (and the significant proportion now vacant). Moreover, land had been devalued reflecting the change in market value for existing use.

It was noted that, for the first time, the charities accounts have now been consolidated with the trust's accounts to form a group.

The Chairman commended the team all the hard work that had led to the completion of the Annual Report, Financial and Quality Account and which the board had **AGREED** to approve.

122-14	**Executive Level Assurance Structure** RT had reviewed the existing executive level assurance structure, following agreement by the board that the senior team should focus on both day to day delivery and longer term planning. He presented a revised structure which would come into effect from 1st June 2014, to align with operational and other management changes currently being implemented; this in turn would provide board assurance that the trust was 'managing for today, yet planning for tomorrow'. The Chairman observed the new structure reflected the balance of operational and strategic work currently underway, whilst mirroring the new board agenda. RT reminded the board that he would provide written updates from the Clinical Cabinet with effect from next month. The Board **NOTED** the changes to the Executive level assurance structure
STRATEGY	
123-14	**Delivering Excellence QVH 2020 (monthly update)** As part of his monthly update, RT reported that the QVH 2020 programme manager would be joining the trust imminently; in addition, a series of monthly Connect articles, linking in with QVH 2020 was being developed. The board **NOTED** the contents of the update.
124-14	**Site Redevelopment (monthly update)** In HB's absence, RT summarised progress on work to date and reminded the board that the final account in respect of the theatre rebuild would be considered under the private session of the board. The board **NOTED** the contents of the report
125-14	**Capital Programme (monthly update)** RT reminded the board that this year's Capital Programme would focus on IT investment and a business plan setting out proposals would be submitted to the board during Q2. Medical equipment and backlog maintenance were also included. The board **NOTED** the contents of the update
126-14	**Sustainable Development (annual report)** In HB's absence, RT précised the annual Sustainable Development report. RT asked the board to be mindful that Sustainable Development was currently a high priority for the Department of Health and raised concerns that the issue was not high enough up the board's agenda; with this in mind, he was considering options for appointing a board lead. **[Action: RT]**
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
127-14	**Clinical Cabinet** RT noted that frequency of Clinical Cabinet meetings had been affected by the recent series of bank holidays; however, reiterating SF's earlier comments, he noted good progress was being made in respect of trauma capacity.

	The board **NOTED** the contents of the update.
128-14	**Audit Committee** JT had earlier provided a verbal update on the previous day's meeting to consider the annual report and accounts. The next standard quarterly meeting was scheduled for 4th June. The board **NOTED** the contents of the update.
GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
129-14	**Report from the Governor Representative** • BG reported the recruitment process for a new Chairman had not run smoothly of late because of significant difficulties in identifying interview dates suitable for all shortlisted candidates and interview panel members , but that interview arrangements were now in place. • The Chairman had just been advised that Julie Mockford (MaxFacs Prosthetics), Mansoor Rashid (Specialty Doctor, Plastics) and Shona Smith (Specialist Nurse Practitioner) had agreed to stand as Staff Governors. As there were three candidates for the three staff vacancies the election was uncontested, and the new staff governors will take on their role from 1 July 2014. The Chairman asked that details of these appointments be communicated formally to the board **[Action: LH]** Mabel Cunningham and Carol Lehan have both served six years (2 terms) on the Council and will step down on 30 June, and on behalf of the board, the Chairman extended his thanks to them for their diligence and hard work.
130-14	**Observations from the Chairman and Non-Executive Directors** There were none.
QUESTIONS FROM OBSERVERS	
131-14	There were none
MOTION TO EXCLUDE THE PRESS AND MEMBERS OF THE PUBLIC	
132-14	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 corporate governance.

Chairman…… Date……..

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
May 2014 meeting						
1	**114-14**	MIU to be invited to present at future board seminar.	**LH**	**June**	MIU is on list of invitees. Corporate Affairs team liaising with Dept. to identify a suitable date	**Pending**
2	**116-14**	RMN staffing figures to be provided to SB on a weekly basis	**AP**	**June**	Implemented with immediate effect	**Complete**
3	**116-14**	Action plan to be developed to address high levels of bed occupancy on C-Wing.	**AP**	**June**	Agreement to develop discharge lounge which will ease congestion on the ward. In addition, a discharge nurse is now allocated 5-days per week which is improving patient and staff experience. Review of data collection to obtain better understanding of ward utilisation; this information is now collated within Safe Staffing report.	**Complete** **Complete**
4	**117-14**	Deputy Director of Nursing to attend future board seminar to provide update on Leadership Development.	**LH**	**June**	Dep DoN attending Board seminar session 31 July to provide update	**Pending**
5	**126-14**	Board lead for Sustainable Development agenda to be identified	**RT**	**July**	**Update 18 06 2014:** RT to circulate to Board members requesting expressions of interest	**On track**
6	**129-14**	Details of new staff governor appointments to be circulated to the board.	**LH**	**June**	Email circulated 22 May 2014	**Complete**
7	**135-14**	Chairman to write individually to Mike Bennett and Heather Bunce to thank them for their contribution to the success of the new theatres.	**PAG**	**June**	**Update: 19 06 2014:** Letters to be drafted and posted prior to month end.	**On track**
8	**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**	**July**	LH to discuss with RT 20.06.14 and set timetable for completion	**On track**

April 2014 meeting						
9	**082-14**	Detailed breakdown of capital expenditure to be circulated to board.	**RT**	~~**May**~~ **June** **Oct**	**1.** 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 **2. Update 19.06.2014:** Detailed business case in respect of proposed IT expenditure to be submitted to board in October 2014	**On June agenda** **On track**

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**145-14**
Report from:	**Amanda Parker, Director of Nursing**
Author:	**Amanda Parker, Director of Nursing**
Report date:	**12 June 2014**
Appendices:	**A: Quality & Risk Report** **B: Director of Infection Prevention & Control Report** **C: Complaints Report** **D: Safe Staffing**

Patients: safe staffing and quality of care

Key issues

1. This report provides information on;
    - Quality dashboard covering patient and staff safety, patient experience, quality account metrics, CQUINs and infection control metrics (Appendix A)
    - Incidents that have occurred during the last month and the outcome of incidents reported two months ago (Appendix A)
    - Infection control issues and actions taken during the last month (Appendix B)
    - Information on complaints and claims received during the last month and the detail of closed complaints (Appendix C)
    - Safe staffing information including information on safety, outcome, experience and ward management. This is supported by the shift by shift, day by data on planned staffing and actual staffing of the wards (Appendix D)

2. Specific areas from the dashboard (Appendix A) where metrics have not met identified targets are;
    - World Health Organisation pre-surgery checklist compliance reported at 91% (page 2)
    - Friends & Family Test score within the Minor Injuries Unit (MIU) lower than 80 (page 2)
    - Return rate of Friends & Family Test forms less than 20% (page 2)
    - Friends & Family Test score within Sleep Disorder Centre lower than 80 (page 2)
    - Reassessment of nutritional screening after 7 days for inpatients score less than 95% (page 3)
    - Medication administration errors higher than anticipated (page 3)
    - Consent of elective patients prior to surgery; score lower than 75% overall and specifically in Plastics and Maxillo facial teams (page 3)

3. One serious incident was reported during May, involving the extraction of the wrong teeth. A full root cause analysis investigation is underway (page 9).
4. One amber rated incident was reported in May, involving failure to remove an eyelid ‘bolster’; investigation showed this was the failing of an individual doctor (page 9).

5. Other incidents reported in May are under investigation. Trends identified so far relate to drug errors, Caldicott incidents, documentation, communication failure, inappropriate treatment, investigation or care and non-physical assault. None of these resulted in moderate or severe harm (pages 7-8).

6. Lessons learned following investigation into the amber incidents from April has resulted in investigation of one individual's action. Following an inoculation injury the correct actions were taken by staff to support the injured staff member (page 10).

7. Infection control concerns (Appendix B) are;
    - Onsite presence of microbiologists (page 1).
    - Availability of sterinis machines for cleaning of rooms that have accommodated patients with known / potential infections (page 1).
    - Vacancies within the hotel services team affecting the capacity to clean (page x).

8. The monthly complaints, claims and patient experience report (Appendix C) included four complaints;
    - Two related to communication from the theatre team in regard to pre-operative care, post-operative care and waiting times (page 1)
    - One indicated concern about a referral to social services (page 2)
    - One related to delay to surgery (page 2).

9. Two complaints were closed during May; one resulted in no formal response required by the patient as they met with staff for a discussion (page 2). There was no specific learning from these complaints.

10. Overall patient experience has been good with feedback provided by patients on the NHS Choices website (pages 2 & 3) and the friends and family test scores by department and trust wide achieving good scores, although within both MIU and the sleep disorder centre it would be good to see more people rating their care as excellent. Managers have been asked to look at what would improve patients' experience so that more service users felt able to rate their experience as excellent.

11. The safe staffing information data pack (Appendix D) shows nursing vacancies continue to be an issue on three ward areas (pages 2, 5, & 9). Statutory and mandatory training and appraisal rates are a moderate issue within Canadian Wing (page 2). It should be noted this is the area with the highest vacancy rate. Occupancy rates remain high within Canadian Wing, this is reported at 10.00 and rates can exceed 100% as new patients are being admitted while others wait to be discharged. Of interest is new information provided on average length of stay (pages 3, 4, 6 & 8). Temporary staff use and sickness are noted to be issues within the burns unit during May (pages 7 & 9).
12. The information on planned and actual staffing has been submitted via Unify as an aggregated figure for the month as required by the Department of Health. The information provided on pages 11-20 is published and accessible to patients on the trust website, with a link to the information on the NHS Choices website. No shifts during the month were considered unsafe and where actual staffing did not meet planned staffing, details of the

mitigating actions or circumstances which meant that care was still considered to be safe are also set out.

Implications of results reported

13. The above areas have been highlighted because of the potential impact on CQUINS, patient safety and patient experience. The Serious Incident may also impact on the Trust's reputation with the commissioners, Monitor and Care Quality Commission for delivery of safe care.
14. There is no information that would suggest that any one group of patients with a protected characteristic has been adversely affected.

Action required

15. The following actions are required to address the issues raised in the report:
    - Further action to improve the 'sign out' aspect of the WHO checklist, as this is currently scoring at 80% (page 5)
    - Completion of a root cause investigation into the Serious Incident and investigation into all other reported incidents
    - Monitoring of the microbiology contract and vacancies within hotel services
    - Proactive responses to all complaints
    - Further development of the safe staffing report, using the NICE guidance due for publication in July to inform further the information presented.

Link to Key Strategic Objectives

16. The issues raised can potentially affect adversely all of the trust's key strategic objectives, however many also support delivery of 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

17. Issues identified are already reflected within the Corporate Risk Register and, where relevant, the Board Assurance Framework.

Regulatory impacts

18. Nothing within the report has an impact on the Trust's ability to comply with its CQC authorisation nor Monitor governance / continuity of service risk ratings.

Recommendation

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

Clinical Cabinet & Trust Board
Quality & Risk Management Report

June 2014 (May 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>April 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 uploaded during the month

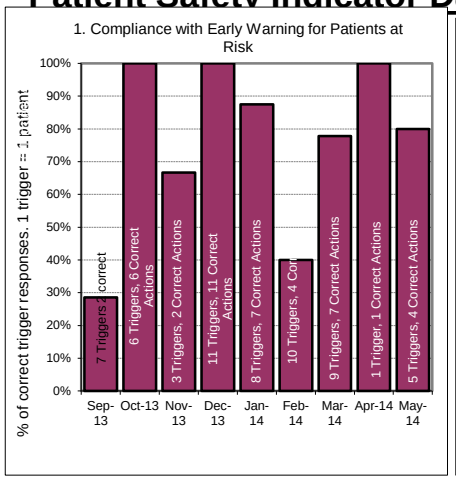
6. **Policies uploaded in May**

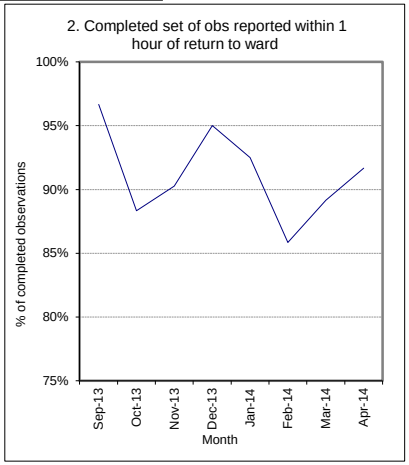
Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	ality Dashboard 2014 / 15 Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
CQUIN	VTE prophylaxis	100%	>95%	100%	100%											100%
	VTE in hospital/RCA undertaken	100%	0/100	0	0											
	FFT Score acute in-patients	86%	>80	88	86											87
	Number of responses	NEW	30%	72%	37%											
	FFT score MIU	85%	>80	76	77											
	Number of responses	NEW	20%	21%	8%											15%
	FFT Annual Staff Survey	NEW	>4	Annual Score												#DIV/0!
	Dementia >75 trauma asked indicative question	93%	90%	80%	100%											90%
	Dementia >75 having diagnostic assessment	100%	90%	100%	100%											
	Dementia > 75 referred for further diagnostic advice	89%	90%	100%	100%											
	Dementia training for staff	—	65%	81%	77%											
	Dementia clinical leads identified	—	NA	Reported twice yearly						Reported twice yearly						
	Dementia carers monthly audit	100%	NA													
	Safety thermometer data submission	100%	Y/N	Y	Y											
	Harm free care rate	100%	>95%	100%	98%											
	No new harm rate (aquired at QVH)	100%	>95%	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%		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	WHO Checklist compliance - Quantative (100% compliance is CCG CQUIN)	96%	>95%	96%	91%											#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!

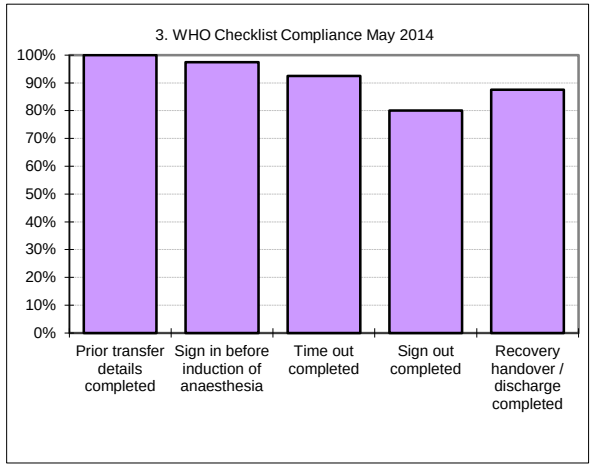
Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	ality Dashboard 2014 / 15 Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date 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											1
	Claims per 1000 spells	1		1.4	0.0											
	FFT Score acute in-patients	86%	>80	88	86											1
	% score for likely and very likely to recommend QVH		>90%	99%	100%											
	FFT score MIU	85%	>80	76	77											
	% score for likely and very likely to recommend QVH		>90%	99%	97%											
	FFT score OPD	82%	>80	82	81											1
	% score for likely and very likely to recommend QVH		>90%	98%	98%											
	FFT score DSU	93%	>80	-100	90											
	% score for likely and very likely to recommend QVH		>90%	0	98%											76
	FFT score Sleep disorder centre	76%	>80	78	74											98%
	% score for likely and very likely to recommend QVH		>90%	99%	97.0%											#DIV/0!
	FFT score Therapy	NEW														
	Mixed Sex accommodation breach	0	0	0	0											
	Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	—	>90%	92%	97%											
Patient Safety	Number of Pressure ulcer development Grade 2 or over acquired at QVH	8		0	0											
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	NEW	>95%		100%											
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	NEW	>95%		80%											
	Patient Falls resulting in no or low harm	16	—	4	1											
	Patient Falls resulting in moderate or severe harm or death	NEW	—	0	0											0.9
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	NEW	>95%	100%	73%											
	Avoidable patient falls identified on the Safety Thermometer	—		0	0											
	Serious Incidents (including Never Events)	5		0	1											
	Total number of incidents involving drug / prescribing errors	NEW		13	10											
	No & Low harm incidents involving drug / prescribing errors	NEW		13	10											0.0
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	NEW		0	0											
	Reduced errors on zero tolerance anti-microbial prescribing audits	—		Requesting clarity												
	% Medication errors	—		Requesting clarity												
	Medication administration errors per 1000 spells	1.3		0.7	3.6											
	To take consent for elective surgery prior to the day of surgery (Total)	72.2%	75%	84.7%	69.6%											
	To take consent for elective surgery prior to the day of surgery (Max Fax)	60%		68.2%	69.7%											
	To take consent for elective surgery prior to the day of surgery (Plastics)	46%		84.3%	65.1%											1
	To take consent for elective surgery prior to the day of surgery (Corneo)	81%		95.0%	88.5%											
	Number of outstanding CAS alerts	NEW		0	0											0%
	Number of reported incidents relating to fraud, bribery and corruption	NEW		0	0											

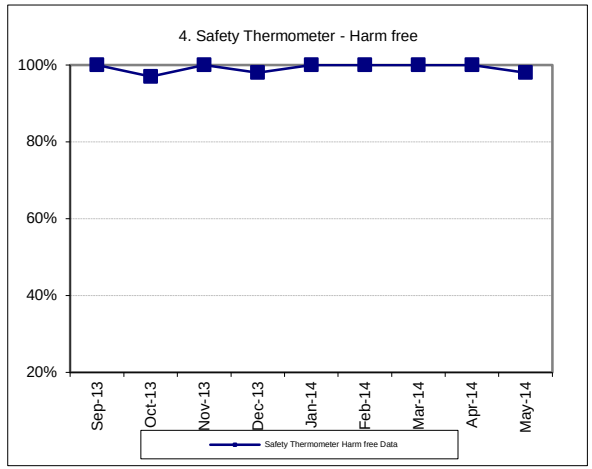
Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	ality Dashboard 2014 / 15 Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Staff Safety	Staff incidents causing harm	58		9	8											
	RIDDOR (Patients & Staff)	4		1	0											0
	Mandatory training attendance	71%	80%	82%	78%											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%
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0											0%
	E-coli bacteraemia	0	0	0	0											0%
	MSSA bacteraemia	0	0	0	0											
	MRSA screening - elective	96%	>95%	97%	97%											
	MRSA screening - trauma	98%	>95%	95%	97%											
	Trust hand hygiene compliance	95%	>95%	99%	100%											

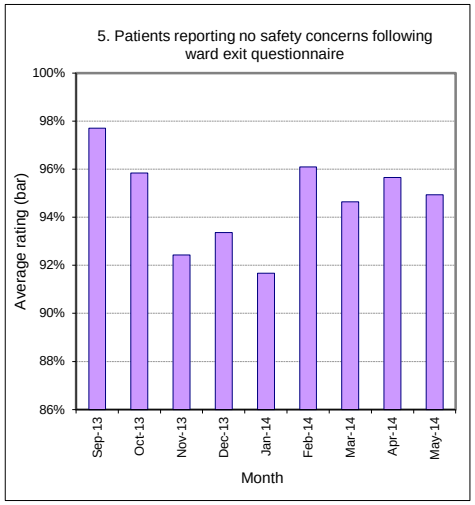
Patient Safety Indicator Dashboard

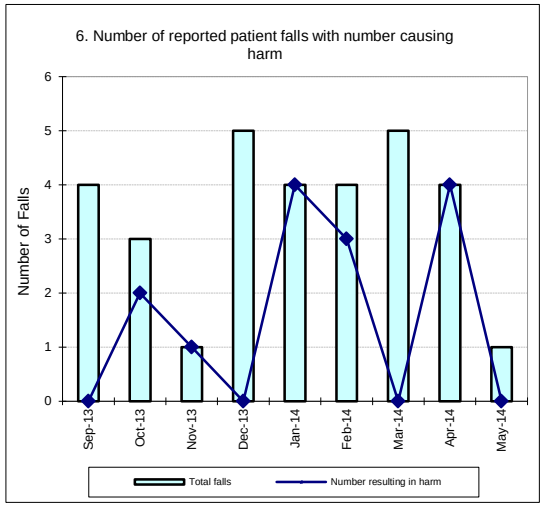


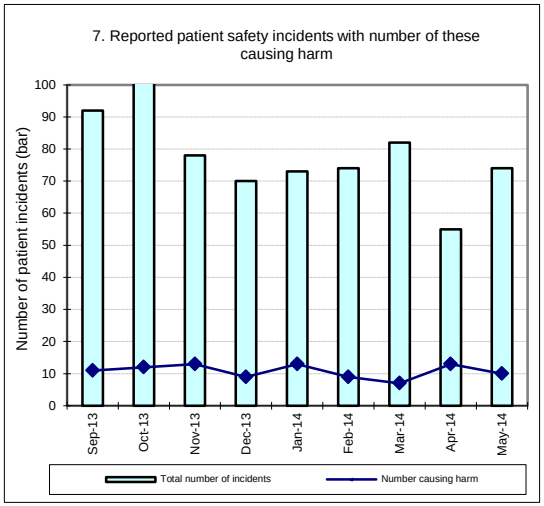


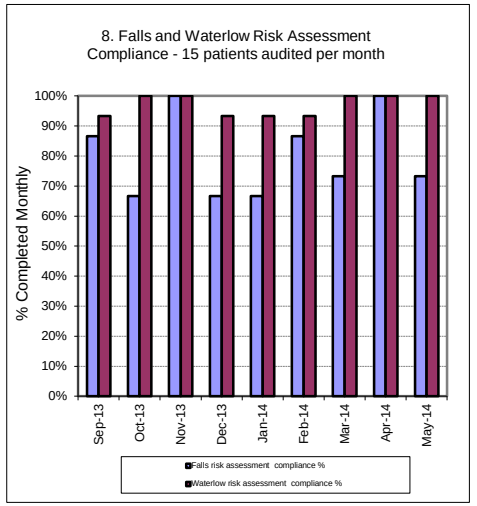










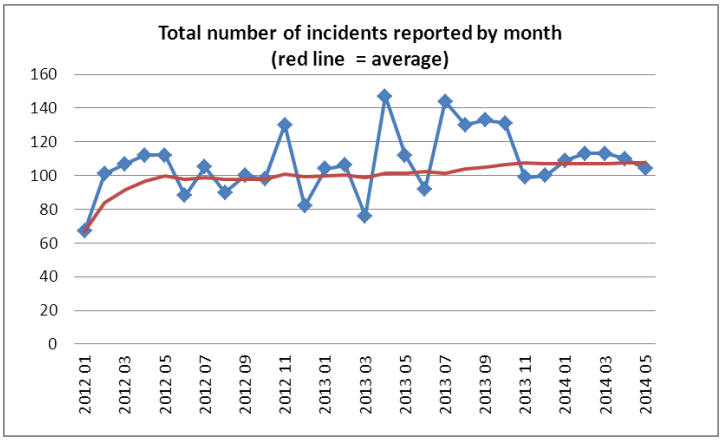


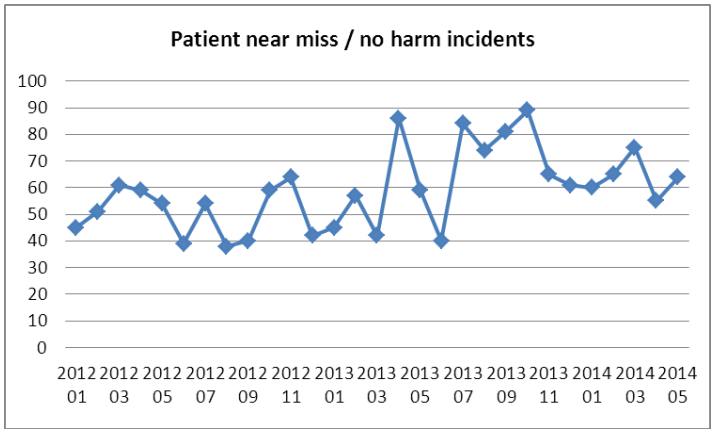
Incidents Open and Closed Data 2014/15

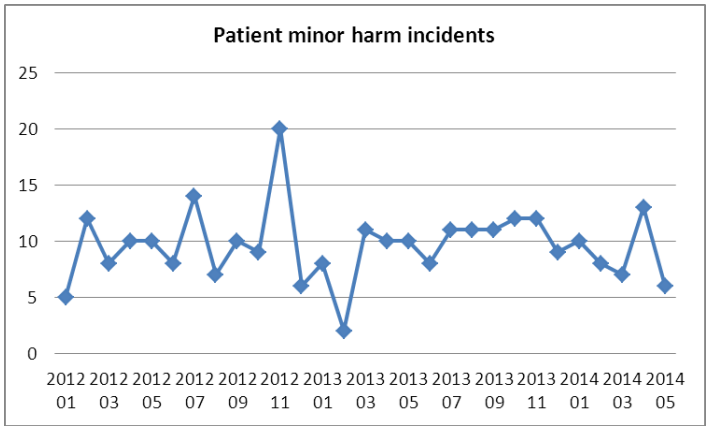
Type		2013/14		April		May		
	Carried forward from previous year	Actual	Closed	Total	Closed	Total	Closed	Total Number Outstanding to date
Red Incidents		**5**	**3**	0	1	1	0	**2**
Amber Incidents		**46**	**30**	2	5	0	1	**12**
All Incidents *	111	**1422**	**1363**	110	99	104	103	**182**

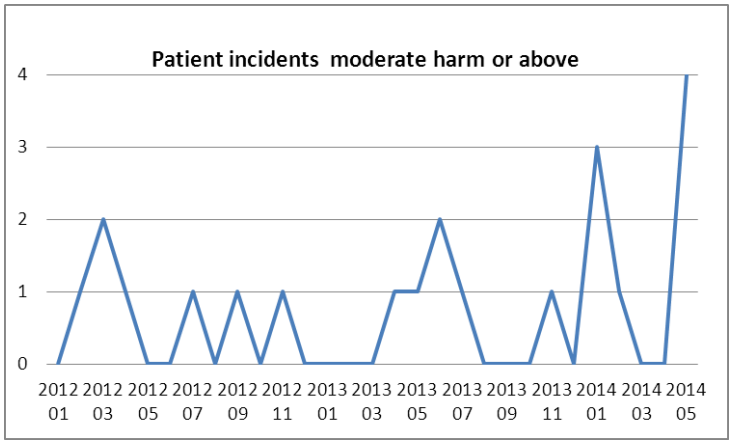
***** The total column for all incidents denotes the number reported for the month

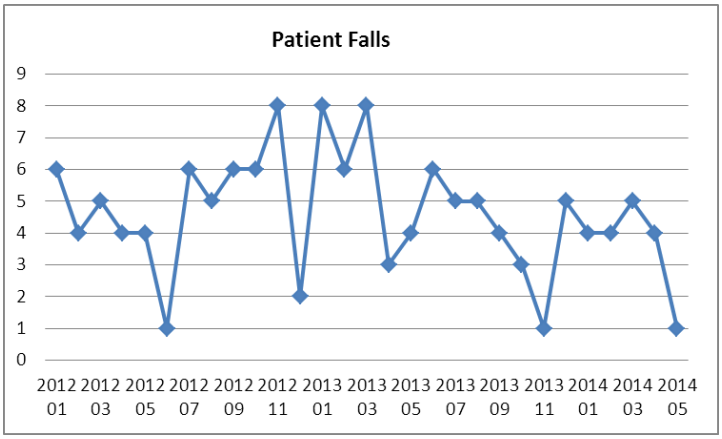
Incident Trend Analysis











Trends / issues following incidents reported in May 2014

<u>All drug errors (n=11)</u> (Note coincidentally – same number as April)

The majority of the drug error incidents reported in May 2014, related to administration (n=5). All of the five incidents were about the omission of drugs, with one focussing on reduced pain control for a patient, (femoral and sciatic blocks had been stopped). A statement has been requested from the Nurse as part of the investigation in to this incident.

Other drugs included in the drug administration incidents for May included paraceutamol, metformin, betahistine, simvastatin, hydroxychloroquine and montelukast, but no trends were identified.

Of the 4 prescribing drug errors, no trends were identified, and incidents ranged from the omission of a dose when Deltaparin was prescribed for a high risk patient (due to age and prexisting comorbidities), through to a patient's allergies that were stated differently on the drug chart when compared to the electronic discharge notice.

<u>Caldicott issues/Information Governance (n=7)</u>

3 of the 7 incidents related to the misfiling of Patients notes. There was no identifiable trend for the remaining incidents.

April saw six incidents reported where Patient Identifiable Data (PID) e.g. patient lists, and discharge notifications had been left in the Quiet Study Area or the Library. A reminder was given to Junior Doctors about confidentiality, and no similar incidents have been reported during May. One PID incident was reported in May - A Blood Form had been torn

in half and disposed of in a Black-Topped bin (The item was removed and placed in the confidential waste).

Documentation (n=7)

The most notable incident involved a paediatric patient who arrived on Peanut Ward having been transferred from The Royal Alexandra Hospital, Brighton. The patient went to Theatres on the trauma list for the repair of a partially amputated left middle finger. It was noticed that no clerking notes had been completed prior going to Theatre. The documentation from the referring hospital was available. A consent form had been completed and signed. The operation note (post-surgery) did not state which hand or finger had been operated on.

3 of the 7 incidents occurred in the Outpatients Department – examples included a Histology report filed in the wrong patient's notes and a referral letter also filed in the wrong patients notes.

Communication failure (n=5)

The majority of reported incidents for May related to poor communication between departments (4/5). One incident was about the misinterpretation of protocols by one the Trusts Transport Providers (NSL) and the Sleep Centre – The issue will be raised with the Transport Provider via the key performance indicator reviews and routine meetings. The patient suffered no adverse effects and was given breakfast at the time.

Inappropriate Treatment, Investigation or Care (n=5)

One Serious Incident is included in the five incidents reported in May. The details of this incident appear later in the report under the New Internal "Red/Amber" Incidents Section.

No particular trend could be identified with any of the remaining incidents – all were in different locations involving different people.

One patient was transferred from another hospital following the receipt of unsatisfactory care. The patients surgery was delayed due to all of the information not being received in a timely and complete manner.

A further incident referred to an incorrect Radiograph that had to be retaken, and a further incident referred to the on-call Anaesthetist being asked for advice on the use of a disposable local anaesthetic infusion device that was being used in the Trust. Difficulty in monitoring infusions and no in-built alarm system have been identified as risks with this pump, therefore this device is not routinely used at QVH. The decision was made by the Director of Nursing and the Medical Director to use an alternative pump.

Non-Physical Assault (n=5)

All but one of the incidents reported in May were "face to face" verbal abuse situations - mainly patients considering that staff were rude or service not acceptable – there has been no evidence to substantiate these claims at this point in time. Security support was required on two of the incidents. There was one verbal abuse case over the telephone.

New internal “red/amber” incidents – 1 x Red (SI) and 1 x Amber

1 x Internal red incident - A Serious Incident (SI) was reported on STEIS by the Trust for May 2014 (reference: 2014/16931). The investigation and completion of the Root Cause Analysis (RCA) report is underway.

This related to the incorrect extraction of four first premolars and upper midline supernumery on 19th March 2014. The patient had been referred to QVH by a specialist orthodontic practitioner for extraction of both upper first pre-molars and a midline supernumery tooth.

The patients Specialist Orthodontic Practitioner noticed the error at a follow-up visit on the 19th May 2014. The Specialist Orthodontic Practitioner did not inform the patient of the error and reported back to QVH on 22nd May 2014.

1 x Amber incident was reported (ID 12052) (categorised as an internal amber due to the learning, as there was no adverse effect/harm to the patient).

The patient underwent upper and lower eyelid fornix reconstruction 28/01/14. At her 12/03/14 Outpatient Appointment fornix bolsters were due to be removed and some documentation was included in the notes. The patient attended 14th May 2014 with a red eye, and poor vision. A bolster was found to be in-situ which had to be removed on that day.

The doctor concerned (who has since left the Trust) had requested a nurse to remove the bolsters and the nurse interpreted this as those that were visible. This was completed. However there was an additional bolster that was set deeper on the inside of the patient’s eyelid that was retained. Doctors have responsibility to remove the deeper set bolsters (not nurses).

The protocol has been reviewed and no changes were required as this was a communication and education error by an individual doctor (who has since left the Trust) and the Nurse involved.

Please review directorate incident listing reports for full incident data for May by Directorate.

Please encourage all staff to report any actual or near miss incidents involving patients, staff and visitors.

ID	Risk	Incident date	Directorate	Service	Location (type)	Severity	Closed	Incident Summary	Investigation Summary	Category
11923	Amber	07/04/2014	Anaesthetics	Theatre Services	Main Theatres (General)	No Harm/Near Miss		Anaesthetic machine monitoring section could not be turned on during pre-op checks. It was found that the switch was locked / stuck into the off position - the space between the switch and the housing for the switch had been glued into the off position. The machine had been defaced all along the back with drug calculations in indelible pen. Machine taken out of service.	This resulted in delays to surgery for 2 theatres. Escalated to Director of Anaesthetics. Head fo Risk has discussed with DoN and MD and MD will lead on the investigation	Equipment failure / misuse
11924	Amber	07/04/2014	Plastics	Medical (Doctors)	Theatre 9	No Harm/Near Miss		Surgeon sustained innoculation injury from known HIV, Hep B and C patient.	Protocol followed; PEP not indicated as low risk. To be followed up by occupational health. Reported as RIDDOR. RCA undertaken.	Innoculation Incident / Injury

Policies Uploaded in May 2014

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

- Operating List Ordering Policy (Clinical) CPC.

APPENDIX B

INFECTION PREVENTION & CONTROL
Monthly Report – May 2014

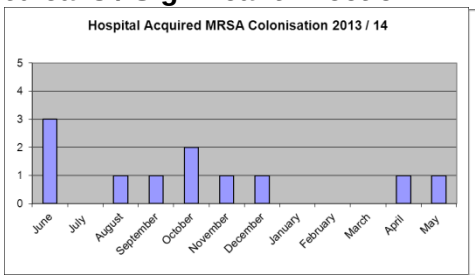
Surveillance					
	New this month	Year to date (target)	IC mandatory training	Overall attendance at 1.5.14: 80.59% (not incl booked)	
E.coli bacteraemia	0	0	**Trustwide Quarterly Results – Q4**		
MRSA positive blood cultures	0	0 (0)	MRSA Screening:	Elective: 95.71%	Overall 95.93%
VRE/GRE positive blood cultures	0	0		Trauma: 96.65%	
C.difficile	0	0 (0)	Hand Hygiene / BBE:	Hands: 98.41%	
MSSA positive blood cultures	0	0		BBE: 98.55%	

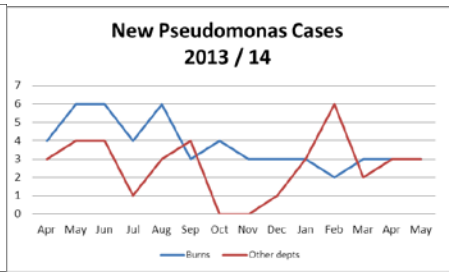
	All Theatres	Burns/EBAC	Corneo	MD/Stepdown	Maxfax/Ortho	MIU	OPD x2	PAC	Peanut	Recovery	Rehab	RT	Sleep	Therapies	X-ray
Screening – elective	97	85		97								95	96		
Screening – trauma	97	100		94								98	n/a		
Total new MRSA: 11		5					2	3	1						
Pos on admission: 6		*4*						*2*							
Previously positive 2							*1*	*1*							
Hospital acquired: 1									*1*						
Unknown: 2		*1*					*1*								
Hand hygiene	100	100	100		100	100	100	100	100	100	100	100	100	100	100
BBE	100	100	100		100	100	100	100	100	100	100	100	100	100	100

Areas of Concern

- Antimicrobial prescribing – Review of guidelines, annual audit and reminders at clinical mandatory training to discuss abx with Microbiologist. Patients reviewed by Consultant Microbiologist twice a week.
- Ability of BSUH to provide electronic reporting in usable format – On risk register, DIPC liaising with BSUH for new format
- Positive MRSA specimen results missing from BSUH daily labsheet - Reported to Pathology Lead for review. BSUH looking into possibility of providing a new format for ICNs.
- Inaccurate reporting of Streptococci infections on BSUH daily labsheet – As above
- Only one Sterinis machine working – Business case submitted and quotes being obtained by Supplies Dept.
- Hotel services team understaffed – Meeting held, Deep cleaning program postponed and Domestic staff allocated to clinical areas, non-clinical areas staff informed of interim arrangements. Bank staff requested as short term measure whilst process for recruitment of permanent staff followed.

Outbreaks / Significant Infection:





- MRSA acquisition for paediatric patient (not reportable). RCA completed. Patient not screened for MRSA on admission as per DH guidance, no signs of infection, therefore potentially positive on admission but assumption of HAI as no baseline swabs; patient a regular attender for dressing changes. No treatment required; wound now fully healed. IC precautions implemented, no secondary cases. IPACT to deliver teaching on hand hygiene to therapists to increase compliance.

- Patient admitted from RSCH to Burns for just over 24hrs as developed sepsis, cause unknown, then transferred back to RSCH ICU. Patient confirmed C.diff positive. No antibiotics given by QVH, not attributable to QVH. BSUH reported to HPA and completed RCA process.

Estates Issues		
Area	**Issue**	**Action**
Dental lab	Carpet	New quote required.
Prosthetics	Lack of hot water	Works started April for 16 weeks.
Jubilee	Heating not functioning	Works started April for 16 weeks.
Carpets	Carpet remains in areas in trust	New list required from Estates for prioritisation by IPACT.
Corridor	Decoration	Completed. Decoration timetable being updated.
OPD waiting areas	Increased temperature in hot weather	DIPC and CEO supporting application for portable air handling units. Estates to check the order has been raised. Estates to email Matrons with purchase details.
Pharmacy	Office carpet smells	Removed and replaced.
Disposal of waste in pts homes	Guidance states clinical waste created in pts homes should be returned for safe disposal on site	New RCN guidance published, policy updates approved by ICC. Training sessions to take place, equipment to be ordered to ensure safe transport of waste.
Corneo OPD	Male staff toilet has mould on the ceiling/walls	Outstanding still to be investigated by Estates.
CWing	Wards need general repair, painting, holes filled, bumpers on walls added vents and radiators cleaned.	Date for works to be negotiated with Matron, possibly July/August. Potential to decant to Rycroft.
EBAC	Ventilation grills are dirty	On regular cleaning programme but Estates and Hotel Services to consider increased frequency. Radiator covers for Burns which will not require Estates sourced, order being raised.
PAC	Examination room 11 has a leak	Leaks caused through the windows still require attention. Estates to complete works on the guttering at the back of the building. Awaiting Project Manager.
Public Toilets	All require refurbishment	Female toilet outside RDU to be fully refurbished. Other toilets require general redecoration.
Burns	Possibility of installing permanent hand wash basins in the corridors	Cost & waste disposal to be discussed at IPACT meeting.
Burns	Dept needs general repair following IPACT inspection	Mostly completed.
Burns	Following Peter Hoffman (PHE report) need to check if the siderooms are delivering positive or negative pressure ventilation	Estates to arrange for outside company to check.
Burns	Theatre filters alarming	Checked by company and early warning system requires change. Safe to use, replacement order raised by Estates.
Burns	Theatre doors damaged	Repaired.
Theatre Corridor	Flooring damaged	Willmott Dixon to repair date to be arranged. 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.
Xray	Ceiling collapsed; rainwater leaks in several rooms	Completed.

Risk Register		
Risk	Number	Current situation
Lack of hand wash basins	442 (rated 6)	Portable sinks in situ until works complete
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. Telephone cover available. Infection control nurse hours increased.
Portable aircon units	631 (6)	Only use at heatwave level 3 or above.
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.

Other Audit Results

PLACE inspection – Clinical – RT, MD, Rycroft Non-Clinical – Breast Care Nurses offices, porters lodge, hotel services.
Monthly theatre cleaning audit – Matron & IPACT conducted in the new theatres, noted sticky floors, some dirty floors and equipment being replaced before dry – Supervisor asked to review urgently, Matron & Hotel Services to monitor.
Saving Lives – limited data received, not comparable with other months as sample too small. Saving lives audit process being reviewed as forms not being returned.
Cleaning chart spot check – some improvement required in many areas; managers informed and to be reaudited.
Couch and mattress spot check – 49 checked, of these 4 mattresses had strike through. 5 couches damaged. Reported to managers to condemn and replace, and to remind staff to check after every patient discharge. Decontamination of mattress process being reviewed.
Hand hygiene roadshow – general improvement; Peanut won the competition. Advice given for, eg, dry hands at time of inspection.
Paperwork spot check – ITU excellent, Peanut excellent. Improvement needed in RT and MD as forms for, eg, PVC, not completed. Burns, big improvement, only minor bits not completed (managers informed).
MRSA decontamination – improvement required in documentation. Patient management satisfactory, staff knowledge has improved. Audit process being reviewed.

Other Information

- OPD Teaching on management of patients with MRSA
- Legionella, Corneo, Peanut and New theatres have an on-going issue with low positive results which reduce after flushing for 10 minutes. Estates to discuss actions with Consultant Microbiologist. Head of Estates to ensure Hotel Services team are flushing the areas daily and documenting. Hotel Services Manager to be asked to carry out spot checks to ensure completed correctly. Repeat testing. Water units safe to use.
- Priorities for infection control over the next year sent to the Head of Finance.
- Meeting held re potential relocation of Max Fax mould storage area as dead squirrels found in room. Currently room closed and full decontamination advised prior to relocation. Risk assessments completed.

Queen Victoria Hospital
NHS Foundation Trust

APPENDIX C

Monthly complaints, claims and patient experience report

1 May 2014 – 31 May 2014

This report provides and overview of all activity during this period.

Monthly complaints, claims and patient experience report

1 May 2014 – 31 May 2014

Complaints

Complaints received. During this period there were 4 formal complaints received. The following is a summary of the complaints that were received during this period:

Theatres

1. Patient seen in clinic for melanoma. Scheduled for local anaesthetic/sedation. On day of surgery on down as local therefore cancelled. It was then discovered that patient hadn't been pre-assessed. When this was done they omitted to do ECG which patient then had done by GP.

   Following surgery told by ward that stitches would need to be taken out in 7 days. As ward couldn't get hold of dressing clinic would send a referral. Having not heard daughter contacted dressing clinic who said that they had no record of referral. Daughter feels that if she hadn't contacted hospital then mother stitches would not be removed. Several issues regarding communication need to be addressed.

Theatres

2. Patient arrived and reported to theatre reception at 7.55am having been asked to arrive at 8am.

   Patient saw the receptionist who was noted put a tick by her name. At 10am patient still hadn't gone through and went back to the same receptionist who said that another patient was being operated on. By 1pm patient still not seen and saw receptionist who, on walking out the main door saw patient and said 'haven't you still been seen' and carried on walking out the door. Patient later overheard the nursing staff say 'this is an absolute disaster'. Patient understands that during her time in the reception area the staff were trying to ring her mobile phone not knowing that she was actually in the hospital. Feels that the receptionist/nurse was appeared to be doing two jobs was very abrupt towards patients.

   Patient later told that the receptionist/nurse did not put patients name on the board. This member of staff did apologise to the patient but also said that she didn't know what she could have done differently. Patient can't understand why if the receptionist had her ‘foot in both camps’ why the staff were trying to get hold of the patient as the member of staff who she checked in with would have

known that she already here. At 14:00pm it is understood that it was realised that patient had been here since first thing this morning when she checked in and she was then taken through.

Peanut

1. Referral to social services which parents feel was totally inappropriate.

Plastics

2. Alleged delay to surgery on face.

Closed complaints: There were 2 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).

Plastics

1. **Medics -** Query and concerns about consultation that patient had.

   Outcome *– Consultation with patient was entirely appropriate. Patient was informed that it would not be appropriate to perform any surgery on her breast area.* ***Unsupported.***

Burns

2. **Nursing -** Mother of patient raised concerns that care of wound wasn't appropriately looked after which she feels resulted in patient getting septicaemia and being on ITU in Pembury.

   Outcome - Patient and mother met with senior nurse (Alison Munday) and full explanation regarding concerns about treatment were given. Patient did not wish a formal response from Trust.

Claims

There were 0 new claims opened during this period. Overall there are 40 claims.

Patient comments & FFT

NHS Choices

There were 2 new comments posted onto the NHS Choices website.

Excellent from start to finish. From the moment you walk into the door until the moment you leave this hospital exudes quality and care. I was never left wondering what was going on and even though I had a few hours wait for my operation I never felt forgotten.

The surgeon that completed my surgery to remove a cyst from my head was professional and made me feel at ease the whole time, his colleagues in the theatre were all happy and very professional. I was shocked that the operation only took 10 minutes and I was then passed onto the great after care team.

If you ever have a referral to this hospital for anything you will not be disappointed at the level of care that is offered in what is a smaller than average hospital in what people assume is a failing NHS. Brilliant!

Visited in May 2014. Posted on 05 May 2014

Trust response: We are delighted to receive your review and recommendation. Thank you for taking the time to share your experience and express your kind appreciation for the care you received. It is important to us that we make all our patients as comfortable as possible during their time with us, however short, and it is always pleasing to hear when we achieve the standards we set ourselves. Kind regards, Nicolle Tadman, Patient Experience Manager

Minor hand surgery

I had a great experience with QVH and will not hesitate, not for a second, to recommend this place to anybody.

On the afternoon of Friday the 25th of April 2014 I had a broken wine glass accident resulting in a laceration of the side of my left little finger. I went to the nearest minor injuries hospital in Edenbridge but was sent from there (with a letter) to QVH as they could not provide X-ray.

I waited in the QVH minor injuries unit for about an hour to be seen by a member of nurse staff. I expected some waiting (I was not the only one there) so I did not see it as a problem at all. When I got called in things started happening fairly quickly - X-ray, doctor's assessment, admission to Margaret Duncombe ward, operating theatre and 1h micro surgery nerve repair under local anaesthetics and back to Margaret Duncombe ward. I was discharged on the same day.

A week after the surgery I had the stitches out at the plastic surgery dressing clinic and another week later I had an appointment with a physiotherapist. I am on the mend now and will return for a check-up in June.

I was very happy with all the care I received indeed. Everybody was so nice, especially the team in the operating theatre, very informative. I knew exactly what was happening all the time I spent in QVH. I was so very well looked after and really impressed by the quality of care and everyone's attitude.

So here comes my big and sincere Thank You. Well done QVH, you are doing a great job! Keep it up.

Visited in April 2014. Posted on 13 May 2014

Trust response: The Trust would like to thank you for taking the time to share your positive experience of the treatment you received at Queen Victoria Hospital. It is always gratifying to read such comments and it is also pleasing to know that our hospital services have made such an impact.

Please be assured that your comments have been passed on to the manager of the Minor Injuries Unit and the Matron for our Theatres Services who also wish to convey their thanks. We extend our good wishes and all the best with your continued recovery.

Kind regards, Nicolle Tadman - Patient Experience Manager

FFT

The FFT scores for May is 86 and the % score for extremely likely/likely is 100%.

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

MD	+86	100%
RT	+86	100%
Peanut	+100	100%
Burns	+83	100%
Sleep	+74	97%
MIU	+77	97%
Trauma	+83	98%
OPD	+81	98% (this is for all outpatient episodes)
DSU	+90	98%

The following chart is a comparison of specialist hospitals and their FFT scores for April 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	74	100	74.00%	93
PAPWORTH	566	974	58.11%	86
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	279	385	72.47%	87
ROYAL MARSDEN	185	527	35.10%	93
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	300	462	64.94%	73
STOKE MANDEVILLE HOSPITAL	258	992	26.01%	80

Appendix D

SAFE STAFFING INFORMATION

Information attached provides details for May 2014 on;

- Staff utilisation
- Staff training
- Patient experience
- How safe care has been
- Activity
- Ward staffing shift by shift showing planned and actual with action taken when required

This information is provided for Canadian Wing (Margaret Duncombe and Ross Tilley wards) Peanut ward, Burns ward and Burns ITU.

CANADIAN WING								
Staff utilisation	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies wte/hrs Est = 62.88	10.1WTE 1624hrs	7.76 WTE 1288.7hrs	<5%	12%				Vacancies have been advertised
Temporary staffing Exc RMN Bank / Agency hours	494.25 268.40	530.10 431.30	<10% 235.8 + vacancy	-327.3				No action required
Sickness	4.5%	2.4%	<2%	+ 0.4%				No action
Shifts meeting Est	83%	97%	>95%	-12%				21 shifts out of 120 not meeting establishment - staffing deemed safe due to acuity level of patients or ward closed
Training / Appraisal	**No/%**		**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	71.0%	61.91%	>85%	-23.09%				Action rquired below target
Appraisals	69.4%	67.69%	>85%	-17.31%				Action rquired below target
Drug Assessments	95%	96%	>95%	0%				On track no action required
Friends and Family Test Score **MD / RT**	84 88	89 85	>80	4				On track no action required
Staff Friends and Family Test Score								
Budget	2		>0	2				On track no action required

MARGARET DUNCOMBE	APRIL	MAY	2014					
Safe Care	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0				On track no action required
Falls	1	0	0	1				For discussion at ward meeting
Medication errors	3	5	0	3				No harm to patients - these were related to ommission of administration
MRSA/Cdiff	0/0	0/0	0	0				On track no action required
VTE reassessment	90%	100%	95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100%	100% 30%	>95%	5% -65%				Staff have been reminded about the 7 day review of patients nutrituion scoring
Activity	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy (10am)	122%	129%	<90%	32%				Bed occupacy is excessive, exceeds 100% as patients are within discharge area while other patients have been admitted. Risk raised % and actions to develop discharge area off ward being taken
Bed utilisation	104%	93%	<100%	-7%				On track no action required
Patient numbers	175	158						
Average length of stay		32.8Hrs						
Average acuity								

ROSS TILLEY	APRIL	MAY	2014					
Safe Care	**No/%**	**NO/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	1			–	On track no action required
Falls	3	1	0	3			\	For discussion at dept meeting - no harm to patient
Medication errors	5	0	0	5				To be rasied and discussed at ward meeting
MRSA/Cdiff	0/0		0	0				On track no action required
VTE reassessment	93%	91%	95%	-2%			\	1 patient not reassessed in 24 hours
Nutrition assessment MUST / 7 day	100% 100%	100% 100%	>95%	5% 5%			–	On track no action required
Activity	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	90%	119%	<90%	29%				
Bed utilisation	37%	107%	<100%	7%				
Patient numbers	165	199					–	
Average length of stay		34.9Hrs						
Average acuity								

Peanut								
Staff utilisation	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies Est = 25.00	1.2 WTE 199hrs	1.72wte 286hrs	<5%	7%				Recruitment to occur
Temporary staffing Exc RMN Bank / Agency	151 0	160.15 23.45	<10% 93.75 + vacancy	-196				Bank covering establishment vacancies
Sickness	4.7%	3.8%	<2%	+1.8%			/	Sickness decreased, carrying 1 long-term sickness case
Shifts meeting Est	99%	96%	>95%	0%				
Training / Appraisal	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	81.0%	81.29%	>85%	-3.71%			/	Plan in place
Appraisals	93.9%	87.10%	>85%	+2.10%			\	On track no action
Drug Assessments	100%	100%	>95%				\	On track no action
Friends and Family Test Score	83	100	>80	3			\	On track no action
Staff Friends and Family Test Score								
Budget	-4		>0	-4				1K is related to activity, 1,6K staffing and 1.3K non pay during April, mattresses and duvets were purchased

Peanut	APRIL	MAY	2014					
Safe Care	**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			–	
Medication errors	1		0	1				
MRSA/Cdiff	0/0	0/0	0	0			–	
VTE assessment	NA	NA						
Nutrition assessment	NA	NA						
Activity	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy Taken at 10.00 daily excluding weekends	75%	64%	<95%	-20%				
Bed utilisation								
Patient numbers								
Average length of stay		5.5Hrs						
Average acuity								

BURNS UNIT								
Staff utilisation	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies Est = 32.85	WTE 0	1.6 WTE 266hrs	<5%	5%			–	Vacancies advertised
Temporary staffing Exc RMN Bank / Agency	390.35 78.0	398.15 114	<10% 123.1hrs + vacancy	+ 123				Action required - covering maternity leave and annual leave
Sickness	1.7%	4.1%	<2%	+2.1%			/	Sickness increased due increase in cough,cold & flu and carrying 1 long-term sickness case
Shifts meeting Est	90%	96%	>95%	-5%			–	Saffing identified as safe due to acuity of patients
Training / Appraisal	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	85.0%	80.25%	>85%	-4.75%			/	Below target
Appraisals	55.6%	58.82%	>85%	-26.18%			/	Action required
Drug Assessments	97%	95%	>95%	0%			–	
Friends and Family Test Score	91	100	>80	11			–	
Staff Friends and Family Test Score								
Budget	16		>0	16				

BURNS WARD	APRIL	MAY	2014					
Safe Care	**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	0	0				On track no action required
VTE reassessment	94%	100%	95%	-1%				On track no action required
Nutrition assessment MUST/7 day review	100%	100% 100%	>95%	5% 5%				On track no action required
Activity	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	88%	78%	<95%	-7%				On track no action required
Bed utilisation								
Patient numbers	35	28						
Average length of stay		36.5Hrs						
Average acuity					8			

ITU								
Staff utilisation	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies Est = 16.16	4.3 WTE 714hr	2.40 WTE 386 hrs	<5%	15%			–	Vacancies being recruited to
Temporary staffing Exc RMN Bank / Agency	174.40 132.0	151.30 280.20	<10% 60.6hrs + vacancy	+ 14				No action required
Sickness	8.4%	14.59%	<2%	+12.59%			/	Sickness high due to carrying 2 long-term sickness cases
Shifts meeting Est	98%	95%	>95%	0%			–	
Training / Appraisal	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	84.0%	79.17%	>85%	-5.83%			/	Fallen slightly below target, action required
Appraisals	60.0%	50.0%	>85%	-35.0%			/	Action required below Trust target for the last two months
Drug Assessments	97%	95%	>95	0%				
Friends and Family Test Score								
Staff Friends and Family Test Score								
Budget	-4		>0	-4				4K under budget is all related to activty

ITU	APRIL	MAY	2014					
Safe Care	**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				On track no action required
MRSA/Cdiff	0		0	0				On track no action required
VTE reassessment	94%	100%	>95%	-1%			/	
Nutrition assessment MUST/7 day review	100%	100% 100%					–	
Activity	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy								
Bed utilisation								
Patient numbers								
Average acuity								

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	MAY	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	5	1	5	1	
2	6	2	6	2	
3	5	2	5	2	
4	4	1	4	1	
5	3	1	3	1	
6	4	2	5	2	
7	6	2	6	2	
8	3	2	3	2	
9	3	2	3	2	
10	3	2	3	2	
11	3	2	3	2	
12	4	2	4	2	
13	5	2	5	2	
14	4	2	5	2	
15	3	2	3	2	
16	3	1	3	1	
17	4	2	5	3	
18	4	2	3	2	
19	3	1	3	1	
20	3	0	3	1	
21	5	2	5	1	unable to cover HCA shift, ward safe
22	4	2	4	2	
23	5	2	5	2	
24	4	2	6	2	
25	4	2	4	2	
26	3	2	3	2	
27	3	2	3	2	
28	3	2	3	2	
29	5	2	5	2	
30	4	3	4	2	unable to cover HCA shift, ward safe
31	3	1	3	1	
MD DAY	121	55	125	55	
HOURS	1391.5	632.5	1438	633	
Percentage Achieved			103.3	100	11

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 MAY

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	1	4	1	
2	4	1	4	1	
3	4	1	4	1	
4	2	1	2	1	
5	2	1	2	1	
6	4	1	4	1	
7	4	1	4	1	
8	4	1	4	1	
9	4	2	4	2	
10	2	1	2	1	
11	2	1	3	1	
12	3	1	2	1	
13	2	1	2	1	
14	4	1	4	1	
15	3	2	2	2	
16	4	1	4	1	
17	3	1	2	1	only 10 inpatients
18	3	1	2	1	only 12 inpatients
19	3	1	3	1	
20	5	0	5	0	
21	4	1	4	1	
22	4	1	4	1	
23	3	2	3	2	
24	2	1	2	1	ONLY 10 inpatients
25	3	1	3	1	
26	2	1	2	0	only 12 inpatients, No step down
27	2	1	2	1	
28	2	1	2	1	
29	3	1	3	1	
30	3	2	3	2	
31	3	1	2	1	13 pt no SDU pt safe staffing
MD NT	97	34	93	33	
HOURS	1115.5	391	1070	380	
Percentage Achieved			95.88	97.1	

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	MAY	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	1	
2	3	2	3	2	
3	3	2	3	2	
4	2	1	2	1	
5	3	1	3	1	
6	4	3	3	3	staff sickness
7	3	2	3	2	
8	4	2	4	2	
9	4	2	4	2	
10	4	1	4	1	
11	4	1	4	1	
12	4	2	4	2	
13	4	2	4	1	1 x HCA shift not covered
14	4	2	4	1	x1 hca shift not covered
15	3	2	3	2	
16	4	2	4	2	
17	4	3	4	1	hca shift not coverd
18	4	2	4	1	hca shift not coverd
19	4	2	4	2	
20	4	2	4	2	
21	5	2	4	2	1 trained covering discharge
22	4	2	4	2	
23	4	2	4	2	
24	5	2	5	1	
25	5	2	4	1	12 patient only safe staffing
26	4	2	4	2	
27	4	3	4	3	
28	4	2	4	2	
29	3	2	3	2	
30	4	3	4	2	hca shift not coverd
31	3	1	3	1	
RT DAY	117	60	114	52	
HOURS	1345.5	690	1311	598	
Percentage Achieved			97.44	86.7	13

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 MAY

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	sickness- (17 pts inc 2 corneo on 1/4 drops) therefore sdu nurse moved to back fill
2	3	1	3	1	
3	2	1	2	1	
4	2	1	2	1	
5	3	1	3	1	
6	3	1	3	1	
7	3	1	3	1	
8	3	1	3	1	
9	3	1	3	1	
10	3	1	3	1	
11	3	1	2	1	ward has nine inpatients.
12	3	1	2	1	13pts
13	3	0	3	0	hca not covered
14	3	1	3	1	
15	4	2	4	2	
16	3	1	3	1	
17	3	1	2	1	14pts
18	3	1	3	1	
19	4	2	4	2	
20	3	1	3	1	
21	4	1	4	1	
22	3	1	3	1	
23	4	2	4	2	
24	3	1	3	1	
25	2	1	2	1	
26	3	1	2	1	pt number 14, ITU support. Agency DNA
27	3	1	3	1	
28	3	1	4	1	
29	3	1	3	1	
30	3	1	3	1	
31	3	1	3	0	12 pt. safe staffing
RT NT	94	33	90	32	
HOURS	1081	379.5	1035	368	
Percentage Achieved			95.74	97	

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	MAY	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	1	
2	3	1	3	1	
3	2	2	2	2	
4	2	1	2	1	
5	2	1	3	0	
6	3	1	3	1	
7	3	1	3	1	
8	2	1	2	1	
9	3	2	3	2	
10	2	1	2	1	
11	2	1	2	1	
12	3	1	3	1	
13	3	1	3	0	no HCA but only 4 patients
14	3	1	3	1	
15	3	0	2	0	
16	3	1	2	1	
17	3	1	3	1	
18	3	1	2	1	1 inpatient
19	1	2	1	2	
20	3	1	3	1	
21	3	1	3	1	
22	3	1	2	1	ward manager to help on ward
23	3	1	2	2	extra HCA to cover Tr, ward safe
24	2	2	1	2	PAU to help
25	3	2	3	2	
26	2	0	2	0	pau staff to assist am
27	3	1	3	1	
28	3	1	2	1	one went home sick at 11:00
29	3	1	3	1	
30	3	2	4	2	
31	2	2	2	2	
PN DAY	82	36	77	35	
HOURS	984	432	924	420	
Percentage Achieved			93.9	97.2	15

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 **MAY**

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	1	0	No in patient
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	
19	2	0	2	0	
20	2	0	2	0	
21	2	0	2	0	
22	2	0	2	0	
23	2	0	2	0	
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	nurse moved from the burns unit to support
PN NT	62	0	61	0	
HOURS	744	0	732	0	
Percentage Achieved			98.39	0	

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	MAY	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	1	
2	3	1	3	1	
3	3	1	3	1	
4	3	1	2	1	Using itu staff to support as necessary
5	3	1	3	1	
6	4	1	2	1	staff sickness- itu to support+ manager in scrubs
7	3	1	3	1	
8	3	1	3	1	
9	3	1	3	1	
10	3	1	3	1	
11	3	0	2	1	only 2 inpatients
12	2	1	2	1	
13	2	2	2	2	
14	2	2	2	2	1 HCA helped on C-Wing
15	2	1	2	1	
16	2	0	2	0	only x2 patients so safe
17	2	2	2	2	
18	2	1	2	1	
19	2	0	2	0	
20	3	1	3	1	
21	2	1	2	1	only 2 inpatients & 1 rehab
22	2	1	2	1	
23	3	1	3	1	
24	2	1	2	1	
25	2	1	2	0	only 2 patient ITU helping
26	3	1	3	1	
27	3	1	3	1	
28	3	1	2	1	only 2 self caring patients + 1 RMN
29	2	2	2	2	
30	3	1	2	2	2 patients ward safe
31	2	0	2	0	
BC DAY	80	31	74	32	
HOURS	960	372	888	384	
Percentage Achieved			92.5	103	17

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 **MAY**

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	1	2	1	
2	2	0	2	0	
3	2		2	0	
4	2	0	2	0	
5	2	0	2	0	
6	2	0	2	0	
7	2	1	2	0	
8	2	1	2	1	
9	2	1	2	1	
10	2	0	2	0	
11	2	0	2	0	
12	2	0	2	0	
13	2	0	2	0	
14	2	1	2	1	
15	2	1	2	1	
16	2	1	2	1	
17	2	2	2	2	
18	2	0	2	0	
19	1	0	1	0	x1 patient on ward x1 rehab Site practitioner based on burns
20	2	0	2	0	x1 patient on ward x1 rehab
21	1	1	1	1	
22	1	1	1	1	
23	2	0	2	0	
24	2	0	2	0	
25	2	0	2	0	
26	2	0	2	0	
27	2	0	2	0	
28	2	1	2	1	
29	1	1	1	1	itu assisting
30	2	1	2	1	
31	2	0	1	0	2 pt, ITU staff to support
BC NT	58	14	57	13	
HOURS	**696**	**168**	**684**	**156**	
Percentage Achieved			**98.28**	**92.9**	

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	MAY	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	1	2	1	
2	2	1	2	1	
3	2	2	2	2	
4	2	2	2	2	
5	2	0	2	0	
6	2	1	2	1	x1 pt (hdu)+ itu to assist ward
7	3	1	3	1	
8	3	0	3	0	
9	4	0	4	0	
10	4	0	4	0	
11	3	0	3	0	
12	2	1	2	1	
13	3	0	2	0	1 Tr on call, to cover staff sickness
14	3	0	2	1	1 Tr on sick leave
15	3	0	3	0	
16	3	2	2	1	covering outreach am.
17	3	1	3	1	
18	3	1	2	0	no patients, helping of the ward
19	3	1	3	1	
20	2	2	2	2	
21	2	2	2	2	
22	2	0	2	0	
23	2	0	2	0	no ITU pts, helping on ward & EBAC
24	2	1	2	1	staff helping ward
25	2	0	2	0	staff helping ward
26	2	0	2	0	
27	1	0	1	0	0n call
28	2	0	2	0	
29	2	0	2	0	
30	2	0	2	0	no pts
31	2	0	1	0	no pt, 1 staff o/c if required
ITU DAY	75	19	70	18	
HOURS	900	228	840	216	
Percentage Achieved			93.33	94.7	19

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 MAY — **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	third ITU nurse moved to SDU to free up nurse to cover RTW.
2	3	0	2	0	safe staff 1 pt in ITU
3	2	0	2	0	
4	2	0	2	0	
5	2	0	2	0	
6	3	0	3	0	
7	3	0	3	0	HCA helping from ward
8	3	0	4	0	covering outreach
9	5	0	5	0	
10	3	0	3	0	ITU covering Outreach bleep
11	3	0	3	0	
12	3	0	3	0	
13	3	0	3	0	
14	3	0	3	0	
15	4	0	4	0	
16	3	0	3	0	
17	3	0	3	0	
18	3	0	2	0	no patients, helping on the ward
19	2	0	2	0	
20	2	0	2	0	
21	1	0	1	0	No patients. Site practitioner to assist if admission
22	2	0	2	0	
23	2	0	2	0	
24	3	0	3	0	covering outreach
25	1	0	1	0	No Pts. Site Prac to assist if admission
26	3	0	1	0	One on call No PT
27	1	0	1	0	one pt at night
28	2	0	2	0	
29	2	0	2	0	
30	2	0	2	0	
31	2	0	2	0	no pt staff to help burns ward +Outreach bleep
ITU NT	79	0	76	0	
HOURS	**948**	**0**	**912**	**0**	
Percentage Achieved			**96.2**	**0**	

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**146-14**
Report from:	**Stuart Butt, Interim Director of Finance & Commerce**
Author:	**Dean Janes, Coding and Contracts Manager**
Report date:	**18 June 2014**
Appendices:	**A: Performance Report** **B: Exception Report** **C: Glossary**

Operational performance: targets, delivery and key performance indicators

Key issues

1. Trust income from patient activity was above plan in Month 2.
2. Demand in the form of referrals remains static and first outpatients remain static however inpatient and outpatient waiting lists show signs of increasing with particularly high additions to waiting list in April.
3. The aggregate 18 week targets were met in month however the Trust failed to achieve the admitted target in two specialities – ophthalmology and other (sleep). There was also one patient on an incomplete pathway who waited over 52 weeks.
4. Two urgent operations were cancelled for a second time in May.
5. One never event was reported in May. The detail of this will be picked up within the quality report.

Implications of results reported

6. There is a potential for increased waiting list pressure if waiting times continue to increase. The higher than usual additions to waiting list in April may have an impact in coming months.
7. Currently the adverse performance against the operational standards highlighted above will not impact on the Trust's Monitor rating however there will be financial penalties applied by commissioners.

Action required

8. Further detail on the failed operational standards is provided within the exception report.

Link to Key Strategic Objectives (delete those not applicable)

- Outstanding patient experience
- Operational excellence
- Financial sustainability

9. 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.

10. More relevant is the adverse impact on patient experience and operational excellence of the 18 week breaches and cancelled operations.

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

- Currently the performance reported in this paper does not impact on either our CQC authorisation or our Monitor rating governance risk rating.

Recommendation

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

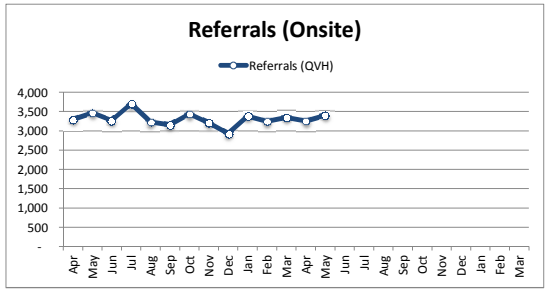
Queen Victoria Hospital NHS
NHS Foundation Trust

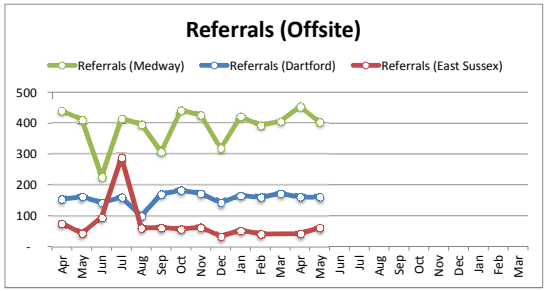
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Stuart Butt

Trust Level Report (All Services)

Period : 2014-15 Month 02 (May)

DEMAND



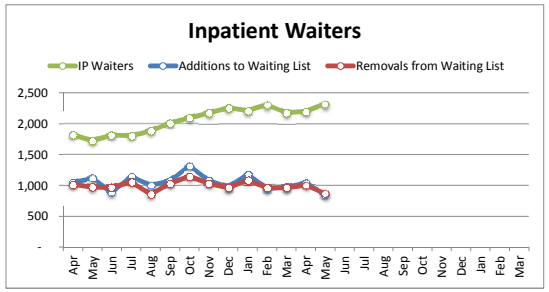


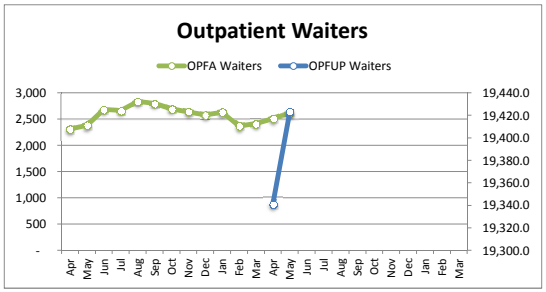
Onsite referrals increased slightly in May but are still lower than referrals in May 2013

Offsite referrals from Medway are lower in May but the number of referrals from East Sussex are higher than usual. Dartford referrals are steady.

Generally, demand (in the form of referrals) is steady and relatively static in May.

WAITING LIST





The number of patients on the inpatient waiting list is at the highest level since April 2013 and has risen for 2 months.

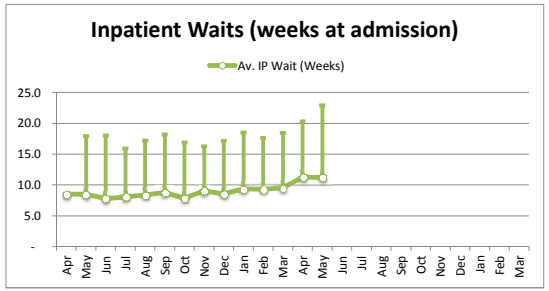
Additions to the inpatient waiting list were particularly high in April.

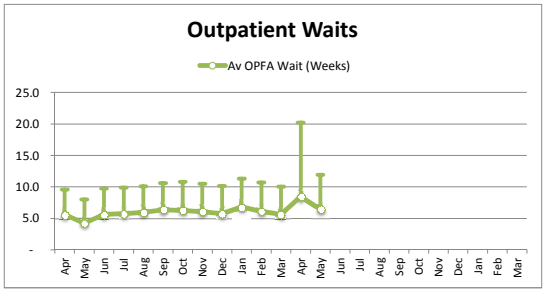
Additions to the waiting list have outstripped removals for two consecutive months.

The number of patients waiting for new outpatient appointments rose for the 3rd month running in May although the new outpatients waiting list is still lower than the peak seen in August 2013.

Patients waiting for an outpatient follow-up rose in May (by almost 100 patients).

WAITING TIMES





Overall average inpatient wait is now 11.2 weeks but has not risen since April (11.3 weeks).
The range of inpatient wait times also increased in May

Average outpatient wait time (for a new appointment) is at 6.4 weeks
The spike in wait time, and corresponding increased variation of wait times, in April looks to have been cleared due to validation of the outpatient PTL.

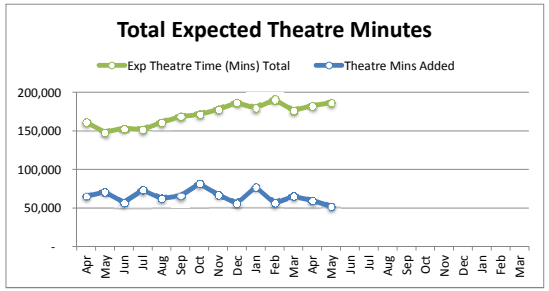
Queen Victoria Hospital NHS
NHS Foundation Trust

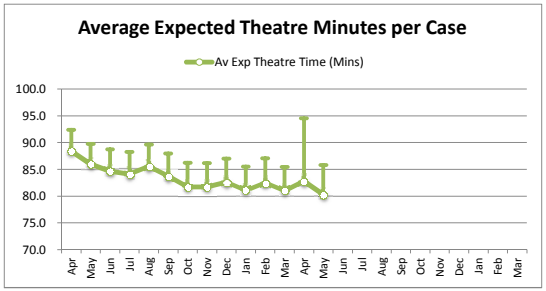
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Stuart Butt

Trust Level Report (All Services)

Period : 2014-15 Month 02 (May)

THEATRE MINS

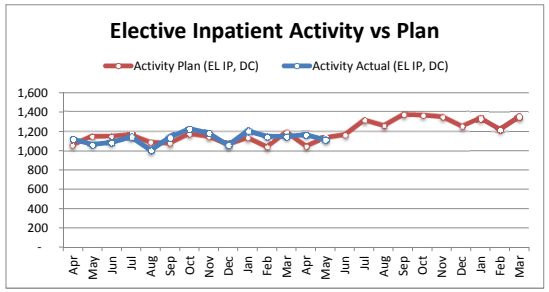


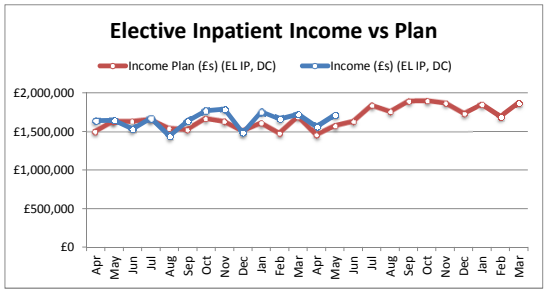


Total expected Theatre Minutes in May remained high
Theatre minutes added in May was the lowest figure since April 2013

Average expected theatre minutes per case (and the range of minutes per case) were low in May.

Elective Inpatients

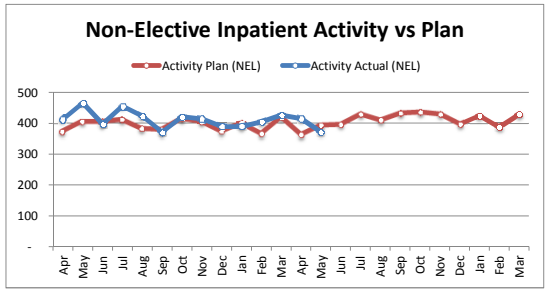


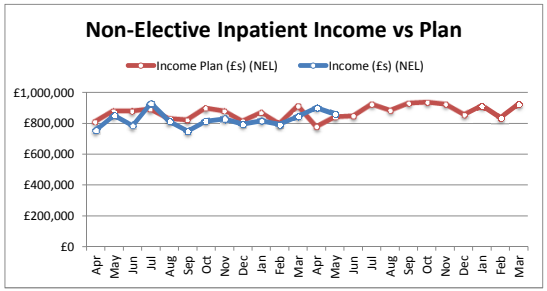


Elective activity was lower than plan in May but income was above plan. We encountered a more-complex-than-planned casemix for Elective work in May.

The higher levels of planned activity, and income, seen from June onwards are representative of the various initiatives around theatres.

Non-Elective Inpatients





Non-Elective activity (spells) were well below plan in May but the corresponding income was only slightly above plan. This suggests a more-complex-than-planned casemix in the month.

Queen Victoria Hospital NHS
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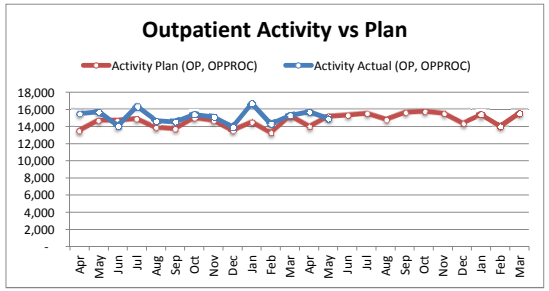
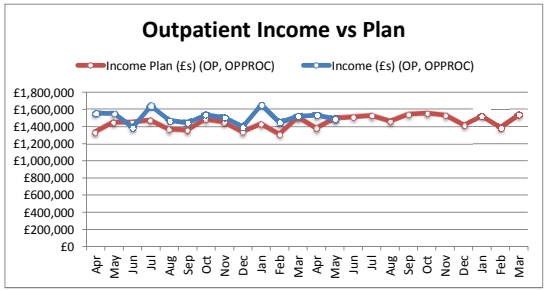
Executive Director: Stuart Butt

Trust Level Report (All Services)

Period : 2014-15 Month 02 (May)

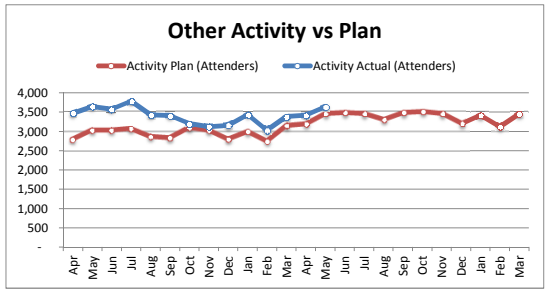
Outpatients

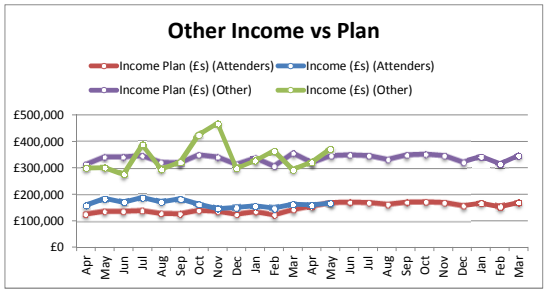




Outpatient activity and income was on-plan in May after being well above plan in April.

Other Activity/Income

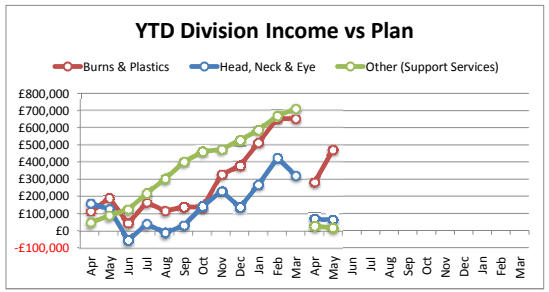


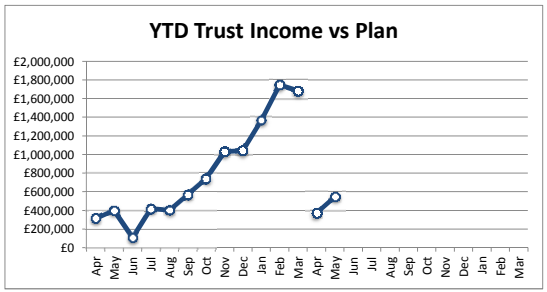


Activity for Attenders (MIU and Diagnostics) was slightly above plan in May, as was the corresponding income.

Drugs and Devices income in May pushed "Other Income" above plan. Non-Burns critical care was on-plan for the month (and the year so far)

Income vs Plan





Trust Income versus plan rose in May

Head, Neck and Eye and Support Services were on-plan but supplemented by a strong performance in Burns and Plastics in May.

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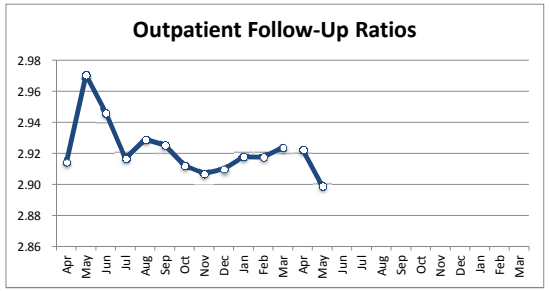
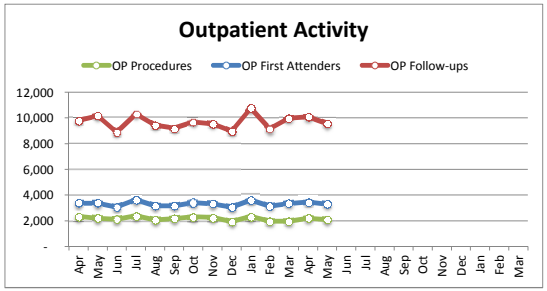
Follow-up Ratios

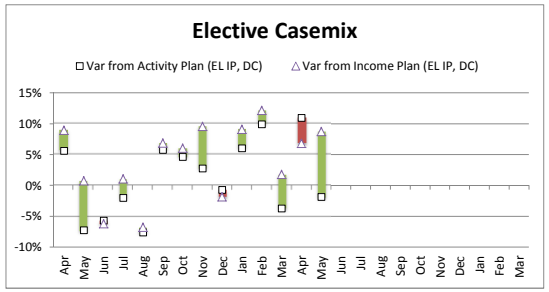


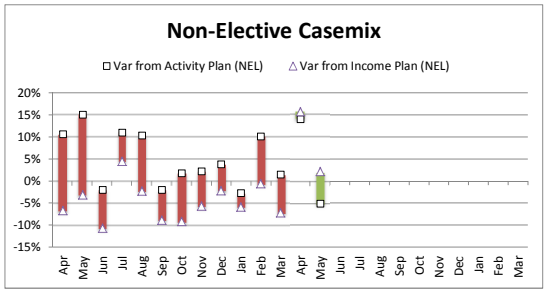


The overall Trust outpatient follow-up ratio fell to the lowest level since April 2013 but targets are all defined at specialty level.

Outpatient first attenders and follow-ups dropped in May.
The level was outpatient procedures remained steady.

Case Mix





Elective casemix was more complex than planned in May

Non-Elective casemix was also more complex than planned but income was under-plan due to low levels of activity.

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

KPIs in-Month

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%	90.8%	FINAL	£400 per breach	Monthly
CB_B2	Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	95%	96.6%	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%	92.4%	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%	99.5%	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 ser	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	1	estimate	£5,000 per Service User (incomplete RTT pathway waiting over 52	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	2	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 unti	Monthly
NEVER	Never Events	0	1	FINAL	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%										
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%										
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%										
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%										
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%										
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%	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	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%	96.6%	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%	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%	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%	TBC										
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%	TBC										
0	CB_B18	0	0	0	0	0	0	0	0	0	0	0	0	TBC	TBC										
0	CB_A15	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	CB_S6	0	0	0	0	0	0	0	0	0	0	0	0	0	1										
99%	DQ1A	99.2%	99.3%	99.4%	99.4%	99.4%	99.4%	99.5%	99.5%	99.5%	99.6%	TBC	TBC	TBC	TBC										
99%	DQ1B	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	TBC	TBC	TBC	TBC										
95%	DQ2	98.0%	98.5%	98.4%	98.1%	98.1%	98.2%	98.1%	98.2%	98.2%	98.3%	TBC	TBC	TBC	TBC										
0	CB_S10	0	0	0	0	0	0	5	5	0	0	0	0	0	2										
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%										
TRUE	FORM	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										

We achieved the RTT18 aggregate targets for the month.

6-week Diagnostic wait times were achieved in April.
Cancer wait times for May were achieved. The 62 day screening target was not achieved in April but the de minimis is 5 cases for the quarter (1.5 in April) so this is not reportable (to Monitor) for Q1.
VTE assessment score for April and May
Data Quality metrics only available at the SUS post-reconciliation inclusion date to will be reported in arrears. We are expecting to achieve these metrics.
There were no Never Events in April although one is reportable in May.
The target for "No urgent operation should be cancelled for a second time" was failed - we reported 2 such cases in May. The data source is the monthly SITREPs (submitted nationally).
There was one reported 52+ week waiter for May.

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Trust Level Report (All Services)
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14/15 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	Q1 Perf	Q1 Achieved	Q1 Scoring	Q2 Perf	Q2 Achieved	Q2 Scoring	Q3 Perf	Q3 Achieved	Q3 Scoring	Q4 Perf	Q4 Achieved	Q4 Scoring	
M1C	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	90.5%	Achieved		0.0%			0.0%			0.0%			
M2C	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	95.1%	Achieved		0.0%			0.0%			0.0%			
M3C	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	92.4%	Achieved	0	0.0%		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	#DIV/0!		0	#DIV/0!		0	#DIV/0!		0	
M5E	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	92.3%	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	66.7%	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	97.6%	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	96.6%	Achieved	0	#DIV/0!		0	#DIV/0!		0	#DIV/0!		0	
M11H	Cancer 2 week (all cancers)	93%	1.0	96.6%	Achieved		#DIV/0!			#DIV/0!			#DIV/0!			de minimis <5 cases per Quarter
M12H	Cancer 2 week (breast symptoms)	93%	1.0	DM	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											
						0			0			0			0	

13/14 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	Q1 Perf	Q1 Achieved	Q1 Scoring	Q2 Perf	Q2 Achieved	Q2 Scoring	Q3 Perf	Q3 Achieved	Q3 Scoring	Q4 Perf	Q4 Achieved	Q4 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	

2014-15 Q1 Monitor Targets and Indicators

For the 2014-15 QUARTER 1 Monitor Risk Assessment Framework Return we can, currently, only confirm RTT18 scores for April and May and Cancer scores for April.
We achieved the RTT18 aggregate targets for the month but a failure in any month in the quarter means a failed quarter overall, so there is a residual risk against failure in Q1

Q1 Cancer scores will depend on our May and June figures (not available at time of publication) but there are currently no concerns based on April scores.

Queen Victoria Hospital NHS
NHS Foundation Trust

RTT18 Update
Board report – 26th June 2014

Performance Exception Report			
Month	May 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 	May In patient aggregate = **90.79 %** against target of 90% Specialities failed: • Corneo (22 out of 178 =87.15 %) • Other (10 out of 95 = 89.5%) May out-patient aggregate = **96.62%** against target of 95% Specialities failed: • Cardiology (1 out of 19 = 94.74%) May - Incomplete Pathways aggregate = **92.45%** against target of 92% Specialties failed • Plastics (227 out of 2190 = 89. 63%) Incomplete RTT pathway waiting over 52 weeks at the end of the relevant month = **1**		
Reason for Variation	The contributing factors to this month RTT breaches were within the following specialties: • Corneo – have lost a clinical fellow since May which has meant that clinic and operating capacity have been reduced. Where possible extra sessions have been provided however a further clinical fellow has subsequently gone off sick which has further compounded the issue. Recruitment for a replacement fellow is underway. • Sleep Studies (Other) speciality also has been impacted by some loss of capacity due to the heating refurbishment in Jubilee as well as seeing a significant amount of increased referrals which has placed pressure on the diagnostic part of the service. • Oral Surgery - Significant capacity issues with Middle and junior doctor grades within Max Fac due to a number of vacant posts / sickness which is impacting on clinics and IMOS surgery in particular. Plus there has been a lack of capacity to provide treatments in Orthodontics due to vacancies and increase in demand.		

	• Plastics – majority of the capacity issues within this specialty relate to long waiters within the Hand surgery team which are consultant to do cases. In addition there was a gap in cover following consultant retirement and the new replacement starting. Also Plas X list capacity has been reduced to accommodate new consultant job plans which will be reinstated when Theatre 11 opens later this year. In May one patient has an open pathway over 52 weeks for the following reason • A patient was referred to us for treatment from BSUH at week 49 in their pathway following delays at Brighton in obtaining test results. Whilst it was a QVH consultant seeing the patient at Brighton it was their responsibility to manage the patient pathway at that time and the team here was not alerted to any concerns. As BSUH had no theatre capacity QVH accepted the patient for treatment in order to prevent any further delays to their care. Discussions surrounding reallocating this breach to Brighton are taking place and QVH is currently awaiting a response from BSUH.
Impact	**Patient Outcomes / Experience**
	Longer patient waits
	Financial Position
	Financial penalty applied by CCGs is forecast to be circa £ 31K (tbc)
	Monitor Targets / Contractual Requirements
	Exception report submitted to CCG and Monitor Impact on Monitor risk rating – green however it should be noted a third consecutive quarter failure in Q1 of 14/15 would place organisation ' under review'
Actions to be taken to address variation and ensure all specialities continue to maintain performance	**Sleep** • Locum consultant for Sleep Studies is in place providing 4 more clinics a week – now being made substantive. • 7th night opening during Q1 is planned. • Daytime CPAP treatment and fitting continues **Corneo** • Extra LA operating sessions have been organised between April through to October on Saturdays (once a month) and likely to continue for 6 months • Extra sessions for complex corneo procedures are in place to secure further additional capacity to reduce backlog for these particular procedures • Locum Associate Specialist for 5 sessions a week is now also being used to backfill clinical fellow sessions as well • Full time Orthoptist post starts in July to further increase outpatient capacity within the specialty **Plastics** • Extra Saturday operating for Plastic Surgery are planned between April and October with all junior doctors in place. • Th 11 DC LA capacity o Due to delays in recruitment of additional staff the plans to open up all 7x LA DC sessions in a further theatre in the old complex are not possible from July. However operational team is exploring options to open as many sessions as possible during July and Aug based on safe staffing levels. Almost all staff will be place by Sept to enable Th 11 to open fully • Replacement for retired hand consultant and new Orthoplastic post have now started plus overall Hand theatre capacity has been increased from June.

- New Senior Hand fellow to start in Sept to coincide with Th 11
- Review of Hand cases being undertaken by consultants to see if any can be passed onto registrars / fellows or onto new consultant posts
- Breast cases continue to be pooled within Plastics to reduce waiting times of other breast consultants
- Locum breast consultant in place providing additional consultant operating for breast cases.
- Plans for replacing retiring Burns Consultant post in Sept well underway and is now out to advert

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 Aug (depending on recruitment of additional staff in Theatres) Trust plans to create one extra IMOS 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, additional nursing hours to support additional clinic as well as exploring a locum consultant post x 1 day a week to reduce waiting times

Intensive Support Team (IST)

IST recommendations have now been prioritised into a detailed action plan. A summary of the key actions provided outlined in the table overleaf

	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	Will be completed by July 2014
2	Central referral point has been recommended	Will be in place by 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 later in June
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 July
5	Review demand and capacity using IST developed tools with their support	Plastics Directorate analysis is complete and being used. All other specialties to be completed by July
6	Implement process for booking pre-assessment and surgery date at same time (with 3 weeks apart)	Being discussed at pre-assessment meeting on the 19th June
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 patients is to be put into effect from July
9	Trust to introduce partial booking for follow up appointments – will need to purchase software to make this possible	Procurement being commenced – part funded by Safer Hospital, Safe Wards Technology funding

General actions for all areas

- Validation to continue - proposal put forward to substantively increase hours for pro-active validation as well as complete a one off validation of all open pathways to be complete by the end of July.
- Discussing with theatre about not giving up lists until last possible minute when we know we have a surgeon to allow patients to be booked thus maximizing capacity for each specialty.
- Focus on improving Theatre start times in theatres to facilitate adding smaller cases on at start on end of list where possible
- Ensure clinics are coded as patient attended more promptly and accurately, particularly with regard to off-sites.
- 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 has now been developed to monitor peaks in referrals and conversion rates to assist capacity planning

Forecast position for June and return to plan

For June the Trust will also be reporting a further 2 x 52 week breaches

- 2 breaches are confirmed in Orthodontics – these breaches have arisen due to an administrative error, whereby the wrong clinic outcome code had been completed at the time of their 1st appointment. This error only came to light following IST recommendations to redesign the 18 week patient tracker. As soon as the error was identified the patients have been booked for treatment this month, staff have been alerted and trained again. In addition the rest of the Orthodontic waiting list is being validated urgently

In addition during June there is a risk that the Trust will not achieve the inpatient aggregate target due to peaks in trauma and elective demand, clinical priority for cancer cases, shortages of staff and continued reductions in backlog in all specialities.

The Directorates are continuing to proactively manage waiting lists through weekly operational meetings and increasing capacity to reduce waiting times where possible. The Trust has predicted for Q2 that QVH will fail the inpatient aggregate as backlog clearance is expedited to coincide with the additional staff and LA DC operating sessions in order to achieve a long term sustainable 18 week position. 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 exact plan and modelling of this is being done in conjunction with the support of the IST and will be made available towards the end of June.

Forecast outturn	Forecast for end of year incorporating YTD 2014 figures are as follows • Inpatient Trust aggregate = 90.24% against target of 90% • Outpatient Trust aggregate = 96.22% against target of 95% • Open Pathways aggregate = 95.6% against target of 92%
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.

Glossary

The following is intended to provide guidance when reviewing the charts in this report:

Data Area	Chart Name	Detail
Demand	Referrals (Onsite) Referrals (Offsite)	These charts indicate overall demand for our services from external sources i.e. referrals into QVH East Grinstead (onsite) and referrals into Dartford, Medway and East Sussex (offsite). N.B. Dartford does not provide referral data therefore first outpatients are used as a proxy for referral data. Included in the data are referrals from: • GPs • General Dental Practitioners (GDPs) • Other A&E departments • Direct Access referrals e.g. to therapy • Consultants at other hospitals • QVH Minor Injuries Unit • Other external health professionals – optometrists, practice nurses etc. Excluded from the data are: • Referrals from our own QVH departments or Consultants – this would not necessarily indicate 'new' demand For context, the specialities that receive the highest number of referrals in order are: maxfac, hands, physio, burns, skin, sleep, breast.
Waiting List	Inpatient Waiters	The purpose of this chart is to show the total elective 'order book'. This chart is not intended to be used to measure the management of waiting lists or waiting times – it simply represents the totality of the work the Trust has committed to undertake. IP waiters = In Patient waiters: the number of patients waiting for an elective procedure irrespective of whether they have a To Come In (TCI) date or not. This chart includes planned patients. It is a snapshot taken monthly. Additions to Waiting List = the number of patients who were added to the waiting list in the month, again irrespective of whether they have a TCI date or are planned. Removals from Waiting List = the number of patients who were removed from the waiting list in the month either through admission or for another reason.

Data Area	Chart Name	Detail
		Additions and Removals from the waiting list do not contain "planned" patients, whereas the numbers of inpatients reported on the waiting list does. This means, where additions and removals are very similar, you *can* see a disproportionate increase/decrease in the size of the total waiting list (IPs) due to the addition/removal of planned patients. These latter two data items, additions and removals, will reflect to some extent the number of working days in the month.
	Outpatient Waiters	The purpose of this chart is to show new demand waiting to be seen i.e. referrals have been received and a decision has been made to see the patient. This is a key indicator as a percentage of these patients will convert to requiring surgery. (See 'Activity Ratios' section later). Therefore changes in the profile of this chart can impact on the profile of the inpatient waiting list as well as affect outpatient waiting times and 18 weeks. It is important to note that physio appointments are included here as the 3rd highest volume of referrals. These appointments are much less likely to affect the inpatient waiting list profile. OPFA waiters = Outpatient First Attendance waiters: the number of patients waiting for a first outpatient appointment. OPFUP waiters = Outpatient Follow-up waiters: the number of patients waiting for a follow-up outpatient appointment.
Waiting Times	Inpatients (weeks wait at admission)	The purpose of this chart is to show how long patients wait on average to be admitted. This is for all patients admitted irrespective of whether they were planned or not. Again, this is not intended for management of waiting time standards such as 18 weeks but to show experience of waits for all patients. The black lines represent the range of wait times in the month, but exclude extreme cases, by means of displaying one *standard deviation* from the mean (average). Approximately two-thirds of all our wait times should exist within this range (one standard deviation). Av. IP Wait (weeks) = Average In Patient Wait in Weeks: this is the average length of time, in weeks, patients who were admitted in the month waited from being added to the waiting list to being admitted.
	Outpatients	The purpose of this chart is to show how long patients wait on average for their first outpatient appointment. The black lines represent the range of wait times in the month, but exclude extreme cases, by means of displaying one *standard deviation* from the mean (average). Approximately two-thirds of all our wait times should exist within this range (one standard deviation). Av OP Wait (weeks) = Average Outpatient Wait in weeks: this is the average length of time, in weeks, patients who had their first

Data Area	Chart Name	Detail
		outpatient appointment in the month waited from referral.
Theatre Minutes	Total Expected Theatre Time (Estimated) - Minutes	The earlier waiting list charts showed how many individual patients are waiting for surgery. The purpose of this chart is to show how many minutes of theatre time are committed on the total elective 'order book'. This measure is more sensitive to complexity than just numbers of patients. It represents exactly the same cohort of patients in the waiting list charts therefore it is not intended to be used in the management of waiting time standards such as 18 weeks. Exp Theatre (Mins) Total = total number of estimated minutes on the waiting list for elective procedures. This is a snapshot taken each month. Theatre Mins Added = in month, the number of theatre minutes added to the waiting list for elective procedures. This will, to some extent, be affected by the number of working days in the month.
	Average Expected Theatre Time (Estimated) - Minutes	The purpose of this chart is to show whether the cases being added to the waiting list are changing in complexity (where theatre time required for procedure is the proxy measure used for complexity). Av Exp Theatre Time (Mins) = for the elective theatre cases added in month this is the average time allocated per procedure. The *range* of Expected Estimated Theatre Minutes per case is shown by the black lines – representing one *standard deviation.*
Elective Inpatients	Activity	The purpose of this chart is to show whether the Trust's elective activity is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. Activity Plan (EL IP, DC) = this is the activity plan in the units of elective in-patient admissions (min. overnight stay) and day cases. Activity Actual (EL IP, DC) = this is the actual activity that occurred during the month in the units of elective in-patient admissions (min. overnight stay) and day cases.

Data Area	Chart Name	Detail
	Income	The purpose of this chart is to show whether the Trust's elective activity when priced using the national tariff (or locally agreed prices where applicable) is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. Income Plan (£s) (EL IP, DC) = this is the income plan derived from the activity (above) in the units of elective in-patient admissions (min. overnight stay) and daycases. Income (£s) (EL IP, DC) = this is the actual income derived from the activity (above) in the units of elective in-patient admissions (min. overnight stay) and daycases.
Non Elective Inpatients	Activity	The purpose of this chart is to show whether the Trust's non-elective activity (locally referred to as trauma) is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. Activity Plan (NEL) = this is the activity plan in the units of non elective in-patient admissions. Activity Actual (NEL) = this is the actual activity that occurred during the month in the units of non elective in-patient admissions.
	Income	The purpose of this chart is to show whether the Trust's non elective activity when priced using the national tariff (or locally agreed prices where applicable) is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. In this particular instance, the plan has a significant step increase between 2012-13 and 2013-14. This is because the income plan now includes the previous block contract for burns activity. The burns activity was always included in the activity charts but zero-priced as a separate commissioning body was invoiced a block amount for this work. This changed on 1st April 2013. Income Plan (£s) (NEL) = this is the income plan derived from the activity (above) in the units of non elective in-patient admissions. Income (£s) (NEL) = this is the actual income derived from the activity (above) in the units of non elective in-patient admissions.

Data Area	Chart Name	Detail
Outpatients	Activity	The purpose of this chart is to show whether the Trust's outpatient activity is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. This includes all forms of outpatients – new, follow up and procedures. Activity Plan (OP, OPPROC) = this is the activity plan in the units of outpatient new, follow up and procedures. Activity Actual (OP, OPPROC) = this is the actual activity that occurred during the month in the units of outpatients new, follow up and procedures.
	Income	The purpose of this chart is to show whether the Trust's outpatient activity when priced using the national tariff (or locally agreed prices where applicable) is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. This includes all forms of outpatients – new, follow up and procedures. Income Plan (£s) (OP, OPPROC) = this is the activity plan in the units of outpatient new, follow up and procedures. Income Actual (£s) (OP, OPPROC) = this is the actual income derived from the activity.
Other	Activity	The purpose of this chart is to show whether the Trust's activity falling outside of the aforementioned categories is meeting, exceeding or falling short of the plan each month. The chart represents two years' worth of data to easily identify any plan changes year on year. The step change in the plan between 2012-13 and 2013-14 was the unbundling of outpatient diagnostics from the outpatient appointment itself and the requirement to count, and charge for, these separately. Attenders cover: • MIU attenders (walk in patients); and • Radiology Attenders (direct access patients, outpatient diagnostics [because these are now unbundled from tariff] and AQP ultrasound) Activity Plan (Attenders) = this is the activity plan for this cohort of patients. Activity Actual (Attenders) = this is the actual activity that occurred during the month for this cohort of patients.

Data Area	Chart Name	Detail
	Income	The purpose of this chart is to show whether the Trust's activity falling outside of the aforementioned categories is meeting, exceeding or falling short of the plan each month when priced using the national tariff. The chart represents two years' worth of data to easily identify any plan changes year on year. The step change in the attenders plan between 2012-13 and 2013-14 was the unbundling of outpatient diagnostics from the outpatient appointment itself and the requirement to count, and charge for, these separately. The 'other' category covers income that is not easily related back to single units of activity for e.g. PbR exempt drugs. Income Plan (£s) (Attenders) = this is the income plan for this cohort of patients. Income (£s) (Attenders) = this is the actual income derived from the activity. Income Plan (£s) (other) = this is the income plan for all other chargeable items that do necessarily relate back to a single unit of activity. Income (£s) (other) = this is the actual income derived for this area.
Income vs plan	YTD Divisional Income vs plan	The purpose of this chart is to show income vs plan for all activity outlined above aggregated at Divisional level for the divisions of burns and plastics; head, neck and eye and support services.
	YTD Trust Income vs plan	The purpose of this chart is to show income vs plan at a Trust level.
Follow Up Ratios	Outpatient Follow-up Ratio	The purpose of this chart is to show the overall ratio of Outpatient Follow-ups to Outpatient First Attenders year-to-date but is reset at the start of April each year. For example, our final follow-up ratio for 2012-13 was almost exactly 3:1 (3 follow-ups to every 1 first attender). This is a key indicator because failure to achieve contract target ratios will result in a financial penalty but also excessive follow ups restricts the capacity to see new patients at a higher tariff.
	Outpatient Activity	The purpose of this chart is to show the actual levels of activity for Outpatient First Attenders (OP First Attenders), Outpatient Follow-ups (OP Follow-ups) and Outpatient Procedures each month. This chart is designed to support the Outpatient Follow-up Ratio chart directly before it. The lines show the levels of activity underpinning the ratio.

Data Area	Chart Name	Detail
Activity Ratios	Referrals	The purpose of this chart is to show the ratios between activity and referrals in the month in question. If we have admitted the same number of elective patients, in a particular month, as the number of referrals received in the same month then the ratio would be 1.0 The chart can be used to identify trends in activity **relative to** referrals. High ratios may suggest activity has remained steady whilst referrals have dropped, or referrals have remained steady and activity has increased. The ratios are displayed on 3 lines – one for Outpatient First Attenders *relative to referrals* (Referral->OPFA), one for Elective Admissions or Daycases *relative to referrals* (Referral -> EL/DC) and one for Outpatient Procedures *relative to referrals* (Referral->OPPROC).
	Outpatient First Attenders	The purpose of this chart is to show the ratios between activity and initial assessments (Outpatient First Attenders) in the month in question. If we have admitted the same number of elective patients, in a particular month, as the number of initial first outpatient assessments seen in the same month then the ratio would be 1.0 The ratios are displayed on 2 lines – one for Elective Admissions *relative to Outpatient First Attenders* (OPFA->EL/DC) and one for Outpatient Procedures *relative to Outpatient First Attenders* (OPFA->OPPROC).
Case mix	Elective Casemix	Casemix refers to the *complexity* of the patients we encounter. As a simple proxy for a complexity index we look at the relative performance (vs plan) of activity and income. For example, if activity is 10% **behind** planned levels but income is 10% **higher** than planned then it is fair to infer that the cases encountered yielded more income **per case** than planned. This aforementioned example suggests a lower number of cases than expected, but each case was worth considerably more than planned (£s). Green Bars represent a more *complex casemix* than expected whereas red bars represent a *more simple (or less complex) casemix* than expected. Where complexity is as planned the bar will not be visible – since income variance (from plan) and activity variance (from plan) will be at the same level. This particular chart indicates casemix for Elective Admissions and Daycases together.
	Non Elective Casemix	As above (casemix) but for non-elective admissions (sometimes referred to as Trauma internally).

Report to: Board of Directors
Meeting date: 26 June 2014
Reference number: 147-14
Report from: Stuart Butt, Interim Director of Finance & Commerce
Author: Bill Stronach, Deputy Director of Finance
Report date: 19 June 2014
Appendices: A: Finance Report

Finance Report May 2014

Key issues

The financial performance report to the Board this month details the trust's financial performance for the year to May 2014.

	Plan YTD (£k)	Actual YTD (£k)	Variance to Plan
Turnover	9,192	9,691	499
EBITDA	365	730	366
Surplus	(228)	172	400
Continuity of service risk rating	3	4	1

NB Table subject to rounding differences.

The financial position is ahead of plan by £400k driven by additional activity above the relatively low plan months for April and May

Income

Income is ahead of plan by £499k

The activity plan for April reflected the anticipated impact of the transfer to the four new theatres, the bank holidays and the electrical shut down. Trust staff worked effectively to mitigate the effects of these disruptions and to utilise the capacity that was available to them. This could also be reflected in the May activity recorded.

The income plan assumes 100% achievement of CQUIN. The actual income assumes 50% achievement and this estimate will be revised once the actual performance against targets is known. This is intended to be a prudent assumption rather than reflecting concern over performance. For month 2, 50% of CQUIN is £103k.

Penalties of £72k have been accrued for RTT18 week breaches.

Expenditure

Pay is overspent by £151k but non-recurrent and prior year costs of £189k make the recurrent position favourable.

Non Pay is underspent by £17k which includes a non-recurrent benefit of £89k from prior year contract settlements (with respect to emergency threshold charges)

Cash

Cash balance stands at £5,945k. This is an improvement of £2.29M on the year- end balance of £3,655k because of reduced debt balances.

Continuity of service rating

The Continuity of service rating plan of 3 is for the first quarter, and reflects both the planned deficit of £124k for the quarter and the £389k debt repayment due in June.

The stated actual of 4 is for May. This rating reflects cumulative performance so is adversely affected when the loan repayment is made in June. Should the current level of overperformance continue the rating would rise to 4.

Risks

Key risks are to the achievement of the higher activity plans in future months with optimal utilisation of activity resources, cost control within activity levels and the level of penalties incurred or incentives achieved.

Action required

The paper details the further action required.

Link to Key Strategic Objectives

Financial sustainability, (minimising risks outlined will contribute positively to the financial sustainability KSO).

Implications for BAF or Corporate Risk Register

The corporate risk register should be updated to reflect risks identified in this paper.

Regulatory impacts

Information reported in this paper does not impact on either our CQC authorisation or our Monitor continuity of services rating.

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report – Public
May 2014
Month 2

18 June 2014

Executive Director: Stuart Butt

Contents

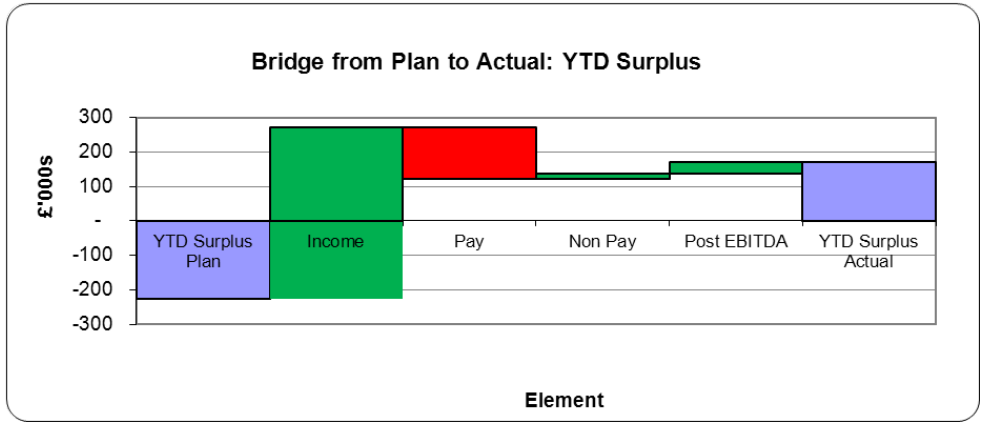
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M2 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure	CM 13-14	Current Month			YTD 13-14	Year to Date		
	Actual £k	Actual £k	Budget £k	Variance £k	Actual £k	Actual £k	Budget £k	Variance £k
Income	*4,881*	5,023	4,760	263	*9,526*	9,691	9,192	499
Pay	*(3,052)*	(3,341)	(3,174)	(166)	*(6,157)*	(6,499)	(6,348)	(151)
Non Pay	*(1,291)*	(1,257)	(1,260)	3	*(2,532)*	(2,462)	(2,479)	17
EBITDA	*538*	425	326	99	*837*	730	365	366
EBITDA %	*11.0*	*8.5*	*6.9*	*1.6*	*8.8*	***7.5***	*4.0*	*3.6*
Post EBITDA	*(257)*	(263)	(296)	33	*(526)*	(558)	(592)	34
Donated assets		-	-	-		-	-	-
Surplus (Deficit)	***281***	**163**	**30**	**133**	***310***	**172**	**(228)**	**400**

Continuity of Service Risk Rating	Metric	Level 4 threshold			Score	Weighted score	
Liquidity days	43	0			4	50%	2
Debt Service Cover	3.9	2.5x			4	50%	2
Combined Score			1	2	3		**4.0**



Summary

- The Trust has achieved a surplus of £163k that includes a net charge of £90k for non-recurrent costs and credits. The underlying surplus is £253k compared with £281k last year.
- Non recurrent charges include prior year costs, pay settlements and provision adjustments associated with our NHS contracts.
- The reported surplus is consistent with achieving a Monitor Continuity of Service Rating of 4 for the quarter against a plan of 3. Achievement of this rating is subject to month 3 performance.

Issues

- Income year to date includes adjustments for:
  - CQUIN of £103k, accrued at 50% as is standard practice for the trust until the value is known with greater certainty
  - Penalties and challenges of £72k
  - Reducing the ERT penalty by £127k against the plan, reflecting expected commissioner payments.
- Pay year to date includes non-recurrent and prior year costs of £189k, making the recurrent position favourable.
- Non pay includes the benefit of £89k following the settlement of outstanding emergency threshold charges from 2013-14.

Risks.

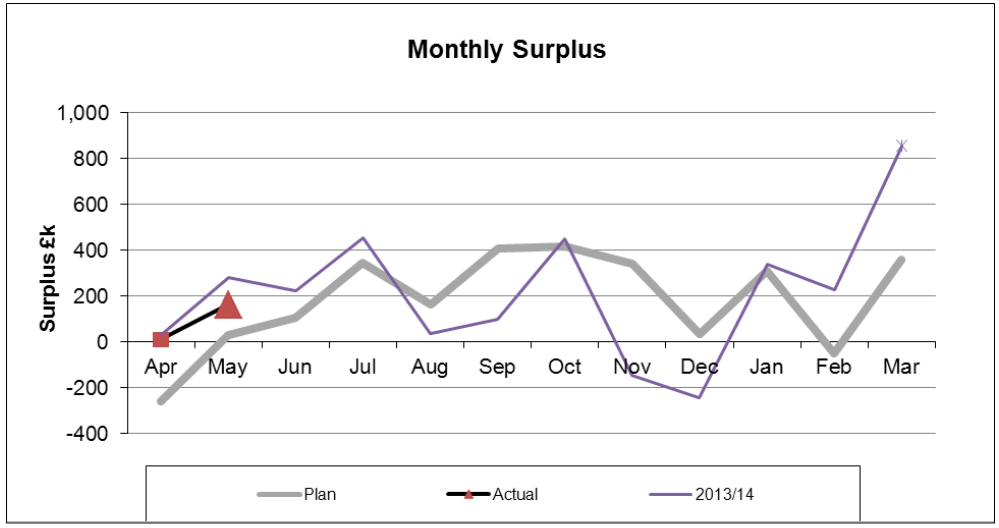
- Key risks are to the achievement of the higher activity plans in future months, cost control and the level of penalties / incentives.

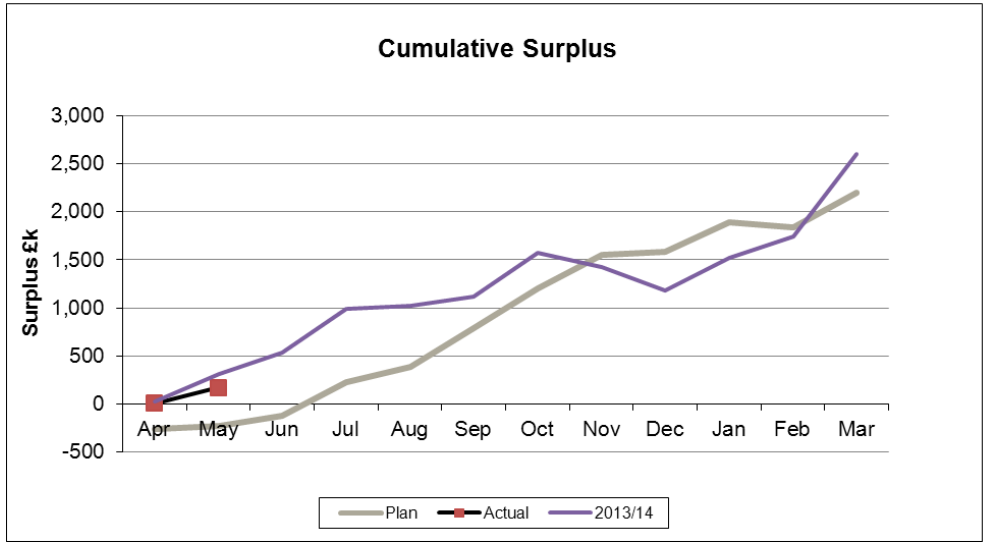
Actions

- Ensure additional capacity is established and utilised to deliver planned levels of activity.
- Ensure delivery against targets such as CQUIN and RTT18.
- The review and continuation of cost control measures.

Summary Trend Position - M2 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust





Summary

- The cumulative surplus is ahead of plan at M2 and has provided for a CoSRR of 4.

Issues

- Our financial plans show the requirement to deliver an increasing surplus in the coming months and reflects the phasing of additional activity.
- 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 therefore surplus..

Risks

- The achievement of our activity plans for the agreed investment is critical to delivering future contributions.

Actions

- The resourcing and timing of additional activity/investment plans is currently the subject of a detailed review and will be subject to routine monitoring by the senior management team.

Pay Analysis – M2 2014/15

Queen Victoria Hospital NHS Foundation Trust

Pay Costs By Staff Group	Current Month Variance £'000	YTD Month 2 Actual £'000	Budget £'000	Variance £'000
Clinical Staff				
Consultant (Including locum)	(1)	1,249	1,215	(33)
Junior medical (Including locum)	(33)	872	812	(60)
Nursing (including bank)	87	1,348	1,491	143
Scientific, therapeutic and technical	(19)	1,045	1,019	(26)
Healthcare assistants	10	265	282	17
Agency:				
Agency other medical	(6)	15	9	(5)
Agency nursing & HCA, other	(23)	31	1	(30)
RMN agency (for recharge)	(1)	28	34	6
Agency scientific, T&T	(14)	27	6	(21)
TOTAL CLINICAL STAFF	**(2)**	**4,880**	**4,869**	**(11)**
Non-Clinical Staff				
Chair & Neds	2	16	20	4
Executives	(98)	170	72	(98)
Admin & clerical	(33)	1,140	1,116	(23)
Maintenance & support	(0)	229	232	3
Agency non-clinical	(35)	65	40	(25)
TOTAL NON-CLINICAL STAFF	**(165)**	**1,619**	**1,479**	**(140)**
TOTAL STAFF COSTS	**(166)**	**6,499**	**6,348**	**(151)**

Summary

- Pay is showing as overspent by £151k, within this £138k of spend is non-recurrent cost and fully provided for within existing budgets.
- A further £51k relates to 2013/14 costs notified late in relation to payments to our medical staff.

Issues

- Consultant overspend is caused by back pay so is not expected to recur at this level.
- Junior medical includes unplanned cover for absence and back pay so again is not expected to continue at this level although there is further work to control this spend.
- Nursing continues to underspend and offsets with the relevant agency costs.
- Scientific costs reflected expenditure in theatres but this is more than offset by savings in nursing.

Risks

- There is a need to identify the underlying areas of over spending and address at a cost centre level.

Actions

- Revised controls for additional staff and better management of ad-hoc payments.

Non Pay Analysis – M2 2014/15

Queen Victoria Hospital NHS Foundation Trust

Expense Category	YTD Actual £k	YTD Budget £k	YTD Variance £k	%Variance	YTD Month 2
DRUG EXPENSES	201	183	**-18**	-10%	12k over on Anaesthetics
CLINICAL SUPPLIES & SERVICES EXPENSES	1,440	1,442	**3**	0%	Under spend on medical equipment & prostheses. Over on activity related sleep studies equipment and Oph. lenses.
GENERAL SUPPLIES & SERVICES	81	78	**-3**	-4%	
ESTABLISHMENT EXPENDITURE	314	301	**-14**	-5%	Transport (Patient Taxis) & general travel claims. Histology accreditation costs.
PREMISES AND FIXED PLANT	421	383	**-38**	-10%	Energy - Gas Costs, computer maintenance,
OTHER NON PAY EXPENSES	12	93	**81**	87%	Released 13-14 income provision of £114k.
RESEARCH AND DEVELOPMENT	-6	0	**6**		
	2,462	**2,479**	**17**	**1%**	

Summary

- Overall positive variance of £17k, although there is £86k net benefit from prior year and non-recurring items that makes the variance adverse £69k. The net adverse variance reflects increased activity.

Issues

- Non pay costs remain an area for enhanced management attention.

Risks

- Drugs, clinical supplies and premises costs are risk areas but they are also areas where there is potential for cost improvement.

Actions

- Enhanced cost control and cost improvement plan.

Capital – M2 2014/15

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	2014/15 Plan £000s	YTD Spend £000s	Forecast £000s	2014/15 Total Spend £000s
Estates projects				
13/14 Projects:				
Jubilee heating	310	8	302	310
Burns heating	100	-	100	100
Other projects	125	-	125	125
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	17	288	305
Medical Equipment	500	20	480	500
IT Equipment	1,400	60	1,340	1,400
Grand Total	3,300	106	3,194	3,300

Summary

- The trust is behind against its capital plan and work is underway to ensure the appropriate resources are available to deliver to the agreed timetable.

Issues

Capital expenditure and the associated schemes have been delayed although some of the material projects are not scheduled to commence until later in the year.

Risks

- Business cases need to be developed and approved in line with internal and external controls.

Actions

- The trust is currently reviewing the status of all capital projects to better understand the resource requirements and phasing of these developments.

Balance Sheet – YTD M2 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	36,930	37,158
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	36,930	37,158
Current Assets			
Inventories	415	411	416
Trade and Other Receivables	8,939	6,911	7,553
Cash and Cash Equivalents	3,655	5,945	4,852
Current Liabilities	(6,574)	(6,350)	(6,294)
Sub Total Net Current Assets	6,436	6,917	6,527
Total Assets less Current Liabilities	43,647	43,847	43,685
Non-Current Liabilities			
Provisions for Liabilities and Charges	(554)	(582)	(582)
Non-Current Liabilities >1 Year	(8,933)	(8,933)	(8,933)
Total Assets Employed	**34,159**	**34,333**	**34,170**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	15,923	15,760
Revaluation Reserve	6,173	6,173	6,173
Total Tax Payers Equity	**34,159**	**34,333**	**34,170**

Summary

- Net current asset position continues to be strong.

Issues

- Debtors remain at a high level due to delays in CCG payments for over performance although the position is improving and has continued to improve in June.
- Cash balance has improved with the reduction in debtors.

Risks

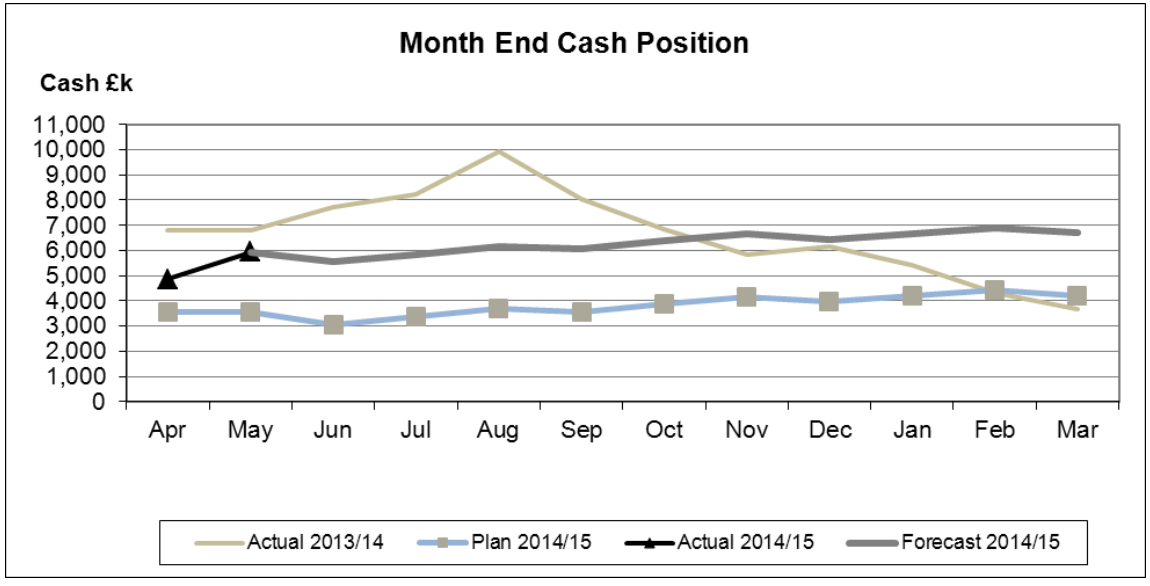
- Continued balance sheet strength relies on surplus performance.

Actions

- Continued focus on the management and collection of disputed/late payments.

Cash – M2 2014/15

Queen Victoria Hospital NHS Foundation Trust



Summary

- Cash is above plan at £5.9m and expected to continue to be above plan for the rest of the year because of the receipt of legacy debt and the reduction in the particularly high level of debt seen at the end of March.

Issues

- Progress on reducing debt and increasing cash has continued in June.

Risks

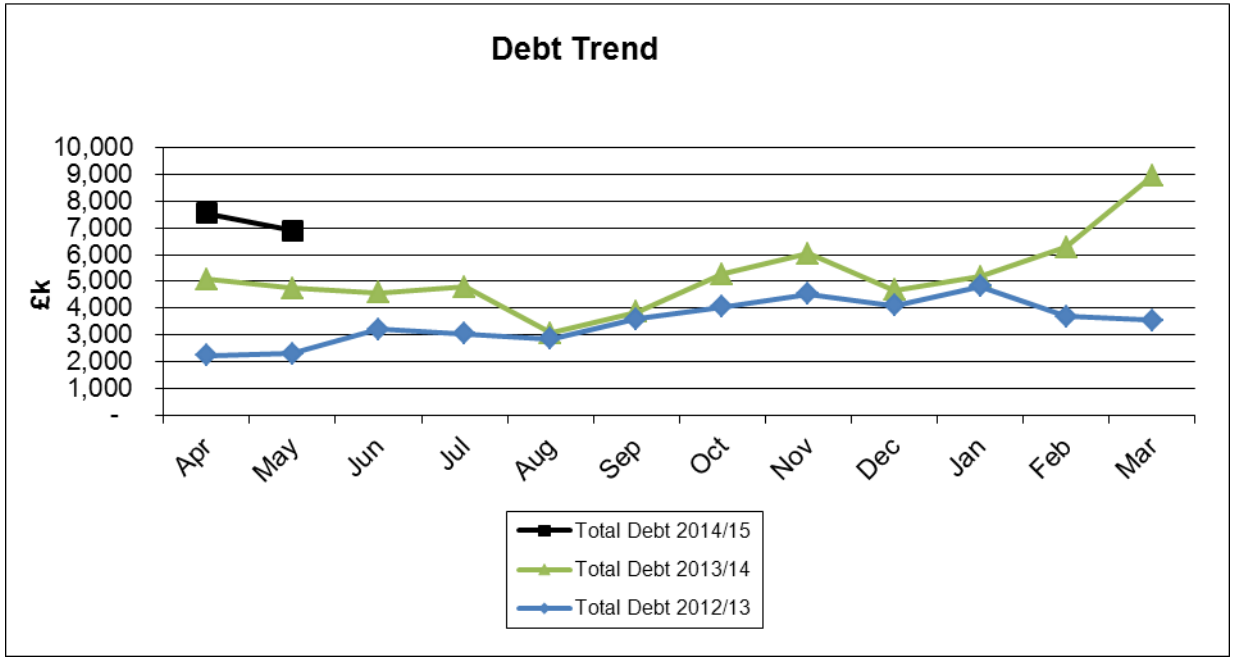
- Future cash balances are materially dependent on the maintenance of the surplus position.
- Future cash balances also reflect the repayments on the theatres loan.

Actions

- Overdue debt is being chased.

Debtors – M2 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust



Summary

- Debt is continuing to fall below the historically high level seen at the end of 2013/14.

Issues

- Contracts for 14/15 don't include the expected growth so any growth will be subject to delayed payment.
- CCGs with smaller activity levels are becoming non contracted activity and this delays payment too.
- Payments received so far in June mean that balances should continue to reduce from June onward.
- Further legacy debt payments of £122k were received in June.
- The reduction in older debt means that a reduction in the bad debt provision is expected.

Risks

- Payment of older NHS invoices.
- Payment of over performance invoices.

Actions

- Overdue debt is being chased.

Creditors – M2 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Better Payment Practice Code May 2014	2013/14 Outturn # Inv's	2013/14 Outturn £'000s	Current Month # Inv's	Current Month £000s	YTD Month # Inv's	YTD Month £'000s
Total Non-NHS trade invoices paid	15,071	21,255	1,219	1,254	2,406	2,455
Total Non NHS trade invoices paid within target	9,386	15,087	692	742	1,516	1,550
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**57%**	**59%**	**63%**	**63%**
Total NHS trade invoices paid	1,082	4,544	68	482	173	966
Total NHS trade invoices paid within target	624	2,858	24	252	65	486
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**35%**	**52%**	**38%**	**50%**

Summary

- Creditor payment performance continues to be disappointing despite attempts to improve performance.

Issues

- The standard report, provided by our finance system supplier, that we use to calculate performance doesn't adequately reflects such issues as disputes and the receipt of credit notes. We are producing our own report that should address this and more accurately reflect performance.
- The trust has sufficient resource to pay promptly and isn't delaying payment.
- Performance is against a 30 day target and late payment of invoices that aren't disputed is usually only a few days late.

Risks

- Payment delays leading to supply problems.

Actions

- Increased resource in place to correct performance.
- Daily action on invoices on hold.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**148-14**
Report from:	**Graeme Armitage, Head of HR & Operational Development**
Author:	**Caroline Haynes, Deputy Head of HR**
Report date:	**17 June 2014**
Appendices:	**A: Workforce Performance Report**

Workforce update - May 2014

Key issues

1. Nursing vacancies represent a quarter of all vacancies and actions are being taken to ensure proactive on-going recruitment is taking place to address this.
2. Bank and agency usage continues to decrease thanks to the control measures put in place earlier this year.
3. The sickness rate for the Trust remains above Trust target due to both short-term and long-term absence cases.
4. The main reason for absence remains Anxiety and Depression.

Implications of results reported

5. Vacancies, sickness absence and bank and agency usage 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.

Action required

8. Continue to deal proactively with nursing recruitment through increased links with local universities, prospective recruitment on Canadian Wing and recruitment from the EU.
9. Continue with the controls for agency and bank usage which require senior management approval for non-clinical and over-establishment cover.
10. Continue to manage sickness absence proactively through collaboration between line managers, Human Resources and Occupational Health.
11. Promote mental wellbeing through various activities including the Positive Minds Day on 10th July 2014.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

12. 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

13. The issues raised at paragraphs 1 – 4 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.

14. 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.

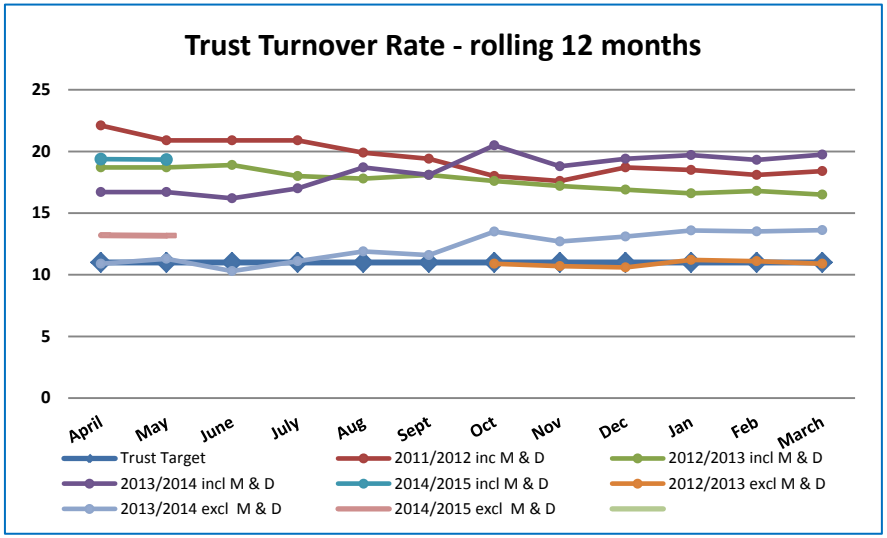
Regulatory impacts

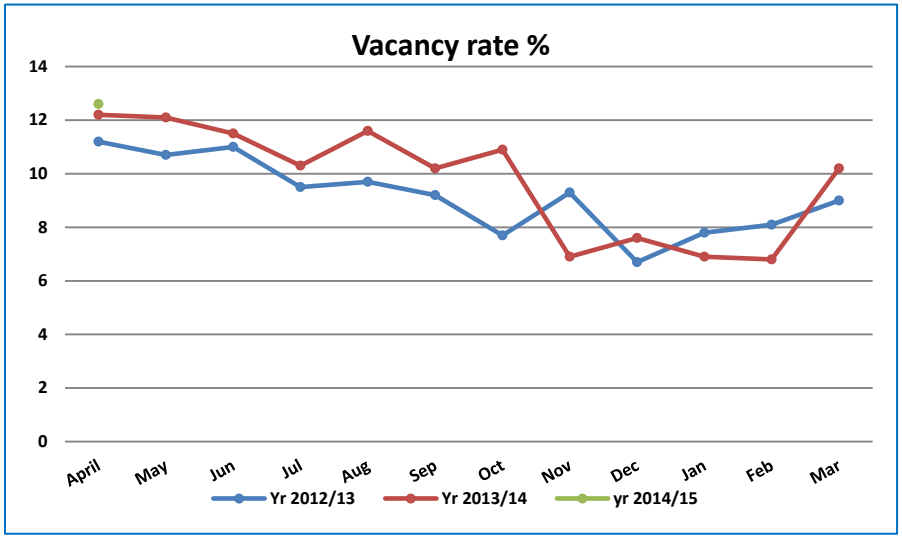
15. Although there is always a potential for staff absences to compromise quality of care and have a detrimental impact on the experience of other staff, it is not felt that the level of staff absence (either through vacancies or sickness absence) prevailing currently is a genuine threat to regulatory compliance. Safety is maintained through use of temporary staff; while this is not sustainable in the long term, it is generally an effective way to ensure that short term staff shortages are managed with minimum impact on patients.

Recommendation

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

HEADLINE HR KPIs June 2014





Staff Movements	Jun-13	July 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14
Headcount	928	937	930	938	942	960	959	967	971	971	966	966
WTE in Post	790	795	788	789	807	819	820	825	823.78	823.78	816.86	816.07
WTE Funded Establishment	867.69	867.69	867.99	867.99	867.99	867.99	867.99	867.99	867.99	867.99	897.51	897.51
New Hires	7	15	37	21	33	12	6	16	29	7	10	7
Leavers	6	13	43	12	24	6	14	11	22	15	9	9
Maternity Leave	13	16	15	18	18	19	21	16	17	19	19	20
Vacancy Rate	11.5%	10.3%	11.6%	10.2%	10.9%	6.9%	7.6%	6.9%	6.8%	10.2%	12.6%	N/A
Turnover Rate	0.86%	1.39%	4.62%	1.27%	2.51%	0.73%	1.46%	1.14%	2.05%	1.65%	0.93%	0.93%

Rolling 12 Monthly Turnover Figures	Jun-13	July 13	Aug 13	Sep 13	Oct13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14
12 Month Turnover (including Medical & Dental)	16.2%	17.0%	18.7%	18.1%	20.5%	18.8%	19.4%	19.70%	19.32%	19.74%	19.38%	19.34%
12 Month Turnover (Excluding Medical & Dental)	10.3%	11.1%	11.9%	11.6%	13.5%	12.7%	13.1%	13.59%	13.51%	13.62%	13.21%	13.17%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 31st May 2014 stayed very similar to last month with only a 0.04% difference to 19.34% (including medical and dental) and by 0.04% to 13.17% (excluding medical and dental).

During May there were 7 new starters to the Trust and 9 leavers (8.31 FTE) with a monthly turnover rate for February of 0.93% (1.02% FTE). Staffing stability is at 96.65%, this indicates that the organisational staffing core is stable.

Medical and Dental have the highest turnover for May with 2 WTE post (1– voluntary resignation – better reward package 1- voluntary resignation – other/not known), followed by Paediatrics at 1.67 WTE (1-voluntary resignation – Incompatible working and relocation). Other reasons for leaving in May were 1 - Voluntary Resignation – lack of opportunities, 1 – Voluntary Resignation – better reward package, 1 - voluntary resignation – promotion, 1-dismissal – capability.

Vacancies Rates (figures 2 month in arrears)

Vacancy rate for April was at 12.6% of which 32 WTE were actively being recruited to. Bank and agency are being used to the total of 47.55 WTE. The reason for this is the need to cover maternity leave (currently 20 employees on maternity leave) and long-term sickness (20 employees with sick leave of 4 weeks or more)

Recruitment

Activity levels for May currently have 40.3 WTE of active vacancies currently being worked on, of which 10.4 WTE are Nursing posts and 10.1 WTE Medical and Dental. Average recruitment timescales remain 5 weeks, from advert to conditional offer letter. Further work still remains to be completed to support managers turnaround their shortlisting's within the 5 working day KPI.

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.

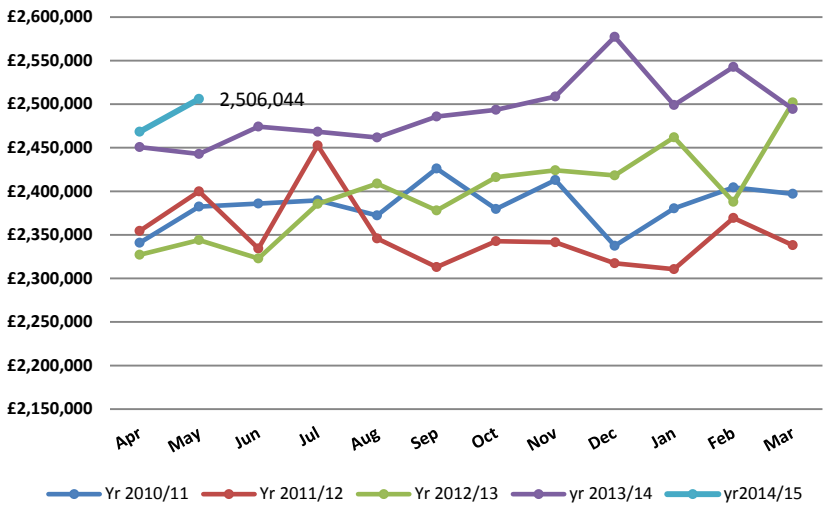
Actions

- 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.
- Progress recruitment from the EU

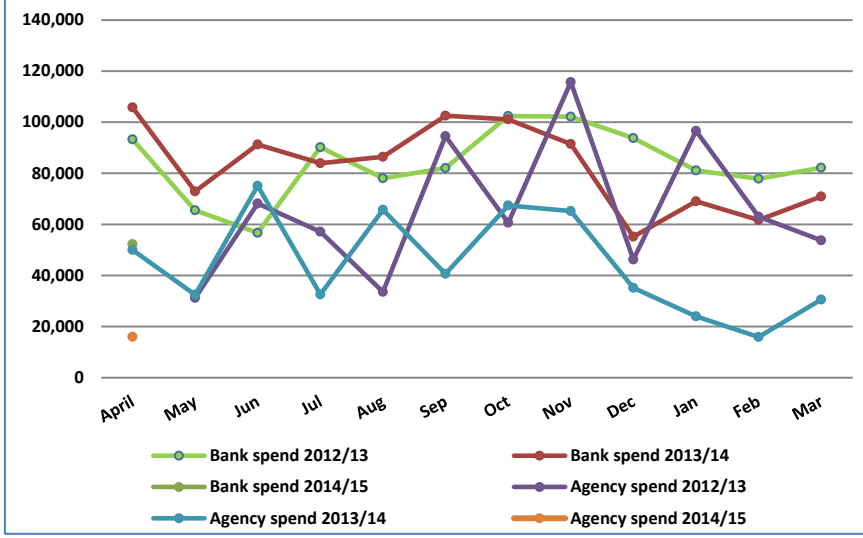
RAG Rating

HEADLINE HR KPIs

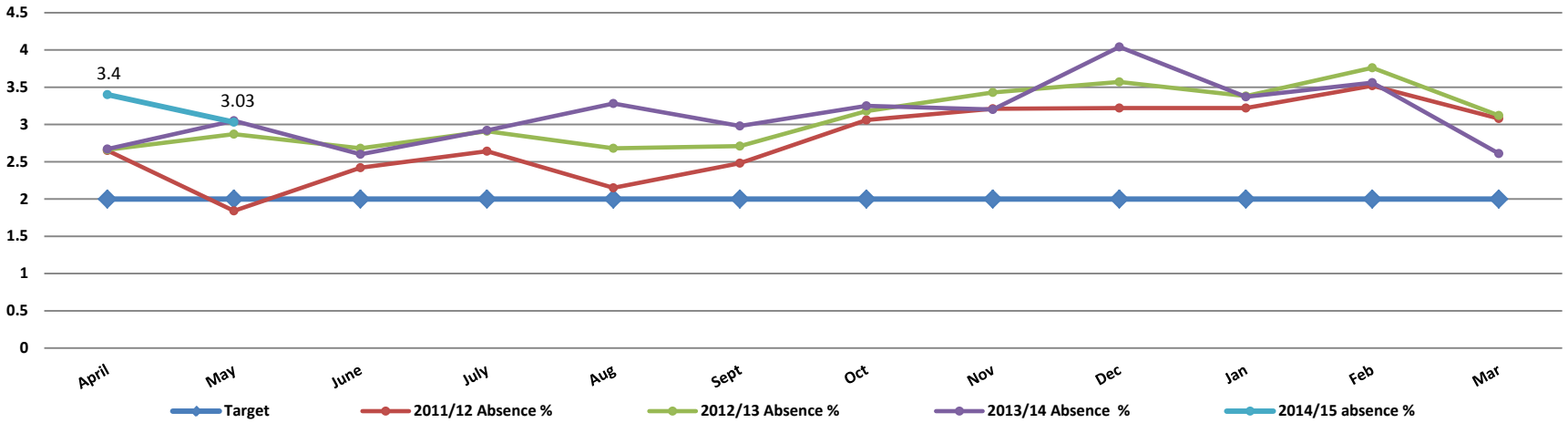
Total Pay Bill per month (excluding on costs)



Bank & Agency Spend



Trust Absence Timeline



HEADLINE HR KPIs

Pay Bill – (1 month in arrears) reported pay does not include on costs.
Pay for May increased slightly to £2,506,044, May has always seen a rise in pay due to budgets being released and payment being made to employees for annual inflation rise (this year a non-consolidated payment has been made).

A breakdown of the split between total staff paid WTE and bank/agency and overtime is reported in arrears and for April 14, shows WTE staff in post was 816.86, total WTE paid 867.9 (inclusive of 36.12 Bank WTE, 11.43 Agency WTE and 3.49 over-time WTE). Tighter monitoring of budgets and robust controls in place for the use of bank and agency workers has seen a significant fall, over the last 6 months bank WTE has fallen from it highest 50.65 WTE in September 2013 and agency from 49.45 WTE.

Bank and Agency usage – (figures are 2 month in arrears)
Bank and agency spend for April was £68,187 a combined decrease of £33,616 over last month, compared to April 2013 when bank and agency spend was £105,778 (55% higher). All departments reduced their bank and agency spend apart from ITU whose expenditure increased due the requirement to cover sickness which stands 8.4%.

Lower bank and agency expenditure in Peanut and Burns was due to acuity being low and wards having adequate staff to patient ratio.

The Bank/agency combined fill rate for April was 68%, this is below Trust Target of 80%, 8335.52 hours (52.28%) were filled by bank and 2501.95 hours (15.69%)were filled by agency.

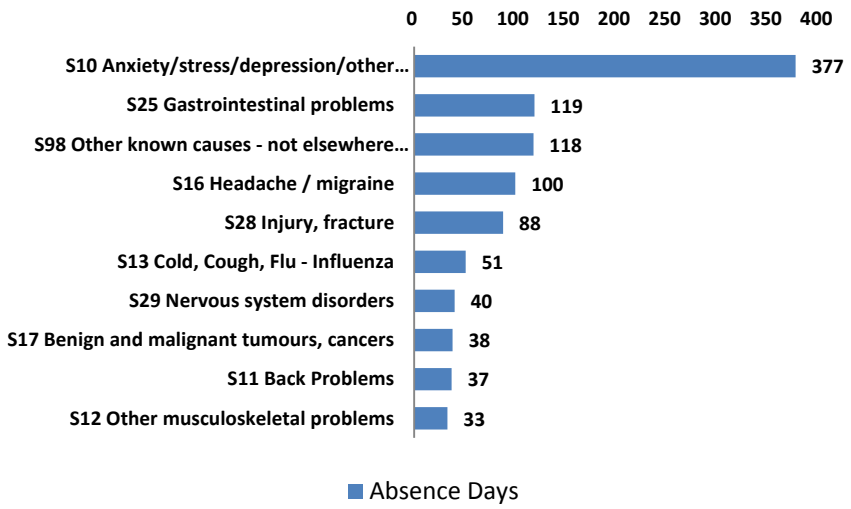
Exception areas
Canadian Wing reduced their bank and agency spend for April to (£16,507), however they are the highest users of bank and agency, exceptions were due to excessive bed occupancy, sickness at 4.5% and vacancies.

Actions

- Monitor controls put in place and review in July 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

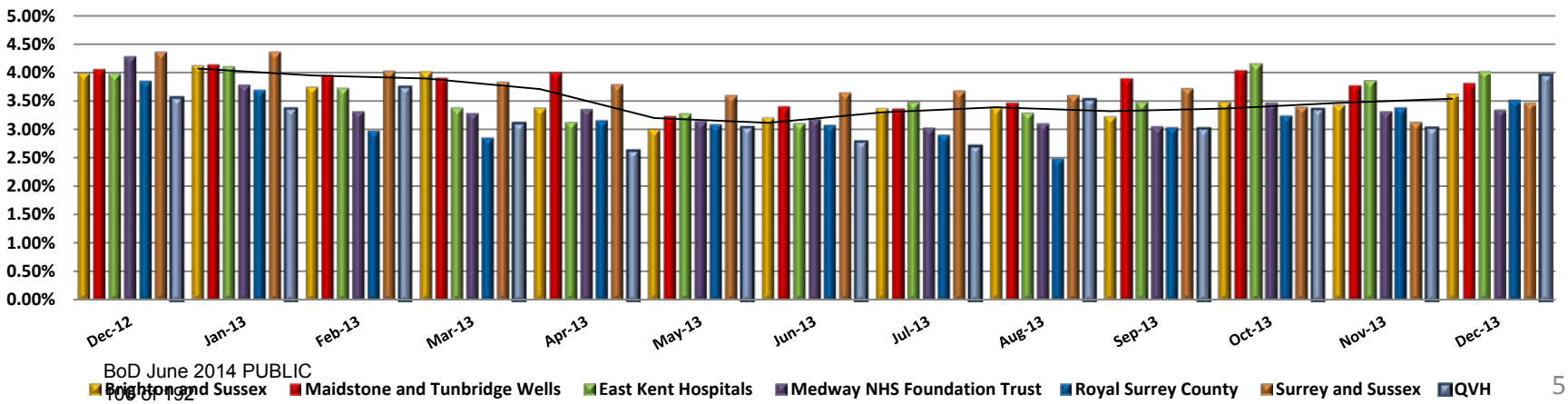
HEADLINE HR KPIs



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

Staff Group	Estimated Cost	FTE Days Lost
Add Prof Scientific and Technic	£3,922	48.12
Additional Clinical Services	£6,759	128.08
Administrative and Clerical	£11,152	227.08
Allied Health Professionals	£2,238	18.47
Estates and Ancillary	£4,966	56.80
Healthcare Scientists	£0	0
Medical and Dental	£1,079	5.00
Nursing and Midwifery Registered	£25,656	259.87
Grand Total	£55,773	737.42

Current information provided from HSCIC for the period November 2012 and December 2013 (shown below) shows that QVH reported sickness absence for December was one of the highest in comparison to Kent, Surrey and Sussex.



HEADLINE HR KPIs

Sickness/Absence
Sickness absence remains an area of concern and is significantly above the Trust target of 2%. In December 2013 the rate was 4.04%, but this did fall to 3.40% in April 2014. There were 1038 absence days during May. Short term sickness absence remains an issue with 326 days lost in May due to short term sickness absence, this meant that 157 staff had short-term sickness, 21 of those staff had 2 episodes or more of absence each. Long term sickness has risen consistently for the last 6 months, with a slight fall in April 14.

Absence reasons
Of the total of 1038 absence days lost due to sickness, the most significant reason was anxiety/stress/depression which totalled 377 days (37.4% of total absence). The highest number of episodes, which can be mapped back to short term sickness absence was Gastrointestinal problems accounting for 63 absence days.

Exceptions
The main affected areas are ITU at 14.59% have 2 long term cases of sickness and 5 short term cases, Site Practitioners at 13.72% a small department with 2 long term sickness cases, Building & Engineering Building at 12.20% with 1 long-term and 1 short-term sickness case. Pre-assessment at 6.26% with 1 long term and 2 short term sickness cases, Minor Injuries Unit at 6.26% with 1 long term and 3 short term sickness cases. Theatres at 5.43% have 4 long-term sickness cases and 39 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, 6 people are on formal stage 1 of the policy and 4 at formal stage 2. There has been 1 person who has been off on long term sick due to instigation of disciplinary actions, there is no date of return however active management of the case is on-going.

Action taken place
Line managers, Occupational Health and HR have been working together to tackle those staff who have exceeded targets and ensuring that meetings take place to discuss absence.

Actions
•The Human Resources department will continue to work closely with line managers and heads of services to ensure management of absence is in line with Trust policy.

RAG Rating

HEADLINE HR KPIs

Payroll

All staff were paid on time, Overpayments increased from 0 to 12 for May an increase in an amount from 0 to £1490.20. There were 5 interim payments made in May, due to managers error when finalising shifts on HealthRoster. Payroll errors remain at 1.

Employee Relations

There were 3 new cases reported in May 2014.

Casework

There are 18 open cases in the Trust which are being proactively managed. 11 of these are ill health capability cases and in 1 of these cases the employee has been dismissed with notice on the grounds of capability. There are 2 Capability Performance cases where formal action plans are in place. There is 1 Grievance case which is about to be started. There are 3 Discipline and Conduct cases, 2 of which are at the investigation stage and 1 who has gone on long term sick due to the commencement of disciplinary action. There is 1 complex Employment Tribunal claim with a pre-hearing set in early July.

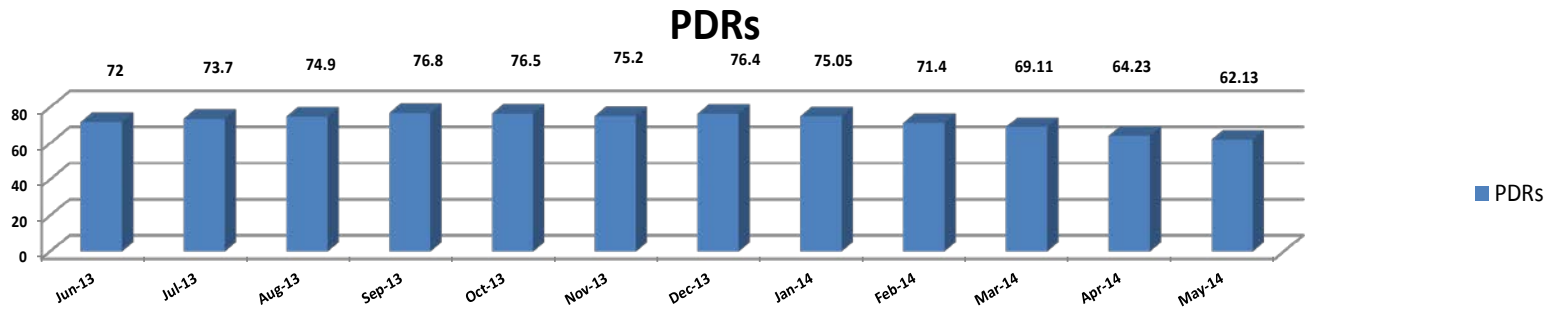
Actions

•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



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

Directorate	Jun-13		Jul-13		Aug-13		Sep-13		Oct-13		Nov-13		Dec-13		Jan-14		Feb-14		Mar-14		Apr-14		May-14		
Anaesthetics & Theatres (Dir)	67.41%	↓	65.22%	↓	73.19%	↑	70.59%	↓	71.13%	↑	73.10%	↑	60.58%	↓	54.35%	↓	49.28%	↓	48.91%	↓	47.83%	↓	50.71%	↑	**140**
Head, Neck & Eye (Dir)	58.93%	↑	63.16%	↑	72.41%	↑	82.76%	↑	79.66%	↓	79.28%	↓	71.88%	↓	69.23%	↓	56.72%	↓	54.55%	↓	50.00%	↓	52.17%	↑	**69**
Inpatient Services (Dir)	79.31%	↑	77.78%	↓	76.72%	↓	76.52%	↓	76.23%	↓	72.36%	↓	71.43%	↓	71.90%	↑	75.21%	↑	72.41%	↓	63.48%	↓	62.39%	↓	**117**
MIU (Dir)	70.59%	→	88.24%	↑	84.21%	↓	77.78%	↓	83.33%	↑	83.33%	→	83.33%	→	84.21%	↑	84.21%	→	68.42%	↓	63.16%	↓	52.63%	↓	**19**
Corporate	72.04%	↑	61.38%	↓	71.43%	↑	70.62%	↓	72.00%	↑	96.00%	↑	74.75%	↓	91.30%	↑	63.64%	↓	45.83%	↓	33.33%	↓	48.00%	↑	**25**
Outpatient Services (Dir)	81.01%	↑	84.81%	↑	77.63%	↓	80.00%	↑	76.92%	↓	78.21%	↑	75.31%	↓	74.68%	↓	70.00%	↓	77.50%	↑	76.83%	↓	81.25%	↑	**80**
Paeds & Clinical Support (Dir)	79.45%	↑	80.99%	↑	80.54%	↓	79.19%	↓	75.00%	↓	66.88%	↓	80.65%	↑	84.62%	↑	84.08%	↓	84.08%	→	83.23%	↓	76.77%	↓	**155**
Plastic & Burns (Dir)	80.95%	→	82.81%	↑	88.89%	↑	92.06%	↑	92.31%	↑	86.55%	↓	83.33%	↓	81.54%	↓	78.79%	↓	67.19%	↓	39.68%	↓	41.94%	↑	**62**

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

Medical & Dental - PDR Achieved against 100%

Directorate	Jun-13		Jul-13		Aug-13		Sep-13		Oct-13		Nov-13		Dec-13		Jan-14		Feb-14		Mar-14		Apr-14		May-14		
Anaesthetics & Theatres (Dir)	70.00%	↑	80.00%	↑	83.33%	↑	96.77%	↑	96.88%	↑	93.75%		93.75%	→	90.63%	↓	87.50%	↓	87.10%	↓	80.65%	↓	62.50%	↓	**32**
Head, Neck & Eye (Dir)	54.72%	↑	58.49%	↑	62.75%	↑	67.35%	↑	66.04%	↑	84.91%	↑	84.91%	→	79.25%	↓	74.55%	↓	70.91%	↓	67.27%	↓	62.00%	↓	**50**
Nursing Management & Risk (Dir)	100.00%	↑	100.00%	→	100.00%	→	100.00%	→	100.00%	→	100.00%	→	100.00%	→	100%	→	100%	→	100%	→	100%	→	0%	↓	**1**
Paeds & Clinical Support (Dir)	50.00%	↑	50.00%	→	50.00%	→	50.00%	→	50.00%	→	60.00%	↑	60.00%	→	50.00%	↓	25.00%	↓	33.33%	↑	33.33%	→	33.33%	→	**3**
Plastic & Burns (Dir)	62.75%	↑	64.71%	↑	64.00%	↓	78.00%	↑	74.51%	↓	92.59%	↑	92.59%	→	92.45%	↓	92.45%	→	86.27%	↓	82.69%	↓	84.31%	↑	**51**

HR KPIs

PDRs

Appraisal rates have continued to decrease overall for the month of May from 64.23% to 62.13%. Three of the areas continue to drop, however the remaining areas have all increased their compliance rate.

The overall compliance rate for Medical & Dental staff has continued to fall from 75.35% to 69.34%. Nursing Management & Risk has dropped from 100% to 0% but this is due to only 1 person in the department and by being out of date will show as 0%. Paeds & Clinical Support have also remained the same this month but they are only at 33.33%. Plastic & Burns have increased their compliance from 82.69% to 84.31%

Exceptions

Continued areas of under performance, i.e. less than 50% are Corporate 48.00% and Plastic & Burns 41.94%. These areas are chased on an on-going basis to ensure their figures improve.

Medical and Dental's lowest performing area remains Paeds & Clinical Support who have a had a compliance rate of 33.33% for the last few months. However this accounts for 2 out of 3 people being non-compliant.

Actions

Appraisal completion remains a high priority and a concentrated effort by the directorates and HR to data cleanse and target individual cases of non-compliance.

Points to be aware of: There is an amnesty until the end of 2014 with regards the PDR's to bring individuals into line with their increment dates so some will be remaining as non-compliant for some months. However if individuals are considerably out of date there is the expectation that managers will give them an interim PDR. Also there is no way to show that PDRs have been booked with staff or that they have actually taken place but HR are awaiting the completed paperwork to enter the PDR date onto the system so again individuals are showing as red.

Managers are checking the data on their monthly reports and advising us of any anomalies to investigate which is positive.

The June data shows the following

45 appraisals should have been completed by the end of May 2014
15 have been completed – Compliance Rate 33%
16 are currently compliant considering the refresher amnesty that has been granted this year – Compliance Rate 68%
14 are still out of date

RAG Rating

Statutory and Mandatory Training as at 4.6.14

Count of Competence Match	Competence Match				Trust Overall (Expired + Compliant)
Competence Name	Non Compliant	Expired but Booked	Compliant	Grand Total	
Adult & Paediatric BLS - annual|	9.74%	11.16%	79.11%	100.00%	90.26%
Child Protection Level 1 - 3 yearly|	14.84%	1.65%	83.52%	100.00%	85.16%
Child Protection: Level 2 - 3 yearly|	35.00%	4.31%	60.69%	100.00%	65.00%
Child Protection: Level 3 - 3 yearly|	65.67%	0.00%	34.33%	100.00%	34.33%
Conflict Resolution - 3 yearly|	33.39%	9.16%	57.45%	100.00%	66.61%
Emergency Planning: annual|	18.29%	6.20%	75.51%	100.00%	81.71%
Equality, Diversity & Human Rights - once|	27.95%	0.00%	72.05%	100.00%	72.05%
Infection Control: annual|	13.31%	6.81%	79.88%	100.00%	86.69%
Information Governance - annual|	22.26%	2.64%	75.10%	100.00%	77.74%
Manual Handling - Clinical - annual|	29.88%	6.91%	63.21%	100.00%	70.12%
Manual Handling - Non-clinical - 3 yearly|	20.94%	2.48%	76.58%	100.00%	79.06%
Risk: annual|	13.41%	6.00%	80.59%	100.00%	86.59%
Safeguarding Adults - 3 yearly|	22.97%	2.74%	74.29%	100.00%	77.03%
Grand Total	21.89%	4.81%	73.30%	100.00%	78.11%

Statutory & Mandatory Training

Statutory and mandatory training Trust figures have dropped slightly from 79.35% to 78.11% (73.30% compliance excluding those who are booked onto another course) but course completions are remaining steady despite the non-attendance figures. Whilst overall percentage remains just below the 80% target there are on-going measure to ensure compliance and increase the completion rates but these changes require a lot of admin input to finalise the data. For example, all non clinical mandatory training (Risk, Emergency Planning and Infection Control) have gone from annual renewal to 3 yearly renewal in line with the National Passport.

Clinical Specialities remains the area with the largest amount of departments with low compliance rates but is increasing its overall compliance.

Exceptions

Child Protection level 2 – Despite this remaining red, all areas have increased their compliance rate. 64.85% last month to 65.00%.

Child Protection level 3 – Low completion rate across the Trust. As per CPL2 overall areas have increased this month.

Manual Handling Clinical – All areas have increased to above 50% **Peanut have increased again this month from 37.50% to 50%**, Theatres continued to drop from 47.90% to 44.07%, **Site Practitioners** increased from 41.67% to 53.85%, **Sleep Studies remain at** 42.86%

Conflict Resolution **Clinical Specialties remain the main area of concern.**

Actions

Continued investigation by L&D into the areas where compliance is low. Managers have been provided with extra reports to show those individuals whose training is due to expire in 1 month and 2-3 months in addition to showing those more than 3 months out of date. Also a report showing those that did not attend their training to enable them to be chased up and re-booked.

The amendments to the Non-Clinical Mandatory training should start to increase compliance over the next few months.

RAG Rating

Mandatory & Statutory Training by Directorate
As at 4.6.14

Activity	Trust	Corporate	Clinical Specialities	Clinical Support Services
Adult & Paediatric BLS	77.53%	71.43%	71.13%	79.20%
Staff	503	7	97	399
Trained	390	5	69	316
Booked				
Gap	113	2	28	83
Child Protection Level 1	81.94%	85.71%	73.95%	85.71%
Staff	371	168	119	84
Trained	304	144	88	72
Booked				
Gap	67	24	31	12
Child Protection Level 2	61.62%	70.00%	60.00%	61.42%
Staff	581	30	100	451
Trained	358	21	60	277
Booked				
Gap	223	9	40	174
Child Protection Level 3	33.82%	66.67%	NA	32.31%
Staff	68	3	0	65
Trained	23	2	0	21
Booked				
Gap	45	1	0	44
Conflict Resolution	58.24%	80.00%	35.93%	65.21%
Staff	649	25	167	457
Trained	378	20	60	298
Booked				
Gap	271	5	107	159
Emergency Planning	76.24%	81.64%	62.93%	79.85%
Staff	985	207	232	546
Trained	751	169	146	436
Booked				
Gap	234	38	86	110
Equality, Diversity & Human Rights	73.50%	81.16%	61.64%	75.64%
Staff	985	207	232	546
Trained	724	168	143	413
Booked				
Gap	261	39	89	133

Activity	Trust	Corporate	Clinical Specialities	Clinical Support Services
Infection Control	79.39%	79.71%	76.72%	80.40%
Staff	985	207	232	546
Trained	782	165	178	439
Booked				
Gap	203	42	54	107
Information Governance	75.43%	86.47%	63.36%	76.37%
Staff	985	207	232	546
Trained	743	179	147	417
Booked				
Gap	242	28	85	129
Manual Handling - Clinical	62.48%	56.52%	72.63%	60.31%
Staff	501	23	95	383
Trained	313	13	69	231
Booked				
Gap	188	10	26	152
Manual Handling - Non Clinical	75.14%	80.12%	71.43%	70.65%
Staff	370	166	112	92
Trained	278	133	80	65
Booked				
Gap	92	33	32	27
Risk	81.12%	82.61%	77.16%	82.23%
Staff	985	207	232	546
Trained	799	171	179	449
Booked				
Gap	186	36	53	97
Safeguarding Adults	74.01%	81.64%	71.98%	71.98%
Staff	985	207	232	546
Trained	729	169	167	393
Booked				
Gap	256	38	65	153

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

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**149-14**
Report from:	**Amanda Parker, Director of Nursing**
Author:	**Amanda Parker, Director of Nursing**
Report date:	**10 June 2014**
Appendices:	**A: QVH 2020 KS01**

Quarterly update on delivery of Key Strategic Objective 1
Outstanding patient experience

Background

1. The attached document summarises the actions identified in respect of key strategic objective (KSO) 1 – outstanding patient experience. This is a key strand of QVH 2020 and identifies the actions that support delivery of superior care and outcomes for patients, provision of an exceptional environment with outstanding personal service (page 1).

Development process

2. These are the shorter term actions that were identified for achievement during 2014/15 following workshops held across the trust during January and February. These actions have been updated to reflect progress to date during 2014/15.

3. The attached document has been shared with the Clinical Cabinet and is shared at each patient experience group meeting as their action plan also supports achievement of goals associated with delivering an outstanding patient experience.

Key issues

4. The main focus of the actions relate to the key areas of focus: superior care & outcomes, exceptional environment and outstanding personal service.

5. Delivery of the objectives sits across the executive team, with the Director of Nursing coordinating certain aspects through the patient experience group and its associated action plan, and reporting the totality of the KSO.

6. Progress has already been made against a number of the objectives. The main areas of challenge are;
    - Delivery of the safer care module the order has been placed and we are waiting for completion of the purchase so that implementation can commence (page 6).
    - Canadian wing refurbishment is being managed through maintenance monies but is reliant on reduced occupancy to allow vacant rooms/bays to be redecorated (page 10).

- Introduction of an IT system for identification of deteriorating patients; this is a recommendation from recent national reports and will improve outcomes for patients. Currently we are awaiting feedback from a bid to the Nursing Technology Fund (page 6).

7. Other actions in progress involve the senior team, including Non-Executive directors, in improving levels of engagement across the Trust, with the intention that staff should feel able to raise concerns directly to them (page 2). The activities also provide opportunities for the senior team and Non-Executive directors to observe care, staff attitudes and behaviours and to meet with patients and hear their views. This is an on-going objective and attendance itself will not achieve the goal; evidence of improved engagement is required to demonstrate the success of the programme.

8. All patients should benefit from the actions identified within the QVH 2020 plan for 2014/15 and no specific group will be excluded from those benefits.

9. It is recognised that this document provides evidence of progress against the short term issues for KSO 1. The longer term plans need to be incorporated to ensure alignment and to confirm that the short term actions act as enablers for the longer term goals.

Link to Key Strategic Objectives (delete those not applicable)

10. The above information relates to the key strategic objective – Outstanding patient experience.

Implications for Board Assurance Framework or Corporate Risk Register

11. Risks to achieving this objective are included within the current Corporate Risk Register and Board Assurance Framework.

12. No new risks have been identified.

Regulatory impacts

13. Nothing within the paper attached indicates that the organisation is not fully compliant with the Care Quality Commission's requirement for the Trust to be
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

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

Recommendation

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

Key Strategic Objectives (aligned with QVH 2020)	KSO1 - Outstanding patient experience (AP)	KSO2 - World class clinical services (SF)	KSO3 - Operational Excellence (JM)	KSO4 - Financial Sustainability (RH)	KSO 5 - Organisational excellence (GA)
	We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of patients and their families.	We provide a portfolio of world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education & training and innovative research & development.	We provide streamlined services that ensure our patients are offered choice and are treated in timely manner.	We maximise existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.	We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership.
Focus areas (aligned with QVH 2020)	Superior care & outcomes Exceptional environment Outstanding personal service	Clinical Strategy Clinical Outcomes R&D Education & Training	Pathway redesign Capacity review Delivery annual operational plan	Delivery of annual financial plan CIP programme 15/16 - 19/20 Business development programme 14/15 – 19/20	Leadership development Performance Management Innovation & Learning

Board focus & main responsibilities		Board strategic priorities 14/15	Organisational delivery - key strategic objectives		Lead Director
Patients	To provide safe, effective and efficient care and treatment for patients delivered in a friendly and professional manner.	i) Improving the patient experience ii) Improving the estate	KSO 1 Outstanding Patient Experience	i) Superior Care & Outcomes ii) Exceptional Environment iii) Outstanding personal service	Director of Nursing & Patient Experience

KEY STRATEGIC OBJECTIVE 1 Outstanding Patient Experience							
Superior Care & Outcomes - *Care is safe, compassionate, competent and provided by a well led team*							
	KEY ACTIONS 2014/15	**Owner**	**Measure**	**Due**	**Progress**	**R**	**Risk**
	Leadership & Values						
1	The Trust Board to reaffirm its commitment to the highest standards of nursing care and behaviour as part of its wider commitment to excellence in patient care. (C8.1)	CEO	Board meeting minute **HS**	April 2014	Discussed with CEO and to reaffirm at April 2014 board meeting Completed at April Board meeting	G	
2	The Trust Board to take the lead in creating a culture of openness and transparency throughout the organisation through an increased programme of board visits, 'back to the floor' sessions and involvement in	All board members	Board member / senior managers attendance on CIP audits - each board member to have been on at least one CIP during 2014/15	March 2015	P Griffiths G Colwell – Aug 14 J Thornton - July 14 L Porter – July 14 S Fenlon – B Good -	A	

	existing programmes such as 'Compliance in Practice'. (C6.1)		**AS**		A Parker – June 14 R Tyler G Armitage J Morris S Butt		
3	The Trust Board to re-emphasise to all senior management having responsibility for, or interaction with, nursing staff or patients that, under no circumstances, should they, or staff reporting to them, be deflected from a focus on these core responsibilities as a result of involvement in other projects or as a result of a shortage of resources. Any concerns by individuals related to this must be raised by them, and discussed and resolved with the Chief Executive. (C6.2)	CEO	An AOB item on clinical cabinet agenda Observation area on CIP tool **LHR AS AP**	April 2014 May 2014	Added to CIP tool and to clinical cabinet agenda Awaiting feedback from CIP tool use and May clinical cabinet **Actions taken – monitoring required**	A / G	
4	Ensure that all Directors, Governors and Clinicians undertaking visits within the clinical areas are encouraged to feed back any comments or concerns relating to staff attitudes/morale or the quality of patient care directly to the Chief Executive. (C6.4)	CEO	Discussion at clinical cabinet - feedback minutes **LHR** Summary of those undertaking CIP directors / governors **AS**	June 14 May 14 March 15	Board to reflect on all visits at end of board agenda – to be introduced as standing item that is recorded Q1 Governors x Directors x Q2 Governors x Directors x Q3 Governors x Directors x Q4 Governors x Directors x	A	

5	Ensure that the Trust takes appropriate robust action against any individual whose behaviour is not consistent with the core values of the Trust regardless of other positive aspects of their performance. (C6.5)	HHR&OD	HR Board report reflects capability and disciplinary against behaviors **HS** Appraisal documentation identifies core values assessment **CH** Appraisal rates in board papers **HS** Manchester patient safety framework – CQUIN this identifies attitudes/leadership **GA**	Sept 15 May 14 Sept 14 Start June 14	Updated and includes core values Included in board papers Meetings planned	A	
6	The Executive Directors to incorporate in their monthly updates for the Board any negative feedback they have received or concerns they have, relating to staff behaviour including the action taken to address the issues raised. (C6.6)	Exec Directors	Board reports include feedback on visits to clinical areas **HS**	Sept 14	Discussion underway with Lois/CEO if go in front cover along with KSO relevance. Option amended and to be covered at board in NED and Exec updates To commence June 14	A	
7	Support staff in taking a zero tolerance to poor attitude towards colleagues / patients	HHR&OD	Connect article to all staff on zero tolerance and support available to staff **GA**	Sept 14	On track	R	
8	Increased visibility of the Director of Nursing (DN) in clinical areas. When considering management structures	DN	Clinical visits – noted within patient experience section of	June 14	Variety of options in use – main reception desk x 2 per week & ward/area clinical working (May CWing June Theatres)	A	DN capacity

	below, consideration should be given to the existing balance of the DN role between her responsibility for the improvement of nursing standards and her lead role in governance and compliance matters. (C6.3)		board report **AP** New N&Q structure in place and provided to organization **AP** Ward safety/standards information to board each month **AP** Inclusion of OPD / MIU / Theatres **AP**	June 14 June 14 Sept 14	Structure shared with organistaion Proposal to board April 14 – routine reports commenced May 14		
9	The DN to work with the matrons and other senior nursing staff to develop a clear set of QVH nursing standards and behaviours that can be incorporated into recruitment, appraisal and performance management. (C8.2)	DN	Recruitment process evidences VBR and English and numeracy skills **JA** Patient care strategy – roles responsibilities has been revised **AP** Relaunch of strategy and standards occurs **AP**	June 14 May 14 May 14	Process in place – review of recruitments to confirm all aspects are occurring Document launched 7 May at CNO visit Re launch linked to meet the matron / hello my name is…/ safe staffing – safe care / inpatient survey – May 7th	G	
10	Review role of trauma coordinators leading to increased recruitment & retention, **March – July 2014**	DDN/ Matron non elective services	Feedback report from Matron **NR** Recruited to full establishment **NR**	April 14 Oct 14	Summary feedback provided following meetings with staff and Mr Blair / J Morris. New processes in place to reduce call handling Adverts out for recruitment, team also impacted currently with some long term sickness	A	Mixed team crucial for care – staffing a challenge in UK currently

	Safe Care, Safe Staffing						
11	Monthly publication of staffing data. Making use of e-rostering and other workforce data to provide assurance to the Board, staff and patients as to the provision of safe and competent levels of staffing throughout the Trust. (C8.3)	DN	Monthly board report Information on trust website Information on NHS Choices **HS**	June 14	Proposal to board April 14 Proposal agreed – first paper to May board	G	
12	Meet with Allocate to introduce the Safer Care module to the e-roster system, May 2014 to enable monthly reporting of staff vs. acuity patients: **June – August 2014**. (QA) **Strategic Investment Fund (SIF)**	DHHR	Safer Care module in place Ward and board reports informed by safer care module	June 14 Sept 14	Order request with finance awaiting completion of purchase so implementation can commence	R	Availability of SIF
13	Introduction of Vital Pac – IT system for identification of deteriorating patient (QA). **Dependent on successful bid to Nursing Technology Fund**	DDOF	Electronic observations available for alerting	March 15	Bid in – awaiting feedback	R	Dependent on NT Funding
14	Develop an action plan to reduce the use of agency staff – exact level to be recommended by the DN taking into account benchmarked data from similar organisations. (C8.4)	DN	No non RMN agency used Ward / board reports indicate agency / bank / substantive staff	June 14	Usage currently provided each week	A	Availability of nurses to employ to substantive roles
15	Build on the work already started by the Head of Human Resources to establish an integrated scorecard (monthly) for C wing and other clinical areas that makes use of both the	DN	Full suite of scorecards available	Oct 14	Proposal to board April 14 May – first scorecards to be provided to board Not all information can yet be accessed but steady progress	A	

	existing indicators and the outputs from e-rostering highlighted above. Integrating these reports will provide a much fuller picture of both the day to day management and the longer term trends which would provide an improved system of early warning. (C14.1)						
16	Develop a weekly 'flash report' to provide early warning of challenges to staffing levels relative to patient numbers and acuity and inappropriate use of temporary staffing. (C14.2)	DHHR DN	Flash report available from e roster	June 14	A new module for e roster has been provided in the first week of June - this will be able to provide planned and actual availability in advance. Process for using this to be established	A	
17	Chief Executive to charge the Head of Human Resources with taking responsibility for developing and monitoring relevant and timely early warning data. (C14.3)	HHR&OD	Early warning information available **GA**	Sept 14		R	
18	Head of Human Resources to provide a quarterly update to the Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system (C14.4)	HHR&OD	Quarterly report to board **GA**	June 14	Q1 Q2 Q3 Q4	R	
19	Monthly reporting of safety thermometer 'harm-free care' (CQUIN)	DDN	Board dashboard	May 14	Process in place – covered in board dashboard	G	
20	Monthly collection of compliance with WHO checklist (CQUIN)	Matron Periop	Board dashboard	May 14	Process in place – awaiting further audits	A	

	Governance						
21	Whilst we are confident about the effectiveness of both the Quality & Risk and Audit Committees it would seem appropriate, both in the light of the *Frances*, *Keogh* and *Berwick* reports, and in *Monitor's* growing focus on formal governance processes, to review our Board level governance structures. We understand that the interim Director of Corporate Affairs has been tasked with reviewing the Board systems of both corporate and clinical governance. (C16.1)	IHCA	Revised meeting structure in place Minutes from Q&R	June 14 July 14	Discussion over new structures held with IHCA / DN / CEO / GC/ AV New structure proposal in place for clinical governance group / clinical cabinet. New Q&R committee will commence in September 14 (Meeting was planned for August 14) New style will meet bi monthly and in the interim to provide board assurance the Q&R chair (GC) will attend a clinical governance group meeting.	A	
22	As part of a wider review of Trust governance systems, the interim Director of Corporate Affairs to consider how best we can incorporate behavioural and cultural concerns within our governance systems. (C6.7)	IHCA	All meeting agendas cover behaviours / concerns as AOB standing item	Sept 14	To be included in Clinical cabinet from May	G	
23	Establish a monthly executive level Quality & Safety Committee to be chaired by the CE, and review and amend the remit of the existing directorate quality & risk committees and other committees dealing with quality, risk and safety issues to align governance structures and reporting across the Trust. (C16.2)	IHCA	New Q&R process established	June 14	Discussions in place and plan for changes from June 14 Changes to Clinical Governance Group commenced June 14 Q&R changes occur from Sept 14	A	

24	Trend analysis to be included in monthly reporting to the Quality & Safety Committee. (C16.3)	HoR	Trend information available	June 14	Trend information currently included – governance arrangements under review. Revised Q&R will review patient safety and patient experience through in depth triangulation from Sept 14	A	
25	Quality & Safety Committee to define trend reporting requirements to be provided by the Risk Team. (C16.4)	HoR	Trend information informed by Q&R May meeting minutes	June 14	Revised Q&R will review patient safety and patient experience through in depth triangulation from Sept 14	A	
26	Quality & Safety Committee to review the Trust risk registers to ensure it is a 'live document' with risks appropriately identified, graded and escalated. To agree a unified approach for the different registers. (C16.5)	HoR	Trust risk register to Q&R with updated risks BAF to audit committee quarterly Teams review risks at dept / directorate meetings	June 14 June 14 June 14	Risks being updated – Q&R to receive all corporate risks and to do an in depth review of one risk at each meeting BAF under review – 14/15 in progress	A	
27	Monitoring of incidents, including follow up on action plans to be included in monthly agendas for Quality & Safety Committee. (C16.6) Qualitative audit of implementation of WHO 'checklist' – (CQUIN)	IHCA	Monthly meeting established	June 14	Currently goes to CPC to be on monthly agenda – new format commenced June 14	G	
Exceptional Environment - *An environment that provides accommodation and facilities that meet the needs of patients and their families*							
28	Liaise with corporate affairs and review volunteer cover for reception desk ideally covering 0800-1800 July **2014**	IHCA	Front desk covered 0800-1800	July 14	Discussed with C Charman – to extend slots for volunteers and put article in Connect that informs staff they can sit at desk and signpost patients with access to emails available. As a part of DN visibility 7.30-8.30 at volunteer desk x ½ per week	A	

29	Support provision of a discharge lounge / transport waiting area **June 2014.**	Programme Director	Waiting area available for patients	June 14	Area identified within 'old admission lounge'. Included within proposal for MoHs and LOPA's move. Following discussion at site capacity meeting 30th April the option to relocate vending machines and create a space for patients will be developed as a high level proposal that will also be discussed with the League of Friends as they may help to fund – funding agreed.	A	
30	Ward re fresh – painting, removal of arjo baths and replacement with showers etc. **2014/15 capital programme**	Programme Director	Ward redecorated Showers in place	?	Single rooms in Ross Tilley have been commenced Nurses' station RT completed	A	Not noted to be included in capital programme
31	Refurbishment Physio/OT reception area. **2014/15 capital programme**	Programme Director	Physio / OT reception refurbished	Q3	On track	R	
32	Work with hotel service team to review food charter mark guidance and develop actions to work towards gaining a charter mark **March 2015** (CQUIN)	Programme Director	Quarterly reports provided that demonstrate progress against agreed CQUIN actions	March 15	Q1 – action plan seen Q2 Q3 Q4	A	
Outstanding personal service - ***All interactions with patients and their family/carers are caring and compassionate putting the patient at the heart of care.***							
33	Provide programme of engagement to patient experience group **May 2014**	DN	Minutes of PEG	May 14	Programme provided and staff and governors joining CIP etc	G	
34	Act on negative feedback and monitor actions to improve experience. **On-going**	Patient experience manager	Monthly complaints report – C Cabinet Information within Board report Patient stories at Board	May 14 May 14 June14	Reporting process in place	A	

35	Make available drinks for family within ward area **July 2014**	Matron Elective services	Drinks available on ward	June 14	Peanut and Burns in place. C Wing in progress – needs monitoring to ensure available consistently	A	
36	Provide wider availability of information on how to access personal items / newspapers etc. **July 2014**	IHCA	Updated bedside guide	May 14	New guide distributed and includes information	G	
37	Take a zero tolerance to avoidable late start clinics initially identifying the causes August 2014 developing actions to address identified issues **March 2015**	HoOps	Information on clinic start times available Late clinics – evidence of action taken	June 14	Meeting held 10 June to discuss actions identified: a) for New system administrator to devise a dashboard that can show weekly reports regarding clinic start times from Enlighten b) Escalation flowchart in place for nurses to follow in Plastics, Max fac and Corneo when Dr's are late c) Kathy to discuss with OPD Sisters mechanism to record why clinics are running late (as this cannot be collected on Enlighten at the moment) d) Any clinics over 30mins late Datex to be raised e) When new service manager in post they will be responsible for investigating these Datex's further and highlighting trends – this might be template changes / job plan amendments f) Trust policy to be devised to escalate persistent offenders (if not addressed by actions under e)) firstly to Clinical Directors, then to Medical Director as required moving onto displinary process	A	

					if needed. This I suspect will need to be discussed at Clinical cabinet / LNC.		
38	Wifi access for patients. **2014/15 capital programme**	HoIT	Wi Fi available to patients		Wi fi available to staff but not patients Wi fi covers some but not all of trust	A	

Report to: **Board of Directors**
Meeting date: **26 June 2014**
Reference number: **150-14**
Report from: **Steve Fenlon, Medical Director**
Author: **Steve Fenlon, Medical Director**
Report date: **14 June 2014**
Appendices: **None**

KSO2 Delivery of Clinical Excellence

Background

1. This report sets out high level plans for the achievement of Key Strategic Objective (KSO) 2 – World class clinical services, and reports on progress made so far. Further updates will be produced for the board on a quarterly basis.
2. The objectives set out in the attached document have been discussed and agreed at a meeting of the Clinical Cabinet prior to presentation to the board.

Key issues

3. The Medical Director's personal objectives for 2013/14 have been set to reflect the Trust-wide QVH 2020 strategy. They prioritise development and delivery of world class clinical services, focussed on
    - clinical strategy
    - publication of clinical outcome measures
    - research and innovation
    - education and training.

4. The intention is to improve existing services by innovation and measurement of outcomes, develop a better trained medical workforce, and make QVH a centre for research and development. Quality and performance improvements will help to support long term sustainability for the Trust by attracting more patients to proven high quality services. Similarly, it is intended that publication of outcome measures will enable commissioners to make better informed decisions about where to commission services.

5. Financial benefits will be realised by pursuit of a clinical strategy with clear business plans and aligning these to an internal review of medical productivity. Ensuring our quality can be evidenced by outcome measures enables commissioners to commission by outcome and will help to secure and grow the dominant position QVH has for its specialised services.

Clinical Strategy

6. A clinical director of strategy is on post and a number of strategic options are being developed by the Senior Management Team. These were presented to the clinical cabinet and board members on the 3rd march 2014 and gave detail of a widespread consultation exercise with clinicians. The proposals increase existing market share in existing services, develop new services, and secure the burns service by way of partnership arrangement. Priority is given primarily to clinical need (for example burns),

service need (for example addressing waiting list pressures) and financial security (for example securing an on-site MRI scanner).

Publication of clinical outcome measures

7. A project manager for outcomes has begun work with the purpose of building a sustainable mechanism for delivery of more useful information to stakeholders about the performance of consultants at QVH. In addition we are engaging one again with external providers to ensure the end product both meets the needs of the board and is consistent with any other NHS organisations that may be taking this step.

8. May 2014 saw the first published consultant level patient reported outcome measures appear on the hospital website for maxillofacial surgery (http://qvh.nhs.uk/assets/patient_information/OrthognathicOutcomesMay14.pdf This represents a major landmark for the outcomes project and marks the beginning of a programme to deliver five further outcome measures across other specialities. For the years ahead the programme aims to secure more efficient data gathering, bringing together where possible data already collected electronically, and proposing more effective information gathering and identifying the resources needed to achieve this. Existing data relating to clinical governance is spread across a number of areas and a part of the project will be to gather this in one place to provide vital governance assurance to the board and medical leadership at consultant level.

9. Quarterly updates on progress towards achievement of KSO2 will include details of the outcomes project in future.

Research and innovation

10. Research at QVH has been bolstered in the last six months by the appointment of a director of research, Dr Brian Jones, on secondment from the University of Brighton (UOB). Brian has developed new links between QVH clinical activity and the work of the local regenerative medicine network, a collaborative group of academics concerned with essentially wound healing processes. This work has aided those QVH clinicians already engaged in research to bring the laboratory facilities available on site at the Blond McIndoe Centre (BMRF) to bear on their on their research ideas. Brian has also engaged the nursing staff in research activity and put forward a number of individuals for the MRES course run and funded by the UOB. In collaboration with clinical colleagues Brian has put forward a proposal to open a scar tissue bank on the QVH site to enable more ready access to discarded scar tissue (natures regenerative skin tissue) by researchers from QVH, BMRF and UOB. The greater collaboration across the three organisations is an improvement on previous years and will facilitate access to technology and resource by QVH in particular. The research programme existing prior to Brian's arrival has also developed under Julian Giles leadership. Redundant trials have closed and recruitment has focussed on those trials actively supported by clinicians. This has resulted in a large increase in portfolio recruitment, a target of 25% has been

comfortably exceeded. More detail is contained within the annual research report submitted to the board this month.

Education and training

11. Key to delivery of the education strategy is the construction of an education centre from charitable funds and this is making good progress. Engagement with deaneries is on-going to ensure that QVH continues to provide comprehensive training and be a popular destination for trainees and future consultants.

12. Non consultant career grade staff are a missing link in our development of medical staff. Usually recruited for service delivery, these doctors do not receive the support and development of traditional deanery trainees. QVH aims to ensure from the point of appointment, these posts are educational and reflect the value we place in this workforce. This begins from rewriting the contracts and job plans and negotiating with all directorates to ensure the various specialities recognise their responsibilities to these grades.

13. Reputational improvement should also follow enhanced research and education, contributing to the achievement of other KSOs.

Link to Key Strategic Objectives

14. Effective delivery of KSO 2 is fundamental to the delivery of the four other KSOs and the Trust's overarching objective of achieving long-term sustainability. At this stage the proposals for delivery of the objective anticipate its achievement.

Implications for Board Assurance Framework or Corporate Risk Register

15. Risks to achievement of the objective have been reported to the risk manager for incorporation into the Board Assurance Framework.

Regulatory impacts

16. The proposals as drafted so far will support, rather than compromise, the Trust's ability to demonstrate compliance with the Care Quality Commission's standards. They will also enhance the Trust's Monitor continuity of service and governance risk ratings.

Recommendation

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

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**151-14**
Report from:	**Amanda Parker, Director of Nursing**
Author:	**Amanda Parker, Director of Nursing**
Report date:	**10 June 2014**
Appendices:	**A: Corporate Risk Register**

Corporate Risk Register

Key issues

1. Attached is the latest update of the risks on the corporate risk register that are rated 12 or above. All risks have been reviewed during recent months, however it is noted that some risks that have not achieved their residual risk rating have no actions allocated
2. Over the next months the new Head of Risk plans to go through all risks to confirm their rating whether they are local or corporate risks. The board will then receive all risks identified as corporate risks.
3. Key risks to bring to the attention of the board of directors are those currently rated at 12 or above as these pose the most significant risk to QVH. For all these risks the controls in place to mitigate the risk are provided along with further actions in progress or required to further reduce the risk to the organisation.
4. The most significant risk noted is rated 16 and is the potential risk of failure of the clean room. This is a risk where actions to mitigate the risk require adding by the handler and is an aspect of work the head of risk is leading.

Implications of results reported

5. The register demonstrates that the trust is aware of key risks that affect the organisation and that these are reviewed by owners. Presentation of the risk to the board provides an opportunity for challenge to executives about the actions being taken.
6. No specific group/individual with a protected characteristic are affected issues identified within the risk register.
7. 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. The CQC would consider risk management within the category of was the organisation well led.

Action required

8. Over the next two months the head of risk will be reviewing all risks and ensuring they are allocated to either a local, corporate risk register or the board assurance framework. Some may appear in all three. It is planned that the August board should receive the complete corporate risk register rather than just risk rated 12 or above. There will also be information on which risks are new and which have an altered scoring.

Link to Key Strategic Objectives (delete those not applicable)

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

- Financial sustainability
- Organisational excellence

9. The attached risks can be seen to impact on all the trusts KSO's

Implications for BAF or Corporate Risk Register

10. Significant corporate risks have been cross referenced with the trust's Board Assurance Framework which will be presented to the next Audit Committee

Regulatory impacts

11. 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

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

Recommendation

13. The Board is recommended to adopt the attached corporate risk register.

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Principal objectives	Approval status
681	13/02/2014	Failure of cleanroom air handling unit due to wear and tear and age of unit. Latest failure ongoing on 13/02/2014	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	Heather Bunce	John Trinick	Estates Infrastructure & Environment	16	8		03/06/2014	KSO1	Approved
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 summarising the costs associated with move packaging and moving records to free additional space as additional storage space will be required from 31/03/2013 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 commenced 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	Richard Tyler	Jane Morris	Patient Safety	15	3	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	15/04/2014	KSO4	Approved
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.	Heather Bunce	John Trinick	Estates Infrastructure & Environment	15	6		07/03/2014	KSO4	Approved
677	24/01/2014	mis diagnosis	Phillips PACS system upgrade has added an additional anotation on images on PACS web viewer. ie a left wrist will always have an extra right marker added as extra annotation is based on anatomical presentation of body in relation to the cassette.	Anyone viewing images from outside of Radiology may not be familiar with the correct presentation of images and therefore mis-identify the correct body side.	Email communication to all PACS users advising of the issue. Ensuring all radiographers correctly apply left and right markers before sending to PACS to avoid any extra risk to the issue. Currently trying to roll back the web clients to the old version of PACS but there are technical issues causing issues with this control. A warning has now been added to the PACS advising of the error. Modality vendors have been on site and removed the DICOM tag for all new imaging performed.	Steve Fenlon	Angela Eiffert	Patient Safety	15	1		22/05/2014	KSO1	Being 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				In holding area, awaiting review

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Principal objectives	Approval status
159	29/11/2006	Ability to operationally meet 18 week target for all directorates	Failure to meet referral to treatment time of 18 weeks (RTT18)for a second month could result in reduced Monitor rating and a financial loss of 1.2 million. This could be for the trust aggregate failing to meet target which could be more than two specialties failing in one month.	1. Failure to update booking system on changes during pathway - administration errors 2. Failure to update system on patients declining treatment dates 3. Increased number of patients requiring treatment 4. Inadequate number of surgeons or Consultant absence 5. Lack of theatre space (capacity) 6. Poor validation of data.	1. RTT18 PTL established and now circulated daily. 2. Weekly escalation process now established via clinical specialties managers, OPG meeting twice a week to ensure all capacity is fully utilised. 3. 18 week steering group, each specialty highlighting capacity issues in issues log. 4. RTT 18 action plan being reviewed at steering group. 5. Additional theatre lists provided on Saturdays 5. RTT18 clinical outcome recorded on PAS 6. Additional data analyst post to provide cover for DH returns. 7. Clinical outcome forms revised for each specialty. 8. Develop reports to monitor specialty performance, planned w/l with expected TCI, backlog and open pathways monthly. 9. Validation of PTL lists weekly including admitted, non admitted and open pathways. 10. Amended policy incorporates new guidance re planned cases. 11. Training and guidance issued. 12. Monthly review of planned cases without date for attendance at QVH. 13. Develop early warning systems to track increased demand and mismatch with future capacity 14. Proactively discuss W/L each week at OPG for patients 10 weeks plus who do not have TCI date to avoid breach in each speciality 15. Review and validate all pending TCI's for Apr, May, June to ensure patients booked within 18 weeks 16. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably 17. Introduce new LA DC facility by July to increase capacity in main theatres for more complex work.	Richard Hathaway	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 - agreed, being put into trust format Appointment of Access and Performance Manager - Completed 9. Ensure 95% patients are pre-assessed at least 7 days prior to surgery (inc off site)	28/04/2014	KSO2	Approved
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	Richard Hathaway	Jane Morris	Compliance (Targets / Assessments / Standards)	12	8	Introduce and use cancer network databases within QVH for all MDT's.- Completed Streamline current referral pathwaysfor all types of cancer Establish Cancer Group and Cancer Data Management/MDT team for QVH. Proposals in development - Completed Setting up of 2 week skin cancer clinic - Completed Setting up of central referral management - No longer required Implementation of infoflex and Somerset cancer databases on site - completed Introduce same day see and do LOPA slots - Completed Expand use of infoflex system across Trust Establish business continuity cover in the absence of the data co-ordinator - completed - restructure being agreed and implemented from 22nd April - Completed Create local access policy for the Trust- completed Establish project team to integrate the cancer pathway- Completed Process mapping of skin cancer pathway and cancer data - Completed Action plan specifically focused on skin cancer performance to be devised and implemented including process mapping sessions. - Completed Set up QVH cancer improvement steering group - completed Review COSD data completeness and agree action plan to improve % - Completed Employment of data entry clerk to support	28/04/2014	KSO2	Approved

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Principal objectives	Approval status
513	04/01/2012	Potential failure to act on infection concerns due to unavailability of Microbiologist	1. Delay in updating policies 2. Reduced patient care due to review not conducted by microbiologist on site 3. Delay in reporting on specimens 4. Reduced attendance on site by Microbiologist	1. Problems recruiting consultants at BSUH 2. No regular microbiology consultant cover on-site 3. Failure for BSUH to fulfil contract requirements	1.Daily lab sheet of positive specimen results however, not all positive specimen are listed on this sheet. 2. Presence of microbiologist during week 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 training and 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	29/05/2014	KSO1	Approved
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. 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	Richard Hathaway	Nasir Rafiq	Information Governance	12	6	Monitor IG training compliance Deploy encryptioin software to manage use of unauthorised email accounts - Not required	30/04/2014	KSO6	Approved
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	Richard Hathaway	Bill Stronach	Finance	12	6	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	28/04/2014	KSO3	Approved
623	19/07/2013	Failure to meet CQUIN requirements for 2013/14 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	Provide Q3 update to quality and Risk Committee and Board	28/04/2014	KSO3	Approved

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Principal objectives	Approval status
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.	Richard Hathaway	Bill Stronach	Estates Infrastructure & Environment	12	4	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	15/04/2014	KSO4	Approved
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	Steve Fenlon	Jo Davis	Patient Safety	12	4	Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting Summary paper of WHO checklist related incidents developed to bring together actions and assurances. Document to next Clinical Policy and Quality and Risk Committees	01/05/2014	KSO1	Approved
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 investigation / PIR for all C Diff / MRSA cases . 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.	Amanda Parker	Amanda Parker	Patient Safety	12	6	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 inlcude outbreak meetings that continue past discharge of patient s to ensure additional preventtative mesaures identified 2. Review of investigation process - Completed Complete actions from MRAB SI report 6. Monitor microbiologist attendance on site to ensure antibiotic prescribing reviewed	29/05/2014	KSO1	Approved

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Principal objectives	Approval status
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	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	25/04/2014	KSO6	Being reviewed

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**152-14**
Report from:	**Steve Fenlon, Medical Director**
Author:	**Julian Giles, Clinical Lead for Research & Development, and Sarah Dawe Research and Development Manager**
Report date:	**16 June 2014**
Appendices:	**A: Research & Development Annual Report**

Research & Development Annual Report 2013-14

Background

1. This report sets out a review of the Trust's research and development activity over the last year. The report is provided for information, but also to demonstrate the current state of play in connection with the Trust's commitment in QVH 2020 to research and development as part of Key Strategic Objective 2 – world class clinical services.

2. The report has been considered by the Clinical Cabinet prior to presentation to the board.

Key issues

3. The Board is asked to note that recruitment to National Portfolio studies has almost doubled over last year. Since core research and development funding is directly tied to the number of participants recruited, this has resulted in confirmed funding for 2014-15. The increase in recruitment was achieved by the successful new Research Nurse/Clinical Trials Co-ordinator role.

4. A new, fixed-term, Research Director post has been established. This is a joint post with the University of Brighton, and has resulted in closer strategic collaboration with the University and in joint grant applications. The post is funded by the Charitable Funds.

Implications of results reported

5. The new Clinical Trials Co-ordinator role has considerably boosted research activity at the Trust and guaranteed future funding.

6. The Research Director post will facilitate access to major grant awards.

Action required

7. The Trust needs to secure the future of these two key R&D posts. An application will be made to the Charitable Fund in due course, and an indication of the Board's support for the posts and their work would be valuable.

Link to Key Strategic Objectives

6. An expanding R&D programme contributes to outstanding patient experience, world class clinical services, and operational excellence. It contributes to financial sustainability by bringing funding into the Trust.

Implications for BAF or Corporate Risk Register

7. Losing the Clinical Trials Co-ordinator post represents a risk to the Trust because without it core research and development funding would be lost.

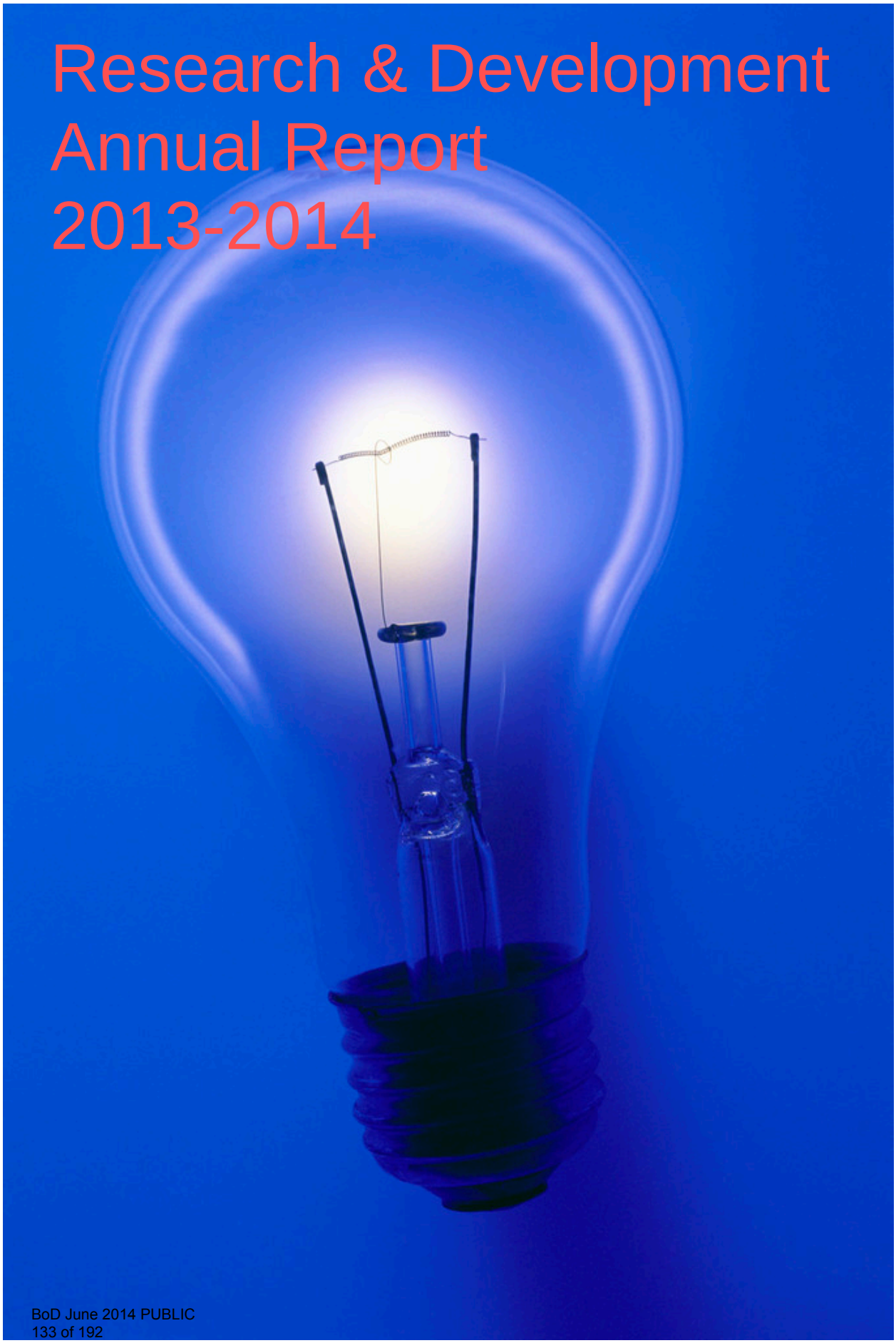
Regulatory impacts

8. The Trust complies with all relevant research legislation and guidance, and the research programme presents no threat to the Trust's Care Quality Commission registration or Monitor risk ratings.

Recommendation

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

Research & Development Annual Report 2013-2014



Queen Victoria Hospital
NHS Foundation Trust

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Foreword

It gives me great pleasure to introduce the Research and Development Annual report.

It has been heartening to see the some of the plans put in place last year beginning to come to fruition. What has been achieved is described within this report however I would like to highlight a few areas.

In January we welcomed Dr Brian Jones to the Trust. Brian is the new Director of Research Development. He is on a one year secondment from the University of Brighton. This post has been funded with the generous support of the Charitable Funds. Brian's role is to develop collaborative projects with our academic partners and to foster greater engagement with research within the Trust. Brian has already proved a great asset to the Trust. He has opened our eyes to the extensive collaborative opportunities that there are available to us both with the University of Brighton and more generally. The University is very active in research and education across the whole spectrum of healthcare provision. For the Hospital to truly embrace a research culture we must strive to get every member of staff enthused and engaged. Research should not be the preserve of a few mildly eccentric academics. The Trust strives to provide truly excellent care. To achieve cutting edge modern care all members of the team must question and develop their care. This extends from the student nurse starting their very first shift on Ross Tilley to the senior Consultant contemplating retirement. Brian has been instrumental in encouraging several nurses to apply to join NIHR research programmes. We wish them every success with these applications.

Brian's expertise, experience and connections have allowed us to consider undertaking a series of research ventures that would hitherto have been impossible. I look forward to providing further details of these in my next report.

The number of patients recruited into National Institute of Health Research (NIHR) Portfolio studies at the Trust has continued to grow. We recruited 122 patients last year almost doubling the number achieved in the previous year. Our success in this helped to guarantee the research infrastructure funding we receive from the NIHR. We have used some of these funds to recruit Debbie Weller as our Research Trials Coordinator. Sarah Dawe, the Trust's R&D Manager, has worked hard to ensure we meet our recruitment targets.

Charles Nduka and his team have been awarded a highly prestigious Wellcome Pathfinder grant to explore new treatment modalities in facial palsy. This project is in collaboration with industry and

academic partners, using new technologies in innovative ways to improve the care of facial palsy patients at the QVH. This is a perfect example of the type of collaborative translational medicine project that the Trust should be at the forefront of developing.

Research continues to be given a high priority within the National Health Service. A duty to use research and evidence-based best practice to improve standards is enshrined in the Health and Social Care Act 2012. It seems likely that the Care Commissioning Groups will closely examine the engagement of Trusts in research when they consider commissioning our services.

QVH has identified research as one priority within its strategy for clinical excellence. Responsibility for this programme rests with the Medical Director, who draws on the support and enthusiasm of the research team to deliver our objectives over the next 5-10 years.

I would hope that this report demonstrates we are developing a culture within the QVH where a commitment to research permeates all aspects of the care we provide for our patients.

Julian Giles
Clinical Lead for R&D
Consultant Anaesthetist

Highlights

- Recruitment to National Portfolio studies is a key focus of our R&D efforts, and the appointment of a Research Nurse helped us to meet and exceed our CLRN target. This in turn guaranteed our core R&D funding for 2014-15. Our CLRN target for 2013-14 was 105 recruits; QVH succeeded in recruiting 122, almost double the previous year's figure. Participation in Portfolio studies is considered a key indicator of a successful R&D programme.
- We have two active grant awards ongoing: 'Can intra-operative passive movement therapy improve recovery?' (RfPB, Julian Giles), and 'Clinical evaluation of the effect that sprayed culture keratinocytes have on early wound healing in children' (Sparks, Baljit Dheansa), which also funds a PhD student.
- We also have one new grant awarded from the Wellcome foundation, which will commence in 2014, 'Mobile interactive remote reassessment or rehabilitation in facial palsy patients' (Charles Nduka).
- The Trust has appointed an academic Research Director, in collaboration with the University of Brighton. Dr Brian Jones is being seconded from the UoB for 4.5 day/wk for a fixed term of one year. This post will act as a catalyst to consolidate and develop the Trust's potential in R&D. Two grant applications have already been developed and submitted – a Clinical Research Fellowship Application which will provide 4 years of funding for a study to improve diagnosis of infection in burns patients, and lead to a PhD; and one for an NIHR-funded MRes programme, also focusing on improving clinical outcomes for burns patients. This will provide full salary cover for the candidate to pursue this degree, and ensure they are eligible for further NIHR funding.
- We were very pleased to host our fourth cohort of undergraduates from Brighton and Sussex Medical School, who spent nine months of their 4th year with us working on research/audit projects, supervised by QVH consultants. Their studies were all presented at our Research Day on Monday 24 June. These student projects have helped to foster closer links with our colleagues at BSMS.
- The Trust was in the top 7.5% nationally for performance in initiating and delivering clinical research.
- At our fourth annual Research Day, which was very well attended, Prof Tony Metcalfe (BMRF) spoke about the world of burns, wound healing, biomaterials, stem cells and regeneration. Our Research Days are helping to build a multidisciplinary approach, and foster a culture where participation in R&D is a regular part of clinical life.
- We have continued our research in the psychosocial aspects of the surgery we undertake, and are developing a collaborative research programme along these lines with Prof Lesley Fallowfield's unit at the University Sussex.
- The Trust is grateful for the support of the CLRN, who have awarded core funding to support a variety of research posts at the hospital. We are actively working with the CLRN to grow research in Portfolio studies and to continue to improve set-up times. The R&D Manager provides training to R&D staff across the patch on behalf of the CLRN.

Research Activity

The number of patients receiving NHS services provided or sub-contracted by the Queen Victoria Hospital NHS Foundation Trust in 2013-14 that were recruited during that period to participate in research approved by a research Ethics Committee was 440.

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

QVH was involved in conducting 37 clinical research studies in 2013-14, as per the tables below.

Active studies 2013-14	Start date	Chief Investigator	Recruitment in 2013-14
SIFTI - Scientific Investigation of the Biological Pathways Following Thermal Injury in Adults and Children	18/11/13	Dheansa, Mr B	3
Trismus Trial: Randomised Pilot Study of Therabite® versus Wooden spatula in the Amelioration of Trismus in Head and Neck Cancer Patients.	07/06/13	Bisase, Mr Brian	1
Effects of deposit build up on prosthetic eyes and the implications for patient comfort	18/09/13	Litwin, Mr Andre	15
Evaluation of centralisation in head and neck cancer (Head and Neck 5000)	16/04/13	Bisase, Mr Brian	46
Upper eyelid loading with platinum segment implants for treatment of lagophthalmos	02/07/13	Malhotra, Mr R.	10
The influence of alar base width on perceived attractiveness	01/05/13	Crawford, Mrs Nicky	110
Socio-economic impact of burn injury on parents and children	01/02/13	Dheansa, Mr B	17
Patients' views on orthodontic treatment in cleft lip palate	16/04/13	Scambler, Dr Sasha	4
Scanoskin: An evaluation of a new modality for diagnosing burn depth – defining thresholds for depths and prediction of healing times. A prospective pilot study using Laser Doppler Imaging as a comparator	01/02/13	Dheansa, Mr B	21

A Randomised Controlled Trial of Pain Experienced During Steroid Injection of Keloid Scars With or Without Prior Cryoanalgesia	13/06/13	Nduka, Mr C	6
Effect of Manuka honey on wound healing: Randomised controlled trial on surgical upper eyelid skin wounds	09/05/13	Malhotra, Mr R	46
Can intraoperative passive movement (IPM) therapy improve recovery?	11/09/12	Giles, Dr J	43
A controlled study analysing tissue and circulating micro RNA signatures in patients with stage I-III malignant melanoma	26/06/12	Banwell, Mr Paul	28
Investigation into NHS reforms on the management of physiotherapy	17/04/12	Jenkins, Fiona (external)	1
A multi-centre, randomised controlled trial assessing the effectiveness of Lugol's Iodine to assist excision of moderate dysplasia, severe dysplasia and carcinoma insitu at mucosal resection margin of oral and oropharyngeal squamous cell carcinoma.	15/08/12	Norris, Mr P	19
A prospective observational study comparing nipple projection in three breast reconstruction techniques; DIEP flap, latissimus dorsi flap and skin sparing mastectomy with implant reconstruction.	03/01/12	Jones, Mr Martin	15
Measurement of Sniff Nasal Inspiratory Pressures, Maximal Intraoral Inspiratory Pressure & Expiratory Pressure in Facial Palsy Patients Using the MicroRPM Device	20/09/11	Nduka, Mr C	0
A randomised controlled trial of pain experienced during the administration of botulinum toxin injection with or without prior cryoanalgesia	27/05/11	Nduka, Mr C	10
Rapid autologous sprayed keratinocytes	01/10/09	Booth, Mr Simon	7

A randomised controlled study comparing a dynamic splinting protocol versus a static splinting with early active motion protocol in EPL (Extensor Pollicis Longus) tendon repairs zones 2-6 after traumatic injury.	10/02/11	Pank, Ms Kathryn	29
The cultural representation of older people	13/03/13	External study	8
The Perspectives of Directors of Nursing in NHS Acute Trust on caring practices	04/12/13	Davies, Mrs M (external)	1
Novel Coronavirus Observational Study (external)	21/10/13	Munday, Ms Alison	0

Studies not involving patient recruitment 2013-14	**Start date**	**Chief Investigator**
Cancer of the tonsils: has it always been associated with Human Papilloma Virus?	31/10/13	Barrett, Dr B
PREDICTR-HNC (Improving treatment selection using Predictive Classifiers of Treatment Response for Head and Neck Cancers and dysplasia)	14/08/13	Barrett, Dr B
Molecular abnormalities in early cancer	02/10/12	Barrett, Dr B
Molecular prediction of metastasis in oral tongue squamous cell carcinoma (external study)	19/07/12	Barrett, Dr B
Clinical evaluation of the effect that sprayed culture keratinocytes have on early wound healing in children (Sparks funded)	20/09/11	Dheansa, Mr B
Expression of fractalkine and its receptor in oral squamous cell carcinoma: is there an association with perineural invasion?	01/10/12	Barrett, Dr B
Enhancing the angiogenic capacity of adipogenic stem cell populations for the repair of soft tissue defects (*OPEN ENDED STUDY WITH BMRF*)		Metcalfe, T
The effect of nanofibre orientation on fibroblast and keratinocyte cells when subjected to mechanical stimulation and its potential for reducing wound contraction (*OPEN ENDED STUDY WITH BMRF*)		Metcalfe, T

Studies fully recruited and in follow up during 2013-14	Start-date	Chief Investigator
An investigation of the efficacy of a single low dose of insulin in the prevention of excessive cutaneous scarring in bilateral breast reduction patients - A phase II clinical trial.	07/04/11	Nduka, Mr C
Appearance-related concerns of women undergoing surgery for acquired and congenital breast conditions and their impact on levels of intimacy and satisfaction with surgery	01/08/08	Nduka, Mr C
Comparison between sheet grafts and 1:1 mesh grafts in burnt patients	01/10/06	Dheansa, Mr B
100 consecutive SSG donor sites - outcome data	01/06/09	Dheansa, Mr B
Extent of extra-capsular fibrosis following breast implant insertion	01/06/06	Jones, Mr M
A patient-centred questionnaire study to investigate the information needs of orthognathic (jaw surgery) patients from a patient's perspective	18/06/12	Ahmad, Dr S

Involvement in NIHR portfolio studies

Accruals for NIHR portfolio studies are recorded and monitored via a national database. The level of CLRN funding received by the Trust is partly determined by accrual figures. Accrual in 2013-14 was 122 participants. In 2013-14 six new NIHR portfolio studies were approved via the CSP system.

- CLRN target for 2013-14 was 105 recruits. QVH succeeded in recruiting 122 (as per table below)
- Recruitment rate almost doubled from 2012-13.

National Portfolio Study	Principal investigator	Recruitment in 2013-14
Can Intra-operative Passive Movement (IPM) Therapy Improve Recovery?	J Giles	44
Lugol's Iodine in Head and Neck Cancer Surgery	Paul Norris	19 – recognised as being one of the top recruiting UK sites
The Cultural Representation of Older People	No local PI	8
Head and Neck 5000	Brian Bisase	46
SIFTI	B Dheansa	4
Health services and delivery	External	1

Funding

Grant funding
The Trust currently has two fully grant-funded studies ongoing, both of which have been underway for two years. The Anaesthetics Department, led by Dr Julian Giles, is running an RfPB grant-funded (**£79,688)** study looking at non-site-specific pain following breast surgery, whilst the Burns Department is working on a collaborative study with the BMRF funded by a grant from Sparks (**£211,402)** to look at the use of sprayed cells on paediatric burns. This grant is supporting the full-time salary of a PhD researcher.

Charles Nduka is working on a study funded by the Wellcome Foundation looking at the use of iPads in supporting rehabilitation exercises for facial palsy patients. The Trust was a co-applicant on the grant, which is worth a total of **£111,015** across all partners.

Baljit Dheansa is developing a collaborative study with the University of Sussex looking at the psychosocial aspects of burns treatment, funded by the Burns Network (**£41,693)**.

Core funding
The CLRN awarded the Trust **£64,418** baseline funding in 2013-14. Baseline funding was allocated according to CLRN guidelines in the following way:

Resource	**Staff**	**Name**	**Allocation**
Research Nurse (to Oct 2013)	Ann	Payne	26755
Research Nurse (from Jan 214)	Debbie	Weller	4857
Research Nurse	Simon	Booth	11411
Consultant	Brian	Bisase	1067
Consultant	Paul	Norris	622
Consultant	Julian	Giles	5382
Research Registrar	Isabelle	Reed	4055
R&D Manager	Sarah	Dawe	4260
Clinical Trials Pharmacist	Judy	Busby	1620
Office Expenses			27
Travel			1163
Workforce Development			178
Overheads			3021

The Trust also received **£4,500** from the Brighton and Sussex Medical School to support the IRP students who undertake fourth-year research projects at the hospital.

External and commercial funding

£7830 was received from a commercial organisation for providing research governance and regulatory services to support Charles Nduka's insulin study. Further income was received as follows:

External study	Income (£)
Oleogel	2,765
Matiss	14,006
Volulyte	1,798
Scanoskin	800

Charitable Funding

The Trust's own Charitable Funds have provided funding for the fixed-term appointment of a Research Director seconded from the University of Brighton (Dr Brian Jones). This is a key strategic investment for the Trust and will be pivotal in developing collaborative work between the Trust and the University, and in developing grant applications. The Charitable Funds have also been instrumental in facilitating local research studies with small pump priming awards, and will continue to be available for clinicians to bid for on a response-mode basis. The Fund has also supported the Trust's psychosocial research work stream.

Infrastructure

The R&D Department presently consists of one Clinical Lead for R&D, one R&D Manager (0.66WTE) and one R&D Assistant (12h/wk). The Trust has also recently recruited a Research Director (fixed term), in conjunction with the University of Brighton. The postholder is a Senior Lecturer at the University of Brighton, on secondment to the Trust for 4.5 days/week for one year. The post is being funded by the Charitable Funds.

Funding was received from the Comprehensive Local Research Network (CLRN) to support the R&D Manager's post – this is limited to 8% of total funding under CLRN rules. Other income to support the R&D infrastructure comes from commercial studies, which in addition to paying general Trust overheads, pay a fee of £800 per study specifically for R&D Department services in processing their applications and setting up contracts. This year the R&D Department has also provided governance and regulatory services on a contractual basis for a commercial study looking at the use of insulin in reducing scarring, bringing in £7828pa.

New R&D Director's role

The new R&D Director as been working on a number of strategies for increasing research engagement and capacity across the Trust. A main focus has been the development of high quality research proposals to the NIHR and other funding streams. At present the Trust has submitted a Clinical Research Fellowship Application for Simon Booth, which if successful will provide four year's of funding for a research project to improve diagnosis of infection in burns patients, and lead to a PhD. We have also submitted an application for an NIHR-funded MRes programme, also focused on improving clinical outcome for burns patients. This will provide full salary cover for the candidate to pursue this degree, and ensure they are eligible for further NIHR funding.

The R&D Director has also been working on the implementation of a PhD project – to be jointly supervised by staff from the University of Brighton, BMRF and QVH – which will focus on understanding the issues around poor levels of burn patient involvement in research activities, and how to improve participation. Some 50% of the required funding has been identified and the remainder is actively being sought from other sources.

It is expected that during 2014 further NIHR Fellowship applications will be developed for eligible staff jointly between BMRF, QVH and UoB. Several longer-term initiatives to improve research capacity and engagement are also being pursued. These include the potential for the development of a scar tissue biobank, and a dedicated MSc course run with the University.

Four peer-reviewed publications from Dr Jones' research group affiliated with QVH have also been produced. Three have been accepted for publication with the fourth currently in revision. A further three publications affiliated with QVH are anticipated in 2014-2015.

Clinical Research Staff

The Trust presently supports one Burns Research Nurse (0.6WTE), and one Anaesthetics Research Registrar (0.2WTE). These are funded out of clinical budgets. A 0.8WTE Research Nurse (Band 6) has also been engaged on a fixed-term basis to support recruitment to National Portfolio studies.

The Trust supported one PhD student in 2013-14, working on a study in conjunction with the BMRF looking at the use of sprayed cultured cells in paediatric burns. This is funded by a grant award won from the charity Sparks, and the student is registered at the University of Brighton.

Some clinical departments also each have their own arrangements for Research Fellows, which are funded by the departments themselves and which are not managed by the R&D Department.

Comprehensive Local Research Network (CLRN)

The Trust is a member of the Surrey and Sussex Comprehensive Local Research Network (CLRN). The Trust works with the CLRN to maximize opportunities for Portfolio studies, identify new studies the Trust may participate in, and implement new national systems and structures. The CLRN distributes R&D resources amongst its members, according to a national algorithm. The R&D Director sits on the CLRN Board, and the R&D Manager regularly attends meetings for LRDOs, working closely with the Senior Manager Dr Kala Ratnajothy and the Lead Research Management & Governance Manager Hazel Crawford. As from 1 April 2014, the CLRN has restructured into the Kent, Surrey and Sussex CRN. The new CRN has reaffirmed its commitment to supporting R&D at the Trust, and will continue to fund its Portfolio work, subject to CRN targets being met. Meeting these CRN targets is a priority area for the Trust.

NIHR CSP

Local approval processes are continually being adapted to meet the evolving requirements of the national NIHR CSP research approvals system and to integrate with the online Integrated Research System. Meeting the demands of CSP is a significant challenge for the Trust, with national targets being increased each year to stretch and improve performance. There have also been new procedures implemented to meet the requirements of the Research Support Services Framework. Study set-up time and time to first recruit and are tracked according to national metrics, with regular data returns made to both the CLRN and NIHR. QVH has performed extremely well all metrics measuring time to approval.

For the most recently available national report collated by the National Institute for Health Research, QVH came in the top four Trusts nationally for performance (out of the 53 most research-active NHS providers who are required to submit). This is based on Q3 data, as national Q4 data is not yet available.

Intellectual property

The Trust engaged the services of NHS Innovations South East to assist with commercializing its intellectual property, and this year they were involved in assessing four potential new innovations, and managing three ongoing ones.

Consumer involvement

QVH works to find meaningful ways to involve consumers in its research activity. We are fortunate to have two very involved consumers who sit on our R&D Governance Committee as patient representatives, and who take a very active role in advising on and monitoring the research activities of the Trust. Consumers are also often involved in the early stages of research projects via focus groups, who feed into protocol development.

Training and Development

The Trust is currently part-funding two therapists through a Masters in Research at Brighton University, and their research will involve the facial palsy service. The Trust is also fully funding a surgical trainee to do a PhD at Brighton University. Plans are also underway to apply for funding for the Burns Research Nurse to undertake a PhD.

Local Training
Individual training tailored to the individual is provided by the R&D Department to all new researchers who require guidance developing their protocols, navigating the approvals process and setting up their studies.

It is a legal requirement that all staff involved in clinical trials complete Good Clinical Practice (GCP) training, and the Trust has facilitated this for staff – either by providing an onsite trainer, enabling access to off-site courses at other Trusts, or by paying for staff to do an individual online course. Commercial companies regularly run refresher GCP courses for staff involved in the clinical trials they run at the Trust.

The R&D Manager regularly attends induction to speak to all new clinical recruits. They are all issued with an R&D pack which includes all up to date R&D policies. This is a useful forum to quickly identify juniors who are interested in R&D, and provide them with guidance and assistance.

CLRN training
The R&D Manager acts as Trainer on behalf of the CLRN providing training in all aspects of research management and governance to R&D staff across Surrey, Sussex and Kent.

The Trust has access to training provided by the CLRN for any studies which are accepted onto the National Portfolio. These mainly focus on GCP training.

Annual Trust R&D Day
We were delighted with the success of our third Trust R&D Day in July, which featured Prof Tony Metcalfe (BMRF) and Matt Gardiner (University of Oxford), as well as showcasing current and planned studies from QVH staff, and studies undertaken by Brighton and Sussex Medical School IRP students. These meetings have proved to be very popular with clinicians from all departments. The full programme was as follows:

- **Prof Tony Metcalfe** Scar Trek: A voyage into the worlds of burns, wound healing, biomaterials, stem cells and regeneration
- **Matt Gardiner**: In search of osteoarthritis biomarkers, *plus - Reconstructive Surgery Trials Network*
- **Naseem Ghazali** – Evaluating potential biomarkers for late effects of H&N cancer radiotherapy
- **Onur Gilleard -** Micro RNA signatures in malignant melanoma
- **Masha Singh** – Objective assessment of microsurgical skill
- **Lexi Thomas** – Beyond smile surgery: Integrating novel technology to improve outcomes
- **Gurprit Bhamrah** - Information needs for orthognathic patients
- **BSMS students**: Nadia Kilburn; Neysan Pucks; William Butterworth; Caroline Rogers

Departmental meetings
Individual departments also run their own Audit & Research meetings, providing a forum to discuss new ideas and present completed studies.

Research Design Service
Our Research Design Service (RDS) at the University of Brighton provides a good service in training staff in RfPB grant applications, with seminars being run at the Trust, and support also provided to individual researchers on a one-to-one basis.

NIHR membership
Dr Julian Giles has been made a member of the faculty of the National Institute for Health Research (NIHR), by virtue of his successful grant application to the NIHR RfPB funding stream. This prestigious award will facilitate access for the Trust to further NIHR funding streams.

Governance Structure

R&D at the Trust is managed via a Research & Development Governance Committee. Its members include: R&D Director, R&D, Director of Nursing & Quality (executive director with responsibility for research governance), the Clinical Lead for R&D, Chief Pharmacist/Clinical Trials Pharmacist, Anaesthetics Lead, Burns Lead, Corneoplastics Lead, Hand Surgery Lead, Maxillofacial Lead, Nursing Lead, Oncoplastics Lead, Healthcare Science Lead, Orthodontics Lead, Clinical Audit Manager, R&D Manager, Finance Dept representative (R&D budget accountant), Designated Individual with responsibility for Human Tissue Authority license, External academic advisor from the BMRF, and an External academic advisor from BSMS. The Committee also has two very active patient representatives who play a valuable role in advising on new projects.

The R&D Governance Committee reports to the Quality and Risk Committee, and the R&D Manager provides a presentation to the Q&R Committee once annually.

The Director of Nursing acts as the Trust's Nominated Consultee, for research participants unable to consent.

The R&D Manager sits on the Eye Bank and Tissue Engineering Committee.

***Trust policies which cover R&D*:** Adverse Event Reporting Policy, Research Fraud Policy, Code of Practice for Researchers, Pharmacy policy for Clinical Trials, Intellectual Property Policy, Overheads

Policy. In addition, we have a comprehensive range of Standard Operating Procedures, in line with national guidance, to ensure consistency in our approach to R&D approvals: P02-Manage Study Participating Planning Tool v1; PO3 Confirm Study Approvals v1; PO4 Setup and Control External Agreements v1; PO5 Setup and Control Internal Agreements v1; PO6 Setup and Control Study Processes v1; PO7- Give NHS Permission v1; PO8-Oversee Study v1; S04-Ensure Study Funding and Approvals are Managed v1; S05-Manage Study Sponsor Planning Tool v1; S06-Give Decision on Sponsoring v1; S07-Provide and Manage External Agreements v1; S08-Ensure NHS Permission is Received by the CI v1; S09-Ensure Study Oversight v1; S10-Ensure Study Closedown is Managed v1.

R&D approvals

The Trust uses national systems to manage the studies in proportion to risk, and has adopted the Research Support Services framework recommended SoPs. The R&D Dept provides extensive guidance with using the national IRAS applications system. Researchers are given one-to-one support with their applications.

There are national CLRN targets for the processing of R&D applications (30 days from the receipt of valid research application; 30 days from NHS permission to first recruit; 70 day overall NIHR target), and QVH has met and exceeded these targets. QVH approval times are reported quarterly to the NIHR, and published on the QVH website.

National NIHR metric for 2013-14	**QVH time in days (Q3 data)**
mean time from receipt of valid research application to NHS permission	5.6
median time from receipt of valid research application to NHS permission	4
mean time from NHS permission to first recruit	24.6
median time from NHS permission to first recruit	28

For the most recently available data, these times place QVH in the top 7.5% for initiation and performance nationwide.

Research Passport – the Trust has fully implemented the nationwide Research Passport system, helping to facilitate studies where researchers are based at multiple sites.

Sponsorship status

The majority of research carried out at QVH is investigator-led ie designed and conducted by our own staff, and these require the Trust to provide structures to support pre-protocol work and peer-review, as well as the subsequent management of active projects.

No research study may begin in the NHS without a Sponsor being identified. The Trust continues to offer its researchers the benefits of providing Sponsor status for the studies they initiate. QVH believes that it is right to support its researchers in developing new projects, and to encourage the spirit of intellectual enquiry, and so continues to provide Sponsorship status for all non-CTIMPs plus phase IV CTIMPs. The Trust's capacity for R&D, and it's commitment to research, is clearly stated in its official RDOCS (R&D Operating Capability Statement), which is a publically available document endorsed by the Board and published on the QVH website, according to national guidelines.

Registered Research & Development projects (with Ethics Approval) ongoing in 2012-13

Post functional outcome of hand burns and effect on quality of life
Chief Investigator: B Dheansa
Status: IRP Study; recruiting

The best outcome after a hand burn is difficult to assess. There is no reliable method of working out how much functional outcome must be regained and how this may affect the patient's quality of life. This study will attempt to collect information about hand function after burn injury in order to develop a validated outcome measure. Key questions are how well do hand burns heal and how does this effect quality of life. We plan to recruit 10 patients with varying depths of hand burns and using several methods of physical and patient focused outcome assessment design a validated tool to assess outcomes

The study has been designed by a medical student in consultation with Surgeons, Nurses, Occupational and Physiotherapists, we have also consulted a patient focus group on the questions they feel are important to research in Burns.

An investigation of the efficacy of a single low dose of insulin in the prevention of excessive cutaneous scarring in bilateral breast reduction patients - A phase II clinical trial. (Commercial study)
Chief Investigator: Charles Nduka
Status: in analysis

The purpose of this trial is to determine the efficacy of a single application of insulin in reducing scar formation. Scarring is an immense clinical problem estimated to affect 100 million patients per annum. Scars affect both appearance and function. Scar tissue's inflexibility and contraction reduces mobility and function of affected body parts, joints and orifices such as the eye and mouth. Scarring results in disfigurement, disability, psychological problems alongside requiring multiple further corrective surgical procedures to reconstruct features and restore function. Currently there is no truly effective anti-scarring treatment available to patients. Development of such a treatment would significantly improve quality of life for thousands of patients per annum, and reduce costs to the NHS. Laboratory research together with a small clinical trial (15 patients) has provided evidence for a novel anti-scarring activity of insulin, where application of a single low dose early after wounding significantly reduces the scar tissue producing cells present and consequently scar tissue. The proposed large-scale multicentre clinical trial involves 75 patients undergoing non cancer related breast surgery to be recruited across two hospital sites. These patients have two identical wounds (one per breast), allowing matched intra-patient placebo control. Each patient after giving informed consent would undergo their elective surgical procedure as per routine apart from each breast wound would be randomly allocated to receive either insulin or the placebo as subcutaneous injection along a 3cm end of the wound. Patients would be followed up as per routine (23wks and 3months) plus two additional follow up appointments at 6 and 12 months. At each of these their wound/scar would be assessed, photographed and a silicone mould taken by the nursing practitioner.

Appearance-related concerns of women undergoing surgery for acquired and congenital breast conditions and their impact on levels of intimacy and satisfaction with surgery
Chief Investigator: C Nduka
Current status: in follow-up

Previous research confirms that plastic surgery can offer psychosocial benefits for women undergoing breast surgery but it does not address *all* the psychosocial experiences of patients or indeed *all* patient groups (Sandham & Harcourt 2007; Harcourt et al., 2003). There is a paucity of research examining the

appearance and intimacy concerns of women undergoing breast surgery for acquired or congenital conditions which this study hopes to address. This is a prospective, longitudinal survey of all women who are undergoing breast surgery (specifically reconstruction, congenital asymmetry, reduction) at the Queen Victoria Hospital. The study will employ standardised measures. Comparisons will be made both within and between patient groups and therefore enable more tailored support as it is currently unclear how they differ in their care needs and the extent to which these needs are met

Rapid autologous sprayed keratinocytes
Chief Investigator: T Cubison, S Booth
Status: in analysis

Burn wounds requiring closure with split skin grafts require skin to be harvested from a donor site. A Donor site usually heals in 10 – 14 days (similar to partial thickness wounds) the donor site heals by a process known as epithelialisation where skin cells from hair follicles divide and move over the wound to close it. We believe that we may speed this process up by using the cells taken from a small piece of skin and reapplying them onto the wound.

We aim to evaluate whether the application of a rapid harvest Keratinocyte suspension improves healing and reduces scarring in skin graft donor sites and use this as a model for deep partial thickness burn injuries. Patients undergoing a skin grafting procedure will be recruited and the skin graft donor site treated with isolated skin cells. The rate of healing will be measured and compared against control areas to give an accurate measurement of wound healing. Image analysis of digital photographs will be used to measure the rate of wound closure. Transepidermal water loss will be used to quantify the permeability of the skin to water. As one of the main functions of skin is to minimise evaporative water loss this is an important measure of its function.

A randomised controlled study comparing a dynamic splinting protocol versus a static splinting with early active motion protocol in EPL (Extensor Pollicis Longus) tendon repairs zones 2-6 after traumatic injury.
Chief Investigator: F Mellington
Status: ongoing – in analysis

This study aims to investigate whether a static splinting with early active motion protocol is as effective as a dynamic splinting protocol, using ROM (range of movement) outcomes.

A pilot study of histological and clinical variables contributing to both a long-term natural history and an estimation of time from injury for normal cutaneous scars taken at routine scar revisions at 4 plastic surgical units in the UK
Principal Investigator: T Cubison
Current status: recruitment complete; in analysis

Keloid and hypertrophic scarring are both disfiguring scars that affect individuals after injuries, operations and burns. There are no universally effective remedies for scaring, and we often have to relay on surgical techniques of scar revision which in reality simply create more scars. Once a scar is created there are few means by which we can control it. Scars can continue to grow larger (keloid scars) or they can be raised, painful, red and associated with joint contractures (hypertrophic scars). Managing scarring takes up a significant proportion of the workload of a plastic surgeon and can seriously reduce the quality of life for the sufferer; nowhere is this seen more commonly than in burnt patients. Surgery has reached a biological frontier when it comes to scarring, having little effective understanding of the process which has lead to a paucity of treatment options. This research will attempt to address scarring in a "back to basics" approach, we are not studying abnormal scarring, which has already been done, but we are trying to achieve a clearer picture of what a normal scar actually represents. With this information

abnormal scarring may become easier to distinguish from normal scarring and so new avenues of therapy can be opened.

Forensic anthropologists are frequently involved with the identification of either living or dead human subjects. To date, there are no studies showing the long-term changes that occur in scars. If a clear set of histological (microscopic) variables that change with time can be established then an accurate estimation of time duration from injury could be achieved. This would give the investigator knowledge as to when an individual has been injured which would provide more information to identify them with. It also has medico legal implications providing a better evidence base for medical witness testimony in court regarding the nature of scars.

Extent of extra-capsular fibrosis following breast implant insertion
Chief Investigator: R Smith
Status: in analysis

Breast cancer is the commonest cancer effecting women in the UK and USA, with over 41,000 and 270,000 cases respectively, being diagnosed annually. A significant proportion of these patients would have previously undergone implant augmentation, either for aesthetic reasons or as part of a previous reconstruction. In a number of cases where such women have subsequently undergone free flap breast reconstruction, we have encountered significant perivascular fibrosis when dissecting out the internal mammary vessels to perform anastomosis. The popularity of the internal mammary artery and vein as recipient vessels has increased over recent years with Quaba et al reporting over 70% of surgeons using them in delayed breast reconstruction.

The formation of a capsule around a prosthetic breast implant is well documented. The extent of fibrosis into the deeper tissues and its effect on recipient vessels for free flap breast reconstruction is not known.

In those women undergoing capsulotomy/capsulectomy we propose to take small biopsies of deeper tissue and examine them histologically for evidence of fibrosis. If there is evidence supporting this theory, then it may influence the reconstructive surgeon to consider an alternative technique in this particular sub group of patients.

Comparison between sheet grafts and 1:1 mesh grafts in burnt patients
Chief Investigator: B Dheansa
Status: ongoing – in recruitment

Meshing is the term used for cutting slits into a split skin graft and stretching it open prior to transplantation. Meshed grafts have a number of advantages over sheet grafts, which are generally perforated by scalpel: 1) Meshed grafts can be stretched to cover a larger area than sheet grafts; 2) the contour of the graft can be adapted to fit an irregular recipient bed; 3) blood and tissue fluid can drain freely through the meshed graft to allow for increased graft take; 4) In the event of bacterial contamination only a small portion of the graft may be lost; 5) meshed graft offers multiple areas for re-epithelialisation. The main disadvantages of meshed grafts are the large area that must heal by second intention, and the persistence of mesh pattern in the healed graft. In areas of cosmetic sensitivity, sheet graft is still frequently used to avoid mesh pattern, but graft loss may be higher for the reasons outlined above. Some of these problems have been addressed by using unexpanded 1:1.5 machine-meshed skin.

Anecdotal evidence suggests that 1:1 mesh has the advantages of machine meshing, but with a similar cosmetic outcome as sheet graft. We are currently the only centre in the UK using a mechanical 1:1 graft mesher.

100 consecutive SSG donor sites - outcome data

Chief Investigator: B Dheansa
Status: recruiting

Split Skin Grafting (SSG) is a common procedure. Although previous reports on skin graft donor sites report healing times, complications and benefits of particular dressings there is a paucity of data on the long term appearance. Healing times range from 7 to 20 days. Delayed healing or donor site infection may significantly affect the long term appearance of a donor site. Equally there is little data comparing patient and clinical views on donor site appearance in the long term. The method of dressing donor sites used in this department differs from other centres.

*Aim***:** To provide information on the long term appearance of split skin graft donor sites and relate this to healing times and complications. In addition, to provide a comparison between patients' and clinical views on the appearance of the donor site. To compare healing and complication rates of this departments dressings protocol with other series.

A prospective observational study comparing nipple projection in three breast reconstruction techniques; DIEP flap, latissimus dorsi flap and skin sparing mastectomy with implant reconstruction
Chief Investigator: Martin Jones
Status: in analysis

Breast cancer accounts for the second highest number of cancer related deaths in UK women. The treatment for a third of women diagnosed with breast cancer will involve total mastectomy and breast reconstruction. A significant proportion of these will choose to undergo breast reconstruction surgery

Research has shown that a principle determinant of patient satisfaction following reconstructive breast surgery is projection of the reconstructed nipple with poor nipple projection often resulting in lower patient satisfaction post breast reconstruction.

Whilst good nipple projection is commonly achieved when creating the new nipple in the operating theatre, the nipple retracts during the months following surgery leaving the patient with a nipple that projects less than their remaining natural nipple on the other breast.

The reconstructed nipple is created using skin from the reconstructed breast mound. Whilst different techniques of nipple reconstruction have been investigated with regard to which technique gives the best long term projection, the effect on long term nipple projection of the different skin type used in nipple reconstruction has yet to be determined. This project aims to compare long term nipple projection in nipples reconstructed with tissue taken from the back, the abdomen and the breast. An evidence base describing the amount of nipple retraction in each of the three skin types, and therefore best long term projection, will be valuable to reconstructive surgeons considering the most appropriate treatment choice for a patient and in determining the appropriate dimensions to be used in nipple reconstruction in order to achieve the required long term nipple projection. This will mean better symmetry of nipple projection between the natural and reconstructed breasts and an improvement in overall patient satisfaction in breast reconstruction.

A Randomised Controlled Trial of Pain Experienced During the Administration of Botulinum Toxin Injection With or Without Prior Cryoanalgesia
Chief Investigator: Charles Nduka
Status: recruiting

Cryoanalgesia is a well-documented technique for reducing pain, preceding local anaesthetics by many years. The first recorded use of cooling to achieve pain reduction in surgery was by Barron Larrey, Napoleon's surgeon who amputated frozen limbs in the Battle of Eylau, in Poland in 1807.

However, the development of new anaesthetic agents and techniques has resulted in a diminished use of cryoanalgesia. Cutaneous cooling is still employed, most commonly to reduce post-operative pain and inflammation and in dermatological laser therapy.

One of the paradoxes of modern surgery is that the administration of local anaesthetics is itself often very painful. A number of techniques has been attempted to abrogate this including topical anaesthetics (e.g. EMLA), or cooling with ethyl chloride spray. However, these techniques are sporadically employed either because they require prolonged application, or only work in very superficial layers of the skin, or are painful or irritant in themselves.

Selby and Bowles demonstrated that prior cryoanalgesia with ethyl chloride spray effectively reduced the pain experienced on venous cannulation. However it was noted in this study that the ethyl chloride was painful on its application.

Patients do worry about medicinal injections. Possibly one of their major concerns is that of the pain caused by these injections. Many surgeons including the principle investigator have used topical ice application to avoid the need for local anaesthetic injection for the shave excision of skin lesions. However this technique is by no means new. Constance Howie in 1971 demonstrated that refrigeration analgesia could be safely used to reduce pain experienced in the removal of donor skin to the extent that the subjects were 'completely unaware' that the grafts were being taken. In this paper the technique involved the application of ice for up to 2 hours, with 'no ill effects'.

As yet the use of cutaneous pre-cooling to reduce pain during Botulinum toxin injection in the treatment of facial palsy, has not been subjected to a randomised trial. The aim of this study is to compare the pain experienced on Botulinum toxin injection of the neck in patients with facial palsy, with and without prior cryoanalgesia. It is generally accepted that a wide range of temperatures provide analgesia but it is suggested that 0-5^{0}C be taken as the standard temperature for surgical anaesthesia (Allen and Crossman, 1943; Lee and Atkinson, 1968)

Measurement of Sniff Nasal Inspiratory Pressures, Maximal Intraoral Inspiratory Pressure & Expiratory Pressure in Facial Palsy Patients Using the MicroRPM Device (SNIP facial palsy)
Chief Investigator: C Nduka
Status: on hold

The MicroRPM instrument is handheld pressure meter for the upper airway. It looks and functions very much like the handheld 'peak flow' meter commonly used in primary healthcare settings (with single use disposable tubes/pieces). The key difference is that as well as breathing through the device via the mouth the patient also sniffs in through a valve that records the pressure generated and gives a digital readout each time. The MicroRPM instrument provides a noninvasive way of recording intraoral (mouth) and intranasal (nose) pressures. These readings indirectly reflect the strength of the chest wall/diaphragm. Hence, the instrument was CE certified as a tool for assessment of the muscles used in breathing (ventilation), and is in widespread clinical use today for this purpose. However, use in this way assumes normal facial muscle function in patients undergoing testing. Weakness or even paralysis may arise in facial muscles due to impaired facial nerve function and is commonly termed facial palsy. In this research study, we will use the MicroRPM instrument to record oral and nasal pressure readings in the standard way, but critically we will make different assumptions in the interpretation of the data. We will not compare datasets between patients but rather we will follow the progress of individual patients through a course of treatment for facial palsy. We will assume that in a facial palsy patient who is otherwise healthy, chest wall and diaphragm function will not alter significantly during a course of facial palsy treatment. We hypothesize that by serially recording pressure values over time we can develop a means of objectively quantifying treatment outcomes in our facial palsy service, specifically using nasal and oral pressures as markers of progress.

Clinical evaluation of the effect that sprayed culture keratinocytes have on early wound healing in children
Chief Investigator: B Dheansa
Status: ongoing; grant funded study; PhD project

Data from patients between the age of 1 and 15 years who have suffered a burn injury and received treatment in the QVH Burns Unit will be used to establish a database of scarring severity following treatment for burn of scald injuries. The data to be stored will be photographs, records of skin colour and the speed of healing. The severity of scarring will be evaluated using the Internationally recognised Manchester scar scale which measures skin colour, scar contraction and skin smoothness and is a recognised measure of scarring. Additional information such as cause of burn, area and depth of burn, time to heal, area healed at each dressing change or prior to treatment and any complications will be assessed or measured and recorded. Other information including referral source, first aid administration, previous health problems, medication and employment status will also be collated for research purposes. Existing data in the form of photographs and Manchester scar scale score will also be used provided the patient has consented to the use of photographic images for research purposes using the consent form currently in use.

A multi-centre, randomised controlled trial assessing the effectiveness of Lugol's Iodine to assist excision of moderate dysplasia, severe dysplasia and carcinoma insitu at mucosal resection margin of oral and oropharyngeal squamous cell carcinoma
Principle Investigator: P Norris
Status: in follow-up

Research evidence suggests that persistence of precancer tissue at the edges of tissue resected to treat oral cavity and oropharynx cancer leads to greater risk of recurrence of cancer at the primary site. Currently, tumour tissue can be distinguished clinically by the surgeon operating to remove cancer. Unfortunately, detected precancer change in the tissue next to the cancer itself is much more difficult. This leads to precancer tissue persisting at the edges of the removed tissue in around a third of patients treated. We aim to test whether use of a staining method will enhance accuracy of removal of precancer tissue. Precancer cells are abnormal in many ways. One effect of the changes is that they cannot store glycogen. This means that they do no stain darkly with iodine, as normal tissue does. This difference may allow us to better identify these precancer cells at the time of cancer excision and so remove all precancer cells at the same time. This may reduce the risk of second primary cancers developing in the same area of the mouth and throat. This study will be a randomised, controlled, blinded trial. Patients will be randomised to have cancer resection with or without the staining method. We will then compare the proportion of cancers removed which have precancer cells at the edges in each of the groups. This will allow us to assess whether this method is effective in helping us to remove all of the precancer tissue. The pathologist will assess resected cancer specimens in exactly the same way as it is carried out currently. They will not know which patients are in the staining group and so assessment of the effect of using the stain is blinded.

Investigation into NHS reforms on the management of physiotherapy
Status: External study, no PI

The aim of this research is to explore the effect of NHS reforms on physiotherapy services in England and Wales. This will cover the period from 1987, focussing on NHS employed physiotherapists and the result of the changes at National, Regional, Primary and Acute provider levels as well as the impact of the implementation of government policies. The impact on patient services and a range of staffing issues will be assessed, analysed and discussed along with an assessment of management quality and management structure. The professionalisation process of physiotherapy will also be analysed. The findings of the proposed research aim to provide information for policy makers at national and local levels, professional bodies and individual AHP professions particularly physiotherapists The objectives are:
• To examine the effects of Government policy for the NHS since 1987 on the management, organisation and provision of physiotherapy services in England and Wales

• To determine the impact that the changes in NHS policy on the professionalisation of physiotherapy
• To assess the extent that the internal professional organisation of physiotherapy stratification
• To determine the apparent advantages and disadvantages of different management models and organisation of physiotherapy services
• To develop and refine an assessment tool to assist in the evaluation of different management models for physiotherapy and which may be transferable to other Allied Health Professions services.

The overarching research question is: What effect has Government policy for the NHS had on the management, organisation and provision of NHS physiotherapy services in England and Wales?

The study design comprises mixed methods.

The influence of alar base width on perceived attractiveness
Chief Investigator: N Crawford
Status: in analysis

The nasal alar base is base of the nostril. The aim of the study is to investigate the effect of widening the alar base on perceived attractiveness in an otherwise idealised frontal facial view. The primary outcome measure is the rating of a series of images with varying alar base widths. The secondary outcome measure will be the point at which the image is unattractive and of concern.

Improving facial aesthetics has been shown to be a strong motivating factor in patients who decide to undergo orthognathic surgery or surgery to the jaws. It is generally accepted that following surgery to the top jaw there can be alterations in nasal soft tissue morphology, particularly affecting the nasal tip and alar base width. It is extremely important that any potentially undesirable side effects in the nasal area are identified in order to fully inform the patient before treatment begins.

An idealised facial frontal view will be generated on a computer using currently accepted criteria. The views will then be manipulated to widen the alar base in 2mm increments to give six female and six male images. All subjects who are eligible will be interviewed and asked for consent. If given, they will be asked to complete a preliminary questionnaire which includes a 10cm visual analogue scale rating concerned with their personal appearance. They will then be shown two sets of idealised frontal facial images, one male and one female series and asked to rate the images on a 10cm visual analogue scale for perceived attractiveness. Subjects will also be asked to mark at what point in the series the image becomes unattractive and unacceptable to them. Subjects will be asked to repeat the rating after exposure to control images three times and an average rating used for analysis. The control images will be male and female photographs not otherwise used in the study.

A patient-centred questionnaire study to investigate the information needs of orthognathic (jaw surgery) patients from a patient's perspective
Chief Investigator: S Ahmad
Status: in analysis

This is a questionnaire based study where we intend to identify if there is a particular part of the orthognathic (jaw surgery) treatment pathway of which patients think we should be providing further information. A number of psychosocial studies amongst orthognathic (jaw surgery) patients show that dissatisfaction after surgery is rarely related to the technical skill of the surgeon but rather from insufficient information prior to treatment. The literature shows satisfaction can be improved by ensuring patients are given appropriate information about all aspects of treatment. There has been little research investigating patients' opinions of the most important information from a patients' perspective that could improve their treatment experience. This patient driven study is being carried out to address this gap which has been identified in the research. In the present study we intend to identify whether there is a particular part of the orthognathic treatment pathway which patients think we should be providing additional information. The study will involve distributing the study questionnaire to presurgery and postsurgery orthognathic patients at the Queen Victoria Hospital, East Grinstead. The questionnaire covers patients' overall treatment experience including the presurgical and postsurgical orthodontic

phase of treatment with fixed appliances (braces), and the surgery (jaw surgery) aspects of treatment. Recruitment will last 5 months.

The results of this study will be used to develop the Queen Victoria Hospital orthognathic department information booklet and checklist for orthognathic patients with the aim of improving patient care.

Micro RNA signatures in malignant melanoma
Chief Investigator: P Banwell
Status: recruiting

Micro ribonucleicacid (miRNA), are small molecules which help regulate a number of important biological processes. Recently links have been made between abnormal production of these molecules and cancer development. Analysis of miRNA levels in malignant melanoma skin cancer has the potential to help predict prognosis and guide treatment to improve outcomes. Before this can be achieved it is essential to identify the specific molecules which are abnormally produced at different stages of the disease. The current study aims to do this by comparing levels of various miRNAs in the blood of: 20 normal adults, 20 patients with melanoma confined to the skin and 20 patients with melanoma that has spread to the lymph glands. In the latter 2 groups, after diagnostic examination has been completed, miRNA levels in melanoma tissue specimens will also be analyzed. All adults undergoing mole removal and being treated for melanoma at the Melanoma and Skin Cancer Unit, Queen Victoria Hospital will be eligible for the study. Samples will be examined at Brighton and Sussex Medical School. Once recruited, adults attending the hospital for mole removal will undergo a single blood test on the day of surgery. The mole will be excised, using a scalpel under anaesthetic, and will undergo routine diagnostic examination. If determined to be benign then the patient will be included into the control group. If diagnostic examination shows melanoma the patient will be included in the 'melanoma confined to the skin' group. Patients in whom melanoma has spread to the lymph glands will undergo a blood test in the preassessment clinic 34 weeks prior to surgery to remove these glands. The estimated duration to collect samples is 6 months. The goal is to complete the study 1 year after the recruitment of the first patient.

Molecular prediction of metastasis in oral tongue squamous cell carcinoma (external study)
Principle Investigator B Barrett
Status: external study

A cDNA microarray study carried out in Utrecht (Netherlands) discovered genetic differences between primary squamous cell carcinomas of the oral cavity and oropharynx that spread to the neck and those that do not. This work leaves the door open to genetic analysis of a tumour of the tongue that has yet to spread to the neck. It may be possible to check the genetic makeup of the tumour, using a combination of antibodies to help surgeons decide how likely a tumour is to spread to the neck and to decide whether or not a neck dissection operation or radiation to the neck is necessary. This could avoid unnecessary morbidity and mortality.

Patients with squamous cell carcinoma of the oral tongue are to be identified with at least 5 year follow up i.e. diagnosed before October 2004. Two groups are to be identified: those with spread to the neck, and those who did not develop spread to the neck. Case notes are to be reviewed and all clinical data and treatment, overall and event free survival are to be recorded. The histopathology slides and blocks of tumour archival material are to be identified will be used to make a tissue microarray. This is a research technique which allows for genetic analysis of samples to be done more quickly than routine techniques. No new samples collection or patient interventions are to be undertaken. The data will then be analysed to see which markers show differential expression between the two groups, or have relationship to overall and event free survival. These markers, used in combination, may be used in future prospective studies and in treatment planning.

Expression of fractalkine and its receptor in oral squamous cell carcinoma: is there an association with perineural invasion?
Chief Investigator B Barrett
Status: ongoing

The diagnosis of oral squamous cell carcinoma (OSCC) is usually made by histopathological, microscopic examination of a small incisional biopsy. Primary treatment follows, which in the majority of cases involves surgical excision of the tumour. The excision specimen is then also examined histopathologically. In compiling the definitive report on the tumour, the pathologist notes the presence of a number of features regarded as prognostically significant. One of these features is perineural invasion (PNI), i.e. a means by which the tumour can spread along nerves to distant anatomical sites. Although PNI might be apparent in the small incisional biopsy, it is often not detected until sections of the much larger excision specimen are available. A simple histological test applied to the incisional biopsy in which PNI is absent, which would indicate whether the tumour has infiltrated nerves elsewhere, would better inform surgical and radiotherapeutic treatment planning. Staining of histological sections of the tumour for the chemokine proteins fractalkine (CX3CL1) and its receptor (CX3CR1) might provide such a test.

Can intraoperative passive movement (IPM) therapy improve recovery?
Chief Investigator J Giles
Status: recruiting

Women who have previously had a breast removed for cancer undergo breast reconstructive surgery at the Queen Victoria Hospital in East Grinstead. These operations are very long. They may take 12 hours. After these operations over half of these patients will experience pain in other areas of the body away from the surgical scar. This pain can often be more painful and distressing than that at the surgical site. This is believed to be due to prolonged immobility in theatre. To address this we have developed a programme of limb mobilisation conducted during surgery (Intraoperative Passive Movements (IPM)). A small study at the QVH has shown that mobilisation effectively reduced this pain in the first 24 hours after surgery. This larger study will test examine if the reduction in pain is sustained and whether IPM improves the quality of recovery after surgery. All potential participants will be identified in the preassessment clinic 3 weeks before surgery. They will be given both verbal and written information. They will be approached again on admission. If they wish to enter the study they will provide written consent. It will be made clear that care will not be affected by nonparticipation. Participants will be randomly allocated to a treatment or control group by the Operating Department Practitioner (ODP). The theatre anaesthetists will not know which study group a participant has been allocated. Subjects will receive a standardised anaesthetic. At two points during the operation the OPD will administer (or not) IPM according to which group they have been allocated. IPM will not interfere or prolong the operation. Outcome will be assessed by comparing morphine use and responses to a questionnaire about the quality of recovery and function 1, 3 and 5 days after surgery.

Effect of Manuka honey on wound healing: Randomised controlled trial on surgical upper eyelid skin wounds
Chief Investigator R Malhotra
Status: in recruitment

Honey has been reported to improve wound healing. Animal studies have shown that honey treated wounds healed faster than control wounds. Human trials have also reported beneficial effect of honey on burn wounds. Manuka honey has antibacterial activity independent of the effect of honey's peroxide activity and osmolarity. The aim of this study is to evaluate the effect of active Manuka honey on wound healing following elective eyelid surgery, in particular upper eyelid ptosis(droopy eyelid) correction and blepharoplasty (removal of excess skin). We have chosen blepharoplasty wounds for this study as this procedure is performed bilaterally and one side can be used as the control. Patients undergoing upper eyelid ptosis correction and blepharoplasty will be identified in the eye clinic and invited to take part in this study. Patients undergoing this procedure are routinely advised to apply vaseline to the eyelid wound postoperatively to reduce the scarring. In this study the patients will be advised to apply Manuka honey on one eyelid wound (twice a day for 6 weeks) in addition to the application of vaseline. The eyelid wound will be assessed postoperatively using Manchester scar grading at 1 week, 1 month and 4 months to identify any difference in wound healing between the two sides. The results of this study will be applicable to all elective surgical and traumatic wounds of the eyelids.

A Randomised Controlled Trial of Pain Experienced During Steroid Injection of Keloid Scars With or Without Prior Cryoanalgesia
Chief Investigator: C Nduka
Status: in recruitment

Patients do worry about medicinal injections and one of their major concerns is that of the pain caused by these injections. Cryoanalgesia (the use of cold to reduce pain e.g. putting ice on a sports injury) is a well documented technique for reducing pain and preceded the development of local anaesthetics by many years. Additionally the injection of local anaesthetic agents is often painful in itself prior to the onset of any analgesia. Thus their use is not routinely indicated to relieve the pain associated with medicinal injections. Anaesthetic creams such as EMLA are used to reduce the discomfort of injection; however the creams often take more than 30 minutes to take effect and can be messy and inconvenient.
Many doctors use topical ice application in their practice in an attempt to avoid the need for local anaesthetic injections in quick or minimally invasive procedures or to ease the pain of injection in children. Although anecdotally effective and widely practiced, evidence is lacking to the efficacy of this method. We propose to investigate the efficacy of cutaneous cryoanalgesia by means of the application of a cooling gel pack prior to injection of steriod into keloid scars. The proposed study would be conducted on a purely voluntary basis by patients over the age of 18 who are attending a single site NHS hospital clinic and have a medical indication to receive steroid injection to keloid scars. Patients will be randomized into two groups (with or without prior cryoanaesthesia) using a cooling gel pack held onto to the area prior to receiving the injection. Subjects will be asked (through the use of visual analogue scales) to rate the pain experienced with needle insertion, steroid infiltration, and finally to rate the overall discomfort experienced during the procedure. The data generated will then be subject to statistical analysis

ScanoskinTM - An evaluation of a new modality for diagnosing burn depth – defining thresholds for depths and prediction of healing times. A prospective pilot study using LASER Doppler Imaging (LDI) as a comparator.
Chief Investigator: B Dheansa
Status: recruiting

Diagnosing burn depth has traditionally been done by subjective assessment and details from the clinical history. Methods such as a pin prick and cap refill have been used in routine clinical practice. Procedures such as biopsy, dye absorption and thermographic analysis have all been described as being highly accurate although, with a range of side effects and limitations. Laser Doppler imaging has been demonstrated to be highly accurate when used in burns between 2 and 5 days but may also be limited by interpretation or confounding factors such as infection or skin marking which would give a high flow scan may mask the true depth of burn. Although LDI is now accepted as the gold standard for burn depth diagnosis; It use has been limited due to expense – the LDIB2 costs in the range of £54,000 thus many UK Units do not have the capital funding for such equipment. ScanoSkin is an amalgamation of propriety image analysis software with a Hi Spec calibrated DSLR (Canon EoS 400D) and polarising filters which allows unique properties of a photographic image to be seen. The image is separated into three layers, the full colour image, a layer identifying the breakdown products of damaged haemoglobin and melanin from blood and skin tissues whilst a third layer reveals underlying blood flow. Clinical analysis of these images if demonstrated to be accurate should aid the clinician in diagnosing burn depth at a significantly reduced cost compared to Laser Doppler imaging. The study will investigate the accuracy of scanoskin technology against our current gold standard of LDI in diagnosing burn depth in adults attending the burn service for treatment.

Molecular abnormalities in early cancer
Principle Investigator: B Barrett
Status: ongoing

Cancers develop over many years in a step wise fashion; usually only the latest stages produce symptoms when the disease has often spread resulting in adverse treatment outcomes. For many cancers, treatment of the disease at its early stage is much more beneficial even with current treatments.

The principal objective of this work is to study the particular molecular characteristics of early (pre) cancer to enable disease markers and drug targets to be identified.

Secondary research questions relate to comparing the molecular differences between early and late cancer. In some studies, a hypothetical molecular difference will have been identified, often through work with cell lines, and the work of this application will provide specimens to test such candidates to determine at what stage of disease they become involved.

Patients' views on orthodontic treatment in cleft lip palate
Principle Investigator: A Cash
Status: external study

While there is extensive literature on the clinical management of cleft, lip and palate (CLP), there is little reported from the perspective of the child or the parent/carer. What is missing from the literature is an understanding of the patients' and parents' perspective on their expectations and experiences of orthodontic treatment including problems they have faced, things that made them worry, what they hoped treatment would achieve and the degree of satisfaction with the final outcome of orthodontic treatment. Whilst treatment may be clinically successful, it is difficult to judge overall success without an understanding of the patient and parent perspective. It is this gap that this study seeks to fill. The aim of this qualitative study is to explore patients' and parents' perspectives regarding orthodontic treatment they have received for cleft lip & palate repair. We shall use semi-structured in-depth interviews to explore the views of patients (aged 14 to 24) and parents who have completed the final definitive stage of orthodontic treatment, that is to say when the top and bottom teeth have been aligned and straightened. All interviews will follow the same topic guide. The interviews will follow an interview schedule to ensure that key areas are covered but will also allow the flexibility for participants to explore and explain their experiences in their own words.

We aim to recruit 30 cleft lip and/or palate patients and 30+ of their parents, where two parents wish to take part they will be interviewed. Patients with associated Craniofacial syndromes will be excluded. In total 60 interviews will be conducted. For participants' convenience, the interviews will be held in a non clinical setting. The researcher will be accompanied by a chaperone when interviewing children. Interviews will be held separately between patient and parent. All interviews will be recorded and transcribed verbatim. Data analysis will be conducted using a thematic framework analysis derived from the literature and developed through the analysis process of transcribed interviews.

Open, Blindly Evaluated, Prospective, Controlled, Randomized, Multicenter Phase III Clinical Trial to Compare Intra-individually the Efficacy and Tolerance of Oleogel-S10 versus Standard of Care in Burns patients
Principle Investigator: B Dheansa
Status: abandoned by Sponsor

Burn injury is a serious pathology, potentially leading to severe morbidity and significant mortality, but it also has a considerable healtheconomic impact. Burns occur at an annual incidence of 2,000 people per million in Europe. Burns can be classified according to the depth of injury into first, second, third and fourth degrees. This study aims to recruit patients with Grade 2a partial thickness burn wounds. Grade 2a partial thickness burn wounds are able to regenerate the skin lesion on their own and wound closure takes 1017 days. This study will compare intra individually (2 wound halves or 2 similar size wound areas within each subject). One half of the wound will be treated with OleogelS10 and the other half with octenilin® Wound Gel for a treatment period of approximately 21 days (the treatment can still continue until the Investigator decides to change medication and/or treatment if wound still open at 21 days), with dressing changes at the latest every second day. The efficacy and tolerance of OleogelS10 with fatty gauze as wound dressing versus octenilin® Wound Gel with fatty gauze as wound dressing will be compared using photographs evaluated by three blinded experts and via patient and Investigator questionnaires. The study aims to accelerate the healing process which reduces the potential associated morbidities to the patient including pain and infection. Importantly, accelerated healing correlates with reduced scarring.

Socio-economic impact of burn injury on parents and children
Chief Investigator: B Dheansa
Status: completed

Having a child with a burn injury can have a profound impact on parents and carers. This study aims to gain a thorough understanding of some of the main social and economic implications of having a burn-injured child. It is a pilot study that will investigate parents' reactions and the impact of injury, and we aim to use the information gained to develop interventions that can then be studied to evaluate their benefit.

We believe this research is very important and highly necessary as so far, there have been no comprehensive studies focusing on the socio-economic implications of paediatric burn injuries on parents and family. The research that has focused on parental factors is predominantly based on psychological factors such as stress, anxiety and role adaptation, in terms of their impact on the child's rehabilitation and recovery. This study aims to understand important socio-economic factors such as financial costs, and impact on work and lifestyle. By gaining an understanding of the important social and economic implications, we can use this information for the development of future research which may benefit burn-injured children and their families.

Head & Neck 5000
Principle Investigator: B Bisase
Status: recruiting; Portfolio study

The overall aim of the programme is evaluate and disseminate the outcome of centralization in Head and Neck cancer (H&N). In order to accomplish this to create a clinical cohort of 5,000 people with H&N and follow up this cohort for two years. This study will be large enough to compare groups by age, site and stage. Data are already collected on the care provided to patients with H&N as part of an ongoing National Head and neck cancer audit – Data on Head and Neck Oncology (DAHNO). The proposed studies will complement these National audit data by investigating the role of patient characteristics not recorded as part of routine care and by examining a broader range of patient-centred and clinical outcomes. Therefore we will collect baseline data on people with H&N that would include age, sex, diagnosis and treatment (including site, histology, stage, date of MDT, date of definitive treatment). Furthermore, additional data will be collected on socioeconomic status (including occupation, education and housing): lifestyle (including smoking and alcohol intake); questions on psychological status and general and cancer specific quality of life questions. These data will be collected at baseline, at 4 months and at 12 months. In addition, we will collect a venous blood sample into 2 labelled EDTA tubes that will be spun, aliquoted, frozen and stored at 80C at the laboratories in Bristol for use in future translational studies. The outcome of the study will allow clinicians and managers to design effective patient-centred multidisciplinary centralised services for people with H&N.

The Perspectives of Directors of Nursing in NHS Acute Trust on caring practices
Chief Investigator: (External) M Davies
Status: In analysis

In recent years, there have been a significant number of high profile exposés of undignified care, neglect and poor practice, which have been a catalyst for a searching debate into standards of care, practice and the nursing profession. Directors of Nursing have a significant role to play in providing assurance of standards of care at Board level (The Kings Fund 2009b). The role of the Director of Nursing in assuring quality and safety has been recognised as important and it is also vital that these key issues are seen as important for all members of the Board (The Burdett Trust 2006). The overall aim is to develop a theory to explain the perceptions of Directors of Nursing in NHS Acute Trusts, on caring practices. In addition, to explore the social, political, professional and organisational challenges facing Directors of Nursing pertaining to managing and responding to these challenges.

Novel Coronavirus Observational Study
Principal Investigator: Alison Munday
Status: recruiting

The SARI BSP is a standardized protocol for the rapid, coordinated clinical investigation of emerging infections causing severe acute respiratory illness. This is the first time that a clinical research agenda has been integrated within the public health response ahead of time and ensures clinical questions are addressed and clinicians are at the heart of the response to the epidemic. Confirmed or suspected cases of severe acute respiratory infection caused by an emerging pathogen will be recruited. In the first instance, we expect to recruit cases of MERS Coronavirus or avian influenza in the UK.

SIFTI - Scientific Investigation of the Biological Pathways Following Thermal Injury in Adults and Children
Principal Investigator B Dheansa:
Status: recruiting

Traumatic tissue damage in general causes haemostatic and inflammatory responses, which contribute to local healing but can also have adverse systemic effects. Some of the released substances (such as adrenal steroids, cytokines, acute phase proteins, soluble adhesion molecules, and microparticles) may be prognostic for outcome or complications (Ilias et al, 2007). Some are already known to have powerful deleterious effects on endothelial cells and platelets (Anderson et al., 2010). There is increasing recognition that aside from their role in preventing blood loss, platelets also interact with the endothelium and contribute to maintenance of vessel integrity and vessel repair (Watson et al., 2010). Thus, released substances may feed back to the local site of damage, or contribute to remote pathology such as shock, shunting in the microcirculation and lung damage. Pro-inflammatory and anti-inflammatory mediators are well described in trauma and burns, in several studies. Measuring potentially relevant biological mediators longitudinally and evaluating their functional effects on platelets, leukocytes and endothelial cells and their interactions, will provide biological evidence of how these factors interrelate and how they correlate with both burn severity and patient age. For example, we may find a non-linear relationship between burn area and activation of various pathways such that, for example, inflammatory mediators rise as a square function of increase in burn area – a finding that would have implications for the clinical threshold for treatment. The results should also yield insight into underlying haemostatic and inflammatory that may be novel therapeutic targets.

Cancer of the tonsils: has it always been associated with Human Papilloma Virus?
Chief Investigator: B Barrett
Status: ongoing; uses historical blocks only

Cancer of the tonsils is occurring with increasing frequency, particularly in younger patients. These tumours are associated with infection by Human Papilloma Virus (HPV), which may be detected by complex molecular methods, or by more starightforward immunohistochemistry using a “surrogate” protein called p16. Cancers expressing p16 appear to have an improved prognosis. It is unknown whether cancer of the tonsils has always been associated with HPV infection, or if this is a recent pathological development. This study aims to determine whether p16 can be identified in tonsillar cancers which were diagnosed in the last five decades of the 20th century, as well as those which occurred in the first decade of the 21st.

PREDICTR-HNC (Improving treatment selection using predictive classifiers of treatment response for head and neck cancers and dysplasia)
Principal Investigator: B Barrett
Status: no patient recruitment as using historical blocks

Head and Neck Cancer (HNC) is the sixth most common cancer in the UK. Despite improvements in treatment such as chemotherapy, radiotherapy and surgery it still carries a poor prognosis. HNC has a ‘premalignant’ phase called ‘dysplasia’ and one in 5 patients with dysplasia may go on to develop an invasive cancer. As well as not currently being able to identify which patients with dysplasia will go on to

develop HNC, one of the main challenges with both dysplasia and HNC is that in each patient with these conditions the cells behave differently. This means patients respond differently to the treatments available. Both cancers and dysplasias of the mouth and throat, and their subsequent treatments have significant effects on the quality of life of patients. It is therefore important to be able to select which treatments are the most effective for each patient, (i.e. individualised therapy) and also to be able to select which of the patients with potentially premalignant lesions will actually progress to cancer to minimise the unnecessary toxicity, morbidity and cost of potentially ineffective treatments.

The specific objectives of the project are:
1) To identify which patients with dysplasia of the mouth and voice box are in the group highly likely to develop a cancer.
2) To develop and validate models to select for surgical treatment those patients at high risk of progressing from precancer to cancer in the mouth and throat
3) To develop and validate models to select those patients with cancers of the mouth and throat most likely to respond to chemotherapy, radiotherapy and surgery.

Trismus Trial: Randomised Pilot Study of Therabite® versus Wooden spatula in the Amelioration of Trismus in Head and Neck Cancer Patients
Principal Investigator: B Bisase
Status: recruiting

The primary aim is to conduct a randomised controlled trial (RCT) comparing exercises using Therabite® versus wooden spatulas (standard care) to prevent or relieve trismus in patients with stage 3 and 4 oral/oropharyngeal cancer. The objectives of the study will be to monitor patient compliance and tolerability, logistics of intervention and outcome sensitivity in terms of jaw exercises, quality of life (QOL) assessments and health economics questionnaires. This is a randomised, open-label, controlled, 2-centre pilot study, to assess the objective and subjective effectiveness and cost-effectiveness of Therabite use compared with wooden spatula in ameliorating trismus in patients treated for stage 3 and 4 oral and oropharyngeal cancer. The principal objective assessment is measurement of maximum jaw opening.

Effects of deposit build up on prosthetic eyes and the implications for patient comfort
Chief Investigator: R Malhotra
Status: recruiting

People who wear a "glass eye" or ocular prosthesis seem particularly prone to developing dry eye symptoms. 90% will be affected by socket discharge, the majority on a daily basis. One of the main causes is obstruction of the oilproducing meibomian glands along the eyelid margins. This is due to a combination of tear deficiency, deposit buildup and microtrauma of the "glass eye" rubbing on the inside of the eyelid. By improving the surface finish of a "glass eye" from standard polish to a smoother contact lens polish, we hope to be able to improve both patient symptoms and the signs of deposit buildup on the prosthesis.

The cultural representation of older people
Chief Investigator: External study
Status: in analysis

For the questionnaires it is hoped that between 10 and 20 responses will be gathered from each acute NHS Trust. With regard to interviewing staff, this will depend on the other stages of the methodology but no more than 5 staff members would be expected to be interviewed from each Trust. Questionnaire participants will be identified by issuing surveys to those wards which encounter older people. The aim is to collaborate with local ward managers in order to disseminate questionnaires to staff. As part of this process, a sample of those who responded will also be selected for interview based upon their willingness to take part.

Upper eyelid loading with platinum segment implants for treatment of lagophthalmos
Chief Investigator: R Malhotra
Status: recruiting

Upper eyelid loading with gold weight or platinum chain is a standard treatment for lagophthalmos (inability to close the eyes completely). Platinum chains have been reported to have fewer complications including astigmatism (change in prescription of glasses), migration (implant migrating in the eyelid tissue), bulging, extrusion and better appearance compared with standard rigid gold implants. The above complications of upper eyelid loading are primarily related to the thickness and bulk of the implanted weight. In this study we will be able to investigate if thinner implants offer any further reduction in complications. Another advantage of the suture-linked platinum segments is the ability to add or remove individual segments if an adjustment of the desired weight is required. The aim of this study is to evaluate the effectiveness of thin platinum weight segments as an alternative to platinum chain in treatment of lagophthalmos. Platinum weight segments are also cheaper than platinum chains and, if found to be effective, will provide a cheaper alternative for upper eyelid loading.

PLANNED PROJECTS – studies which had not been given Ethics Approval as of 01/04/14, but which are expected to start soon

- Quantifying the incidence of obstructive sleep apnoea (OSA) in a surgical cohort attending pre-assessment using both the Epworth Sleepiness Scale (ESS) and the STOP-Bang questionnaire (Tim Vorster)
- Post-treatment care pathway in long-term survivors of head and neck cancer with oral and/or facial prosthesis (N Ghazali)
- International Surgical Outcomes Study (ISOS) - International observational cohort study of complications following elective surgery (Julian Giles)
- A Sprint National Anaesthesia Project (SNAP) to survey patient reported outcome after anaesthesia in UK Hospitals (Julian Giles)
- PRoVENT: Practice of ventilation in critically ill patients without ARDS. An international observational study (Julian Giles)
- S100 & CD31 in tongue cancer (Perineural and vascular invasion in tongue cancer: is detection improved using markers for nerves and blood vessels?) (Bill Barrett)
- Perception of Quality in Anaesthesia (PQA) PROMs data (Julian Giles)
- AQUACEL® Ag+ Extra™ in treatment of partial thickness burns (Simon Booth)
- Use of iPads in facial palsy rehabilitation M.I.R.R.O.R. (Charles Nduka)
- TGFb1 in osteoradionecrosis of the jaws (N Ghazali)
- Accurate measurement of burn wound pH progression (Simon Booth)

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**153-14**
Report from:	**Amanda Parker, Director of Nursing**
Author:	**Ali Strowman, Deputy Director of Nursing**
Report date:	**6 June 2014**
Appendices:	**A: Annual Report**

Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2013-2014

Background

1. The attached annual report provides the trust board with information on how the organisation has met its requirements under the Civil Contingencies Act 2004 (CCA). These are outlined on page 2 of the report. The board is required to receive an annual report on this subject

Key issues

2. Policies that inform staff on actions to take have been updated in line with new national guidance. Management and monitoring occur through on call manager meetings, reports to clinical cabinet (monthly), reports to the quality and risk committee (quarterly).

3. Education and learning occurs via training, testing and follow up after live incidents. Staff are provided with training at induction and annually through the mandatory training programme. At the end of March 83% of staff had completed or were booked for their annual update. Testing occurs in line with CCA requirements (page 3) and the Trust's plan for 2014/15 is provided (page 6).

4. Live incidents related to power failure and loss of IT which occurred during the early months of 2014 highlighted vulnerabilities within the organisation. Action was taken in the short and medium term to resolve power issues.

5. External assurance occurs through the Local Area Team (LAT). In January 2014 the LAT reviewed the Trust's systems and processes and reported back that it was satisfied with the arrangements reviewed.

Implications of results reported

6. IT and power issues identified as a result of incidents were resolved in the short term but long term issues are noted and reflected within the corporate risk register and the board assurance framework.

7. Both issues require business continuity plans to be robust to ensure that trust activity can continue.

Action required

8. Monitoring and revision of business continuity plans is essential activity over the year to ensure plans remain robust.
9. Updating of policies in line with new national guidance supported by education, exercising and identification of lessons learnt following live incidents will ensure we remain well prepared in line with the CCA expectations.
10. This activity is coordinated and monitored by the trusts emergency planning officer (deputy director of nursing)

Link to Key Strategic Objectives (delete those not applicable)

- Outstanding patient experience
- Operational excellence
- Financial sustainability

11. Without robust emergency response plans or business continuity plans in place the Trust may find itself unable to deliver care to patients.

Implications for BAF or Corporate Risk Register

12. Issues related to power and IT are reflected within the 2014/15 board assurance framework and corporate risk register.
13. Issues related to the estate are reflected within the 2014/15 board assurance framework and corporate risk register.

Regulatory impacts

14. Failure to meet the obligations set out in the CCA could affect the Trust's reputation and its ability to comply with contractual and regulatory requirements of the CCG, CQC and Monitor. Breach of these statutory duties are likely to indicate that the Trust was failing to ensure the resilience of the estate and its ability to protect patients, staff and visitors or to provide third party support to others.

15. However, nothing disclosed within the annual report currently affects the Trust's ability to be:

- Safe
- Effective
- Caring
- Well led
- Responsive

16. The observations within the annual report do not have any impact on the Trust's Monitor governance risk rating or continuity of service risk rating.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2013 - 2014

Ali Strowman, Deputy Director of Nursing

Introduction

The Civil Contingencies Act 2004 placed a number of duties on responding agencies to a Major Incident. QVH are categorised as a Category One responder which include the following responsibilities:

- To carry out a risk assessment of our operational areas
- To make emergency plans
- To make business continuity plans
- To ward and inform the public
- To cooperate with other responders through a Local Resilience Forum
- To share information with other responders

During 2013/14, Emergency Preparedness Resilience and Response and Business Continuity Executive leadership within QVH was held by the Director of Nursing and Quality whilst the role of Emergency Planning Officer was enacted by the Deputy Director of Nursing. The Director of Nursing has represented QVH at the Local Health Resilience Partnership (LHRP) meeting and the Deputy Director of Nursing has attended the Sussex Health Resilience Group (SHRG).

Throughout the year, QVH has a responsibility not only to update policies and plans related to Emergency Planning, but also to test these plans and conduct exercises in resilience and Business Continuity. Maintaining effective continuity of our business is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management (BCM).

The Quality and Risk Committee has received quarterly updates in 2013/14 to provide assurance that this work has been undertaken. This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2013/14.

Emergency Preparedness Resilience and Response (EPRR)

Policy

In April 2013, NHS England issued a revised approach to Emergency Planning and rebranded the work as Emergency Preparedness Resilience and Response (EPRR). Along with the new approach came a requirement to make significant changes to policy within QVH. Throughout the year, all policies relating to EPRR were updated to reflect the new approach. Additionally, a Whole Site Evacuation Plan was written and ratified and also tested via a table top exercise in 2013.

Incident Co-ordination Room (ICC)

The ICC was relocated to the Jubilee Meeting Room in 2013 as The Maud Barclay Building was deemed unsafe and is no longer in use. The ICC contents and function has now been fully transferred.

Assurance process

Internally:

Bi-monthly meetings with the on call managers have been held to ensure incidents are reviewed and learning has been captured and actioned. The inclusion of new on-call managers within the rota with limited operational experience makes these bi-monthly meetings a useful forum for discussion and sharing experience. To ensure these managers receive the support required, we operate a buddy system whereby all on-call managers without an operational remit have the contact details of a clinical manager to call for advice as required.

EPRR updates have been received at the Week 4 Weekly Business Meetings. An internal review of meetings was undertaken in QVH, and as a result, the EPRR report was received and noted at the Week 3 Clinical Cabinet meeting attended by the Executive and senior operational leads. The Quality and Risk Committee has received quarterly updates in 2013/14 to provide assurance that this work has been undertaken.

Externally:

All NHS Trusts were required to complete a self-assessment for NHS England on their compliance with the new EPRR approach. A matrix was devised by NHS England for the self-assessment process which was completed by QVH, and subsequent identified work to meet compliance was undertaken. This assessment was reviewed and approved by the trust board of directors. An assurance meeting was then held with NHS England Area Team to discuss our self-assessment. NHS England were assured that QVH has robust systems in place to plan for emergencies and respond and recover to these in a timely way. This assurance process with NHS England is now an annual process and will be repeated in 2014.

Practice-Exercises and Live events

Communication exercises were held in April and November 2013. Issues that arose as a result of conducting the exercises included the Emergency Plan in the Emergency Cupboard was not the most recent version; the Emergency Plan needed to be updated in light of new NHS commissioning structures; unable to contact the CCG as no lead or number available and the fax phone was not working. These issues were all addressed after the exercise.

An off the shelf exercise (by the Health Protection Agency) was undertaken in September 2013 to test the Evacuation Plan. This exercise had an excellent attendance and was well evaluated. Action plans were devised as part of the exercise where amendments to the policy were required. These amendments were made and then the plan was ratified and loaded to the intranet.

QVH were also involved in exercises conducted by NHS England Emergency Preparedness Resilience and Response Team. Exercise Pegasus looked at the whole system response to winter escalation and Exercise Paladin was an exercise designed to test national and regional emergency planning resilience and response (EPRR) management processes to ensure that incident response plans and reporting arrangements were aligned with key partner agencies within the southern region.

QVH also had some internal challenges which tested both the emergency and business continuity plans in 2013/14. These included a power failure, loss of IT and the need to lockdown the trust for a period of time. Debrief meetings, action plans and reports were written following these events.

Exercise, testing and planned updates to QVH policy are planned for 2014/15 and are detailed in **Appendix 1**.

Winter Planning

Policy

QVH Cold Weather Plan (including winter planning) was revised in 2013 to include the new mandatory requirement for 'level 4 black status'. These changes reflect the NHS South of England Escalation Framework to ensure a consistent approach to escalation and management of winter pressures in the South of England's Acute and Emergency Services.

Snow

There has been no snow in the winter of 2013/14 that has impacted on QVH.

Seasonal Flu

During the winter of 2013/14 an active drive was undertaken to vaccinate staff against seasonal flu. The final flu vaccination uptake rate was 55% of the workforce (516 staff), which did not achieve the trust target of 60% The Flu vaccine order has been placed for 2014.

The breakdown of uptake for the vaccination is demonstrated below by staff group:

Staff Group	Number Vaccinated
Nurses	129
Doctors	54
Admin	175
AHP	75
Support staff	48
Other	35

Fit testing
Fit testing took place in all services throughout 2013/14 and this was managed at a departmental level.

Business Continuity
Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of BC Plans for core business activity.

A total of thirty four Business Continuity Plans are required to cover the forty two separate areas or services identified within the Trust. All plans can be accessed from the shared drive under Risk Management. All plans were revised during 2013/14 and additional plans are being drawn up in light of the IT failure. All departmental leads have a copy of their plan.

Other activity undertaken over the year:

- Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme. In March 2013 83% of staff were up to date with or booked to complete their training.
- Bi monthly meeting for on-call managers, control personnel and bleep holders.
- The Trust maintained its membership with the Sussex Resilience forum and has now registered with the National Resilience Extranet replacement system Resilience Direct
- Strategic Leadership in a Crisis Course was hosted by QVH and delivered by NHS England. The majority of the executive and on call manager team have now attended this.

Appendix 1

Queen Victoria Hospital Emergency Planning Exercises for 2014/15					
Activity	Date Planned	Staff required	Date achieved	Report written	Report to Q&R
Communication exercise (required 6 monthly)	23rd April 2014 3.00-5.00 Jubilee Meeting Room	Site Practitioner team, EPO, DoN.			
Review system wide heatwave resilience plan	20th May 2014	EPO			
Lockdown exercise	27th June 2014 11.00 – 12.00 Jubilee Meeting Room	Site Practitioner team, Head of Risk, EPO, DoN.			
3 Yearly Live Exercise	Not required until 2017 as live event in 2014	N/A	N/A	N/A	N/A
Review system wide pandemic SOP	30th June 2014	EPO.			
Review system wide winter resilience including Cold Weather Plan	24th September 2014	EPO.			
System wide Yearly Table Top Exercise to cover Emergency Planning and Business Continuity	3rd October 2014 08.30-13.00 SDC Training Room	Site Practitioner team, On call managers, Matrons.			
Communication exercise (required 6 monthly)	7 November 11.00 – 13.00 Jubilee Meeting Room	Site Practitioner team, EPO, DoN			
Incident room set up exercise	Wednesday, 10 December, 14.00 - 15.00 Jubilee Meeting Room	Site Practitioner team, EPO.			

Report to: Board of Directors
Meeting date: 26 June 2014
Reference number: 154-14
Report from: Lois Howell, Interim Company Secretary and Head of Corporate Affairs
Author: Lois Howell, Interim Company Secretary and Head of Corporate Affairs
Report date: 12 June 2014
Appendices Updated Action Plan

C Wing action plan update

Key issues

1. Completion of the action plan is going well, with 32 of the 54 required actions now complete, several ahead of schedule. Appendix 1 sets out the latest version of the action plan, with dated updates, although unfortunately it was not possible to obtain updates from all action owners prior to production of the report. Verbal updates on these items will be given at the Board meeting.

2. Regrettably three actions are now overdue. The actions and the reasons for the delays are set out below.

Ref	Action	Due	Reason for delay
8.3b	Implementation of Safer Care module of e-rostering system to be assessed and planned	31.05.14	Discussions with developer still underway
8.3c	Training for managers on use of Safer Care module of e-rostering to be developed and delivery commenced	31.05.14	Dependent on implementation of system, as above
16.2d	Implement new Committee and reporting arrangements; commence workplan	31.05.14	The new executive level quality committee will not start to operate until July.

3. Also set out below at appendix 2 are details of the staff / management / board engagement programme required by action 6.1a.

Implications of results reported

4. The delays to the Safer Care module of the e-rostering system do not place patients or staff at any greater risk than that to which they are currently exposed. The introduction and publication of Safe Staffing reporting ensures that staff, patients, visitors and the trust have a clear picture of staffing levels on the wards, reasons for departure from plans and mitigations put in place. The Director of Nursing and Quality monitors these levels regularly and carefully.

5. The delay to the implementation of the Executive level quality committee is unlikely to have a significant impact on quality and safety at the Trust – the proposal represents an enhancement to existing monitoring and management arrangements and the extra time has allowed for plans and systems to be refined to ensure that the committee works as

effectively as possible.

6. It is unlikely that the delays to completion of the actions set out in the table above will have any significant impact on any specific group of patients or staff, or otherwise compromise equalities and/or human rights legislation.

7. There are no third party consequences associated with these delays.

Action required

8. The Interim Head of Corporate Affairs will continue to work with the Head of Human Resources to pursue completion of the outstanding actions. Corrective action is expected within the next few weeks and an improvement in the rate of completion of the action plan should be evident in the next quarterly update.

Link to Key Strategic Objectives (delete those not applicable)

9. Completion of the required actions will support the achievement of KSO 5, organisational excellence, which in turn will help to support all other KSOs.

10. Continued delay to completion of the actions may have an indirect impact on KSO5, but is unlikely to compromise significantly achievement of organisational excellence.

Implications for BAF or Corporate Risk Register

11. There are no significant risks arising from the delays to completion of the action plan that merit inclusion on the Corporate Risk Register or Board Assurance Framework at this stage.

Regulatory impacts

12. Given that the actions which are the subject of the delays are all improvements on existing systems, there is no concern that the failure to complete them on time compromises the Trust's requirement to meet the Care Quality Commission's requirement to be:
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive.

13. There will be no impact on the Trust's Monitor governance risk rating or our continuity of service risk rating as a result of these delays.

Recommendation

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

Trust action plan in response to Canadian Wing Investigation March 2014

LEADERSHIP AND CULTURE					
RECOMMENDATION 6.1: The Trust Board to take the lead in creating a culture of openness and transparency throughout the organisation through an increased programme of board visits, 'back to the floor' sessions and involvement in existing programmes such as 'Compliance in Practice'.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.1a	Executive Team to develop proposals and further actions	iHCA	31.05.14	**20.03.14:** On agenda of Direct Reports meeting 24.03.14 **24.03.14:** Discussed at SMT. Corporate Affairs to develop and administer programme of half day "Back to the Floor" sessions for all Board plus SMT, visits of Depts to Board for 20 minute presentations on strategy, challenges, achievements etc and remind all Board & SMT members to participate in Compliance in Practice visits. Paper setting out arrangements to be presented with next action plan update. **09.05.14:** Seminar and Board / departmental visits programme well developed. "Back to the Floor programme" to be launched by end of month. **31.05.14:** Seminar programme well established. Back to the Floor programme and other engagement opportunities implemented and described in report to June Board meeting.	COMPLETE
6.1b	Chairman, CEO & Director of Corporate Affairs to incorporate into 2014/15 Board development programme	iHCA	30.06.14	**14.04.14:** Board seminar programme produced (to be attached to next action plan update to Board in June) **09.05.14:** Board seminar programme well-developed.	On track

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 6.2: The Trust Board to re-emphasise to all senior management having responsibility for, or interaction with, nursing staff or patients that, under no circumstances, should they, or staff reporting to them, be deflected from a focus on these core responsibilities as a result of involvement in other projects or as a result of a shortage of resources. Any concerns by individuals related to this must be raised by them, and discussed and resolved with the Chief Executive.

Ref	Action	Who	When	Update	Status
6.2a	CEO to refresh Trust Vision and Values, and promote appropriately	CEO	31.05.14	**17.04.14:** This will form part of the QVH 2020 communications strategy; CEO in discussion with Laura Donaldson w/b 21st April regarding communications strategy **09.05.14:** QVH2020 Comms plan agreed, for launch late May **12.05.14:** Article re: Vision and Values to appear in next edition of Connect **31.05.14:** Connect article published; subject to be raised again periodically as opportunities arise	**COMPLETE**
6.2b	Recruitment, Appraisal and performance management policies and processes to reflect expected behaviours	HHR	10.06.14		

RECOMMENDATION 6.3: Increased visibility of the Director of Nursing (DN) in clinical areas. It is acknowledged that the role of the DN, as currently configured, does not permit the DN to spend as much time in the clinical areas as she would like. It is also acknowledged that the long standing vacancy for the Deputy Director of Nursing (DDN) has required the DN to focus more of her time on governance issues. However, when considering management structures below, consideration should be given to the existing balance of the DN role between her responsibility for the improvement of nursing standards and her lead role in governance and compliance matters.

Ref	Action	Who	When	Update	Status
6.3a	CEO and DN to consider revision to role and responsibilities as part of wider structural review.	CEO	31.05.14	**17.04.14:** Initial decision to move Matrons to DN agreed with effect from 1st June. Further discussion with DN scheduled for annual appraisal, late May 2014 **31.05.14:** Appraisal discussion held. Existing clinical engagement activity (including compliance in practice visits) to be enhanced by monthly half day clinical session, and participation in Back to the Floor programme.	**COMPLETE**

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 6.4: Ensure that all Directors, Governors and Clinicians undertaking visits within the clinical areas are encouraged to feed back any comments or concerns relating to staff attitudes/morale or the quality of patient care directly to the Chief Executive.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.4a	DN and iHCA to develop a process for feedback to relevant Executive	iHCA	30.04.14	**14.04.14:** Specific standing item added to end of Clinical Cabinet agenda (chaired by CEO) to ensure prompt feedback from SMT and Clinicians. Specific prompt added to Compliance in Practice feedback forms to encourage reporting on relevant issues from Governors undertaking visits. Dep DN reviews forms, will pass concerns to CEO.	**COMPLETE**
RECOMMENDATION 6.5: Ensure that the Trust takes appropriate robust action against any individual whose behaviour is not consistent with the core values of the Trust regardless of other positive aspects of their performance.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.5a	Review and as required amend Trust Disciplinary and Capability policies	HHR	10.06.14	**17.04.14:** Policies reviewed and found to meet requirements of the action	**COMPLETE**
RECOMMENDATION 6.6: The Executive Directors to incorporate in their monthly updates for the Board any negative feedback they have received or concerns they have, relating to staff behaviour including the action taken to address the issues raised.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.6a	Executive Directors in conjunction interim Head of Corporate Affairs to review existing reporting arrangements. Patient feedback about staff to be incorporated into reports.	iHCA	31.05.14	**17.03.14:** Review of board agenda and reporting processes generally underway; proposals to be presented at workshop / meeting of the board on morning of April Board meeting for implementation at May meeting **14.04.14:** Discussion between DN and iHCA; Patient Stories to be proposed for Board meetings – will include feedback about staff. Specific patient feedback about staff to be included in Patient Experience report to Quality & Risk Committee; template for feedback from Q & R Committee to Board	**COMPLETE**

				will include a specific prompt re: patient feedback. **31.05.14:** New standing item added to board agenda from June meeting onwards – all board members to feedback re: internal and external stakeholder engagement events / incidents, to include reference to staffing issues identified	
RECOMMENDATION 6.7: As part of a wider review of Trust governance systems, the interim Head of Corporate Affairs to consider how best we can incorporate behavioural and cultural concerns within our governance systems.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.7a	Interim Head of Corporate Affairs to develop proposals for inclusion into corporate and clinical governance systems	iHCA	31.08.14	**17.03.14:** As action 6.6a. Review of board agenda and reporting processes generally underway; proposals to be presented at workshop / meeting of the board on morning of April Board meeting for implementation at May meeting **09.05.14:** Revised template for Board reporting includes prompt to explain whether report contents disclose a benefit or threat to Key Strategic Objectives, including "Outstanding Patient Experience" and "Organisational Excellence". Template for feedback from Quality & Risk Committee to Board includes prompt to emphasise any behaviours / staff morale etc issues revealed by Q&R Committee discussions and reports	**COMPLETE**
RECOMMENDATION 6.8: Head of HR to review whether sufficient emphasis in management training and development is given to identifying and dealing with inappropriate behaviour by supervisory staff towards their team members which does not reflect the core values of the Trust.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.8a	Supervision Policy to be reviewed and amended as required to include minimum standards for the	HHR	10.06.14	**12.05.14:** Completed, awaiting DN sign off	On track

	conduct, recording and monitoring of supervision (1:1)				
6.8b	Management Development Programme and HR Best Practice sessions to be reviewed and strengthened in respect of supervision / 1:1 practice	HHR	31.07.14	**17.04.14**: Programme and programme content review commenced	On track

NURSING STANDARDS

RECOMMENDATION 8.1: The Board to reaffirm its commitment to the highest standards of nursing care and behaviour as part of its wider commitment to excellence in patient care.

Ref	Action	Who	When	Update	Status
8.1a	Board to reaffirm its commitment to the highest standards of nursing care and behaviour as part of its wider commitment to excellence in patient care as part of 2013/14 Quality Account / Report	CEO	30.04.14	**17.04.14:** Text included in Quality Account	COMPLETE

RECOMMENDATION 8.2: The DN to work with the matrons and other senior nursing staff to develop a clear set of QVH nursing standards and behaviours that can be incorporated into recruitment, appraisal and performance management.

Ref	Action	Who	When	Update	Status
8.2a	Review existing Nursing Strategy to strengthen link to Trust Values and recruitment, appraisal and performance management processes	DN	17.04.14	**14.04.14:** DN and Dep DN have met to commence review. Existing Nursing Strategy circulated to Matrons for comment on specific enhancements which could be made to each key role. Competing priorities (particularly Quality Account, Annual Report) have delayed full completion of this task. **31.05.14:** Reviewed Nursing Strategy launched by Chief Nursing Officer for England during visit to trust on 7 May.	COMPLETE
8.2b	Review existing role / responsibility descriptors to	DN	17.04.14	**14.04.14:** See update at 8.2a above	COMPLETE

	strengthen link to Trust Values and recruitment, appraisal and performance management processes			**31.05.14:** Revised strategy now included in recruitment packs for relevant staff and on intranet.	
RECOMMENDATION 8.3: Monthly publication of staffing data. Making use of e-rostering and other workforce data to provide assurance to the Board, staff and patients as to the provision of safe and competent levels of staffing throughout the Trust.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
8.3a	E-rostering reporting system to be reviewed to ensure the data is clear, understandable and relevant to users and managers (consultation with managers required)	HHR	30.04.14	**17.04.14:** Review completed. Safe Staffing report coming to board in April 2014. Quality of data to remain under review	COMPLETE
8.3b	Implementation of Safer Care module of e-rostering system to be assessed and planned	HHR	31.05.14	**17.04.14:** Implementation currently under review, discussion with developers in hand.	Overdue
8.3c	Training for managers on use of Safer Care module of e-rostering to be developed and delivery commenced	HHR	30.09.14	As 8.3b above	Delayed
8.3d	Safer Care data outputs to be incorporated into routine reporting	HHR	Per 8.3b time-table	As 8.3b above	On track
8.3e	Nursing establishment to be reviewed in line with NICE staffing recommendations	DN	30.09.14	**03.03.14:** Publication of recommendations not expected until July 2014. DN is part of NICE team developing the guidance. **14.04.14:** DN has produced report on Safe Staffing fore April Board, introducing new metric required by DH re: monitoring and publication of staffing levels **31.05.14:** Specific action completed, but recruitment activity to be maintained to ensure small pool of supernumerary staff available to backfill etc and prevent the problems previously associated with staff taking leave during notice period and other staff shortages	COMPLETE

8.3f	Next available nursing establishment / acuity report to board to reflect outcome of NICE staffing recommendations review	DN	Tbc see 8.3e above		
RECOMMENDATION 8.4: Develop an action plan to reduce the use of agency staff – exact level to be recommended by the DN taking into account benchmarked data from similar organisations.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
8.4a	Review existing weekly process of prospective challenge with Matrons of all planned non-RMN agency staff to ensure effectiveness	DN	31.03.14	**03.03.14:** This process happens routinely at Site Practitioner Meetings **20.03.14:** Review completed – DN satisfied that challenge is robust and effective	**COMPLETE**
8.4b	Review existing process of retrospective weekly review / challenge with Matrons of all non-RMN agency staff used in previous week to ensure effectiveness	DN	31.03.14	**03.03.14:** This process happens routinely at Site Practitioner Meetings **20.03.14:** Review completed – DN satisfied that challenge is robust and effective	**COMPLETE**
8.4c	Review existing process of weekly update on non-RMN agency usage to Finance Director, matrons and CEO to ensure effective	DN	31.03.14	**03.03.14:** This report is emailed out weekly **20.03.14:** Review completed – DN satisfied that challenge is robust and effective	**COMPLETE**
8.4d	Recruit and induct 3 WTE RNs above establishment to allow for recruitment time-lag	DN	31.05.14	**03.03.14:** These posts are currently out to advert **14.04.14:** Recruitment into established post continuing as well as recruitment to supernumerary posts. Interviews conducted 11.04.14; two RNs recruited	On track
8.4e	Review policy and practice in respect of use of annual leave during notice periods	HHR	10.06.14		
PERFORMANCE MANAGEMENT					
RECOMMENDATION 10.1: Review of existing systems of individual performance management; ensure that all managers are competent to performance manage staff and that action is taken promptly to manage underperformance.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**

Trust action plan in response to Canadian Wing Investigation March 2014

10.1a	Metrics for monitoring Performance Management performance of managers to be developed	HHR	30.06.14	**17.04.14:** in progress	On track
10.1b	HR Best Practice sessions to be reviewed to ensure more robust focus on PM issues	HHR	30.04.14	**17.04.14:** Programme reviewed and emphasis on PM included	COMPLETE
10.1c	New appraisal system to be reviewed six months post-implementation to ensure PM elements effective	HHR	31.07.14		On track
RECOMMENDATION 10.2: Introduce 360 degree feed-back for all managers.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.2a	NHS Leadership Academy 360 degree appraisal model to be adapted for use by QVH	HHR	30.06.14	**17.04.14:** Review completed; model is appropriate as drafted	COMPLETE
10.2b	360 degree appraisal process to be implemented	HHR	tbc	**20.03.14:** contingent on results of pending management re-structure, anticipated complete by 31.07.14	On track
RECOMMENDATION 10.3: Ensure all leavers are strongly encouraged to take up the opportunity of an exit interview.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.3a	System for ensuring that exit interview results are fed back to department managers and relevant senior manager effectively to be developed and implemented	HHR	31.05.14	**12.05.14:** system in place. Plan to review in 6 months	COMPLETE
RECOMMENDATION 10.4: Review existing systems of staff feedback, including more frequent use of staff survey. Review possible link to the national work on cultural surveys that is occurring.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.4a	~~Wellbeing & Culture Group to conduct review~~ Staff Family and Friends test to be implemented in June and reported to Board quarterly	HHR	30.06.14	~~**17.04.14:** Next W&C Group meeting end of May – review will be on agenda~~ **12.05.14:** Staff Family and Friends test to be reported to Board from June	On track

Trust action plan in response to Canadian Wing Investigation March 2014

10.4b	~~Results of W&C Group review to be developed into proposals~~ Use of local staff surveys to be increased	HHR	15.08.14	**12.05.14:** Plans for local surveys in train – to involve survey monkey and paper copies	On track
RECOMMENDATION 10.5: Introduce a system of 'talent management' designed to identify existing and potential high performers as well as those with significant development needs.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.5a	Consider results of six month review of new appraisal system to assess effectiveness in talent management	HHR	31.07.14		On track
10.5b	Develop any further actions required post-review	HHR	15.09.14		
RECOMMENDATION 10.6: Ensure that the Board is involved in the annual review of talent management for the top tier of trust leadership					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.6a	Annual Board seminar to review the Trust's senior level structure and to provide input/scrutiny into succession planning for the Board and Senior Management Team.	HHR	30.11.14	**17.04.14:** On board work plan **12.05.14:** Deputy Head of HR designated as Talent Management Lead	On track
MANAGEMENT STRUCTURES					
RECOMMENDATION 12.1: Chief Executive, in discussion with the Director of Nursing, to review the line management of matrons, site practitioners and clinical nurse specialists.					
RECOMMENDATION 12.2: In light of recommendation 12.1, review the respective roles and responsibilities of both the Director and Deputy Director of Nursing.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
12.1/2a	Following on from discussions which have taken place proposals for a new structure to be developed and agreed	DN	31.03.14	**03.03.14:** CEO and DN have discussed Trust needs; draft proposals produced and awaiting further discussion with CEO **17.04.14:** Initial decision to move Matrons to DN agreed with effect from 1st June.	**COMPLETE**

				Interim operational structure to be implemented with effect from 1st June.	
12.1/2b	Implementation plan for new structure to be produced, agreed and actioned	DN	31.07.14	**17.04.14:** Further discussion with DN scheduled for annual appraisal, May 2014. **31.05.14:** New nursing structure to commence 02.06.14	**COMPLETE**
RECOMMENDATION 12.3: Chief Executive to review operational management structures to ensure sufficient focus and resource provided to delivery of key performance and productivity targets					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
12.3a	Review to be undertaken and completed	CEO	30.04.14	**12.05.14:** Interim structure to take effect from 01 June 2014	**COMPLETE**
	Interim structure to be reviewed	CEO	30.09.14		On track
EARLY WARNING SYSTEM					
RECOMMENDATION 14.1: Build on the work already started by the Head of Human Resources to establish an integrated scorecard (monthly) for C wing and other clinical areas that makes use of both the existing indicators and the outputs from e-rostering highlighted above. Integrating these reports will provide a much fuller picture of both the day to day management and the longer term trends which would provide an improved system of early warning.					
RECOMMENDATION 14.2: Develop a weekly 'flash report' to provide early warning of challenges to staffing levels relative to patient numbers and acuity and inappropriate use of temporary staffing.					
RECOMMENDATION 14.3: Chief Executive to charge the Head of Human Resources with taking responsibility for developing and monitoring relevant and timely early warning data.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
14.1/3a	Scorecard based on data and information arising from workforce planning and e-rostering to be developed and introduced	HHR	30.06.14	**17.04.14**: Report to Board in April on Safe Staffing and efficient use of resources. Link to Performance Team's early warning metrics under development; report to Board planned for May. **31.05.14:** Safe Staffing updates included on	**COMPLETE**

				all board agendas from May onwards	
14.2/3a	Flash reporting based on scorecard described at 12.4a to be introduced	HHR	30.06.14		
RECOMMENDATION 14.4: Head of Human Resources to provide a quarterly update to the Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
14.4a	First quarterly report to be presented	HHR	26.06.14	**17.04.14:** On Board work plan	On track
GOVERNANCE					
RECOMMENDATION 16.1: Whilst we are confident about the effectiveness of both the Quality & Risk and Audit Committees it would seem appropriate, both in the light of the Francis, Keogh and Berwick reports, and in Monitor's growing focus on formal governance processes, to review our Board level governance structures. We understand that the interim Director of Corporate Affairs has been tasked with reviewing the Board systems of both corporate and clinical governance.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.1a	Self-assessment based on Trust Development Authority's Board Governance Assurance Framework (BGAF) to be completed	iHCA	31.03.14	**20.03.14:** assessment 70% complete **17.04.14:** assessment complete	COMPLETE
16.1b	Action plan based on outcome of BGAF assessment to be developed	iHCA	18.04.14	**14.04.14:** Draft action plan in development; for discussion at Board seminar 24.04.14 **09.04.14:** Action plan complete – to be presented to Board for adoption 19.05.14	COMPLETE
16.1c	Board workshop on proposed changes to Board governance and reporting arrangements to be delivered	iHCA	24.04.14	**20.03.14:** Discussed with Chairman; board time scheduled **24.04.14:** Workshop delivered	COMPLETE
RECOMMENDATION 16.2: Establish a monthly executive level Quality & Safety Committee to be chaired by the CE, and review and amend the remit of the existing directorate quality & risk committees and other committees dealing with quality, risk and safety issues to align governance structures and reporting across the Trust.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.2a	Review terms of reference of all relevant	CEO	31.03.14	**17.04.14:** Meeting scheduled CE, MS and	COMPLETE

	Committees			DN with interim Head of Corporate Affairs to agree terms of reference, 28.04.14 **12.05.14:** Report on Executive assurance structures on May Board agenda	
16.2b	Revise Committee terms of reference as required	CEO	02.05.14	As above 16.2a	COMPLETE
16.2c	Produce work programme for operational Quality & Safety Committee	iHCA	02.05.14	**14.04.14:** Initial discussions between DN, iHCA and HoR held 14.04.14. Meeting to discuss further booked for CEO, MD, DoN, iHCA on 28.04.14 **31.05.14:** Work programme completed; meetings to start from July	COMPLETE
16.2d	Implement new Committee and reporting arrangements; commence workplan	iHCA	30.05.14	As above 16.2 a **31.05.14:** New Committee to begin meeting from July onwards	Overdue
16.2e	Review effectiveness of new Committee arrangements	CEO	30.11.14		
RECOMMENDATION 16.3: Trend analysis to be included in monthly reporting to the Executive Quality & Safety Committee.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.3a	Report template to be produced	HoR	30.04.14		
16.3b	Trend reporting to begin	HoR	30.05.14		
RECOMMENDATION 16.4: Executive Quality & Safety Committee to define trend reporting requirements to be provided by the Risk Team.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.4a	Trend reporting requirements to be identified and notified to Head of Risk	CEO	11.04.14	**17.04.14:** to form part of discussion CEO, DN, MD, iHCA 28.04.14 **12.05.14:** DN producing workplan for end of May **31.05.14:** Work programme completed; meetings to start from July	COMPLETE
RECOMMENDATION 16.5: Quality & Safety Committee to review the Trust risk registers to ensure it is a 'live document' with risks					

appropriately identified, graded and escalated. To agree a unified approach for the different registers.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.5a	Risk management process to be reviewed by iHCA, DN, HoR	DN	15.04.14	**14.04.14:** iHCA, DN and HoR met 14.04.14 for discussion re: process. iHCA and HoR to meet again to review format. Revisions to process to be discussed as part of Board workshop on Board reporting, agenda etc 24.04.17	**COMPLETE**
RECOMMENDATION 16.6: Monitoring of incidents, including follow up on action plans to be included in monthly agendas for Quality & Safety Committee.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.6a	Allocation of responsibility for incident and action plan monitoring to be reviewed and if required changed	iHCA	30.04.14	**14.04.14:** Discussed by HoR, DN and iHCA – agreement reached. Action Plan owner formally to be designated as key collater of information and responsible for escalating delay to monitoring individual / committee. Incident reports and action plans to be reviewed bi-monthly by Quality & Risk Committee.	**COMPLETE**
WHISTLEBLOWING					
RECOMMENDATION 18.1: It is proposed that the whistle blowing policy is reviewed with the intention of giving greater clarity to staff as to when it is justified to be invoked and therefore when they can expect to receive the protection of anonymity; and also to cover the process to be followed after the whistleblowing occurs.					
RECOMMENDATION 18.2: Whenever a response to a whistleblowing incident is required, the response team should be chaired by someone who is independent of the incident concerned. Exactly who this is will depend on the scale and scope of the incident concerned but it could include the Chief Executive, Executive Director or a Non-Executive Director.					
RECOMMENDATION 18.3: The initial terms of reference should be signed off by the Chair of the response team with the remit to amend the terms of reference in the light of emerging evidence.					
RECOMMENDATION 18.4: Any response should have three parts; 1. Immediate action to be taken to protect staff and patients as appropriate.					

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2. An initial report to determine the facts and recommend any follow up action directly connected to these events. 3. An examination of any broader lessons to be learned and recommendations on addressing these. The timescale for parts two and three should be determined by the Chair of the response team.					
RECOMMENDATION 18.5: Depending on the likely scale of the enquiry, communication should be managed by the Chief Executive, Director of Nursing and Medical Director to ensure that both internal and external stakeholders are managed effectively.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
18.1-5a	Whistleblowing Policy to be reviewed and recommendations 18.1 – 18.5 incorporated	HHR	31.07.14	**17.04.14:** Initial discussions with Staff Side held at JCNC early April **12.05.14:** Dep HHR in discussions with Counter Fraud re: their role. Policy to go to next JCNC meeting.	On track

KEY			
On track	Work on the action has commenced, no delays anticipated	Overdue	Deadline has passed and the action is not completed
Delayed	Delay has occurred or is anticipated	**COMPLETE**	Action is complete and may be removed from action plan

ABBREVIATIONS			
CEO	Chief Executive	**DN**	Director of Nursing
HHR	Head of HR	**iHCA**	Interim Head of Corporate Affairs
HoR	Head of Risk		

Board engagement programme

Recommendation 6.1 of the Canadian Wing Action plan was made as follows:

The Trust Board to take the lead in creating a culture of openness and transparency throughout the organisation through an increased programme of board visits, 'back to the floor' sessions and involvement in existing programmes such as 'Compliance in Practice'.

In response to this recommendation, the Interim Head of Corporate Affairs has collaborated with board colleagues and developed a number of systems and processes by which Board members and other senior managers interact with staff across the trust to promote improved engagement and openness. These systems and processes include

Departmental visits to Board meetings

1. Each month a department or team is invited to attend at a meeting of the Board's members prior to the full board meeting to give a brief presentation about its structure, objectives and challenges, and to answer questions from board members. The invited departments include clinical and non-clinical departments, and are represented by one or two key members. Presentations so far have been from the Human Resources Department and Telemedicine, with Pharmacy due to attend in June.

2. The presentations not only give board members the opportunity to increase their knowledge and the form and function of departments across the trust, but deliver a valuable opportunity for those who do not generally attend the board to meet board members and to be exposed to board level questions. This contributes to the professional and personal development of the individuals concerned, but also helps to break down barriers between the board and trust staff which might otherwise inhibit openness and the raising of concerns.

Back to the Floor

3. The Corporate Affairs department administers a programme of half days visits to departments by all Senior Management team members. The programme is promoted on the intranet and via Connect. The purpose of the visits is for Senior Management team members to experience front line work with the department, meet staff and get a feel for morale and staff experience in the department, as well as to observe patient experience in clinical areas (although all departments including non-clinical departments are encouraged to invite an SMT member to join them.

4. The first visit was complete by Richard Tyler, who spent a morning working with the cleaning teams in May.

5. Again, the purpose of the programme is improved SMT observation of staff and patient experience and the breaking down of barriers between front line teams and senior management, with the intention of improving openness and transparency.

Half a day per month clinical time

6. The Chief Executive now requires all Senior Management Team to undertake a half day of clinical area time per month, improving exposure of clinical teams to SMT members and visa-versa.

Compliance in practice

7. The Director of Nursing and Quality continues to run a programme of Compliance in Practice visits, in which all Board members and Governors are encouraged to participate. The process involves visits to clinical areas and interaction with staff and patients, with feedback passed to the Director of Nursing & Quality's team, which then collates the information noted and feeds it into assessments of compliance with the Care Quality Commission (CQC) standards.

8. The CQC's standards include provisions concerning patient and staff experience, as well as safety and clinical effectiveness, so the visits necessarily prompt consideration of the issues raised by the C Wing Investigation report and provide a mechanism for feedback to management about morale and patient safety issues. The visits also provide further opportunities for staff to interact with Board and SMT members and Governors, thus improving levels of openness and transparency.

Monthly engagement round up and feedback at board

9. In order to ensure that information about patient experience, patient safety, staff experience and other staffing issues gleaned from the exercises described above is captured, a new standing item has been added to the Board's agenda. Under the heading "Stakeholder engagement", Board members will be asking to identify the incident of engagement with key stakeholders, including patients and staff, undertaken in the previous month, and to feedback to the board any notable or concerning findings. This will ensure that matters of interest (both positive and negative) are brought to the board's attention and actions required as appropriate.

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**156-14**
Report from:	**Richard Tyler, Chief Executive**
Committee meeting date:	**17 June 2014**
Appendices	**None**

Report from meetings of the Clinical Cabinet held on 2nd and 16th June 2014

Key issues and actions

1. Trauma Review: Presentation on current trauma performance and concerns were raised regarding increased levels of out of hours operating and trauma capacity. AGREED to initiate full review under auspices of Trauma Management Group with report back in September 2014
2. Theatre 11: Update on staff recruitment. Noted delays in recruitment and proposed mitigation. AGREED mitigation plan subject to further work on costings. Full report to June Board.
3. DH Intensive Support Team: Recommendation to create single point of access for referrals w/e from 14th July: AGREED
4. Quality & Risk Report: received monthly Q&R report and NOTED existing risks 12 and above, clinical incidents and safe staffing data.
5. Policy ratification: Cabinet endorsed Revised Flexible Working Policy
6. Clinical Audit & Outcomes Data: Received annual report and AGREED recommendations
7. Discussion on staff morale (standing item following recommendation from C wing review). Emphasis placed on need for senior management to be 'visible' in front line clinical areas

Link to Key Strategic Objectives

8. Outstanding patient experience
9. World class clinical services
10. Operational excellence
11. Financial sustainability

Implications for BAF or Corporate Risk Register

12. Issues regarding trauma capacity and delay in recruitment to theatre 11 to be reviewed for inclusion on BAF/CRR

Regulatory impacts

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

Recommendation

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

Report to:	**Board of Directors**
Meeting date:	**26 June 2014**
Reference number:	**157-14**
Report from:	**John Thornton, Non-Executive Director**
Committee meeting date:	**4 June 2014**
Appendices	**None**

Report of the Chair of The Audit Committee

Key issues discussed

External Audit

1. Capital Projects and Processes Final report.

   Overall assurance rating is 'requires improving'. Committee discussed not only issues in Estates but the implications for management of all capital projects. Plan is to bring this report to July BOD. Programme Board established to address shortcomings.

Internal Audit

2. Main Accounting Systems

   Deterioration in results compared to last year. Only 'limited assurance' provided in respect of accounts payable. Assurance given that reconciliations are now up to date.

3. Reference Cost Audit

   The report had not been circulated to the Board and a verbal update provided. Audit was not positive on QVH procedures but some of comments were considered to be inaccurate. The final report and response is to be seen by Committee members.

Counter Fraud

4. NHS Protect Quality Assessment Report

   QVH was non-compliant in 10 of the 18 standards measured and overall this was recognised as unsatisfactory; however, several failures were due to one issue concerning the recording of incidents. The Committee considered whether efforts to achieve 'green on all measures' was justified given limited resources and scale of the Trust. Compliance with NHS Protect standards will use up a significant part of our Counter Fraud resource for the year, with implications for more proactive work.

Additional information or assurance sought

5. An internal Audit (IA) review of Theatres and processes had provided a 'significant assurance' report. But there were a number of findings concerning areas for improving efficiency. It was agreed that a further review into specific areas could have benefits; however, it was considered this should be delayed until new structure had a chance to bed in. This will be considered alongside other priorities for use of IA resource.

Implications for Board Assurance Framework or Corporate Risk Register

6. There were no items identified which should be added to the Corporate Risk Register (CRR) or the Board Assurance Framework, (BAF).

Recommendation

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