Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 25 June 2015

Session in private at 11.30
Session in public at 13.00

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

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 25 June 2015

Members (voting):

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

In full attendance (non-voting):

Director of Human Resources & OD	-	Graeme Armitage
Director of Operations	-	Sharon Jones
Head of Corporate Affairs & Company Secretary	-	Kathleen Dalby
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode (apologies)

QVH 2020 – 15/16 Priority List

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

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Agenda: session held in private Thursday 25 June 2015 at 11.30		
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Any other business (by application to the Chair)		
142-15	*Beryl Hobson, Chair*	-

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147-15	**Update from the Chief Executive, including:** • Update on implementation of recommendations following the spoke-site review • Sustainable waiting lists: update on review of demand and capacity • C-wing action plan update • Criteria for approving locations for off-site activity • Letters from the Secretary of State for Health, Department of Health Director General: Finance, Commercial and NHS and the Chief Executive of Monitor *Richard Tyler, Chief Executive*	16
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Members of the public		
164-15	**Observations from members of the public** *Beryl Hobson, Chair*	-
165-15	Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature *Beryl Hobson, Chair*	-
Evaluation of board meeting		
166-15	*Beryl Hobson, Chair*	

Date of the next meetings		
Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 30 July at 13:00	**Q&R:** 02 July 2015 at 09:00 **F&P:** 20 July 2015 at 14:00 **N&R:** 30 July 2015 at 09:00 **Audit**: 09 September 2015 at 14:00 **Charity:** 24 September at 09:00	**Public**: 09 July 2015 at 15.00

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Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 321 May 2015, 13.00 – 16.00, The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT** *For accuracy, it should be noted that item 123-15 was taken ahead of 121-15*	
Present:	Beryl Hobson, (BH)	Trust Chair
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Ian Playford (IP)	Non-Executive Director
	Lester Porter (LP)	Non-Executive Director
	Dominic Tkaczyk (DT)	Interim Director of Finance
	Jo Thomas (JMT)	Director of Nursing & Quality
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources & Organisational Development
	Kathleen Dalby (KD)	Head of Corporate Affairs & Co Sec
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Interim Director of Operations
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	John Thornton (JT)	Non-Executive Director
Public Gallery:	Fiona Long (FL)	Interim Deputy Director of Nursing for QVH

WELCOME

111-15 **Welcome, apologies and declarations of interest**

The Chair welcomed IP to his first public board meeting since his appointment as non-executive director.

JMT was congratulated on her recent appointment as substantive Director of Nursing and Quality.

The Chair noted that this would be the last meeting for both DT and JM who would be leaving the trust in early June. She thanked them both for their hard work and contribution to the hospital.

Fiona Long, who was observing discussions today, was welcomed to the meeting.

Apologies had been received from John Thornton. It was noted that BG had to leave at 4pm.

There were no new Declarations of Interest.

The Chair reminded the board that the reason this month's meeting had been scheduled a week earlier than usual was to take account of prescribed deadlines for approval of the annual report and accounts. In some instances, report authors had been unable to submit written reports this month and verbal updates would be provided instead.

Finally, BH reported that the findings of the 2014 national inpatient survey had been released this morning. These showed that QVH continued to achieve some of the best feedback from patients in the country. BH asked that the board's congratulations be extended to all concerned.

PATIENT STORY

112-15 **Patient Experience**

RT updated the board on his recent experience as an outpatient at the trust. He was impressed by the standard of surgical care he received and was reassured that patient pathways were working effectively.

STANDING ITEMS	
113-15	**Draft minutes of the meeting session held in public on 30th April 2015 for approval** • 89-15: 'Once' to read 'one' • 89-15: 'enhanced' to read 'overtime' • 89-15: Reporting of pressure ulcer levels should read: 'JMT explained that a high number of these were the result of very long theatre sessions and assured the board that particular care was already given to vulnerable patients'. With these changes, the minutes were **APPROVED** as a correct record.
114-15	**Matters Arising & Actions Pending** The board reviewed the current record of matters arising and actions pending. The update was received and **APPROVED**.
115-15	**Update from the Chief Executive** Due to deadline restrictions this month, the Chief Executive provided a verbal rather than written update. Highlights included the following: • There should be a degree of continuity following the results of the recent general election, with nothing to suggest any major changes at present. The 7-day working initiative was now a key focus. This sat within the QVH vision for community services. However, funding would continue to cause concern. • The second wave of new models of care emerging from the Five Year Forward View vanguard programme was launched on 20th May. As reported last month, Sam Jones (instrumental in developing the Dalton model of care work) would be asked to support lobbying for QVH to become a vanguard site for the new models of care. • Discussions relating to burns services between QVH and BSUH were progressing well; • The new operations structure was due to go live on Monday 1st June. Additional key appointments made since the last update included Deputy Director of Finance, Business Manager for Plastic Surgery and interim Business Manager for Eyes and Oral Surgery. Clinical Director appointments were scheduled for 8th June. • The Maxfacs team, led by consultant Ken Sneddon, had undertaken a successful pilot scheme running weekend tooth extraction clinics. BH thanked RT for his report, the contents of which were **NOTED** by the board.
RESULTS AND ACTIONS	
116-15	**Patients: safe staffing and quality of care** JMT presented this month's update A new safe staffing template was presented in this month's report but this was only partially populated due to earlier reporting deadline. As not all metrics were available at the time of the report being written JMT reported the following highlights: • Achievement of safe staffing levels throughout March. Whilst establishment figures had been a concern, new staff had been recruited to both Canadian wing and Peanut Ward. • The CCG had confirmed payment in full for the 2014/15 Q4 CQUIN schemes; • Of the 65 incidents relating to patients in April, 59 were graded as no harm or near misses, with 6 graded as minor harm. None were categorised as moderate or severe harm • Two grade 2 QVH acquired pressure ulcers had been reported in April. These were due to friction, not length of theatre stay. New tape and patches were being trialled by the ward to see if this would reduce pressure damage. • Falls continue to decrease with only 2 reported in April. • No serious incidents occurred in April • Friends and Family Test metrics continue to score strongly, although outpatient areas were not performing as well as inpatient this month. As previously agreed JMT had further explored the

	percentage of patients 'unlikely or extremely unlikely' to recommend QVH. This month the highest figures were in trauma. It was hoped that new trauma pathways would help to address this. • A revised CQC Hospital Intelligent Monitoring report was anticipated The Board went on to discuss matters arising from the update including: • Clarification of the complaints process; • A request by GC for incident reporting to be refined in line with annual reporting metrics; **(Action: JMT)** • A request by LP to ascertain if there was direct correlation between MIU waiting times and 'FFT' scores (noting that plastics trauma patients were also sent to the same area); **(Action: JMT)** The medical director provided an update on the recent 'never event' relating to wrong site tooth extraction. He agreed to circulate a summary of findings to the board **[Action: SF]**. Although there had been no harm to the patient, the board was reminded of the reputational repercussions for the trust. The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
117-15	**Operational performance: targets, delivery and key performance indicators** JM presented April's report, highlighting the following: • Confirmation that the trust had achieved compliance with the Trust aggregate admitted RTT with all specialities; • The trust was compliant with the aggregate non-admitted RTT target for all specialities except Cardiology, Plastics and Rheumatology. (As there were less than 20 patients in Rheumatology, this would not be reportable as a speciality breach as per Monitor guidance); • The trust continues to forecast compliance with all three targets for May. (It was noted that the trust had now attained sustainable waiting time targets for the last six months. The Chair commended JM and her team for the work undertaken to achieve this); • The trust achieved all cancer waiting times in March except for 62 days, with a total of 4 breaches. JM asked the board to note that one patient had been incorrectly allocated to QVH. The trust was currently in contact with the organisation concerned to amend the 'open Exeter' system; however even with this patient excluded the trust would still have failed this target for March; • The trust achieved all cancer waiting times for quarter 4 except for 62 days, with a total of 9.5 breaches of this standard reported between January and March, (the majority being recorded in February). JMT asked the board to note that nationally, cancer targets were the worst on record. She also pointed out that 81% of all breaches featured patients whose pathway had started elsewhere. The Chair thanked JM and the board **NOTED** the contents of the report.
118-15	**Financial performance** Due to deadline restrictions this month, DT provided a verbal rather than written update. Highlights included:: • Pay and non-Pay were both underspent; • The Cost Improvement Programme (CIP) was being achieved; • Income in April was down, with an adverse variance to plan of £75k. However, much work had been done by operational teams to ensure activity would be achieved this year. RT noted that the weekly 'flash' report also indicated that activity was starting to improve. (It was noted that April had also been a short month due to the Easter break). The Chair reminded the board that the new Finance and Performance Committee would be effective from June. BH thanked DT for his report, the contents of which were **NOTED** by the board.

119-15	**Contracts update** Due to deadline restrictions this month, DT provided a verbal rather than written update drawing the board's attention to the following: • Contract negotiations had now concluded. All contracts had now been signed off; • There was little evidence currently to indicate CCGs (Care Commissioning Groups) were achieving Quality, Innovation, Productivity and Performance (QIPP) targets; • There was no indication there would be any change to 'low priority' procedures this year; • The trust was still waiting to hear if Monitor was likely to refer the tariff issue to the Competition and Markets Authority (CMA). If so, the issue could take some time to resolve. However, due to the level of provision set aside in this year's budget, the trust should not be adversely affected by any delay. The Chair thanked DT for his update, the contents of which were **NOTED** by the board.
120-15	**Workforce** GA provided the board with an update on workforce key performance indicators. As a consequence of the meeting being brought forward it had not been possible to update some of the data including sickness absence reporting. Main themes emerging in April were highlighted as follows: • Turnover at the start of Q1 stood at 15.58%. Whilst still above the trust target of 11% the position remained stable. GA reminded the board of the steps taken to address turnover. These included the bank/overtime initiative, recruitment open days and improved exit interview/data collection. • An increase in pay, bank and agency, although this had been anticipated as it occurred prior to implementation of the bank/overtime initiative. However, during the first month of operating the new initiative there was a significant shift back towards bank rather than agency use. GA noted that staff continuity would improve patient experience and quality of care. But the situation would be closely monitored to ensure staff were not overworked. • Vacancy rates. It was noted that the gap between the funded establishment whole time equivalent (WTE) and the in-post WTE was still too high, although it had improved during Q4. As reported under item 116-15, successful recruitment to vacancies on Canadian Wing would have a positive impact on sickness and bank/agency use in this area. • Levels of compliance for statutory and mandatory training continue to improve. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
121-15	**Staff Survey 2014** GA reminded the board that following publication of the 2014 QVH annual staff survey, he had commissioned a more detailed analysis of survey results over the last 3 years. This was to ensure that any potential trends could be identified and built into an action plan. GA asked the board to remain mindful that, whilst this report would be focusing on the negative aspects of the results, the trust was still performing well in comparison to other specialist acute trusts. The full staff survey report had been circulated to the board for information. In each area the most significant decline was shown and to which staff groups these are attributable. The action plan would therefore include each relevant area with appropriate actions and time scale assigned to them. In addition, a visual indication ('heat map') across all areas associated with the survey over the last 3 years had been produced. This showed that a greater level of engagement and focus was required

	for non-qualified clinical, administration and estates and facilities staff groups. GA noted that addressing their concerns was likely to impact most positively on future results. GA reported the main areas of focus would be: • Quality of appraisal; • Objective setting; • Individuals involvement in decision making; • Support for line managers; • Contribution to patient care; and, • Health and wellbeing. The Board went on to discuss matters arising from this update including: • Confirmation that the action plan would target both frontline and managerial staff. GA reminded the board that cultural changes would be addressed through the new leadership and management development framework (see item 122-15); • The importance of protecting the confidentiality of the survey whilst ensuring the correct staff groups were being targeted; • Ensuring staff survey results were linked with other metrics, (for example, sickness absence and recruitment); • Concern that disengaged staff could have a detrimental impact on the organisation, and consideration as to whether performance management might be appropriate in these instances; • Confirmation that methods similar to those used during the recent organisational restructure would be adopted to encourage staff engagement with this process. It was agreed that a formal action plan would be returned to the board in June **[Action: GA]** The Chair thanked GA for his comprehensive update. The Board **NOTED** the contents of the report, in particular the improvement areas highlighted in sections 4.1 to 4.19 of the full staff survey report
STRATEGIC PRIORITIES	
122-15	**Quarterly update on delivery of Key Strategic Objective (KSO) 5: Organisational Excellence** GA provided the board with an update on progress against the objectives identified in delivering KSO5 (organisational excellence). Highlights included: • Implementation of the 'SafeCare' system, planned opening of the simulation suite and launch of the new leadership and management development framework.GA agreed to circulate the link to the framework to the board **[Action: GA]**; • As reported previously, progress had been maintained in most areas apart from three-year workforce planning. GA confirmed that this was now scheduled for 2015/16; • A revised set of objectives for KSO5 had been agreed and would form the basis for quarterly updates throughout 2015/16. These would focus on the non-clinical infrastructure, junior doctors and leadership development. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
123-15	**Board Development Programme** In advance of the formal report scheduled for June 2015, GA provided the board with a verbal update of progress on the board development programme. This would include: • Emphasis on organisational culture, relevant to all key strategic objectives (KSOs); • Additional focus on equality and diversity issues; • Expansion of the teambuilding work started at the end of last year to improve the board's function as a unitary board. • An improved induction process for executive and non-executive directors; • Greater emphasis on safeguarding and risk issues; and,

	• Media training. It was confirmed that a budget had now been agreed for board development. BH reminded the board that plans were underway for a further board away day in July. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
GOVERNANCE	
124-15	**Corporate Risk Register** JMT presented the latest Corporate Risk Register (CRR) noting that little had changed since last month's update. However, it was noted that the latest version did not include the latest update to the Estates services risk (ID 670). This had now been reduced and the correct rating would be reflected in next month's report. Further to discussions regarding the format of the CRR at last month's meeting, JMT confirmed that risks were grouped in scores, according to owner. There were no further questions and the board duly **NOTED** the contents of the update.
125-15	**Board assurance framework development update** JMT provided a formal review on the board assurance framework (BAF) seminar held last month. Further work was required to develop a new BAF with progress to be presented at future board seminars. There were no further questions and the board duly **NOTED** the contents of the update.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
126-15	**Clinical cabinet** RT advised there was nothing significant to report following last month's Clinical Cabinet meetings. There were no questions and the board duly **NOTED** RT's comments.
127-15	**Nomination and remuneration committee** LP presented an update highlighting key issues discussed at the last Nomination & Remuneration Committee meeting. He drew particular attention to the planned appraisal process, noting that this was due to start in May, with a view to key conclusions being reported to the committee at its meeting in July. GA agreed to circulate appraisal documentation to board members, to include the process and timescales. **[Action: GA]** There were no further questions and the board duly **NOTED** the contents of the update.
128-15	**Quality and risk committee** GC presented a report on the latest Quality and Risk Committee. The board was asked to note that the trust would no longer subscribe to the Academic Health Science Network (AHSN) in 2015/16 as part of cost saving measures. There were no further questions and the board duly **NOTED** the contents of the update.
NEXT MONTH'S AGENDA	
129-15	KD presented next month's draft agenda for comment. It was noted that a formal report on board development and an update on the board governance

	review would also be included on the agenda. Due to the forthcoming changeover in personnel, JM reminded the board that there could be a problem with timely submission of next month's operational report, particularly as Department of Health (DH) deadlines occasionally fall after board deadlines. The board **NOTED** the contents of the draft agenda and subsequent verbal updates.
STAKEHOLDER AND STAFF ENGAGEMENT	
130-15	**Feedback from events and other engagement with staff and stakeholders** • BH continued to meet staff throughout the trust, and hoped to attend trust-wide team meetings as part of her regular programme of work; • LP reported on an NHS Providers NED forum which he had attended recently; • As this was her last meeting before leaving the trust, JM took the opportunity to thank the board for its support over the last five years and wished the new team all the best for the future. In turn, BH thanked JM for the significant contribution she had made to the organisation. In particular, it was noted that JM had been instrumental in improving overall performance, and in the last year had made significant progress in developing both trauma capacity and the longer term strategy for burns services, as well as leading all of our work on the electronic patient record.
MEMBERS OF THE PUBLIC	
131-15	**Observations from members of the public** There were none.
132-15	Further to paragraph 39.1, and annex 6 of the Trust's Constitution, it was agreed that members of the public should be excluded from the remainder of the meeting in order to enable the board to discuss confidential information concerning the trust's finances and matters of a commercially sensitive nature

Chair …… Date ……

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
May 2015 meeting						
1	**116-15**	Incident reporting to be refined in line with annual reporting metrics.	**JMT**	June	Verbal update to be provided at board	**Pending**
2	**116-15**	Identify any correlation between MIU waiting times and 'FFT' scores, (noting that plastics trauma patients are also sent to the same area)	**JMT**	June	Verbal update to be provided at board	**Pending**
3	**116-15**	Summary of 'never event' findings (as reported at May meeting) to be circulated to board	**SF**	~~June~~ Sept	18 06 2015 To be presented in conjunction with Theatres Review update in September	**Pending**
4	**121-15**	Formal action plan to address results of 2014 staff survey to be submitted to June board meeting	**GA**	June	On June agenda	**Pending**
5	**122-15**	Link to 'Leadership and management development framework' to be circulated to the board for information	**GA**	June	Verbal update to be provided at board	**Pending**
6	**127-15**	Details of appraisal process, timescales and documentation to be circulated to board for information	**GA**	June	Verbal update to be provided at board	**Pending**
April 2015 meeting						
7	**93-15**	Information Management & Governance Group to be tasked with improving IG toolkit submission scores	**DT**	-	Confirmed that this will be part of the IM&G's work programme for 2015/16.	**Complete**
8	**94-15**	Data relating to employee relations to be better anonymised within Workforce reporting.	**GA**	May		**Complete**
9	**95-15**	Evidence of IT integration within the QVH2020 programme to be enhanced within the current governance structure. The board to consider this at a future meeting.	**KD**	TBA	Will be built into board work programme once details of board governance review have been finalised	**Pending**
10	**99-15**	Risks rating and narrative relating to theatre doors to be reviewed and updated.	**JMT**	May	**21 05 2015** • Original electric doors replaced; • Original risk related to Musculo-skeletal injuries. All doors working normally and this can now been removed from risk register	**Complete**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
11	**100-15**	Annual DoI forms to be circulated to board for completion and return	**KD**	May		**Complete**
12	**100-15**	Integrated procedural document to be drafted which will describe QVH policies and procedures to ensure that directors meet the 'Fit and Proper Person test' criteria.	**KD**	~~June~~ July	Pending ongoing work within HR department.	**On July agenda**
13	**102-15**	Audit committee ToRs to be clarified prior to amendment.	**KD**	June	Verbal update to be provided at meeting	**Pending**
March 2015 meeting						
14	**73-15**	Action plan to be developed to tackle areas of concern highlighted in the Staff Survey.	**GA**	May	On board agenda for May 2015	**Complete**
15	**73-15**	As part of the current governance review, the group to reconsider establishing a board workforce sub-committee in order to improve board and corporate level focus on staff wellbeing.	**BH**	June	**30.04.2015** Today's agenda to include details of latest review **21.05.2015** On June agenda	**On June agenda**
16	**74-15**	Risk rating with regard to maintaining continuous Estates services to be reviewed as a result of actions in place to mitigate risks.	**RT**	June	**30.04.2015** DT and RT to meet and discuss with Head of Estates. Revised risk register to be presented to board in May **21.05.2015** Risk revised down to 9 but still to be reflected in latest version of risk register	**Complete**
17	**79-15**	SF to update board on 'Repeated behaviours to be found within successful organisations' as identified by Richard Bonher, visiting fellow of the King's Fund.	**KD**	TBC	**30.04.2015** Presentation to be programmed into board work programme for 2015/16	**Pending**
February 2015 meeting						
18	**034-15**	Whistleblowing policy to undergo further evaluation to incorporate new recommendations following *Freedom to Speak up* and returned to BoD for review in April.	**GA**	~~April~~ July	**21.04.2015** The changes incorporated following the Freedom to Speak up review need to be agreed at the Quality and Risk Committee before this policy returns to the Board for ratification. The next meeting of the Q&R committee is the 7th May 2015. **21.05.2015** Further review required, linked to 'Freedom to speak up'. To be returned to board in July.	**On July agenda**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
19	**035-15**	Future Safe Staffing reporting to include quality matrix for Theatres	**JMT**	~~March~~ June	**26.03.2015** This will be included no later than May **21.05.2015** Scorecard now enhanced but not populated due to early scheduling of May board meeting	**Pending**
20	**035-15**	Board to receive update on progress for CQC inspection once visit is confirmed.	**JMT**	June	**26.03.2015** This will be scheduled for May **11 05 2015** BH and RT agreed this will now be scheduled for June	**On June agenda**
21	**037-15**	Board to be apprised how best the trust might to achieve sustainable waiting lists in the long term.	**RT**	June	**30.04.2015** RT undertaking broader review of demand and capacity. Will provide board with an update in June.	**On June board agenda**
22	**051-15**	Recommendations following spoke site review to be implemented	**RT**	June	**30.04.2015** Ongoing. Update to be provided at June board.	**On June board agenda**
December 2014 meeting						
23	**331-14**	Board to be apprised of criteria used when approving locations for off-site activity	**RT**	June	**30.04.2015** Update to be provided at June board.	**On June board agenda**
24	**338-14**	C-Wing Action plan to be returned to board for review in June 2015	**KD**	June	Incorporated into CEO report to June meeting pf the board.	**On June agenda**
July 2014 meeting						
25	**181-14**	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**	~~Oct~~ ~~Dec~~ TBA	This will form part of the wider organisational review which will start in October 2014 **21.10.14:** Review has commenced, not expected to conclude until December **18.12.14** Review still underway **21 05 2015** With completion of organisational review, this action is now complete.	**Complete**
May 2014 meeting						
26	**136-14**	Monitor's "Well-Led" assessment framework to be	~~**LH**~~	~~Aug~~	**08.07.14:** Presentation to be made to	**Ongoing**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
		implemented as part of the governance review. LH to liaise with RT regarding next steps, and board to be updated accordingly.	**KD**	~~Oct~~ ~~Dec~~ ~~Mar~~ July	October Nomination & Remuneration Committee **15.09.14:** Well Led Review template to be used as framework for Board self-assessment commencing at December away day. **21.10.14:** Current Governance Review led by Chair Designate to be based on Well – Led Framework **01 02 2015** As LH has now left the trust this will be picked up by KD **17/06/15** Will be incorporated into CQC inspection planning to be discussed at July board meeting.	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th June 2015
Agenda item reference no:	147-15
Author:	Richard Tyler, Chief Executive
Date of report:	17th June 2015
Appendices:	A1 letter from Secretary of State A2 letter from David Williams A3 letter from Monitor A4 annex to letter from Monitor B1 letter from Simon Stevens B2 letter from Bruce Keogh C1 NHS Providers briefing

CHIEF EXECUTIVE'S REPORT JUNE 2015

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

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

CHIEF EXECUTIVE'S REPORT
JUNE 2015

TRUST ISSUES

Executive Team

I am pleased to welcome Claire Stafford, Director of Finance & Performance, and Sharon Jones, Director of Operations. This completes the Trust Executive team.

In addition I am pleased to confirm the following clinical director appointments:

Plastics – Mark Pickford (continuing appointment)
Head & Neck – Ken Sneddon (new appointment)
Eyes – Damian Lake (new appointment)
Sleep – Peter Venn (new appointment)
Anaesthetics – Tim Vorster (new appointment)
Rachael Liebmann – Deputy Medical Director & Clinical Director for Clinical Infrastructure

I would also like to thank the outgoing clinical directors, Ken Sim, John Tighe and Asit Khandwala for all of their hard work and support to both myself and especially to Steve Fenlon.

Finance & Operational Performance

The newly created Finance & Operational Performance Committee (FOP) held its first meeting on 15th June. A full report is contained elsewhere on the agenda. The committee considered the month 2 finance & activity figures. The detailed month two report is contained elsewhere on the agenda. As at month 2 the overall Trust position is showing a year to date deficit of £109k. This is the result of lower than planned activity levels, particularly in month 1. It was noted that the Director of Operations is undertaking a detailed review of the annual plan in order to take appropriate remedial action. It was agreed that FOP would consider the initial diagnostic at its August meeting with a full report and action plan, if required, being prepared for the September Trust Board.

Waiting Time Targets

The Trust achieved aggregate compliance with the 18-week referral to treatment (RTT) targets in May and is forecasting compliance in June. Referral to treatment time targets have been reviewed by Sir Bruce Keogh, NHS National Medical Director, and this is likely to result in changes to national reporting arrangements (see below).

The Trust achieved all cancer waiting time targets in March with the exception of the 62-day target. The main reason for the breach was the long-wait experienced by a small number of patients at another a trust prior to onward referral to QVH. This is being addressed with the Trust concerned and on-going monitoring and governance will form part of the review of existing hub & spoke arrangements (see below).

Sustainable Waiting Lists (Matters Arising 21 037-15)

The Board has discussed previously the challenge of achieving sustainable waiting lists when dealing with a relatively small number of patients and high level of sub-specialisation. This is intrinsically linked to our ability to predict and manage both demand and capacity. To this end the Director of Operations is reviewing demand and capacity as part of the wider review of activity referred to above. This will form part of the report to the September board and inform both in-year recovery, if required, and the 2016/17 business-planning round.

Hub & Spoke Services (Matters Arising 22 051-15 & 23 331-14)

The Board considered an initial review of hub & spoke provision at its February meeting. The review was instigated as part of the wider strategic review *QVH2020*. The review highlighted gaps in the existing financial and clinical governance arrangements for the

spoke sites. To this end the Medical Director, Director of Nursing and Director of Operations are undertaking a review of existing arrangements. This will inform the wider review and it is proposed to bring a further report to the September Board.

C-Wing Action Plan (Matters Arising 24 338-14)
The Board at its December 2014 meeting considered the C-wing action plan. At that stage it was noted that 45 of the 54 recommendations had been completed. Of the nine remaining recommendations four related to the introduction of the Safer Care module of the e-rostering system. The Safer Care module is now in place. The remaining recommendations related to the organisational restructure and specifically the development of appropriate systems for monitoring and managing individual and departmental performance. Systems of individual performance management have been addressed through the Organisational Excellence workstream, as reported to the May Board, and departmental performance review is being addressed by the Executive Team as part of its review of existing governance structures. On this basis I recommend that the action plan is formally closed.

NATIONAL ISSUES
Financial Controls & Productivity
The financial challenges facing the NHS have received considerable media attention since the general election. As the Board will be aware a considerable percentage of the NHS providers are planning for deficits during 2015/16. In addition there are a number of health economies that are projecting deficits in both commissioning and provision.

In the light of these pressures the Department of Health has been working with NHS England, the Trust Development Agency (TDA) and Monitor to look at how best to bring expenditure back within accepted limits. This has involved a review of known areas of high expenditure alongside consideration of the powers available centrally to bring expenditure under control. This review of expenditure has focused on agency staff, external consultants, interim executives and the remuneration of Trust executive directors.

The Secretary of State for Health has written to the Chairs of all NHS Providers asking for assurance as to the systems and processes in place for reviewing executive pay with a request for a formal response by 30th June. The Trust's Nomination & Remuneration Committee is scheduled to meet on 25th June to consider its formal response to the Secretary of State's request.

In addition the Department of Health has written to all Trust Chief Executives setting out proposals for greater control over agency expenditure and consultancy contracts, and the Chief Executive of Monitor has written to all NHS Foundation Trust Chairs and Chief Executives setting out Monitor's expectations in these areas.

Copies of these three letters are attached as annex a.

The letters outline both the areas of high potential expenditure and the powers available to the regulators to intervene. In respect of these powers, the TDA is looking to intervene actively with those providers who are already in receipt of external support whilst Monitor is proposing to intervene with those Foundation Trusts who are in breach of their license. In addition the Chief Executive of NHS England has proposed joint interventions in those health economies that are financially challenged from both a commissioning and provider perspective.

As the Board is aware, NHS Foundation Trusts (FT) are afforded greater freedoms than non-foundation trusts. In essence an FT is given a license to operate and as long as it does not breach the conditions of its license is free to operate as it sees fit in the best interests of the patients and population it serves. As such the ability of the Department of

Health or Monitor to intervene in the running of an FT is limited to regulation via the existing conditions of the license or additional legislation to amend the terms of the license.

However an FT needs to be aware of the wider political and public environment in which it operates. In this context whilst we are not in breach of our license it is important that we take seriously the concerns raised by the Secretary of State and our regulators regarding cost pressures and financial control. To this end, as noted above, the Trust will respond formally to the Secretary of State by 30th June as required. In addition I have asked the Director of Human Resources & Organisational Development to review our existing controls over agency expenditure, interim appointments and external consultancy to ensure that we follow best practice as outlined in the letters attached as annex A.

Sir Bruce Keogh review of 18-week referral to treatment times (RTT)
Simon Stevens asked Sir Bruce Keogh to review the key NHS Constitutional Standards to ensure that they are not giving rise to unintended consequences. As part of this review Sir Bruce reviewed the existing 18-week referral to treatment time targets. As the Board is aware there are three 18 week RTT targets; admitted, non-admitted and open-pathways. Sir Bruce has concluded that the first two targets offer a disincentive to treat patients once they have breached 18 weeks whilst the most effective measure of a Trust's performance is the open-pathways targets as this accurately reflects the current state of a Trust waiting list. At present the national target for open-pathways is 92% of patients on the waiting list waiting under 18 weeks. As at the end of May the Trust figure was 96%. At the time of writing we are waiting for operational guidance on the implementation of these new proposals. The letters from Simon Stevens and Sir Bruce Keogh are attached as annex B.

Lord Carter review of operational productivity in NHS Providers
Lord Carter of Coles is the Chair of the NHS Procurement and Efficiency Board which is tasked with helping the NHS to identify opportunities to cut waste, save money and drive efficiencies. Lord Carter published his interim report on 11th June with a fuller update planned for autumn 2015. NHS Providers have produced a useful briefing which is attached as annex C. Lord Carter's findings will help inform our longer term productivity programme which is being led by the Director of Finance & Performance.

Changes at Monitor
Sir David Bennett, current Monitor Chief Executive, has announced that he will stand down from the role later this year. An extract from his statement is included below;

After more than 5 years at the helm I have decided to step down from my role in Monitor. The government has decided that it wants to press ahead and establish a closer relationship between Monitor and TDA and so now is the right time for me to make the move.

Richard Tyler

June 2015

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
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Chairs:
NHS Trusts
NHS Foundation Trusts
Clinical Commissioning Groups

Cc' ALB Chairs (for info)

- 2 JUN 2015

Dear Colleague,

Keeping control of the paybill while ensuring we can recruit and retain high quality staff is a crucial part of meeting the efficiency challenge. Reforming the way we pay for NHS staff is a very high priority and must include a review of the pay of the most senior staff in the NHS (Very Senior Managers – VSMs) – chief executives and executive directors. Although these staff do important jobs and deserve to be fairly rewarded, it is vital that we do not lose sight of the need to ensure that executive pay remains proportionate and justifiable. More junior staff subject to tight restraint over their pay have the right to expect this as do the public more widely.

Although we have reduced the number of senior managers across the NHS by over 1,800 the latest figures still suggest that more than half of all directors in provider trusts are paid between £100,000 and £142,500 with more than one fifth paid amounts over £142,500. At a time of financial pressure, it is right to question the need to pay so many NHS staff more than the Prime Minister. The overall reward package is not just about pay, but also includes deferred pay in the form of NHS pensions. It cannot be right to treat pension benefits as though they are entirely separate from the employment offer.

I am therefore writing today to outline the following:

- Firstly, to urge you all to urgently review your policies on executive remuneration and consider whether the amounts paid are necessary and publicly justifiable.

- To advise you that I shall extend to NHS Trusts the current requirement for ambulance and community NHS Trusts, to first seek the approval of the

Chief Secretary to the Treasury for appointments above the Prime Minister's salary of £142,500.

- I am also requesting that all FTs and CCGs seek the views of ministers via Monitor and NHS England respectively before making appointments to Boards/ Executive Boards with a salary higher than the Prime Minister's. In addition, that you advise me of those current salaries which are higher than the Prime Ministers and your justification.

- To highlight particular attention to the pay of interim Board members and ensure that you follow the relevant HMT guidance on interim appointees paid on an "off-payroll" basis. Treasury guidance on such appointments states very clearly that Board members should be on the payroll of the organisations they lead unless in exceptional, short-term cases. The same rules apply to senior officials filling roles with significant financial responsibility. Can you please ensure that HMT's guidance on "off payroll" appointments is rigorously followed.

- In addition, I believe the daily rates paid for such appointments amount, on an annual basis, to pay which is excessive and indefensible. Can you please ensure that where there are exceptions, the daily rates involved do not normally exceed what would be paid to substantive appointments.

- Clamping down on "retire and return" to ensure that very senior staff cannot gain financially, from this at a cost to the taxpayer. I have concerns that very senior staff use the retire and return provisions of the NHS pension scheme to access their full pension and lump sum and then continue in full-time work. The provisions were not designed for senior staff to gain financially. I will look to extend existing rules so employees' new salaries plus their pension on returning to employment cannot be more than the original salary prior to retirement. It is unacceptable, particularly for VSMs leading organisations receiving additional tax payer support, to be better off by taking their pension and returning almost immediately to the NHS.

- To set out my expectation that the new redundancy terms for NHS staff in England apply to all newly appointed VSMs (unless staff are on statutory redundancy terms) and existing VSMs where section 16 is referenced in their contracts. The new redundancy terms for NHS staff in England are now more effective than before and it would be wholly unacceptable to have very senior staff leaving on significantly better compensation packages than more junior colleagues.

The last Government legislated for the "claw back" of contractual redundancy benefits on return to public sector employment for staff earning £100k or more. The new law will be in place in April 2016. This Government will introduce an overall contractual redundancy cap of £95k. Alternative employment where ever possible must be the priority so we retain valuable skills. Redundancy should be the very last resort.

I have also considered options for better control of VSM pay across the system, and will be taking these forward in the coming weeks. These include the following:

- introducing a national VSM pay framework with benchmarked rates for executive roles, and a more effective approach to transparency and disclosure (e.g. central publication of VSM pay rates for each organisation alongside the benchmarked rate). If these measures cannot be implemented effectively on a voluntary, "comply or explain" basis, I will strongly consider taking additional legal powers. In addition, it is important that the new pay framework is informed by any relevant recommendations following publication of The Rose Review.

I recognise that effective leadership is crucial if we are to improve outcomes for patients. Getting this right is a team effort, and my expectation is that there should be no significant difference in the terms and conditions of senior leadership teams and those working on the front line. I do not believe it is acceptable that some senior managers experience the high levels of pay, with year on year increases, as a matter of course.

By the end of June I would very much welcome your plans and thoughts on:

- reviewing your policies on executive remuneration and whether the amounts paid are necessary and publicly justifiable;
- to note that NHS trusts will be required to seek the approval of the Chief Secretary to the Treasury on VSM pay which is more than the PM's - £142,500 - before making any appointments;
- via Monitor and NHS England, that FTs and CCGs should mirror the process in the rest of the NHS for appointing VSMs paid more than the PM;
- providing me with details of your current VSM salaries that are higher than the PM's and your justification;
- the introduction of a national pay framework for executive roles and how appropriate rates can best be benchmarked;
- assuring me that Board members and those filling roles with significant financial responsibility paid "off payroll" all meet the Treasury guidance and where they do not, the action you plan to take to rectify the situation.

In addition, I ask that you confirm to me in writing that you will personally scrutinise and approve any new VSM appointments in your organisation.

My officials will make contact with you as quickly as possible to provide further guidance about the information I have requested and will provide standard templates for your colleagues to complete.

I look forward to receiving your conclusions in June and continuing to work with you on this crucial aspect of the financial challenges we have to address.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

Department of Health

David Williams
Director General, Finance, Commercial and NHS
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BY EMAIL

NHS Foundation Trust Chief Executives
NHS Trust Chief Executives
Clinical Commissioning Group Accountable Officers

2 June 2015

As we all know, the NHS is facing substantial financial pressure over the next five years. The NHS has developed the Five Year Forward View which the Government has accepted and the Government has committed to provide the additional £8bn funding identified in the plan. NHS leaders, with our support, are focussed on planning how to deliver the £22bn efficiency savings identified in the plan. A collective effort across the whole NHS will be needed to deliver those savings.

2015-16 is a particularly challenging year. The NHS is facing increased prices for agency staff, pressures on the prices paid for clinical and non-clinical supplies and increased litigation costs, amongst other items. The current planned provider financial deficit is not sustainable and needs to be addressed.

Sound financial discipline is a necessary underpinning to the continued improvements in quality and performance that we all want to see. It is important that the NHS acts together to ensure we achieve the most from our collective bargaining power and work together to reduce these pressures where we can. Many of you have told us that your greatest concern is on the price of agency staff, where rates for individual shifts are rapidly reaching exorbitant levels.

This letter outlines some specific measures which we are taking to focus the collective bargaining power of the NHS, as well as a number of other initiatives designed to reduce cost pressures on litigation, procurement and increase the supply of nursing staff.

We have been working closely with NHS England (NHSE), Monitor and the NHS Trust Development Authority (TDA) on what specific measures to adopt. As a result, we will require providers who are receiving financial support from the Department to comply with these controls, along with all NHS Trusts, Foundation Trusts in breach of their licence and CCGs. The Department will continue to apply similar controls to all of its Arms' Length Bodies. However to have maximum effect, we are asking all other parts of the NHS to apply them. Indeed we expect all parts of the system to support these necessary measures and work with us to make them as effective as possible as we implement them. The Department has asked NHSE, Monitor and the TDA to support their sectors in moving towards financial balance and specifically to take the lead in introducing these controls.

NHSE, Monitor and the TDA will write later today setting out the details of the controls and how they relate to your organisations, but in summary:

- Organisations will be required to procure all agency staff from frameworks. Off-framework arrangements will not be permitted except in exceptional circumstances;

- NHS Trusts and Foundation Trusts in receipt of financial support or in breach of their licence will have a ceiling put on the level of spend they are able to incur on agency staff;
- A shift-based or day/hourly rate-cap will be set for agency staffing. Exceeding this cap will only be possible in exceptional circumstances;
- All professional services consultancy contracts above £50,000 will require sign-off from NHSE, Monitor or the TDA. Similar controls on these three bodies will continue to be exercised by the Department ;
- The Department will be writing separately to set out expectations on the remuneration of Very Senior Managers.

Monitor will also be consulting on changes to the regulatory regime for Foundation Trusts through its Risk Assessment Framework.

Implementation

The control over consultancy applies with immediate effect for all CCGs, Arms' Length Bodies, NHS Trusts and Foundation Trusts in receipt of financial support. The controls over agency staff will be rolled-out as soon as practicable from 1 July and be fully in place by the start of September. They will initially apply to nursing staff and then to other clinical and management staff. NHSE, Monitor and the TDA will be working with you over the next few weeks on how this control will operate.

Details about how the limits on agency spend and the use of non-framework suppliers will operate will be discussed with your regulators over the next few weeks, but we are clear that exceptions will be rare. However while the focus is necessarily on saving money, we are clear that this should not compromise patient safety. Where there is a high risk to patient safety the 'exceptions process' should be followed and we are consulting with Monitor and the TDA on how this will work.

We are also working on other initiatives designed to reduce the cost pressures on the system. There are three particular items where we are looking for your support to develop proposals and take the work forward:

- The Department and NHS Litigation Authority (NHSLA) are working with the Ministry of Justice and others in Government to review a number of issues including the potential to introduce fixed legal costs for clinical negligence and reviewing whether 'After the Event Insurance' costs should continue to be recoverable from the defendant in a clinical negligence claim.
- Health Education England (HEE) and the NHS system leaders are working to bring nurses back into the workplace. HEE have invested in training additional numbers of nurses which will begin to yield an increase in nursing staff numbers from 2017. In the interim, HEE and NHS leaders are investing in a continued major national campaign that will allow former nurses to return to the workforce. HEE's programme fast tracks experienced nurses back into the NHS in 3-6 months.
- We are looking to change how the NHS leverages better shared procurement options to maximise the benefit to the NHS. Our intention is that use of collective procurement channels will be mandatory for all providers in receipt of financial support, to apply from

later this financial year. However, we are looking to consult widely on how this will be developed.

Over the next few weeks NHSE, Monitor and the TDA will be working with you to develop these plans further, but we are looking to you for your collective support in delivering the efficiencies needed to ensure that the £8bn additional funding is used to best effect and we can deliver a sustainable NHS.

Yours sincerely

DAVID WILLIAMS
DIRECTOR GENERAL, FINANCE, COMMERCIAL and NHS

ANNEX A

1. Agency Staff Controls

The total spend by providers on agency staffing was over £3.3bn in 2014-15 - an increase of more than 28% since the previous year. Much of the increase has been driven by individual provider assessments of the number of additional nursing staff required to meet safe staffing levels and which is met from the agency market. Agency staff are generally more expensive than employed or 'bank' staff. Agency staff engaged through framework arrangements often offer a good value and flexible resource, but there are an increasing number of agency engagements which are procured off-framework, at vastly increased rates. There is evidence that some agencies hold back agency staff at framework rates to force trusts into a situation where they have to engage off the framework. The controls we are putting in place are designed to improve the collective bargaining power of the NHS by requiring agency staff to be procured from a framework and at less than a maximum allowable rate per shift.

Use of Frameworks: All agency staff will be procured from existing framework agreements. Off-framework arrangement may only be used in exceptional circumstances. All providers have access to one or more local framework arrangements and all providers have access to a national framework operated by Crown Commercial Services. Requiring providers to use only these frameworks will reduce the average cost of agency nursing staff. Where providers wish to procure off-framework this will be in exceptional circumstances and will be overseen by the Trust Development Authority or Monitor. Similar controls already apply to the Department and its Arms' Length Bodies (ALBs) and will be extended to Clinical Commissioning Groups, with details to be worked out shortly.

Application of a shift based rate cap: There will be maximum rates set for grades and specialities of staff on a geographical basis. Breaking this cap will only be permitted in exceptional circumstances and will be overseen by one of the Trust Development Authority, Monitor, the Department or NHSE. Requiring providers to engage only at levels below this cap will reduce the average cost of agency staff. Initially this cap will apply to nursing staff, but will be extended to other clinical, medical and management/administrative staff. Capped rates will be reduced from the initially set level over time.

Setting of a ceiling for Agency spending by providers: There are currently no limits on the amount of resource which providers can spend on Agency resources. For providers in receipt of financial support or in breach of their Monitor licence, a maximum level of agency spend will be set. The level will be set locally by the TDA or Monitor based on reductions in current levels of spend, a percentage of overall nursing costs, geographical workforce factors, the relative size and nature of the trust the type of services that a trust delivers and the type of trust (acute, mental health, community, etc). Spend against the ceiling will be overseen by the TDA and Monitor who will consider what action is required if the cap is breached.

2. Management Consultancy

NHS providers spent £420m on consultancy services in 2014-15, with a further £160m spent by NHSE and clinical commissioning groups. Consultancy can be a good source of independent advice and provide additional capacity to support delivery, but this is not always the case.

For providers in receipt of financial support or in breach of their Monitor licence all consultancy contracts above £50,000 would require approval in advance from Monitor or TDA. An organisation intending to procure or let a consultancy contract will submit a request for approval to TDA or Monitor who will then consider whether in their view it represents good value for money. The decision on approval will be made by a panel of senior staff from Monitor or the TDA.

Approval would most likely be given for contracts which were in support of a national programme such as 'Vanguard' or internal/external audit. Monitor are developing guidance on behalf of the sector on the type of consultancy that is likely to be approved.

Consultancy which is approved will be subject to subsequent reporting on the value-added by that consultancy work and Monitor and TDA will maintain a database of the consulting work engaged by the sector to understand more fully what the sector is paying for.

Similar arrangements already apply to the Department and its ALBs and these controls will continue.

Application to bodies other than providers

The Department and its ALBs (including NHSE) are already subject to similar controls, and these will continue. The controls will also apply to CCGs.

3. Very Senior Managers Pay

Junior staff in the NHS are subject to tight restraint over their pay, but this is not always transparently the case for the pay of very senior managers. VSMs have some of the most important jobs in the country but it is vital that we do not lose sight of the need to ensure that executive pay remains proportionate and justifiable. Latest figures show that half of all directors in provider trusts are paid between £100,000 and £142,500, with more than a fifth over £142,500. The department is asking all provider remuneration committees to review their policies on executive remuneration and consider whether they remain justifiable. We are specifically asking remuneration committees to ensure that Treasury guidance on off-payroll engagements for senior staff are followed rigorously. This guidance requires all board members and all staff with significant financial responsibilities to be on payroll. We are also announcing a series of measures on transparency and disclosure, the use of retire and return provisions and that we will consult on a national VSM pay framework and benchmarked rates for executive roles. We are looking for these to be applied voluntarily but will consider taking additional legal powers if this is necessary.

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Making the health sector work for patients

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FT Chairs and Chief Executives

2 June 2015

Sent via email

Dear Chair and Chief Executive

The NHS faces a continuing and significant challenge to simultaneously improve quality, meet access targets and drive up productivity. Meeting this challenge means there can be no let-up in the pace and scale of change in provider organisations.

Last year was the first year that the foundation trust sector as a whole ended the year in deficit. 77 out of 152 trusts lost money. Although this year's plans are more realistic than last year's, they would result in a worse performance for the sector. Put simply, this is unaffordable.

It is in the light of the scale of the challenge that the whole NHS faces that the Department of Health has written to us all earlier today setting out what it wants us to do to make sure the foundation trust sector plays its part in addressing this challenge. This letter sets out what we plan to do in Monitor in support of that. It describes four main initiatives.

First, this year we will be increasing our scrutiny of annual plans, including site visits and face-to-face meetings with a number of trusts. This is already under way.

Second, as part of our normal interventions at foundation trusts in breach of their licence for financial reasons, we will be requiring the adoption of best practice approaches to spend in a number of critical areas. Initially, this will cover spend on agency staff and management consultancy.

Third, we will be consulting shortly on some changes to our Risk Assessment Framework intended to provide a greater focus on the efficiency with which resources are used.

Finally, alongside TDA we will continue our efforts to make sure the best possible support is available to providers as you engage on this next phase of improvement.

As we embark together on this undoubtedly challenging agenda, I want to emphasise two critical points. First, all of us in Monitor recognise that driving further change and improvement at the front line is not easy. This is why I have placed so much emphasis in recent months on the need to ensure more and better support is available to you when and where you need it. Second, as we implement the

initiatives described in this letter, we will endeavour always to do so in the spirit of foundation trust policy: our interventions should be proportionate, value-adding and consistent with the notion of earned autonomy.

Reviewing annual plans

After NHS foundation trusts submitted their draft plans to us on 7 April we wrote to everyone with feedback on their plans and announcing that we would be carrying out a programme of site visits to some providers. We have now decided that our internal teams will visit the 43 foundation trusts with the largest individual deficits. These visits cover 85% of the forecast foundation trust sector gross deficit. They are already under way and the early results offer encouraging evidence that if we work with you to challenge your plans we can identify areas where further savings or efficiencies can be made. The process will be most exhaustive for foundation trusts who are requesting interim cash support from the Department of Health.

After each visit we will hold an executive-led challenge session with foundation trust boards. As far as possible we will aim to agree what revisions can be made to plans to make them more stretching, but we reserve the right to use our legal powers where agreement cannot be reached. We will monitor financial performance against these revised plans for the rest of the year in some detail, using our own staff as well as a small group of experienced NHS professionals where appropriate.

Adopting best practices in key areas of spend

Getting the best value out of every pound spent is a key objective of the foundation trust regime and local controls frameworks. While I continue to believe that local accountability for spending is the best way to maximise value for money in the long term, there is clear evidence that foundation trusts and the wider NHS are not achieving this today in some areas. As a result, we are introducing a Monitor approval process for some specific areas of spend in foundation trusts that are in breach of their licence for financial reasons. We will do this alongside the package of support in these areas outlined below and in a way designed to minimise the administrative burden on providers.

We have worked with NHS England and the NHS Trust Development Authority (TDA) to identify initial areas where we believe the NHS could obtain better value for money. We have identified agency costs and management consultancy costs and will introduce approval processes for both.

The approval process for management consultancy costs comes into force with immediate effect, covering all new contractual commitments by foundation trusts in breach of their licence, for spending greater than £50,000 (please note that internal and external audit, and local counter fraud services, are not included within the

approval process). We will require submission of a business case to Monitor for approval. Interim guidance on the requirements is attached to this letter as Annex A. The Annex also sets out the support we will be making available to assist providers in sourcing and managing consultants, and ensuring that we don't all pay several times over for the same technical advice.

The approval processes for agency costs will be introduced from 1 July for nursing, with complete implementation by 1 September. These approval processes will include: a trust-specific ceiling on the percentage of staff that can be employed on an agency basis; a cap on the maximum rates of agency pay for different types of staff; and a list of approved frameworks. There will be a mechanism for local managers to override these limits in the interests of patient safety, with a retrospective review. We will be engaging widely with foundation trusts on the best way to design and implement these controls so that we can collectively regain some control over our labour costs and become less reliant on expensive agency staff. This engagement will include the national series of events under way with TDA and DH on managing agency staff, and the improvement support set out below.

While these approval processes apply to foundation trusts in breach of their licence for financial reasons, all other foundation trusts are asked to comply voluntarily as we believe they should genuinely help trusts to make more effective use of their resources.

Modifying the Risk Assessment Framework

Monitor's *Risk Assessment Framework (RAF)* currently directly assesses the risk that foundation trusts might become insolvent, threatening the continuity of services to patients, and also includes general provisions on financial governance, requiring boards to operate efficiently and plan robustly.

However, the seeds of a solvency problem generally manifest as an income and expenditure deficit some time before a provider is at risk of running out of cash. In the recent past, and unlike earlier years, we have not used the RAF to signal that the point to act decisively is when a deficit is first reported or even anticipated. Unfortunately, several boards have failed to act until much later when financial problems have become more deep-rooted.

We have also found over the last two years that foundation trust plans have become much less robust, with many providers delivering weaker results than planned and thereby denying boards and Monitor the ability to use plans to identify and respond to risks.

We therefore intend to re-establish two previously used metrics: one tracking deficits and another the accuracy of planning.

We are also anxious to ensure that all boards are sharply focused on the overall efficiency with which resources are used in their trusts and so we will also be proposing to include in the RAF an explicit measure of value for money reinforced by a requirement to focus on efficiency in the *Foundation Trust Accounting Officer Memorandum.*

We will publish a consultation document later this week detailing these proposed changes to the RAF.

Supporting improvement

I recognise that delivering improvements in efficiency while maintaining quality becomes steadily more challenging as each year passes. However, there is still much evidence of considerable differences in practice across similar organisations. There is also scope for much more innovation and adoption of new ideas from other countries and other industries. I am anxious, therefore, to do all that we can to make sure the best possible support is available to provider organisations as you pursue these improvement opportunities.

There are some excellent examples of support already available in the NHS but we need many more. So, we are working with TDA to ensure there is a joined-up effort to take currently known best practice, and specifically that which will have a rapid impact, and work out how to deploy it at scale. We are going to build some of these capabilities ourselves in our new Provider Sustainability Directorate, developing ideas such as our Agency Intensive Support Team and making them available to all providers. We are also working with our partners to make sure that the existing resources spent by the NHS in this area are targeted at the right priorities. We will also be looking to high performing trusts to support others by applying their best practices to other providers in a scaled-up version of buddying.

Yours sincerely

David Bennett
Chief Executive

cc Stephen Hay, Managing Director of Provider Regulation
Jason Dorsett, Financial Reporting and Risk Director
Adam Sewell-Jones, Executive Director of Provider Sustainability
Regional Directors

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Annex One

Consultancy spending approval process: Initial guidance to NHS foundation trusts

Summary

1. Monitor, the NHS Trust Development Authority (TDA) and NHS England are jointly implementing an approval process over consultancy spend among NHS providers and NHS commissioners.

2. Monitor, TDA and NHS England recognise that consultancy supports NHS organisations in making key operational and strategic improvements, and also that Monitor and TDA themselves require providers to commission substantial amounts of consultancy work. However, we know that the NHS often achieves poor value for money from this expenditure. We cannot continue to spend on this scale without getting maximum value for money. The approval process will require NHS providers and NHS commissioners to demonstrate the value for money of proposed consultancy support against a number of assessment criteria.

3. From 2 June 2015, NHS foundation trusts receiving interim support from the Department of Health and NHS foundation trusts that are in breach of their licence for financial reasons are required to secure advance approval from Monitor before:

    - signing new contracts for consultancy projects over £50,000
    - extending or varying existing contracts or incurring additional expenditure to which they are not already committed (where the total contract value exceeds £50,000)

4. All other NHS foundation trusts, particularly those in breach of the financial conditions of their licence, under investigation by Monitor for financial breaches or planning a deficit for 2015/16, are strongly encouraged to comply. Monitor will take into account contracts that are poor value for money when considering the need for regulatory action concerning any potential breaches of governance licence conditions.

5. From 2 June 2015, NHS foundation trusts covered by this approval process must send Monitor a post-implementation report on all procured and let

consultancy projects, detailing the benefits and value-add of these and identifying where intellectual property of wider benefit to the NHS has been created. Where contracts are multi-year, Monitor may request interim reporting.

Rationale

6. Spending by NHS providers on management consultants was £420 million in 2014/15, having risen substantially over recent years. We recognise that consultancy can add value when local management teams lack either the capacity or capability to address issues, and also that Monitor and TDA themselves require providers to commission substantial amounts of consultancy work. However, we know that the NHS often achieves poor value for money from this expenditure either because the work is poorly scoped, procured and managed, or because the findings are not fully implemented.

7. Given the current level of provider deficit we cannot continue to spend on this scale without getting good value for money. We are therefore putting in place support and an approval process at a national level so that only good value for money consultancy is commissioned and, where possible, generic technical advice is widely shared within the NHS.

Support

8. Monitor is committed to providing a greater degree of support to foundation trusts commissioning consultancy services and will make this support available over the summer.

9. This support will consist of:

- Guidance to support foundation trusts to meet the assessment criteria for approval of a business case. We will publish detailed guidance and FAQs on our website towards the end of June
- generic scopes for common management consultancy projects
- standard contract clauses requiring consultants to make non-commercially sensitive work widely available
- bespoke advice and support for the largest projects

- direct engagement with the major management consultancy firms on how the new approval process will operate.

The approval process

10. Consultancy contracts over £50,000 require prior approval by Monitor (the £50,000 threshold includes irrecoverable VAT and other costs, eg expenses). Foundation trusts are required to submit a business case approval form to businesscases@monitor.gov.uk; this will be reviewed by Monitor's Foundation Trust Consultancy Approval Panel. This panel exercises the authority of the Chief Executive, the Managing Director of Provider Regulation and the Finance, Reporting and Risk Director.

11. The approval process comes into effect on 2 June 2015 and applies to all future contracts, including those where contractual negotiations are in progress.

12. Foundation trusts are required to secure advance approval from Monitor before extending or varying existing contracts or incurring additional expenditure to which they are not already committed, where the total value of the contract (including the proposed extension) exceeds £50,000. Foundation trusts are required to submit a business case for the extension value prior to the contact being extended.

13. The approval process applies to contracts that are accounted for as revenue expenditure. It does not currently apply to contracts accounted for as capital expenditure.

14. For the purposes of this approval process, 'consultancy' is defined as in the 'NHS Manual for Accounts' (strategy; finance; organisational and change management; IT; property and construction; procurement; legal services; marketing and communications; human resources, training and education; programme and project management; technical).

15. Certain areas are initially exempt from the approval process. Foundation trusts are **not** currently required to submit a business case to Monitor for approval of:

    - contracts below £50,000 (including irrecoverable VAT and other costs)
    - interim management and day rate contractors

16. Consultancy procurement that has been formally directed by Monitor's regulation or enforcement undertakings is included in the approval process.

Foundation trusts directed to procure support by Monitor are required to submit a business case for the proposed procurement that demonstrates value for money against the assessment criteria.

17. Please note that internal and external audit, and local counter fraud services, are not included within the approval process.

Having a business case approved

18. Please send business case approval forms to businesscases@Monitor.gov.uk.

19. The panel will review each business case against a number of assessment criteria. For proposed consultancy expenditure within the scope of the approval process (as outlined in the previous section), foundation trusts are required to provide evidence of the value of this against the criteria outlined below:

Assessment criteria	
Criteria we are assessing	**What we are looking for**
Ambition to deliver something of value, importance and relevance	• Evidence that the trust's strategic and operational objectives are supported by this proposed work. We are looking for relevance to your organisation's business plans • Evidence on how this work aligns with the local health economy strategy • Specific deliverables that clearly support the overall objectives of the work and the organisation's business plans • Details of the clinical case where the proposed work directly affects the provision of services for patients or quality improvement • An explanation as to why the proposed service cannot be resourced internally or sourced from peer organisations. We are also looking for efforts to ensure skills will be transferred to permanent staff, where appropriate • An outline of what the impact will be on the trust objectives and business planning, staff and patient care if approval is not given for the business case
Clear scope	• Evidence that the scope is clear, defined and well thought through • Detail on how the scope has been developed including any engagement with patients, clinicians, commissioners

	or suppliers
Robust contract management	• Evidence that the trust can manage the supplier, control spend and hold the supplier account for delivering value for money • Assurance that the trust can deliver the scope as planned • Details of payment structure, particularly details of approaches to link payment to deliverables, eg arrangements to ensure effective communication between staff approving and processing payments and the project team receiving and evaluating the work
Capacity to implement findings/recommendations	• Evidence that the trust has the capacity to act on or implement findings/recommendations of the procured work • Examples of previous success in realising benefits
Timeline of work	• Evidence of a well-thought-through and realistic timeline, with details on when expected outcome will be delivered
Robust implementation review proposal	• An outline of how the effectiveness of the consultancy support procured will be reviewed, with particular focus on benefits and value add
Value on price	• Evidence of the proposed procurement/resourcing method, including how you reached or propose to reach the decision that this is the best way to meet your business requirements (some evidence of options appraisal) • Evidence of sourcing the best value supplier and evidence of negotiation over rates • Details of the basis of payment and why this will achieve best value, eg does the contract propose a fixed fee, contingent fee, etc and how will any risks within the payment structure be managed? • Details of agreed benchmarking rates, referencing where possible agreed framework rates
Wider use of findings	• Whether or not there are any contractual restrictions to sharing the outcomes of this work with the wider sector. Where the outcomes are not commercially sensitive, we will expect all future work to be made available for the wider benefit of the NHS, particularly where the advice is technical and likely to be generic to similar situations • We expect this right of access to be written into contracts. You should check that a contract clause is in place allowing for the wider use of any generic technical findings, and also that the deliverables have been scoped so that such technical work is as far as possible separated from any commercially sensitive elements of the scope

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20. Approval will be given to business cases that clearly demonstrate good value for money against the assessment criteria. Approval will also likely be given to externally funded projects that support a national programme such as the Five Year Forward View 'Vanguard' models.

21. Business cases can be submitted either after the conclusion of a procurement process or in advance of procurement. However, cases submitted in advance of procurement will need to include sufficient details to provide assurance that the criteria will be met.

22. Cases do not need to be long. Strong cases can be presented concisely and without excessive supporting statements. Poorly written or excessively long cases are likely to take us longer to decide on.

23. On completion of approved consultancy projects, foundation trusts are required to submit to Monitor a report detailing the benefits of the work and value add.

Compliance

24. All other NHS foundation trusts, particularly those in breach of the financial conditions of their licence, under investigation by Monitor for financial breaches or planning a deficit for 2015/16, are strongly encouraged to comply. Monitor will take into account contracts that are poor value for money when considering the need for regulatory action concerning any potential breaches of governance licence conditions.

25. From Q2 2015-16, Monitor will collect detailed financial data on consultancy contract procurement within our regular monitoring templates.

26. Evidence suggesting organisations are seeking to avoid this approval process through splitting contracts, manipulating contract scope or substituting contracts with high cost interims or secondees from consultancies will be subject to follow-up by Monitor.

27. Please send all queries to businesscases@Monitor.gov.uk

Publication Gateway Reference 03545

VIA EMAIL ONLY

To: CCG Accountable Officers
Chief Executives of NHS Providers

Skipton House
80 London Road
London
SE1 6LH

4 June 2015

Dear Colleague

Improving access and simplifying measurement

The NHS has made dramatic reductions in recent years in waits for care, which has been a key driver in record rates of public satisfaction with our services. We are determined to lock in that achievement, and go further cutting waits for other services, including mental health.

In doing so, we want to ensure that the way the key NHS Constitution standards are tracked makes sense for patients and does not give rise to unintended consequences. To that end I asked the NHS' National Medical Director, Sir Bruce Keogh, to review how this is being done.

I attach the recommendations from Bruce's review. In short, he recommends that all headline patient waiting times guarantees are retained. But he recommend that we rationalise the way we track Referral to Treatment times by now focusing on the one measure that tracks the complete patient experience - the so-called 'incomplete' standard. He also proposes to extend to further ambulance trusts the pilots proposed in the urgent and emergency care review.

Having considered these recommendations, and discussed them with the Secretary of State, we have decided to accept the recommendations in Bruce's letter in full. Our aim is that these should take effect very quickly, and NHS England will be issuing operational implementation guidance shortly.

Yours sincerely

Simon Stevens
CEO, NHS England

Bruce Keogh
Medical Directorate
80 London Road
SE1 6LH

Mr Simon Stevens
Chief Executive
NHS England

4th June 2015

Dear Simon,

Making waiting time standards work for patients

You have asked me to review some of our current waiting time measures to ensure they make sense for patients and are operationally well designed. There is concern that, in a small number of instances, some targets are provoking perverse behaviours and the complexity of others is obscuring their purpose and meaning.

18 weeks Referral to Treatment Times (RTT)

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. That is an important commitment which must be maintained. However, we currently measure this in three potentially conflicting ways – through the admitted, non-admitted and incomplete standards.

It has become increasingly clear that within this confusing set of standards there are in-built perverse incentives. The admitted and non-admitted standards penalise hospitals for treating patients that have waited longer than 18 weeks. As soon as a patient has crossed this threshold, a hospital will effectively receive a black mark for treating them. While hospitals may be the ones penalised directly, the true penalty is for the patient. This cannot be right.

To tackle this situation, the incomplete standard was introduced in 2012, incentivising hospitals to treat patients who have been waiting the longest. The "incomplete" standard measures all patients still waiting at the end of each month – so it includes every patient on the waiting list, not just those treated in that particular month.

The positive effect of the incomplete standard was clear: the number of patients waiting longer than 18 weeks reduced by almost 100,000 in the year following its announcement. In the last year, we announced a temporary suspension of the admitted and non-admitted standards to encourage hospitals to treat long-wait patients. The results were compelling with record numbers of long-wait patients treated. It is absurd, however, to find ourselves in a situation where we had to suspend our own waiting time targets to do what is right for patients

So my advice is that we abolish the admitted and non-admitted measures as soon as practically possible, using the so-called incomplete standard – the only measure which captures the experience of *every patient* waiting – as our main measure. This would reduce tick-box bureaucracy and expose hidden waits. We should update our system of fines for those hospitals with long wait times in line with this change, and also ensure those patients who choose to wait longer have their wishes accommodated without penalising the hospital. This approach will be simpler; more focused, and most importantly will ensure the NHS concentrates on treating all patients as quickly as possible.

Ambulances

The current NHS Constitution standards for ambulances encourage the service to respond to urgent calls (Red 1 and Red 2) within eight minutes. The intention is to ensure that the most urgent cases are dealt with as quickly as is possible. Calls are triaged by the ambulance service and allocated to one of a number of "Red" or "Green" categories. Those patients within categories Red 1 and Red 2 are then to be responded to within eight minutes, with less urgent cases having longer times for response.

There is some evidence that the standards are not being as effective as they could be, particularly because in haste to meet the target many non-urgent calls are incorrectly classified as Red 2. As a result, ambulances are dispatched unnecessarily and are then unavailable when more urgent, life-threatening calls arrive.

To explore whether adjustments to the standard could prevent this problem, a pilot was conducted in the South West where the ambulance service spent up to an additional 120 seconds assessing each call's urgency prior to assigning it to a category and responding. The pilot's initial results have been encouraging. The proportion of calls resolved over the telephone increased and, as a result, vehicles spent less time on the road so that more vehicles were available to dispatch to genuinely urgent calls.

Therefore I recommend we expand the current ambulance pilot, based on emerging findings from the Urgent and Emergency Care Review. New pilots must be founded on hard evidence and analytical rigour with a sharp focus on safety. I will work with the ambulance services to set out details of the proposed changes and geographies in summer 2015 and I will make a definitive recommendation on national standards by autumn 2016.

Accident & Emergency (A&E)

The A&E standard has been an important means of ensuring people who need it get rapid access to urgent and emergency care and we must not lose this focus. I do not consider that there is a case for changing the 4 hour standard at this time. However, my recent Urgent and Emergency Care Review has suggested we need to look at a wider range of measures if we are to drive improved outcomes across the system.

For a hospital to pass the 95% standard, it must admit or discharge 19 out of 20 patients within four hours. In practice, more than half of those 19 patients can be discharged home fairly quickly. What the NHS is currently trying to do is offer better services, closer to home for those patients – rapid access to a GP appointment or clinical advice over the telephone, for example. This is good for patients and also good for hospitals – freeing them up to focus on those patients most in need of specialist care. But it also means that hospitals will be left with a higher proportion of complex patients, and therefore their performance will seem worse. So, the way the target is calculated means that hospitals in communities with good out of hospital and community services, such as primary care or urgent care centres, could perversely be penalised because they see fewer minor complaints.

As we begin implementation of redesigned urgent and emergency care services in various parts of the country later this year, **we should consider how to include these broader services within our access standards, alongside a wider range of clinical measures.**

Other areas

We continue to see large increases in referrals for diagnostics and cancer tests. This is a good thing, but it does mean waiting time targets will come under increasing pressure. Despite this, they are an important means of focusing on providing high quality care and I think they remain appropriate. The cancer targets will also be addressed more holistically by the independent cancer taskforce under the chairmanship of the CEO of Cancer Research UK.

In relation to mental health, NHS England has been leading the world in its pursuit of equal emphasis on mental and physical health. A key part of securing parity has been to commit to the introduction of waiting times standards for mental health services, to match those that have been in place for physical health for 15 years. In 2015/16 we are starting with some psychological therapies and early intervention in psychosis, and over five years we will have introduced standards for a range of services. This is a hugely important step.

Reporting arrangements

Current arrangements for reporting performance are extremely uncoordinated. Standards report with different frequencies (weekly, monthly and quarterly) and on different days of the week. This makes no sense - it creates distraction and confusion. We receive feedback that this makes it difficult for people to have one transparent, coherent picture of performance at any one time.

My recommendation is therefore that we standardise reporting arrangements so that performance statistics for A&E, RTT, cancer, diagnostics, ambulances, 111 and delayed transfers of care are all published on one day each month. Mental health waiting times statistics will follow the same pattern once available, and we will consider whether other data collections can be similarly aligned.

To conclude, I would like to emphasise that the NHS has made massive progress over the last two decades – reducing waits for treatment from several years to only a few months. I would like our NHS to be evidence based, outcomes focussed and driven by values. Where there is strong evidence that changing standards will improve services for patients, we should have no hesitation in adapting our approach. If we abide by this principle, I am confident that waiting time standards will continue to make an important contribution to overall quality of care in the NHS.

Yours sincerely,

Sir Bruce Keogh
National Medical Director
NHS England

on the day BRIEFING

the association of foundation trusts and trusts NHS providers

LORD CARTER REVIEW OF OPERATIONAL PRODUCTIVITY IN NHS PROVIDERS

BACKGROUND

In June 2014, Lord Carter of Coles was appointed as Chair of the NHS Procurement and Efficiency Board. He was tasked with helping the NHS identify opportunities to cut waste, save money and drive efficiencies. Since October 2014, Lord Carter and his team have been analysing data from a cohort of 22 trusts[1], ranging from some of the largest acute trusts in the country to district general hospitals, to identify a more sophisticated and comparable way of measuring efficiencies between hospitals.

Based on this work, Lord Carter has today published his interim report which covers a number of areas:

- The adjusted treatment index (a new measure of provider efficiency)
- The efficiency opportunity
- Next steps for roll out to the sector

This is an interim report for the Secretary of State; a fuller update will be published in Autumn 2015. As well as summarising the interim report, this briefing provides some answers to the key questions you might have in response to this work and outlines our role and initial views on the project.

1. The Adjusted Treatment Index

The interim report introduces the concept of an Adjusted Treatment Index (ATI) which is a standardised comparable measure of provider efficiency. Other countries have adopted measures of efficiency such as a cost per adjusted admission to compare relative performance of their hospitals but the report indicates that up until now there has been no way of genuinely comparing provider efficiency, other than the reference cost index.

The ATI has been derived through publically available data from the NHS Reference Cost collection and published accounts of NHS providers, supplemented by data collected from the cohort of 22 trusts to provide additional context. The ATI will allow providers to compare their cost per unit of weighted output within a cohort, both at the organisational level as well as specific cost lines (such as workforce, clinical supplies and services) to provide greater granularity in cost variation.

[1] The 22 trusts are: Imperial College Healthcare NHS Trust, Central Manchester University Hospitals NHS FT, University College London Hospitals NHS FT, Cambridge University Hospitals NHS FT, Royal Free London NHS FT, Mid Yorkshire Hospitals NHS Trust, Portsmouth Hospitals NHS Trust, Northumbria Healthcare NHS FT, Plymouth Hospitals NHS Trust, East Sussex Healthcare NHS Trust, Buckinghamshire Healthcare NHS Trust, Bolton NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, University Hospitals of Morecambe Bay NHS FT, Ipswich Hospital NHS Trust, Salisbury NHS FT, North Cumbria University Hospitals NHS Trust, Hinchingbrooke Healthcare NHS Trust, University Hospitals Birmingham NHS FT, Salford Royal NHS FT, Countess of Chester Hospital NHS FT

At a glance, the ATI can help providers recognise whether they are outliers, and in which areas of spend. The ATI can not identify whether variances between providers can be explained simply by necessary differences in practices or whether there are genuine opportunities for efficiency improvement. The work with the cohort of 22 helped identify the reasons for any cost variation and the potential for efficiency improvements.

2. The efficiency opportunity

The report highlights that the NHS could save up to **£5bn per annum by 2019/20** through efficiency opportunities identified by the review team's work with the 22 trusts.[2] This headline figure is made up of:

- Workforce and workflow savings in the order of £2bn:
    - Better management of productive time – the review found that 'non-productive' time for nurses varied between 22-26% in the cohort of 22.
    - Tight management of annual leave, sickness and appropriate use of training – this could lead to up to 4% increase in productive time.
    - Better balance between clinical productive time and administrative tasks, ensuring clinical staff are released to focus more on patient contact – reviewing the management costs using the ATI metric across all NHS hospitals revealed a ten-fold variation between providers, potentially due to factors such as the use of shared services for back and mid-office functions.

- Improved hospital pharmacy and medicines optimisation, estates and procurement management could lead to savings in the order of £3bn:
    - There is considerable variation in the provision of hospital pharmacy services across the country – there are differences in prescribing of medicines and variation in pharmacy staffing numbers, skills mix and deployment. These changes would necessitate the need for system wide changes.
    - A detailed understanding of estates operations based on local situation is required – the review team is developing a diagnostic tool to help providers obtain a more detailed view of their estate and facilities so that they can identify efficiency opportunities. From the cohort of 22, early indications are that approximately 14.5% potential savings could be made, which represents a £150 million annual saving.
    - Better procurement - The NHS could save £1bn by 2020 by cutting the number of everyday consumable lines from 500,000 to less than 10,000. Good practice suggests that there should be price variation within the supply chain between 1-2%; in the NHS there is variation of up to 35% for identical products. The report suggests that there are greater savings to be had by managing the demand for products through better inventory management rather than price reductions alone.

3. Next steps

Last week the Secretary of State highlighted that acute trusts will be informed of an estimated savings sum based on the metric deemed to be achievable by the review team by September. Between September and December, the review team will work with hospitals to finalise and agree the sum, and from January, trusts will need to implement the changes.

[2] It is worth highlighting that Lord Carter indicates in the report a number of times that he is reluctant and cautious to put a figure to the savings which could be generated

However, it is clearly outlined in the report that further work and testing is needed before the ATI is adopted across the NHS provider sector including:

- Further work with the 22 cohort hospitals to further identify new savings and begin delivery of the savings already identified. Lessons learnt from this process should determine how the outcomes of the project will be applied to the wider sector.
- Add a further 10 hospitals to the cohort over the summer and to further validate and refine the work carried out with the initial 22
- Develop a series of resources for trusts to use to inform 2016/17 planning including a series of modules on workforce, pharmacy, estates and procurement to encourage good practices.
- Over the summer, the review team will also publish details of a 'model' NHS hospital, which is not covered in depth in the interim report. This would include guidance on what a model NHS hospital could look like in terms of operational productivity and cost, and would include different modules such as on the emergency department, different types of wards, operating theatres, pathology, radiology and administration costs.

Lord Carter will publish a fuller report on NHS productivity in Autumn 2015. From early 2016, the first cut of country wide hospital level productivity data based on the ATI will be published. Lord Carter makes clear in the report that it is not his responsibility to take forward implementation, which means that there still need to be detailed discussions about how the findings from the report will be taken forward at both the national and local level.

4. Questions and answers

Below we attempt to consider some of the key questions you might have with regard to the interim report. Please do get in touch if you have any further questions not addressed in the below and we will take these to the DH staff leading this work.

1. How is the ATI different to the reference cost index (RCI)?
   - We have been advised by the review team that the RCI and ATI are sufficiently different to provide new insights in to cost variation, and we will be working with them further to test this in more detail. Conceptually we understand that the two metrics are similar in that they are calculated from a ratio of expenditure to clinical output. Both the RCI and ATI can be reported as an overall measure for all procedures (the organisation wide RCI and headline ATI respectively) but they report different levels of granularity. Like the RCI, the ATI figures can be shown for elective inpatients or outpatients, but the ATI can also be used to explore productivity from different angles. For example the examination of clinical output compared to each provider's expenditure on estates or use of staffing. To do this, additional data sets are used to derive the ATI including detailed provider accounts and staffing numbers, and adjustments are included to ensure the validity of comparisons between trusts. Unlike the RCI which is only published on an annual basis with a considerable time lag, the ATI at different angles could also be used to provide in-year measures to see variation once you take account of activity and staff numbers at different points in the year.

2. How does this work take in to account providers with different case-mix of services?
   - Similar to the RCI, the clinical output of a trust is calculated by aggregating the range of different procedures performed by each trust using the cost-weights and activity information for each procedure. Therefore, more complex procedures generally have higher cost weights. If you consult Appendix A of the report, you will see from the example that the metric is expressed within a cohort of comparable trusts allowing for more meaningful review. Important to the work is not just the production of the ATI but the work with the trust to understand the extent to which the variation is

explainable within a group of comparable trusts – this was the key approach taken with the 22 and we would encourage the review team to follow this approach when rolling out to the sector.

3. How has the ATI been developed?
   - The metric has been developed through a combination of top down analysis of the reference cost collection and published accounts of NHS providers. Calculation of the headline metric requires two steps. First, the volume of each type of treatment delivered by each hospital is weighted by the average cost across all hospitals of each type of treatment. This is used to determine the cost-weighted output for that provider which is the denominator of the productivity indicator. Second, the actual costs the trust incurred in producing their cost weighted output are calculated to produce the numerator for the productivity indicator. This operational expenditure is adjusted for clinical and non-clinical outputs not covered by Reference Costs, so a like for like figure is used to derive the productivity indicator, which is a cost per unit of output.

4. What kind of efficiency is the ATI measuring?
   - This index focuses on the potential for technical efficiency – those measures which could improve the relationship between providers' inputs, costs and activity (e.g. workforce, estates, procurement) – rather than allocative efficiency, which means making the right choices for the services and activities delivered based on best possible set of outcomes (e.g. system redesign). Therefore, it is clear that this work can significantly contribute to efforts to meet the £22bn 'efficiency' challenge facing the NHS, but further work is still required with the sector to understand what work will be needed to support providers in realising other efficiency opportunities.

5. Will this work be used as part of a regulatory approach?
   - First and foremost, Lord Carter sees this work as developed in partnership with trusts for trusts. Lord Carter makes clear in his report that although it is not up to him to decide how to implement the work, he considers that "*a regulatory approach will probably fail to capture the imagination and engagement of hospital boards. It is more important that boards take ownership themselves and collaborate with each other to identify and share best practice…I do believe they need support, and this support needs to be seen as helpful and non-directive*.' In the context of recent developments to extend the Risk Assessment Framework to include 'value for money' and the proposal for the CQC to include efficiency as one of the key criteria for rating the quality of leadership, we will be discussing this issue with the Monitor's Board to reinforce the message that this work should not be used as a regulatory stick against providers.

6. Is the work applicable to ambulance, community and mental health trusts?
   - Although the initial work to develop the index has been developed by acute providers, it will be applicable beyond the acute sector after further development work. We are strongly encouraging the review team to include ambulance, community and mental health trusts to work through this in the same collaborative way they have done with 22 acute trusts.

7. Does the report acknowledge that further work is required at the national level to support local providers address some of the inefficiencies identified?
   - Although this is only an interim report, it does suggest that some fundamental changes will be needed to support providers to release the savings identified. This might include:

- The current contract with NHS Supply Chain might need to be renegotiated before it has run its course. Whereas other countries have strong adherence to a 'core list' of products with hospital compliance levels of over 90%, the NHS Supply Chain contract was not set up to deliver this kind of approach as hospitals make their own decisions about the products they want to use.
- Changing the relationship between clinicians and representatives of medical device companies. The report suggests the creation of decision-making groups (possibly above the level of individual providers). It indicates that the sector might need its own version of the 'Sunshine Act' from the US which requires medical devices and drugs manufacturers to report all their financial relationships with clinicians and teaching hospitals.
- Developing a single NHS electronic catalogue supported by strict policies so that employees and suppliers work in a system that does not allow alternative purchasing arrangements for core items.

8. Are these the same savings which have been identified previously by the national bodies? Will they deliver anywhere near the scale reported or required?
   - It is clear that some of the potential saving areas, particularly in procurement and estates, have been identified previously in other reports such as Monitor's *Closing the Gap* publication[3]. However, the key difference with the Carter review is that the findings have been validated by close working with frontline providers to confirm the potential for further efficiency. It also clearly articulates that additional resources, investment and infrastructure will be required to release some of the technical efficiencies identified, and this process is multi-annual, rather than expecting £5bn could be realised automatically.

9. If my trust is not part of the cohort of 22, or extension to 32, what does this work mean for my organisation?
   - The report highlights that the plan is to adopt the ATI across the NHS Provider sector but that further work is required over the summer to validate and test the findings. It is likely that your trust will be contacted from the Autumn by the review team for them to inform you about where your trust would sit on the ATI and for you to use this to understand variations in efficiency within a cohort of comparable providers. After this initial work, it has been suggested that all acute trusts will have an agreed savings programme as part of your regular cost improvement plan development.

5. NHS Providers view

We have welcomed the interim report (please see our press release at Annex A) and in particular support the way in which Lord Carter and the review team have worked together with 22 NHS providers to validate, test and develop their findings. This work can only represent a small contribution towards the £22bn efficiency challenge facing the sector – which Lord Carter himself recognises – but the collaborative way in which this has been developed should form a blueprint for the wider efficiency work which needs to take place.

We also welcome the recognition that many of the savings opportunities identified are in part due to existing structures and frameworks which have created barriers at the local level to delivering these savings, rather than failures in NHS management.

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284044/ClosingTheGap091013.pdf

We support the work which has gone in to developing the efficiency 'index' and consider that the most valuable part of this project has been the bottom up testing and refinement the team have done with the 22 trusts. It's clear that the index in itself cannot be used to explain where variation in efficiency is legitimate so the tool needs to be recognised first and foremost as a way to help comparable trusts understand their potential for additional efficiency rather than a crude measure for ranking trusts.

There are clearly a number of challenges with implementation and we will need to closely engage with the review team and the national bodies. As far as possible, this work needs to align with the normal business cycle for trusts as part of their regular savings programme, and implementation needs to be supportive rather than directive as Lord Carter intended. Any savings programme identified through this work needs to be validated and owned by individual providers rather than by their regulator.

6. Our engagement

We have been actively engaging with Lord Carter himself and his review team over the past months to help provide input in to the project and to ensure that the work is co-developed with the provider sector. These meetings have been constructive and it has been clear that the project team has been working to ensure that the outputs are developed in collaboration with providers and will be genuinely meaningful in the future. We our pleased that our messages on regulatory approaches and the need to engage senior leadership teams within provider organisations have been reflected in Lord Carter's report.

We are currently working with the 22 cohort trusts to draw out their learning and experiences from the project to provide insights for the wider sector – we are trying to organise a meeting in the fringes of our Finance and Commercial Leads network meeting on 18 June so please do get in touch if you are interested and able to attend this. Please contact Edward.Cornick@nhsproviders.org if you are interested in attending this meeting.

We are also exploring with Lord Carter and the review team how to engage the wider sector in this work to ensure that there are appropriate opportunities for input across all sectors of our membership. This is likely to take the form of workshops and briefing sessions through our regular network programme.

Annex A NHS Providers Press Statement

Taking a collaborative approach: NHS Providers responds to the Carter interim review on NHS operational productivity

Responding to the interim report on the operational productivity of NHS providers by Lord Carter, NHS Providers chief executive Chris Hopson, said:

"The NHS faces a major challenge in closing the £30 billion 2020 funding gap identified in the NHS Five Year Forward View. The service also needs to demonstrate it is maximising value for money for the taxpayers who fund the NHS.

"Our members tell us that they have worked extremely hard over the last five years to realise efficiency savings that have been high by NHS historical standards. NHS providers, for example, delivered £2.5 billion of efficiency savings last year alone. However, our members also tell us, strongly supported by the evidence, that the scope to realise efficiency savings using the current approaches is rapidly drying up. If we are to save the £22 billion the Five Year Forward View is targeting, we need to do something different.

Contact: Phillippa Hentsch, Funding & Resources Advisor phillippa.hentsch@nhsproviders.org

"We therefore strongly welcome Lord Carter's early work with 22 NHS providers to identify where there is scope for further efficiencies. We particularly welcome the data driven, sector led, bottom up, approach he is using. This work is starting to look at NHS efficiency in a different, more granular, more evidence based, way than ever before. It rightly focuses on the importance of eliminating unnecessary variation both within and between providers, recognising that some variation is both desirable and necessary.

"Lord Carter's early data suggests there could be savings of up to £5 billion per annum. His report rightly highlights four factors that will be key to realising savings of the type he has identified:

- There is "no one single action we can take" – concerted management effort will be needed in all providers across a wide range of different areas of activity;
- This will take time – "we could look to savings of up to £5 billion per annum, but only "by 2019/20";
- The need for "management grip". Our members tell us they do not have enough managers to do all three of restoring NHS finances and performance, transforming models of care and, now, realising these new types of efficiency;
- The need for "quality data", "metrics to measure relative performance", and "adopting best practices and modern systems", together with the need for greater management capacity, will require significant "funding".

"Perhaps most importantly of all, Lord Carter recognises the importance of securing local management commitment in each NHS trust to using this data effectively. This review must be seen as a valuable, sector led, management tool developed by providers, for providers. In Lord Carter's own words "a regulatory approach will probably fail to capture the imagination and engagement of hospital boards". We strongly endorse his view that the role of the Department of Health, NHS England, TDA and Monitor is to provide "support that [is] seen as helpful and non-directive".

"NHS Providers is pleased to be working closely with Lord Carter and his team to help develop this important work as it progresses and to provide sector input alongside our members".

Ends

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 June 2015
Reference number:	148-15
Report from:	Director of Nursing & Quality
Author:	Director of Nursing & Quality
Report date:	17 June 2015
Appendices:	Reports on: 1: Safe Staffing 2: Patient experience, complaints & claims 3: Infection control

Patients: safe staffing and quality of care

Key issues

1. This report provides information on:
   - Safe staffing and whether safe staffing levels are being achieved as per national recommendation and information on how safe and well led each ward is (Appendix 1).
   - Quality and risk management with information provided on quality and safety metrics.
   - Information on new and closed complaints, claims and patient experience feedback (appendix 2).
   - Infection prevention and control issues and actions (appendix 3).

Safe staffing

2. Safe staffing levels were achieved throughout May.
3. Areas of concern continue to be the vacancy rates on Canadian Wing however 6.21 wte has been recruited and are starting in post from now through to end of September.
4. Sickness on Canadian Wing has reduced significantly this month with the return of a number of staff from long term sickness however sickness on Burns ITU is currently 5.7%.

Quality and risk management

5. There has been a 34% increase in incident reporting in May.
6. Of the 97 incidents relating to patients in May; 87 are graded as no harm near misses; 7 are graded as minor harm; 3 are graded moderate harm.
7. Three grade 2 QVH acquired pressure ulcers developed in May.
8. Four falls were reported in May; 2 on burns ward; 1 on Ross Tilley;1 on Margaret Duncombe; no harm was caused by any of these incidents.
9. One serious incident has been logged in May this occurred in a spoke site; RCA is underway.
10. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.

Infection control

11. One case of MRSA (not bacteraemia) has been reported; RCA in progress; patient is under the care of QVH and another Trust
12. One incident of vancomycin resistant enterococci (VRE) has been identified in Burns; full RCA in progress.

Complaints, claims and patient experience

13. There were five new complaints opened in May 2015; one related to medical communication; two related to communication and two related to clinical care. Three of the five have been graded as potentially moderate; complaints include delay in treatment and a missed diagnosis of a child which has been referred to the NHS Litigation Authority.
14. Two complaints were closed; one about communication and waiting times which was upheld and the other to a prescribing issue where a patient was given antibiotics they were allergic to; a full apology has been given to this patient.
15. Four new claims are being investigated and no claims were closed.
16. The average FFT percentage for patients extremely likely/likely to recommend was 99%.

Implications of results reported

17. Additional agency and bank staff continue to be used however there is a general decrease in the number of booked agency shifts (non RMN) in most areas during May.

Action required

18. Continue with plans for recruitment and retention of substantive staff to reduce agency use.
19. Continue with review of offering enhanced rates of pay for nurses working extra hours.

Link to key strategic objectives

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

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

Implications for the board assurance framework (BAF) or corporate risk register (CRR)

21. No new implications for either the BAF or the CRR.

Regulatory impacts

22. The CQC Hospital Intelligent Monitoring rating for QVH has reduced from 6 to 5 with an overall risk score of 3 however no new issues have occurred in May which adversely impact on our ability to comply with CQC registration or our Monitor governance risk rating.

Recommendation

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

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

Introduction

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

Since the last board report I have spent some clinical time working on the Burns ward and Peanut ward alongside our ward teams, caring for patients and speaking to their relatives. I participated in the multidisciplinary burns meeting led by a consultant with all team members able to challenge and clarify treatment plans including health, social and psychological support. Patients and family talked to me about their satisfaction and positive experience and a plaudit about the food was received. Care was tailored to individual's needs and this was evidenced by observing a patient attending for a dressing change who was still traumatised from the initial event more 2 weeks previously this was addressed professionally and expertly by the nurse and appropriate actions identified and documented so that this could be followed up at next visit. The shift on Peanut was busy with 3 inpatients and a full day case list with requests to add additional cases. Staff were very accessible to patients and families. Safeguarding assessments were evident for all children and there was an informal teaching about this topic in progress for the students to illustrate the complexity of one of the cases. The feedback left by families going home was important to staff and the ward sister made a point of sharing the individual comments to staff members. The information from CIP is consistent with my finding from the ward that there is a high standard of compassionate care, both the wards areas are very clean and staff are approachable. Specific feedback has been given directly to the ward managers.

Safe Staffing

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

1. The revised safe staffing charts are included in this report in Appendix 1. Canadian Wing staffing levels have significantly improved due to the return of staff from long term absence. Staffing is reviewed daily in response to demand and capacity and managed via the safer care module on the e-roster system.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
SAFE STAFFING - % of staff actually on duty against those planned	Margaret Duncombe Registered staff Day shift	103%		99%	100%											100%
	Margaret Duncombe Support staff Day shift	98%		98%	102%											100.2%
	Margaret Duncombe Registered staff Night shift	99%		97%	99%											98.0%
	Margaret Duncombe Support staff Night shift	99%		95%	100%											97.3%
	Ross Tilley Registered staff Day shift	96%		99%	98%											98.7%
	Ross Tilley Support staff Day shift	94%		103%	100%											101.5%
	Ross Tilley Registered staff Night shift	95%		99%	98%											98.2%
	Ross Tilley Support staff Night shift	89%		100%	91%											95.3%
	Peanut Registered staff Day shift	98%		98%	96%											96.9%
	Peanut Support staff Day shift	99%		92%	100%											95.9%
	Peanut Registered staff Night shift	97%		97%	98%											97.5%
	Peanut Support staff Night shift	100%		100%	100%											100.0%
	Burns Registered staff Day shift	96%		98%	97%											97.1%
	Burns Support staff Day shift	101%		94%	97%											95.2%
	Burns Registered staff Night shift	99%		98%	100%											99.2%
	Burns Support staff Night shift	104%		100%	100%											100.0%
	ITU Registered staff Day shift	96%		98%	100%											98.8%
	ITU Support staff Day shift	103%		100%	100%											100.0%
	ITU Registered staff Night shift	95%		103%	100%											101.3%
	ITU Support staff Night shift	100%		100%	100%											100.0%

CQUINS

2. May updates show assessments are reaching our expected targets.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
CQUINS	Dementia >75 trauma asked indicative question	93%	90%	87%	90%											
	Dementia >75 having diagnostic assessment	95%	90%	100%	100%											
	Dementia >75 referred for further diagnostic advice	100%	90%	100%	100%											
	Dementia training for staff	87%	65%	92%	94%											
	Dementia strategy	_	NA	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	AK1 Acute Kidney Injury	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Sepsis	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Human factors training	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Improving patients with mental health experience of trauma pathways at QVH	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			

Patient Experience

3. There were five new complaints opened in May 2015. One related to medical communication with an initial risk rating of moderate relating to a delay in a removal of a splinter; two are related to communication and assessed as minor; two are related to clinical care and both initially graded as moderate; a patient has stated that their finger was broken during a physiotherapy rehabilitation session following surgery; this case has also been referred to the NHS Litigation Authority. The other involves a 4 year old child whereby a fractured arm that was not diagnosed on presentation in MIU; the patient returned a week later when the fracture was then confirmed and treated; the patient was then recalled to have their arm re-plastered. Investigations are underway on all five complaints. There were two complaints closed one about communication and waiting times which was upheld; the other relates to a prescribing issue where by a patient was given antibiotics that they were allergic to; a full apology was given to the patient and the staff involved have received appropriate re-training; the issue has also been raised at local ward meetings to act as a reminder to staff of the correct drug administration procedure.

4. There were four new claims opened in May 2015 as yet there are very limited details; no claims were closed. A more detailed summary is contained within the patient experience report in appendix 1.

5. We continued to sustain our FFT recommendation from patients that they would recommend us at 99%.

6. Analysis, undertaken by the Nursing Times, about the 2014 national inpatient survey shows QVH as the best performing trust for nursing performance, and also for having sufficient nurses on duty. The score for nursing performance was 9.34 and for having sufficient staff on duty was 9.46 (maximum score possible was 10). The 4 key questions asked on nursing were;

   - When you had important questions to ask a nurse, did you get answers that you could understand?
   - Did you have confidence and trust in the nurses treating you?
   - Did nurses talk in front of you as if you weren't there?
   - In your opinion, were there enough nurses on duty to care for you in hospital?

7. There was also a league table of the worst performing trust for nursing performance and having sufficient staff on duty. This was reviewed to see if any of our spoke providers appeared on these lists. Medway appeared on the worst for overall staffing list at 6.48 but not on the worst list for nursing performance. None of our other spoke providers appear on either list. As a result of this information and triangulation of other quality metrics, Medway will be prioritised as the next spoke site visit by QVH quality and risk team. Currently the quality team is compiling a list of headline metrics on each spoke site for review monthly to assist with determining the level of assurance regarding the quality of services provided at spoke site, this will include CQC ratings, FFT data, health and safety reviews, datix reports (where QVH provides staff at spoke sites). Once the scorecard has been developed it will be presented at Quality and Governance Committee.

Patient Safety

8. There were one hundred and forty eight incidents reported in May which represents a 34% increase in reporting this month. Of the total reported incidents ninety seven related to patients; of these, seven caused minor harm and three caused moderate harm.

9. There were three grade two pressure ulcers acquired at QVH during May; these were acquired on Margaret Duncombe ward. A root cause analysis is being undertaken on all three cases; results of the trials on Ross Tilley in relation to new tapes and dressings are awaited.

10. There were four patient falls in May; two on burns ward; one on Ross Tilly and one on Margaret Duncombe; no harm was caused in any of these incidents.

11. There is one incident in May that involves a QVH Doctor operating off site, where a tooth was incorrectly removed and re- implanted immediately. This was initially logged as an SI by QVH whilst awaiting more information about the incident. It became apparent that this was a never event and needed to be logged by the hospital where the incident took place. A full RCA is underway and the finding from this will be shared with investigators at the hospital where the incident took place, to maximise the learning opportunities for each organisation. The medical director has commissioned a piece of work to scope the feasibility of only consultant grade staff operating on patients off site.

Source		Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
					April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Safety	Safety Thermometer	Safety thermometer data submission	100%	Y/N	Y	Y											
		Harm free care rate (NATIONAL) - one month delay	NEW		94%												
		Harm free care rate (QVH)	97%	>95%	97%	95%											96%
		New harm free care rate (acquired at QVH)	99%	>95%	97%	97%											97.3%
		VTE initial assessment (Safety Thermometer)	100%	>95%	100%	100%											100.0%
		Patient Falls assessment completed within 24 hrs of admission	90%	>95%	100%	97%											98.6%
		% of completed nutritional screening assessments (MUST) within 24 hours of admission	99%	>95%	100%	100%											100.0%
		% of patients who have had a (MUST) reassessment after 7 days	92%	>95%	86%	100%											93.0%
		Patient Falls resulting in no or low harm	49	—	2	4											3
		Patient Falls resulting in moderate or severe harm or death	1	—	0	0											0
		Number of Pressure ulcer development Grade 2 or over acquired at QVH	11		2	2											4
		Serious Incidents	10		0	1											1
		Never Events	2		0	1											1
		Total number of incidents involving drug / prescribing errors	210		19	21											40
		No & Low harm incidents involving drug / prescribing errors	209		19	21											40
		Moderate, Severe or Fatal incidents involving drug / prescribing errors	1		0	0											0
		Medication administration errors per 1000 spells	2.2														
	Consent	To take consent for elective surgery prior to the day of surgery (Total)	74%	75%	67.1%	72.4%											69.8%
		To take consent for elective surgery prior to the day of surgery (Max Fax)	70%		73.9%	87.1%											80.5%
		To take consent for elective surgery prior to the day of surgery (Plastics)	72%		61.5%	66.7%											64.1%
		To take consent for elective surgery prior to the day of surgery (Corneo)	84%		83.3%	80.0%											81.7%
		Number of outstanding CAS alerts	2		0	0											0
		Number of reported incidents relating to fraud, bribery and corruption	1		0	0											0
	Theatres	Perioperative patient thermoregulation management	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		Pressure ulcer management	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		Reducing nil by mouth times	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		WHO Checklist compliance - Qualitative (100% compliance is CCG target)			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		WHO Checklist compliance - Quantitative (100% compliance is CCG CQUIN)	96%	>95%	_	98%											

Staff Safety

12. Ten staff incidents were reported during May; all reports have been assessed as minor harm; four of the ten are needlestick injuries and the remaining six are related to minor staff incidents. There are no RIDDOR reportable staff incidents for May.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Staff Safety	Staff incidents causing harm	96		7	10											17
	RIDDOR (Patients & Staff)	2		1	0											1
	Mandatory training attendance	78%	80%	70%	76%											
	Flu vaccine uptake	53%	60%	Not due till October												

Infection Control

13. Cleaning standards continue to be monitored closely and the standard of cleaning is improving in the trust. There are 12-15 cleaning audits per week and the compliance rate is above 80%. Results are sent to ward/department manager and the matron. Only one audit in May was below 80%, which was the ground floor of main outpatients, action plan was put in place and the re-audit score was 94%.

14. There has been 1 incidence of vancomycin resistant enterococci (VRE) in the burns unit, a full RCA is in progress. There has been one case of MRSA (not a bacteraemia) in a corneo patient, a full RCA in progress. We are unable to establish is this is avoidable or unavoidable; as this patient is being cared for in two acute trusts; lessons learnt were to remind doctors about bare below the elbow during clinical care and a reminder to complete the blood culture audit tool; a review of cleanliness audits has also taken place.

15. Visit in May to Synergy in Redbridge following relocation of the service was satisfactory overall, some issues such as de-cluttering and attention to the fabric of the building were noted and this will be re-audited in July.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
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	1	0	0	0											0
	E-coli bacteraemia	0	0	0	0											0
	MSSA bacteraemia	1	0	0	0											0
	MRSA screening - elective	96%	>95%	99%	98%											197%
	MRSA screening - trauma	97%	>95%	97%	96%											193%
	Trust hand hygiene compliance	98%	>95%	99%	99%											198%

Care Quality Commission (CQC)

16. Inspections by the CQC are now being announced on a monthly basis giving Trusts a 20 week notice period. QVH does not have a date yet for inspection the earliest the CQC could undertake booked inspection would be November 2015.

17. In preparation for a CQC inspection we have carried out a Trust wide self-assessment; this required staff to complete a questionnaire and managers/team leads to formulate an action plan with achievement dates where areas of need are identified. Action plans and agreed dates of completion are being monitored by the compliance officer. The assessment tool asks questions under the five CQC domains; staff could answer yes; no or not applicable. Findings have identified some consistent themes including gaps in in mandatory training and staff not having an up to date personal development plan (PDP).

18. A revised CQC Hospital Intelligent Monitoring was published at the end of May 2015. The QVH rating has changed from 6 to 5 with an overall risk score of 3. The change in banding relates to 5 central alerting system (CAS) and 2 national reporting and learning system (NRLS) delays in data submission and registration risk issues with medical and dental staff. The CAS and NRLS reporting mechanisms have been reviewed and amended to prevent this happening again. The last delay in submission was February 2015. The registration issue involves our dentists and dual registered doctors who are registered with the General Dental Council (GDC). The registration year for the GDC is 1 January – 31 December, an internal report showed all of our dentists and dual registered doctors staff are compliant with GDC registration. An additional manual check of all of our dentists and dual qualified doctors who were listed as having expired on 31 December 2014 confirms they all have valid registration. Previously the General Medical Council (GMC) interfaces with electronic staff record (ESR) where the GDC does not, the medical workforce manager has amended this process to include GDC interface.

Appendix 1

SAFE STAFFING DATA

CANADIAN WING 2015 / 2016		APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Staff Utilisation		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies	wte	2.82	4.09											7.5%	18%				Recruited into 6.21 WTE awaiting clearance/ checks not currently in post for May 2015
Est =	(hrs)	458.25	664.62																
Temp staffing	Bank	680.8	662											10% 235.8+ vac	-12%				1.0 WTE currently working in OPD due to HR issue. CW Establishment total 60.8 WTE
exc RMN	Agency	508	527																
Sickness %		6.1%	1.7%											2%					This figure is based on the CW Establishment of 60.8 WTE
Training / Appraisal		No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %		74.5%	93.5%											85%	-19%				Improved from 74.5% in April
Statutory & Mandatory%		77.6%	68.1%											85%	-7%				Figures from SDC
Drug Assessments %		100%	100%											95%					2nd consecutive month at 100%
Staff FFT Score %		_	_											_					
Budget (YTD)		-6,866	-2,607											>0					Overspend on pay, see above
Margaret Duncombe																		Trend	Improvement Plan/Actions
Shift meets est %	RN	99%	100%											95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day	HCA	98%	102%											95%					
Shift meets est %	RN	97%	99.1%											95%					
Night	HCA	95%	100%											95%					
Ross Tilley																		Trend	Improvement Plan/Actions
Shift meets est %	RN	99%	98.2%											95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day	HCA	103%	100%											95%					
Shift meets est %	RN	99%	97.6%											95%					
Night	HCA	100%	90.6%											95%					

CANADIAN WING 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Margaret Duncombe																		
Pressure Ulcers	2	3											0					1 grade 1 and 1 grade 2 PU (new product being trialled)
Falls	0	1											0					Second consecutive month with no falls
Medication Errors	8	8											0					
MRSA / C. diff	0/0	0/0											0 / 0					No CDI or MRSA for whole of 2014/15
Incidents Reported (Datix)	14	19																All incidents relating to MD
VTE reassessment %	100%	100%											95%					Second consecutive month at 100% compliance
Nutrition MUST assessment	100%	100%											95%					Second consecutive month at 100% compliance
7 day review	100%	100%																
Patient numbers	146	143											N/A					Highest number since July 2014
Patient FFT Score %	97.0%	99.0%											95%					Decrease of 1% in month
Ross Tilley																		
Pressure Ulcers	1	0											0					New product to reduce friction being trialled
Falls	1	1											0					Minor harm, decrease from April
Medication Errors	8	8											0					
MRSA / C. diff	0/0	0/0											0 / 0					No MRSA in 2014/15 no CDI since October 2014
Incidents Reported (Datix)	9	16																
VTE reassessment %	100%	100%											95%					In month improvement (80% compliance in April)
Nutrition MUST assessment	100%	100%											95%					100% compliance since December 2014
7 day review	100%	100%																
Patient numbers	170	175											N/A					Patient number about the same
Patient FFT Score %	98.0%	100%											95%					No change in performance in month

BURNS WARD 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	0	0											0					No grade 2 PU since August 2014
Falls	0	2											0					2 falls in May prior to this no falls since Feb 2015
Medication Errors	1	0											0					
MRSA / C. diff	0/0	0/0											0 / 0					No MRSA bacteraemia or CDI for 2014 /15
Incidents Reported (Datix)	2	7																
VTE reassessment %	100%	66.7%											95%					significant decrease for May; Matron to feed back
Nutrition MUST assessment	100%	100%											95%					Action in place to address reassessment
7 day review	50%	100%																
Patient numbers	21	25											N/A					Patient numbers remain consistent
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	2.07	3											7.5%	6.8%				Vacancy rate at 6.8%. Establishment information not currently available for 2015/16
Est = (hrs)	337.30	450																
Temp staffing Bank	464.15	95											10%	62.5%				Bank and agency use significantly decresed in May
exc RMN Agency	84	208.5																
Sickness %	NA	1.7%											2%					Data not available due to early Board Report
Shift meets est % RN	98%	96.6%											95%					
Day HCA	94%	96.9%											95%					
Shift meets est % RN	98%	100%											95%					
Night HCA	100%	100%											95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	64.5%	100%											85%	-20%				From March to May improved from 54.4% to 100%
Statutory & Mandatory%	83.9%	84.0%											85%	-1%				attendance steadily improving
Drug Assessments %	100%	100%											95%					Compliance of 100% since Nov 2015
Patient FFT Score %	100%	100%											95%					FFT at 100% since Feb 2014
Staff FFT Score %	_	_											_					
Budget (YTD)	-72,094	-90,508											>0					

BURNS ITU 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	0	0											0					
Falls	0	0											0					No falls throughout 2014/15
Medication Errors	2	4											0					
MRSA / C. diff	0/0	0/0											0 / 0					No MRSA bacteraemia or CDI in 2014/15
Incidents Reported (Datix)	8	5																
VTE reassessment %	100%	100%											95%					Achieved 100% compliance throughout 2014/15
Nutrition MUST assessment	100%	100%											95%					Achieved 100% compliance since Jan 2015
7 day review	100%	100%																
Patient numbers	N/A	N/A											N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	0	6.6											7.5%	0.0%				April figures not available; current vacancies 6.60
Est = (hrs)	0	984																
Temp staffing Bank	191	28.5											10%					overall bank and Agency reduced for May and in line with vacancy
exc RMN Agency	504	709																
Sickness %	N/A	5.7%											2%					1long term sickness (2 maternity leave)
Shift meets est % RN	98%	100%											95%					Achieved on or above standard since November 2014
Day HCA	100%	100%											95%					
Shift meets est % RN	103%	100%											95%					Achieved on or above standard since January 2015
Night HCA	100%	100%											95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	66.7%	95.0%											85%	-18%				Significantl improvement from April
Statutory & Mandatory%	71.9%	84.0%											85%	-13%				Improvement from April
Drug Assessments %	87.0%	77.0%											95%					slight decrease in assessments this month
Patient FFT Score %	_	_											95%					
Staff FFT Score %	_	_											_					
Budget (YTD)	-159	-2,378											>0					

PEANUT WARD 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	0	0											0					No PU during 2014/15
Falls	0	0											0					No falls during 2014/15
Medication Errors	0	0											0					
MRSA / C. diff	0/0	0/0											0 / 0					No MRSA/CDI during 2014/15
Incidents Reported (Datix)	2	1																
Patient numbers	10	206											N/A					significant increase in activity/patient numbers for May
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	1.75	3											7.5%	7.0%				Recruited to full establishment start dates between June and August
Est = (hrs)	285.16	450																
Temp staffing Bank	240.5	119.5											10%	*9%				bank and agency use significantly improved this month
exc RMN Agency	71.3	54.75																
Sickness %	N/A	5.5%											2%					2 staff on long term sickness absence
Shift meets est % RN	98%	96.2%											95%					Decrease in HCA cover on day shift, covering ward clerk leave
Day HCA	92%	100%											95%					
Shift meets est % RN	97%	98.4%											95%					Improved trained night nurse cover
Night HCA	100%	100%											95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	80.0%	98.0%											85%	-5%				significant improvement for May
Statutory & Mandatory%	82.0%	93.5%											85%	-3%				Improved position from April
Drug Assessments %	100%	90%											95%					decrease in May
Patient FFT Score %	100%	100%											95%					Achieved 100% since September 2014
Staff FFT Score %	_	_											_					
Budget (K)	-1,663	-9,440											>0					

Monthly patient experience report

1 May 2015 – 31 May 2015

Monthly patient experience report

1 May 2015 – 31 May 2015

Complaints

Open complaints: There were 5 complaints opened during this period. All complaints received are acknowledged, investigated and responded to. Actions identified are monitored for completion by the monthly clinical governance group.

Plastic Surgery

1. **Trauma/In-patient - Medical – clinical care/communication** – The patient sustained a splinter injury to their thumb on 9 April. They were seen in MIU that day and returned on 11 April for removal of the splinter. They were subsequently seen thereafter on 13, 17, 24 April where patient raised concerns, as they could still feel something still in their thumb. Patient was then again seen on 8 May 2015 and again on 20 & 21 May. There was a delay in the full removal of the splinter which occurred on 22 May 2015. The patient is very upset by delay and that they had informed the staff on several occasions that there was something in the thumb but feel that these concerns were ignored. **Investigating lead – Consultant and Clinical Lead**

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

   Comment/Action – Still undergoing investigation.

2. **Trauma/inpatient - Medical – communication –** This is a joint complaint with St Richards Hospital and SECAMB who will provide QVH with the outcome of their investigation which will be incorporated into one response.

   This 8 year child sustained an injury to the soft tissue on top of their fingertip, as a result of the finger being trapped in a door. The mother of the patient called an ambulance who advised that they should make their own way to St Richards Hospital. It is alleged that there was then a delay in treatment being provided when they arrived. The patient was then referred to QVH, where again an ambulance was unavailable and the mother of patient drove to QVH. Upon arrival at 22:00pm the surgeons attempted to reattach the soft tissue under local anaesthetic but due to pain this was deferred until morning for surgery under GA. The child's mother also claims that the doctors failed to visit patient after surgery and no information was given to them on discharge as to whether the surgery would succeed or any aftercare information was provided. **Investigating lead – Clinical Lead**

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

   Comment/Action – Still undergoing investigation.

Sleep Disorder Centre

3. **Outpatient - Medical – communication -** When patient telephoned and spoke with clinician, the patient felt that he laughed at her disability of MS. **Investigating lead – Patient Experience Manager**

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

   Comment/Action – The **c**linician involved is adamant that they did not laugh at the patient's disability but rather with the circumstances that they found themselves in when speaking to both the patient and her husband. An apology within the letter was conveyed to the patient on behalf of the Trust for any upset that may have been caused.

Therapies

4. **Outpatient – Therapies – Clinical care:** The patient alleges that following hand surgery at their finger was broken during a physiotherapy session which resulted in the patient requiring further surgery. The patient has asked for a full investigation and also for compensation. A complaint and a claim can run parallel and this case has also been referred to the NHS Litigation Authority. **Investigating lead – Therapy Services Manager**

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

   Comment/Action – Still undergoing investigation and awaiting comments. Please be aware that at the time of the writing of this report the physio records at cannot be located. The physio notes are currently stored in an office in Jubilee Centre and a member of the physio team has been undertaking searches to try and locate these.

Minor Injuries Unit

5. **Nursing – Clinical care:** This 4 year old child initially attended having fallen onto their arm. The child was examined in MIU and discharged with no injury. The patient then returned 1 week later as their arm had swollen. At this presentation an X-ray was performed which showed that there was a clear fracture. The arm was then plastered. The child was asked to return to have the arm replastered as the initial plaster cast was not high enough. The child's parents are concerned about the failure to diagnose the fracture to arm and that the plaster cast appears to have been applied incorrectly. They would like to have a full explanation.

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

   Comment/Action – Still undergoing investigation.

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.

Plastic Surgery

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

   At his appointment in November 2014 the patient says that he mentioned to clinician (locum) that the nodes in his groin appeared raised. However this was dismissed by the clinician 'as not being important' and 'that this was nothing to worry about', which at the time brought relief to the patient.

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

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

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

   Comment/Action – The clinician failed to review the patient when he raised concerns about a raised node. This resulted in this being untreated for a short period of time and the patient then have a dissection and radiotherapy. It is not known whether the patients outcome would have been differed had the nodes been noted earlier. **Outcome – upheld**

2. **Inpatient - Medical/Nursing – Prescribing issue –** The patient was written up and given penicillin based antibiotics. The patient is allergic to penicillin (rash appears on neck) and was wearing a red bracelet. There were also alerts within the patient's health records. **Investigating lead – Matron/Clinical Lead**

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

   Comment/Action – Apologies given to this patient. The doctor who prescribed the medication has been spoken to by the clinical director and the nurse undergone an oral drug administration assessment and has discussed this with her clinical educator. In addition this case has been discussed at a recent ward meeting to highlight the importance of checking patient's medication, prior to the administration. **Outcome – upheld**

Claims

Open claims: There were 4 new claims opened during this period. Overall there are 55 claims. A quarterly report is provided to the Quality and Risk Committee on claims paid, lessons from claims are disseminated through the Joint Hospital Audit meeting each quarter.

Incident date	Claim date	Directorate	Service	Description	Initially Complaint
20/11/2013	06/05/2015	Plastics	Medical	Limited information provided other than it relates to wide local excision for melanoma.	No.
26/11/2013	28/04/2015	Plastics	Medical	Following surgery for removal of supraclavicular lipoma patient says that they are suffering from loss of movement in arm and shoulder. Patient alleges that they were not made aware of the risks associated with this type of surgery. The Claimants solicitors have been advised to contact BSUH directly. At the time of this patients surgery QVH were offering bed capacity for some BSUH patients. The actual surgery was performed by a BSUH surgeon and their team.	Yes.
20/05/2014	14/05/2015	Plastics	Medical	Misdiagnosis of Carpal Tunnel Syndrome.	No
19/11/2012	27/05/2015	Physiotherapy		Alleges that finger was broken during a physio session which resulted in patient requiring further surgery. Patient has asked for a full investigation and compensation.	Yes (complaint no.4 above)

Closed claims: There were no claims closed during this period.

Patient comments, surveys & Friends and Family Test

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

There were 12 new comments posted onto the NHS Choices/Patient Opinion websites this month. The following is the link to Patient Opinion

Friends and Family Test

The Trust wide FFT scores for in-patients in May was **100%** of our patients would recommend us. **315** inpatients out of a possible **549** inpatients completed the questionnaire which is a **response rate of 57.4%.**

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

Area	Total Responses	Total Eligible	Response rate	Percentage recommended	Percentage Not recommended
MD ward	116	143	81.1%	100%	0%
RT ward	123	175	70.3%	100%	0%
Peanut ward	63	206	30.6%	100%	0%
Burns ward	13	25	52.0%	100%	0%
Sleep centre	129	159	81.1%	93%	0%
MIU	305	1065	28.6%	99%	1%
Trauma	148	632	23.4%	99%	0%
OPD	1172	11941	9.8%	97%	1%
DSU	47	592	7.9%	100%	0%

Please note that this is the first month that all patients that were admitted to Peanut were asked the FFT question, whereas previously only those patients 16+ were asked, hence the increase in the total in those eligible and the response returns. It is hoped that there response rate will increase over the next month.

A review of the MIU waiting times and FFT 'unlikely' and 'extremely unlikely' scores for April 2015 has been undertaken to ascertain whether there is a direct correlation between them.

The information that is available looks at the percentage of patients that were seen in MIU within 4 hours. The waiting time target for MIU patients is 95% and the average for the month of April was 99.25%

As part of FFT, one of the questions that we ask is 'was there anything that could have been improved?' In April 2015, overall 591 trauma patients came in for treatment via MIU. Of the 148 trauma patients who completed a FFT questionnaire – 36 trauma patients provided a reply to this specific question. 7 patients made the following comments specifically about the waiting time, 5 of which said that were 'likely' or 'extremely likely' to recommend the trauma service to family or friends. The findings support that there is no correlation between concerns about waiting times and FFT recommendations.

We will be displaying the negative comments within the unit and encouraging patients to provide their suggestions on where we can improve the overall patient experience. In addition there is a review on how best to communicate waiting times to patients.

'The length of time waiting, no coffee machine or food' - respondent scored 'extremely likely' to recommend.

'Waiting' – respondent scored 'likely' to recommend

'The waiting time is so long' - respondent scored 'likely' to recommend

'Very good but very busy and very short staffed' – respondent failed to score recommendation question

'**The staff were really scatty and my appointment was overdue by 1.5 hrs'** – patient scored 'unlikely' to recommend.

'Waiting time' patient scored 'likely' to recommend

'timekeeping' patient scored 'likely' to recommend

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

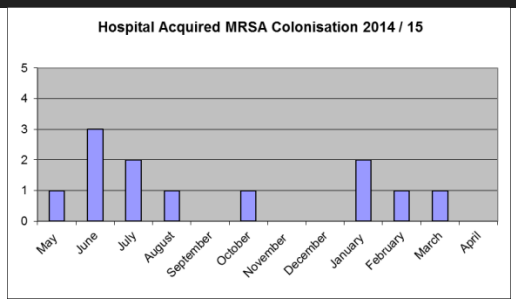
Trust	Total Responses	Total Eligible	Response Rate	Percentage recommended	Percentage Not recommended
Moorfields Eye Hospital NHS Foundation Trust	790	1579	50%	99%	0%
Papworth Hospital NHS Foundation Trust	568	955	59.5%	97%	1%
Queen Victoria Hospital NHS Foundation Trust	213	347	61.4%	99%	0%
The Royal Marsden NHS Foundation Trust	596	4181	14.3%	96%	1%
Royal National Orthopaedic Hospital NHS Trust	400	758	52.8%	97%	1%
Stoke Mandeville Hospital	379	3588	11.1%	98%	1%

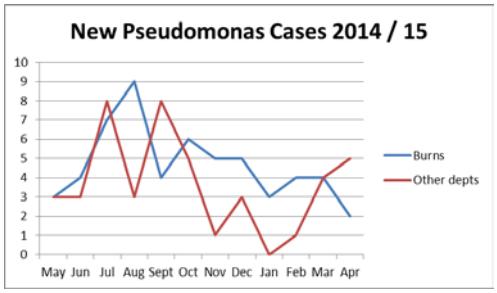
INFECTION PREVENTION & CONTROL
Monthly Report – May 2015

Areas of Concern

- Levels of cleaning around the Trust have improved. IPACT continue to monitor. Overall Trust score for May: 85%.
- Work on the rooms in main X-ray is planned so the service currently being provided from Rycroft ward can return to x-ray which will re-provide a decant area in an emergency situation/enable estates works in clinical areas; however, equipment is stored in the bays. IPACT continue to coordinate the clearing of the area.
- Antimicrobial prescribing and the potential for over prescribing – review of the guidelines continues as required, annual audit and reminders are given to clinical staff at mandatory training to discuss antibiotic use with the Microbiologist. Patients are reviewed by the Consultant Microbiologist twice a week.
- Ability of BSUH to provide electronic reporting in a usable format to IPACT. This has been put on the risk register and the DIPC is liaising with BSUH. Progress is monitored at the Pathology contract meeting.
- Inaccurate or missing results from the daily laboratory sheet provided by BSUH (eg, MRSA positive results). Following discussion at the contract meeting in August, BSUH looking into possibility of providing a new format for the Infection Control Nurses (ICNs). The DIPC receives progress updates regularly. Datix completed as required.
- Results provided from the Winpath system appear to be name sensitive and results requested by NHS number or hospital number alone may not identify results. In addition not all results on ICE when on Winpath. Raised at the Pathology meeting, added to the risk register. Datix completed and BSUH asked to investigate as required.

Outbreaks / Significant Infection:





- Patient previously confirmed Corynebacterium Ulcerans positive has been treated and rescreened. The swabs sent pre and post antibiotics returned clear.
- IPACT investigated potential norovirus outbreak on the Burns Unit however there was no outbreak, one patient symptomatic. Infection control precautions implemented.
- There has been one incidence of Vancomycin Resistant Enterococci (VRE) in a wound swab from a patient on the Burns Unit; a full RCA has been completed. Source of acquisition unknown as patient being cared for in two acute Trusts. Not reportable to Public Health England. No secondary cases. Lessons learnt: remind Doctors to be bare below the elbows during clinical care, Doctor to be reminded to complete the blood culture audit tool and Domestic Supervisor to score all cleanliness audits.
- There has been one case of Meticillin Resistant Staphylococcus Aureus MRSA (not a bacteraemia) in a Corneo patient; a full RCA is in progress.

Risk Register

Risk	Number	Current situation
Lack of hand wash basins	422 (rated 6)	Portable sinks in situ where risk identified or risk assessment completed
Carpets in clinical areas	478 (6)	Replacement programme ongoing, IPACT have requested a copy to prioritise areas for the next financial year
Pseudomonas	566 (6)	Testing programme in place, ongoing. To be closed after 18 months of consecutive negative results.
BSUH microbiology	513 (6)	Not providing sufficient PA's on site. Telephone cover available. Onsite cover provided twice a week since January. Reduced from 12 to 6 at ICC April 2015 as the situation has improved.
Portable aircon units	631 (6)	Only for use at heatwave level 3 or where room temperatures exceed an acceptable level. Use in clinical areas only in conjunction with IPACT.

Surveillance

	New this month	Year to date (target)	IC mandatory training	Overall attendance at 01.04.15: 78.9% (clinical and non-clinical)
E.coli bacteraemia	0	0	**Trustwide Quarterly Results – Q4**	

MRSA positive blood cultures	0	0 (0)	MRSA Screening:	Elective: 98.0%	Overall 97.7%
VRE/GRE positive blood cultures	0	0		Trauma: 96.4%	
C.difficile	0	0 (0)	Hand Hygiene / BBE:	Hands: 99.4%	
MSSA positive blood cultures	0	1		BBE: 98.6%	

	All Theatres	Burns/EBAC	Corneo	MD/Stepdown	Maxfax/Ortho	MIU	OPD x2	PAC	Peanut	Recovery	Rehab	RT	Sleep	Therapies	X-ray
Screening – elective	97	100		97								100	100		
Screening – trauma	97	100		89								99	n/a		
Total new MRSA:															
Pos on admission:															
Previously positive:															
Hospital acquired:															
Unknown:															
Hand hygiene	100	100	100	86	100	100	100	100	100	100	100	95	100	100	100
BBE	90	94	88	100	100	86	100	100	100	100	100	100	100	100	100

Trust Cleanliness

The Trust has to comply with the Patient-Led Assessments of the Care Environment (PLACE) standards. The Domestic Supervisor undertakes 12-15 cleanliness audits weekly; a score above 80% shows compliance. Results are sent to the Ward/Dept Manager; scores below 80% are provided to the Matron of the area. Only one audits this month area was below the 80% which was Main Outpatients Downstairs. An action plan was put in place with resulting improvement, as next audit score was 94%.
Overall score for May: 85%

The National PLACE Inspection for QVH was completed on 6th May. All wards and most outpatient areas were audited, including MIU. We had 7 patient representatives from NHS Health Watch and the same amount of staff from QVH. The results of this inspection will be available nationally in August 2015.

Training

- All planned mandatory training delivered.

Policies

- Isolation policy
- Personal protective equipment policy
- Management of spillage of blood and body fluid.

All existing policies reviewed and updated as required.

Complaints

- None

Audit Results

PLACE inspections **– Clinical –** Sleep Centre, **Non-clinical** – Radio Queen Vic, Nursing and Quality corridor, IT offices, Old Pre-Assessment building. Action plan sent to Manager and Matron for completion following visit. Manager asked to notify Hotel Services when all actions complete.
Monthly MRSA Screening – Trauma 96 % Elective 98 %
Monthly Theatre cleaning inspection – Recovery audited - medical device ledges require cleaning. Beverage bay - requires general cleaning. Discharge lounge – nurses station requires de-cluttering.
Monthly Burns cleaning inspection – Postponed.

Legionella and Pseudomonas Surveillance and Management

Legionella sampling for April were clear.
Pseudomonas sampling – Next due in August.
<100.00cfu/l non detectable level (no further action required)
>100.00 - <1000.00 (Instigate flushing regime, investigate possible source, instigate rectification works)
>1000.00cfu/l (2 & 10 minute samples to be taken, investigate possible source, instigate rectification works).

Estates Issues

Area	Issue	Action
Carpets	Carpeted area for replacement in areas in Trust	Updated list to be provided to IPACT for prioritisation when new financial year budgets released. No update available May 15.
C-Wing	Pt bathroom refurbishment	All completed.

C-Wing	Wards need general repair, flooring replaced, painting, holes filled, bumpers on walls, vents and radiators cleaned	Estates to devise programme of work and submit to IPACT for review. Potential to decant to Rycroft. Drop down radiator covers being costed. No update available May 15.
Public Toilets	All require refurbishment	Trust wide review postponed. Works on the drains in the male toilet in A-Wing corridor, dates to be confirmed. No update available May 15.
Burns	Possibility of installing permanent hand wash basins in the corridors	March Estates and Facilities Group meeting cancelled, added to update report, to be raised at the meeting in April. No update available May 15.
Burns	Following Peter Hoffman (PHE report) to check if the side rooms are delivering positive or negative pressure ventilation	March Estates and Facilities Group meeting cancelled, added to update report, to be raised at the meeting in April. No update available May 15.
Burns Theatre	Doors damaged	Estates obtained quotes for new slider doors but further quote being obtained for swinging doors.
Burns	Potential structural work to divide the 4 bedded bay into 2 side rooms on Burns	Discussed, unlikely to take place. All outstanding actions on the Burns MRSA outbreak action plan being rag rated.
Burns	Plug socket installation outside the rehab flats	Completed.
Theatre Corridor	Flooring damaged	Quotes and samples being obtained for new flooring.
Theatres	Panelling peeling away under the scrub sink in Theatre 4	Reported to Estates and Wilmott Dixon 17/2/15. Estates have chased the outstanding repair, awaiting response. No update available May 15.
Pharmacy	Require allocated hand washing facilities	Risk assessment completed. IPACT observed the process for managing leeches. Protocol requested for review. Urgent sink installation requested for the `good inward area` as leeches preparation undertaken.
Pharmacy	Possibility of mixer tap installation at the hand washing sink	Estates investigated and unable to do.
Photographic	Urgent carpet replacement in reception office as taped together and room with 3D scanner now used by patients	Estates notified 26/11/14. Informed no funding available. For review in the new financial year.
Physio/OT	Outside patient toilets smell and require refurbishment	Estates reviewed drains and toilet connections all satisfactory. No further reports to help desk.
Refreshment area (by RT)	Conversion of old LOPA area to patient refreshment area	Currently appointing contractor.
Day treatment Centre	Conversion of old AWT Rowntree changing rooms to LOPA treatment room.	IPACT reviewed plans and tender process started.
Secretaries office DA72 (Main Corridor)	Number of cracks and peeling paint on the walls / ceiling, from which dust falls onto desks. Rain water entering via a crack near electrical equipment. Overhead light not working.	Relocation taking place on 29th May.
Eye bank	Leak in the QVH lab and office.	Quotes for new flooring requested. Repairs to roof via Blond McIndoe as they own the building. Advised all work stopped and deep cleaning following repairs.

General Information

- Visit to Synergy in Redbridge following the relocation of service. ICN noted some areas within the Unit that required attention relating to the fabric of the building and de-cluttering. To be re-audited in July.

Abbreviations

Abx	Antibiotics	ICC	Infection Control Committee
BBE	Bare below the elbows	ICNS	Infection Control Nurse Specialist
BSUH	Brighton & Sussex University Hospital	IPACT	Infection Prevention & Control Team
CAUTI	Catheter associated urinary tract infection	ITU	Intensive Therapy Unit
C.difficile/C.diff	Clostridium difficile	MDR	Multi drug resistant

CQC	Care Quality Commission	MSSA	Meticillin sensitive Staphylococcus aureus
C-Wing	Canadian Wing	MRSA	Meticillin resistant Staphylococcus aureus
DH	Department of Health	OPD	Out Patients Department
DIPC	Director of Infection Prevention & Control	PAC	Pre Assessment Clinic
E.Coli	Escherichia Coli	PHE	Public Health England
GRE / VRE	Glyptopeptide / Vancomycin resistant enterococci	PLACE	Patient led assessment of the care environment
HCAI	Healthcare associated infection	PPE	Personal protective equipment
HPA	Health Protection Agency	RCA	Root cause analysis
IC	Infection control	Strep A	Group A Streptococcus

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 25th June 2015
Reference number: 149-15
Report from: Sharon Jones, Director of Operations
Author: Sharon Jones, Director of Operations
Report date: 17th June 2015

Operational Performance: Targets, Delivery and Key Performance Indicators
CQC Domains – Responsiveness to People's Needs & Effectiveness

Key Performance Indicators

1. The main area of negative variance for Trust income from patient activity for Month 2 is within the Plastics Business Unit. Diagnostic work across all the business units has commenced to understand the issues so that short term corrective actions can be taken and longer term sustainable plans developed;

2. The Trust continues to forecast compliance at an aggregate level for all three 18 week targets and all targets were met for the month of May. However further work is being undertaken to ensure that there is resilience over the summer period, both in terms of bookers and schedulers being available, as well as clinical staff;

3. The Trust is awaiting national guidance regarding changes in the reporting of the 18 week referral to treatment target. Sir Bruce Keogh has recommended, and it has been accepted, that the non-admitted and admitted targets will be dropped and only the incomplete target kept. The incomplete target is that 92% of patients who have not yet started treatment should have been waiting no more than 18 weeks. This is because the non-admitted and admitted elements are complex and perverse targets that can have the unintended consequence of allowing long-wait backlogs to build up. The manner in which the targets were weighted meant that the incentive was to treat the person who had not yet missed the target rather than someone who had waited longer than 18 weeks. QVH treats patients in order by clinical priority and then in the sequence they were added to the waiting list. Therefore the longest waiters are treated first and we consistently achieve this target. However it is important that we continue to treat all patients as promptly as possible;

4. There are no breaches of 52 weeks forecast for May;

5. The Trust achieved all cancer waiting times in April except for the 62 day target. There were a total of 7 breaches for this target. Five of the seven breaches involved patients on a shared pathway with other hospitals. Four of these breeches sit with Medway Foundation Trust and one with the Royal Marsden. Whilst contact and conversations are held with these trusts, breaches for patients on joint pathways with Medway will remain a risk. Medway has not been reporting its 18RTT since November 2014, and had been planning to commence reporting at the beginning of June, but has now delayed this until the end of July. The two patients that were QVH 62 day breaches needed a complex suite of diagnostics undertaken. However the relevant business managers will be working with the clinicians to understand how these can be flagged up sooner with the appropriate remedial action and whether the diagnostic pathways can be shortened. A Patient Access Manager has been appointed who will add some further capacity to this work;

6. There were no urgent operations cancelled for a second time in May;

7. There were 8 operations cancelled on the day of admission in May, all of which have either been treated as per NHS 28 days guarantee or have chosen to wait;

8. The exact Trust MIU performance in May was not available at the time of writing this report however the Trust has consistently been performing above 95%;

9. The Trust has achieved the 99% diagnostics performance standard and delivered 99.7% of diagnostics, just narrowly missing 100% due to 2 sleep breaches. The Business Manager is working with the sleep team to look at opportunities to ensure the pathway is as efficient as possible.

Implications of results reported

Activity

The activity plan requires recovery to ensure delivery of the financial plan.

18 weeks

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

Cancer

The Trust has not met the 62 day cancer standard for two subsequent months which will attract a penalty.

Actions being taken to sustain compliance

Activity

Each business unit is undertaking a review of the causative factors resulting in lower than planned performance. Plans will be developed to increase capacity and reviewed by executives.

18 weeks

1. Key actions in place:-
    - A further focus on the specialties will be put in place so that there is more emphasis on prospective management of named patients by breach date;
    - There is also a need to further understand available capacity, not just in terms of availably slots, but that the Trust has the capacity to book into these slots and also to treat in these slots;
    - Weekly forecast update is being provided to the Board;
    - Patient Access Manager appointed and commences in the autumn;
    - Extra operating sessions are being organised as required to ensure the Trust continues to maintain compliance;
    - The Trust has opened a further Orthodontic treatment room this month alongside the appointment of a locum consultant to support the achievement of sustainable waiting times within the department. The impact of this against the current activity levels will be closely monitored;
    - The Trust is still also securing extra capacity at Centre for Sight for the more complex corneal patients who cannot currently be treated at QVH, as well as continuing with Saturday operating twice a month. An additional locum Consultant Ophthalmologist is being recruited to further improve the capacity within the speciality to meet demand;
    - Extra clinics are being held to reduce waiting times at off sites particularly for oral surgery.

Cancer

2. Main risks to achieving compliance with cancer waiting times are as follows:-
    - The Trust's cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at QVH, complex multi-organisational pathways and late secondary referrals;
    - Late referrals from off sites are a recurrent issue;
    - Incorrect listing of patients as routine rather than urgent and or suspected cancers.

3. Actions being taken to mitigate the risks include:-
    - Liaising with management teams off site to improve processes for joint pathways;
    - Contacting individual trusts when an immediate breach has occurred due to unavailability of visiting consultant or any other reason, raising our concern and asking them to review systems;
    - New data collection process surrounding cancer waiting times and the cancer outcomes & services dataset (COSD) have been introduced using Infoflex as the single cancer database source for waiting times within the Trust, which will be supported with a revised tracking system in the next few months;
    - Ongoing training of admin teams and reinforcing to junior doctors about the correct listing of patients.

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

4. The performance in month contributes to the financial sustainability objective however there will be penalties applied for failing the 62 day cancer target.
5. 18 RTT and access are an important reflection of QVH's responsiveness to people's needs and effectiveness.

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 25 June 2015
Reference number: 150-15
Report from: Clare Stafford, Director of Finance and Performance
Author: Clare Stafford, Director of Finance and Performance
Report date: 8 June 2015
Appendices: A: Finance report M2

Finance Report M2 May 2015

Key issues

1. The financial performance report details the trust's financial performance for the two months to 31st May 2015.

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	5,220	5,272	(52)	10,016	10,304	(288)
EBITDA	451	466	(15)	574	692	(118)
Surplus	126	137	(11)	(75)	33	(109)
Continuity of Service risk rating (CoSRR)	4	4	-	4	4	-

NB table subject to rounding differences.

2. The Trust delivered a £126k surplus for the month, slightly lower than planned. The cumulative deficit now stands at £109k.

3. The Trust has maintained a Continuity of Service Risk Rating of 4.

Implications of results reported

4. The Trust must continue to improve the throughput of activity in order to deliver the planned level of income and achieve the budgeted surplus.

Action required

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

Link to Key Strategic Objectives

- Operational excellence
- Financial sustainability

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

Implications for BAF or Corporate Risk Register

7. Nothing new to add.

Regulatory impacts

8. The financial performance keeps the Monitor Continuity of Service Risk Rating at 4 and does not have a negative impact on our governance rating.

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
May 2015

Executive Director: Clare Stafford

Contents

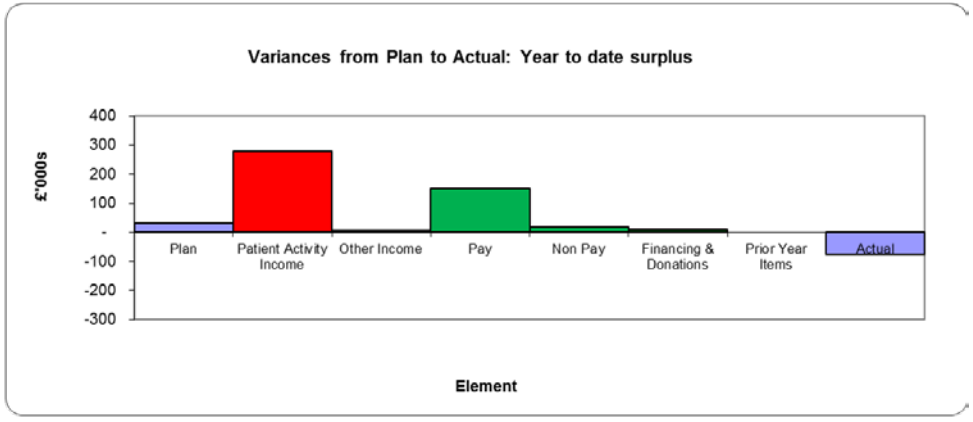
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M02 2015/16

Queen Victoria Hospital NHS Foundation Trust

Financial Performance	2015-16	14-15	May 15-16			14-15	Year to Date 2015-16		
Income and Expenditure	Annual Plan £k	M2 14-15 CM Actual	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	M2 14-15 YTD Actual	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	58,607	*4,733*	4,849	4,910	(61)	*9,077*	9,300	9,580	(280)
Other Income	4,343	*290*	371	362	9	*615*	716	724	(8)
Pay	(40,994)	*(3,340)*	(3,338)	(3,396)	58	*(6,500)*	(6,640)	(6,792)	152
Non Pay	(16,987)	*(1,257)*	(1,431)	(1,410)	(21)	*(2,462)*	(2,802)	(2,819)	17
Operational EBITDA	**4,970**	*426*	**451**	**466**	**(15)**	*730*	**574**	**692**	**(118)**
as a %	*7.9*	*8.5*	*8.6*	*8.8*	*-0.2*	*7.5*	*5.7*	*6.7*	*-1.0*
Financing & Donations	(3,953)	*(263)*	(325)	(329)	4	*(558)*	(649)	(659)	9
Current Year Surplus / (Deficit)	**1,017**	*163*	**126**	**137**	**(11)**	*172*	**(75)**	**33**	**(109)**
Surplus (Deficit) %	1.6%	*3.2%*	2.4%	2.6%	-0.2%	*1.8%*	-0.8%	0.3%	-1.1%

Continuity of Service Risk Rating	Metric	Level 4 threshold	Score	Weighted Score	
Liquidity days	46	0	4	50%	2
Avg Debt Service Cover	1.8	2.5x	3	50%	1.5
Combined Score (1 to 4)					**4**



Summary

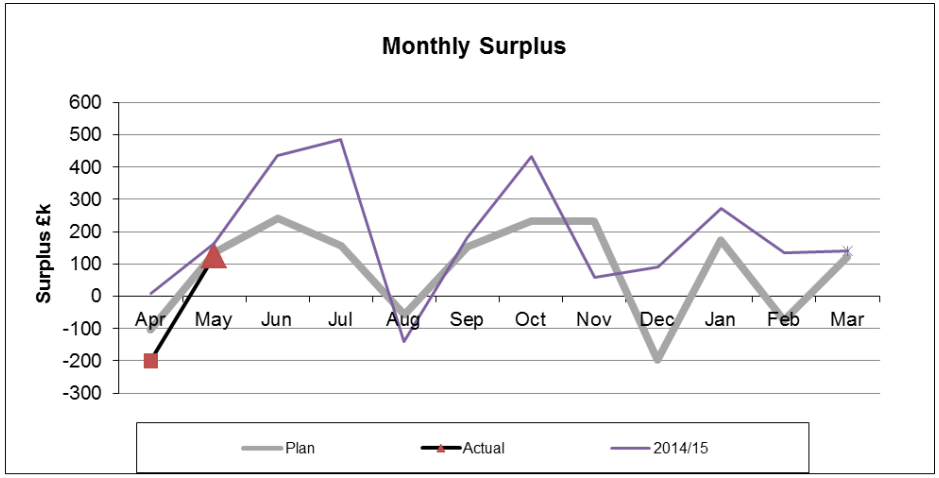
- Month 2 position is a surplus of £126k; £11k behind the plan for the month.
- The year to date position is a £75k deficit, against the plan of £33k surplus; £109k worse than plan.
- The key variance to plan is a shortfall in patient income within the Plastics Division. The Trust's income plan was based on the planned activity for 2014/15, plus additional activity for the investments made in ENT in 2014/15 and Orthodontics and Trauma in 2015/16.

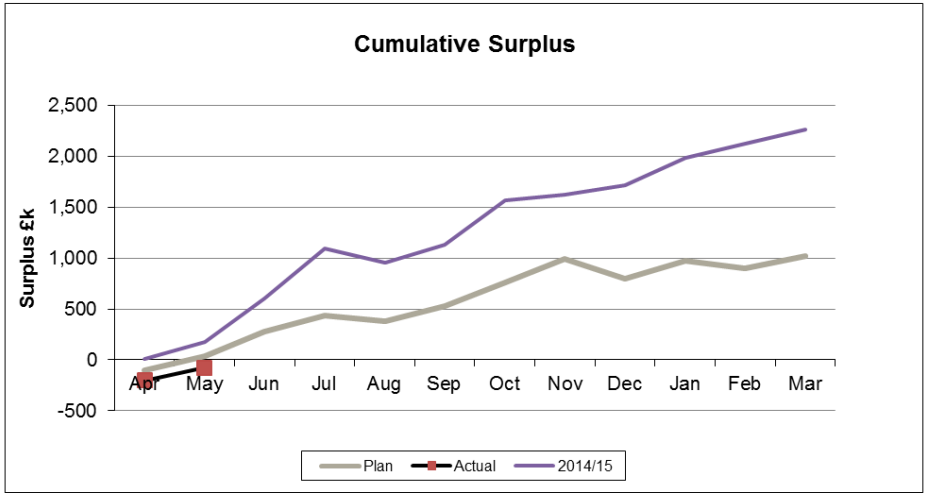
Issues

- The Continuity of service risk rating is 4, as planned.
- The activity plan must be recovered quickly or further expenditure reductions will be required to ensure the Trust delivers the planned surplus.

Summary Surplus Trend Position – M02 2015/16

Queen Victoria Hospital
NHS Foundation Trust





Summary

- The cumulative deficit is £75k

Divisional Performance Summary – M02 2015/16

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Patient Income		Other Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
1 Operations															
1.1 Plastics															
1.11 Breast	(47)	6	(0)	(8)	(1)	(0)	3	6	3,850	281	326	(45)	636	633	4
1.12 Burns	32	(109)	(0)	-	1	2	(0)	1	7,554	668	638	30	1,132	1,244	(111)
1.13 Hands	(72)	(83)	0	4	0	(3)	(9)	(4)	12,890	1,009	1,089	(80)	2,034	2,121	(87)
1.14 Skin	80	2	(2)	2	0	1	(1)	(1)	4,427	451	374	77	732	729	3
1.15 Plastics	-	-	-	-	(15)	(50)	8	4	(3,355)	(286)	(280)	(7)	(605)	(559)	(46)
1.1 Plastics Total	(6)	(185)	(2)	(2)	(15)	(51)	1	6	25,365	2,123	2,147	(25)	3,930	4,167	(237)
1.2 Oral															
1.21 Head & Neck	(26)	(44)	2	4	5	1	10	30	5,605	469	478	(8)	906	915	(8)
1.23 Orthodontic	(33)	(40)	(0)	(0)	9	28	(4)	1	1,739	120	148	(28)	273	284	(11)
1.24 Prosthetics	(10)	8	2	(1)	7	19	5	1	(432)	(32)	(35)	3	(46)	(73)	27
1.2 Oral Total	(69)	(76)	3	3	21	49	11	32	6,912	558	590	(33)	1,133	1,126	8
1.3 Eyes															
1.31 Corneoplastic	(21)	(32)	0	0	30	23	12	7	2,752	239	234	4	415	450	(35)
1.32 Oculoplastic	3	4	-	-	0	0	(3)	(4)	137	12	12	0	22	22	(0)
1.33 Eye Bank	-	-	1	(7)	(0)	(1)	(2)	3	(174)	2	(14)	17	5	(29)	34
1.3 Eyes Total	(18)	(28)	1	(7)	30	23	7	6	2,714	253	232	21	441	443	(1)
1.4 Sleep															
1.41 Sleep	(66)	(92)	(1)	(2)	2	2	32	58	2,013	139	172	(33)	295	328	(33)
1.4 Sleep Total	(66)	(92)	(1)	(2)	2	2	32	58	2,013	139	172	(33)	295	328	(33)
1.5 Clinical Support															
1.51 Imaging	6	17	(15)	(19)	(2)	(6)	(4)	2	299	11	26	(15)	41	47	(6)
1.52 Pathology	-	-	5	10	(1)	(18)	(0)	3	(1,493)	(120)	(124)	4	(255)	(249)	(6)
1.53 Therapies	1	(2)	17	15	12	23	(3)	(1)	(711)	(30)	(58)	28	(87)	(121)	34
1.54 Pharmacy	2	14	2	1	4	5	(18)	(14)	(80)	(17)	(6)	(11)	(9)	(14)	6
1.55 Medical Photography	-	-	(2)	(3)	3	6	(0)	0	(183)	(14)	(15)	2	(27)	(30)	4
1.5 Clinical Support Total	9	29	8	4	16	9	(25)	(11)	(2,168)	(170)	(177)	7	(336)	(367)	32
1.6 Ops Admin															
1.61 Ops Admin	26	(0)	-	-	(0)	(0)	14	19	35	44	3	40	24	5	19
1.62 Elderly	4	3	-	-	(6)	(11)	5	11	5	4	1	3	3	1	2
1.63 Rheumatology	(3)	(5)	-	-	0	(1)	-	-	80	4	7	(3)	7	13	(6)
1.64 Cardiology	(2)	2	-	-	(0)	1	1	1	83	6	7	(1)	18	14	5
1.6 Ops Admin Total	26	0	-	-	(6)	(11)	20	31	204	57	18	40	52	32	20
1 Operations Total	(124)	(351)	9	(4)	48	21	45	122	35,040	2,959	2,981	(22)	5,516	5,729	(212)

Summary

- This analysis shows financial performance by division.
- The yellow highlights indicate areas that need further investigation to recover the position.
- Significant variance to plan:
  - Breast - activity income is £47k below plan in month 2
  - Burns – is £109k behind plan for the year to date. The current month includes a large accrual for a long stay ITU patient
  - Plastics has also overspent by £50k on pay so far this year
  - Hands – is £72k behind on the month
  - Oral and Corneo are also behind on income being offset in the short term by pay savings

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

Divisional Performance Summary – M02 2015/16

Queen Victoria Hospital NHS Foundation Trust

Summary

Issues

Variance by type: in £ks	Patient Income		Other Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
2 Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure															
2.11 Perioperative Care	-	-	(0)	(1)	67	77	(16)	(47)	**(6,949)**	**(529)**	**(579)**	**50**	**(1,128)**	**(1,158)**	**30**
2.12 Elective Care Nursing	-	-	2	4	21	13	19	16	**(4,916)**	**(367)**	**(410)**	**42**	**(787)**	**(819)**	**33**
2.13 Emergency Care Nursing	(11)	(3)	(2)	(3)	0	(49)	(12)	(30)	**(3,180)**	**(287)**	**(263)**	**(24)**	**(618)**	**(533)**	**(85)**
2.14 Anaesthetics	-	-	(2)	(5)	(4)	4	(12)	(19)	**(3,292)**	**(292)**	**(274)**	**(18)**	**(568)**	**(549)**	**(19)**
2.15 Appointments & Records	-	-	-	-	3	2	(5)	(2)	**(648)**	**(56)**	**(54)**	**(2)**	**(108)**	**(108)**	**(0)**
2.1 Clinical Infrastructure Total	(11)	(3)	(2)	(5)	87	47	(25)	(81)	(18,985)	(1,532)	(1,581)	49	(3,208)	(3,167)	(42)
2.2 Quality & Compliance															
2.21 Risk	-	-	(1)	2	2	5	(13)	(3)	**(704)**	**(71)**	**(59)**	**(12)**	**(114)**	**(117)**	**4**
2.22 Clinical Audit	-	-	-	-	2	5	0	0	**(119)**	**(8)**	**(10)**	**2**	**(15)**	**(20)**	**5**
2.2 Quality & Compliance Total	-	-	(1)	2	4	9	(13)	(3)	(823)	(78)	(69)	(10)	(129)	(137)	9
2.4 Practice Development															
2.41 Practice Development	-	-	(1)	1	(0)	(0)	8	13	**124**	**17**	**10**	**7**	**34**	**21**	**14**
2.4 Practice Development Total	-	-	(1)	1	(0)	(0)	8	13	124	17	10	7	34	21	14
2.5 Director of Nursing															
2.51 Director of Nursing	-	-	(1)	(1)	1	3	2	3	**(767)**	**(62)**	**(64)**	**2**	**(122)**	**(128)**	**6**
2.5 Director of Nursing Total	-	-	(1)	(1)	1	3	2	3	(767)	(62)	(64)	2	(122)	(128)	6
2 Nursing & Clinical Infrastructure Tota	**(11)**	**(3)**	**(4)**	**(2)**	**92**	**60**	**(29)**	**(68)**	**(20,451)**	**(1,654)**	**(1,703)**	**48**	**(3,425)**	**(3,411)**	**(13)**

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

Divisional Performance Summary – M02 2015/16

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Patient Income		Other Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
3 Finance and Non Clinical Infrastructure															
3.1 Non Clinical Infrastructure															
3.11 Hotel Services	-	-	(3)	(2)	(2)	1	(14)	(8)	(1,748)	(165)	(146)	(19)	(301)	(291)	(9)
3.12 Estates	-	-	(2)	(3)	3	5	8	18	(1,995)	(157)	(166)	9	(312)	(332)	21
3.13 IMT	-	-	(0)	(0)	2	3	(7)	0	(546)	(51)	(46)	(5)	(88)	(91)	3
3.1 Non Clinical Infrastructure Total	-	-	(5)	(6)	3	10	(13)	10	(4,289)	(372)	(357)	(15)	(701)	(715)	14
3.2 Commercial Development															
3.22 Commerce	-	-	-	-	(6)	(14)	1	1	(563)	(53)	(47)	(6)	(107)	(94)	(13)
3.2 Commercial Development Total	-	-	-	-	(6)	(14)	1	1	(563)	(53)	(47)	(6)	(107)	(94)	(13)
3.3 Finance Department															
3.31 Finance	-	-	0	0	(12)	(25)	(4)	(4)	(992)	(98)	(83)	(16)	(194)	(165)	(29)
3.3 Finance Department Total	-	-	0	0	(12)	(25)	(4)	(4)	(992)	(98)	(83)	(16)	(194)	(165)	(29)
3.4 Finance Other															
3.41 Other I&E	74	74	19	19	(54)	55	(7)	7	(1,133)	(74)	(105)	31	(56)	(211)	155
3.42 Financing	-	-	-	-	-	-	-	-	(3,953)	(325)	(329)	4	(649)	(659)	9
3.43 Suspense	-	-	-	-	-	-	(10)	(23)	-	(10)	-	(10)	(23)	-	(23)
3.44 Income	(0)	0	-	-	-	-	-	-	-	(0)	-	(0)	0	-	0
3.4 Finance Other Total	74	74	19	19	(54)	55	(17)	(16)	(5,086)	(409)	(435)	26	(728)	(870)	141
3 Finance and Non Clinical Infrastructu	74	74	14	13	(69)	26	(33)	(9)	(10,931)	(932)	(922)	(10)	(1,731)	(1,844)	113
4 Human Resources and Organisational Development															
4.1 Human Resources															
4.11 Human Resources	-	-	(0)	1	(1)	(0)	(8)	(7)	(761)	(72)	(63)	(9)	(134)	(127)	(7)
4.1 Human Resources Total	-	-	(0)	1	(1)	(0)	(8)	(7)	(761)	(72)	(63)	(9)	(134)	(127)	(7)
4.2 Education															
4.21 Education	-	-	(5)	(6)	(0)	(1)	1	(0)	5	(4)	0	(4)	(6)	1	(7)
4.2 Education Total	-	-	(5)	(6)	(0)	(1)	1	(0)	5	(4)	0	(4)	(6)	1	(7)
4 Human Resources and Organisational	-	-	(5)	(5)	(2)	(1)	(7)	(8)	(755)	(76)	(63)	(13)	(140)	(126)	(14)
5 Corporate															
5.1 Board															
5.11 Board	-	-	-	-	(15)	28	5	(2)	(654)	(64)	(54)	(10)	(83)	(109)	26
5.1 Board Total	-	-	-	-	(15)	28	5	(2)	(654)	(64)	(54)	(10)	(83)	(109)	26
5.2 Op Mgmt															
5.21 Op Mgmt	-	-	-	-	1	12	(0)	(0)	(855)	(71)	(71)	1	(130)	(143)	12
5.2 Op Mgmt Total	-	-	-	-	1	12	(0)	(0)	(855)	(71)	(71)	1	(130)	(143)	12
5.3 Corporate Affairs															
5.31 Corporate Affairs	-	-	-	-	1	1	(3)	(18)	(337)	(31)	(28)	(3)	(73)	(56)	(17)
5.3 Corporate Affairs Total	-	-	-	-	1	1	(3)	(18)	(337)	(31)	(28)	(3)	(73)	(56)	(17)
5 Corporate Total	-	-	-	-	(14)	41	2	(20)	(1,846)	(165)	(154)	(12)	(286)	(308)	21
6 Medical Director															
6.1 Research															
6.11 Research	-	-	(0)	(0)	4	7	(0)	(0)	(99)	(5)	(8)	3	(10)	(17)	7
6.12 Research Projects	-	-	(4)	(8)	(1)	(2)	0	0	58	(0)	5	(5)	(0)	10	(10)
6.1 Research Total	-	-	(4)	(9)	3	5	0	0	(41)	(5)	(3)	(2)	(10)	(7)	(3)
6 Medical Director Total	-	-	(4)	(9)	3	5	0	0	(41)	(5)	(3)	(2)	(10)	(7)	(3)
Grand Total	(61)	(280)	9	(8)	58	152	(21)	17	1,017	126	137	(11)	(75)	33	(109)

Summary

Issues

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

Balance Sheet – YTD M02 2015/16

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet for: Month 2 2015/16	2014/15 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,705	37,382	37,571
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,705	37,382	37,571
Current Assets			
Inventories	440	440	438
Trade and Other Receivables	8,351	7,137	6,462
Cash and Cash Equivalents	6,548	6,753	7,196
Current Liabilities	(7,880)	(6,591)	(6,672)
Sub Total Net Current Assets	7,459	7,740	7,425
Total Assets less Current Liabilities	45,164	45,122	44,996
Non-Current Liabilities			
Provisions for Liabilities and Charges	(588)	(616)	(616)
Non-Current Liabilities >1 Year	(8,156)	(8,156)	(8,156)
Total Assets Employed	**36,420**	**36,350**	**36,224**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	18,382	18,313	18,187
Revaluation Reserve	5,801	5,801	5,801
Total Tax Payers Equity	**36,420**	**36,350**	**36,224**

NB Analysis is subject to rounding differences

Summary

Issues

- Non-current liabilities will reduce in year due to theatre loan repayments in June and December with a corresponding cash reduction of £778K.
- The loan principal of £11.1million is repayable over 13 years from Dec 2013 to June 2026
- The loan interest is payable from revenue, currently £240k PA.
- Cash balances rely on prompt payment by commissioners. The position has improved but the trust is affected by financial pressures within the health economy.

Capital – M02 2015/16

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	2015/16 Plan £000s	YTD Spend £000s	Ordered £000s	Forecast £000s	2015/16 Total Spend £000s
Estates projects					
14/15 Projects:	-	40	6	-	46
15/16 Projects:					
Corneoplastic electrical upgrade	212	-	2	210	212
Jubilee refurbishment	377	2	18	356	376
Consultants' offices	130	-	-	130	130
Other projects	161	26	24	66	116
Medical Equipment	690	115	61	514	690
IT Equipment					
Infrastructure improvement	2,000	-	-	2,000	2,000
Electronic Document Management	295	-	-	295	295
Smart scheduling	250	-	-	250	250
Other projects	405	40	74	291	405
Grand Total	**4,520**	**223**	**185**	**4,112**	**4,520**

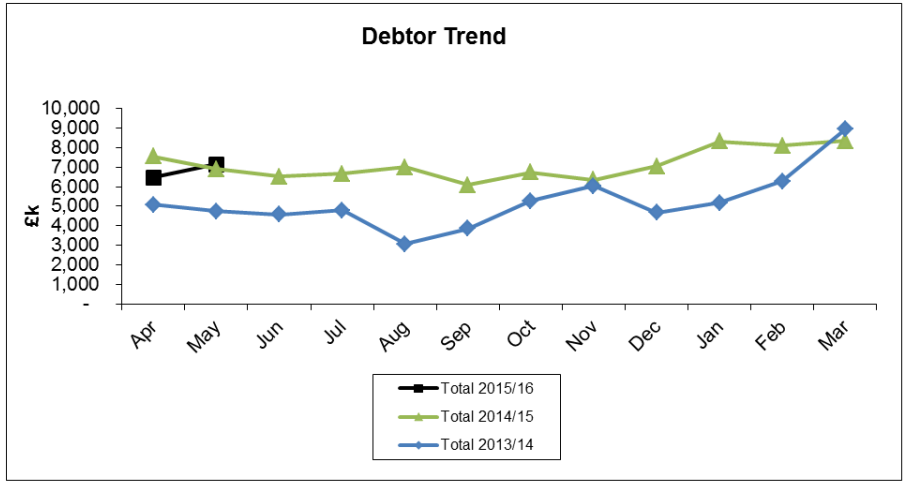
Summary

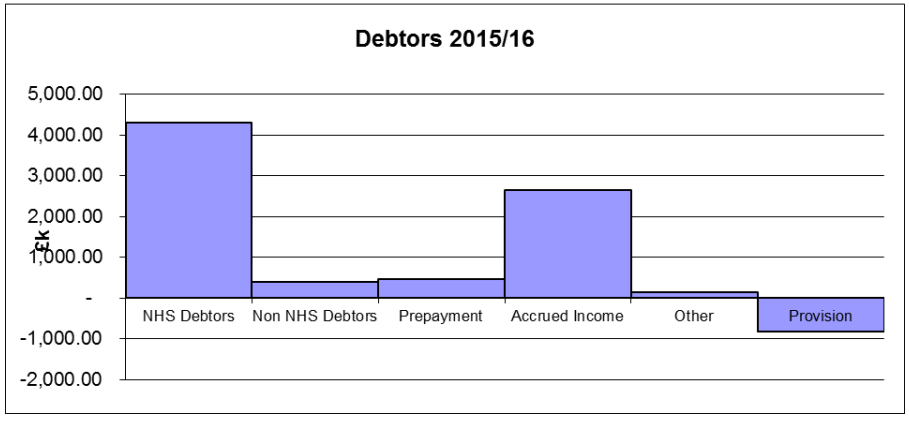
Risks

- Sufficient project management is key to the delivery of capital projects so this is being built into future delivery plans.
- The timing of the programme will be reviewed to ensure schemes are delivered to realistic timescles.

Debtors – M02 2015/16

Queen Victoria Hospital NHS Foundation Trust





Summary

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

Issues

- Debtor balances are at high levels because of some delayed payments and the delay caused by high levels of over-performance. Work continues with commissioners to reduce outstanding balances.
- Accrued income includes income over-performance that is to be agreed and then invoiced.

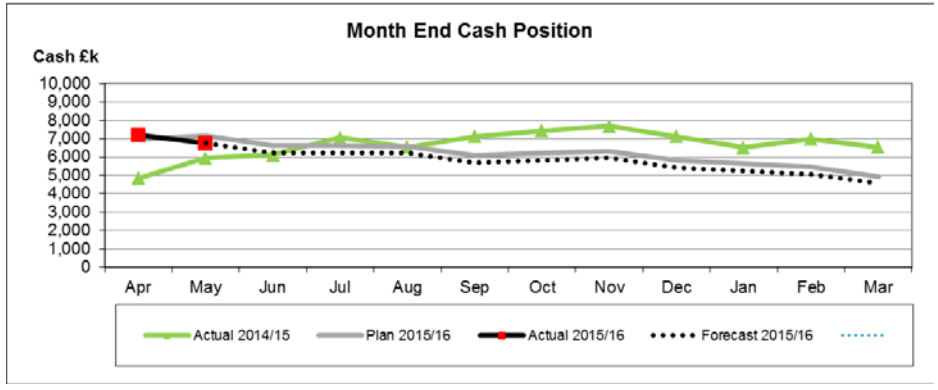
Risks

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

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M02 2015/16



Summary

- The cash balance at month 2 is £6,753k

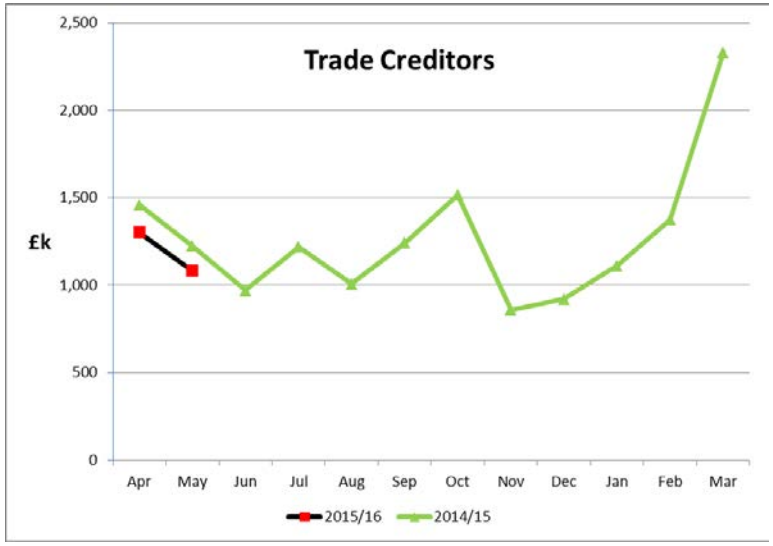
Risks

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

Actions

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

Creditors – M02 2015/16



Better Payment Practice Code May 2015	2014/15 Outturn # Invs	2014/15 Outturn £k	Current Month # Invs	Current Month £k	YTD # Invs	YTD £k
Total **Non-NHS** trade invoices paid	15,882	16,661	1,546	1,547	2,915	3,946
Total **Non NHS** trade invoices paid within target	10,806	11,312	1,294	1,296	2,481	3,494
Percentage of Non-NHS trade invoices paid within target	**68%**	**68%**	**84%**	**84%**	**85%**	**89%**
Total **NHS** trade invoices paid	933	5,241	59	275	170	777
Total **NHS** trade invoices paid within target	505	3,037	51	251	129	611
Percentage of NHS trade invoices paid within target	**54%**	**58%**	**86%**	**91%**	**76%**	**79%**

Summary

- Trade creditors have now dropped back to more normal levels after the peak in month 12 of 14/15 which was due to capital expenditure creditors.

Issues

- Payment performance YTD against the 30 day target has improved significantly this year, but is still below target.
- Daily monitoring of invoices on hold is helping to ensure prompt payment.

Risks

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

Actions

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

Report to:	Board of Directors
Meeting date:	25 June 2015
Reference number:	151-15
Report from:	Clare Stafford, Director of Finance and Performance
Author:	Elin Richardson, Head of Commerce
Report date:	9 June 2015
Appendices:	2015/16 Contract Report

2015/16 Contract Report

Key issues

1. This paper provides an update on commissioner contracts for 2015/16 and background information on the activity assumptions.

2. Final negotiated commissioner agreements have better reflected the prior year's outturn than in previous years. This should minimise the risk of over performance in year.

3. The number of contracts is increasing for roughly the same levels of activity. This introduces a risk to the Trust around the transactional burden of increased reporting in varying formats along with the potential for increased data challenges both in and between contracts.

4. Not all commissioners have been able to provide their activity plans in the level of detail required for uploading into our contract management software and therefore analysis at more granular level (i.e. by commissioner by activity line) is not available this month.

5. Headline performance is available the following conclusions can be drawn:
   - At Month 2 the Trust was under performing against all commissioned activity by £70k.
   - This was driven largely by an under performance in specialised services – underperforming by £265k.
   - There is a long stay burns patient with a significant critical care stay that has not yet been discharged and has not been accrued within these figures – this will remove this under performance in future months.

Implications of results reported

6. Currently the results reported here do not represent adverse implications.

Action required

7. Full activity plans need to be completed to achieve the granularity of monitoring.

8. The increasing transactional burden requires constant review.

Link to Key Strategic Objectives (delete those not applicable)

- Financial sustainability

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

Implications for BAF or Corporate Risk Register

10. There are currently no implications for the BAF or Corporate Risk Register.

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

2015/16 Contract Report

Prepared for Finance and Performance Committee and Board of Directors

9th June 2015

Elin Richardson, Head of Commerce

1.0 Executive Summary

This paper provides an update on commissioner contracts for 2015/16 and background information on the activity assumptions.

Final negotiated commissioner agreements have better reflected the prior year's outturn than in previous years. This should minimise the risk of over performance in year.

The number of contracts is increasing for roughly the same levels of activity. This introduces a risk to the Trust around the transactional burden of increased reporting in varying formats along with the potential for increased data challenges both in and between contracts.

Not all commissioners have been able to provide their activity plans in the level of detail required for uploading into our contract management software and therefore analysis at more granular level (i.e. by commissioner by activity line) is not available this month.

Headline performance is available the following conclusions can be drawn:

- At Month 2 the Trust was under performing against all commissioned activity by £70k.
- This was driven largely by an under performance in specialised services – underperforming by £265k.
- There is a long stay burns patient with a significant critical care stay that has not yet been discharged and has not been accrued within these figures – this will remove this under performance in future months.

2.0 Contract Status for 2015/16

2.1 Signed Agreements

The contract negotiation process for 15/16 has concluded in terms of all contracts being agreed in principle. There were no escalated disputes. In terms of each individual agreement the status is as follows:

- CCG Commissioned Services – signed.
- NHS England Commissioned Services (i.e. dental and specialised) – agreed in principle. We are currently awaiting contract documentation and detailed activity plans.

- Sussex MSK Partnership for Mid Sussex – 14/15 contract extended. 15/16 elements agreed in principle and contract documentation to be agreed.
- Sussex MSK Partnership for East Sussex – this is a new contract where negotiations have started.
- AQP Non Obstetric Ultrasound was a 3-year contract now entering the 3rd year.

2.2 Estimated Annual Contract Values

Estimated Annual Contract Values (EACV) are the total full year values that commissioners anticipate they will spend with the Trust. These are split into 12 monthly payments where actual activity is then reconciled and under performance credited or over performance invoiced. These have been received for all our contracts except the East Sussex MSK contract which is under negotiation.

Commissioners take varying approaches to setting their EACVs – some, but not all, include growth; the majority include reductions associated with their own QIPP schemes.

These are detailed in appendix 1 below and show the variance from the 14/15 outturn. This shows that CCGs reduced their overall values by £300k – less that 1% of their total 14/15 outturn. This is expected to further reduce because a new contract will be agreed for the provision of East Sussex MSK. NHS England have anticipated greater reductions in dental activity - £263k in total which is 2%.

These final EACVs better reflect the prior year's outturn than in previous years where the gap has been significantly greater. This should minimise the risk of over performance in year. However the number of contracts is increasing for roughly the same levels of activity. This introduces a risk to the Trust around the transactional burden of increased reporting in varying formats along with the potential for increased data challenges both in and between contracts.

2.3 Indicative Activity Plans

Indicative Activity Plans are the detailed plans underpinning the EACVs. These are at point of delivery (POD) and HRG level. These have currently only been received for the CCG commissioned services. All plans are required to be loaded together into our contract management software and therefore without the others, POD level reporting against commissioner plans is not available this month. However headline performance data is available and covered in section 3 below.

2.4 Activity Planning Assumptions

In developing the EACVs and IAPs commissioners should set out their activity planning assumptions by which the Trust can be monitored in year. Should these assumptions not be met processes for review and potentially withholding payment can be put into place.

A summary of these activity planning assumptions is shown below in Appendix 2.

3.0 Headline Performance at Month 2

Although POD level analysis against commissioner plan is not available for Month 2, overall performance is available and is shown below.

Table 1 – Month 2 YTD Income against Commissioner Plans

Commissioner	Month 2 YTD plan	Month 2 YTD actual	Variance YTD
General Acute Contract (CCG commissioned)	£5,612,080	£5,630,861	£18,781
NHS England - Dental	£1,944,000	£2,085,571	£141,571
NHS England - Specialised	£1,210,333	£944,748	-£265,585
Non Contract Activity	£251,883	£273,264	£21,381
Sussex MSK Partnership	£90,045	£85,292	-£4,753
AQP Non Obstetric Ultrasound	£26,115	£31,282	£5,167
Overseas Visitors	£3,603	£15,366	£11,763
Private Patients	£5,842	£8,837	£2,996
Military	£406	£279.10	-£127
Offender Health	£1,391	£211	-£1,180
WHSSC	£156	£144.00	-£12
Sub Total CCGs	**£9,145,854**	**£9,075,855**	**-£69,999**

This shows that overall the Trust is behind commissioner plans by £70k (0.7%) driven predominantly by an under performance in specialised activity. However there is a long stay burns critical care patient that has not been accrued for in these figures that will remove the majority of that under performance when the patient is discharged.

Chart 1 below shows the total income per month for CCG commissioned services over a period of 14 months. This shows total income in line with the final quarter of 14/15 and similar to Months 1 and 2 of last year.

Chart 1 – Total Income from CCG commissioned services

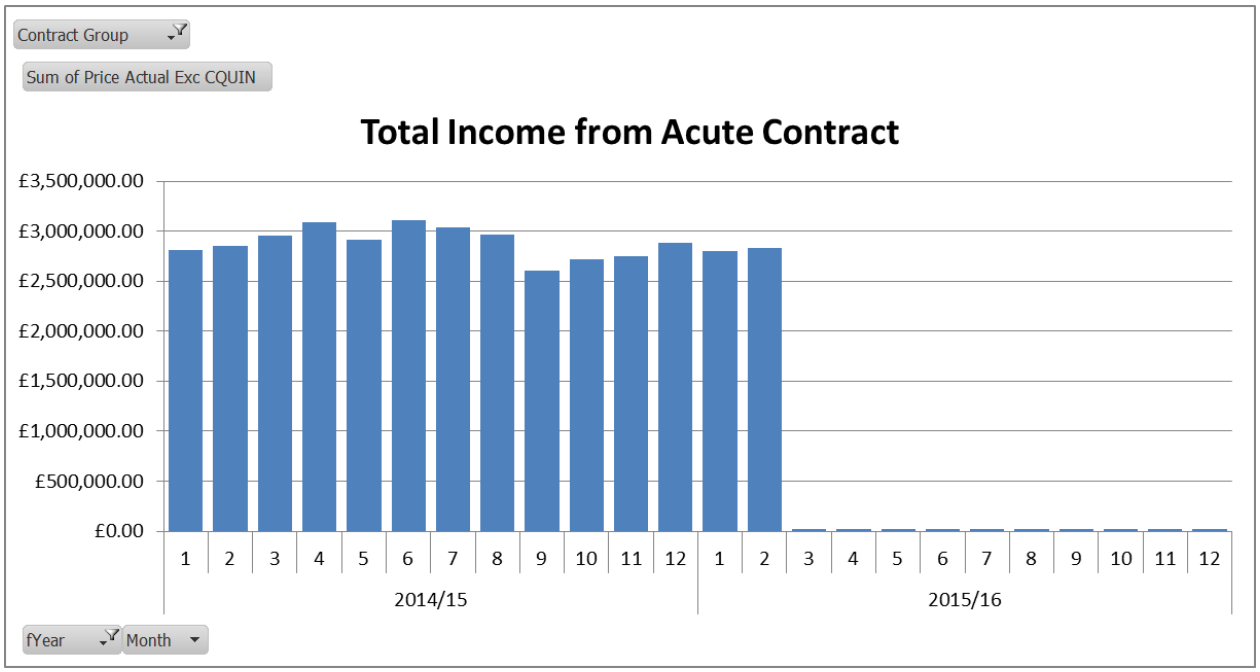


Chart 2 below shows, for the CCG commissioned services, the trends for admitted patient care (day cases, inpatient electives and non electives) over the same time period.

Chart 2 – Admitted Patient Care for CCG commissioned services

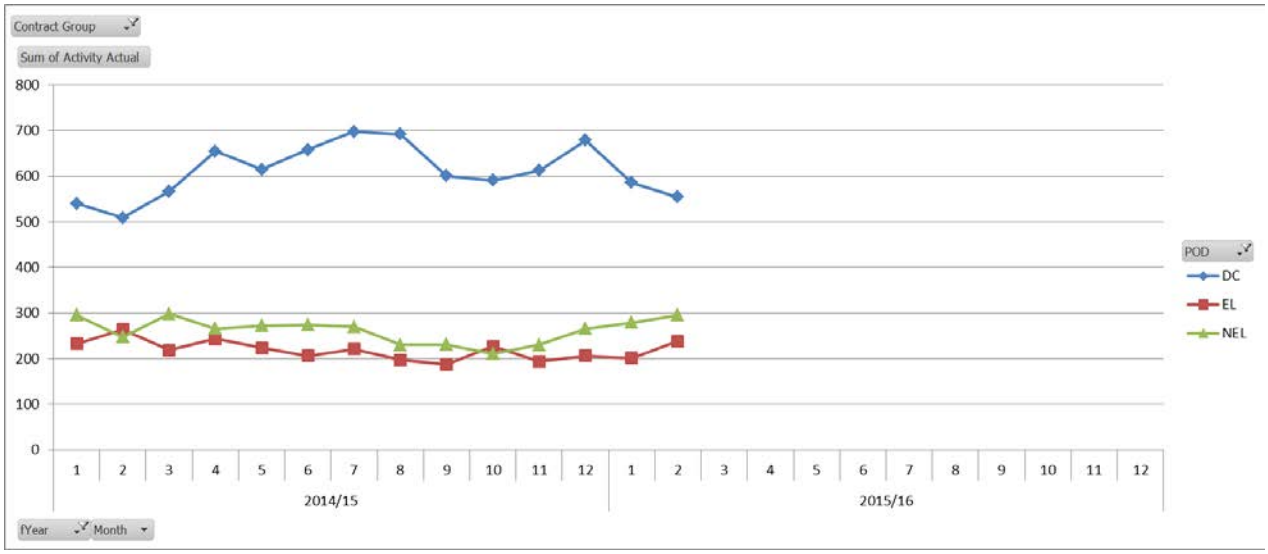


Chart 3 below shows the total income per month for NHS England commissioned dental services over a period of 14 months. This shows total income in line with the previous year.

Chart 3 – Total income from NHS England dental commissioned services

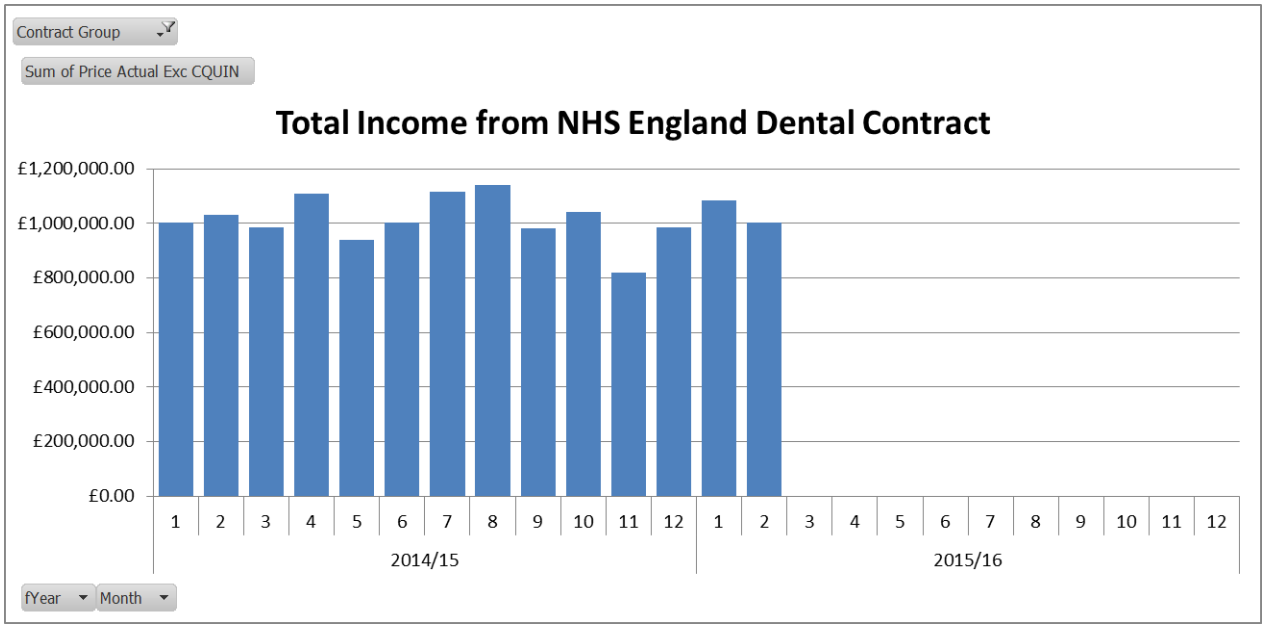


Chart 4 below shows, for the NHS England dental commissioned services, the trends for admitted patient care (day cases, inpatient electives and non electives) over the same time period.

Chart 4 – Admitted Patient Care for NHS England dental commissioned services

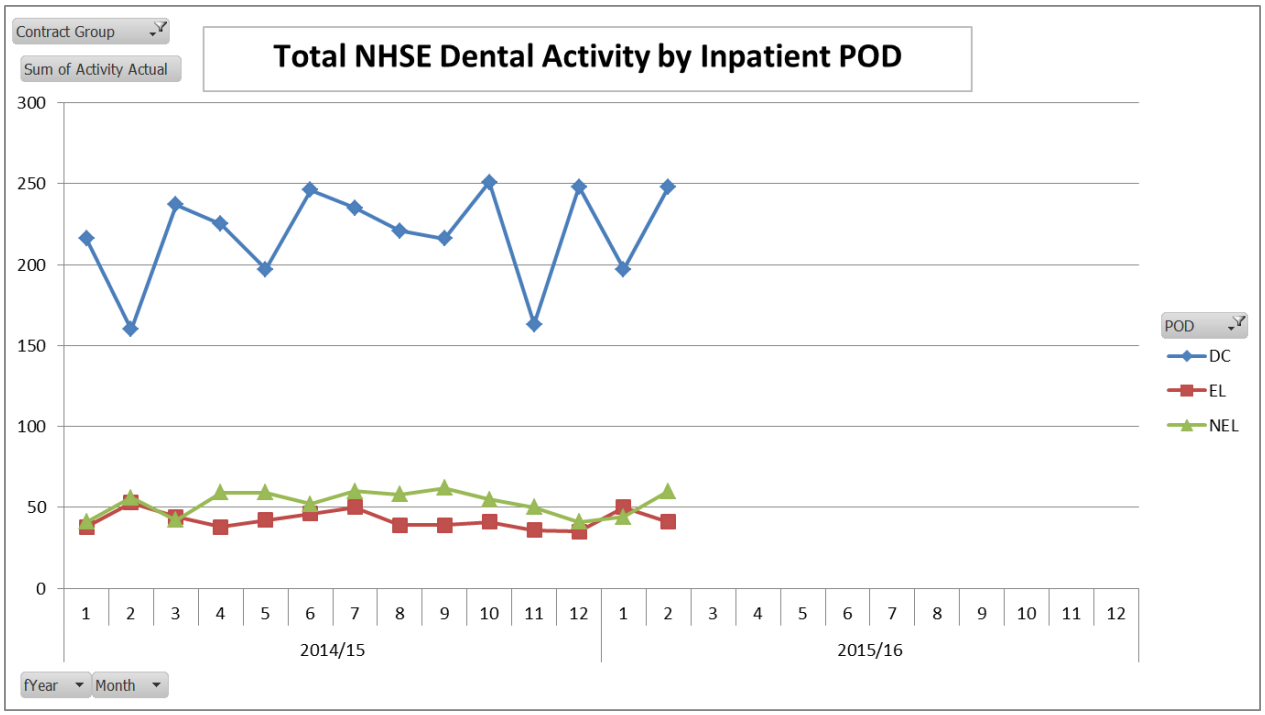


Chart 5 below shows the total income per month for NHS England specialised commissioned services over a period of 14 months. This shows the lower performance in Months 1 and 2 when compared with the previous year and accounting for the under performance to plan. However, as mentioned, there is a long stay burns patient with critical care bed days that has not been accrued for in these figures. The specialised contract averaged 28 critical care bed days per month last year whereas in the first two months of this year the average was 5 per month. This is highlighted in Chart 6.

Chart 5 – Total Income from CCG commissioned services

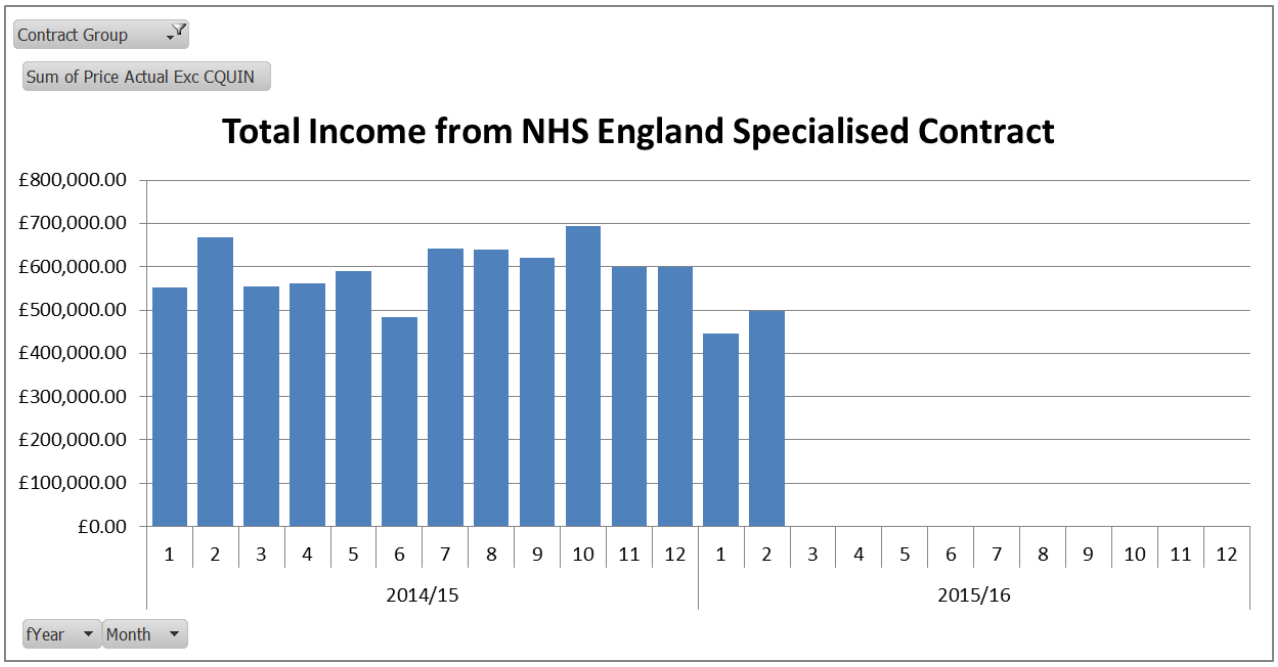
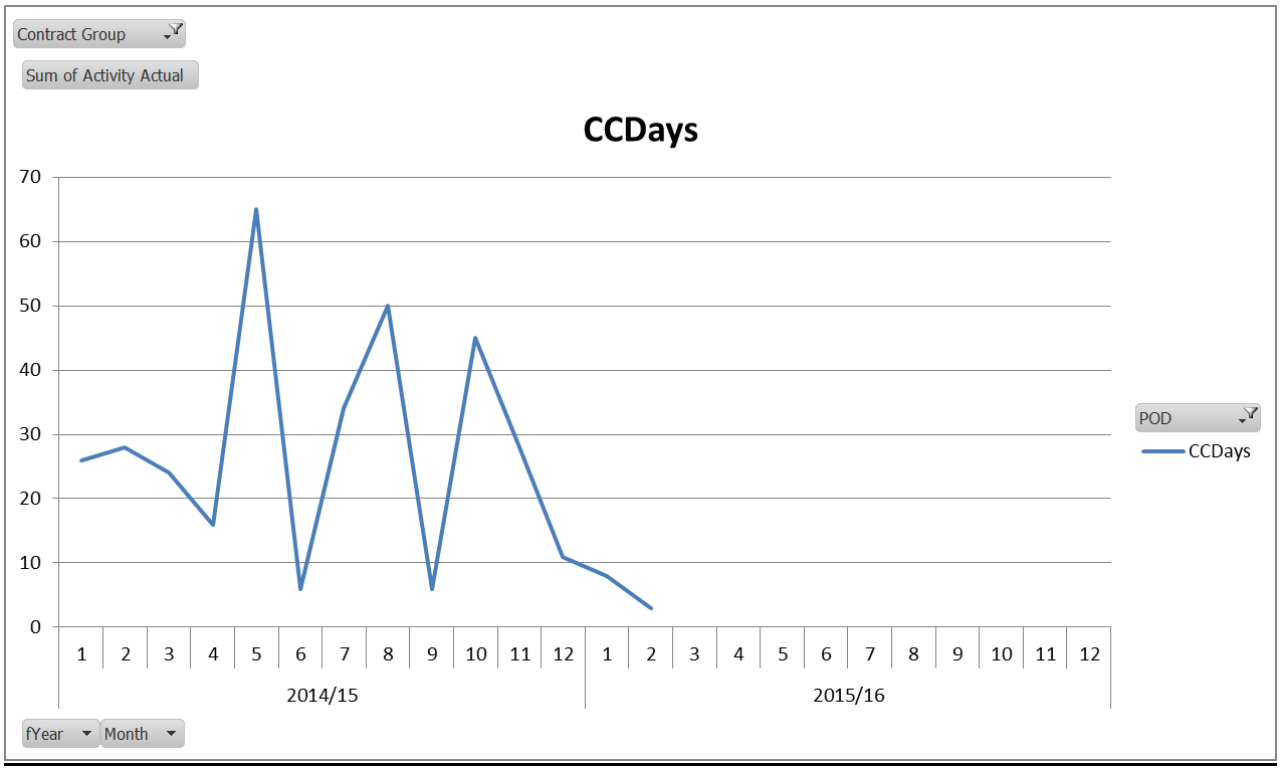


Chart 6 – Critical Care bed days within NHS England Specialised Services contract



End.

Appendix 1 – Comparison of Commissioner EACVs with Month 12 2014/15 Outturn

CCG Name	EACV	M12 Actual	Variance to M12 actual	Notes
NHS HORSHAM AND MID SUSSEX CCG	£4,987,290	£5,409,192	-£421,902	
NHS WEST KENT CCG	£4,729,674	£4,948,804	-£219,130	
NHS HIGH WEALD LEWES HAVENS CCG	£3,134,058	£3,326,141	-£192,083	£96k of this reduction is MSK for which there is no sub contract
NHS EAST SURREY CCG	£2,745,005	£2,581,187	£163,818	
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG	£2,481,681	£2,357,622	£124,059	
NHS MEDWAY CCG	£2,480,309	£2,399,157	£81,152	
NHS COASTAL WEST SUSSEX CCG	£2,111,435	£2,004,573	£106,862	
NHS HASTINGS AND ROTHER CCG	£1,717,086	£1,684,704	£32,382	
NHS CRAWLEY CCG	£1,529,038	£1,582,777	-£53,739	
NHS BRIGHTON AND HOVE CCG	£1,040,279	£1,009,664	£30,615	
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	£1,027,420	£1,042,528	-£15,108	
NHS SWALE CCG	£956,597	£953,780	£2,817	
NHS SURREY DOWNS CCG	£764,171	£768,475	-£4,304	
NHS CANTERBURY AND COASTAL CCG	£695,817	£679,166	£16,651	
NHS SOUTH KENT COAST CCG	£766,134	£749,492	£16,642	
NHS BEXLEY CCG	£574,857	£561,623	£13,234	
NHS BROMLEY CCG	£646,102	£580,003	£66,099	
NHS ASHFORD CCG	£523,530	£540,454	-£16,924	
NHS GUILDFORD AND WAVERLEY CCG	£432,896	£427,542	£5,354	
NHS THANET CCG	£496,270	£465,823	£30,447	
NHS CROYDON CCG	£373,098	£306,674	£66,424	
SUSSEX MSK PARTNERSHIP	£540,269	£139,168	£401,101	This contract was only in operation for 3 months. The remainder is within the outtrun position of the mid-Sussex CCGs.
Sub Total CCGs	**£34,212,747**	**£34,518,549**	**-£305,802**	
NHS England - Specialised Services	£7,262,000	£7,218,756	£43,244	
NHS England - Dental - Surrey and Sussex	£5,041,000	£5,107,000	-£66,000	
NHS England - Dental - Kent	£6,181,000	£6,378,000	-£197,000	
NHS England - Dental - London	£442,000	£442,000	£0	
Sub Total NHS England	**£18,926,000**	**£19,145,756**	**-£219,756**	
NCA	£1,511,299	£1,511,299	£0	
AQP NOUS	£156,690	£156,690	£0	
Private	£35,050	£35,050	£0	
OSV	£21,618	£21,618	£0	
Offenders	£8,347	£8,347	£0	
Military	£2,438	£2,438	£0	
WHSSC	£935	£935	£0	
GRAND TOTAL	**£54,875,124**	**£55,400,682**	**-£525,558**	

Appendix 2 – Summary of Activity Planning Assumptions

Group	Activity Area	Standard required (threshold)	Assessment Method	Consequence of Breach	Review period
Elective	Low Priority Procedures (Prior Approval Schemes) – Ensure that for any procedures identified within the Clinical Policies document that they are undertaken in line with the requirements of the same, or that a prior approval has been received from the CCG	100% compliance with each Commissioner's policy & procedure	SUS data, reviewed monthly using an SPC approach. Trust to investigate activity as required	Non Payment of activity listed agreed as a result of the investigation.	M
Elective	MSK services for Bexley CCG (now chargeable to Kings College as Lead Accountable Provider)	100% compliance with CCG criteria	SUS data, reviewed monthly	Data challenge, non-payment for activity included in CCG criteria	M
Elective	MSK services for Brighton & Hove CCG, Crawley CCG and Horsham & Mid Sussex CCG	100% compliance with CCG criteria	SUS data, reviewed monthly	Data challenge, non-payment for activity included in CCG criteria	M
Elective	MSK Services for Eastbourne, Hailsham & Seaford CCG and High Weald, Lewes & Havens CCG	100% compliance with CCG criteria	SUS data, reviewed monthly	Data challenge, non-payment for activity included in CCG criteria	M
Elective	Ophthalmology / Plastics Services for High Weald, Lewes & Havens CCG	4% reduction on current New to Follow up ratio	SUS data, reviewed quarterly	Investigate activity as required with agreed actions	Q

Group	Activity Area	Standard required (threshold)	Assessment Method	Consequence of Breach	Review period
Elective	Pre-operative bed days	Monitor total numbers	Review of quarterly SUS Data	Investigate activity as required with agreed actions.	Q
Elective	WA14Z's (Planned Procedures Not Carried Out)	4% reduction on Trust WA14Z admissions where the coding identifies the reason as being within the Trust's control.	Review of quarterly SUS Data.	Non Payment of activity over threshold	Q
In patients	Excess Bed days as a proportion of total Bed days	4% productivity improvement against 14-15 outturn.	Review of quarterly SUS Data	Non Payment of activity over threshold	Q
Out-Patients	Consultant to Consultant referrals – to ensure adherence to consultant to consultant policy and PbR guidance	Compliance with the policy. Ratios to be agreed based on number of First outpatient appointments in 2014/15.	SUS data, reviewed monthly using an SPC approach. Trust to investigate activity as required	As outlined in the Consultant to Consultant Policy	Q
Out-patients	Out-patient New to Follow Ups	Monitor ratios by Specialty	Review of quarterly SUS Data	Investigate activity as required with agreed actions.	Q

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th June 2015
Reference number:	152-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	17th June 2015
Appendices:	Workforce report appendix A

Workforce Report Update – June 2015

Key issues

1. Turnover has fallen to just over 15% following a downward trend towards the Trust target of 11%. This remains under close monitoring but indicates that the improvements in recruitment and retention are beginning to have a positive effect.

2. Changes to the recruitment process are being implemented including a regular survey of new starters (included this month). Rotational posts in nursing have been advertised and supported by Brighton University and anticipating that we may have gaps in our junior doctors for Plastics we have over recruited to Trust posts to minimise the impact of those provided through the Deanery.

3. Agency costs have reduced following the introduction of overtime rates for bank work. This is part of the 3 month pilot which is likely to be extended to allow for consultation with staff side on the introduction of a single enhanced flat rate for substantive QVH staff undertaking bank work. Options for this are currently being modelled.

4. The Trust sickness absence rate increased slightly as a result of an increase in planned operations/medical procedures. The changes in Occupational Health provision will help to support an overall reduction this year as well as the support from HR to managers on helping to manage more effectively sickness. Rapid access to Trust services for QVH staff is also to be introduced in the year.

5. Whilst not covered in the report we have received feedback for the GMC survey completed by our junior medical staff. This follows concerns raised by juniors last year which have been reviewed and actions taken. The outcomes form the latest survey are very positive with all but one area now rated as very good.

Implications of results reported

6. The Trust's workforce performance is good and whilst there are areas for improvement the actions taken to address them are impacting positively. Close monitoring will continue

however particularly in relation to turnover, statutory and mandatory training, recruitment and appraisals.

Action required

7. The Director of HR/OD maintains close monitoring of objectives identified within this report to ensure progress or remedial action as required.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

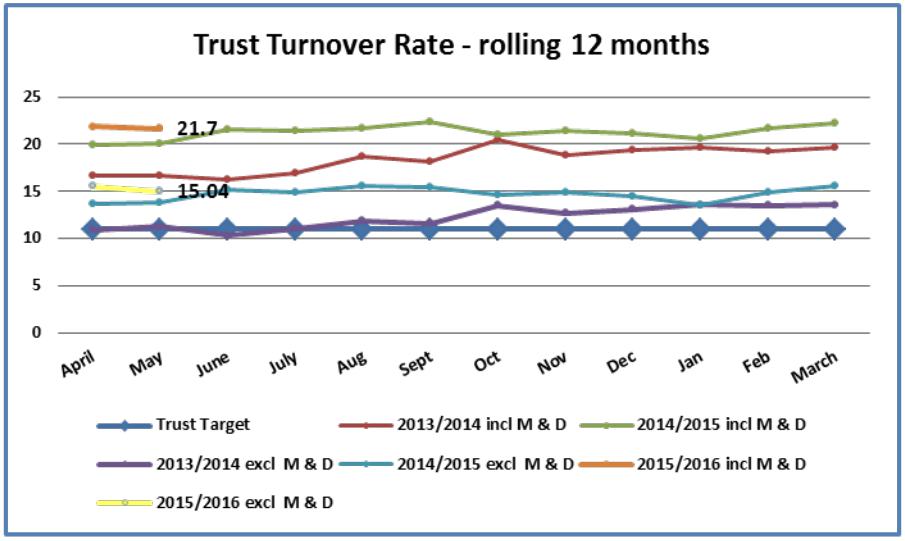
Implications for BAF or Corporate Risk Register

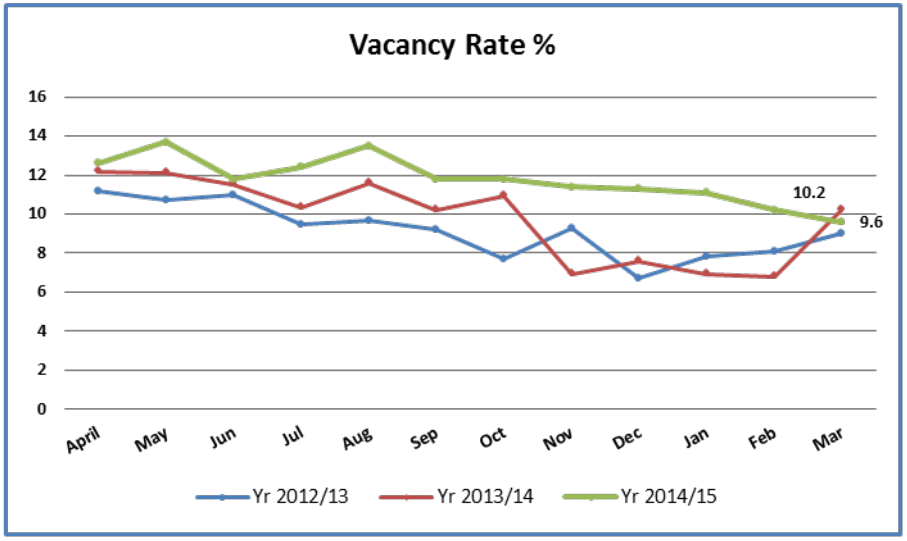
8. The issues raised at paragraphs 1 – 5 above are closely monitored. The mitigations are currently felt to provide assurance that these issues are not impacting negatively on the Trust's overall performance.

Recommendation

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

HEADLINE HR KPIs June 2015





Staff Movements

	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb15	Mar 15	Apr 15	May 15
Headcount	966	967	965	957	961	965	966	965	973	965	979	978	977
WTE in Post	816.07	816.78	816.79	816.79	812.47	816.49	818.86	818.48	825.73	820.25	832.99	830.22	828.82
WTE Funded Establishment	897.51	897.51	897.51	897.51	897.51	897.18	897.14	897.14	897.14	897.14	897.14	N/A	N/A
New Hires	7	19	10	23	24	23	12	8	15	26	16	10	6
Leavers	9	21	12	44	17	17	12	12	7	33	19	7	8
Maternity Leave	20	17	16	19	20	18	16	16	13	13	12	14	14
Vacancy Rate	13.7%	11.8%	12.4%	13.5%	11.8%	11.8%	11.4%	11.3%	11.1%	10.2%	9.6%	N/A	N/A
Turnover Rate Headcount	1.04%	2.18%	1.35%	4.62%	1.77%	1.76%	1.24%	1.24%	0.72%	3.42%	1.94%	0.72%	0.82%
Turnover Rate (FTE)	0.93%	2.07%	1.24%	4.49%	1.69%	1.66%	1.14%	1.15%	0.66%	3.60%	1.96%	0.64%	0.87%

Rolling 12 Monthly Turnover Figures

	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov14	Dec14	Jan 15	Feb 15	Mar 15	Apr 15	May 15
12 Month Turnover (including Medical & Dental)	20.15%	21.55%	21.45%	21.66%	21.61%	20.97%	21.47%	21.09%	21.70%	21.84%	22.24%	21.90%	21.67%
12 Month Turnover (Excluding Medical & Dental)	13.79%	15.19%	14.93%	15.57%	14.87%	14.74%	14.96%	14.50%	14.95%	15.15%	15.61%	15.58%	15.04%

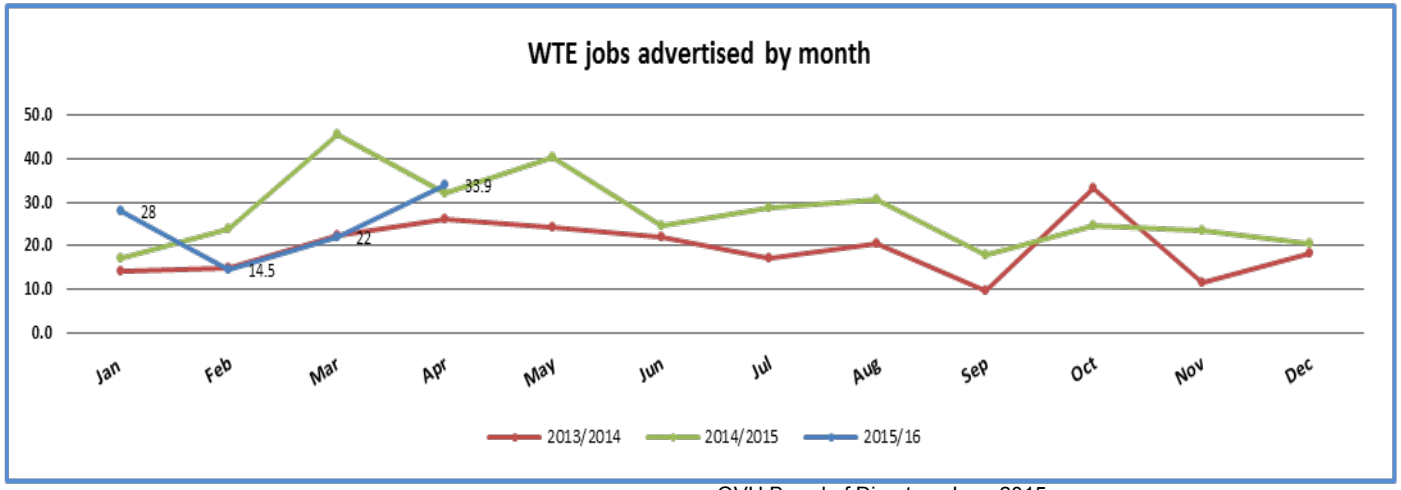
HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Staff turnover in the Trust for the last 12 month rolling period ending May 2015 (excluding Medical and Dental) has reduced slightly to 15.04% compared to the previous 12 month rolling period for April 2015 which was 15.58%.

There were 8 leavers (5.19 FTE) in May 2015, a monthly turnover rate of 0.82 % representing a decrease of 0.10% compared to April 2015. The Leavers for May 2015 were from Nursing, Medical and Dental, Admin and Clerical, Additional Clinical Services and Add Prof Scientific and Technical. The reasons for leaving included 1 member of staff who retired. There were 5 voluntary resignation, which included 1 - promotion to another Trust, 1 – child dependents, 1 – relocation and 2 – reason unknown. Medical and Dental had 2 leavers which were due to the end of their fixed-term contract.

HR&OD implemented a new exit questionnaire at the end of May 2015 to capture feedback from leavers, so that concerns can be addressed. All leavers will now be asked to either complete an online leavers survey, or as an alternative have an interview with HR or a designated manager. HR will analyse leavers feedback to address concerns raised and share with managers where appropriate. It is anticipated that the choice given to leavers will result in higher numbers of staff providing valuable feedback.



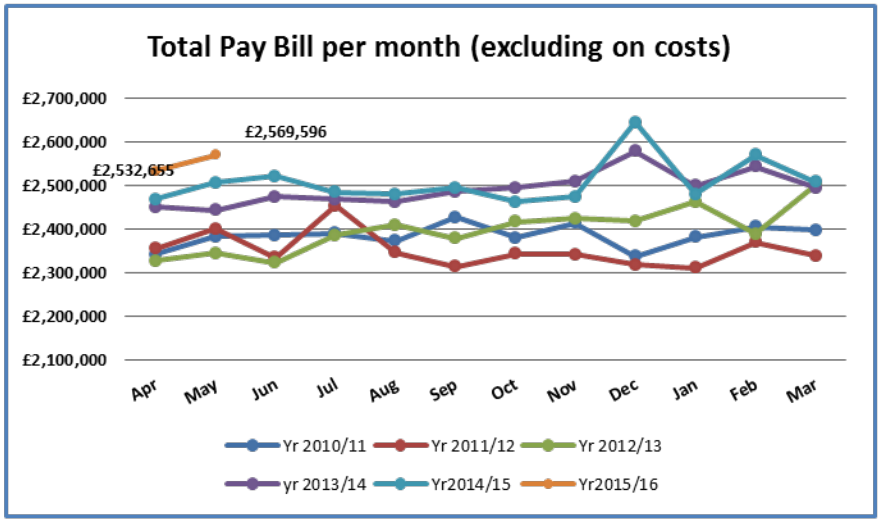
RAG Rating

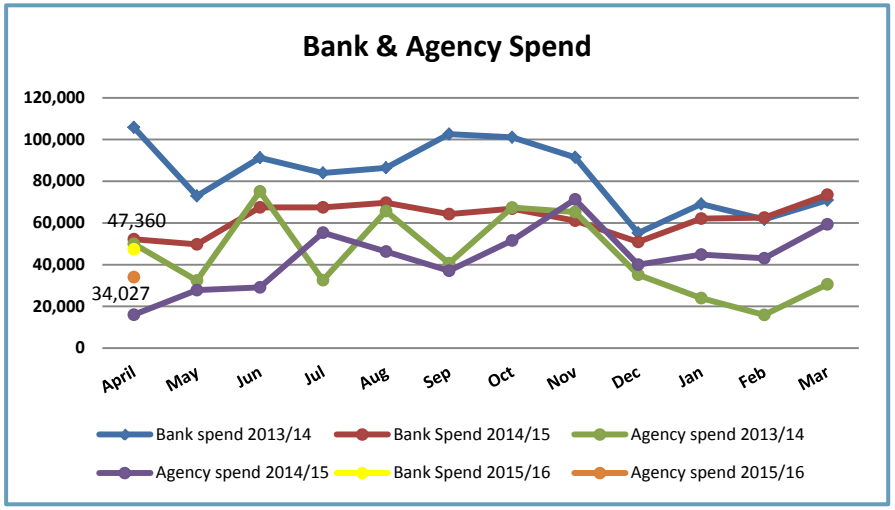
HEADLINE HR KPIs

HEADLINE HR KPIs

Survey Question	Excellent	Good	Satisfactory	Inadequate	Poor
Quality of the advertisement	62%	38%	0%	0%	0%
Information about the post	42%	58%	0%	0%	0%
The overall application process	54%	46%	0%	0%	0%
The interview arrangements	62%	38%	0%	0%	0%
The structure of the interview	62%	38%	0%	0%	0%
Notification of the interview outcome	77%	23%	0%	0%	0%
Responsiveness of the recruitment team	62%	38%	0%	0%	0%
The overall recruitment process	54%	46%	0%	0%	0%

HEADLINE HR KPIs





Pay Bill – (1 months in arrears) the total pay figures, reported does not include on costs. Pay for May 2015 has increased slightly by £25,518 to £2,532,655. April and May has always seen a rise in pay due to budgets being released, and incremental increases.

A breakdown of the split between the total WTE (Whole Time Equivalent) staff paid in the Trust and the WTE for bank/agency/overtime paid is reported in arrears. For March 2015 this showed that the WTE staff in post was 832.99. However the total WTE paid includes 35.58 WTE Bank Staff, 59.54 WTE Agency Workers (excluding RMNs) and 3.18 WTE of over-time hours worked was 931.29 WTE. The Budgeted establishment inclusive of temporary staffing is budgeted at 902.71, currently the paid WTE inclusive of temporary staffing is at 931.29, which indicates that the paid WTE is over the budgeted establishment by 28.58 WTE for March.

Payroll

All staff were paid on time and in accordance with the agreed timetable and pay advices (slips) were all distributed on time. All payments were made to correct bank accounts and employees. Payroll accuracy remains at 99.98% month on month. No complaints were received in the period.

There were 3 new overpayments for April 2015. The overpayment was due to Incorrect calculation of Tax and National Insurance and set up error for a new starter. A recovery plan is in place for one of the overpayments, we are still to receive notification of a plan for the other. Interim payments increased from 2 to 5 and payroll errors remained at 0.

RAG Rating

HEADLINE HR KPIs

RAG Rating

Bank and Agency usage – (figures are 2 month in arrears)
Bank expenditure for April 2015 has decreased by 35.5% to £47,360. This may be due to the pilot scheme that is in place at the current time, this can only be clarified when the final expenditure on overtime has been reviewed in August 2015. Agency expenditure (excluding RMN) has decreased by 27% to £34,027.

The Bank fill rate for April 2015 is at 82.4%, and in total 7193 hours were requested, 4740 hours were filled by bank staff and 1672 were filled by agency workers, resulting in 781 hours that were not filled. The unfilled hours were either not required or covered by overtime or additional hours worked by part time staff.

The temporary three month pilot aimed at reducing agency costs has now been operating for 6 weeks, preliminary figures indicate a reduction in Agency use but this needs to be monitored over the full 3 months of the pilot to ensure the reasons for the reduction are attributable to the pilot.

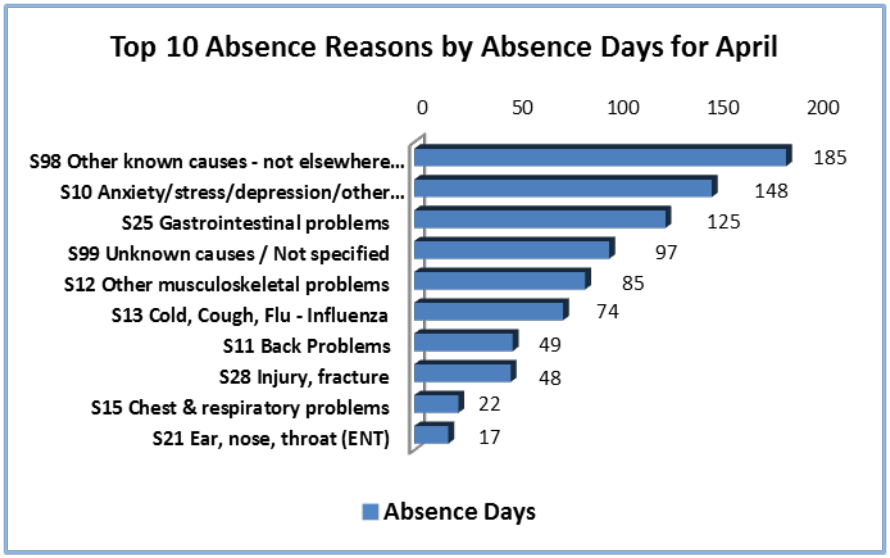
Work is now underway to agree a single enhanced rate for bank payable to our substantive staff across the Trust. Consultation with staff-side representatives will commence in July 2015. Discussions with Matrons and the Deputy Director of Nursing on this have been useful and a number of options are currently being costed.

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

- ITU which saw a slight rise in expenditure for Bank and agency staff, with a combined amount of £21,810. This is an increase of £1127 (5.1%). The increase in expenditure is due to establishment vacancies.
- Canadian Wing which saw a fall in expenditure for bank and agency staff, with a combined amount of £21,439. This is a decrease of £16,893 (44%) over bank and agency expenditure for March 2015.
- Corneo nursing saw a decrease in expenditure for both bank and agency staff, with a combined expenditure of £8,389. This is a decrease of £3958 (32%) over bank and agency expenditure for March 2015.

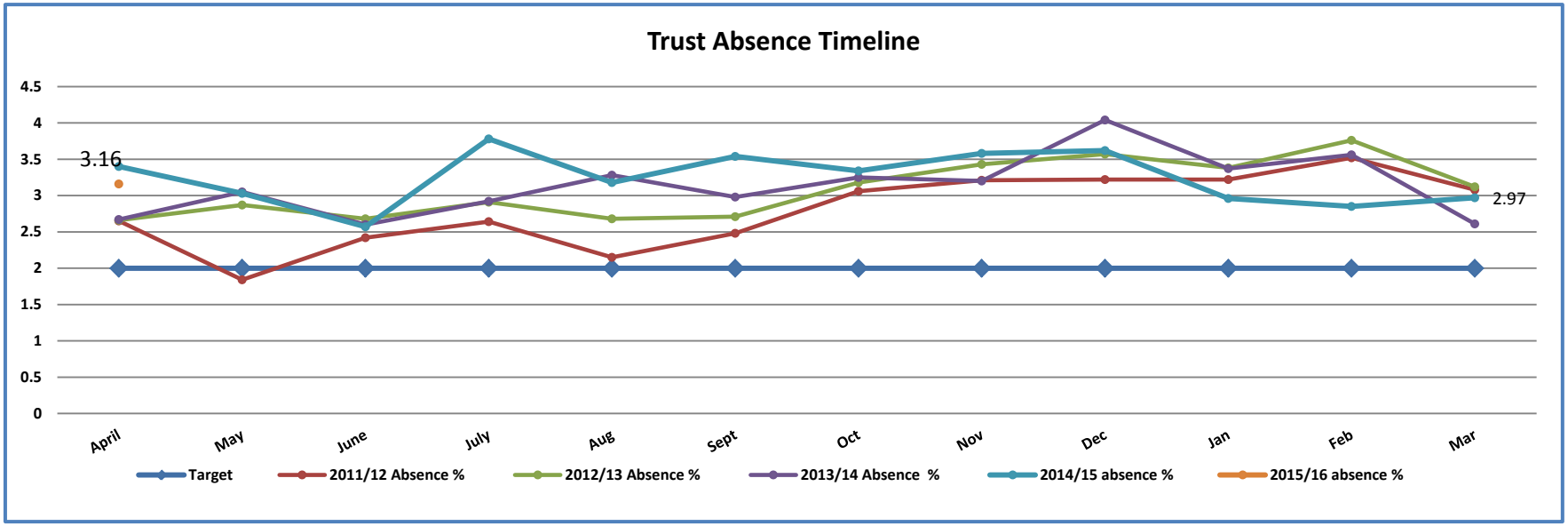
Actions
- Monitor controls put in place and review in month by month.
- Senior managers to sign off before any bank or agency agreed to avoid unnecessary use of bank/agency workers.
- Tighter financial controls on departments budgeted establishment.

HEADLINE HR KPIs



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

Staff Group	FTE days lost	Estimated Cost
Add Prof Scientific and Technical	122.29	£12,193
Additional Clinical Services	121.84	£8,012
Administrative and Clerical	137.57	£9,752
Allied Health Professionals	26.72	£2,338
Estates and Ancillary	68.26	£3,750
Healthcare Scientists	0.00	0.0
Medical and Dental	49.15	£6,780
Nursing and Midwifery Registered	252.61	£25,781
Total	778.44	£68,605



HEADLINE HR KPIs

RAG Rating

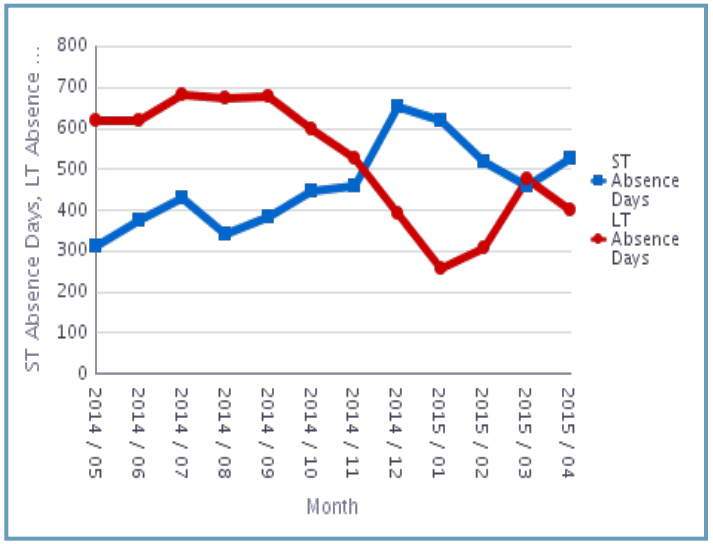
Sickness Absence

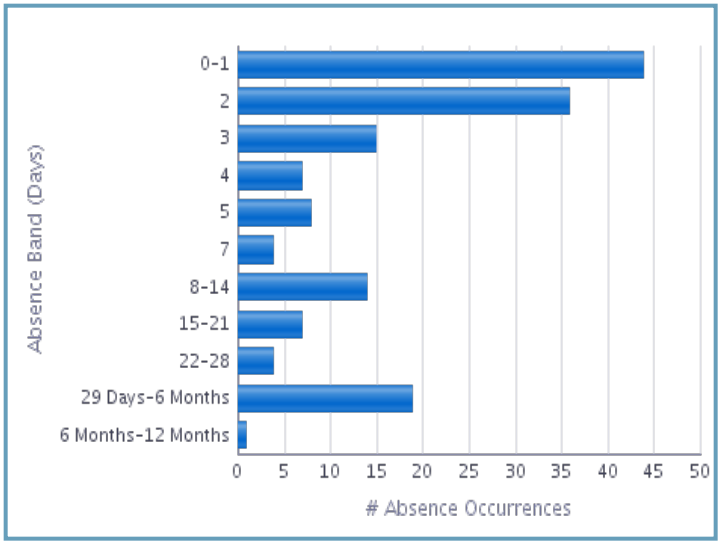
Sickness absence rates continue to fluctuate across the Trust and remain above the current overall outturn target of 2%. In April 2015 there were 140 episodes of short-term sickness, with the highest number of short-term sickness cases for the third month running being Cough, Cold and Flu, equating to 24.0% of all short-term sickness reported . Gastrointestinal problems being the second highest level of short-term sickness recorded at 20.5%.

Long-term sickness cases which have continuous absence of 20 days or more have increased from 16 to 20 for April. However 8 of those long term sickness cases are due to return to work this month (June 2015). Long-term sickness began to rise again in the months of February and March, with the main cause being Stress, Anxiety and Depression. In terms of medical staff, it is anticipated that one long term sickness absence case involving a junior doctor will be resolved in early June. HR are closely monitoring the rise in long-term sickness and will be working with managers and delivering additional training.

There were 924 absence days lost (778.44 WTE) due to sickness in April. The average WTE days lost to sickness for April was 0.95 days with a cost to the Trust of £24,608. Monday was the highest first day absence, for a continuing month, a recurring trend for the Trust – work is being undertaken to identify any individuals who take sickness absence on a Monday.

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





HEADLINE HR KPIs

Sickness Absence continued

Nursing Absence

Nursing had the highest sickness absence in April with 49 occurrences of sickness, 5 are long-term cases and 44 are short-term sickness cases relating to Cough, Cold and Flu and Gastrointestinal problems. The highest reported sickness within nursing were;

- Paediatrics – 8.30**%** with a total of 7 occurrences totalling 72 days, two of which are long-term sickness. The main cause of sickness was , other known causes – not elsewhere classified.
- Burns Ward – 7.71% with a total of 11 occurrences of sickness totalling 79days. The main cause of sickness was cough, cold and flu.
- Minor Injuries Unit– 5.81% with a total of 6 occurrences of sickness totalling 34 days, one of which is long-term sickness. The main cause of sickness was cough, cold and flu.

Admin and Clerical Absence

Had the second highest sickness absence levels in April with 38 occurrences of sickness of which three are long-term cases and 35 are short-term sickness cases, relating to cough, cold and flu and other known causes – not elsewhere classified.
The highest reported sickness within admin and clerical were;

- Admissions and Appointments – 5.32% with a total of 5 occurrences totalling 20 days. There were various causes of sickness.
- SLR Skin– 3.07% with a total of 4 occurrences totalling 18 days. The main cause of sickness was due to , other known causes – not elsewhere classified.

Add Prof Scientific and Technic Absence

Has the third highest sickness for April with 19 occurrences of sickness, 2 x long-term sickness and 17 short-term sickness cases relating to Gastrointestinal problems.

- Theatres (Practitioners) – 14 occurrences of sickness totalling 85 days. The main cause of sickness was Unknown Causes – Not Elsewhere Specified and Gastrointestinal problems.
- SLR Clean (Technician) – 1 occurrences of sickness totalling 30days, one of which is long-term sickness case. The main cause of sickness is anxiety/stress/depression.

Actions

The Managing Sickness Absence Policy and Procedures is currently been reviewed by Staff Side and HR are aiming to launch the new Policy in July 2015. The new policy has a much more robust approach to managing sickness absence

RAG Rating

HEADLINE HR KPIs – Casework

Employee Relations

- **Formal Conduct –** 1 case ongoing investigation, disciplinary hearing took place in May and employee has returned to area of work and first level warning was issued.
- **Capability –** ongoing 2 nursing staff
- **Probation –** 1 ogoing case which is due to conclude in June.
- **Suspension / Redeployment - 1** case is currently on a phased return to there area of work following redeployment to allow a disciplinary investigation to take place.

Employee Relations – Medical Workforce

- **Capability** - Trust Registrar – on fixed term contract until end of October 2015. Formal management concluded as improvement in performance has been seen. Restrictions no longer in place. Being overseen by Educational Supervisor.
- **Formal Conduct** - Consultant – investigation being undertaken. Investigation has now been concluded and the outcome is that no further formal action will be taken. Both doctor and complainant informed.
- **New investigation –** Trainee - Investigation being undertaken anticipate conclusion in 2 weeks. Practice is restricted.

Case Type	Number of cases
Conduct (formal)	1
Conduct (informal)	0
Bullying & Harassment	0
Capability	2 (formal) 0 (informal)
Long-term sickness	16
Short-term sickness (formal)	9
Change Management	0
Grievance	2
Whistleblowing	0
Probationary	1
Appeals	0
Suspension / Redeployment	1
Flexible Working	0
Dismissals	0
Total cases	**32**

RAG Rating

Statutory and Mandatory Permanent Staff Training – 1.6.15

Competency Name	Expired	Expired but Booked	Match	Grand Total	Trust Overall (Booked+Match)
CSTF Equality, Diversity and Human Rights - 3 Years	39.53%	2.54%	57.93%	100.00%	60.47%
CSTF Health, Safety and Welfare - 3 Years	27.29%	4.16%	68.55%	100.00%	72.71%
CSTF Infection Prevention and Control - Level 1 - 1 Year	54.32%	0.00%	45.68%	100.00%	45.68%
CSTF Infection Prevention and Control - Level 1 - 3 Years	16.67%	1.02%	82.31%	100.00%	83.33%
CSTF Infection Prevention and Control - Level 2 - 1 Year	21.99%	6.24%	71.77%	100.00%	78.01%
CSTF Information Governance - 1 Year	39.10%	1.36%	59.54%	100.00%	60.90%
CSTF Moving and Handling - Level 1 - 3 Years	28.80%	1.76%	69.44%	100.00%	71.20%
CSTF Moving and Handling - Level 2 - 1 Year	34.71%	7.00%	58.30%	100.00%	65.29%
CSTF NHS Conflict Resolution (England) - 3 Years	34.51%	3.66%	61.83%	100.00%	65.49%
CSTF Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	24.51%	9.47%	66.02%	100.00%	75.49%
CSTF Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	25.82%	9.84%	64.34%	100.00%	74.18%
CSTF Safeguarding Adults - Level 1 - 3 Years	26.80%	2.71%	70.48%	100.00%	73.20%
CSTF Safeguarding Children - Level 1 - 3 Years	24.94%	2.37%	72.69%	100.00%	75.06%
CSTF Safeguarding Children - Level 2 - 3 Years	36.60%	3.65%	59.75%	100.00%	63.40%
CSTF Safeguarding Children - Level 3 - 3 Years	32.56%	0.00%	67.44%	100.00%	67.44%
LOCAL Emergency Planning - Non-Clinical - 3 Yearly	24.33%	1.34%	74.33%	100.00%	75.67%
LOCAL Emergency Planning: annual	29.99%	6.86%	63.15%	100.00%	70.01%
LOCAL PDR - annual	45.12%	0.00%	54.88%	100.00%	54.88%
Grand Total	**31.22%**	**3.70%**	**65.08%**	**100.00%**	68.78%

Statutory & Mandatory Training Commentary

Overall the figures have all decreased this month across the board from 77.06% to 68.78%. The expired figures have increased from 22.94% to 31.22%, the 'Expired but Booked' figure has dropped from 5.30% to 3.70% whilst the overall match figure has dropped from 71.75% to 65.08%.

There has been a different mix of training courses this month - whilst there have been 32 instead of 28 courses last month, there have been more courses aimed at some staff rather than specifically for clinical or aimed at all staff that increases overall reported compliance. We have also had more non-mandatory training courses.

167 permanent staff are showing 100% completion of the above competencies which is an increase from last months 122.

Exceptions & Actions

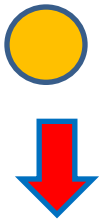
All of the competencies have decreased their compliance percentage this month.

Three of the competencies have continued to decline for the last three months – PDR (532 not current from 348 last month – 39.82% to 45.12% expired), Infection Control Level 1 – 1 year (44 Domestics & Porters in Clinical Areas – 46.58% to 54.32% expired) and Moving & Handling Level 2 – Clinical Staff (31.63% to 34.71% although this currently equates to 253 out of date rather than 173 last month).

The Staff Group that is showing the least compliance completion rate for permanent staff is Medical & Dental at 56.13% for the reported competencies. The next lowest staff group is showing 69.78% completion.

There are plenty of spaces available on courses as some are run at 25-50% capacity. The individuals are not booking themselves onto courses.

RAG Rating



Occupational Health - April 2015

There was a total of 30 referrals to the OH service for April, 20 Management and 10 Self Referrals.

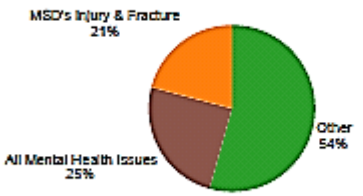
Please find below the breakdown of reasons for referrals to the OH service. Please note that for April Work Related Stress and Non Work Related Stress remain the same, depressive episodes has increased.

Reasons For Referral YTD - Detailed Breakdown

Event Reason For Referral	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	Total
Surgical Procedures		5%	12%	40%	14%	38%	6%	7%	13%	13%	31%	17%	16%
Medical Condition	20%	16%	12%	7%	10%	8%	24%		25%	13%	13%	25%	14%
Short Term Sickness	20%	5%	8%	7%	24%	8%	12%	13%	25%	19%		8%	13%
Injury / Fracture Non Work Rela..		11%	12%	13%	10%		6%	13%	6%	13%	6%	8%	9%
Non Work Related Stress	27%		4%	13%		8%			6%	13%	13%	8%	7%
Work Related Stress	7%	5%	16%	13%		8%		7%	6%	6%	6%	8%	7%
MSD Problem Non Work Related	7%	5%	4%		5%	8%	6%	13%	13%	13%		8%	7%
MSD Problem Work Related	13%	5%	12%		10%		6%	20%			6%		7%
Depression		5%			5%	8%	6%	7%	6%	6%		17%	5%
Bereavement		16%			5%		6%				13%		4%
Mental Illness	7%	5%	4%				12%	13%					4%
Gynaecological					14%		12%						3%
Maternity Related Concerns / P..			4%			8%	6%				6%		2%
Neurological		5%	4%	7%	5%								2%
Cancer		5%				8%		7%					2%
Cardiovascular		5%											1%
Endocrine			4%										1%
Liver Disease			4%										1%
Ophthalmic											6%		1%
Respiratory Conditions		5%											1%
Skin Disorders										6%			1%

Occupational Health - April 2015

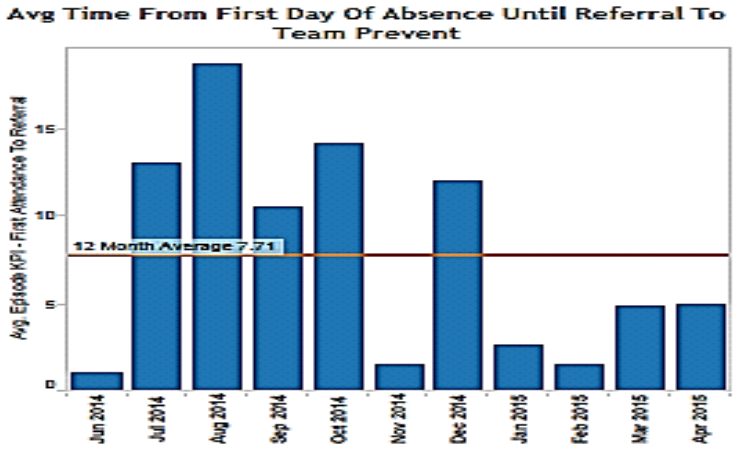
Reasons For Referral YTD - Summary



Mental Health currently accounts for 25% of all referrals into the service (YTD).

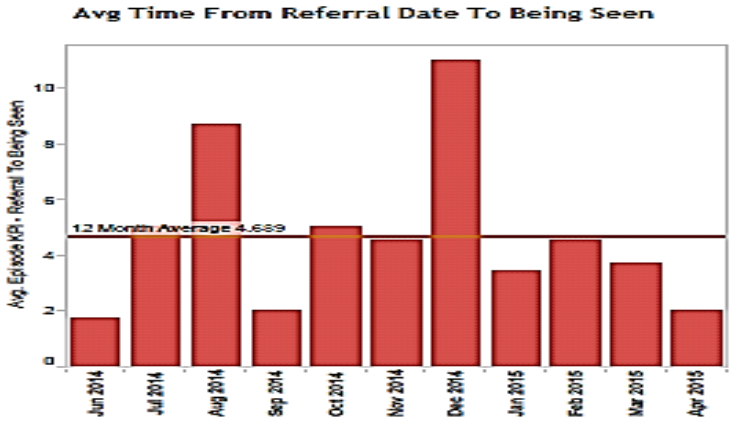
Of the management referrals seen, 11 were found to be fit or fit with adjustments and 2 employees declared to be unfit. Please note the discrepancy in numbers can be explained; i.e. there were 20 referrals received, these are the cases that were kept open, however going forward with the new electronic system, these outcomes will be captured at assessment.

Below demonstrates the average timeline into the referral;

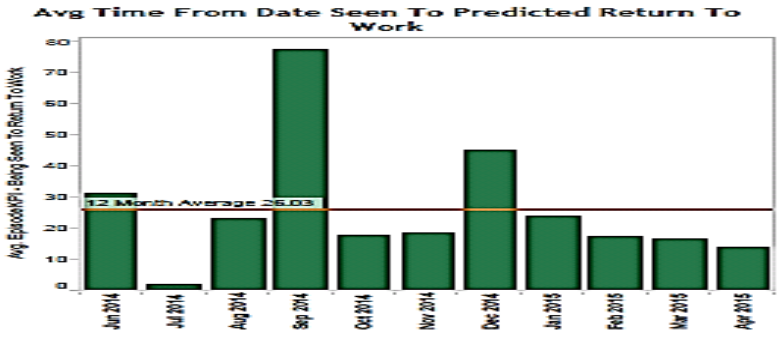


The graph represents that days lost from the first day of absence until a referral into the service is generated; currently it is less than 5 working days. The trend line for the 12 month absence is 7.71 days.

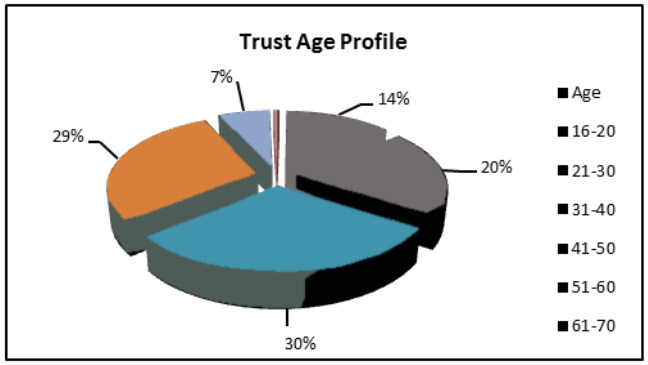
On average appointments are offered within 4.6 working days, for the last month it has been 2 days.



The 12 month average for a return to work currently sits at 26 days, however in the last month the average expected return to work date is12 days.

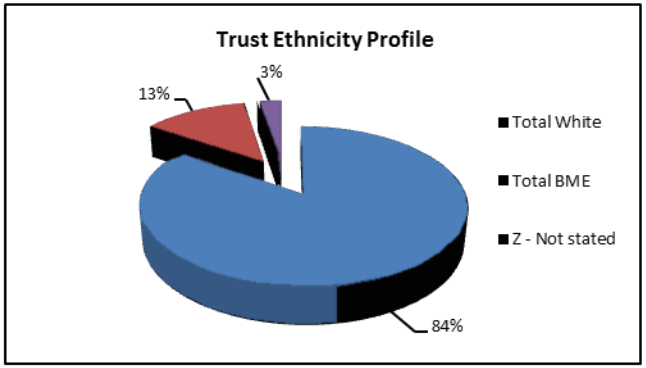


Equality & Diversity

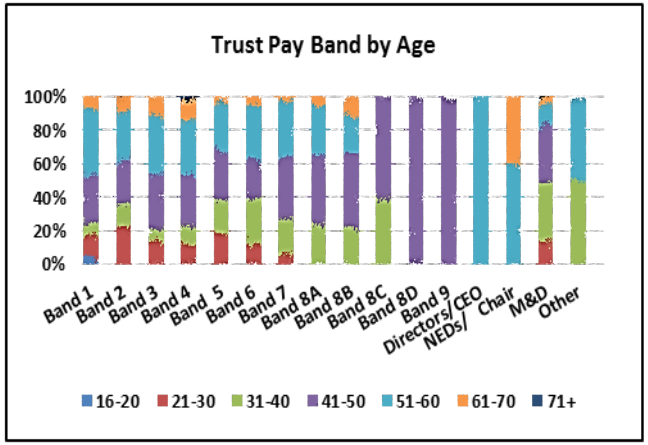


There has been no significant changes in the staff age ranges employed by the trust from the previous year. The majority of Trust employees are aged 41-50 , this reflects the Sussex population. There is a high percentage of staff (36%) aged 51+, which indicates that the Trust has an ageing workforce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

RAG Rating



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



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

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

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th June 2015
Reference number:	153-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	17th June 2015
Appendices:	1: Action plan appendix A

Staff Survey Action Plan – June 2015

Key issues

1. The attached action plans follows the detailed review and analysis of the last 3 years staff survey results. The action plan addresses the 6 main themes from the analysis presented to the Board in May 2015 and whilst this includes a number of initiatives, managers across the organisation will be tasked to review and address the detail of the report relevant to their areas of responsibility.

2. Progress will be monitored on a quarterly basis but the impact of changes are unlikely to have an immediate impact on the 2015 staff survey. However because the report clearly identified certain staff groups where improvements need to take place it will be necessary to plan additional engagement sessions with those groups.

3. To improve our response rate this year there will be earlier communication to all staff of the survey and our target response rate i.e. 70%. There will also be communications about the positive actions taken since the last survey and how we have responded to staff opinion. The communications teams will help to support this. In addition work will operations managers will be undertaken to provide staff with time to complete the survey which issued.

Implications of results reported

4. The Trust's strategy in 'Delivering Excellence' relies on the motivation of staff and their opinion of the Trust as an employer. The action plan is aimed towards helping to address areas identified by staff which will improve their working environment and employee experience.

5. This action plan represents the start of a longer term approach to seeing year on year staff survey improvements.

Action required

6. The Director of HR/OD maintains close monitoring of objectives identified within this action plan to ensure progress or remedial action as required.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

Implications for BAF or Corporate Risk Register

7. The issues raised at paragraphs 1 – 3 above are closely monitored. The mitigations are currently felt to provide assurance that these issues are not impacting negatively on the Trust's overall performance.

Recommendation

8. The Board is recommended to note the contents of the action plan.

Queen Victoria Hospital NHS
NHS Foundation Trust

Staff survey action plan

Survey area	Activities	Lead by	Target date	Link to current people related issues / plans
Performance appraisal	• Review the current appraisal process and forms to improve quality and outcomes. Included in the process will be: - Revalidation criteria for nurses and doctors - Overall performance assessment rating - Individual objectives linked to team/department/corporate objectives (golden thread) - Organisational behaviours linked to the Trust's values - Increase the number of formal appraisals to a minimum of two per annum i.e. mid-year and full appraisal (April/October) - Arrange a staff focus group to provide feedback / ideas on revised appraisal process and 'test'. These will be particularly focussed towards our problem areas e.g. Estates / Facilities and Admin	DHR/OD	Revised appraisal and process launched October 2015 and will including manager and staff engagement. Spot checks to be carried out on current process and findings fed back into the review.	Culture of high performance – the current appraisal process does not necessarily encourage a culture of high performance. Inclusion of an overall performance assessment rating will help to raise the profile of performance appraisals, and the performance of individuals Improve the quality of the

	• Once new appraisal process and forms agreed, deliver performance appraisal workshop training for all managers (responsible for appraising staff) and workshops for staff – workshops to cover process as well as 'appraising staff effectively'. • Continue to random sample performance appraisals from each business area to check quality	DHR/OD SMT / DHR/OD	Workshops to be delivered for Managers and Staff in Q3 and Q4 To be confirmed once new appraisal process in place and will be on-going	performance appraisal meetings – streamlining the process and delivering appraisal training is aimed at improving the quality of the appraisal experience and outcomes
Setting clear objectives / key performance indicators	• Each business area of the Trust to set team / department objectives (linked to the corporate objectives) and develop key performance indicators against which individual performance will be measured, linked to performance appraisal • Directors / Heads of Service to cascade the team / department objectives to staff and explain the link to corporate objectives and new performance appraisal process • Using the Picker additional analysis, managers to work through the areas of the survey which are relevant to their service e.g. Admin staff not meeting regularly as a team to discuss team effectiveness.	SMT SMT	End of Q2 End of Q2	Performance Management – having clear set of objectives within each of the business areas will help to improve performance more effectively as well as assist in the achievement of the corporate objectives Expectations of performance clearly expressed – clearer for staff and improve their understanding of their contribution towards the corporate objectives

Building leadership capacity and capability Devolved decision making	Estates, Facilities, Administration and unqualified clinical healthcare staff have indicated a lack of involvement in decision making and a lack of ability to individually make improvements to their role. In each of these areas there has been a lack of leadership and direction. In the short term managers will be required to undertake a greater level of staff engagement: • In each area managers will be required to develop department plans in conjunction with their staff. This will include annual business planning, job design and service developments. • The recent management re-structure brings into the Trust several new managers to lead the organisation. They will be provided with individual leadership development to ensure they are equipped to support their staff in performing to high standards. In addition the management teams of the newly formed Business Units will also undergo a Business Development programme. This will include: o Individual contribution to delivering high standards of patient care o Staff engagement o Managing performance o Dealing with difficult conversations o Healthcare in a competitive market o Marketing services o Legal frameworks for high performance o Team building o Understanding the financial regime	DHR/OD and Director of Ops Director of HR&OD	From mid Q2 Programme to commence by end of Q3	The lack of leadership in Estates and Facilities is being addressed through the appointment of a Head of Non-Clinical Infrastructure. They will be in place by the beginning of July and will work closely to the Director of Finance. The development programmes will not only support the management teams to deliver against challenging objectives but will be geared to ensuring they work alongside their operational/frontline staff to gain their views and allow them to influence the future delivery of service. The actions in this section

	• Regular monitoring of staff opinion in those areas where lack of leadership, engagement and opportunities to influence decision making will be undertaken. The aim will be to build on initiatives which support improvements and to address those which have a negative impact. The monitoring will also help to identify areas of good practice which can then be shared across the organisation.	DHoHR with Director of Ops and Business Managers	Monitoring will begin via Survey Monkey in Q2	will take time and therefore the impact on the 2015 Staff Survey are uncertain. In some areas the position may worsen before they begin to improve. The importance therefore of the monitoring therefore will be to review progress against medium to long term goals.
Recognition and praise	• Develop an employee / Team of the month / quarter scheme, where staff nominate colleagues to receive recognition (certificate and voucher e.g. £50/£100) for excellent performance / demonstrating the values of the organisation. The winners will be decided by a panel consisting of: o Member of SMT o Board member o Staff side representative o Patient representative o HR representative The communications team will publicise the winners each month (and staff nominated) including a 'blog' of the winners comments • The Recruitment and Retention Task Group identified	DHR/OD & Comms Team	Launch by end of Q2 By end of Q2 -	The aim of this initiative will be to improve employee engagement through more regular recognition of achievements. Winners will also be put forward for the annual staff awards Contributes to the reduction in sickness absence –

	rewarding those staff with excellent sickness records as a means to recognising their contribution and helping to promote a positive approach to improving overall sickness levels. Therefore in discussion with the Director of Finance, Director of Operations and Deputy Director of Nursing staff reward schemes will be developed such as: o Rewarding staff with an additional days annual leave where they achieve 100% attendance over a 12 month period o All staff to receive a half day Christmas shopping day • In addition negotiations are taking place to introduce a single rate across the Trust for bank work. This will be paid to our substantive staff who work bank shifts and will be an enhanced rate to reward staff who undertake additional work for the Trust. This will also help to reduce Agency costs.	DHR/OD	12 month period to be calculated by using the employees start date in the job role (at QVH) Agreement to reward scheme by end of Q2 and introduced from Q3	achievement of 2% sickness absence levels Recognising and rewarding staff that go the extra mile and make a positive contribution within and outside their own business area
Health and Wellbeing	• HR in conjunctions with representatives from Occupational Health, operations, admin and	DHR/OD and Occupational	Two health & wellbeing days to	Reduce sickness absence, providing support to staff

	estates/facilities will organise a series of Wellbeing Days throughout the year. These have tended to be ad-hoc in the past but well received. The aim will be t run 4 per year and will cover: o Free health checks (blood pressure, BMI, cholesterol, blood sugar levels), receiving counselling (debt/stress), receive relaxation treatments, attend talks on nutrition and healthy lifestyles, participation in a fitness challenges	Health	be delivered by end of Q4	when they need it and to help them to develop way of preventing ill-health
	• Rapid access to the Trust's services has also been agreed to be implemented. This provides QVH staff access into Trust services with the aim of supporting them back into work as soon as possible.	DHR/OD and Occupational Health	By end of Q3	Giving staff access to treatment onsite – speed up their return to work
	• Qnet (Intranet) – develop a section dedicated to Health & Wellbeing where staff can find self-help information and tips on living healthy lifestyles.	DHoHR and Occupational Health	By end of Q3	
	• Changes to the service provided by Occupational Health have also been implemented providing 24/7 telephone advice and an improved booking system		Completed	
	• A Mindfulness pilot is being introduced to support managers and staff to recognise and deal with stress / anxiety	DHoHR	Pilot to commence in Q2	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th June 2015
Reference number:	154-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	17th June 2015
Appendices:	A: Board development programme

Board Development Programme - 2015

Key issues

1. The attached paper sets out the Board development programme for the next 12 to 18 months. The focus is on developing our relationships as a unitary Board to ensure we operate effectively and that the organisation is well led.

2. The paper sets out a number of approaches which will be taken forward flowing a discussion at the Board and finalising the programme.

Implications of results reported

3. The Board Development Programme is designed to equip individual members and the Board as a whole to work effectively together. The principles outline in Monitors Well-Led guidance have been incorporated.

Action required

4. The Chair supported by the Director of HR/OD and Head of Corporate Affairs will be responsible for driving forward the programme.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

Implications for BAF or Corporate Risk Register

5. There are no adverse implications for the BAF or Corporate Risk Register.

Recommendation

6. The Board will discuss the programme at the meeting in June 2015 and thereafter members will be requested to approve the programme.

BOARD DEVELOPMENT PROGRAMME 2015/16

1 Purpose

1.1 The purpose of this programme is to make best use of the time and resource available to achieve the Board's goal of maintaining Queen Victoria Hospital NHS Foundation Trust as an innovative and high performing organisation.

1.2 The programme aims to complement the personal development plans of individual directors; the back to the floor programme and visits carried out by directors with the Trust's services. In addition and as a part of the Boards overall development account will be taken of stakeholder feedback i.e. staff, commissioners and patients, to influence the Board's decision making and ways of working.

1.3 The programme will support our goal of operating as a unitary Board and working to the principles of Monitor well-led governance framework. It also balances external and internal inputs, aligns with the objectives of the Trust's values and behaviours and where appropriate will links to the Trust's emerging leadership strategy.

2 Accountability

2.1 The Chair supported by the Director of HR/OD and Head of Corporate Affairs, will be responsible for ensuring that these activities are scheduled planned and completed.

2.2 The whole board, individually and jointly will be responsible for ensuring a commitment to participation in all elements of the programme and the Chair supported by the Director of HR/OD will ensure that the programme outcomes are reviewed against the agreed success criteria to inform the following year's programme.

3 Funding

3.1 An allocation of £50K has been made to support the activities associated with this programme. This reflects the importance of continuous development for Board members and to ensure that whilst we strive to achieve our strategic aims it is done so with in the context of high performance and in the best interests of patients at all times.

4 Shaping organisational culture

4.1 As an effective board we need to shape a culture for the organisation which is ambitious, self-directed, responsive, and encourages innovation. We have a commitment to openness and transparency and to put patients and communities at the centre of everything we do. This aligns with the Trust's vision/strategy and reflects the NHS values, as defined in the NHS Constitution. Please see diagram below.

NHS Constitution

- Respect and dignity
- Improving lives
- Commitment to quality of care

4.2 Members of the Board will need to model behaviours associated with our values to embed the culture, so that it becomes a reality and tangible to our staff and patients alike. Therefore the Board needs to be seen as a champion of these values in the way it operates and behaves. Research shows that effective boards and their members exemplify seven principles of public life:

1. **Selflessness**
2. **Integrity**
3. **Objectivity**
4. **Accountability**
5. **Openness**
6. **Honesty**
7. **Leadership**

NB: These are the Nolan Principles please see - https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

4.3 As a unitary Board we should have a drive to challenge discrimination, promote equity of access and quality of services as part of developing the strategic direction. We should therefore promote an approach to accountability and engagement which is consistent with the values and culture we seek to promote for the organisation.

4.4 A number of new directors have joined the Trust Board recently including a new Chair and therefore the focus of the Board's development this year must initially be on team building and on firming direction. Activities associated with the programme will include:

- Defining and shaping the appropriate organisational culture
- Exploring and defining the organisation's risk appetite
- Supporting and modelling a values-driven organisation
- Promoting and enabling creativity and innovation close to service delivery
- Providing leadership for staff engagement
- Pro-actively learning about and engaging with our local communities

Proposed Board Development Activities

5 Director Development

5.1 Throughout the year there will be a series of Board seminars providing opportunities for Executive and Non-Executive Directors alike. This will enable them to gain an understanding of the services provided by the Trust and to review and influence the strategic direction. Additionally, they will receive updates on legislative changes and the impact for the organisation. This will improve Board member's overall knowledge base and technical skills.

5.2 As an example, a Safeguarding seminar would cover serious incidents; safeguarding adults and children. The seminars will take place, as is presently the case, on the same day as full Board meetings and will mainly be presentations followed by question and answer sessions with the clinical lead or subject matter expert.

5.3 In addition, these seminars will also be sued to provide Board members with their statutory and mandatory training updates where possible.

5.4 Where individual development needs are identified through the director/CEO direct reports and Chair/NED appraisals, these will be met following discussion with the individuals concerned.

(Please also see Appendix A)

6 Induction

6.1 This will be geared to new Chair, Executive Directors, Non-Executive Directors (NED) and CEO direct reports.

6.2 The induction programme for Board members will include:

- A comprehensive induction pack outlining key contacts, roles and other relevant information about the Trust
- An induction event covering the structure of the NHS/Trust, specific roles within the Trust and other areas of good governance
- Planned service orientation visits
- Planned informal discussions with senior managers and clinical directors

NB: see outline Induction Programme at Appendix B

7 Team Building

7.1 Team building sessions will assist Board members to work together on developing our approach as a unitary Board whilst gaining a greater insight into the drivers for them being part of the Board. These sessions will incorporate profiling technique e.g. Myers Briggs (MBTI) which will provide individuals and the whole Board with feedback and discussion to understand each other's behaviours and perspectives. Periodically there will be 360 degree appraisal to ensure wider understanding of how Board members are perceived both within and external to the organisation.

8 Communications and the media

8.1 Dealing with the media effectively may be necessary for any member of the Board and therefore specific training on this will be provided by 'Media First' to improve skills in media handling. This is likely to be a one off training session organised for the whole Board.

9 Externally available development

9.1 The King's Fund has a varied schedule of short, evening sessions based in London. These sessions are exclusively for Chairs and NEDs. Example of the sessions available are:

- Everything you wanted to know about governors but were afraid to ask
- The sustainability agenda for boards

Please also refer to http://www.kingsfund.org.uk/leadership/blp/events

9.2 Foundation Trust Network (FTN) meetings and courses. These sessions are geared towards NEDs and Chairs and are available throughout the year. The Chair will agree with individual NEDs, through their 1 to 1 discussions, development opportunities which can be met from these externally provided session.

9.3 Additionally, NED's will also be encouraged to attend HFMA courses and NHS Providers conferences.

10. Executive Management Team

10.1 The Chief Executive will agree with executive directors and direct reports a personal development plan (PDP) as part of their individual appraisal. The PDP will focus on the development of skills and experience necessary to perform effectively at board. New directors (i.e. first appointment at director level) may also require additional coaching / mentoring and will be organised by agreement with the Chief Executive.

10.2 The NHS Leadership Academy provide a range of programmes to support senior managers especially those aspiring to leading healthcare organisations in the future. They include the Director Programme (previously known as the Top Leaders Programme) aimed at directors with a minimum of 2 years Board level experience. This again will be agreed by the Chief Executive with individual directors, who will be sponsored to attend these programmes as they involve project based work which are designed to benefit the host organisation.

11 Whole Board evaluation

11.1 Board effectiveness will be reviewed biannually to include perspectives of all major stakeholders. This is to be followed by discussion and action planning.

11.2 It will also be important that we commission an external Board review in line with the recommendations within the Monitor, Well-Led Board guidance. In preparation for this to take place in 2017, an internal self-assessment will be planned to take place in 2016.

Appendix A

Sessions for Executive and Non-Executive Director Development

1. Understanding Risk Appetite and risk mitigation – An externally facilitated workshop to give the Board an opportunity to understand different perspectives on risk appetite, and debate what this means for the Trust.

2. Branding and Marketing – making the most of the QVH brand in an increasingly commercial and competitive market. Externally facilitated.

3. Patient Experience – ensuring patient experience is at the forefront of decision making and strategy.

4. Staff and stakeholder engagement – how the Board will develop more effective engagement with our staff and key stakeholders. This will link to the Board's approach to culture and values.

5. Strategic direction – testing the Boards unity on the Trust's strategic direction, ensuring individuals views and opinions are taken into account and agreement on how the Board will measure its successes.

Appendix B

QVH NED INDUCTION – suggested programme

What	Who to arrange?
On appointment Contract sent out (within 8 weeks) – cross checked with advert Payroll info received DBS checks Fit and proper persons and conflicts declarations Get dates in diary - board, JCHA, Governors, relevant Board committees, staff awards etc.	 HR HR HR Corporate Affairs Corporate Affairs
Formal Induction Courses Internal – intro to QVH NHS Providers – intro to NED role in NHS Statutory and Mandatory training IT – get set up on Good app	1st Monday and Tuesday of each month. (Corporate Affairs / HR to book) Corporate affairs to check next available course HR/ Corporate Affairs Corporate Affairs to organise with IT
Meetings Chair – to cover overview of QVH and role within wider NHS. Governors. Board meetings (probably 1st meeting on 1st day. Also build in the Chair taking them for lunch on their 1st day) CEO – corporate strategy/ operational plan. Corporate structure Other NEDS – role of sub-committees FD – financial, estates and facilities strategy Medical Director – medical workforce – structures, issues Director of nursing – Quality, quality accounts, safe staffing Director of Ops- operational overview Director of HR – workforce Head of Corporate affairs – overview of board and governors programme. Dates etc. Regulatory regime	Corporate affairs – to try and keep as far as possible to the order set out on the left, as there is a logical progression NED to liaise with (Jean?) to set up meetings?

Governor rep on the board – overview of council of governors IT (re setting up Good app if necessary) (Other people as necessary) Tour of site & visits to certain departments **Reading & other support information** **Own reading** QVH website QVH constitution QVH Monitor license https://www.gov.uk/government/groups/queen-victoria-hospital-nhs-foundation-trust Minutes of past board and council of governors meetings (on QVH website) Last 3 years accounts NHS Providers introduction to NHS (link?) NHS Acronym buster – this is also available as an app (www.nhsconfed.org/acronym-buster) NHS Providers website http://www.nhsproviders.org/home/ Monitor website https://www.gov.uk/government/organisations/monitor CQC website inc QVH info http://www.cqc.org.uk/provider/RPC/reports HFMA website	Corporate affairs to organise (Corporate Affairs to ensure NED has access to subscriptions to NHS Providers HFMA HSJ
Other meetings Clinical Audit meeting Perhaps attend a meeting of all committees	Corporate affairs to let NED have dates
Compliance in practice visit (each NED required to do at least 1 in the course of a year)	Corporate Affairs to ensure NED's name and details passed to Gavin

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 June 2015
Reference number:	155-15
Report from:	Jo Thomas, Director of Nursing and Quality
Author:	Jo Thomas, Director of Nursing and Quality
Report date:	16 June 2015
Appendices:	QVH2020 KSO1

Quarterly update on delivery of Key Strategic Objective 1

Outstanding patient experience

Key issues

1. The attached document summarises the quarter 1 actions identified in respect of key strategic objective 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.
2. The short term actions that were identified for2014/15 have been achieved are the longer term objectives and new objectives for KSO1 will be updated quarterly during 2015/16. New Objectives include:
    - Strategy for human factors at QVH and roll out to teams
    - Plan to improve experience of mental health patients in QVH trauma pathway
    - Measurable improvement in food experience for patients at QVH
    - Improvements in environment for patients with dementia
3. The attached document will be shared with the Clinical Cabinet and is monitored at patient experience group where additional actions required to achieve the plan are commissioned to support delivery an outstanding patient experience.

Implications of results reported

4. The progress reported impacts on the quality of patient care and experience so robust management of these actions remains a priority.

5. Progress continues to be made against the objectives. Quarter 1 progress shows 6 actions have turned from amber to green, no actions are red and no green actions have turned amber. The 4 areas where are:
    - All directors, NEDs and some governors undertaking CiP and increasing visibility with walkabouts.(action 4)
    - Safe care modules has been added to e-roster (action 12)
    - Compliance with WHO checklist, this will continue to be monitored through 2015/16 (action 20)
    - Monday to Friday cover on volunteers reception desk from 0900-1600 achieved (action 28)
    - Early warning information is now being used across the operational teams including SafeCare; the Director of HR&OD has agreed with the CEO that a further system at this time is not required.
    - From June work is in progress to enhance the benefit of allocate software
6. The main areas of challenge remain;

- Recruitment to vacancies and retention of staff
- Realistically and effectively allocating estates resources to projects that benefit the majority and facilitate safe care.
- Transition from interim structure to new one and induction of new staff throughout QVH.

7. Actions in progress that involve the senior team including Non-Executive directors are anticipated to improve staff familiarity with the senior team and feel able to raise concerns directly to them. 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, for success engagement is required.
8. There has been a significant increase in governor participation of the Trust's CiP (compliance in practice) programme.
9. All patients should benefit from the actions identified within the QVH 2020 plan for 2015/16 and no specific group will be excluded.
10. Achievement of actions will support improved safety and outcomes for patients and an improved experience. All of these aspects are a key focus for our commissioners, Monitor and the Care Quality Commission.

Link to Key Strategic Objectives

- Outstanding patient experience

11. The above information relates to the key strategic objective – Outstanding patient experience.
12. Risks to achieving this objective are included within the current Corporate Risk Register and Board Assurance Framework.
13. No new risks have been identified

Regulatory impacts

14. Nothing within the paper attached indicates that the organisation is not:
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

15. There is no impact on our Monitor governance risk rating or our continuity of service risk rating as a result of this paper.

Recommendation

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

Key Strategic Objective 1 – Outstanding Patient Experience

Board Update June 2015

Jo Thomas – Director of Nursing

KSO1- Outstanding Patient Experience

Leadership and Values

Following organisational restructure the Board confirmed at the 2015/16 priority setting away day its commitment to the aspiring to excellence and commitment to the highest standards of nursing care and behaviour as part of the wider commitment to excellence in patient care

Raising visibility and profile of board, NEDs and governors continues with walkabouts and regular CiP visits to wards. The director of nursing is using this information when working in clinical areas to further validate the findings and understand the impact on patient care and experience.

Whistleblowing policy and process have been reviewed in the light of recent national guidance. There is very little use of the whistleblowing access at QVH however “Ask Richard” and “Tell Jo” web sites are well used and encouraged. To ensure staff have a variety of ways of being heard.

The head of risk is undertaking a course in human factors training in June and following this will develop a strategy and plan to utilise the relevant elements and incorporate into trust working in partnership with our staff. The detail of this will be presented to the Quality and Governance Committee.

Safe Care, Safe Staffing

SafeCare has been implemented and went live in March 2015. The acuity levels of patients and staff hours are available in real time and provide additional support to professional judgement about the safety of care and a mechanism to demonstrate this. It also provides a visible overview of workforce which has facilitated in smooth transfer of staff to other areas when there are gaps in workforce or high acuity. Nursing and HR Directors are reviewing the outcomes with matrons and ward leads to promote greater staffing efficiency.

There has been a successful response to recruitment in Canadian Wing with only 2 wte vacancies remaining. New staff have already started and further start dates planned June through September.

QVH bid to nursing technology fund was not successful and this action will not be taken forwards in 2015/16.

Safety thermometer data collection has been fully established and on-going data submission and monitoring of this will continue. WHO checklist continues monthly with a qualitative check each month re compliance, which remains at 100% and a more detailed quarterly review.

Governance

The medical director continues to chair the monthly clinical governance group, providing detailed executive level scrutiny and alignment with quality, safety, risk, effectiveness and experience issues throughout the trust. Further development of governance and risk reporting will be developed in 2015/16 to standardise the approaches to this in the clinical infrastructure directorate and business units.

Exceptional Environment

Work has commenced to provide a waiting area for relatives in the area adjacent to Ross Tilley ward. This will have drinks station and vending machines as well as comfortable seating.

There have been 2 meetings in March and May to scope out the requirements and actions for further improvements in food experience. A small task and finish group has been commissioned to take forwards the work (and address the food comments comments in the national inpatient survey 2014), chaired by a governor and reporting into the Patient Experience Group. There are several actions identified; the key ones include improving choice, engagement with patients particularly head and neck and burns patients to ask patients what they would like to be different and having printed menus with pictures of the various food options and dietary information (including allergy alerts) in the wards.

We are in the process of applying for the bronze food charter mark.

There are 2 bids currently going to league of friends to improve experience for patients with dementia; new crockery, beakers and water jugs and new plain weave curtains. Head of Estates is aware of the new requirements for flooring and distinction of colour between floors, walls and door frames. Replacement flooring will meet this standard as will all redecorating in clinical areas.

Outstanding Personal Service

Drinks stations are available in all day rooms for patients and their families and carers.

Initial data has been collected in reducing late starts in out-patient clinics during 2014/15 changes have been made following the collation of reasons for the late starts; a review of this data is due to be carried out to evaluate further. The FFT response rates in our out-patient areas is low and we are targeting this issue by promoting staff to remind patients to fill in a form as they complete their consultation and at time of booking additional appointments and scoping the possibility of adding this as a visual reminder on the television screens. The new FFT reporting system is planned to start in July 2105 and it is hoped that this system of texting patients to seek their experience of QVH will improve the reporting in these cohorts.

There is now wifi access free for all patients in the clinical areas.

Outstanding Patient Experience - Key Projects Priorities 2014-2020

1.Superior care and outcomes 2.Exceptional environment 3.Outstanding personal service	14/15	15/16	16/17	17/18	18/19	19/20
Governance structure review	x	x	x	x	x	x
Electronic monitoring & alert system			x			
Safer care module	x					
Staff education	x	x	x	x	x	x
Measure nurse competence though observed practice (ROOPS)	x	x				
Improve outpatient follow-up rational		x				
Leaflets available electronically in Easy Read format			x			
Leaflets available for visually impaired			x			
New doors at car park entrance area CWing		x				
Car park & pathways level with no trip hazards				x		
Clear signage to all departments		x				
Full time presence 0900 -1600 main entrance desk		x				
New ward area ~70% single rooms						x
All beds have TV available						x
Wi fi available for patients	x					
All corridors enclosed and warm						x
Food is consistently of good quality and variety		x				
Drinks available for ward visitors	x					
Consultation room within wards for family meetings						x
Wait area for family / friends with vending food	x	x				
Outpatients have water / drinks machines		x				
Outpatients have access to type talk TV		x				
Relative / patient overnight accommodation						x
Introduce privacy and dignity forum for staff	x					
Roll out FFT to all areas as per national guidance	x					
Governors and NEDS to join CIP assessments	x					
Develop practical toolkit for leaders in line with leadership development	x					

QVH 2020: Outstanding care delivered by outstanding people

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) ii)	Improving the patient experience Improving the estate	KSO 1 Outstanding Patient Experience	i) ii) iii)	Superior Care & Outcomes Exceptional Environment 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	**Board Lead**	**Measure**	**Date**	**Progress**	**RAG**	**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	April 2014	Discussed with CEO and to reaffirm at April 2014 board meeting Completed at April Board meeting. Reaffirmed at board away day prioritiy setting for 2015/16 in February 2015	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 existing programmes such as 'Compliance in Practice'. (C6.1)	All board members	Board member / senior managers attendance on CIP audits - each board member to have been on at least one CIP during 2015/16.	March 2015	All members have done at least one CIP in 2014/15. Current review of CIP with view to be done bi-monthly and inspections to commence at 2pm. G Colwell – June 15 J Thornton - May 15 / June 15 L Porter – S Fenlon – B Goode – R Tyler – G Armitage – June 15 B Hobson – June 15 J Thomas – Apr 15 / May 15	G	

					C Stafford **S Jones**		
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 Directors and Govenors to ask staff about meeting core responsibilities whilst on CIP vistits and walkabouts	April 14 July 15	Added to CIP tool and to clinical cabinet agenda, continues in 2015/16 Witten on CIP forms and verbal feedback at board	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 Director of Nursing and Chief Executive. (C6.4) Executive Directors to incorporate any negative feedback in their monthly updates for the Board they have received or concerns they have, relating to staff behaviour including the action taken to address the issues raised. (C6.6)	CEO Exec Directors	Discussion at clinical cabinet - feedback minutes Directors / governors provide summary of CIP visits to Board Information in board reports	June 14 March 15 and ongoing	Item remains as a standing agenda on clinical cabinet for 2015/16 Board to reflect on all visits at end of board agenda – to be introduced as standing item that is recorded, continues in 2015/16 Q1 Governors Directors	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)	DHR	HR Board report reflects capability and disciplinary against behaviors Appraisal documentation identifies core values assessment Appraisal rates in board papers Manchester patient safety framework – CQUIN this identifies attitudes/leadership Implement Human Fcators methodology	Sept 15 May 14 Sept 14 Start June 14 Start June 2015	Included from September 14 Updated and includes core values . Appriasal paperwork and process currently being reviewed Included in monthly board papers Meetings all milestones achieved for this in 2014/15. Trust will train manager booked to undertake training in June 2015. Enagaement with HEKSS to share human factors learning	G	
6	Support staff in taking a zero tolerance to poor attitude towards colleagues / patients	DHR	Connect article to all staff on zero tolerance and support available to staff	Sept 14	To occur as a specific communication exercise. A further communication to go out toall Staff in the Autumn to remind them of our support for zero tolerance in terms of poor attitude towards patients and colleagues.	A	
7	Increased visibility of the Director of Nursing (DN) in clinical areas. 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	DN	Clinical visits – noted within patient experience section of board report New QVH structure in place and provided to organization	June 14 Ongoing June 15	Regular walkkabouts and vistis to departments, Clinical Fridays Structure re- circulated by CEO in June with organistaion	A	

	standards and her lead role in governance and compliance matters. (C6.3)		Ward safety/standards information to board each month Inclusion of OPD / MIU / Theatres		Proposal to board April 14 – routine reports commenced May 14 Templates commenced but review of content required - monthly reports are provided to areas currently		
8	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 Patient care strategy – roles responsibilities has been revised Relaunch of strategy and standards occurs	June 14 ongoing 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 care / inpatient survey	G	
	Safe Care, Safe Staffing						
9	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,DHR	Monthly board report Information on trust website Information on NHS Choices	June 14 ongoing	Proposal to board April 14 Worforce and safe staffing data in monthly board reports Monthly reporting to Board continues and will be supplemented with data from the safefeCare module implemented earlier this year.	G	
10	Safer Care module to the e-roster system, May 2014 to enable monthly reporting of staff vs. acuity patients: June – August 2014. (QA)	DHR	Safer Care module in place Ward and board reports informed by safer care module	June 14 Sept 15	System went live from March 2015. June 2015- work in progress to enhance the benefit of allocate software	G	
11	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 ongoing	Usage currently provided each week Establisment review planned for July 2015 Recruitment programme underway. 5 staff recruited from recruitment day bookedin January 2015 further event in june 2015.	A	Availability of nurses to employ to substantive roles

12	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. (C14.1)	DN	scorecards collated monthly	Oct 14 ongoing	Proposal to board April 14 May – first scorecards to be provided to board Not all information can yet be accessed but steady progress. Further work will be linked to the introduction of the Safe Care module May 2014 scorecards revised in monthly board report	A	
13	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)	DHR DN	Flash report available from e roster	Nov 14 July 15	Due to delayed roll out of safe care module flash report work has been postponed. DN to review the feasibility of a weekly flash report. June2015: Safe care module rolled out across all in-patient area's. Prives the day patient acuity and numbers and for 24 hours in advance Absencereporting is added in retrospectively as relies on access to a computer at point of reporting, moving staff across the system between the wards also added retrospectively ie needs handsets to deliver real time data.	A	
14	Chief Executive to charge the Head of Human Resources with taking responsibility for developing and monitoring relevant and timely early warning data. (C14.3)	DHR	Early warning information available	Nov 14	In progress linked to activity above and due date deferred to November. Discussion has shown that this is most effective when linked to safe care module Early warning information is now being used across the operational teams including SafeCare and DHR has agreed with CEO that a futher system at this time is not required.	G	
15	Head of Human Resources to provide a quarterly update to the	DHR	Quarterly report to board	June 14	Q1 Referred to within HR September report Q2 Updated within individual KSO	A	

	Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system (C14.4)				Q3 Updated within individual KSO Q4 Updated within individual KSO		
16	Monthly reporting of safety thermometer 'harm-free care' (CQUIN)	DN	Board dashboard	May 14 ongoing	Process in place – covered in board dashboard	G	
17	Monthly collection of compliance with WHO checklist (CQUIN)	DN	Board dashboard	May 14 ongoing	Process in place – Audited each month – information provided within CQUIN update, milestones all achieved for 2014/15. May 2015 monthly reporting on WHO continues	G	
	Governance						
18	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. (C16.1)	Chair	Revised meeting structure in place Minutes from Q&R	June 14 July 14 Jan 15	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. Further review being undertaken by chair implementation October 2015	G	
19	As part of a wider review of Trust governance systems, Head of Corporate Affairs to consider how best we can incorporate behavioural and cultural concerns within our governance systems. (C6.7)	KD	All meeting agendas cover behaviours / concerns as AOB standing item	Sept 14 ongoing	To be included in Clinical cabinet from May	G	
20	Establish a monthly executive level Quality & Safety Committee to be	MD	New Q&R process established	June 14	Discussions in place and plan for changes from June 14	G	

	chaired by MD, 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)				Changes to Clinical Governance Group commenced June 14 chaired by MD Q&R changes occur from Sept 14 . Action completed		
21	Trend analysis to be included in monthly reporting to the Quality & Safety Committee. (C16.3)	DN	Trend information available	June 14 ongoing	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. Action completed	G	
22	Quality & Safety Committee to define trend reporting requirements to be provided by the Risk Team. (C16.4)	DN	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. Now established June 2015. Ongoing triangulation meetings in place with updates included in the quarterly Risk Report which is included in the Q&RC papers	G	
23	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)	DHR	Trust risk register to Q&R with updated risks BAF to audit committee quarterly	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. Completed Re formatted BAF reviewed at Audit committee September 14 and November 14 Update June 2015: BAF seminar held at Trust Board workshop on 30/04/2015 and progress update given at May Audit Committee. BAF under further development for 2015/16.	G	

24	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)	DN	Monthly meeting established	June 14	Currently goes to CPC to be on monthly agenda – new format commenced June 14 June 2015: A summary of the learning log and action points is included in the quarterly risk report that is reported to the Q&RC WHO checklist – The quarterly WHO audit was completed as per the 2014/15 local CQUIN achieving all milestones and full payment. Monthly monitoring will continue in 2015/16	G	
Exceptional Environment - ***An environment that provides accommodation and facilities that meet the needs of patients and their families***							
25	Liaise with corporate affairs and review volunteer cover for reception desk ideally covering 0800-1800 July 2014	KD	Front desk covered 0800-1800	July 14 May 15	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.Currently 2 volunteers available for 0700 starts Following review of activity from volunteers reception desk it was decided May PEG that cover would be best utilised between 0900 and 1600. Currently able to cover Monday to Fridday with volunteers for these times	G	
26	Support provision of a discharge lounge / transport waiting area June 2014.	DF	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. Waiting area being created in old LOPA theatre but currently there is no discharge	G	

					lounge, due to capacity issues. After 5pm OPD patients still waiting for transport are looked after in CWing dayrooms and included in safercare module.		
27	Ward re fresh – painting, removal of arjo baths and replacement with showers etc.	DF	Ward redecorated Showers in place	Mar 15	• 4 single side rooms in Ross Tilley have been redecorated. • Nurses' station RT has been decorated. • D bay RT has been redecorated. • Creation of new wet rooms and removal of Arjo baths completed. • 2 single side rooms in MD ward redecorated. • 14 Volunteers from Transco are due to attend site in the next couple of weeks to assist estates department with further decorating in Canadian wing wards including remaining ward bays and day rooms. This work is being coordinated with ward manager.	G	
28	Refurbishment Physio/OT reception area	DF	Physio / OT reception refurbished	Q3	On track. Refurbishment to commence on week beginning 15 June 15.	A	
29	Work with hotel service team to review food charter mark guidance and develop actions to work towards gaining a charter mark March 2015 (CQUIN) Further work on patient experience of food to continue. Identified as Quality Account priority for 2015/16	DN	Quarterly reports provided that demonstrate progress against agreed CQUIN actions, quarterly updates to board and PEG	March 15 April 15	All work completed for charter mark in 2014/15 application in progress. X2 mdt meetingshave taken place , planning a patient engagement exercise re food and to target Burns and Head and Neck patients. June 2015 Sub- group formed led by governor to report into PEG	A	

Outstanding personal service - *All interactions with patients and their family/carers are caring and compassionate putting the patient at the heart of care.*							
30	Provide programme of engagement to patient experience group	DN	Minutes of PEG	May 14	Programme provided and staff and governors joining CIP etc. completed	G	
31	Act on negative feedback and monitor actions to improve experience.	DN	Monthly complaints report – C Cabinet Information within Board report Patient stories at Board	May 14 May 14 June14	Reporting process in place, completed	G	
32	Make available drinks for family within ward area July 2014	DN	Drinks available on ward	June 14	Peanut and Burns in place. C Wing in progress – needs monitoring to ensure available consistently.Placed in day room for easy accesss. Completed June 2015, in place for each area.	G	
33	Provide wider availability of information on how to access personal items / newspapers etc. July 2014	KD	Updated bedside guide	May 14	New guide distributed and includes information, completed	G	
34	Take a zero tolerance to avoidable late start clinics initially identifying the causes August 2014 developing actions to address identified issues March 2015	DHR	Information on clinic start times available Late clinics – evidence of action taken	June 14	Meeting held 10 June actions identified: a) New system administrator to devise a dashboard that can show weekly reports regarding clinic start times from Enlighten b) Flowchart in place for nurses to follow in Plastics, Max fac and Corneo if Dr's are late c) 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	A	

					persistent offenders (if not addressed by actions under e)) firstly to Clinical Directors, then to Medical Director as required moving onto displinary process if needed. Meeting held December and work is progressing Update June 2015 a) – This information is now avaialble b) – Escalation process in place c) – Adhoc audit – results sent to J Morris. d)- Significant decrease in late starts, staff aware and escalate if need arises e)– Started 1 June f) – This is done by completing a datix will highlight s and speaking to appropriate clinical lead		
35	Wifi access for patients. 2014/15 capital programme	**DF**	Wi Fi available to patients		Wi fi available to both staff and patients June 2015; Patient are now able to register and start using the free wi-fi to connect to the internet. Wifi access points have been installed in all waiting areas and in 2016/17 wireless will be available from everywhere as part of the infrastructure Improvement Programme.	G	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th June 2015
Reference number:	156-15
Report from:	Steve Fenlon, Medical Director
Author:	Steve Fenlon, Medical Director
Report date:	17th June 2015
Appendices:	NA
Recommendation:	This report accompanies and provides background information to the regular update to the Board. The Board is asked to note the contents. A separate paper has been prepared with further details of the clinical outcomes project.

Key strategic objective 2: world-class clinical services: quarterly update

1. Clinical strategy (updates elsewhere by head of commissioning)

1.1. Themes of clinical development strategy:

1.1.1. On-site: maximise performance, new surgical business, community facing services.
1.1.2. Off-site: spoke development
1.1.3. On and off-site: network development such as trauma

1.2. Seven day services:

Medium term aims are to increase and demonstrate the level of out of hours (OOH) cover, so far as possible within the Ten Keogh objectives, but within existing staff and financial resource. QVH has submitted 5 areas of compliance to the CCG for their approval.

Increased consultant presence beyond existing emergency non-resident cover will require investment including supporting staff and facilities to realise any benefit.

Likewise six or seven day provision of elective activity as 'work as normal' requires modelling and costing to assess the quality and performance benefit against the cost in recruitment and pay. Currently elective Saturday activity is ad hoc. This may change as QVH intends to pursue lower limb reconstructive surgery and remodel its trauma provision both in and out of office hours.

1.3. Working through the onsite surgical pathway, assess and address the quality and performance of surgical activity.

1.4. Clinical governance review underway: early changes proposed include:

1.4.1. Structured governance meetings covering all areas of clinical practice
1.4.2. Monthly joint audit meetings held in the education centre bringing all clinical governance strands together get more staff to attend
1.4.3. Return of protected time on Monday mornings 0800-1000 simulation training (effect on activity) paper to executive team due.

1.4.4. Identify the total teaching resource-focus fixed teaching where possible Monday protected time only
1.4.5. Meetings of audit, research and risk leads, aligned to strategy and issues for QVH
1.4.6. Identify areas of clinical risk for further analysis.

2. Publish consultant-level clinical outcomes
Lead: Steve Fenlon, Project Manager: Jacqueline Packer

2.1. Collate current consultant level safety metrics allowing review for revalidation.

Currently this spreadsheet is populated manually from disparate data. No further update due to lack of audit staff.

The following outcome measures are updated on the internet by the consultants:

- Orthognathic surgery
  http://qvh.nhs.uk/our_services/consultants/mr_jeremy_collyer.php
- Orthodontics http://qvh.nhs.uk/our_services/consultants/dr_lindsay_winchester.php
- Head and Neck Surgery
  http://qvh.nhs.uk/our_services/consultants/brian_bisase.php

Breast (and other tissue transfer) reconstruction: A national PROM registry by BAPRAS (led by Anita Hazari) has begun collecting data uploaded by individual surgeons on their electronic logbook and will be available to review in Q3.

Anaesthesia: A 'computer-on-wheels' (COW) is employed in the recovery unit to collect patient reported quality feedback. The QVH anaesthetic department working with the research department have launched a trial into quality outcome measures in anaesthesia commencing June 2015.

Burns: A large amount of data on burns healing for adults and children is submitted nationally. It has not proved possible to break this down by consultant due to the multidisciplinary nature of burns care stretched over long periods of time and invariably involving more than one surgeon. Data from IBID is part of our routine quality accounts by service, key measures have been identified and clarity is being sought to enable national comparison.

Sleep disorder patients: Evolved from a local audit based on national parameters, patients are now scoring their improvement in condition and this data will supply PROMs for the sleep centre in future. It is expected the sleep unit will begin to submit patient data to the Quality Account for the first time in 14-15

Eye services: Consultants in this speciality have joined a national website, iwantgreatcare.org, created to enable patient feedback for individual doctors. A link has been placed on the QVH website to these consultants and we are encouraging consultants in other specialities to adopt this route free of charge to QVH.

http://qvh.nhs.uk/our_services/corneoplastics_and_ophthalmology/mr_andre_litwin.php

2.2. General outcome developments

A further paper has been submitted to all board members for the June board meeting

linked to the future of consultant level outcomes publication for QVH.

3. Clinical research and development
Leads: Steve Fenlon, Medical Director; Julian Giles, Clinical Lead for Research and Brian Jones, Director of Research and Development

3.1. Research activity:

3.2. Grants awarded from bids made during 2014-15:
- I4i bid successful, with an award of £850K jointly to QVH, UOB and University of Nottingham (Principle investigator Charles Nduka)
- Addition contingency funding from the NIHR awarded in recognition of research activity in 2014, £13K
- MRC application successful, DPFS dressings (with collaborators) £1.1m awarded (£200K for QVH)
- UOB contributed £18k to assist setting up QVH biobank

3.3. Grants submitted awaiting response:
- EME burns dressing change (with collaborators) £1.5m
- MRC confidence in concept (UOBath) £46k
- Merz to part fund scarring study (oculoplastic dept)
- EOI to collaborate with 8 others in NovoNordisk antibiotic resistance project €8m

3.4. National Institute for Health Research update:

3.4.1. Accrual targets exceeded by 60% in 2014-15 (hence fund uplift above)
3.4.2. CRN funding confirmed at £67K for 15-16 (increasingly tight budgets)

3.5. Collaboration/networks:

3.5.1. High level meeting CEO and Dean UOB with action plan
3.5.2. BSMS Dean has visited BMRF and QVH April 15, awaiting outcome
3.5.3. Biobank steering group working through options, Imperial collaboration possible
3.5.4. Trust research day 15 June 2015

4. Education and training
Leads: Steve Fenlon, Medical Director; Ed Pickles, Director of Medical Education (DME) and Helen Moore, Medical Education Manager (MEM)

4.1. Board approval to proceed to FBC for a multi-professional education centre on the QVH site with 2 preferred options. Funding TBC, timelines needed to maintain momentum.

4.2. Opening of a temporary simulation suite on 15 May with funding for equipment provided by HEKSS. Simulation training has begun. Decision needed for allocation of protected time for staff to enable team building and multi-disciplinary education as part of the human factors work.

4.3. An action plan submitted and underway to address deanery and GMC concerns resulting from trainee feedback. Feedback training, opening education facilities, managing behavioural issues and is part of a holistic approach to recruitment and retention of junior staff and non-consultant career staff. The GMC surveys for all trainees have just been published (June 15) with no mention of bullying or undermining behaviour and more positive ratings across all domains in particular maxillofacial surgery. Actions will continue to address any shortfalls.

4.4. A shortage of deanery supported trainees has to be addressed by recruitment of trust grade doctors. This presents a number of challenges, but excellent consultant engagement in recruitment, retention and management of trust grade doctors in difficulty where necessary is beginning to show benefits. In line with the new directorate structure, the emphasis is on directorate responsibility and managing locally and informally. (See 2015-16 priorities).

4.5. Junior medical staff are encouraged to get involved in their and wider trust issues. A responsive approach by allocating a new temporary rest room has worked well. Quotes have been obtained to refurbish the original surgeons mess: if taken up the temporary mess could then be handed over to other staff working unsocial hours. Improved engagement of trainee staff is reflected in the award of the local audit prize for a trainee audit demonstrating qualitative improvement in hospital handover by both consultant and trainee staff.

4.6. DME is making good progress with above and developing the medical education role. An additional 4 hours per week trust funded time has been provided for 2015-16 to recognise the increasing number of trust grade doctors. It is proposed to split this into 2 hours per week for the DME and 2 hours per week for the lead for simulation to recognise the importance of developing simulation for all trainees within QVH.

4.7. Explore alternative models to deliver medical care at the most basic level. Scope the potential for other professionals to develop into traditional medical roles such as surgical practitioner and expansion of the hand therapist roles. Meetings with SASH have not proved fruitful in this area.

4.8. The DME and Medical Director are exploring changes to the trust induction for doctors, time allocated is less than any other member of the trust workforce and the quality of the induction and excessive e-learning are criticised by trainees-first opinions matter.

5. 2015-16 priorities

Priority 1	**Why**	**How**	**Status**	**Plan**
Sustainable Staffing Solutions for non-consultant grade doctors and dentists	Shortage of deanery trainees Vital for service continuity Non compliant rotas Quality issues	Recruitment changes Allocated DME oversight Local management of performance Speciality and multiprofessional education On site mentoring	Compliant with NHSE-go beyond In place In progress Centre open, review of teaching allocation Sim lead So far with concerns only	Continual redraft of JD/contract/interview process Changes to MHPS act less formally but earlier. Plan for protected time and effect on activity Sim lead appointed, value depends on above Roll out to all off site practitioners Promote trainee

		Trainees forum Spoke review	Forum meeting Underway	engagement eg clin governance review Consider governance alongside performance
Priority 2	**Why**	**How**	**Status**	**Plan**
Improve patient safety-HF training on theatres-Links to theatre productivity	Never events generated in theatre Productivity improvements are essential Plan for 7 day services Assess and challenge the workforce culture	External review Initial responses Appoint theatre manager Invest in HF training/advice Engage widely with staff along the surgical pathway Costs and benefits of extended theatre opening alongside rest of the trust	Done WHO project Theatre Pilots September 2015 Board clarity Alongside new theatre manager and infrastructure directorate Addressed the Keogh ten objectives, go beyond this	Good compliance from low base CQUINN success Encouraging start-needs better data Working with TM prior to arrival Board workshop? Action plan with TM/CD/MD/DDN External Support? Action plan CDs/MD/DDN/DOO case for and against seven day services for medical + other staff

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 June 2015
Agenda item reference no:	157-15
Author:	Kathleen Dalby, Company Secretary on behalf of the Governance Review Group
Date of report:	15 June 2015

Board governance review: recommendations for approval

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

2. A small working group was established to lead the review on behalf of the board.

3. The following paper described the latest progress and requests the board's approval of a series of recommendations so that logistical arrangements can be made in time for implementation from October 2015.

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

    - Meeting agendas for the board of directors will alternate between formal business and informal seminars.
        - Meetings will take place in the first week of the calendar month.
        - Meetings will follow the schedule proposed at appendix 2.
    - The quality and risk committee will meet monthly from October 2015.

Link to key strategic objectives (KSOs)

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

Implications for the Board Assurance Framework or Corporate Risk Register

6. None at present or anticipated.

Regulatory impact

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 June 2015
Agenda item reference no:	
Author:	Kathleen Dalby, Company Secretary on behalf of the Governance Review Group
Date of report:	15 June 2015

Board governance review: recommendations for approval

Background

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

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

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

4. The governance review group's response to this request was provided along with a general update on the progress of the in April 2015.

5. The following paper described the latest progress and requests the board's approval of a series of recommendations so that logistical arrangements can be made in time for implementation from October 2015.

Progress since the last update and recommendations

Board of directors

6. The board previously agreed in principle to alternate monthly meetings of the board between a formal business agenda and an informal seminar agenda.

7. The purpose of the recommendation was to allocate more protected time for strategy development, interaction with staff and patients and board development.

8. The annual schedule set out at appendix 2 shows how the meetings would alternate to provide six business meetings per year and 5 seminar meetings, of which two could be used as away-day events.

9. The board will not meet in August so the proposed schedule works around this so as not to reduce the maximum number of formal business meetings per year.

10. In months when the board does not meet formally, standard performance reports will not be required. Instead, sub-committee assurance reports and a chief executive's report will be circulated to board members for information and included on the agenda for the next business meeting for discussion.

11. The agendas for seminar meetings will include:
    - Presentations from staff colleagues and others focused on strategy and business performance and delivery
    - 'Board to ward' sessions to enable board members to spend time on wards and in departments meeting with staff and patients
    - Workshop sessions on a variety of topics similar to the current seminar sessions.

12. The governor representative will be invited to attend all seminar meetings in full.

13. Business meetings will continue to be held off-site at an appropriate venue until such time as the meetings can be accommodated on-site. Seminar meetings will be held on-site – probably in the staff development centre training room subject to availability.

14. Recently board members were asked to consider moving board meetings from the fourth to the first week of the calendar month. This change would better enable the cycle of reporting and assurance from board sub-committees to the board. All board members could accommodate the change from October 2015.

    Recommendation

15. The board is asked to **APPROVE** the following recommendations so that arrangements for the meetings can be put in place in time for implementation in October:
    - Meeting agendas will alternate between formal business and informal seminars.
    - Meetings will take place in the first week of the calendar month.
    - Meetings will follow the schedule proposed at appendix 2.

Finance and operational performance (F&P) committee

16. F&P has been established in shadow form and held its first meeting on 15 June.

17. Establishing and operating the committee in shadow allows for a phased implementation of the most significant change to the board's sub-committee structure.

18. As recommendation in the last update to the board, public governor Chris Orman has assumed the role of governor representative to the F&P committee until September 2015 when the next round of elections amongst the council of governors which assigns governor representative roles to non-statutory board sub-committees.

19. The committee's first meeting assurance report is included in the papers for the board's meeting on 25 June using a new template. Feedback on the template has been sought from the committee and is also welcome from the wider board so that it might be refined and developed for use by all board sub-committees.

20. The chairman of the committee and the executive director of finance and performance have been asked by the governance review team to conduct their own review of the committee's own sub-committee structure and processes and to make recommendations

to the board of directors in September 2015.

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

Recommendation

22. The board is asked to **NOTE** the development of the F&P committee and to **FEEDBACK** on experiences of the first meeting and the assurance report template.

Quality and risk (Q&R) committee

23. The governance review group previously proposed that the Q&R committee should meet monthly instead of quarterly from October 2015.

24. The purpose of the recommendation was to enable more regular assurance of quality and risk matters in parallel with the work of the F&P committee. Together, the two assurance sub-committees of the board enable it to make changes to the schedule of board meetings described above.

25. As for the F&P committee, the chair of the Q&R committee and the executive director of nursing have been asked by the governance review team to conduct their own review of the committee's own sub-committee structure and processes and to make recommendations to the board of directors in September 2015.

Recommendation

26. The board is asked to **APPROVE** the recommendation for the Q&R committee to meet monthly from October 2015.

Audit committee

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

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

29. At its meeting on 30 April, the board of directors approved the appointment of Lester Porter, Senior Independent Director, to chair the audit committee from 1 June 2015.

30. Subsequent to this meeting, the change was postponed pending further discussion with the trust's external auditors and Monitor

Nomination and remuneration committee

31. No fundamental changes are recommended for this statutory sub-committee of the board of directors.

32. However, the trust chair will take over as chair of the committee from October 2015.

Charity committee

33. At its meeting on 30 April, the board of directors approved a proposal to change the name of its charitable funds advisory committee to ‘charity committee’.

34. No other changes are recommended for this sub-committee of the board of directors in its capacity as corporate trustee of the QVH charity.

Human resources and organisational development (HR&OD)

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

36. Since making that recommendation the governance review group has considered other variations that might better ensure an appropriate profile for HR&OD matters in the trust.

37. The group recommends that board scrutiny and assurance of HR and OD will be provided across the board governance structure as follows:
    - Workforce metrics will be reported to the F&P committee
    - Safe staffing and workforce quality issues will be reported to the Q&R committee
    - Organisational development, staff survey and workforce strategy matters will be reported directly to the board.

38. In addition, the executive team will establish an executive sub-committee to manage human resources issues.

39. As a statutory committee of the board, the nomination and remuneration committee will continue to work to its standard work programme and responsibilities in relation to executive resources and development.

Summary of next steps

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

41. Working with relevant board members and the secretariat team, the company secretary will review/develop and standardise a suite of templates for agendas, minutes and standard reports for the various components of the governance structure.

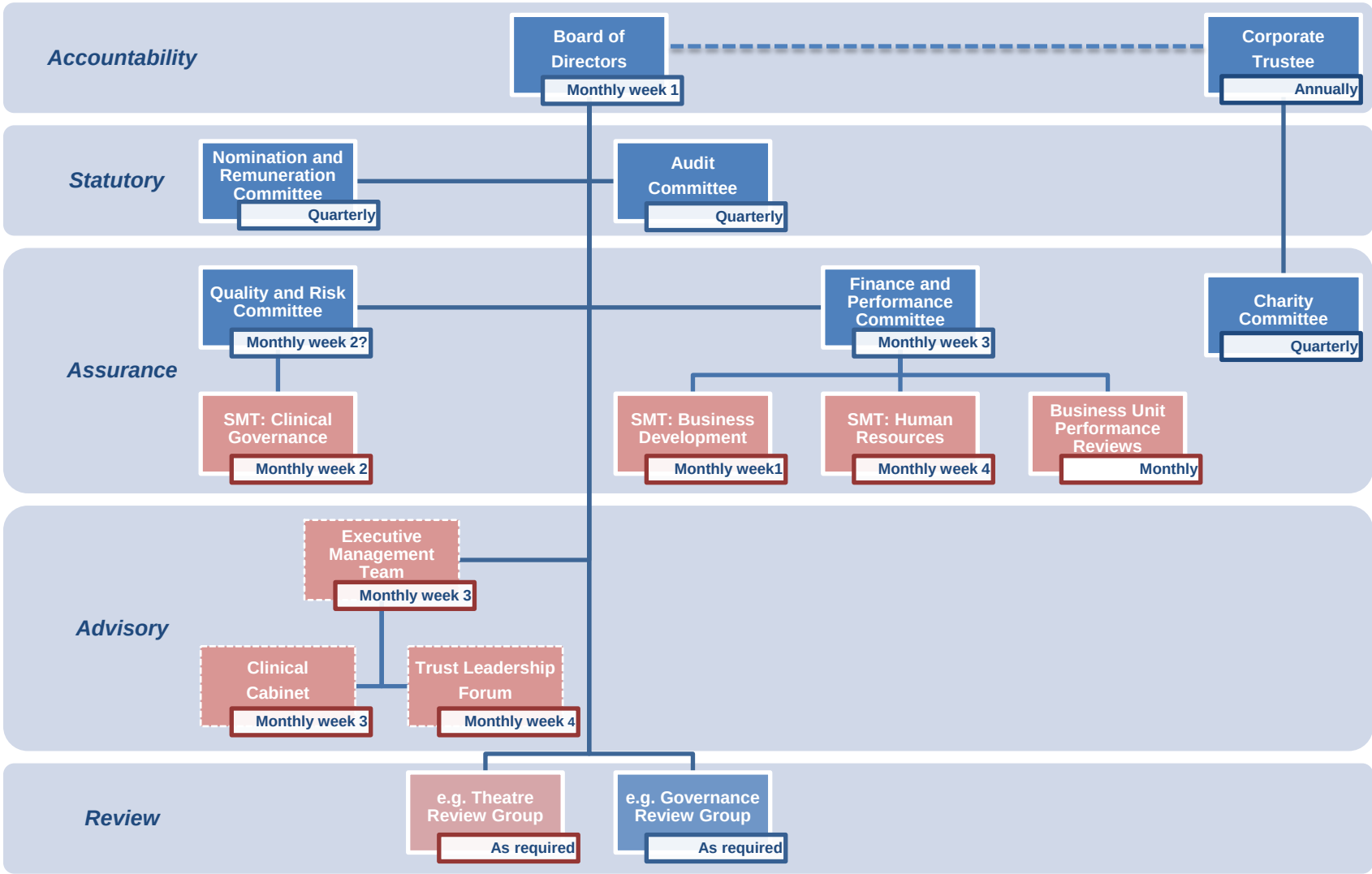
42. The governance review group will also review all relevant terms of reference to ensure that they remain fit for purpose and are consistent with one another.

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

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

Appendix 1: Board and executive governance structure

Queen Victoria Hospital NHS
NHS Foundation Trust



Appendix 2: Annual board meetings schedule

Queen Victoria Hospital NHS
NHS Foundation Trust

	Apr.	May	Jun.	July	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.
BoD business meeting		✓		✓		✓		✓		✓		✓
BoD seminar sessions	✓						✓				✓	
BoD away-day			✓						✓			
BoD as corporate trustee of charity								✓				
Audit		✓	✓			✓			✓			✓
Nom. & Rem.	✓			✓			✓			✓		
F&P	✓	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	✓
Q&R	✓	✓	✓	✓	?	✓	✓	✓	✓	✓	✓	✓
Charity			✓			✓			✓			✓
CoG	✓			✓			✓				✓	

Appendix 3: Board resource and support allocation

Queen Victoria Hospital NHS
NHS Foundation Trust

	Board of Directors	Audit Committee	Nomination and Remuneration Committee	Financial and Operational Performance Committee	Quality and Risk Committee	Charity Committee
Chair:	Beryl Hobson	John Thornton	L. Porter (to Sept) B. Hobson (from Oct)	John Thornton	Ginny Colwell	Lester Porter
NED members:	Ginny Colwell Ian Playford Lester Porter John Thornton	Ginny Colwell	Ginny Colwell Beryl Hobson Ian Playford John Thornton	Beryl Hobson Ian Playford	Lester Porter	Beryl Hobson
ED members:	Chief Executive Medical Director Director of Nursing Director of Finance	None – statutory committee	None – statutory committee	Chief Executive Director of Finance Director of Nursing	Chief Executive Medical Director Director of Nursing Director of Finance	Medical Director Director of Finance
Other board-level attendees:	Director of HR/OD Director of Operations	Chief Executive Director of Finance Director of Nursing	Chief Executive Director of HR/OD	Director of HR/OD Director of Operations	Director of HR/OD Director of Operations	(Company Secretary)
Governor Representative:	Brian Goode (to Sept.)	None – statutory committee	None – statutory committee	Chris Orman (to Sept.)	Tony Martin	Brian Beesley
Secretariat:	Company Secretary and Deputy Company Secretary	Deputy Company Secretary	Company Secretary	Executive Assistant to the Director of Finance	Executive Assistant to the Director of Nursing	Charity Coordinator
Meeting frequency:	Monthly (alternating agenda from Oct.)	Quarterly	Quarterly	Monthly	Quarterly (to Sept.) Monthly (from Oct.)	Quarterly
Time commitment (not including preparation)	1 day per month 11 months per year	½ day per quarter	¼ day per quarter	¼ day per month 11 months per year?	¼ day per quarter/month 11 months per year?	¼ per quarter

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th June 2015
Reference number:	158-15
Report from:	Clinical Cabinet
Author:	Richard Tyler
Report date:	25th June 2015
Appendices:	None

Report from meetings of the Clinical Cabinet held on 18th May & 1st June

Key issues and Actions

Cabinet **ratified** the following;

1. Employment Break Scheme: Cabinet ratified the revised policy.
2. Checking Professional Registrations: Cabinet ratified the revised policy
3. Serious Untoward Incident 2015/12438: Cabinet signed off the root cause analysis (RCA) arising from the recent information governance incident.

Cabinet received **updates** on the following;

1. Month 1 financial position
2. Monthly quality & risk report
3. Monthly operations report
4. Key Strategic Objective 3 – Operational Excellence
5. Key Strategic Objective 5 – Organisational Excellence
6. Quarterly Strategy & Sustainability Report

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

Implications for BAF or Corporate Risk Register
None

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

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 June 2015
Reference number:	159-15
Report from:	John Thornton, Chair of the Finance and Performance Committee
Author:	John Thornton, Chair of the Finance and Performance Committee
Report date:	15 June 2015
Appendices:	A: Board of Directors' sub-committee: chairperson's assurance report

Board of Directors' sub-committee: chairperson's assurance report for the finance and performance committee

1. Enclosed report to provide assurance to the board following the inaugural meeting of the finance and performance committee held on 15 June 2015.

Recommendation

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

Queen Victoria Hospital NHS Foundation Trust	
Board of directors' sub-committee: chairperson's assurance report	
Sub-committee:	Finance and Performance Committee
Meeting date:	Monday 15 June 2015
Meeting chaired by:	John Thornton, Non-Executive Director
Quorate:	Yes

Meeting attendance	
Committee members present	
Graeme Armitage (GA)	Director of HR&OD
Beryl Hobson (BH)	Trust Chair
Sharon Jones (SJ)	Director of Operations
Chris Orman (CO)	Vice Chairman of the Council of Governors
Ian Playford (IP)	Non-Executive Director
Clare Stafford (CS)	Executive Director of Finance and Performance
John Thornton (JT)	Non-Executive Director (Chair)
Richard Tyler (RT)	Chief Executive
In attendance	
Keith Mansfield (KM)	Interim Deputy Director of Finance
Elin Richardson (ER)	Head of Commerce
Claire Charman (CC)	Executive Assistant to the Director of Finance (Minutes)
Not present/apologies	
None	

Meeting summary	
Agenda item:	**04-15 Draft Terms of Reference**
Assurance:	The committee reviewed the suggested terms of reference to ensure they are appropriate and meet the needs of the organisation.
Decision:	Approval of the terms of reference was DEFERRED as some gaps were identified. It was AGREED that it would be sensible for the committee to have some level of delegated authority (not currently reflected in the document), particularly in view of freeing up the board to concentrate on more strategic business.
Referral/escalation:	Referred back to the Governance Review Group to amend and re-present to the next F&P. • To include a workforce section which will include reviewing In Year HR Performance Metrics and Workforce Planning • Attendance list to include the Director of Nursing • To review the delegated responsibility for sub-committees and reflect in document. CS to undertake a review of the SFIs

Agenda item:	05-15 Work plan
Assurance:	The committee reviewed the draft work plan to ensure all items are captured with appropriate timings.
Decision:	Whilst comprehensive and largely compete some changes in timings were identified and therefore the committee DEFERRED approval of the work plan.
Referral/escalation:	Referred back to CS to update and reflect changes to the terms of reference.

Agenda item:	06-15 Policies for review
Assurance:	There were no policies to review at this meeting.
Decision:	N/A
Referral/escalation:	N/A

Agenda item:	07-15 Operational Performance
Assurance:	The committee were given assurance that while we are awaiting the full guidance following the recommendations made by Sir Bruce Keogh to make changes to the admitted and non-admitted targets, treating patients in a timely way has been and will continue to be our focus. SJ working with teams to review scheduling and reported good engagement with the Sleep team who are working to shorten pathway. Given our reliance on spoke sites and their impact on our ability to meet targets, the committee sought assurance that action is being taken to address management/governance issues. RT and SJ undertaking a review of management processes around spokes.
Decision:	The committee NOTED the operational performance report.
Referral/escalation:	SJ and RT to provide progress update at the next F&P meeting.

Agenda item:	08-15 Finance – Month 2
Assurance:	The committee sought more detailed understanding of parts of the business that are over-performing and under-performing and assurance that clinical staff are fully engaged. RT, SJ and CS gave assurance that this is where they will be focusing their time.
Decision:	The committee NOTED the finance report.
Referral/escalation:	Initial analysis of drivers relating to current theatre productivity to be discussed at the August F&P committee.

Agenda item:	09-15 Finance – Contracts Performance
Assurance:	The committee sought assurance that the contracts were reasonable and appropriate. The committee were assured that contract reflect last year's outturn and is better than previous

	years. CS reported that there will no longer be a separate monthly contracts report and data will be captured in the finance reports. Updates will be provided annually as contracts are negotiated.
Decision:	The committee NOTED the report.
Referral/escalation:	None

Agenda item:	**10-15 Capital Programme**
Assurance:	Given the level of expenditure in 15/16, the committee sought assurance that monitoring is in place to ensure projects are progressed and the capital is spent. The committee sought assurance that effective programme management overview is in place. CS gave assurance that a monthly capital monitoring group has been set up to monitor all aspects of capital closely. The group will review the planning of capital spend which is currently shown on the plan in twelfths and does not reflect when monies will be spent. CS reviewing number of committees/meetings/groups in order to rationalise.
Decision:	The committee NOTED the capital programme update.
Referral/escalation:	CS to revise budget phasing for capital spend.

Agenda item:	**11-15 Cost Improvement Programme**
Assurance:	The committee sought assurance that plans are in place to deliver CIPs given the significant increase in the levels of challenge this year. The committee were assured that CIPs are built into the budgets for this year, however, CS keen to ensure that these can be monitored separately and is looking to introduce a rolling programme.
Decision:	The committee NOTED the report.
Referral/escalation:	This item will remain a high priority for the F&P Committee and will continue to be reviewed monthly.

Agenda item:	**12-15 Business Cases for review**
Assurance:	There were no business cases to review.
Decision:	N/A
Referral/escalation:	N/A

Agenda item:	**13-15 Estate Strategy Update**
Assurance:	RT provided a brief update. Green and Kassab are engaged and working to develop Strategic Outline Case.
Decision:	The committee NOTED the update.
Referral/escalation:	Ongoing monitoring by the F&P Committee

Agenda item:	14-15 IT Strategy Update
Assurance:	CS presented a paper seeking approval to split the business case for the IT infrastructure into two, bringing an initial case to the July board to authorise the enabling works which includes the cabling, cabinets and data centres. The committee sought assurance that there were no additional risks by splitting the project. CS explained to the committee that this is simply bringing forward one part of the existing plan to make earlier progress in support of the implementation on an electronic patient record (EPR).
Decision:	The committee APPROVED the proposal to split the project and present two business cases to the board.
Referral/escalation:	Referred to the Board of Directors • July – network infrastructure works • September – remainder of technology works

Agenda item:	15-15 Reference Costs
Assurance:	Whilst the committee found the information of interest (although there were some noted caveats around reliability), CS stated that the timing of its presentation means it is too late to influence performance in 15/16. CS assured the committee that the 14/15 figures will be presented in September and will form part of the discussions through the business planning process.
Decision:	The committee NOTED the report.
Referral/escalation:	To present 14/15 reference cost figures to F&P in September

Agenda item:	16-15 Any Other Business
Assurance:	It was noted that BH and IP will be on leave for the July meeting. Keen to avoid cancellation of the meeting, the committee AGREED to invite another NED to the meeting. BH noted that Lester Porter is also on leave and therefore recommended that Ginny Colwell to be invited to the next meeting.
Decision:	The committee AGREED to invite Ginny Colwell to the next meeting to ensure the group is quorate and avoid cancellation.
Referral/escalation:	CC to action

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 25 June 2015
Reference number: 160-15
Report from: John Thornton
Committee meeting date: 3 June 2015
Appendices: NA

Report of the Chair of Audit Committee

Key issues discussed

1. Approval of policies and changes to policies

There was discussion about the committee's confidence that there was a reliable process in place for making sure that all policies were being checked and updated on a regular basis. It was accepted that it was not the role of the audit committee to review or sign off on all policy changes. But it was agreed that the committee would receive a bi-annual report from the Director of Nursing to show that the ongoing review of polices across the Trust was taking place and was up to date.

2. Internal Audit Plan 2015-16

New internal auditors Mazars presented a draft plan for the year which had been put together following discussions with outgoing auditors and Trust executive.

The plan was considered to be a little generic and not reflecting the specific needs of the trust or current topical issues. In order not to delay required audit work a list of initial priorities was agreed and a plan will be redrafted by Mazars following further discussions with CS and other executives.

It was noted that the committee has not yet seen the reports from the final audits carried out by CV. These will be picked up and presented by Mazars.

3. External Audit

KPMG proposed that in addition to presenting their normal Annual Audit Letter to the CoG at the AGM they will also present a short document explaining how they reached their conclusions. The committee agreed that this would be helpful.

4. Salary Overpayments Issue

Management had identified that a series of overpayments had been made to six employees in Hotel Services. For three of the employees the payments were quite recent, the amounts owed were small and these had been repaid. However for three of the employees these payments went back as far as 2006 and the cumulative amount owed was £4300.

The individual amounts overpaid each month were small and it would have been hard for employees to identify them within the normal payments. The employees involved were all on low grades and salaries.

Management considered that it would be unreasonable to ask these employees to repay the overpayments and recommended that the trust write-off the payments.

The committee agreed to the write-off but sought an explanation of how this could have occurred and assurance that it could not occur again. An explanation was provided but some concern remained that this could possible occur in the future with different employees. There is an audit of HR included in the current audit plan and it was agreed that this should include a review of payroll data processes.

Implications for BAF or Corporate Risk Register

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 25th June 2015
Reference number: 161-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: N/A
Appendices: 1: Supporting report from medical director

Report of the Chair of the Board Outcomes Group

Key issues

1. The Board Outcomes Group (B.O.G.) was established in 2014 to oversee the delivery of robust, easily understood and accessible outcomes for all our consultants for the benefit of our commissioners, our patients and our staff. It was intended to continue in its supervisory role through to the successful delivery of outcomes for all our consultants/clinical specialties.

2. From the outset, in the absence of a project steering group, the B.O.G was constantly drawn into discussion on detailed operational matters which were outside its intended remit. It also quickly became clear that the success of this project was heavily dependent upon progress on QVH's broader technology strategy, and on external NHS progress in defining the nature of outcomes data for each clinical specialty. As a result it was agreed with the B.O.G.in early 2015 that an operational Project Steering Group should be created, in line with normal QVH practice for significant projects.

3. A document prepared by the Medical Director on the current status of the outcomes project and containing a series of recommendation on the way forward is attached for the information of the Board and has my support.

4. Subject to the Board accepting these recommendations, it is proposed that the Board Outcomes Group is disbanded, and that accountability for delivery is clearly vested in the CEO and Executive team, who will keep the Board regularly informed of progress. It is felt that the B.O.G. is a duplication of resource which is not replicated in any other project within the Trust and represents poor use of Board member time.

Items to be referred to the Board of Directors

The Board is asked to approve the disbandment of the Board Outcomes Group with immediate effect.

Additional information or assurance sought

See attached note from the Medical Director.

Implications for Board Assurance Framework or Corporate Risk Register

There were no items identified which should be added to the Board Assurance Framework or the Corporate Risk Register.

Recommendation

The Board is recommended to note the proposed actions and findings.

Briefing note for the Board of Directors.

Steve Fenlon 12th June 2015

Background:

Collection and publication of clinical outcomes represents a natural progression, beyond measurement of process and compliance, to the opening of the NHS to wider scrutiny. It is a key to good governance. Outcome measures take a number of forms, from very generic (mortality) through general complications affecting many procedures, to quantifying the success of specific procedures according to individual patient reported experience or PROMS. The granularity of the data is also important. Some procedures can be described at the level of an individual practitioner performing an intervention (almost solely consultant medical staff), other care pathways involve so many individuals only clinical team or whole organisation data is appropriate. Progress of this project since 2009 has been slow, this reflects the national experience. Collection, analysis and presentation of the data is not just a massive task, it is easily lost in complexity and the need for balance and context. In 2013 the Board of Directors decided that publication of consultant level outcome data would be a key strategy and incorporated this into QVH 2020.

All NHS providers are mandated to produce limited consultant specific outcome measures in key areas such as hip, knee, cardiac and vascular surgery. Under these national terms, QVH has submitted data over the last two years for head and neck oncology surgery. Though the value of the published data is debatable, it is accepted that the UK is at the start of this journey, and as the information collected improves, it may become more accessible to the stakeholders it was intended for and drive improved standards across the NHS.

in many ways, the world may not be quite ready for outcome measures, but we have pursued, and will continue to pursue, the objective.

As at June 2015:

The board has been sighted on progress with the project over the last year- in summary:

Success:

● Published outcome measures on the QVH trust website with regular updating

● Excellent clinical engagement for those measures.

● Established an executive led steering group charged with driving the project forward and formulating the strategy for future initiatives

● Collation of existing governance information for revalidation and to assure the board

Challenges:

● Outcomes is a project fighting for people and financial resources against many other competing projects, some unforeseen and many having more visible and measurable paybacks.

● Difficulties in data collecting, cleansing and processing with dependency on manual techniques and lack of trust information management resource.

● Lack of confidence in data by clinicians and hence loss of engagement and ability to make progress.

● Uncertainty around resource allocation (only 30K total to the project last year, only £7K for 2015-16)

● Shortage of critical expertise and to a lesser extent financial commitment have hampered progress and dampened enthusiasm.

Future:

We must focus on capturing data that is relevant, reliable and create automated mechanisms whereby this can be easily achieved. Once high quality data is obtained, it must be used to tell a story that is open, lucid and interesting to our various audiences. The information should be used to drive improvement, not as a penal means of naming and shaming-robust mechanisms are already in place to highlight and address performance concerns.

We have made only limited commitment to this project to date and must consider this alongside other priorities. We have attempted to do what we can with what we've got; there is a natural limit to the output from this approach. For this project, as all others, the level of investment will be directly apparent in the quality of the product.

Summarized below are three possible approaches to this project together with a 'ballpark' cost of each option:-

Cost benefit:

Option 1.

Description:
Existing
Benefit:
Part time resource allocated into the audit department to continue to push the current service line outcome reports (up to six outcomes on the trust website). The QVH is a test site for the BAPRAS free tissue surgery database, a comprehensive project driven by surgeons who collect the data themselves and submit to a third party for review analysis and presentation. This is currently provided FOC
Cost:
£7K pa

Option 2.

Description:
As Option 1 plus outsource collection analysis and presentation of the patient's experience of intervention (PROMS) to another provider.
Benefit:
Rapid provision of patient reported outcomes across major service lines with data collection, analysis and presentation included, but not including detailed surgical outcomes.
Cost:
£57K pa

Option 3.

Description:
As Option 1 together with a total outcomes package outsourced to another provider
Benefit:
Undertake with an external provider the whole outcome project including PROMS clinical indicator monitoring and detailed surgical outcomes by consultant. Rapid provision of detailed surgical outcomes and creation of dashboards and public facing outcome stories with control of publicity under detailed specification.
Cost:
Estimated at £100-200K pa

Caveats:

*QVH could procure information management for other clinical areas that would enable some outcome measurement and presentation of data in accessible formats. Essentially the "East Kent Model" could provide outcomes in addition to managing information for performance, targets, activity, coding and finance.

*QVH aims to graduate to a full EPR, but this is several years away. The interim EDM will not provide for data collection and analysis to deliver outcome measures. It is important that future technical developments leading to EPR give some priority to outcome measures.

*With nurse and other professional revalidation, it is likely non-medical outcome measures may need to be adopted, currently other healthcare professions if measured at all are only measured by process rather than outcome.

Recommendations:

● The financial investment required for Option 3 is probably unrealistic given other demands on funding.

● Short term, continue with option 1 which has low cost, low risk, some gains in use of existing information.

● QVH board to ensure the project master plan for information management includes the required level of capability to deliver automated outcome data, ideally alongside data relating to coding, performance and finance.

Following successful implementation of the new technology, there should be a move to Option 2, including, if still necessary, appropriate investment probably supported by an external partner. We will need to decide what our measures of success are before investing as there should be tangible gain beyond implementation of the project.

- It is likely that, in view of the delivery of the technical requirements of this project being a fundamental condition of success, fully automated and accessible outcomes data will be 3 - 4 years in delivery.
- The clinical outcomes steering group to continue to drive the project forward, and to provide 6 monthly updates on progress to the Board of Directors.
- The Board is asked to endorse the recommendations above.

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 30 July 2015
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

PROPOSED SCHEDULE		
MEETING OF A BOARD SUB-COMMITTEE		
09.00 – 10.00	**Nomination and remuneration committee meeting**	
INFORMAL SEMINAR MEETING OF THE BOARD OF DIRECTORS HELD IN PRIVATE		
10.00 – 11.00	**Meeting of the board of directors as corporate trustee of the QVH charity**	
11.00 – 12.00	**Strategy and sustainability: burns care**	Chief Executive and Medical Director
12.00 – 12.30	**Presentation: paediatric care, including burns**	Nicolas Senior, Team Leader - Paediatrics
BUSINESS MEETNG OF THE BOARD OF DIRECTORS: SESSION HELD IN PUBLIC		
13:00 – 16:00		
	PATIENT STORY	
	Safety	Director of Nursing and Quality
	RESULTS AND ACTIONS	
	Patients: safe staffing and quality of care	Director of Nursing and Quality
	Operational performance	Director of Operations
	Financial performance	Director of Finance and Performance
	Workforce	Director of HR and OD
STRATEGIC PRIORITIES		
	Quarterly update on delivery of KSO3: operational excellence	Director of Operations
	Quarterly update on delivery of KSO4: financial sustainability	Director of Finance and Performance
GOVERNANCE		
	Monitor declarations: quarter 1 2015/16	Director of Finance and Performance
	CQC inspection (incorporating Monitor well-led framework)	Director of Nursing and Quality
	Corporate risk register	Director of Nursing and Quality
	Annual report: Emergency preparedness, resilience and response and business continuity	Director of Nursing and Quality
	Statutory duties of co-operation (annual review)	Company Secretary
	Fit and proper persons test: QVH policies and procedures	Director of HR and OD and Company Secretary
	Whistleblowing update	Director of HR and OD
SUB-COMMITTEE REPORTING		
	Clinical cabinet	Chief Executive
	QVH charity	Committee Chair
	Quality and risk	Committee Chair
	Council of governors	Governor Representative