Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 26th March 2015

Session in public at 13.00
Session in private at 16.00

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

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 26th MARCH 2015

Members (voting):

Chairman:	-	Peter Griffiths
Chair Designate & Non-Executive Director	-	Beryl Hobson
Non-Executive Directors:	-	Ginny Colwell
	-	Lester Porter
	-	John Thornton
Chief Executive:	-	Richard Tyler
Medical Director	-	Stephen Fenlon
Interim Director of Nursing and Quality	-	Joanne Thomas
Interim Director of Finance and Commerce	-	Dominic Tkaczyk

In full attendance (non-voting):

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 26th March 2015 at 13:00
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

PUBLIC AGENDA		
No.	**Item**	**Page**
WELCOME		
59-15	**Welcome, apologies and declarations of interest** *Peter Griffiths, Chair*	-
PATIENT STORY		
60-15	**Patient Safety** *Jo Thomas, interim Director of Nursing and Quality*	-
STANDING ITEMS		
61-15	**Draft minutes of the meeting session held in public on 26 February 2015 (for approval)** *Peter Griffiths, Chair*	1
62-15	**Matters arising and actions pending** *Peter Griffiths, Chair*	9
63-15	**Update from the Chief Executive** *Richard Tyler, Chief Executive*	11
RESULTS AND ACTIONS		
64-15	**Patients: safe staffing and quality of care** *Jo Thomas, interim Director of Nursing and Quality*	15
65-15	**Operational performance: targets, delivery and key performance indicators** *Jane Morris, Interim Director of Operations*	46
66-15	**Financial performance: monthly update** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	56
67-15	**Contract Update** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	71

68-15	**Workforce** *Graeme Armitage, Director of Human Resources and Organisational Development*	76
STRATEGIC PRIORITIES		
69-15	**Quarterly update on delivery of Key Strategic Objective One: Outstanding Patient Experience** *Jo Thomas, interim Director of Nursing and Quality*	89
70-15	**Quarterly update on delivery of Key Strategic Objective Two: World Class Clinical Services** *Steve Fenlon, Medical Director*	103
71-15	**Strategic Priorities for 2015/16** *Richard Tyler, Chief Executive*	108
72-15	**2015/16 Budget** *Dominic Tkaczyk, Interim Director of Finance and Commerce*	115
73-15	**Staff Survey Results** *Graeme Armitage, Director of Human Resources & Organisational Development*	121
GOVERNANCE		
74-15	**Corporate Risk Register** *Jo Thomas, interim Director of Nursing and Quality*	143
75-15	**Update in response of *'Savile NHS investigations: lessons learned'* report** *Jo Thomas, interim Director of Nursing and Quality*	157
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD (AND COUNCIL OF GOVERNORS)		
76-15	**Clinical Cabinet** *Richard Tyler, Chief Executive*	166
77-15	**Quality & Risk Committee** *Ginny Colwell, Committee Chair*	168
NEXT MONTH'S AGENDA		
78-15	**Draft agenda for next month's meeting** *Kathleen Dalby, Company Secretary and Head of Corporate Affairs*	169
STAKEHOLDER AND STAFF ENGAGEMENT		
79-15	**Feedback from events and other engagement with staff and stakeholders** *All board members*	-
MEMBERS OF THE PUBLIC		
80-15	**Observations from members of the public** *Peter Griffiths, Chair*	-

81-15	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. *Peter Griffiths, Chair*	-
PRIVATE AGENDA		
COMMERCIAL-IN-CONFIDENCE		
82-15	**Draft minutes of the meeting sessions held in private on 26th February and 12th March 2015 for approval** *Peter Griffiths, Chair*	170
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIR)		
83-15	*Peter Griffiths, Chair*	-

DATES OF THE NEXT MEETINGS

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 30 April at 13:00	**N & R:** 30 April 2015 at 09:00 **Q & R:** 07 May 2015 at 09:00 **Audit**: 20 May 2015 at 14:00 (AR&A/C) 03 June 2015 at 14:00 **CFAC:** 25 June 2015 at 09:00	**Public**: 09 April 2015 at 15.00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 26th February 2015, 13.00 – 16.00, The Council Chamber, East Court, College Lane, East Grinstead RH19 3LT**	
Present:	Peter Griffiths (PAG)	Trust Chairman
	Beryl Hobson, (BH)	Non-Executive Director and Chair Designate
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Dominic Tkaczyk (DT)	Interim Director of Finance
	Jo Thomas (JMT)	Interim Director of Nursing & Quality
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources & Organisational Development
	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)

WELCOME

030-15 **Welcome, apologies and declarations of interest**

The Chair opened the meeting and welcomed back KD from maternity leave; he also welcomed JMT to her first board meeting as interim Director of Nursing and Quality.

There were no apologies and no new Declarations of Interest

PATIENT STORY

031-15 **Patient Experience**

JMT apprised the board of an instance where, due to difficulties experienced within patient transport, an elderly patient had to wait for approximately seven hours until she could leave. Despite the problems, our staff had responded with compassion and made the patient feel welcome and cared for, even providing a bed and a hot meal. The board agreed this was a very positive outcome.

The Chair thanked JMT and the board **NOTED** the contents of her update.

STANDING ITEMS

032-15 **Draft minutes of the meeting session held in public on 29th January 2015 for approval**

The following changes were requested:

- 005-15: JT asked for his initials be distinguished from those of JMT to avoid confusion.
- 006-15: for greater accuracy, JMT asked wording to be altered from 'next report' to 'future reporting'

Taking these amendments into account, the minutes of the meeting were **APPROVED** as a correct record.

033-15	**Matters Arising & Actions Pending** The board reviewed the current record of matters arising and actions pending, the update was received and **APPROVED**.
034-15	**Update from the Chief Executive** RT presented his monthly report, highlighting the following: As agreed last month, the Directors of Finance and of Operations had undertaken a review of any risks arising to achieving the planned year-end surplus and updated the board accordingly at its earlier seminar. As RT had previously reported, the proposed tariff for 2015/16 had been suspended. Further information would be provided during the business planning item later in the meeting. Sir Robert Francis' recently published report *Freedom to Speak Up* was a review of the treatment of whistle-blowers within the NHS. The report contained a number of recommendations for NHS trusts and RT confirmed the QVH policy would be reviewed to ensure these were incorporated where appropriate. Both LP and GC agreed a board discussion on the implications of the report would be useful. GA noted that the current Whistleblowing policy was due to be ratified at the Quality and Risk Committee next week, after which time it would undergo a further evaluation to incorporate new recommendations. It would then be returned to the board for review in April. **[Action: GA/JMT?]** PAG thanked RT for his monthly update, the contents of which were **NOTED** by the board. The Chair thanked RT and the board **NOTED** the contents of his update.
RESULTS AND ACTIONS	
035-15	**Patients: safe staffing and quality of care** JMT reported that the response to the Savile enquiry had been published this morning and suggested the board might take an opportunity to review its conclusions. The report would be considered initially at the Quality and Risk Committee (Q&RC) and any pertinent issues be imparted to the board. Safe staffing levels had been maintained throughout January, although the escalation process had been invoked on four separate occasions during the month. GC requested that future reporting include a quality matrix for Theatres **[Action: JMT]** BH noted the high number of patient falls which had occurred in Canadian Ward in January. JMT agreed this figure was higher than usual but was unaware if this was indicative of any particular problem, although the situation would be monitored. SF sought assurance in respect of cancelled operations and suggested additional clarification regarding context would be useful in future reporting. **[Action: JMT]** JT queried the high level of needle stick injuries sustained by staff. JMT was assured by Occupational Health reports suggesting this was as a result of human error, but agreed to monitor the situation closely. JT also sought clarification with regard to the trust's preparedness for an inspection by the Care Quality Commission (CQC). JMT assured the board that planning for an inspection was well underway and apprised the board of steps the trust was taking to ensure it would be fully

	prepared. Whilst the trust would be inspected during 2015/16, JMT confirmed this would not happen in Quarter 1, and the trust would be informed in April if this was scheduled for Quarter 2. GC reminded the board that an unplanned visit could take place at any time, although both RT and JMT felt the likelihood of an unexpected visit was currently quite low. PAG suggested once the inspection date had been confirmed, JMT could provide the board with an update as to progress. **[Action: JMT]** LP raised concerns at the nil return for the Friends and Family Test in Peanut Ward this month. JMT advised there had been no inpatients in Peanut during the period in question, and it could have been that patients had not been inclined to complete questionnaires. However, she agreed to remind staff of the importance of encouraging patients to complete the test, and would also remind them of the importance of submitting a nil return when appropriate. The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
036-15	**Consent and WHO Checklist** SF presented an update on the Consent for Treatment target, aimed at achieving 'consent before the day of surgery' (CBDOS). He informed the board that it was not considered best practice for consent to be obtained on the day of the procedure; an optimum approach would be to obtain consent at the initial consultation and for this to be merely confirmed on the day of the procedure. SF reminded the board that a staged introduction of this process was adopted as a CQUIN for 2012-13 and became priority 2 of the Quality Account in 2013-14. This has been monitored as a quality indicator during 2014-15. A decision was taken to monitor the percentage of elective procedures consented for surgery before the day of admission by a monthly manual audit of the case notes, and to present the data as a percentage by directorate but to use the aggregate as the target. The latest target (2014-15) is an aggregate figure of 75%. SF apprised the board that all audit and consent data is on paper and manually checked as currently no electronic system exists at QVH for documenting or measuring consent; current audits were undertaken by reviewing 20 time-based samples. GC asked whether the trust should be considering if CBDOS was always good practice, particularly in view of the huge variety of surgical procedures undertaken at QVH. PAG agreed that the trust should not be penalising clinicians if the current rules were inappropriate, however, he expressed concern at the low level of samples taken and suggested that current sampling be expanded whilst ensuring consent was appropriate for good clinical practice. PAG also felt there was some confusion surrounding definitions and that the board was collectively unclear. JMT reminded the board that there were no incidents of patients being treated without consent that that this target related specifically to 'consent before the day of treatment'. RT agreed he and SF would consider the matter further in order to gain a better understanding of the principles raised as blockers, eg lack of forms off-site, insufficient time allocated to the process. This item would then be returned to the board in due course. **[Action: RT]** The second part of this report focused on the World Health Organisation (WHO) checklist. This was in place to ensure routine matters were habitually addressed, enabling capacity to manage any unexpected events. In 2013 a series of engagements was undertaken to embed the full version of the WHO checklist and to notify staff that this was now mandatory. In 2014-15 the trust achieved 95%, and in the current financial year, achieving 95% compliance was signed up as a trust CQUIN (subsequently raised to 100% compliance by the CCG). SF reported that

	during the first month of Q4 compliance was 100% against a target of 100%. The Chairman thanked SF for his update and the board **NOTED** the good progress which had been made in respect of the WHO targets.

037-15	**Operational performance: targets, delivery and key performance indicators**
	JM reported that the trust was compliant at an aggregate level for all three 18-week targets in January. It was also compliant in January for all three 18-week performance targets at specialty level with the exception of Oral Surgery (non-admitted patients), which missed its target by only one patient. JM was confident that the trust was close to sustaining overall performance going forward.
	
	Other key performance indicators included the following:
	• There were no urgent operations cancelled in January.
	• Whilst there were six cancellations on the day of admission in January, all patients were rebooked within the 28 day NHS Guarantee.
	• For Quarter 3, the Trust reported
	  • Non-compliance with 18 weeks due to failure to meet Trust aggregate performance in October and November
	  • Compliance with the cancer standards.
	  • Non-compliance with the diagnosis target due to the Cone Beam CT failure reported in November, (subsequently repaired). The Trust is forecasting compliance with this standard for Q4.
	
	PAG congratulated JM and her team on the excellent performance. In the meantime, however, he asked how close the trust was to achieving its 15-week internal target. RT reported that 75% of patients were now seen within 15-weeks, but reminded the board that this target had been agreed as a means of achieving a sustainable waiting list and was not mandatory. To achieve this would require a further waiting list initiative and he therefore asked the board for guidance as to how this should be managed going forward. PAG requested that, whilst in no way detracting from the team's achievement to date, consideration be given to what was necessary to achieve a sustainable waiting list. Her asked RT to give this matter due consideration and report his findings to the board. **[Action: RT]**
	
	The Chairman thanked JM for her report, the contents of which were **NOTED** by the board.

038-15	**Financial performance: monthly update** DT reported that the trust was £93k ahead of the plan for the year, and on track to achieve surplus at end of year. The January surplus had been improved by £132k through the removal of the Q2 RTT18 penalties. (As reported previously, penalties would not now apply due to the current 18-week performance). Income also included 100% of CQUIN payments for Q1, Q2 and Q3. As discussed at last month's board (and also this morning's seminar), an element of achieving this year's plan had been assisted by carrying across the provision for MRET (Marginal Rate for Emergency Treatment) which had been utilised last month. As reported on several occasions in previous months, capital expenditure was significantly below the phased plan due to the delayed start of the IT network replacement project and reconsideration of the Estates programme; however, the trust had been aiming to spend as much available capital as possible by the end of the financial year to reach the 15% tolerance level required by Monitor. PAG sought and received assurance that some expenditure would include the cost of the new anaesthetic machines (also being partially funded by the League of Friends). The cash position remained healthy. DT confirmed that the intention was to invest in a new IT infrastructure, and a business case would be returned to the board for approval in due course.

	[Action: DT] PAG asked if the anticipated surplus of £250k was realistic and was assured by DT that this was the case. As discussed during the earlier seminar, this would be used appropriately to support next year's financial position. BH asked if Monitor would be likely to raise the issue of capital during its visit to the trust in March. It was noted that this matter had not been raised during the recent conference call with Monitor, and RT concurred that the forthcoming visit was more of an introduction rather than a performance review. BG asked if there might be a direct correlation between the overall increase in day case patients, the reduction in inpatient cases, and the drop in income. PAG agreed that these changes may have cost more in staffing, (not been offset by a reduction of inpatients) with the overall result being that it had cost more to deliver certain activity than it had yielded in income. Whilst RT agreed that the fall in income could be due to the case mix issue, more detail was required before drawing any conclusions. DT agreed to investigate and report back at next month's meeting. **[Action: DT]** The Chair reminded the board that should QVH meet its surplus target, this would be a huge achievement compared to other foundation trusts. He then thanked DT for his update, the contents of which were **NOTED** by the board.
039-15	**Contract update** DT presented the monthly contract update highlighting the following: Whilst the trust had bid to provide services for AQP Non Obstetric Ultrasound (NOUS) and Direct Access Magnetic Resonance Imaging (MRI) for West Kent CCG, feedback indicated QVH had not been successful due to the service being outside the boundaries of West Kent. DT would appeal this decision and keep the board apprised of developments. As reported at last month's meeting, DT reminded the board that NHS England had commissioned at approximately 8% below the 2013/14 outturn, without any demand management schemes in place. DT noted the trust had signed the agreement in good faith, on the basis of an activity / volume mechanism for payment and yet NHS England continued to challenge all over performance. In the meantime, guidance had been released indicating that for 2015/16, NHS England intended to set the baseline at the same level as the MO10 outturn. The board expressed concern at this rationale; again, DT undertook to keep it informed of progress. The Chair thanked DT for what he felt was a very helpful briefing, the contents of which were **NOTED** by the board
040-15	**Workforce** GA reported there were promising signs this month in respect of turnover, vacancies and sickness. Turnover had reduced with a steady trend towards target, and the work of the Recruitment and Retention Taskforce was now starting to have a positive impact. The number of vacancies throughout the year had been higher overall than for the previous two years, but this was in line with the higher turnover rate (in turn driven by the retention problems seen in a few specific areas – eg. Canadian Wing). However, vacancies overall had been falling steadily, a trend which was continuing. The number of live vacancies represented only about 24% of the gap between the funded establishment and the 'in-post' figure. GA asked the board

	to note that the total of all paid staff, (including bank, agency and overtime), was slightly above funded establishment. Although previous years had seen a sharp increase in the number of live vacancies towards the end of Q4 GA anticipated that with tighter controls in place it was hoped that that the number of live vacancies would remain fairly constant, although this would continue to be closely monitored. The position on sickness was positive, with rates continuing to fall. Managers were handling episodes of sickness well. In contrast, however, high sickness levels were being reported in Theatres, particularly in relation to stress and anxiety. GA intended to focus on short term sickness and future reporting would separate long and short term sickness to better monitor future trends. Statutory and Mandatory Training continued to improve, and there was now greater confidence in the quality of data available. The Chair congratulated GA on the recent recruitment initiative and for further information regarding the final 'conversion' rate from the 50 prospective candidates who attended on the day **[Action: GA]** It was agreed that whilst the Recruitment and Retention Taskforce appendix had been useful, only headline figures were required for future reporting. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
STRATEGIC PRIORITIES	
041-15	**Quarterly update on delivery of Key Strategic Objective (KSO) 5: Organisational Excellence** GA reminded the board that this objective was divided into the three core areas of Leadership Development, Performance Management and Innovation. Highlights for this quarter included the following: **Leadership Development** • The formal launch of the Leadership and Management Development Framework was taking place today; it was anticipated this would enable a more effective system of identifying members of staff appropriate for development **Performance Management** • Progress had been maintained within most performance management areas, with the exception of 3-year workforce planning; however a new approach aligned to the 2015/16 business planning process would be adopted for Year 1. (Plans for Years 2 and 3 would be developed during Q1 and Q2 following implementation of the revised management structure). GA assured the board this issue was a priority within the Workforce Strategy and the recently appointed Deputy Head of Human Resources would be driving this forward. • GA noted that further work was being done to develop the current recruitment team, although the revamped Medical Recruitment Team was working well. • SafeCare: GA conceded that e-Rostering had been implemented too quickly and with insufficient resources. However, he explained how the SafeCare module would use existing information systems to provide managers with early warning of potential workforce problems. Implementation of the SafeCare module was now in line with the project plan scheduled to go live in March. Scoping and costs were being worked through for a mobile version which would provide real time scheduling. GA was assured that results would lead to better management decisions. There was greater cooperation between wards which enabled staff to be moved to areas where demands were higher. GA advised that as the national model doesn't fit with our specialist organisation, a bespoke model was being developed for

	Paediatrics and Burns, with successful testing leading to further refinement • GC asked what would be the success criteria of the leadership strategy, and if this would be presented to the board. GA confirmed this would be addressed through the talent management leadership programme. **Innovation** The new education centre was being development under the leadership of Ed Pickles (Director of Medical Education) and Helen Moore, Medical Education Manager. JT noted that the RAG status of this quarterly update was predominantly green and asked if this suggested a new programme might be required. GA explained that this demonstrated most areas were on track but were not complete and would carry over to the next financial year. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
GOVERNANCE	
042-15	**Corporate Risk Register (CRR)** JMT advised the board of the trust's four top risks as follows: • Ability to meet RTT18 targets (a risk now escalated to 20); • Breaching of cancer targets • Failure to main continuous estates services due to staff shortages, and • The impact on the trust's decontamination services due to relocation of core surgical services at Synergy healthcare. A further risk relating to emergency alarm systems in theatres had been rated at 12 but JMT was assured staff were managing this, and that there was no risk to patients. As requested last month, risks which were duplicated in the Board Assurance Framework had now been removed from the Corporate Risk Register. BH referred to the spoke site summary review which had been incorporated into the Strategy and Sustainability report to be considered later in the meeting, and asked if a risk assessment had been undertaken in view of the report's conclusions. JMT concurred there was nothing in place at present, but agreed to action this. **[Action: JMT]** The Chairman thanked JMT for her update, the contents of which were **NOTED** by the board.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
043-15	**Clinical Cabinet** The Chief Executive confirmed there was nothing to report this month.
044-15	**Nomination & Remuneration Committee** LP confirmed he nothing further to add to his written report. As an aside, BH noted that the target date for appointment should be amended from 'before end March' to 'during March' as it was hoped the Appointments Committee would be in a position to make a recommendation to the full Council at its meeting in early April. The board duly **NOTED** the contents of the report.
045-15	**Audit Committee** In addition to the points raised in his written report, JT advised that following a stringent procurement process, the trust had now appointed Mazars (who had recently acquired the

	Deloittes Public Sector internal audit unit) to replace Chantrey Vellacott as its internal auditors. He confirmed he had every confidence in the appointment and the new team would be taking over from the beginning of 2015-16. The board **NOTED** the contents of the report.
NEXT MONTH'S AGENDA	
046-15	Next month's draft agenda was presented for comment, and duly noted by the board.. DT advised that Monitor had delayed submission of the 5-year plan until mid-April which could impact on reporting to the board. JT suggested that the BAF should be removed from the March agenda as he felt the board required an informal debate before being in a position to consider and identify key risks. RT agreed that the March board meeting should focus on priorities and budget setting, and the April meeting could be used to focus on identifying key risk following on from this. KD asked for suggestions which might be considered within the informal seminar next month.
STAKEHOLDER AND STAFF ENGAGEMENT	
047-15	**Feedback from events and other engagement with staff and stakeholders** PAG, BH and RT had met with Sir Nicholas Soames, East Grinstead's local MP who had been very complimentary about the hospital. BH had visited the East Grinstead Museum to learn more about the history of QVH. GC, LP, SF and RT had all undertaken Compliance in Practice visits through the trust and without exception had received very positive feedback from both patients and staff.
MEMBERS OF THE PUBLIC	
048-15	**Observations from members of the public** There were none.
049-15	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**
February 2015 meeting						
1	**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	On April agenda	**On-track**
2	**035-15**	Future Safe Staffing reporting to include quality matrix for Theatres	**JMT**	March		**TBA**
3	**035-15**	Greater level of detail, including context, to be provided in respect of cancelled operations in future reporting.	**JMT**	March		**TBA**
4	**035-15**	Board to receive update on progress for CQC inspection once visit is confirmed.	**JMT**	TBA		**TBA**
5	**036-15**	Board to receive further clarification in respect of Consent Before Day of Treatment (CBDOT)	**RT**	TBA		**TBA**
6	**037-15**	Board to be apprised how best the trust might to achieve sustainable waiting lists in the long term.	**RT**	TBA		**TBA**
7	**038-15**	Board to be apprised of reasons for recent fall in income, and whether this is due to changes in case mix.	**DT**	March		**TBA**
8	**040-15**	Following January recruitment drive, information regarding 'conversion rate' of prospective candidates to be provided.	**GA**	TBA		**TBA**
9	**042-15**	Risk assessment to be undertaken in respect of conclusions following spoke site summary.	**JMT**	TBA		**TBA**
10	**051-15**	Recommendations following spoke site review to be implemented	**RT**	TBA		**TBA**
11	**53-15**	Extraordinary meeting to be convened prior to March board to consider the implications of the tariff in respect to the financial plan 2015/16	**KD**	March	Meeting now arranged for 12th March at 2pm	**Complete**
January 2015 meeting						
12	**009-15**	DT to present options for consideration by the board in respect of management of surplus.	**DT**	Feb 2015	**03.02.2015** Scheduled as part of February seminar programme	**Complete**
13	**028-15**	SF to present report to private session of board evidencing how difficult behaviour is currently tackled.	**SF**	~~Feb 2015~~ TBC	**08.02.2015** On board agenda for February **26.02.2015**	**Pending**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
					Due to time constraints at February board this will now be presented as part of board development workshop in April.	
December 2014 meeting						
14	**331-14**	Board to be apprised of criteria used when approving locations for off-site activity	**RT**	**TBA**	**TBA**	**TBA**
15	**337-14**	Explanation of how key high level risks are identified to be provided at a future board seminar.	**AP**	April 2015	Scheduled as part of April seminar programme	**On track**
16	**338-14**	C-Wing Action plan to be returned to board for review in June 2015	**KD**	June 2015	Now incorporated into 2015/16 work programme	**On track**
November 2014 meeting						
17	**317-14**	Board to receive a presentation in the New Year as to how the new Electronic Patient Record system will affect the organisation as a whole.	**JM**	February	Now scheduled for the board seminar in February 2015	**Complete**
July 2014 meeting						
18	**181-14**	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**	~~Oct~~ ~~Dec~~ TBA	This will form part of the wider organisational review which will start in October 2014 **21.10.14:** Review has commenced, not expected to conclude until December **18.12.14** Review still underway	**Pending**
May 2014 meeting						
19	**136-14**	Monitor's "Well-Led" assessment framework to be implemented as part of the governance review. LH to liaise with RT regarding next steps, and board to be updated accordingly.	~~**LH**~~ **KD**	~~Aug~~ ~~Oct~~ ~~Dec~~ Mar	**08.07.14:** Presentation to be made to October Nomination & Remuneration Committee **15.09.14:** Well Led Review template to be used as framework for Board self-assessment commencing at December away day. **21.10.14:** Current Governance Review led by Chair Designate to be based on Well –Led Framework **01 02 2015** As LH has now left the trust this will be picked up by KD	**Pending**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26th March 2015
Agenda item reference no:	63-15
Author:	Richard Tyler, Chief Executive
Date of report:	13th March 2015

CHIEF EXECUTIVE'S REPORT MARCH 2015

1. Attached is the March report 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
MARCH 2015

TRUST ISSUES

Budget setting 2015/16

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

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

On balance DTR was more financially advantageous to the Trust although not without risk. Under the DTR option the Trust is not eligible for CQUIN payments during 2015/16. CQUIN payments of up to 2.5% of the Trust's budget (£1.2m) are available on delivery of agreed quality improvements. Whilst the payment is not guaranteed the Trust has achieved 100% in previous years. In addition under the DTR option Monitor is able to make in-year changes to the tariff. At present there is no indication of when this might happen but as part of budget setting it has been prudent to include a contingency for a reduction in tariff, and therefore income, at some point during the year.

It against this backdrop that we have set the budget for 2015/16. The detailed figures are included in the Director of Finance's report later on the agenda. However the headlines are as follows:

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

We have made strategic investments of c. £800k. These include; new consultant appointments in corneo-plastics and ophthalmology to meet growing service demands and waiting times; investment in trauma capacity to reduce out of hours operating and delayed admissions; and investments in our management structure to ensure we have the right capacity and capability to support our longer-term sustainability.

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

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

Our budget strategy is not without risk. As the Board is aware we have underperformed on elective in-patient activity during 14/15. Our analysis indicates that this was largely the result of short-term capacity constraints rather than longer-term changes in demand. However we will bring a more detailed paper to the April board setting out proposals for risk mitigation as part of setting the board assurance framework (BAF) for 15/16.

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

Finally I would like to formally record my thanks for all of the hard work that has gone into the 2015/16 budget round. Service managers, supported by the finance team, have worked under considerable pressure and uncertainty to set a budget that enables the trust to continue providing safe, high quality care on a daily basis whilst creating the investment necessary for our longer-term sustainability.

Performance – 18-week recovery plan

I am pleased to confirm that we continue to forecast full compliance in February with the 18-week target at both an aggregate and an individual speciality level for admitted, non-admitted and open patient pathways.

Staffing – organisational restructuring

As reported last month interviews for the Director of Finance took place on 18th February and for the Director of Operations on 25th February. I am pleased to confirm that we have appointed successfully to both posts.

Claire Stafford has been appointed as Director of Finance. Claire joins us from West Hertfordshire Hospitals NHS Trust where she is Director of Operational Finance & Efficiency. Sharon Jones has been appointed as Director of Operations. Sharon joins us from Croydon University Hospitals where she is Director of Transformation & Service Improvement. Both Claire and Sharon will start with us at the beginning of June.

I am also pleased to inform the Board that we have made two further appointments. Nikki Reeves has been appointed as Deputy Director of Nursing and Head of Clinical Infrastructure and Paul Gable has been appointed as the Business Manager for clinical support services.

Monitor Quarter 3 Review

The quarterly review took place in mid-February and I am pleased to confirm that the Trust remains rated green for governance and retains it continuity of service rating of 4.

NATIONAL & REGIONAL ISSUES

The *Forward View* into action: planning for 2015/16

I reported in February that we submitted a bid jointly with primary care colleagues in East Grinstead, Sussex Community Trust, Brighton Integrated Care Services (BICS), South East Coast Ambulance Service (SECAMB) and Help the Aged (East Grinstead) to be considered as a vanguard project. Sadly the bid was not successful. However the work we have undertaken will help shape our joint commitment to develop enhanced primary, community and acute services in East Grinstead.

Richard Tyler
13th March 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26 March 2015
Reference number:	64-15
Report from:	Jo Thomas, Interim Director of Nursing & Quality
Author:	Jo Thomas, Interim Director of Nursing & Quality
Report date:	13 March 2015
Appendices:	Reports on: • Safe Staffing • Patient experience, complaints and claims • Care Quality Indicators (CQUINS) • Quality Account Priorities

Patients: Safe staffing and quality of care

Key issues

1. This report provides information on;

   - Safe staffing and whether safe staffing levels are being achieved as per national recommendations and information on how safe and well led each ward is;
   - Quality and risk management with information provided on quality and safety metrics and incident management;
   - Infection prevention and control issues and actions;
   - Information on new and closed complaints, claims and patient experience feedback;
   - The CQUIN scheme for 2015/16 and the impact of the Deferred Tariff Rollover; and
   - Quality Account updates and process for agreeing priorities for 2015/16

Safe Staffing

2. Safe staffing levels were achieved throughout February.
3. Areas of concern continue to be the vacancy rates and increased use of agency staff required and this is reflected in incident returns made by wards on staff resource.

CQUIN

4. Dementia screening target this month is within agreed target
5. Consent prior to the day of surgery was lower again this month.
6. The Trust Board has opted for Deferred Tariff Rollover (DTR). The impact of this on the CQUIN scheme is significant as the Trust is not eligible for the CQUIN scheme for the entirety of 2015/16 This means there will not be the £1.2 m payment for CQUINs.
7. Work will continue on the 5 quality improvement initiatives and this will be shared with the Board and Commissioners.

Quality and Risk Management

8. One grade 2 QVH acquired pressure ulcer developed in February
9. One serious incident was reported to the Clinical Commissioning Group in February.
10. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.
11. Flu vaccination has finished with a overall shortfall in the desired target of 60% target. Final submission of 53%. Low uptake nationally.

Infection Control

12. New guidance on C Difficile reporting- QVH policy changed to reflect this.
13. Threshold set for zero tolerance in 2015/15 for C Difficile

Complaints, Claims and Patient Experience

14. The results of the National Inpatient Survey are discussed within the Patient Experience report and ientify areas for improvement included the quality and choice of food.
15. There were four new complaints acknowledged during February and these are under investigation and progress is reviewed monthly by the Chief Executive and Director of Nursing. For all closed complaints letters sent are signed by either the Chief Executive or Director of Nursing.
16. Any action identified as the result of a complaint is monitored through the monthly clinical governance group and good progress on closure of actions is reported by the DN.
17. Patient feedback is good, changes made to the scoring methodology of the FFT continue to be reflected within the dashboard.

Implications of results reported

18. Additional agency and bank staff have been required as a result of vacancies on wards.

Action required

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

Link to Key Strategic Objectives

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

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

Implications for BAF or Corporate Risk Register

21. The corporate risk associated with the recruitment of staff remains at a rating of 16.

22. The corporate risks associated with infection control have been reduced to 12.

Regulatory impacts

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

Recommendation

24. The Board is recommended to **NOTE** the contents of the report, in particular the changes to the 2015/16 CQUIN Scheme

Patients: Safe Staffing and Quality of Care

Introduction

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

Safe Staffing

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

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

3. Within the safe staffing metrics the board is directed to the vacancy rate within Canadian Wing.

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

Commissioning for Quality and Innovation (CQUIN)

4. CQUIN targets below were achieved this month.

5. A CQUIN update for 2015/15 is detailed in a separate appendix.

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

Quality Account Priorities for 2015/16

6. The long list was discussed at Clinical Cabinet has been worked up to establish SMART targets for achievement by the Trust. These were presented at Quality and Risk Committee in March. The final list and paper on Quality Account Priorities is detailed in a separate appendix.

Patient Experience

7. There were four new complaints opened in February 2015 and two complaints were closed. The full report can be seen at Appendix 1.
8. Four new claims were opened in February 2015 and are detailed in the full report.

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

Patient Safety

9. There was one grade 2 pressure ulcer acquired at QVH during February. This occurred during an 18 hour theatre case. A Root Cause Analyses is being undertaken.

10. Six patient falls occurred in February. Four falls occurred in clinical areas and two occurred in hospital grounds. Two of the falls resulted in minor harm including bruises and grazes.

11. One new Serious Incident was declared in February 2015. This was an Information Governance and Caldicott Guardian issue. A patient who had undergone surgery at QVH had received a copy of a letter with another patient clinical details printed on the reverse. A full Root Cause Analysis is underway.

12. Trust wide, consent taking prior to surgery has shown a decrease in compliance in February. The Medical Director continues to work with the Clinical Leads to address this patient safety and quality indicator.

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

Staff Safety

13. The mandatory training figure is reported as 76% and the process of data cleansing continues.

14. Flu vaccination has now finished for 2014/15. The Trust final submission to IMMFORM was 53% which fell below the internal target of 60%. However, nationally the uptake was lower than expected. Flu vaccinations have been ordered for 2015/16.

Source	**Description** (Activity per 1000 spells is based on HES Data w hich is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	**2013/14 total / average**	**Target**	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Safety	Staff incidents causing harm	58		9	8	6	10	9	8	13	5	5	11	7	
	RIDDOR (Patients & Staff)	4		1	0	0	0	0	0	1	0	0	0	0	
	Mandatory training attendance	71%	80%	82%	78%	82%	89%	79%	77%	74%	43%*	69%	75%	76%	
	Flu vaccine uptake	55%	60%	0						38.1%	49.70%	51.50%	53%	53%	

Infection Control

15. NHS England Guidance on *Clostridium difficile* infection objectives in 2015/16 has been released. This includes:
    -The RCA process should identify `lapses` in the quality of care. QVH policy has been altered to reflect this.
    -The CCG will continue to review cases. If they conclude that there has not been a `lapse` in care the case may still be attributable to the Trust but a sanction is unlikely.
    - QVH target for 2015/16 remains at zero and the contractual sanction if a breach is identified remains the same at £10,000 per positive case.
    - The Trust now has to consider previous cases, identify common themes and actions to prevent recurrence. All CDIs that are now reportable as SI`s (2 or more cases/patient death or lapses in care) should also be reported on the Strategic Executive Information System (STEIS).

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

Care Quality Commission (CQC)

16. The latest intelligence monitoring report published by the CQC has been released in December 2014 and this is available on their website.

17. Two risks were identified; Never events and 62 cancer target however these were not noted as elevated risks and the trust remained banded as 6 (where 6 is the lowest risk) for priority inspection.

18. QVH has not been identified for in the CQC's next wave of inspections for April – June 2015 although work has commenced on an internal self- assessment to ensure we are prepared for inspection. QVH is anticipating an announced inspection by the CQC from July 2015 onwards and has begun to prepare for this by planning to undertake a Trust wide self-evaluation assessment against the 5 CQC domains and their Key Lines of Enquiry (KLOE) and Regulated Activities. Part of the preparation for the inspection will include staff engagement sessions to raise awareness of the CQC, its role and function, and the KLOE's that are used to inspect services.

SAFE STAFFING DATA – FEBRUARY 2015

CANADIAN WING																
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies wte/hrs Est = 62.88	7.76 WTE 1288.7hrs	9.21 WTE 1480hrs	6.22 WTE 1033hrs	3.83WTE 636hrs	6.38WTE 1025.3hr	6.38WTE 1059.53	11.25WTE 1808hrs	12.41 WTE 1994hrs	12.69 wte 2107hrs	12.70wte 1905	<5%	20%				Action required under established adverts out to recruit
Temporary staffing Exc RMN Bank / Agency hours	530.10 431.30	553.15 360.30	735.15 375.0	836.50 452.30	418.15 499.30	579.00 795.15	648.45 982.40	418.50 471.30	835.45 545.05	563.00 1419.20	<10% 235.8 + vacancy	-158.60				No action required
Sickness	2.4%	1.2%	1.0%	1.8%	1.5%	3.56%	5.29%	4.90%	4.53%	5.59%	<2%	+3.59%				sickness increased due to long term absence
Shifts meeting Est Day RN Support	97.0%	98.0%	100.0%	99.0%	100% 101%	100% 98%	108% 102%	99% 91%	100.4% 101.9%	98.1% 99.2%	>95%					On track no action required
Shifts meeting Est RN day/night Support day/night					99% 100%	98.5% 98%	102% 94%	100% 92%	97.8% 96.9%	97% 90.1%	>95%					On track no action required
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	70.2%	70.3%	63.2%	61.6%	48.0%	64.80%	68.00%	65.00%	75.64%	70.60%	>85%	-14.40				Action required below target
Appraisals	67.7%	70.5%	73.7%	68.9%	66.7%	61.29%	70.00%	76.00%	74.19%	64.91%	>85%	-20.09%				Action required below target
Drug Assessments	96%	98%	100%	100%	100%	100%			100%	100%	>95%	5%				On track no action required
Friends and Family Test Score MD / RT	89 85	94 94	87 91	83 82	73 75	97% 100%	98% 95%	99% 100%	100% 100%	100% 98%	>95%	+3 +2				Scoring methodology changes to percentage rating
Staff Friends and Family Test Score		79 17														
Budget (K)	15	6	12.6	-24	-37	-22	-52	-80	-91		>0	-187.4				Over spend on nursing budget due to reliance on bank and agency to cover established posts

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

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

BURNS UNIT																
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 30.63	1.6 wte 266hrs	6.40 wte 1028hrs	7.40 wte 1229hrs	6.40 wte 1062.85	6.50wte 1044.6	6.53WTE 1084.44	6.53WTE 1044.64	6.50WTE 1044.64	5.50wte 913 hrs	5.07 760.50	<5%	16.5%				Vacancy on establishment
Temporary staffing Exc RMN Bank / Agency	398.15 114	466.30 128.55	400.45 573.0	335.0 216.0	124.45 78.0	301.25 137.45	212.30 42.00	226.00 144.00	271.20 180.00	370.55 180.00	<10% 114.8hrs + vacancy	-353.95				No action required
Sickness	4.1%	4.79%	2.42%	1.98%	0.75%	0.66%	2.05%	6.46%	3.72%	3.17%	<2%	+1.17%				
Shifts meeting Est Day RN Support							100 103%	100% 100%	95% 95%	98.7% 96.6%						
Shifts meeting Est Night RN Support	96%	99%	98%	92%	100%	98%	109 100%	97% 100%	98% 100%	96.2% 120%	>95%					Staffing identified as safe due to acuity of patients
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	80.25%	83.60%	77.10%	75.91%	58.79%	74.17%	78.00%	70.00%	83.99%	77.69%	>85%	-7.31%				Below target
Appraisals	58.82%	66.67%	86.21%	80.00%	79.31%	80.00%	80.00%	77.00%	70.97%	56.67%	>85%	-28.33%				Below target
Drug Assessments	95%	97%	97%	94%	90%	90%			100%	100%	>95%	-1%				Action required
Friends and Family Test Score	100	94	100	100	100	100%	100%	100%	100%	100%	>95%	20				Scoring methodology changes to percentage rating
Staff Friends and Family Test Score		79 17														
Budget	3	15	-14.6	-90	-95	-99	-101	-124	-127			-632.6				Overspend is split between income and non pay

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

ITU																
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 16.16	2.40 WTE 386 hrs	0 WTE 0.0	.44wte 73.0	1.76 wte 292.28	2.76wte 443.5	2.76WTE 458.35	1.76WTE 282.85	1.76WTE 282.85	0.76 wte 122hrs	1.76	<5%	11.00%				action required
Temporary staffing Exc RMN Bank / Agency	151.30 280.20	238.40 112.30	124.4 426.0	249.30 414.00	64.00 184.00	119.30 444.00	239.45 600.50	95.20 100.20	152.30 234.00	160.45 235.25	<10% 60.6hrs + vacancy	+71.05				
Sickness	14.59%	7.01%	5.52%	2.30%	2.15%	2.09%	1.67%	13.46%	4.12%	1.94%	<2%	-0.06				
Shifts meeting Est Day RN Support	95%	91%	97%	96%	99%	96%	100 58%	93% 125%	97% 110%	95% 100%	>95%	2%				
Shifts meeting Est Night RN Support							102 100	94% 100%	97% 100%	91% 100%						
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	79.17%	83.60%	76.00%	80.27%	56.42%	78.57%	78.00%	70.00%	78.85%	72.44%	>85%	-12.56%				Fallen slightly below target, action required
Appraisals	50.0%	46.67%	33.33%	37.71%	38.46%	53.85%	53.00%	62.00%	53.85%	53.85%	>85%	-31.15%				Raised directly with manager
Drug Assessments	95%	97%	97%	94%					100%	100%	>95	-1%				Action required
Budget	-7	-25	-48	-62	-63	-47	-3	-22	-40		>0	-317				Pay oversepnd

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

Peanut																
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Vacancies Est = 25.00	1.72wte 286hrs	2.2wte 365hrs	2.2wte 365hrs	.63wte 104.62	.63wte	1.0WTE 166.07	1.35WTE 216.96	1.99WTE 319.82	1.99 wte 330hrs	1.99wte 298.50	<5%	8%				No action required
Temporary staffing Exc RMN Bank / Agency	160.15 23.45	289.20 0	328.05 7.30	331.0 35.0	196.45 20.00	212.45 0.00	230.10 25.00	166.00 35.30	179.55 82.30	246.30 28.00	<10% 93.75 + vacancy	-147.95				
Sickness	3.8%	4.36%	10.03%	8.43%	6.05%	6.42%	10.87%	4.93%	6.03%	8.90%	<2%	+6.90%				
Shifts meeting Est Day RN Support	96%	100%	97%	94%	99%	98%	105% 97%	100% 89%	95% 97%	98.7% 100%	>95%					No action required
Shifts meeting Est Night RN Support							106 100	100% 100%	100% 100%	89.3% 100%						
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Stat and Mand compliance	81.3%	85.00%	67.20%	77.69%	58.54%	73.28%	69.00%	63.00%	80.96%	78.24%	>85%	-4.04%				Action required
Appraisals	87.1%	96.77	84.38%	87.10%	87.88%	84.38%	78.00%	77.00%	73.33%	85.71%	>85%	+0.71%				On track no action
Drug Assessments	100.0%	95.5%	88.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>95%	-8%				On track no action
Friends and Family Test Score	100	100	66	-100	100	88%	100%	100%	N/A	N/A	>95%	-14				Scoring methodolgy changes to percentage rating
Staff Friends and Family Test Score		79 17														
Budget	-6	-5	-6.6	-12	-17	-15	-18	-25	-25		>0	-129.6				This is asplit between pay, non pay and income

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

Commissioning for Quality (CQUIN) position 2015/16

The CQUIN intentions for 2015/16 are evolutionary: an opportunity to consolidate efforts on national goals from previous year's schemes whilst shifting the focus on to new national goals. The Five Year Forward View has set the vision for promoting wellbeing and preventing ill health with a key intention to align incentives to reform payment approaches and contracts.

The value of the CQUIN scheme is 2.5% of the actual annual contract (as defined in the2015/16 NHS Standard Contract). This equates to 1.2 million for QVH, 0.5% for national CQUIN and 2% for local schemes.

National CQUINs applicable to QVH are:

- Acute Kidney Injury
- Mental Health, Dementia
- Sepsis

Locally negotiated CQUINS with Commissioners are:

- Human Factors training
- Mental Health support for trauma patients

The 2015/16 national tariff payment system consultation launched last year has progressed and providers were offered the choice of an Enhanced Tariff Option (ETO) or Default Tariff Rollover(DTR).

After detailed analysis of the two options and careful consideration by the Board the Trust has opted for DTR. The impact of this on the CQUIN scheme is significant: the Trust is not eligible for the CQUIN scheme for the entirety of 2015/16 This means there will be no contractual arrangement with the commissioners for the national and local CQUINS and no 1.2 m income.

The five CQUIN schemes remain important to the Trust and the intention to drive quality improvements in all of these remains. However to avoid confusion the 5 schemes will be referred to as internal quality improvement initiatives and there will be no contractual monitoring of these by Commissioners.

Next Steps

The Medical Director and the Interim Director of Nursing will review the 5 quality improvement initiatives and reset achievable milestones within the resources available.

A quarterly report will be produced for the Quality and Governance Committee and updates for the Board.

We will share progress against the initiatives with the Commissioners but no as part of contract monitoring.

The revised quality initiatives will be presented to the Quality and Risk Committee in May 2015.

Queen Victoria Hospital NHS
NHS Foundation Trust

Monthly complaints, claims and patient experience report

1 February 2015 – 28 February 2015

This report provides an overview of all activity during this period. During this period there were 5 formal complaints received. This is the same as last month. The following is a summary of the complaints that were received.

Monthly complaints, claims and patient experience report

1 February 2015 – 28 February 2015

Complaints

Open complaints: There were 4 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.

Maxillofacial

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

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

   Comment/Action – Still undergoing investigation.

Canadian Wing

2. **Medical/Nursing - Safety –** Patient was written up and given penicillin based antibiotics. 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/Chief Pharmacist**

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

   Comment/Action – Still undergoing investigation and awaiting comments.

Plastic Surgery

3. **Medical/nursing – Access and waiting/communication** – The patient sustained a laceration to the arm and was initially seen at Eastbourne hospital. A referral was made to QVH via the trauma co-ordinator who told patient to attend MIU following which he would be admitted for surgery. When patient met with doctor on MIU he found her 'every abrupt, snappy and rude.' The patient does not recall the clinician asking if it was all right if a work experience observer could stay during the consultation.

   Patient was then informed that they would not booked in for surgery that day and that they would need to come back the following day where they would be put on the trauma list. Patient returned at 7am as was told to and had to wait until 9pm before surgery was performed. Patient also assured by Site Practitioner that they had put them on the theatre list for Wednesday.

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

   Comment/Action – Still undergoing investigation and awaiting comments.

Preassessment Unit

4. Nursing care – communication/attitude – The patient raised concerns about the attitude and lack of compassion that was displayed by one of the nursing staff.

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

   Comment/Action – Still undergoing investigation and awaiting comments.

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.

Peanut wars/burms

1. **Medical/nursing – clinical care –** Concerns raised by mother of patient in relation to the treatment provided. Patient had initially been treated at Bristol and mum feels that the care provided here conflicts with the treated provided by referring hospital. Have asked for care to be referred onto C&W. **Investigating lead – Clinical Lead**

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

   Comment/Action - The burns treatment provided to the patient was appropriate, however there were communication issues and also a lack of clarity in relation to the patients scar management. This has resulted in a patient information leaflet regarding the therapeutic use of Micropore tape is being produced. **Outcome – upheld in part**

Physiotherapy

2. **Therapy - treatment provided** – Following hand surgery patient felt that therapists had overworked his hand. Patient concerned that damage may have occurred. **Investigating lead – Consultant/Therapy Lead**

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

   Comment/Action – It was arranged for the patient to have an urgent appointment to be reviewed by consultant. Patient's finger was very badly broken and it was a very poor fracture. Patient has been reassured that the therapists have not caused any damage and that the patient is to continue with therapy, which at times maybe painful. The patient will be reviewed by consultant in 3-4 weeks. **Outcome – unsupported.**

Claims

Open claims: There were 4 new claims opened during this period. Overall there are 48 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	Specialty	Description
n/k	25/02/15	N/K	Medical (Doctors)	During inpatient admission patient contracted tuberculosis. Have requested from the patient solicitors further information as the last admission we have recorded for patient is 2000. There is a 3 year limitation period in which to make a claim for compensation.

n/k	02/02/15	MAXILLOFACIAL	Medical (Doctors)	Patient had multiple tooth extractions which are alleged to have been removed for no reason for these being undertaken.
19/03/2013	30/01/15	CANADIAN WING	Nursing	Following Septorhinoplasty, nasal splint, nasal packs and stitches were allegedly removed 24 hrs following surgery by one of the nursing staff, whereas splint should have remained for 1 week.
01/10/14	18/02/15	MAXILLOFACIAL	Medical (Doctors)	Claimant attended on the trauma list. Following an x-ray this confirmed that patient had a broken jaw and that a wisdom tooth should also be removed. Patient underwent surgery to repair their jaw but the wisdom tooth was not removed. The wisdom tooth later became infected resulting in patient being readmitted for surgery.

Closed claims: 0 claims were 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 6 new comments posted onto the NHS Choices/Patient Opinion websites.

Anonymous gave Plastic surgery at Queen Victoria Hospital (East Grinstead) a rating of 5 stars

care

all the staff were very friendly & helpful you were always well cared for

Visited in January 2015. Posted on 30 January 2015

Anonymous gave Plastic surgery at Queen Victoria Hospital (East Grinstead) a rating of 5 stars

treatment

The treatment I have received the communication has been outstanding the staff wonderful clinics and treatment all on time what more can I say Thank you

Visited in January 2015. Posted on 06 February 2015

Lisa Johnston gave Surgery - Breast at Queen Victoria Hospital (East Grinstead) a rating of 5 stars

Bilateral Mastectomy with immediate DIEP reconstruction

I had a bilateral Mastectomy with immediate DIEP reconstruction at QVH on the 21st January 2015.

Everybody made my visit perfect at, what was, probably the strangest time in my 40 years of life. My consultant put me at ease with his warm smile and approach, the nurses were all lovely and attentive...they make you feel like you are the only one they are caring for while you are there.

I was a very shy girl with regards to showing off certain parts of my body but these Nurses, Consultants and Doctors made this side of treatment easy to cope with.

Thank you East Grinstead for being there when I needed you...The NHS and its staff are all amazing! x

Visited in January 2015. Posted on 08 February 2015

Anonymous gave Oral and Maxillofacial Surgery at Queen Victoria Hospital (East Grinstead) a rating of 5 stars

Excellent Continuity

I have recently visited the clinic twice within the last 4 weeks. I was particularly impressed by my most recent visit which was the Wednesday 11th February in the morning where I saw a doctor for the second time, he has such a great manner and was very respectful of my wishes about having a general anaesthetic. The continuity was extraordinary and I saw the same doctor and nurse on both occasions who had a great rapport. The nurse even remembered that I had horses and asked after them while leading me to the room which was a nice touch. The consultant also came in to confirm my treatment and he respected his colleagues decision and my wishes. Great teamwork by all and every member of staff I saw looked happy in their work even when a clearly busy clinic. I hope this thanks gets back to the right people and receive the praise that they deserve.

Visited in February 2015. Posted on 18 February 2015

paul w gave Plastic surgery at Queen Victoria Hospital (East Grinstead) a rating of 5 stars

EPL/ thumb tendon transfer

Excellent hospital with excellent staff. I had to undergo hand surgery, and I must say this has to be the best hospital in the south east if not the country. I was always kept informed when there was a delay in my treatment. Five stars from me.

Visited in February 2015. Posted on 25 February 2015

paul gave Rehabilitation at Queen Victoria Hospital (East Grinstead) a rating of 5 stars

Hand therapy

I had a visit to the physiotherapy dept. today 25/2/2015. I have to say how professional and lovely the hand therapist was, as I'm sure they all are. I know they are only doing their job, but hey give praise where it`s due. I always leave this hospital with a smile on my face, as it`s never a chore to visit it.

Visited in February 2015. Posted on 25 February 2015

National Inpatient Survey 2014

The results presented here are from the Inpatient Survey 2014, carried out by Picker Institute Europe on behalf of the Queen Victoria Hospital NHS Foundation Trust. This survey is part of a series of annual surveys required by the Care Quality Commission for all NHS Acute trusts in England. The Picker Institute was commissioned by 78 UK trusts to undertake the Inpatient Survey 2014. The survey is based on a sample of consecutively discharged inpatients who attended the Trust in June, July or August 2014.

The annual survey of patients at all hospital trusts in England covered all aspects of patients' care and treatment, including the way they were treated by doctors and nurses, the information they were given and their views on cleanliness, comfort and quality of food. These findings help the NHS to improve the way it cares for and treats patients, enabling hospital trusts to see how they are doing year-per-year and how they compare with others.

A total of 850 patients from your Trust were sent a questionnaire. 830 were eligible for the survey, of which 405 returned a completed questionnaire, giving a response rate of 49% (average response rate 45%). The response rate for the Inpatient survey in 2013 was 50%.

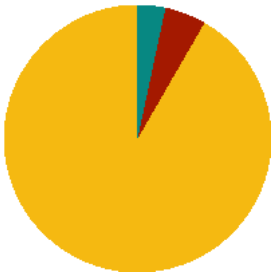
Key facts about the 405 inpatients who responded to the survey:

- 74% of patients were on a waiting list/planned in advance and 23% came as an emergency or urgent case.
- 72% had an operation or procedure during their stay.
- 51% were male; 49% were female.
- 13% were aged 16-39; 32% were aged 40-59; 24% were aged 60-69 and 31% were aged 70+.

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

- Overall: 96% rated care 7+ out of 10.
- Overall: treated with respect and dignity 95%.
- Doctors: always had confidence and trust 93%.
- Hospital: room or ward was very/fairly clean 100%.
- Hospital: toilets and bathrooms were very/fairly clean 99%.
- Care: always enough privacy when being examined or treated 96%.

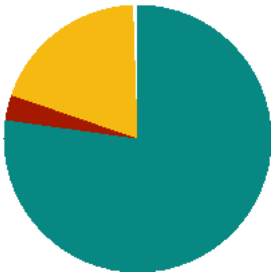
Have we improved since the 2013 survey?



A total of 60 questions were used in both the 2013 and 2014 surveys.

Compared to the 2013 survey, QVH Trust is:

- Significantly BETTER on 2 questions
- Significantly WORSE on 3 questions
- The scores show no significant difference on 55 questions



How do we compare to other trusts?

The survey showed that QVH Trust is:

- Significantly BETTER than average on 48 questions
- Significantly WORSE than average on 2 questions
- The scores were average on 12 questions

Problem Score Summary

The following are areas where we could improve the patient experience.

- Score significantly worse than average.

Area	Question	Trust	Average	
Planned admission 5	Not offered a choice of hospital	77%	69%	-
Care	Could not always find staff member to discuss concerns with	40%	61%	-
Hospital 22	Not offered a choice of food	39%	21%	-

The findings will be looked at in more detail and an action plan drawn up to ensure that we continually seek to improve our services and are confident that we are offering QVH patients the very best care.

Friends and Family Test

The role out of FFT is a national CQUIN by the end of 2014/15 we are required to achieve a return rate of 40% for inpatient returns and 20% for MIU.

The Trust wide FFT scores for in-patients in February was **99%** of our patients would recommend us. **99** inpatients out of a possible **359** inpatients completed the questionnaire which is a **response rate of 27.9%.**

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	41	132	31.1%	100%	0%
RT ward	49	186	26.3%	98%	0%
Peanut ward	0	9	0%	0%	0%
Burns ward	9	29	31.0%	100%	0%
Sleep centre	42	131	32.1%	98%	0%
MIU	195	769	25.4%	93%	3%
Trauma	136	523	26%	90%	4%
OPD	253	10138	2.5%	98%	1%
DSU	16	643	2.5%	100%	0%

The following chart is a comparison of specialist hospitals and their FFT scores for December 2014 (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	75	96	78.13%	100%	0%
Papworth Hospital NHS Foundation Trust	568	919	61.81%	98%	1%
Queen Victoria Hospital NHS Foundation Trust	114	342	33.33%	100%	0%
The Royal Marsden NHS Foundation Trust	119	259	45.95%	98%	0%
Royal National Orthopaedic Hospital NHS Trust	251	475	52.84%	98%	0%
Stoke Mandeville Hospital	162	801	20.22%	97%	1%

Priorities for 2015/16 Quality Account

Proposals for the quality account priorities for 2015/16 have been sought from staff, commissioners and the Council of Governors. These were further informed by feedback from the strategic review *QVH 2020 Delivering Excellence* and have been discussed at Clinical Cabinet. The full list and initial recommendation are attached for information in appendix 1.

Priorities

1. **Scheduling of elective surgery**

For patients knowing their planned surgery date is a key priority as it allows them to plan their personal arrangements accordingly. The national guidance on managing waiting lists identifies that all elective patients should be given reasonable offer of date for surgery at least 3 weeks in advance. This does not apply to cancer patients as organisations are required to meet shorter timescales for this group and at QVH for some of our more complex patients we have to plan their surgery dates around the availability of donor tissue required for surgery.

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

Current baseline: Month 1-10; average 57.8%

Target for patients knowing their surgery date 3 weeks in advance:

Q1 60% Q2 70% Q3 80% Q4 80%

2. Expand trauma capacity to reduce waiting time for patients waiting for trauma surgery

QVH prides itself on providing a good patient experience for all our services. Whilst this is generally true, further improvements can be made. One such area is our current QVH trauma service, which in the last year has reached a maximum level of capacity and is on average turning away up to 4 referrals a week. There have also been occasions where elective patients have been cancelled, or some trauma cases have to wait long lengths of time to be treated and are being operated on out of hours all of which are not seen to be in line with best practice. Therefore the vision for trauma services at QVH includes creating additional capacity to further improve these services. This will enable the organisation to reduce waiting times following injury by offering one stop treatment services as well as provide increased access and support to lower leg trauma within the region.

Therefore a priority for the Trust during 2015/16 is to increase available theatre capacity for trauma patients from Q1. This will ensure that QVH can provide a service that enables 90% of cases to be treated within 24 hours of admission and almost eradicate the need to operate on cases out of hours between 10pm – 1am. In addition to these two measures we will monitor the overall patient's waits for treatment, number of attendances and length of stay.

a) % of patients treated within 24hours of admission currently 88% by Q3 we will ensure 90% of all patients are treated within 24 hours and aim to achieve 92% by the end of Q4.
b) % Patients operated on OoH's i.e. after 10pm reduced by 50% for example Dec there were 6 so 50% reduction would be 3 patients.

3. Improving patient experience of food provided at meal times and snacks throughout the 24 hours period, 7 days a week

The challenge to provide appetising, nutritious food to a wide range of patients at varying levels of recovery in hospital is always going to be a difficult one. However, we must listen and learn from the feedback of our patients and strive to improve the way we produce, choose and serve meals to our patients. Responses to some of the food questions from the 2014 Picker Institute inpatient survey showed QVH scores to be significantly worse than the previous survey. The aggregate score for FFT food scores in Quarter 3 was 34% of patients rated their food as fair or poor compared with 56% of patients rating their food as very good or good for the same period. Following some further patient and public engagement our aim is to see a decrease in the FFT scores of patients rating food as fair or poor decrease to less than 20%.using the FFT food score feedback tool.

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

Q1 Engagement exercise and fair and poor ratings <30 %

Q2 fair or poor ratings <25 %

Q3fair or poor rating<20%

Q4 sustain fair or poor ratings at <20% with poor ratings not above 5%

Appendix 1

Long List Quality Account Priorities 2015/16

There were 7 new recommendations made and one continuation of a current quality account priority: scheduling of elective surgery. These were:

- Histopathology turnaround times. Suggested by QVH clinician

- Improving the Out-Patient Department (OPD) experience: carry out a review of the use of Waiting areas 1,2 and 3. When Clinics are running behind time, there is no flexibility in the Check in system to call patients to another waiting area. Thus creating overcrowding in one particular area with a lack of seating, leaving patients standing for some considerable time. Suggested by Council of Governors

- Increase Parking facilities for Patients / Visitors.

We all know that Parking is an issue at most Hospitals, QVH being included. I would like to see the Board make this item a very high priority. Additional Parking can be provided within the existing footprint of the Estate, by providing a mezzanine level over the existing Car Park and/or providing Car Parking spaces on the land between the old Jubilee ward and the boundary with Holtye Road. Suggested by Council of Governors.

- Improve the safety of the Walkways in the Covered way from Hotel Service through to the sliding doors on the Main Street. Suggested by the Council of Governors

- Expand trauma capacity to reduce waiting time for patients waiting for trauma surgery. Suggested by the Clinical Commissioning Group)

- Food improvement from patient's perspective. Multiple recommendations received as well as being identified as a problem in the inpatient survey 2014 published in February 2015.

- Elective consent taken prior to day of surgery. Suggested by Clinical Cabinet

- Scheduling of elective Surgery. Suggested by clinical cabinet as the progress made in 2014/15 has not yet reached the outcome standard.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26th March 2015
Reference number:	65-15
Report from:	Jane Morris, Interim Director of Operations
Author:	Jane Morris, Interim Director of Operations
Report date:	17th March 2015
Appendices:	Appendix A – Commerce KPI report

Operational performance: targets, delivery and key performance indicators

Key Performance Indicators

1. Trust income from patient activity was under plan in Month 11.

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

3. The Trust was also compliant in February for all three 18 week performance targets at a speciality level except for Rheumatology who were not complaint for open pathways.

4. The Trust is forecasting compliance for all three 18 week targets in March and at speciality level.

5. There are no breaches of 52 weeks for February.

6. The Trust achieved all cancer waiting times in January.

7. There were no urgent operations cancelled in February.

8. There was one patient cancelled on the day of admission in February who was rebooked within the 28 day NHS Guarantee.

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

10. The Trust achieved the diagnostic target for February

Implications of results reported

18 weeks

11. 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.

12. The Trust has now received confirmation that no penalties will be applied from July to November, as QVH achieved backlog reduction and compliance by 1st December, as per the agreement reached with the CCG's earlier this year.

Actions being taken to achieve compliance

18 weeks

13. Key actions in place

- Operational Control centre is now fully embedded and meets three times a week. This group focuses on providing targeted lists of patients to be booked by secretaries, waiting list progress as well as addressing immediate operational issues so that backlog continues to reduce as per trajectories
- Information provided to the above is now fully embedded to support the operational team.
- Weekly forecast update is being provided to the Board
- Extra operating sessions are being organised as required for Hands, Max Fac and Corneo to ensure the Trust continues to maintain compliance.
- Extra Saturday clinics have continued to run in Orthodontics and are planned until the end of March in order to increase capacity for treatments. A further 30 patients are also projected to be treated with an external provider between now and March in order to sustain the backlog reduction seen in November.
- The Trust is still also securing extra capacity at Centre for Sight until February, for the more complex corneal patients who cannot currently be treated at QVH as well as continuing with Saturday operating twice a month until the end of March.

Cancer

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

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

15. Actions being taken to mitigate the risks include

- Liaising with management teams off site to improve processes
- Training of admin teams and reinforcing to junior doctors about the correct listing of patients
- Contacting individual Trusts when an immediate breast breach has occurred due to unavailability of visiting consultant and asking them to review systems

- An interim manager has completed a review and new data collection process surrounding cancer waiting times and COSD is being introduced in Jan with a new tracking system.

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

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

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

Implications for BAF or Corporate Risk Register

18. Risks associated with this paper have been reviewed and Corporate Risk Register has been updated accordingly to reflect the sustained performance since December

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Operational Update for Trust Board
26th March 2015

1. Operational Performance Update

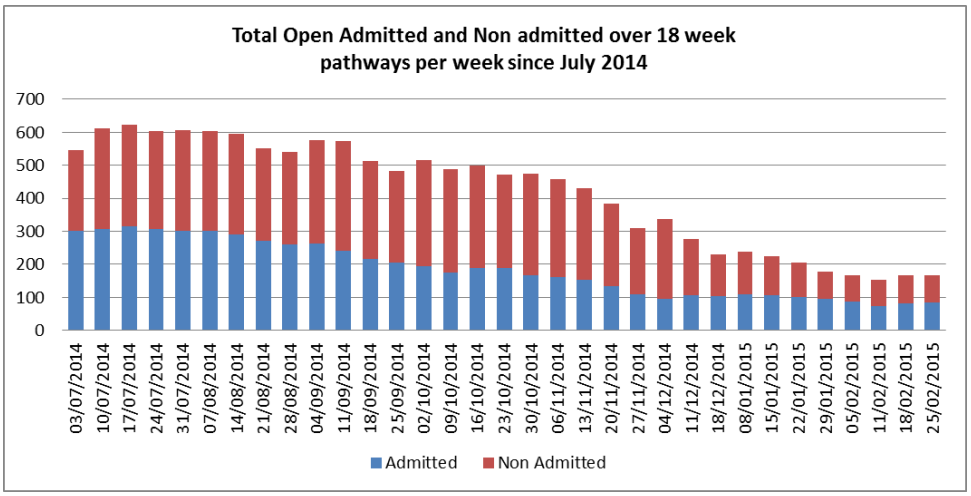
i. 18 weeks

In February the Trust achieved aggregate compliance with all three 18 week targets and with all specialities, except for Rheumatology open pathways as shown in the table below.

Speciality	Total Patients	Patients over 18 weeks	18 week % compliance
Ophthalmology	208	10	95.19%
Oral Surgery	209	13	93.78%
Plastic Surgery	621	44	92.91%
Other	103	0	100.00%
Admitted Total	1141	67	94.13%
Ophthalmology	146	1	99.32%
Oral Surgery	589	27	95.42%
Plastic Surgery	429	16	96.27%
Cardiology	23	1	95.65%
Rheumatology	12	0	100.00%
Other	127	3	97.64%
Non Admitted Total	1326	48	96.38%
Ophthalmology	827	31	96.25%
Oral Surgery	1865	70	96.25%
Plastic Surgery	1636	88	94.62%
Cardiology	63	3	95.24%
Rheumatology	20	2	90.00%
Other	459	1	99.782%
Open Pathway Total	4870	195	96.00%

The forecast for March based on the patients currently booked, shows we have aggregate admitted RTT compliance both at a Trust and speciality level.

Progress on reducing the overall numbers of patients waiting over 18 weeks has been maintained over the last two months providing continued assurance that the Trust is progressing towards long term sustainable position (see graph below).



Actions that are in place

- Operational Control centre is now fully embedded and meets three times a week. This group focuses on
    - providing targeted lists of surgical patients to be booked for admission by secretaries, review waiting list size, progress towards scheduling patients at least 3 weeks ahead as well as addressing immediate operational issues so that backlog continues to reduce as per trajectories
    - Providing targeted lists for outpatients to ensure they are booked and/ or reviewed before breach date
- Information provided to the above is now fully embedded to support the operational team.
- Weekly forecast update is being provided to the Board
- Extra operating sessions are being organised as required for Hands, Max Fac and Corneo to ensure the Trust continues to maintain compliance.
- Extra Saturday clinics have continued to run in Orthodontics and are planned until the end of March in order to increase capacity for treatments. A further 30 patients are also projected to be treated with an external provider between now and March in order to sustain the backlog reduction seen in November.
- The Trust is still also securing extra capacity at Centre for Sight until February, for the more complex corneal patients who cannot currently be treated at QVH as well as continuing with Saturday operating twice a month until the end of March.
- Additional hours for validation put in place earlier this year have continued and are being reviewed as part of business planning along with dedicated analyst for 18 weeks
- Pooling of lists amongst consultants continues

ii. 52 week breaches

No patients have breached 52 weeks since November and none are forecasted for March. Therefore the Trust total of 8 patients reported waiting over 52 weeks within 14/15, due to breaches earlier this year, remains unchanged.

iii. Cancer

Trust cancer waiting times for April to Dec is shown in the table below.

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

QVH achieved all cancer standards for January. The forecast position for cancer performance for February is not available at the time of writing this report. A verbal update will be provided at the Trust Board in March.

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

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

Actions being taken to mitigate the risks include

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

iv. Cancelled Operations

In February there was one patient cancelled on the day of surgery due to an operating list that overran. This patient was rebooked within the 28 day guarantee.

There were no urgent patients cancelled for a second time in February.

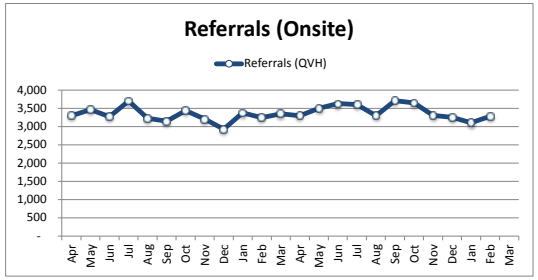
Queen Victoria Hospital NHS
NHS Foundation Trust

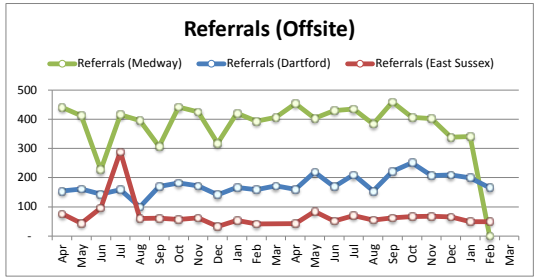
Author Dean Janes (Contracts & Coding Manager)
Author Jane Morris (Interim Head of Operations)

Trust Level Report (All Services)

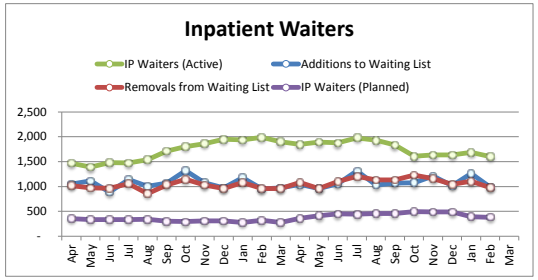
Period : 2014-15 Month 11 (February)

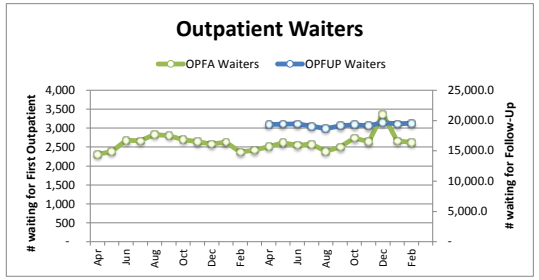
DEMAND



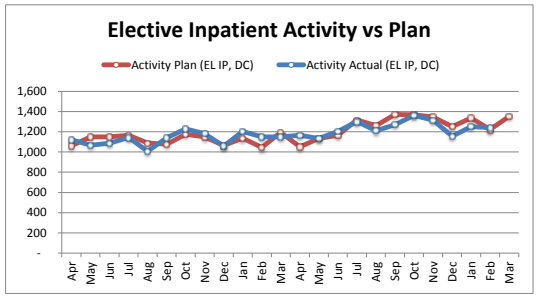


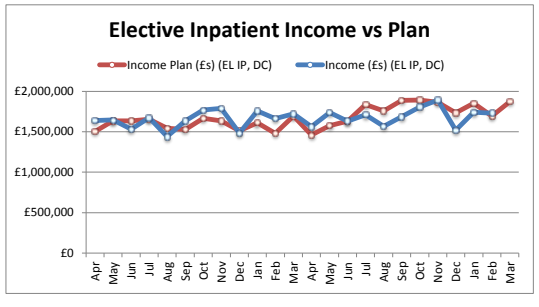
WAITING LIST





Elective Inpatients





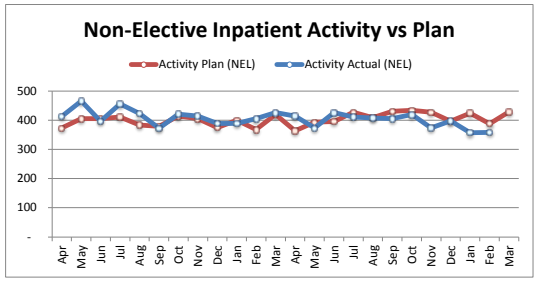
Queen Victoria Hospital NHS
NHS Foundation Trust

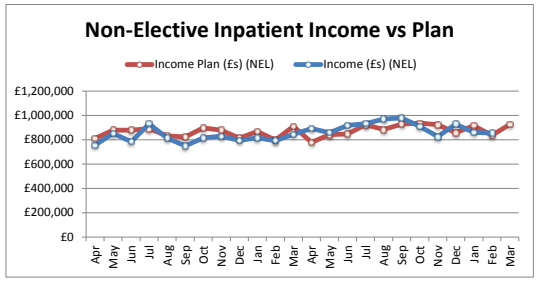
Author Dean Janes (Contracts & Coding Manager)
Author Jane Morris (Interim Head of Operations)

Trust Level Report (All Services)

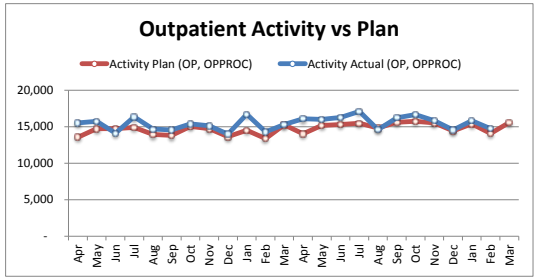
Period : 2014-15 Month 11 (February)

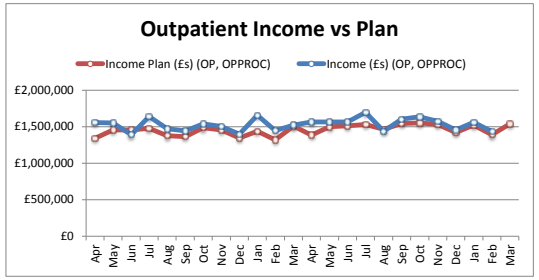
Non-Elective Inpatients



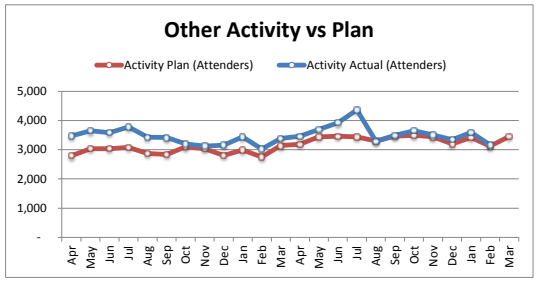


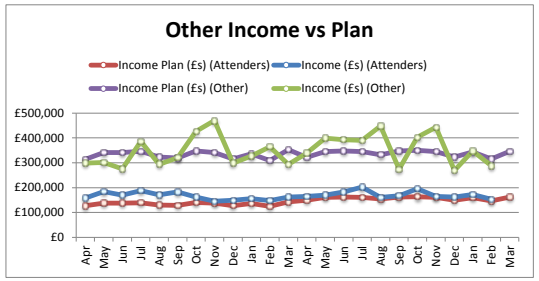
Outpatients





Other Activity/Income





"Other" income is Excluded Drugs and Devices
"Attenders" is a combination of Radiology and MIU activity

Queen Victoria Hospital NHS
NHS Foundation Trust

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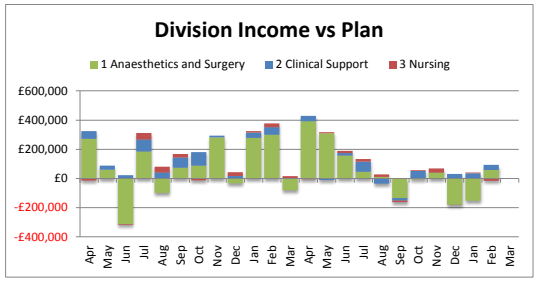
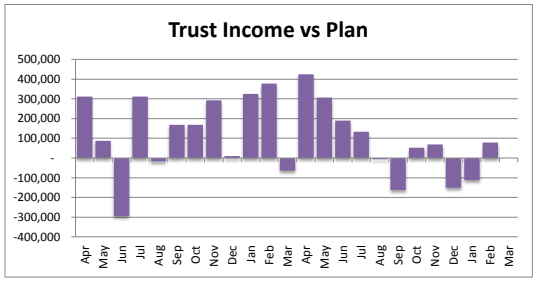
Trust Level Report (All Services)

Period : 2014-15 Month 11 (February)

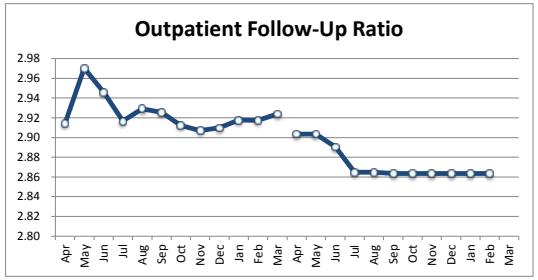
Income vs Plan

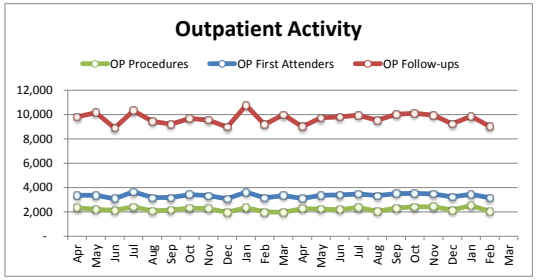




N.B. This graph has been changed from YTD to 'in-month' figures

Follow-up Ratios





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KPIs Progression

Previous Months:

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Operational Standards	Threshold
90.5%	90.8%	88.0%	85.0%	83.0%	84.7%	86.9%	86.7%	91.6%	91.99%	94.13%		Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral	90%
95.1%	96.6%	94.1%	94.0%	92.6%	92.2%	91.6%	84.9%	95.7%	95.70%	96.38%		Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	95%
93.3%	92.4%	91.5%	91.3%	90.5%	90.6%	91.8%	95.4%	95.9%	96.16%	96.00%		Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92%
100.0%	100.0%	100.0%	100.0%	99.8%	98.1%	99.1%	96.8%	99.6%	99.8%	99.7%		Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	99%
99.5%	99.5%	99.3%	99.83%	99.26%	99.23%	98.38%	99.53%	98.76%	99.64%	99.47%		Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%
96.6%	96.9%	99.3%	94.6%	99.0%	99.1%	96.8%	95.0%	94.9%	94.2%	TBC		Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93%
#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A		Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for OPFA	93%
97.9%	95.6%	94.5%	97.5%	96.9%	98.7%	96.1%	100.0%	98.0%	96.2%	TBC		Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%
97.6%	95.2%	98.0%	98.0%	93.5%	100.0%	92.3%	100.0%	100.0%	100.0%	TBC		Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94%
92.3%	87.5%	84.6%	75.0%	80.5%	88.2%	94.1%	96.9%	94.4%	88.4%	TBC		Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%
66.7%	0.0%	0.0%	66.7%	100.0%	50.0%	66.7%	#N/A	TBC	TBC	TBC		Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	90%
100.0%	100.0%	#N/A	100.0%	#N/A	100.0%	#N/A	#N/A	#N/A	#N/A	TBC		% of Service Users waiting no more than 62 days for 1st definitive treatment following a consultant's decision to upgrade the priority of the Service User (all can	85%
1			0			TBC			TBC			Operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons not offered another binding date within 28 days	0
0	0	0	0	0	0	0	0	0	0	0		Zero tolerance MRSA	0
0	0	0	0	0	0	1	0	0	0	0		Minimise rates of Clostridium Difficile	0
0	1	3	2	0	1	1	0	TBC	0	0		Zero tolerance RTT waits over 52 weeks for incomplete pathways	0
99.2%	99.3%	99.5%	99.4%	99.4%	99.4%	99.4%	99.4%	99.5%	99.5%			Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (A	99%
99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.7%			Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (C	99%
99.4%	99.0%	98.7%	98.4%	98.4%	98.3%	98.3%	98.3%	98.4%	98.4%			Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	95%
0	2	2	0	1	0	0	0	0				No urgent operation should be cancelled for a second time (Monthly SITREPs)	0
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%		VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95%
TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE				Publication of Formulary	TRUE
0	1	0	0	1	0	0	0	0	0	0		Never Events	0

14/15 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	QUARTER 1			QUARTER 2			QUARTER 3			QUARTER 4			
				Perf	Achieved	Scoring	Perf	Achieved	Scoring	Perf	Achieved	Scoring	Perf	Achieved	Scoring	
M1C	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	89.8%	Not met		84.2%	Not met		88.4%	Not met		91.1%			
M2C	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	95.3%	Not met		92.9%	Not met		90.7%	Not met		96.0%			
M3C	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	92.4%	Not met	2	90.8%	Not met	2	94.3%	Achieved	2	96.1%		0	
M4D	A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	99.5%	Achieved	0	99.3%	Achieved	0	98.5%	Achieved	0	99.5%		0	
M5E	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	89.7%	Achieved		81.2%	Not met		95.1%	Achieved		88.4%			de minimis <5 cases
M6E	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	1.0	50.0%	Not relevant	0		Not relevant	1		Not relevant	0			0	de minimis <5 cases
M7F	Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	96.4%	Achieved		97.2%	Achieved		97.4%	Not met		100.0%			
M8F	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0		Not relevant			Not relevant			Not relevant					
M9F	Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0		Not relevant	0		Not relevant	0		Not relevant	1			0	
M10G	Cancer 31 day wait from diagnosis to first treatment	96%	1.0	96.7%	Achieved	0	97.7%	Achieved	0	98.0%	Not met	1	98.2%		0	
M11H	Cancer 2 week (all cancers)	93%	1.0	96.8%	Achieved		97.6%	Achieved		95.6%	Achieved		94.2%			de minimis <5 cases
M12H	Cancer 2 week (breast symptoms)	93%	1.0	#N/A	Not relevant	0	#N/A	Not relevant	0		Not relevant	0			0	de minimis <5 cases
M20M	Clostridium Difficile -meeting the CDiff objective	0	1.0	0	Achieved	0	0	Achieved	0	1	Not met	1	1		0	
M21	MRSA - meeting the MRSA objective	0	N/A	-	Achieved		-			-						
						2			3			5			0	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 26th March 2015
Reference number: 66-15
Report from: Dominic Tkaczyk, Director of Finance and Commerce
Author: Dominic Tkaczyk, Director of Finance and Commerce
Report date: 18th March 2015
Appendices:

Finance Report M11 February 2015

Key issues

1. The financial performance report details the trust's financial performance for February 2015.

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	5,029	4,717	312	56,135	54,369	1,766
EBITDA	180	246	(66)	5,030	5,102	(72)
Surplus	133	(50)	184	2,121	1,844	276
Continuity of Service risk rating (CoSRR)	4	4	-	4	4	-

NB table subject to rounding differences.

2. The Trust is £276k ahead of the surplus plan for the year with increased income offset by increased costs and after the beneficial impact of £928k from the revision of prior year estimates. In month the Trust made a surplus of £133k being £184k above plan, after the beneficial impact of £78k from prior year debt recovery and £240k of donated asset income.
3. The Trust is maintaining a Continuity of Service Risk Rating of 4.

Implications of results reported

4. Achieving the reported surplus of £2,121k to Month 11 provides some assurance that the planned surplus of £2,205k for the year is achievable. This performance underpins the forecast to Monitor which is a year-end surplus of £2,445k being plan plus £240k additional income for donated assets.

Action required

5. Future plans continue to rely on increased activity and work continues to mobilise the resources required. Delivery of the action plans to meet performance targets is critical but costs need to be controlled when looking to reduce patient waiting times.

Link to Key Strategic Objectives

- Operational excellence

- Financial sustainability

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

Implications for BAF or Corporate Risk Register

7. Nothing new to add.

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
February 2015
Month 11
26th March 2015

Executive Director: Dominic Tkaczyk

Contents

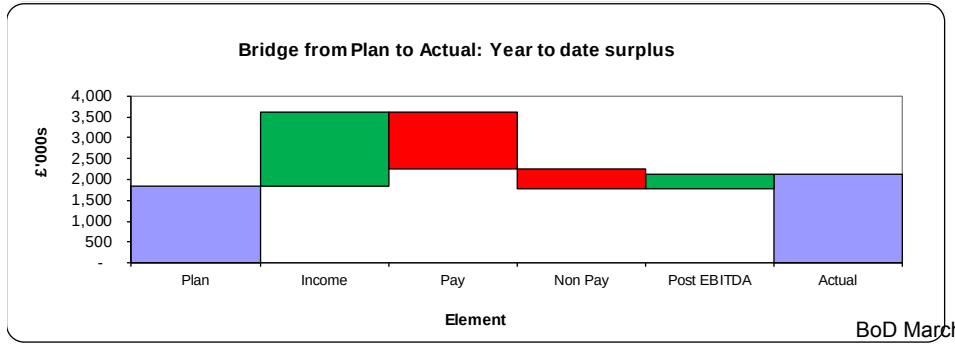
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M11 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance	2014-15	13-14	February 14-15			13-14	Year to Date 2014-15		
Income and Expenditure	Annual Plan £k	M11 13-14 CM Actual	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	M11 13-14 YTD Actual	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	55,788	*4,572*	4,610	4,403	207	*50,248*	52,069	50,919	1,150
Other Income	3,763	*348*	419	314	105	*3,612*	4,066	3,450	616
Pay	(38,401)	*(3,245)*	(3,545)	(3,215)	(331)	*(35,083)*	(36,475)	(35,187)	(1,288)
Non Pay	(15,394)	*(1,284)*	(1,381)	(1,256)	(125)	*(14,192)*	(15,559)	(14,081)	(1,478)
Operational EBITDA	**5,756**	***391***	**102**	**246**	**(144)**	***4,585***	**4,102**	**5,102**	**(1,000)**
as a %	*9.7*	*8.0*	*2.0*	*5.2*	*-3.2*	*8.5*	*7.3*	*9.4*	*-2.1*
Financing & Donations	(3,553)	*(319)*	(46)	(296)	250	*(3,443)*	(2,909)	(3,257)	348
Current Year Surplus / (Deficit)	**2,203**	***72***	**56**	**(50)**	**106**	***1,141***	**1,193**	**1,844**	**(652)**
Prior Year Items	-		78	-	78		928	-	928
Total Surplus / (Deficit)	**2,203**	***72***	**133**	**(50)**	**184**	***1,141***	**2,121**	**1,844**	**276**
Surplus (Deficit) %	3.7%	*1.5%*	2.7%	-1.1%	3.7%	*2.1%*	3.8%	3.4%	0.4%

Continuity of Service Risk Rating	Metric	Level 4 threshold	Score	Weighted score	
Liquidity days	52	0	4	50%	2
Debt Service Cover	2.9	2.5x	4	50%	2
Combined Score (1 to 4)					**4**



Summary

- The Trust is £276k ahead of the surplus plan for the year including £928k benefit from the revision of prior year estimates and £240k Donated asset.
- The February in month position is £184k ahead of plan including £78k benefit from the prior year.
- The underlying position is one of increased income more than offset by additional costs.

Issues

- The reported year to date surplus of £2,121k (3.8% surplus) is consistent with the annual plan of £2,203k (3.7% surplus).
- Income includes the recognition of 100% of CQUIN.
- Income reflects estimated performance penalties of £420k year to date. The February surplus has been improved by £172k through the reduction in penalty estimates as performance improves and the recognition of £28k of CQUIN relating to January.
- Pay costs include additional interim agency costs covering vacancies and initiatives.
- The Continuity of service risk rating is 4, as planned.
- The Trust continues to forecast achievement of the planned surplus .

Risks.

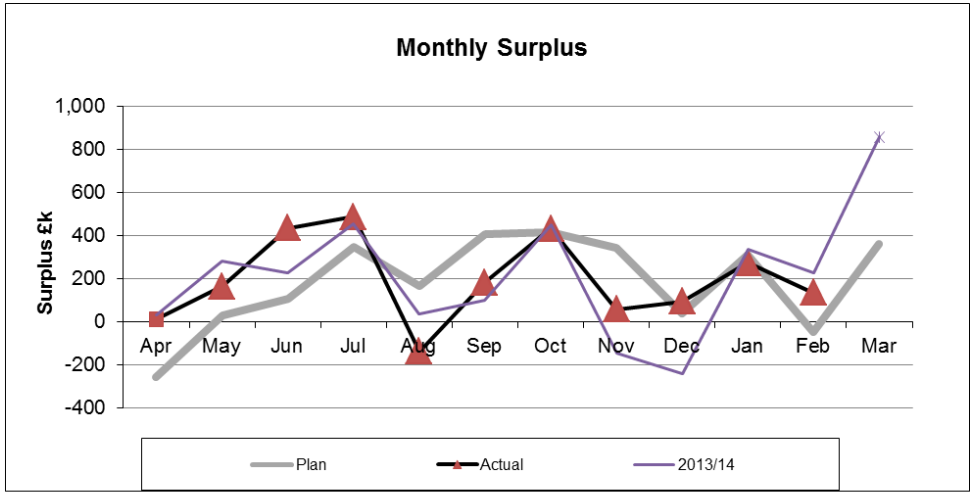
- Key risks are the achievement of activity plans, cost control and the level of penalties / incentives.

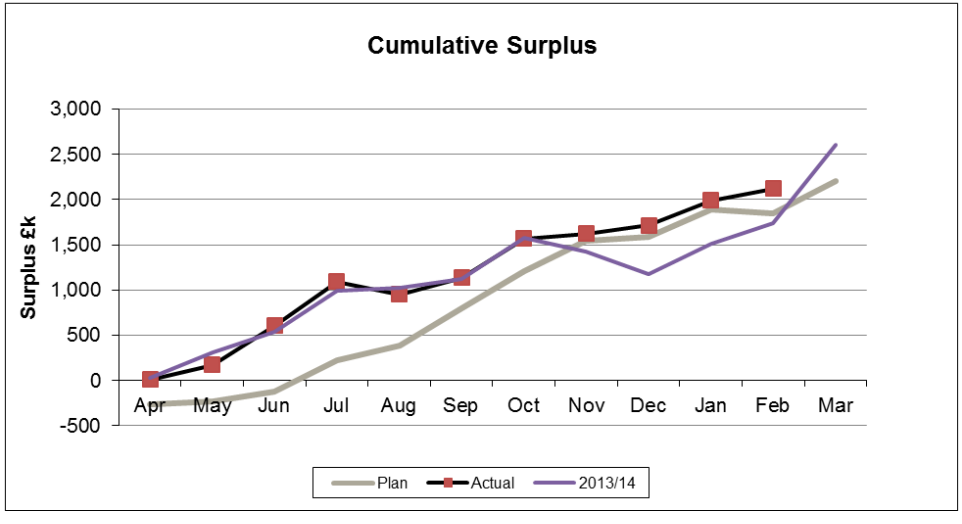
Actions

- Actions are being implemented to deliver additional activity and to meet performance targets (to reduce penalties and achieve incentives).

Summary Trend Position – M11 2014/15

Queen Victoria Hospital
NHS Foundation Trust





Summary

- The cumulative surplus is marginally ahead of plan and ahead of the same period in 2013-14.

Risks & Issues

- The trust surplus is sensitive to the achievement of income targets as costs are predominantly of a fixed base nature. March has the third highest activity plan so it is essential that this is met or exceeded in order to make the annual surplus plan .
- Cost control remains critical and additional activity needs to be delivered at marginal cost rates.

Actions

- Monitoring of forecast levels of activity, and taking remedial action where necessary, is undertaken at a senior management level at the Weekly Operations Meeting. This meeting also looks at pay and non-pay costs.

Divisional Performance Summary – M11 2014/15

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Patient Income		Other Income		Pay		Non Pay		Financing		Prior Year			Total Current Month			Total Year To Date		
Direct Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Anaesthetics and Surgery																			
Plastics	(123)	(411)	22	55	(47)	(192)	(1)	86	-	-	-	-	24,362	1,776	1,925	(148)	21,725	22,186	(461)
Oral	(159)	(314)	5	44	(21)	(151)	(7)	(77)	-	-	-	-	6,987	337	519	(182)	5,874	6,373	(499)
Ophthalmology	131	618	4	10	(49)	(98)	(6)	(149)	-	-	-	-	2,583	270	191	80	2,741	2,361	380
Sleep	11	398	0	12	(13)	(86)	(0)	(285)	-	-	-	-	1,852	138	139	(1)	1,731	1,692	39
Theatres	-	-	(20)	(23)	(13)	(74)	(46)	(85)	-	-	-	-	(6,637)	(622)	(543)	(79)	(6,257)	(6,075)	(182)
Anaesthetics	-	-	(2)	(4)	1	4	(6)	(50)	-	-	-	-	(3,335)	(283)	(277)	(7)	(3,105)	(3,056)	(50)
Administration	1	63	(0)	(1)	(6)	(35)	3	8	-	-	-	-	(630)	(53)	(51)	(2)	(542)	(577)	35
Anaesthetics and Surgery Total	(139)	353	10	92	(147)	(631)	(63)	(551)	-	-	-	-	25,182	1,563	1,902	(340)	22,167	22,904	(737)
Clinical Support																			
Radiology	37	128	2	49	(5)	(89)	(2)	(32)	-	-	-	-	117	30	(2)	32	166	110	56
Pathology	-	-	-	-	-	-	20	24	-	-	-	-	(653)	(31)	(52)	20	(573)	(596)	24
Histopathology	-	-	13	5	4	41	9	(29)	-	-	-	-	(981)	(55)	(81)	26	(882)	(899)	17
Pharmacy	20	33	1	7	(0)	8	(23)	(29)	-	-	-	-	(64)	(11)	(8)	(3)	(40)	(60)	19
Surgical Appliances	(0)	6	-	-	0	0	(3)	(10)	-	-	-	-	8	(3)	0	(3)	4	7	(4)
Prosthetics	12	(80)	1	18	2	119	4	9	-	-	-	-	(315)	(10)	(30)	19	(224)	(290)	66
Medical Photography	-	-	2	(3)	(0)	(6)	0	0	-	-	-	-	(136)	(9)	(11)	2	(133)	(125)	(9)
Therapies	10	81	(0)	23	(1)	2	(1)	(8)	-	-	-	-	(543)	(44)	(52)	8	(403)	(500)	97
Psychotherapy	0	(3)	-	-	1	16	0	7	-	-	-	-	(125)	(9)	(11)	1	(95)	(114)	20
Clean room	-	-	(1)	58	1	12	(10)	(47)	-	-	-	-	(183)	(25)	(15)	(10)	(144)	(167)	23
General Specialities	(2)	(33)	-	-	(11)	(49)	6	36	-	-	-	-	218	9	16	(7)	151	198	(47)
Clinical Support Total	76	131	18	156	(9)	55	1	(79)	-	-	-	-	(2,657)	(158)	(245)	86	(2,173)	(2,435)	262
Nursing																			
MIU	(1)	113	-	-	5	(12)	1	(15)	-	-	-	-	539	44	38	6	578	492	87
Inpatient	(9)	(31)	13	13	(28)	(159)	14	(123)	-	-	-	-	(5,661)	(485)	(475)	(10)	(5,491)	(5,190)	(301)
Outpatient	-	-	3	7	(7)	(1)	2	(65)	-	-	-	-	(2,238)	(188)	(185)	(3)	(2,111)	(2,051)	(60)
Audit and Risk	-	-	32	113	2	88	(5)	(29)	-	-	-	-	(1,608)	(105)	(134)	29	(1,303)	(1,474)	172
Research	-	-	11	69	(8)	(59)	(3)	(3)	-	-	-	-	(74)	(6)	(6)	0	(60)	(68)	8
Nursing Total	(10)	82	59	202	(36)	(143)	9	(235)	-	-	-	-	(9,043)	(740)	(763)	22	(8,386)	(8,291)	(94)
Sub-total Operational Services	(73)	566	86	450	(192)	(720)	(53)	(865)	-	-	-	-	13,482	664	895	(231)	11,609	12,178	(569)
Estates and Hotel Services																			
Estates	-	-	(1)	(14)	4	7	(19)	(408)	-	-	-	-	(1,989)	(188)	(171)	(16)	(2,233)	(1,818)	(415)
Hotel Services	-	-	(6)	(12)	(5)	(42)	(32)	(84)	-	-	-	-	(1,659)	(180)	(137)	(43)	(1,658)	(1,519)	(138)
Estates and Hotel Services Total	-	-	(7)	(26)	(0)	(35)	(52)	(492)	-	-	-	-	(3,648)	(367)	(308)	(59)	(3,891)	(3,338)	(553)
Human Resources	-	-	2	79	(3)	6	(18)	(35)	-	-	-	-	(746)	(82)	(63)	(19)	(632)	(683)	51
Human Resources Total	-	-	2	79	(3)	6	(18)	(35)	-	-	-	-	(746)	(82)	(63)	(19)	(632)	(683)	51
Finance																			
Finance Commerce IT	-	-	(0)	22	(14)	112	14	61	-	-	-	-	(2,328)	(194)	(194)	(0)	(1,939)	(2,134)	195
Finance Other	280	584	19	45	-	(0)	(17)	(68)	250	348	78	999	(3,054)	354	(256)	609	(893)	(2,801)	1,908
Finance Total	280	584	19	67	(14)	112	(4)	(6)	250	348	78	999	(5,382)	159	(450)	609	(2,831)	(4,935)	2,103
Corporate	-	-	4	46	(121)	(651)	1	(79)	-	-	-	(71)	(1,504)	(241)	(125)	(116)	(2,134)	(1,379)	(755)
Corporate Total	-	-	4	46	(121)	(651)	1	(79)	-	-	-	(71)	(1,504)	(241)	(125)	(116)	(2,134)	(1,379)	(755)
Grand Total	207	1,150	105	616	(331)	(1,288)	(125)	(1,478)	250	348	78	928	2,203	133	(50)	184	2,121	1,844	276

Summary

- This analysis shows financial performance by division.

Issues

- The three operational divisions are showing adverse variances on patient income, pay and non-pay.
- Estates and Hotel Services have an adverse variance due to £300k for disposal of the theatre unit and increased costs from the continued rental of the unit.
- Human Resources are benefiting from higher than expected training income.
- Finance patient income reflects the central CQUIN and penalties position.
- Finance also includes the recognition of benefits from release of prior year income and debt provisions £999k, and the other underspends partially offset the increased costs in Corporate that reflect interim pay costs.

Risks

- Improved performance in the operational areas is needed to meet the year end forecast.

Actions

- Continued action to meet targets.

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

Income by Point of Delivery – M11 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

POD Month 11	Current Month Actual £K	Current Month Plan £K	Current Month Variance £k	Year to Date Actual £k	Year to Date Plan £k	Year to Date Variance £k
Day Case	1,081	906	175	10,935	10,127	807
Elective	696	846	(150)	8,288	9,739	(1,451)
Non Elective	875	864	11	10,191	9,984	207
Exclusions	251	237	14	3,069	2,781	287
Outpatient First Attendance	322	398	(76)	4,582	4,662	(80)
Outpatient Follow Up	696	718	(22)	8,851	8,450	402
Outpatient Procedure	284	308	(23)	3,866	3,641	225
Minor Injuries	51	64	(13)	721	759	(38)
Radiology	128	91	37	1,220	1,086	134
Critical Care	25	59	(34)	766	694	73
Sub total	**4,409**	**4,490**	**(81)**	**52,489**	**51,923**	**566**
CQUIN reduction	28	-	28	-	-	-
Penalties	158	-	158	(308)	-	(308)
ERT deduction	14	(87)	101	(112)	(1,004)	892
Total Penalties Provision	**200**	**(87)**	**287**	**(420)**	**(1,004)**	**584**
Patient Activity Income	**4,610**	**4,403**	**207**	**52,069**	**50,919**	**1,150**

Summary

- Patient income by point of delivery (POD) was £81k behind plan in M11 (before performance adjustments) with elective inpatients showing a significant adverse variance.
- The in month improvement in CQUIN performance reflects the change in the assumption for January from 75% to 100%. As Q1 to q3 were all achieved at 100% it is reasonable to assume Q4 is more than likely to be also fully compliant.
- The reduction in the penalties is taken from the additional risks provision as performance improves.

Issues

- Income by POD is at the full rate, i.e. it assumes 100% CQUIN, no penalties and no reduction for ERT. These are accounted for separately.
- CQUIN has been planned at 100% achievement. CQUIN for Q1-Q3 is reflected at 100% based on agreement with commissioners and is now assumed at 100% for January and February. 100% CQUIN was achieved last year.
- The penalties relate to 18 week breaches and other contractual penalties; these remain subject to commissioner agreement.
- ERT was prudently assumed to be suffered at 100% in the budget but contracts reflected an improved position. The financial provision assumes ERT is incurred at a provider not CCG level.

Risks

- Elective inpatient activity continues to be significantly below plan but is being offset by increased emergency and day case activity .
- Planned activity/income relies on additional capacity being utilised effectively.

Actions

- To explore and identify the reasons for elective under performance and take the necessary steps to achieve the planned levels of activity.
- Continue to progress plans for full achievement of CQUIN and reduce costs associated with penalties.

Penalties: Issues / Risks

- Within income there is an accrual of £**420k** for penalties and challenges (activity data is still to be finalised and any penalties are to be agreed with commissioners).

Provision for Income Performance Penalties 2014/15	M1 £	M2 £	M3 £	M4 £	M5 £	M6 £	M7 £	M8 £	M9 £	M10 £	M11 £	Year to Date
RTT18 Admitted	2,400	2,400	10,800									**15,600**
RTT18 Non-Admitted	600	0	2,000									**2,600**
RTT18 Open pathways	7,200	5,200	8,200									**20,600**
Sub total RTT18	**10,200**	**7,600**	**21,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38,800**
52 week waiters (estimate)	0	5,000	15,000	10,000	0	5,000	5,000	0	0			**40,000**
Urgent operation cancelled for 2nd time	0	10,000	10,000	5,000	0	0	0	0	0			**25,000**
Never Events (estimate)	0	1,000	2,000	1,000	1,000	0	0	0	0			**5,000**
Data Challenges (estimate)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000			**9,000**
Outpatient Follow Up Ratios								85,600	11,200			**96,800**
Diagnostic Unbundling Risk Share									69,000			**69,000**
BPT Cataract Penalty									24,220			**24,220**
Additional Risks									186,143	-28,333	-157,810	**0**
Sub total non RTT penalties	**1,000**	**17,000**	**28,000**	**17,000**	**2,000**	**6,000**	**6,000**	**86,600**	**291,563**	**-28,333**	**-157,810**	**269,020**
Total Penalties	**11,200**	**24,600**	**49,000**	**17,000**	**2,000**	**6,000**	**6,000**	**86,600**	**291,563**	**-28,333**	**-157,810**	**307,820**
Emergency Rate Threshold reductions	22,506	1,853	34,973	6,609	61,482	82,293	5,365	-33,109	-56,000		-13,857	**112,114**
CQUIN reduced achievement provision										28,333	-28,333	**0**
Grand Total	**33,706**	**26,453**	**83,973**	**23,609**	**63,482**	**88,293**	**11,365**	**53,490**	**235,563**	**0**	**-200,000**	**419,934**

- The ERT and additional risk penalties provision for Q4 has been released with a benefit of £172k showing in the February surplus.
- CQUIN to February is now recognised at 100% with a benefit of £28k showing in the February surplus.
- The detailed calculation of penalties is still being undertaken.
- Last year total penalties and challenges were £307k.

Actions

- Robust management of 18 week performance standards continue.
- Agreement of penalties with commissioners.

Cost Improvement Analysis – M11 2014/15

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes built into budgets 2014-2015	Annual Plan £000's	Month 11 Plan	Achieved £000's	Achieved %	Shortfall
Pay	337	309	279	91%	29
Clinical Supplies	233	213	169	79%	44
Non Clinical Supplies	142	130	14	10%	117
Other non operating expenses	170	156	133	85%	23
Total Cost Improvement Programmes	**882**	**808**	**595**	**74%**	**213**

Summary

- At M11 the trust is achieving 74% of the cost improvement plan.

Issues

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

Risks

- A 26% shortfall on plan is a risk for the full year of £233k.

Actions

- Conclusion of disposal of leased building.
- Additional procurement savings.

Balance Sheet – YTD M11 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet for: Month 11 2014/15	2013/14 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,211	36,407	36,359
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	36,407	36,359
Current Assets			
Inventories	415	421	417
Trade and Other Receivables	8,939	8,093	8,323
Cash and Cash Equivalents	3,655	6,983	6,530
Current Liabilities	(6,574)	(6,851)	(6,709)
Sub Total Net Current Assets	6,436	8,646	8,561
Total Assets less Current Liabilities	43,647	45,053	44,920
Non-Current Liabilities			
Provisions for Liabilities and Charges	(554)	(616)	(616)
Non-Current Liabilities >1 Year	(8,933)	(8,156)	(8,156)
Total Assets Employed	**34,159**	**36,281**	**36,148**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	17,871	17,738
Revaluation Reserve	6,173	6,173	6,173
Total Tax Payers Equity	**34,159**	**36,281**	**36,148**

NB Analysis is subject to rounding differences

Summary

- Net assets improve with the generation of the surplus.

Issues

- Debtor balances have improved since the previous month as commissioners reduce outstanding balances.
- Non-current liabilities have reduced in year due to the theatre loan repayments made in June and December.

Risks

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

Actions

- Re-forecasting of the capital expenditure plan.
- Continued focus on reducing debtor balances.

Capital – M11 2014/15

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	2014/15 Plan £000s	YTD Spend £000s	Committed £000s	Forecast £000s	2014/15 Total Spend £000s
Estates projects					
13/14 Projects:					
Jubilee/Burns heating	450	256	1	-	257
Other projects	92	50	15	-	65
14/15 Projects:					
Corneoplastic electrical upgrade	100	3	8	25	35
Fire compartmentalisation	160	-	-	-	-
A Wing repairs	100	-	-	-	-
Meeting rooms	50	-	-	-	-
Carbon reduction	50	-	-	-	-
Wet rooms	24	6	25	41	72
Canadian Wing waiting area	-	3	5	52	60
Other projects	374	92	81	40	212
Medical Equipment	550	561	1,098	16	1,675
IT Equipment	1,400	329	78	141	547
Grand Total	**3,350**	**1,298**	**1,311**	**315**	**2,925**

Summary

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

Issues

- Following review the forecast for IT spend in this financial year has been reduced to £547k. The key project within IT is a replacement network to support more advanced clinical systems.

Risks

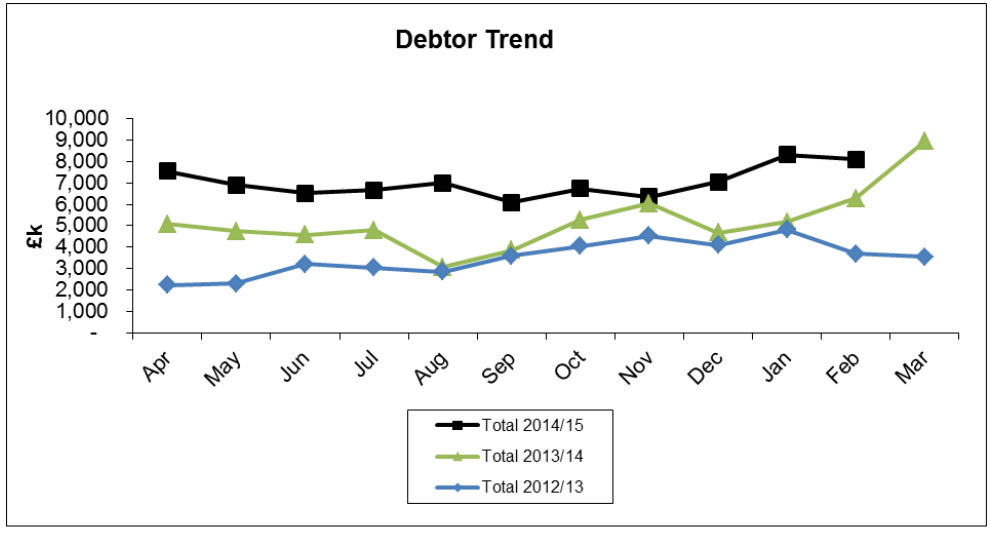
- Sufficient project management is key to the delivery of capital projects so this is being built into delivery plans.

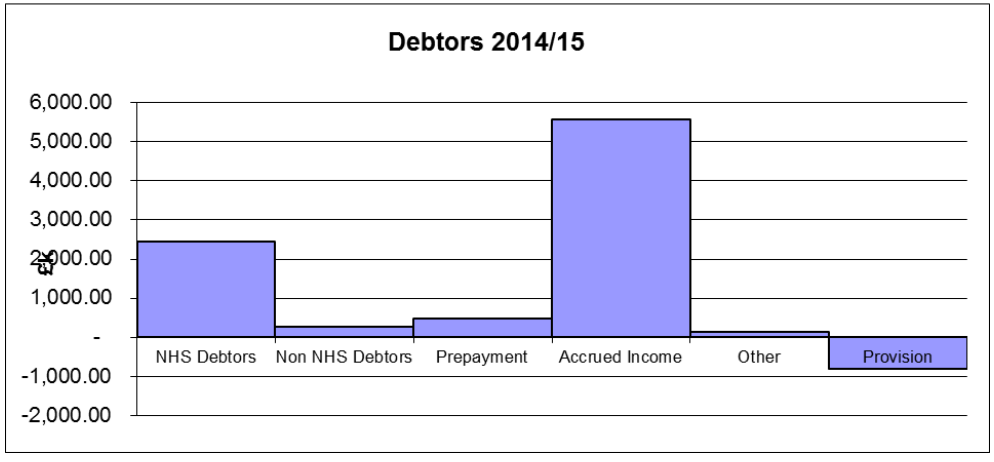
Actions

- Deliver planned projects.

Debtors – M11 2014/15

Queen Victoria Hospital NHS Foundation Trust





Summary

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

Issues

- Debtor balances are at high levels because of some delayed payments and the delay caused by high levels of over-performance. Work continues with commissioners to reduce outstanding balances.
- Accrued income includes income over-performance that is to be agreed and then invoiced.
- The bad debt provision is subject to monthly review and has been reduced by £120k this month and is now down to reasonable expected levels.

Risks

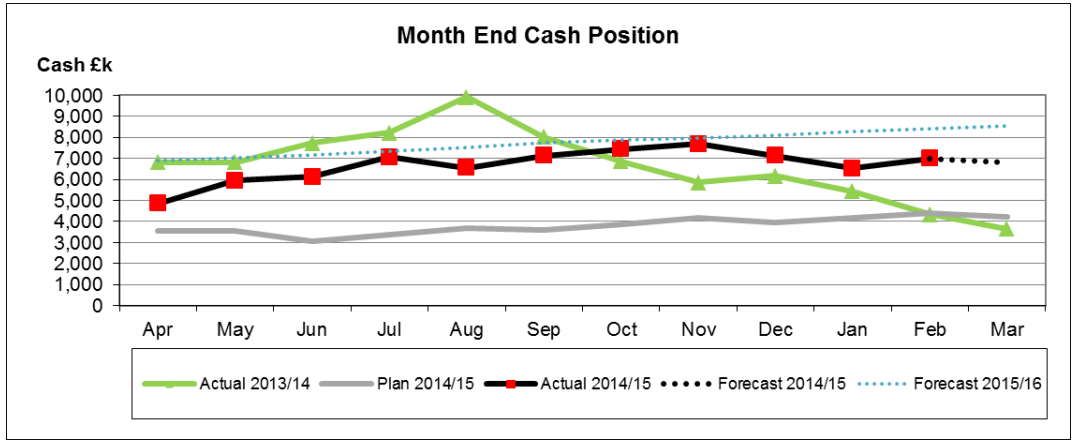
- Debt arising from over performance against income plans is slower to be paid.

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M11 2014/15

Queen Victoria Hospital NHS Foundation Trust



Summary

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

Issues

- Cash balances are projected to remain at a high level to the year end.

Risks

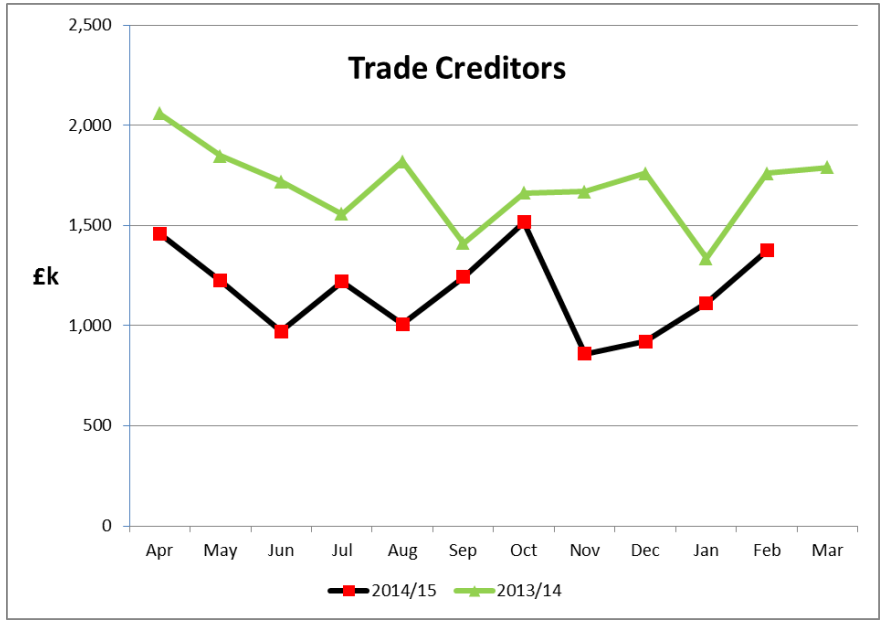
- Cash balances are sensitive to the level of surplus, payment performance of commissioners and the level of capital spend so these are risk areas.

Actions

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

Creditors – M11 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust



Summary

- Trade creditors continue to be below 2013/14 levels.

Issues

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

Risks

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

Actions

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

Better Payment Practice Code February 2015	2013/14 Outturn # Inv's	2013/14 Outturn £k	Current Month # Inv's	Current Month £k	YTD # Inv's	YTD £k
Total **Non-NHS** trade invoices paid	15,071	21,255	1,344	1,346	14,432	14,969
Total **Non NHS** trade invoices paid within target	9,386	15,087	1,135	1,142	9,669	9,978
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**84%**	**85%**	**67%**	**67%**
Total **NHS** trade invoices paid	1,082	4,544	72	379	871	4,771
Total **NHS** trade invoices paid within target	624	2,858	56	186	453	2,682
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**78%**	**49%**	**52%**	**56%**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	Thursday 26th March 2015
Reference number:	67-15
Report from:	Dominic Tkaczyk, Interim Director of Finance and Commerce
Author:	Elin Richardson, Head of Commerce
Report date:	Tuesday 17th March 2015
Appendices:	Contract Update (public)

2014/15 Contract Report

Key issues

1. This paper provides an update on activity and income performance against the signed contracts with the commissioners.
2. Trust actual income and activity is higher than the external commissioner plans at Month 11.
3. Over performance is predominantly in day cases.
4. An update on 18 week penalties and emergency rate threshold is provided.

Implications of results reported

5. Over performance against the external commissioner plans was anticipated both because commissioners commissioned below 13/14 outturn and because of the Trust growth plan. There is a risk that commissioners will challenge this over performance due to their financial constraints.

Action required

6. At this stage the key action is continued monitoring, accurate reporting and timely responses to commissioner challenges.

Link to Key Strategic Objectives

- Financial sustainability

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

2014/15 Contract Report

Prepared for Board of Directors

17th March 2015

Elin Richardson, Head of Commerce

1.0 Executive Summary

The Trust continues to over perform against external contracts with CCGs and NHS England but the rate of over performance has decreased.

Over performance remains predominantly due to:

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

In month commissioners have confirmed that financial penalties for 18 week breaches in July to November inclusive are not applicable due to the actions to reduce backlog and thus secure required performance from December onwards. Commissioners also confirmed emergency rate threshold is only applicable at Trust level.

2.0 Overall Contract Performance

Table 1 below shows the year-to-date performance against all contract and non-contract activity before the removal of any penalties / adjustments. This shows that the Trust has over performed against these plans by £4m at Month 11 (no change from £4m at Month 10). This is a reduction in the on-going level of over performance from 9.5% to 8.7%. This will in part be due to the commissioner plan being phased in straight twelfths rather than for working days.

The greatest over performance remains in areas where signed contracts are in place i.e. General Acute (CCG contracts 8% over year to date), and dental and specialised (NHS England contracts 6% and 17% over year to date). Over performance on the dental contract has slowed down and actual in month performance was under plan.

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

Contract Group	YTD M11 Plan £	YTD M11 Actual £	Variance £
General Acute	£29,134,938	£31,595,666	£2,460,728
Dental	£10,487,850	£11,126,730	£638,880
Specialised	£5,612,025	£6,565,432	£953,407
NCA	£1,444,524	£1,314,102	-£130,422
AQPNOUS	£0	£143,866	£143,866
non-England NCA	£70,315	£80,935	£10,620
Private Patients	£57,970	£31,207	-£26,763
SMSKP	£0	£29,181	£29,181
Overseas	£34,250	£21,296	-£12,954
Offenders	£3,280	£7,811	£4,531
Military	£4,322	£7,278	£2,956
WHSSC	£0	£935	£935
Grand Total	**£46,849,474**	**£50,924,438**	**£4,074,964**

3.0 CCG Contracts for Acute Care

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

Table 2: Performance against general acute care contracts

CCG	YTD M11 Plan	YTD M11 Actual	Variance
NHS HORSHAM AND MID SUSSEX CCG	£4,207,795	£5,059,705	£851,910
NHS WEST KENT CCG	£3,981,126	£4,524,359	£543,233
NHS HIGH WEALD LEWES HAVENS CCG	£2,813,996	£3,059,314	£245,318
NHS EAST SURREY CCG	£2,129,531	£2,399,820	£270,289
NHS MEDWAY CCG	£2,024,363	£2,155,029	£130,665
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG	£2,166,893	£2,148,642	-£18,251
NHS COASTAL WEST SUSSEX CCG	£1,737,767	£1,836,769	£99,003
NHS HASTINGS AND ROTHER CCG	£1,499,797	£1,534,805	£35,008
NHS CRAWLEY CCG	£1,364,423	£1,465,641	£101,219
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	£673,496	£946,483	£272,987
NHS BRIGHTON AND HOVE CCG	£1,160,377	£922,870	-£237,507
NHS SWALE CCG	£892,438	£868,890	-£23,548
NHS SURREY DOWNS CCG	£520,170	£708,670	£188,500
NHS SOUTH KENT COAST CCG	£651,551	£681,282	£29,732
NHS CANTERBURY AND COASTAL CCG	£574,264	£616,921	£42,657
NHS BROMLEY CCG	£601,860	£524,118	-£77,741
NHS BEXLEY CCG	£562,829	£518,876	-£43,953
NHS ASHFORD CCG	£344,829	£493,261	£148,432
NHS THANET CCG	£484,236	£429,469	-£54,768
NHS GUILDFORD AND WAVERLEY CCG	£394,809	£400,683	£5,873
NHS CROYDON CCG	£348,387	£291,559	-£56,829
Grand Total	**£29,134,938**	**£31,587,166**	**£2,452,228**

At Month 11 the Trust had over performed by £2.4m against these contracts. Continuing the trend from previous months the greatest over performance (in value) is with our host commissioner Horsham and Mid Sussex CCG.

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

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

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

Table 3: General acute care split by Point of Delivery (POD)

Point of Delivery (POD)	YTD M11 Plan £	YTD M11 Actual £	Variance £	YTD M11 Activity Plan	YTD M11 Actual Activity	Variance
Non elective	£6,489,865	£6,603,992	£114,127	2,994	2,876	-118
Day case	£6,256,327	£7,514,042	£1,257,715	5,374	6,721	1,347
Elective inpatient	£5,428,726	£5,163,479	-£265,247	2,520	2,419	-101
Outpatient First Attendance	£2,314,895	£2,395,173	£80,278	22,001	22,257	256
Outpatient Follow Up	£5,018,277	£5,647,007	£628,731	78,688	86,754	8,066
Exclusions	£1,049,118	£1,539,123	£490,005	0	0	0
Outpatient Procedures	£874,729	£896,357	£21,628	5,268	6,021	753
MIU attendances	£658,049	£675,220	£17,171	10,124	10,388	264
Radiology	£795,422	£1,013,998	£218,576	19,480	25,014	5,534
Other	£142,207	£147,275	£5,068	470	428	-42
Grand Total	**£29,027,614**	**£31,595,666**	**£2,568,052**	**146,919**	**162,878**	**15,959**

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

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

4.0 NHS England Contract for Specialised Care and Dental Services

Table 4 below shows the year-to-date over performance for the NHS England contract covering specialised services and dental. This shows over performance of £1.5m at Month 11 down from £1.7m at Month 10. This is again before the application of any penalties.

Table 4: Performance against the NHS England contract

Contract Name	YTD M11 Plan £	YTD M11 Actual £	Variance £
NHS England Specialised	£5,612,025	£6,565,432	£953,407
NHS England Dental	£10,487,850	£11,126,730	£638,880
Grand Total	**£16,099,875**	**£17,692,162**	**£1,592,288**

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

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

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

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

Point of Delivery (POD)	YTD M11 Plan £	YTD M11 Actual £	Variance £	YTD M11 Activity Plan	YTD M11 Actual Activity	Variance
Elective inpatients inc. day cases	£1,844,322	£ 2,213,142	£368,820	900	1092	192
Non elective inpatients	£1,503,034	£ 1,698,041	£195,007	603	692	89
First outpatients	£269,331	£ 341,941	£72,610	1,044	1,329	285
Follow up outpatients	£1,218,261	£ 1,360,694	£142,433	4,742	5,291	549
Critical care bed days	£349,099	£ 569,665	£220,566	142	315	173
Other	£435,579	£ 397,038	-£38,541	428	149	-279
Grand Total	**£5,619,627**	**£6,580,521**	**£960,895**	**7,860**	**8,868**	**1,008**

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

Point of Delivery (POD)	YTD M11 Plan £	YTD M11 Actual £	Variance £	YTD M11 Activity Plan	YTD M11 Actual Activity	Variance
Elective inpatients inc. day cases	£2,922,558	£ 3,201,562	£279,004	2,548	2,833	285
Non elective inpatients	£1,119,793	£ 1,193,570	£73,777	641	609	-32
First outpatients	£1,542,596	£ 1,656,228	£113,632	10,867	11,763	896
Follow up outpatients	£1,283,482	£ 1,358,319	£74,837	14,666	15,492	826
Outpatient procedures	£2,417,370	£ 2,809,765	£392,395	15,545	17,732	2,187
Critical care bed days	£306,713	£ 121,866	-£184,847	276	114	-162
Other	£895,338	£ 785,420	-£109,918	120	149	29
Grand Total	**£10,487,850**	**£11,126,730**	**£638,880**	**44,664**	**48,692**	**4,028**

5.0 Risks against contract income

Confirmation was received in month that the 18 week penalties would not be applied to activity in July, August, September and November as the aggregate target was met from 1st December onwards.

18 week penalties did apply in Q1 and no further penalties in this area are forecast for the remainder of the year.

6.0 Emergency Rate Threshold (ERT) update

Agreement was reached at the March Programme Board that the emergency rate threshold was only applicable at entire Trust level. At Month 9 £126k was potentially available for re-imbursement. However as total non elective over performance has slowed this amount is likely to reduce.

End.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26th March 2015
Reference number:	68-15
Report from:	Graeme Armitage, Director of HR & Organisational Development
Author:	Graeme Armitage, Head of HR & Organisational Development
Report date:	18th March 2015
Appendices:	A: Workforce Performance Report

Workforce update – March 2015

Key issues

1. Progress continues with regard to vacancies and sickness and although turnover has increased slightly this is expected for February due to junior doctor's rotations. Pay has increased slightly as a result of increased use of bank and agency but this has been necessary to ensure safe staffing levels. The highlights therefore this month are as follows;

2. Turnover rose by 0.61% in February 2015 which although is against the trend for the last quarter, the reason for this is the regular February (also occurs in August) changeover of junior doctors in training and therefore was expected. Recruitment continues to be a priority and in March 2015 a second recruitment open day was held specifically for doctors interested in working within Plastic Surgery. NB: at least 3 new HCA's were appointed as a result of the nursing/admin recruitment day held in January 2015.

3. The total percentage of vacancies has reduced again for the 5th successive month, however the number of live vacancies has increased (i.e. 28wte) with the gap between the funded establishment and the in post figure being 98.67wte representing 28% of all vacancies. This is an increase of 3% over last month. Noticeably, the total of all paid staff, which includes bank, agency and overtime, is slightly above funded establishment. Previous years have seen a sharp increase in the number of live vacancies towards the end of Q4 however, with tighter controls in place and with little scope to increase establishments for next year; we are not seeing this trend in 2014/15. It is anticipated this will now remain the position to the end of the financial year.

4. Pay increased slightly in February 2015 but overall still remains in line with the funded establishment. The use of bank and agency has increased to support areas where higher turnover would otherwise affect safe staffing. In these areas, the bank and agency staff used are individuals who work regularly with QVH and therefore provide consistency in the delivery of care to patients as they are familiar with our standards and practices. All ward areas are using the SafeCare module to adjust staffing levels to patient needs which is helping managers to more effectively plan the use of their resources. Monitoring of this will become part of the workforce report in 2015/16.

5. Reported sickness has fallen again to 2.85% and is at the lowest level for 8 months. There is now an encouraging trend of improved sickness management as the current figures

include the expected impact of seasonal colds and flu together with an increase in the number of long term sickness cases. The reduction has been the result of better management of sickness cases, improved training and support for managers and a proactive approach to addressing, in particular, long term cases. Monitoring of the increase in bank and agency use to cover sickness is however under close review as it is anticipated that one of the benefits of the SafeCare module within e-roster, will be a reduction in sick leave following improved resource management. The target for 2015/16 will remain at 2% however, the plan will be to achieve this in year i.e. by the end of Q3 and thereafter to be sustained.

6. Statutory and Mandatory Training also shows further signs of improvement. Overall compliance now stands at just 71.70% with a further 4.12% of those who are non-compliant booked onto relevant courses. The number of training sessions has been increased where required to assist staff to maintain their personal compliance and managers are utilising the improved reporting available to them to address areas of non-compliance. The Learning and Development team are receiving far few queries and continue to enhance the reporting for managers; we can expect to see the overall position to steadily improve over the next 3 to 4 months.

Implications of results reported

7. The workforce metrics within this report have an impact on the quality of patient care and so robust management of those remain a priority.
8. The Trust has a duty to make reasonable adjustments to those covered by the Equality Act 2010 and this is taken into account when managing sickness absence.
9. Workforce data is shared with NHS England and may be used by commissioners.
10. The efficient use of resources is essential to being a well-run organisation and therefore effective and accurate workforce information being provided to managers through the HR teams supports managers to make good decision which impact positively on their services.

Action required

11. Turnover and recruitment have been highlighted as the main areas for concern at present and therefore have been prioritised accordingly. A Recruitment Task and Finish Group has been established to address the issues found in the areas most affected. Progress is being monitored monthly.

12. Continue with the controls for agency and bank usage which require senior management approval for non-clinical and over-establishment cover.

13. Continue to manage sickness absence proactively through collaboration between line managers, Human Resources and Occupational Health.

14. Further review of workforce metrics including breakdown of average staff costs in comparable services, e-rostering performance, recruitment timescales and staff development.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

15. Vacancies, sickness absence and bank and agency usage have an impact on the quality of patient care, cost more to the organisation and affect the wellbeing of staff who are at work. Therefore although the core stability of the Trust's workforce is very good i.e. over 95% turnover issues are being actively addressed and improvements to recruitment being implemented.

Implications for BAF or Corporate Risk Register

16. The issues raised at paragraphs 1 – 6 above are already included in the Corporate Risk Register and Board Assurance Framework where they impact on ensuring safe staffing levels and quality of services provided. The mitigations are currently felt to provide assurance that these issues are not impacting negatively on the Trust's overall performance.

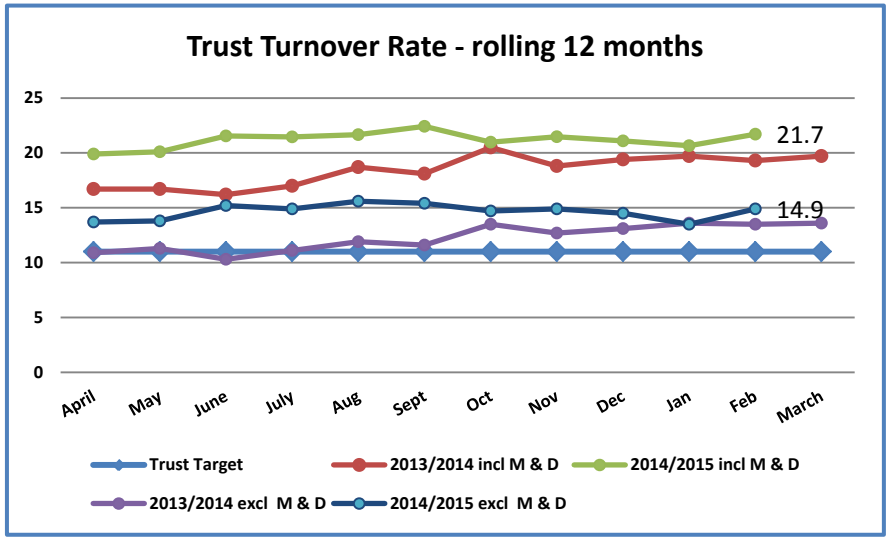
Regulatory impacts

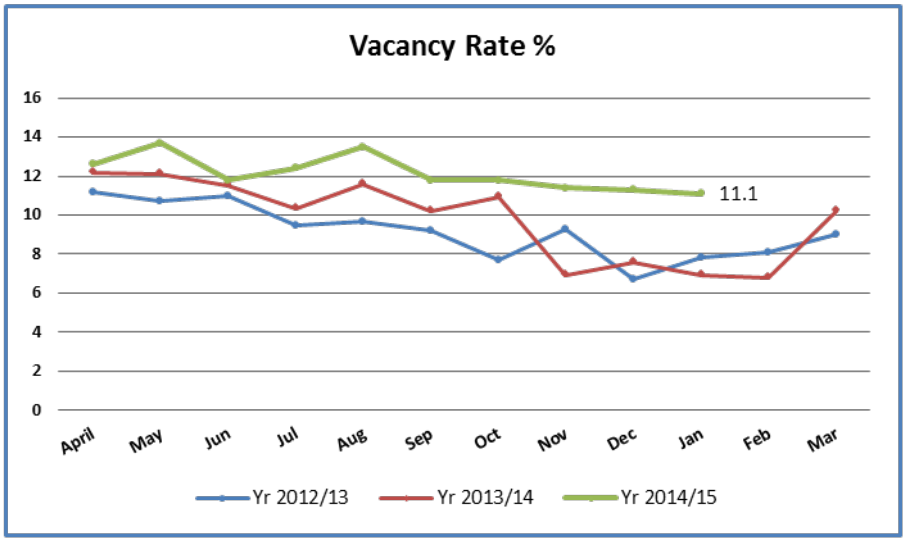
17. Although there is always a potential for high turnover and staff sickness to compromise quality of care and have a detrimental impact on the experience of other staff, it is not felt that the level of turnover and staff sickness prevailing currently is a genuine threat to regulatory compliance. Safety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

Recommendation

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

HEADLINE HR KPIs March 2015





Staff Movements

	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb15
Headcount	971	971	966	966	967	965	957	961	965	966	965	973	965
WTE in Post	823.78	823.78	816.86	816.07	816.78	816.79	816.79	812.47	816.49	818.86	818.48	825.73	820.25
WTE Funded Establishment	867.99	867.99	897.51	897.51	897.51	897.51	897.51	897.51	897.18	897.14	897.14	897.14	897.14
New Hires	29	7	10	7	19	10	23	24	23	12	8	15	26
Leavers	22	15	9	9	21	12	44	17	17	12	12	7	33
Maternity Leave	17	19	19	20	17	16	19	20	18	16	16	13	13
Vacancy Rate	6.8%	10.2%	12.6%	13.7%	11.8%	12.4%	13.5%	11.8%	11.8%	11.4%	11.3%	11.1%	N/A
Turnover Rate Headcount	2.37%	1.55%	1.04%	1.04%	2.18%	1.35%	4.62%	1.77%	1.76%	1.24%	1.24%	0.72%	3.42%
Turnover Rate (FTE)	2.05%	1.65%	0.93%	0.93%	2.07%	1.24%	4.49%	1.69%	1.66%	1.14%	1.15%	0.66%	3.60%

Rolling 12 Monthly Turnover Figures

	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov14	Dec14	Jan 15
12 Month Turnover (including Medical & Dental)	19.70%	19.32%	19.74%	19.94%	20.15%	21.55%	21.45%	21.66%	21.61%	20.97%	21.47%	21.09%	21.70%
12 Month Turnover (Excluding Medical & Dental)	13.59%	13.51%	13.62%	13.67%	13.79%	15.19%	14.93%	15.57%	14.87%	14.74%	14.96%	14.50%	14.95%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 28th February 2015 remains fairly static over previous months, however increasing slightly from 2.37% in February 2014 to 3.42% in February 2015.

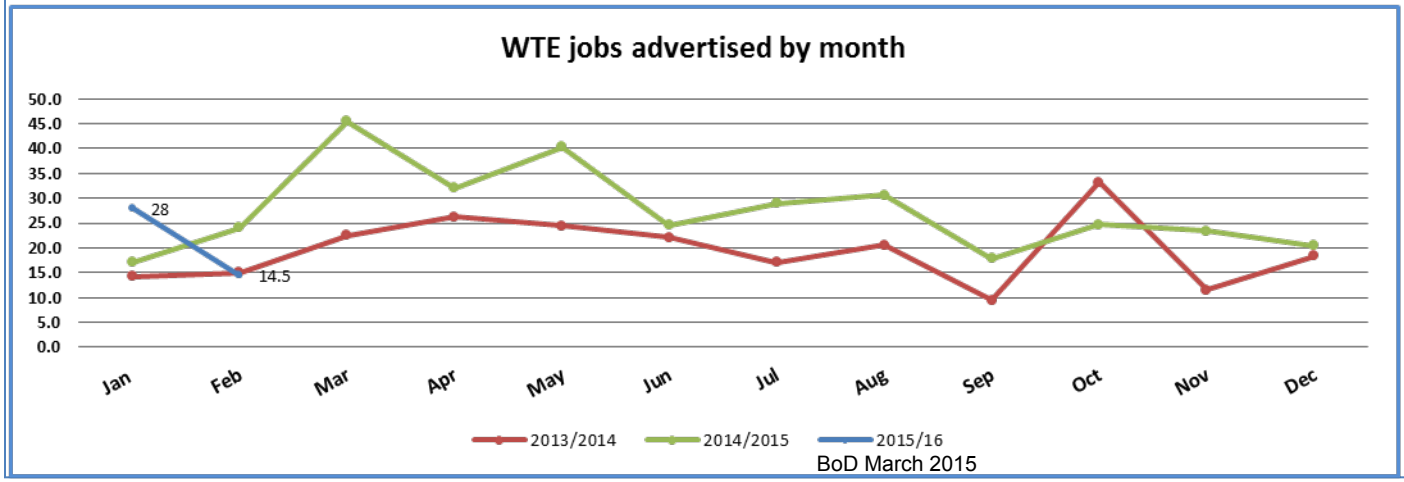
February saw 26 (25.76 FTE) new starters to the Trust, 18 of which were doctors, 6 admin and clerical and 2 additional clinical services. . There were 33 leavers (29.51 FTE) with a monthly turnover rate for February of 3.42% an rise of 2.7% over last month, this is due to the doctors turnaround for February. Staffing stability is at 96.17%.

The majority of Leavers for February were due to Medical and Dental rotation with 13 leavers.

- Clinical staff saw 13 leavers with 5 of the 13 from Theatres (2 – leaving remaining on bank, 2 flexi retirement 5- leaving due to promotion 1- better reward package 1 – no employment 2 – unknown.
- Admin & Clerical saw 7 leavers 1 – relocation, 1 – retirement, 1 - adult dependents 1 – lack of opportunities , 1- unknown

Vacancies Rates (figures 2 month in arrears)

Vacancy rate for January is 11.1% of which 28 WTE were actively being recruited to. Bank and agency were being used to the total of 79.18 WTE. The reason for this is the need to cover establishment vacancies, maternity leave (currently 13 employees on maternity leave) and long-term sickness (10 employees with sick leave of 4 weeks or more) 3 have had operations and 1 employee is due to be dismissed in March . The vacancy rate saw a slight fall of 0.2% for January , this follows the slow downward trend since May 2014.



RAG Rating

HEADLINE HR KPIs

Vacancies/Recruitment (figures 2 months in arrears)

There were 14.5 WTE vacancies advertised in February 2015 of which included, 3.0 WTE Nursing posts and 4.0WTE existing to recruit to Burns, 3.5 WTE Admin and Clerical posts and 4.0 WTE Medical and Dental posts.

There were 15 job offers of employment made in February, this includes 2 internal promotions. There was 1 positions that was not appointed to and 3 ongoing adverts.

- Eye Bank Technician . No suitable candidates on first advertisement, re-advertised.
- Corneo Staff Nurse – Corneo Nursing – ongoing advert on NHS Jobs - with previous staff getting internal promotions to other wards in the Trust, this has left Corneo with 5.0 WTE staff short, this is putting increased pressure on the department.
- Canadian Wing – ongoing advert on NHS Jobs
- Burns – have recruited to 2.0WTE posts and have re-advertised for the remainder 4.0WTE

The recruitment team operate a 5 week target to complete pre-employment checks after the offer of employment has been made. Through February 2015 there have been no breaches of recruitment targets and new candidates appointed have been cleared within 3 weeks of the offer letter being sent out.

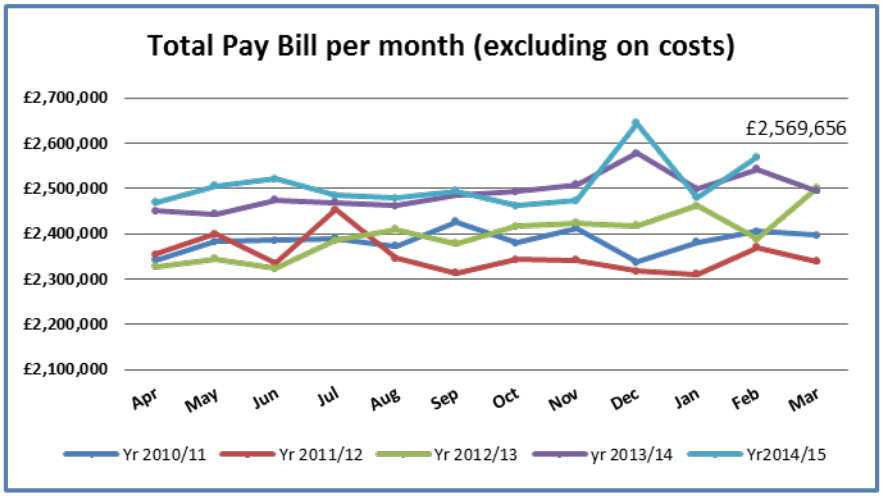
Exceptions

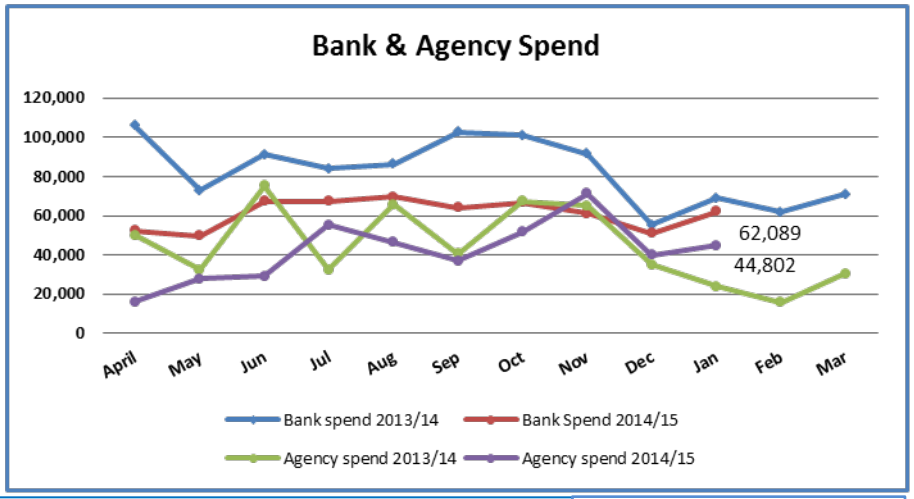
- Canadian Wing currently has 50.41 WTE against a budget establishment of 62.88 WTE a gap of 12.41 WTE, approximately 19% of their staffing .
- Corneo Nursing currently at 10.80WTE against a budgeted establishment of 15.0WTE a gap of 4.2WTE, approximately 28% of their staffing.
- Burns currently still recruiting to 4.0WTE Band 5 nurses.

Actions

- Heads of department & key managers notify recruitment ASAP after a resignation letter is received and begin filling the vacancy, commencing the ECF process.
- Rotate nursing staff to gain skills in other nursing areas, allowing cross cover in areas hard to fill
- Implement local Recruitment and Retention Premia in accordance with Agenda for Change

HEADLINE HR KPIs





Pay Bill – (1 months in arrears) reported pay does not include on costs. Pay for February increased by £89,868 to £2,479,788. the increase in expenditure follows the trend for February 2014.

A breakdown of the split between total staff paid WTE and bank/agency and overtime is reported in arrears and for January 2015, shows WTE staff in post was 825.73 however total WTE paid was 907.03 this is inclusive of 33.44 WTE Bank, 45.74 WTE Agency (excluding RMNs) and 2.12 WTE over-time. The Budgeted establishment inclusive of temporary staffing is budgeted at 902.71, currently the paid WTE inclusive of temporary staffing is at 907.03, which indicates that the paid WTE is over budgeted establishment by 4.32 WTE for January.

Bank and Agency usage – (figures are 2 month in arrears)
Bank expenditure for January was £62,089 an increase of 18 % over last month, this is on trend with the same period last year. Agency expenditure (excluding RMN) was £44,082 a increase of 9.2% for January, this is on trend with the same period last year.

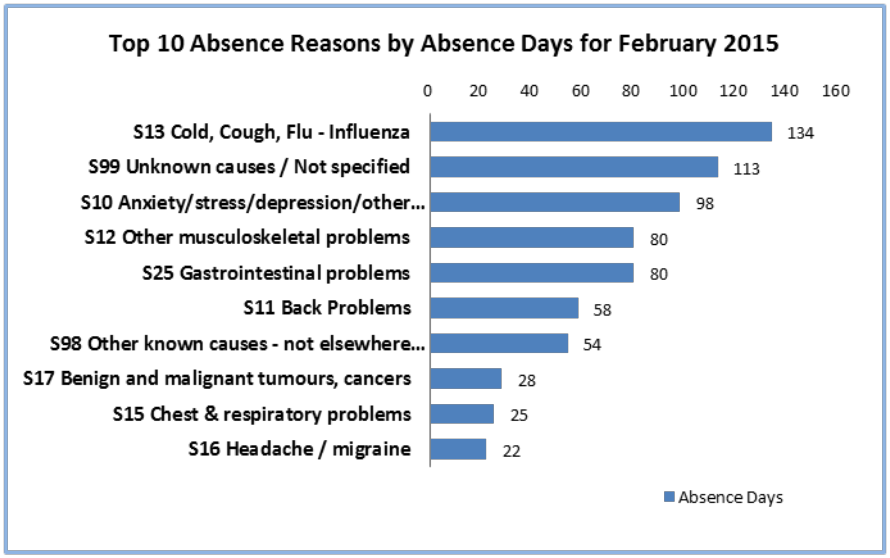
The top three highest users of bank and agency expenditure were Canadian Wing at a combined amount of £30,422 an increase of 25.5%. ITU has a combined expenditure of £11,069 43% from last month, this is due to high patient activity. Burns Centre has a combined expenditure of £10,043 a decrease of 13.5% due to high patient acuity and additional workload.

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

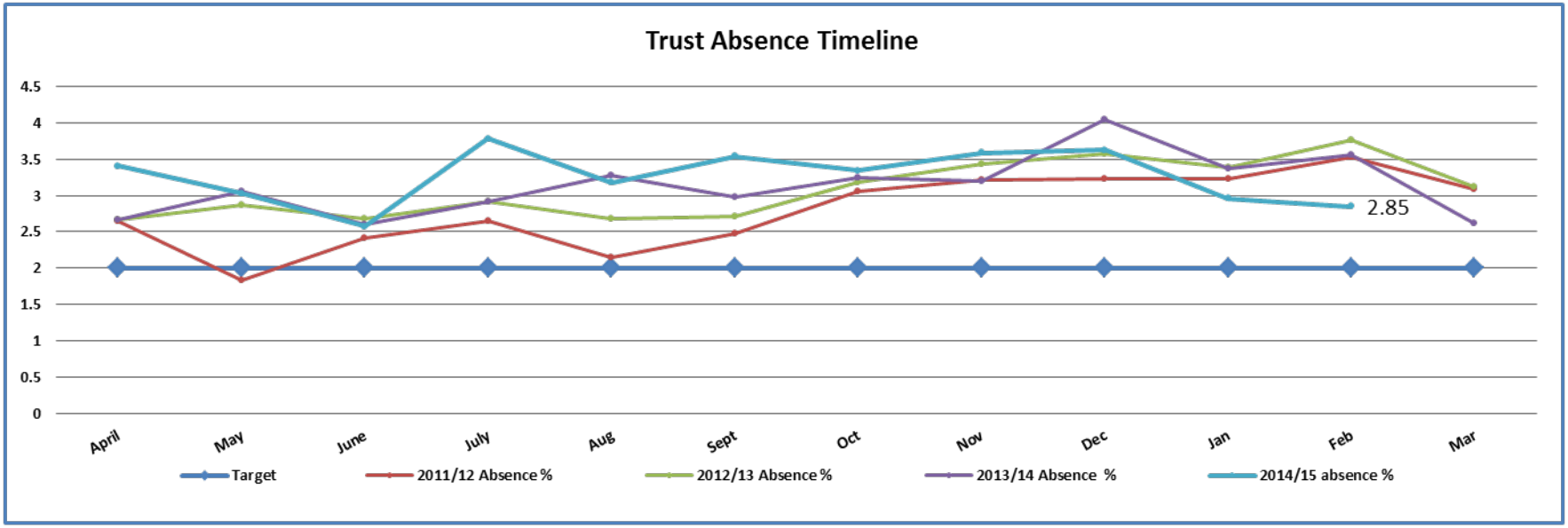
RAG Rating

HEADLINE HR KPIs



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

Staff Group	Absence days lost	Estimated Cost
Add Prof Scientific and Technical	72.01	£8,319
Additional Clinical Services	165.25	£9,994
Administrative and Clerical	149.97	£10,986
Allied Health Professionals	10.81	£1,283
Estates and Ancillary	51.78	£3,132
Healthcare Scientists	0	£0
Medical and Dental	47.90	£7548
Nursing and Midwifery Registered	164.88	£15,507
Total	662.60	£56,769



HEADLINE HR KPIs

Sickness/Absence

Trust sickness for February is at 2.85% a fall of 0.11% from last month and the lowest since July 2014. Reported cases of long-term sickness increase from 6 to 10, of which 2 employees returned in February, 3 of the long-term cases are due to operations and 1 long-term is due to be dismissed in March .

There were 149 episodes of short-term sickness throughout February, with the highest number of short-term sickness cases being Cough, Cold and Flu, equating to 33% of all short-term sickness reported and gastrointestinal problems being the second highest level of short-term sickness, equating to 17% of all short-term sickness recorded.

Long term sickness cases which are over 28 days have Increased from 6 to 10 for February (2 of which are being dealt with under the capability due to ill health. The top three main causes reported are 1) Benign and malignant tumours/cancer and 2) Injury, fracture, 3) Back problems.

There were 756 absence days lost (662.60 FTE) due to sickness. The average days lost to sickness for February was 6.50 days with a cost to the Trust of £56,769. Monday was the highest first day absent for a continuing month, a recurring trend for the Trust – work is being undertaken to identify any individuals who take sickness absence on a Monday.

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

Nursing Registered had the highest sickness absence in February with 39 occurrences of sickness, 2 x long-term cases and 37 short-term sickness relating to Cough, Cold and Flu and Gastrointestinal problems. The top nursing wards are;

- Canadian Wing – Cough, Cold and Flu and Asthma
- Theatres – Cough, Cold and Flu
- Paediatrics – Gastrointestinal problems and Cough, Cold and Flu
- Outpatients – Cough, Cold and Flu

Additional Clinical Services has the second highest sickness for February with 38 occurrences of sickness, 2 x long-term sickness and 36 short-term sickness cases relating to Cough, Cold and Flu and Gastrointestinal problems.

- Theatres - Unknown Causes not else where classified
- Maxillofacial Nursing – Cough, Cold and Flu and Gastrointestinal problems
- Canadian Wing - Cough, Cold and Flu

RAG Rating

HEADLINE HR KPIs

Sickness Absence continued

Admin and Clerical staff had the third highest sickness absence in February with 33 occurrences of sickness, 3 x long-term cases, of which 2 employees returned in February and 30 short-term occurrences of sickness due to 1)Cough, Cold and Flu, 2)Stress/Anxiety and Depressions 3)Unknown causes not elsewhere specified. The top admin and clerical departments are;

- SLR Skin, Breast - Hands and Burns, due to Cough, Cold and Flu and Migraine.
- SLR maxillofacial - due to Cough, Cold and Flu and Stress/Anxiety/Depression.
- Admissions and Appointments – due to Stress /Anxiety/Depression and Cough, Cold, Flu
- Human Resources – due to Stress/Anxiety/Depression.

Exceptions

The main affected areas are; Clean Room at 33.33%, this should be noted that this is a small department of 3 carrying 1 x long-term sickness over 28 days.

Plastics – Hand and skin at 31.24%, 2 cases of Stress/Anxiety/Depression currently 14 days each and 2 short-term sickness cases.

Telephones at 16.09%, a small department with long-term sickness due to surgery.

Site Practitioners at 10.08%, a small department carrying 1 x long-term sickness since April 2014 and 2 short-term sickness cases for January. The employee on long-term sickness has put in a formal request for ill-health retirement as there is no chance this employee will be able to return to work. Recruitment is underway to replace the long-term sick employee which will hopefully lesson the stressors within the department.

Peanut at 8.90%, 2 x long-term sickness cases and 8 short-term cases relating to Cough, Cold and Flu and Gastrointestinal problems.

Actions

The HR Advisors are working with managers and occupational health to manage short-term sickness in line with Trust policy and procedures.

The e-Rostering team are looking to remove sickness that is being recorded as “Sickness not Specified “and “Unknown causes not specified” as a sickness reason as a true record of sickness is not possible whilst these options are available to chose from.

RAG Rating

HEADLINE HR KPIs

Payroll

All staff were paid on time, overpayments increased from 1 to 2, with the amount increasing from £1729.06 to £8824.25. The overpayment was due to late notification of termination and incorrect change of hours. 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 reduced from 26 to 1 and payroll errors increased from 0 to 1.

Employee Relations

The HR Advisors have been actively managing long-term sickness with a further 4 employees returning to work in January 2015, there are 2 existing long-term cases that are currently being managed and 1 new case this month. One long term case will be dismissed in March under Capability due to ill-health for a terminal sickness.

There was 1 new informal short-term sickness case and 10 existing cases being actively managed in-line with Trust policy. There is 1 new case of formal short-term sickness and 4 existing cases.

There are no cases of formal disciplinary or conduct this month, although 2 new cases of informal conduct.

There are potentially two change management cases pending approval (theatres and peanut).

Case Type	Number of cases
•Disciplinary	0
•Bullying & Harassment	0
•Conduct	2 (informal)
•Capability	2 (formal) 1 (informal)
•Long-term sickness	10
•Change Management	1
•Grievance	0
•Whistleblowing	0
•Probationary	0
•Appeals	0
•Suspension	0
•Flexible Working	0
•Dismissals	0
	Total 15

RAG Rating

Statutory and Mandatory Permanent Staff Training – 2.3.15

Competency Name	Expired	Expired but Booked	Match	Grand Total	Trust Overall (Expired + Matched)
276|LOCAL|Emergency Planning - Non-Clinical - 3 Yearly|	15.56%	3.33%	81.11%	100.00%	84.44%
276|LOCAL|Emergency Planning: annual|	11.67%	8.25%	80.08%	100.00%	88.33%
276|LOCAL|PDR - annual|	38.05%	0.00%	61.95%	100.00%	61.95%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	40.14%	3.94%	55.92%	100.00%	59.86%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	19.77%	5.20%	75.03%	100.00%	80.23%
NHS|CSTF|Infection Prevention and Control - Level 1 - 1 Year|	38.03%	0.00%	61.97%	100.00%	61.97%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	14.25%	1.94%	83.80%	100.00%	85.75%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	9.94%	9.09%	80.97%	100.00%	90.06%
NHS|CSTF|Information Governance - 1 Year|	30.97%	1.74%	67.29%	100.00%	69.03%
NHS|CSTF|Moving and Handling - Level 1 - 3 Years|	22.30%	3.97%	73.73%	100.00%	77.70%
NHS|CSTF|Moving and Handling - Level 2 - 1 Year|	29.52%	9.23%	61.25%	100.00%	70.48%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	30.57%	4.14%	65.29%	100.00%	69.43%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	21.62%	6.77%	71.62%	100.00%	78.38%
NHS|CSTF|Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year|	22.24%	6.43%	71.32%	100.00%	77.76%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	19.26%	3.25%	77.49%	100.00%	80.74%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	13.81%	2.55%	83.64%	100.00%	86.19%
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	27.64%	2.18%	70.18%	100.00%	72.36%
NHS|CSTF|Safeguarding Children - Level 3 - 3 Years|	32.43%	0.00%	67.57%	100.00%	67.57%
Grand Total	**24.18%**	**4.12%**	**71.70%**	**100.00%**	75.82%

Statutory & Mandatory Training

The overall Trust figure of statutory and mandatory training matching requirements has again increased from 70.36% to 71.70%. The Trust Overall Figure has also increased from 74.88% last month to 75.82%. The majority of Competency completions have remained the same or increased slightly this month This is due to continued competency re-alignments and more accurate reporting for managers.

Exceptions

Infection Control The Level 1 – 1 yearly renewal for Non Clinical Domestics & Porters as they are often in clinical areas, has increased significantly from 28.89% to 61.97%. This has been achieved by a specific departmental session and a further one is booked to increase compliance further.

Equality, Diversity & Human Rights. Despite remaining in red, the overall figures have increased again this month from 58.15% to 59.86% and individuals are booking onto future courses. We have 34 confirmed bookings and approximately 346 staff still requiring the training.

ACTIONS: Still approx 1200 Local competencies still to amend to CSTF's. To be completed by end of March.

RAG Rating

Conversion rate from the January Nursing/Administration Recruitment Day

Vacancy	Applied	Interviewed	Appointed
Healthcare Assistant Canadian Wing	5	5	3 – Canadian Wing 1 – Maxfac
Healthcare Assistant Theatres	1	1	0
Cancer Data Coordinator	1 (applied prior to event)	1	1

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26 March 2015
Reference number:	69-15
Report from:	Jo Thomas, Interim Director of Nursing
Author:	Jo Thomas, Interim Director of Nursing
Report date:	17 March 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 4 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. Along with the shorter term actions that were identified for achievement during 2014/15 a timetable for longer term aims for achievement is provided.
3. The summary demonstrates good progress is being achieved against priorities identified for this year.
4. The attached document will be shared with the Clinical Cabinet and is shared at each patient experience group meeting as this groups action plan supports achievement of goals associated with delivering an outstanding patient experience.

Implication of results reported

5. Progress continues to be made against the objectives many of these associated with the review of governance structures and the commencement of monthly clinical governance meetings that now report into a quality and risk committee that meets every two months with papers presented that reflect assurance of activity undertaken.
6. Quarter 4 progress shows; 20 green actions (17 previously), 18 amber (21 previously) and 0 red.
7. The main areas of challenge remain;
    - Recruitment to vacancies
    - Improvements to the patients menu which are hoped will improve patient perception of food.
8. 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.
9. There has been a significant increase in governor participation of the Trust's CiP (compliance in practice) programme.

10. All patients should benefit from the actions identified within the QVH 2020 plan for 2014/15 and no specific group will be excluded from benefiting.
11. 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

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

Regulatory impacts

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

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

Recommendation

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

KEY STRATEGIC OBJECTIVE 1 Outstanding Patient Experience							
Superior Care & Outcomes - *Care is safe, compassionate, competent and provided by a well led team*							
	KEY ACTIONS 2014/15	**Owner**	**Measure**	**Due**	**Progress**	**R**	**Risk**
	Leadership & Values						
1	The Trust Board to reaffirm its commitment to the highest standards of nursing care and behaviour as part of its wider commitment to excellence in patient care. (C8.1)	CEO	Board meeting minute **HS**	April 2014	Discussed with CEO and to reaffirm at April 2014 board meeting Completed at April Board meeting	G	
2	The Trust Board to take the lead in creating a culture of openness and transparency throughout the organisation through an increased programme of board visits, 'back to the floor' sessions and involvement in 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 2014/15 **AS**	March 2015	P Griffiths – Sept 14 G Colwell – Aug 14 J Thornton - July 14 L Porter – July 14 S Fenlon – Feb 15 B Goode – Mar 15 A Parker – June 14 /Aug 14 R Tyler – Oct 14 G Armitage - J Morris – Oct 14 D Tkaczyk – B Hobson – Dec 14	A	
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	CEO	An AOB item on clinical cabinet agenda Observation area on CIP tool	April 2014 May 2014	Added to CIP tool and to clinical cabinet agenda Awaiting feedback from CIP tool use and May clinical cabinet **Actions taken – monitoring required**	G	

	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)		**LHR AS AP**				
4	Ensure that all Directors, Governors and Clinicians undertaking visits within the clinical areas are encouraged to feed back any comments or concerns relating to staff attitudes/morale or the quality of patient care directly to the Chief Executive. (C6.4)	CEO	Discussion at clinical cabinet - feedback minutes **LHR** Summary of those undertaking CIP directors / governors **AS**	June 14 May 14 March 15	Board to reflect on all visits at end of board agenda – to be introduced as standing item that is recorded Q1 Governors x 12 Directors x 1 Q2 Governors x 14 Directors x 4 Q3 Governors x 12 Directors x 5 Q4 Governors x 20 Directors x 5	G	
5	Ensure that the Trust takes appropriate robust action against any individual whose behaviour is not consistent with the core values of the Trust regardless of other positive aspects of their performance. (C6.5)	HHR&OD	HR Board report reflects capability and disciplinary against behaviors **HS** Appraisal documentation identifies core values assessment **CH** Appraisal rates in board papers **HS** Manchester patient safety framework – CQUIN this identifies attitudes/leadership **GA**	Sept 15 May 14 Sept 14 Start June 14	Included from September 14 Updated and includes core values Included in board papers Meetings planned and action plan for delivery in place	G	

6	The Executive Directors to incorporate in their monthly updates for the Board any negative feedback they have received or concerns they have, relating to staff behaviour including the action taken to address the issues raised. (C6.6)	Exec Directors	Board reports include feedback on visits to clinical areas **HS**	Sept 14	Discussion underway with Lois/CEO if go in front cover along with KSO relevance. Option amended and to be covered at board in NED and Exec updates To commence June 14 Occurs routinely	G	
7	Support staff in taking a zero tolerance to poor attitude towards colleagues / patients	HHR&OD	Connect article to all staff on zero tolerance and support available to staff **GA**	Sept 14	To occur as a specific communication exercise – on track	A	
8	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 their responsibility for the improvement of nursing standards and lead role in governance and compliance matters. (C6.3)	DN	Clinical visits – noted within patient experience section of board report New N&Q structure in place and provided to organization Ward safety/standards information to board each month Inclusion of OPD / MIU / Theatres **JT**	June 14 June 14 June 14 Sept 14	Variety of options in use – main reception desk x 2 per week & ward/area clinical working May CWing June Theatres July Theatres August Canadian Wing Structure shared with organistaion Proposal to board April 14 – routine reports commenced May 14 Templates commenced but review of content required - monthly reports are provided to areas currently – No progress this quarter New Interim DON in post; clinical visits will continue as well as reports to the board relating to clinical and safe staffing issues **JT**	A	DN capacity

9	The DN to work with the matrons and other senior nursing staff to develop a clear set of QVH nursing standards and behaviours that can be incorporated into recruitment, appraisal and performance management. (C8.2)	DN	Recruitment process evidences VBR and English and numeracy skills **JA** Patient care strategy – roles responsibilities has been revised **AP** Relaunch of strategy and standards occurs **AP** **JT**	June 14 May 14 May 14	Process in place – review of recruitments to confirm all aspects are occurring Document launched 7 May at CNO visit Re launch linked to meet the matron / hello my name is…/ safe staffing – safe care / inpatient survey – May 7th	G	
10	Review role of trauma coordinators leading to increased recruitment & retention, **March – July 2014**	DDN/ Matron non elective services	Feedback report from Matron **NR** Recruited to full establishment **NR**	April 14 Oct 14	Summary feedback provided following meetings with staff and Mr Blair / J Morris. New processes in place to reduce call handling. Adverts out for recruitment, team also impacted currently with some long term sickness - recruitment occurring – almost to full establishment	A	Mixed team crucial for care – staffing a challenge in UK currently
	Safe Care, Safe Staffing						
11	Monthly publication of staffing data. Making use of e-rostering and other workforce data to provide assurance to the Board, staff and patients as to the provision of safe and competent levels of staffing throughout the Trust. (C8.3)	DN	Monthly board report Information on trust website Information on NHS Choices **HS**	June 14	Proposal to board April 14 Proposal agreed – first paper to May board	G	
12	Meet with Allocate to introduce the Safer Care module to the e-roster	DHHR	Safer Care module in place	June 14	Safecare live in 4 wards from 1 March 2015. Erostering monitoring data input by the wards to	G	Availability provider /

	system, May 2014 to enable monthly reporting of staff vs. acuity patients: **June – August 2014**. (QA) **Strategic Investment Fund (SIF)**		Ward and board reports informed by safer care module	Sept 14	ensure accuracy. Safecare training ongoing within wards. SafeCare Project commenced in 3/11/14 with a Kick-Off Meeting where the implementation strategy was agreed with the Chief Nurse and Matrons. 4 Inpatient Wards participated in the project - Burns Ward, Burns ITU, Canadian Wing, Peanut Ward - the system has been implemented, acuity and dependency tools tested and agreed, and is providing live data from 1 March 2015.		HR team / IT
13	Introduction of Patient monitoring system – IT system for identification of deteriorating patient (QA). **Dependent on successful bid to Nursing Technology Fund**	DDOF	Electronic observations available for alerting	March 15	Bid submitted to nursing technology fund – awaiting feedback which is due in January Bid was unsuccessful. Added to IMT capital programme 2015/16 but needs to have the infrastructure in place before proceeding.	A	Dependent on NT Funding
14	Develop an action plan to reduce the use of agency staff – exact level to be recommended by the DN taking into account benchmarked data from similar organisations. (C8.4)	DN	No non RMN agency used Ward / board reports indicate agency / bank / substantive staff	June 14	Usage currently provided each week Recruitment programme underway. Recruitment day booked for January Recruitment task and finish group set up; event planning in progress **JT**	A	Availability of nurses to employ to substantive roles
15	Build on the work already started by the Head of Human Resources to establish an integrated scorecard (monthly) for C wing and other clinical areas that makes use of both the existing indicators and the outputs from e-rostering highlighted above. Integrating these reports will provide	DN	Full suite of scorecards available	Oct 14	Proposal to board April 14 May – first scorecards to be provided to board Not all information can yet be accessed but steady progress Further work will be linked to the introduction of the Safe Care module	A	

	a much fuller picture of both the day to day management and the longer term trends which would provide an improved system of early warning. (C14.1)						
16	Develop a weekly 'flash report' to provide early warning of challenges to staffing levels relative to patient numbers and acuity and inappropriate use of temporary staffing. (C14.2)	DHHR DN	Flash report available from e roster	Nov 14	A new module for e roster has been provided in the first week of June - this will be able to provide planned and actual availability in advance. Process for using this to be established Issues with this have delayed the ability to provide flash reports. With the implementation of SafeCare the Trust now has the ability "realtime" to see that the 4 inpatient areas are safely staffed, and where they might appear overstaffed Ward Managers can redeploy staff in advance and therefore reduce the need for temporary resources	A	IT issues
17	Chief Executive to charge the Head of Human Resources with taking responsibility for developing and monitoring relevant and timely early warning data. (C14.3)	HHR&OD	Early warning information available **GA**	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	A	
18	Head of Human Resources to provide a quarterly update to the Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system (C14.4)	HHR&OD	Quarterly report to board **GA**	June 14	Q1 Referred to within HR September report Q2 Updated within individual KSO Q3 Q4	A	
19	Monthly reporting of safety thermometer 'harm-free care' (CQUIN)	DDN	Board dashboard	May 14	Process in place – covered in board dashboard	G	

20	Monthly collection of compliance with WHO checklist (CQUIN)	Matron Periop	Board dashboard	May 14	Process in place – Audited each month – information provided within CQUIN update	A	
	Governance						
21	Whilst we are confident about the effectiveness of both the Quality & Risk and Audit Committees it would seem appropriate, both in the light of the *Frances*, *Keogh* and *Berwick* reports, and in *Monitor's* growing focus on formal governance processes, to review our Board level governance structures. The interim Director of Corporate Affairs was tasked with reviewing the Board systems of both corporate and clinical governance. (C16.1)	HoCA	Revised meeting structure in place Minutes from Q&R	June 14 July 14	Discussion over new structures held with IHCA / DN / CEO / GC/ AV New structure proposal in place for clinical governance group / clinical cabinet. New Q&R committee will commence in September 14 (Meeting was planned for August 14) New style will meet bi monthly and in the interim to provide board assurance the Q&R chair (GC) will attend a clinical governance group meeting. Further trust-wide governance review being undertaken by chair designate supported by a small working group. BoD agreement in principle to recommendations with a view to implementation by 1 October 2015.	G	
22	As part of a wider review of Trust governance systems, the Head of Corporate Affairs to consider how best we can incorporate behavioural and cultural concerns within our governance systems. (C6.7)	HoCA	All meeting agendas cover behaviours / concerns as AOB standing item	Sept 14	To be included in Clinical cabinet from May	G	
23	Establish a monthly executive level Quality & Safety Committee to be chaired by the CE, and review and amend the remit of the existing directorate quality & risk committees and other committees dealing with	HoCA	New Q&R process established	June 14	Discussions in place and plan for changes from June 14 Changes to Clinical Governance Group commenced June 14 Q&R changes occur from Sept 14	G	

	quality, risk and safety issues to align governance structures and reporting across the Trust. (C16.2)				Now incorporated into trust-wide governance review.		
24	Trend analysis to be included in monthly reporting to the Quality & Safety Committee. (C16.3)	HoR	Trend information available	June 14	Trend information currently included – governance arrangements under review. Revised Q&R will review patient safety and patient experience through in depth triangulation from Sept 14	G	
25	Quality & Safety Committee to define trend reporting requirements to be provided by the Risk Team. (C16.4)	HoR	Trend information informed by Q&R May meeting minutes	June 14	Revised Q&R will review patient safety and patient experience through in depth triangulation from Sept 14. Now established	G	
26	Quality & Safety Committee to review the Trust risk registers to ensure it is a 'live document' with risks appropriately identified, graded and escalated. To agree a unified approach for the different registers. (C16.5)	HoR	Trust risk register to Q&R with updated risks BAF to audit committee quarterly Teams review risks at dept / directorate meetings	June 14 June 14 June 14	Risks being updated – Q&R to receive all corporate risks and to do an in depth review of one risk at each meeting BAF under review – 14/15 in progress Re formatted BAF reviewed at Audit committee September 14 and November 14	A	
27	Monitoring of incidents, including follow up on action plans to be included in monthly agendas for Quality & Risk Committee. (C16.6) Qualitative audit of implementation of WHO 'checklist' – (CQUIN)	HoR	Monthly meeting established	June 14	Currently goes to CGG to be on monthly agenda – new format commenced June 14	G	
Exceptional Environment - ***An environment that provides accommodation and facilities that meet the needs of patients and their families***							
28	Liaise with corporate affairs and review volunteer cover for reception	HoCA	Front desk covered 0800-1800	July 14	Discussed with C Charman – to extend slots for volunteers and put article in Connect that informs	A	

	desk ideally covering 0800-1800 July **2014**				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 March 15 update: Jo Davis contacted about staffing the desk with a member of theatre team in the mornings, as most of the patients arriving early are for theatres. Last year a volunteer covered 4- 6pm but it was not busy enough to warrant a volunteer unless they had something else to do while sitting there – explained to DN she was happy with that. A volunteer covers Mon - Thurs 7.30 - 9am and sees an average of 15 people in that time. He is not well supported at that time of day – fortunately he has a nursing background and is quite self-sufficient but it would be of concern to take any more volunteers at that time of day without adequate support. Maps are now up-to-date and it is easier for patients to find their way. Letters to patients now have a diagram map on the back too.		
29	Support provision of a discharge lounge / transport waiting area **June 2014.**	Programme Director	Waiting area available for patients	June 14	Area identified within 'old admission lounge'. Included within proposal for MoHs and LOPA's move. Following discussion at site capacity meeting 30th April the option to relocate vending machines and create a space for patients will be developed as a	A	

					high level proposal that will also be discussed with the League of Friends as they may help to fund – funding agreed. Project document in place with planned work for Q3/4 Designs complete for relatives room on C wing. Awaiting appointment of builder. Work likely to be done in Q1 15/16		
30	Ward re fresh – painting, removal of arjo baths and replacement with showers etc. **2014/15 capital programme**	Programme Director	Ward redecorated Showers in place	?	Single rooms in Ross Tilley have been commenced Nurses' station RT completed. Project plan re conversion of bathrooms to wet rooms commencing (Sept 14)	A	Not noted to be included in capital programme
31	Refurbishment Physio/OT reception area. **2014/15 capital programme**	Programme Director	Physio / OT reception refurbished	Q3	On track for completion end March 2015	A	
32	Work with hotel service team to review food charter mark guidance and develop actions to work towards gaining a charter mark **March 2015** (CQUIN)	Programme Director	Quarterly reports provided that demonstrate progress against agreed CQUIN actions	March 15	Q1 – action plan seen Q2 – changes made during November 14. Updates provided within CQUIN report Q3 - complete Q4 – in progress	A	
Outstanding personal service - ***All interactions with patients and their family/carers are caring and compassionate putting the patient at the heart of care.***							
33	Provide programme of engagement to patient experience group **May 2014**	DN	Minutes of PEG	May 14	Programme provided and staff and governors joining CIP etc	G	
34	Act on negative feedback and monitor actions to improve experience. **On-going**	Patient experience manager	Monthly complaints report – C Cabinet Information within Board report	May 14 May 14	Reporting process in place	G	

			Patient stories at Board	June14			
35	Make available drinks for family within ward area **July 2014**	Matron Elective services	Drinks available on ward	June 14	Peanut and Burns in place. CW: drinks trolleys now situated in each of the day rooms. We ask for a small donation from visitors towards the cost which is put back into the hotel services budget. Shortly we will also have the new cafe area at the entrance to CW.	G	
36	Provide wider availability of information on how to access personal items / newspapers etc. **July 2014**	IHCA	Updated bedside guide	May 14	New guide distributed and includes information	G	
37	Take a zero tolerance to avoidable late start clinics initially identifying the causes August 2014 developing actions to address identified issues **March 2015**	HoOps	Information on clinic start times available Late clinics – evidence of action taken	June 14	Meeting held 10 June to discuss actions identified: a) for New system administrator to devise a dashboard that can show weekly reports regarding clinic start times from Enlighten Completed b) Escalation flowchart in place for nurses to follow in Plastics, Max fac and Corneo when Dr's are late Completed c) Kathy to discuss with OPD Sisters mechanism to record why clinics are running late (as this cannot be collected on Enlighten at the moment) Completed d) Any clinics over 30mins late Datex to be raised Completed e) When new service manager in post they will be responsible for investigating these Datex's further and highlighting trends –	A	

					this might be template changes / job plan amendments Completed f) Trust policy to be devised to escalate persistent offenders (if not addressed by actions under e)) firstly to Clinical Directors, then to Medical Director as required moving onto displinary process if needed. This I suspect will need to be discussed at Clinical cabinet / LNC. To be completed by new service manager for outpatients when in post after June. Meeting held December and work is progressing		
38	Wifi access for patients. **2014/15 capital programme**	HoIT	Wi Fi available to patients		Wi fi available to both staff and patients	G	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 26th March 2015
Reference number: 70-15
Report from: Dr Steve Fenlon, Medical Director
Author: Dr Steve Fenlon, Medical Director
Report date: 18th March 2015
Appendices: NA

KSO2 World Class Clinical Excellence.

KSO2 (1): Clinical strategy
(to be updated within CEO report)

- Seven-day services: This is a project for the medium to long term. Non-elective care requires changes to working practices and engagement with the anaesthetic department now. Trainees and the site practitioner team are also helping to examine the medical care of patients at QVH. Medium term aims are to increase out of hours (OOH) cover as far as possible within the Keogh objectives, whilst not increasing costs. This project has made good progress against the ten criteria of non elective seven day cover; QVH has submitted 5 areas of compliance to the CCG for approval. Remaining areas are being addressed, increased consultant presence beyond existing emergency non-resident cover will require investment including supporting staff and facilities to realise any true benefit and will require a full cost/benefit analysis. Likewise operational work to focus on seven-day provision of elective activity becoming 'work as normal' requires a clear business case before further progress will be made.

KSO2 (2): Publish Consultant Level Clinical Outcomes
(Lead Steve Fenlon, project manager Jacqueline Packer)

- Collate current consultant level safety metrics: This data is now presented as a single spreadsheet to provide board level assurance of the consultant's safety and performance against a range of metrics. This spreadsheet is complete and can be shared at individual level with consultants to agree data validity and address concerns. The spreadsheet is available for review by trust senior management, and is of particular use to the medical director for the purposes of revalidation. Currently this is populated manually from disparate data, but it is planned to continue to update monthly.

- To deliver six outcome measures from services across the trust for publication on the trust website in 2014-15 (Priority 2 of the Quality Account 2014-15): This has, as expected, proved to be a challenging target to meet and ultimately we have managed to bring three outcome measures to publication within nine months. We have succeeded in publishing on the website outcome measures for QVH consultants within the following specialities for all 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

The original aim was to publish six measures, there are many other domains which have made good progress but failed to make it on to the publication list for 14-15, the reasons are detailed here:

- Breast reconstruction: A local database devised and maintained by the lead for breast surgery collected details of major reconstructive surgery and some patient feedback. This database was stand alone and could not be linked to patient centre or any other QVH source. As a result the individual patient data lacked context, final patient results for surgery could not be linked back to patient demographics, risk factors and outcomes following further surgery. Publication risked challenge on these grounds and could not be justified. Introduction of a new national PROM registry by BAPRAS (led by Anita Hazari) has now negated further development of the local database.

- Anaesthesia: A local database and manual collection of recovery profiles maintained by the lead for safety for anaesthesia provided information used by the department to quality assure itself and publish as part of existing quality accounts. As with the breast database it was impossible to link to sufficient patient demographics to ensure a reasonable comparison between consultants at QVH. In addition the high level of manual work required made this databased unsustainable. This was recognised early in the project and a successful charitable fund bid for a laptop linked to Patient Centre enabled more comprehensive data collection including PROM data from recovery. A delay in procurement saw these laptops enter service in Q4 leaving insufficient time to feed back data for checking and agreeing prior to publication in any form by the end of Q4, though this work is now routine data collection for the recovery team.

- 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. The IBID data could not be downloaded from their database despite multiple attempts as is it designed more for commissioning purposes than outcome measures, though it incorporates clinical outcomes. Data from IBID remains 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. Validation and agreement of data collection is still needed, but it is expected the sleep unit will begin to submit patient data to the Quality Account for the first time in 14-15

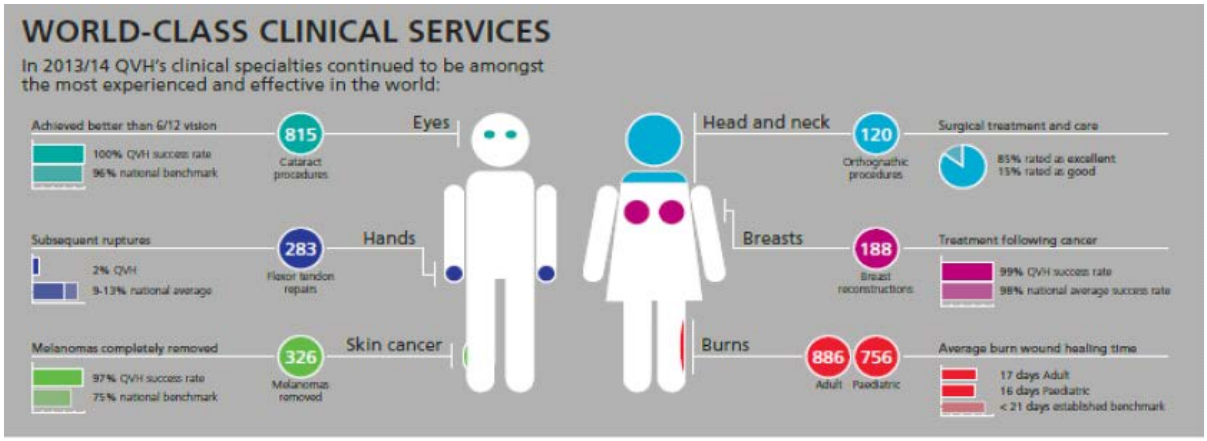
- Eye services: Consultants in this speciality have joined a national website, iwantgreatcare.org, set up to enable patient feedback for individual doctors. A link has been placed on the QVH website to these consultants and we are encouraging consultants in other specialities to adopt this route which is free of charge to QVH. Though this provides PROM measurement by consultant, it is selective according to the patients desire to leave feedback, so it was felt should not be submitted as one of the six for priority 2, but may become more representative if widely adopted in future. An example is shown below.

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

- Priority 2 Quality Account Summary: We set ourselves a high target of six outcome measures from zero. Although we have not achieved all six measures for the Quality Account, the narrative makes it clear that impressive progress has been made in many areas and offers great opportunities for this project going forward. This has been achieved mostly by the effort of the project manager for outcome measures, Ms Jacqueline Packer, who has formed and developed the project to a new level over the last year.

General Outcome developments

- General work has focussed on making outcome measures accessible to those that really matter, the patients. A pictorial representation of our services has been created and used as a model to shape future publication of some of this work.



- The future shape of outcome measures for the QVH.
  Outcome measures are of use to a wide audience but at their most fundamental level form part of the Trust's obligation to be open with its service users. A greater understanding of our performance good and less good is vital. Whilst the wider NHS talks outcome measures, it doesn't walk them, their implication and open publication remains very limited. PROMs are likely to form an important part of the national outcomes framework and for us are essential. We have consulted with a number of companies now specialising in this area with a clear specification of our needs and a who could meet them at what cost.

  This has been a developmental process for some of us at QVH, effectively beginning from nothing. We have a picture for the future which is realistic and accepts the limits placed on not just QVH but the wider NHS with its poor record in clinical electronic data management. Potentially EPR could address some of this, though it remains to be seen if EDM, the choice imposed on QVH, is capable. Money alone does not suffice, expertise in data management remains difficult to source in the public sector. We were lucky to have a project manager with experience from the private sector and an eye to what could be achieved. The findings of EKBI, who provided external assessment of our capabilities, describe much of what may be the future of outcome measures for QVH and some clear milestones to achieve this. Intrinsic is investment in 'insight', not just computers but resource able to identify and manage information across the trust, its spoke sites and wider NHS. In a small trust there is often a dependence on 'word of mouth' in preference to data. High level interpretation of data collected independently of service providers yields information that gives insight and allows informed debate. We continue to push the limits and linkage of our current data systems to promote the necessary input and delivery of outcomes with existing resource. To achieve outcome data equivalent to the

leaders in the field is a laudable ambition; the need for which must ultimately be measured against other board priorities.

KSO2 (3) Clinical research and development
(Leads Steve Fenlon, Julian Giles, Clinical Lead for Research, Brian Jones, Director of Research Development)

Updates from last report

- 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

- Grants Submitted awaiting response:
    - EME burns dressing change (with collaborators) £1.5m
    - MRC application DPFS dressings (with collaborators) £1.1m
    - 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

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

- Colloboration/Networks
    - High level meeting CEO and Dean UOB with action plan
    - BSMS Dean to visit QVH April 15
    - Biobank steering group working through options, Imperial collaboration possible
    - Trust research days planned for QVH 15-16

KSO2 (4) Education and Training
(Leads Steve Fenlon, Ed Pickles, Director of Medical Education and Helen Moore, Medical Education Manager)

- 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.

- Establish a temporary simulation suite as part of the above with funding for equipment provided by HEKSS, this is in process of being put together and awaiting some minor estates work together with purchase of classroom materials to be funded from QVH. Equipment is now on QVH site and medical staff have received training on use of the simulation equipment.

- The action plan to address deanery concerns resulting from trainee feedback to both HEKSS and the GMC has been accepted and actions are underway led by the Director of Medical Education (DME) and Medical Education Manager (MEM). This has required investment in feedback training, education facilities, investigation and treatment of behavioural issues and is part of a holistic approach to recruitment and retention of junior staff and non-consultant career staff.

- Trainee shortfall is currently addressed by recruitment of trust grade doctors, A recruitment plan has been put together (seen by Board at November meeting). A very successful recruitment day was held on the 17th march attended by over 50 potential plastic surgical trainees from across the globe.

- Re-engaging with junior medical staff has begun with the trainees' forum to discuss theirs and trust issues. A temporary rest room has been established and trainees will be invited to trust meetings to better voice their opinions and gather their input to some of the trust issues.

- Director of Medical Education appointed November 2014; making good progress with above and developing the medical education role. An additional 4 hours per week trust funded time is provided to recognise the increasing number of directly employed trainees (i.e. non-deanery trainees who we are fully responsible for and who do not receive any educational support outside of QVH). These doctors require greater not lesser support and it is hoped this clinician time will begin to address the issue.

- 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. On going meetings with colleagues at SASH to monitor the development of the PA role.

Recommendation:
This report accompanies and provides background information to the regular update to the Board. The Board are asked to **note** the contents. A presentation has been prepared with further details of the outcomes project.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 26th March 20115
Agenda item reference no: 71-15
Author: Richard Tyler, Chief Executive
Date of report: 11th March 2015

BOARD PRIORITIES 2015/16

Key Issues
The Board considered an initial set of priorities at its seminar on 17th February. It was agreed that the Board would focus on a limited number of priorities that aligned with the Trust's overall strategic direction as set out in its five-year plan *QVH 2020*. The attached set of slides reflects the outcome of the board seminar and further discussion with the Trust executive team. Included against each priority is a brief description of the proposed action and the executive lead.

Implications
QVH 2020 sets the strategic direction for the trust. The successful implementation & delivery of these priorities will form another important step towards the long-term sustainability of the organisation.

Action Required
The Board is asked to review the priorities as set out in the attached slide pack and agree, subject to any amendments made during the meeting, that these are the Board priorities for 2015/16.

Links to Strategic Objectives
This links to all five strategic objectives.

Implications for BAF or Corporate Risk Register
The BAF for 2015/16 will be revised in the light of the proposed board priorities and reported to the April meeting of the trust board for sign off.

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

Recommendation
The Board is asked to **SUPPORT** the priorities for 2015/16 as set out in the attached slide pack subject to any amendments made during the Board meeting.

Board Priorities 2015/16

QVH 2020 – A vision for sustainability & growth

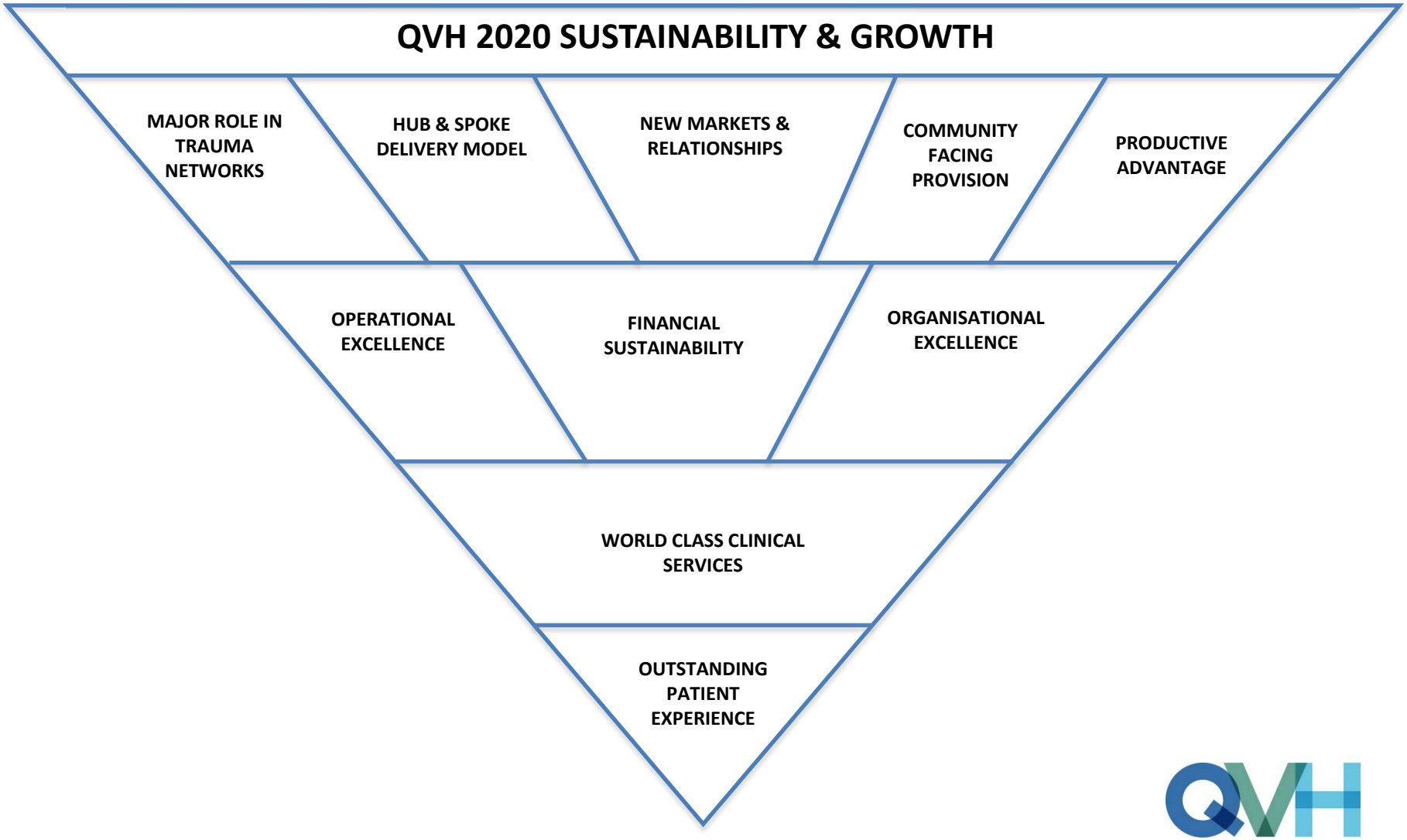
Queen Victoria Hospital NHS
NHS Foundation Trust

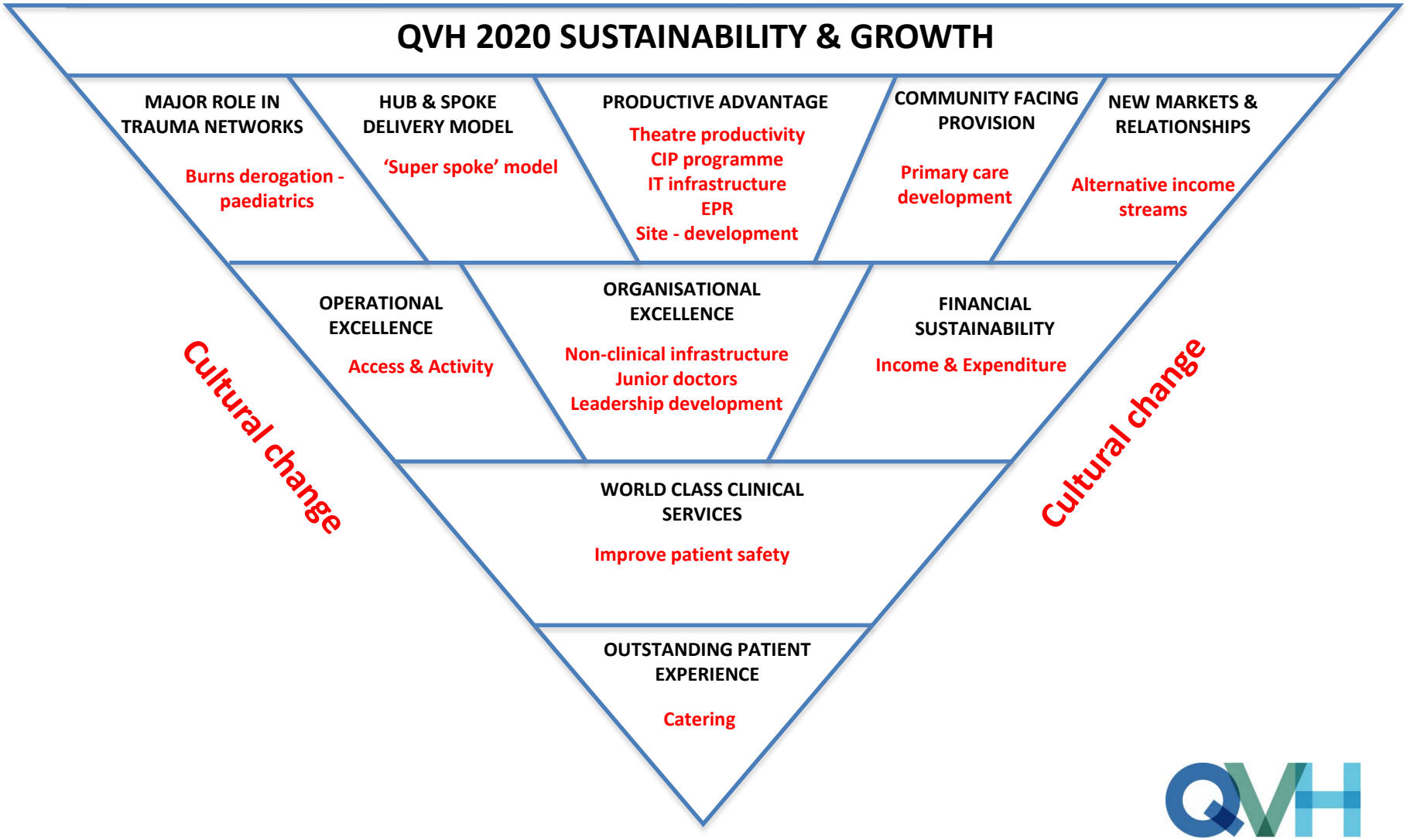
Service Area	A future where
Specialist Surgery, Burns and Rehabilitation	▪ We retain our position as the major provider of specialist reconstructive surgery, burns and rehabilitation for SE England ▪ Our major base for burns and trauma is co-located with a Major Emergency Centre in SE England with planned surgery in East Grinstead and satellite unit(s). ▪ Through our strategic partnership with Kings, MTW & BSUH we have strengthened our services and have fit for purpose facilities with the required clinical support on site ▪ We have been able to further extend our reach into Surrey and Kent
Routine Elective Surgery	▪ We have grown our market share in hand, breast, skin, cornea, sleep and max-fax surgery ▪ We have a significant private business alongside our NHS business which has increased our flexibility and value, and we work in partnership with consultants to grow both businesses to our mutual benefit ▪ Our outreach services all add value to our business and are strategically located to to provide excellent patient access and ensure patient flows into QVH
Community Facing Services	▪ We provide, in partnership with the local federation of primary care practices an integrated primary and community care service on our site and in the local community which incorporates 3 practices, community nursing and rehab services, rapid access to diagnostics, geriatricians, walk in centre ▪ These services contribute to avoiding unnecessary admissions and enabling earlier discharge from hospital for East Grinstead patients

QVH 2020 – Delivering excellence

Queen Victoria Hospital NHS
NHS Foundation Trust

KSO 1	KSO 2	KSO 3	KSO 4	KSO 5
Outstanding Patient Experience	World Class Clinical Services	Operational Excellence	Financial Sustainability	Organisational Excellence
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 the patient and their families.	We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative R&D	We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.	We maximize 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
Director of Nursing	Medical Director	Head of Operations	Director of Finance	Head of HR & OD


QVH 2020 SUSTAINABILITY & GROWTH
MAJOR ROLE IN TRAUMA NETWORKS
HUB & SPOKE DELIVERY MODEL
NEW MARKETS & RELATIONSHIPS
COMMUNITY FACING PROVISION
PRODUCTIVE ADVANTAGE
OPERATIONAL EXCELLENCE
FINANCIAL SUSTAINABILITY
ORGANISATIONAL EXCELLENCE
WORLD CLASS CLINICAL SERVICES
OUTSTANDING PATIENT EXPERIENCE


QVH 2020 SUSTAINABILITY & GROWTH
MAJOR ROLE IN TRAUMA NETWORKS
Burns derogation - paediatrics
HUB & SPOKE DELIVERY MODEL
'Super spoke' model
PRODUCTIVE ADVANTAGE
Theatre productivity
CIP programme
IT infrastructure
EPR
Site - development
COMMUNITY FACING PROVISION
Primary care development
NEW MARKETS & RELATIONSHIPS
Alternative income streams
OPERATIONAL EXCELLENCE
Access & Activity
ORGANISATIONAL EXCELLENCE
Non-clinical infrastructure
Junior doctors
Leadership development
FINANCIAL SUSTAINABILITY
Income & Expenditure
Cultural change
Cultural change
WORLD CLASS CLINICAL SERVICES
Improve patient safety
OUTSTANDING PATIENT EXPERIENCE
Catering

QVH 2020 – 15/16 Priority List

Queen Victoria Hospital NHS
NHS Foundation Trust

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Meeting date: 26th March 2015
Reference number: 72-15
Report from: Dominic Tkaczyk
Authors: Dominic Tkaczyk and Keith Mansfield
Report date: 13th March 2015
Appendices: None

Budgets 2015/16

Background

1. This paper proposes setting a revenue budget and a capital plan for 2015/16.

Key issues

2. The Trust has adopted the Default Tariff Rollover (DTR) for setting its tariff prices in 2015/16. As the Board is aware the consequence is that the Trust will not receive CQUIN funding of up to £1.2m. However the alternative tariff option, Enhanced Tariff Option (ETO) would reduce income by a further £700k.
3. The revenue budgets presented today are the result of considerable work by business and corporate units to set realistic budgets and to deliver cost improvement programmes of £1.7m (2.7% of budget).
4. The plan therefore in 2015/16 is for a surplus of £1m and the paper set out the impact on the Trust of planning for a lower surplus than planned previously.
5. The Board had also indicated that it would support as higher level of capital investment in 2015/16, in particular to invest in the IT infrastructure. The plan for 2015/16 is a spend of £4.5m compared to £2.4m in the original plan.

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.

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Regulatory impacts

- The plan has been assessed against the Monitor financial and risk ratings and the Trust continues at a risk rating of 4 and green for governance.

8. Does what we are reporting have any impact on our Monitor governance risk rating or our continuity of service risk rating? No

Recommendation

- The Board is asked to approve the revenue and capital budgets for 2015/16.

Revenue and Capital Budgets for 2015/16

Summary

The revenue budget presentation for Board approval today has been prepared against a backdrop of uncertainty concerning tariff and the level of income the Trust should plan for. Following discussion it was agreed that the Trust should adopt the Default Tariff Rollover (DTR) option because this was assessed to be more financially advantageous in 2015/16 even after taking into account the loss of CQUIN funding.

At the extraordinary Board of Directors meeting on 12 March a financial plan was presented showing an expected surplus of £1m. This is less than the outturn of this and previous years and also less than the expected surplus of £2.5m for 2015/16 in the Trust's five year forecast. This paper explains the reasons for the reduction in surplus and whether a smaller surplus could have any impact on the Trust's services and its risk ratings.

The paper also requests approval for the capital programme which is an increase on the planned figure by £2.1m to £4.5m.

Context

The table below is extracted from the five year plan. It shows the performance for the last four years, the plan for 2014/15, which is on target, and the plan for four subsequent years.

Surplus before impairments and restructuring costs	2010/11 £k	2011/12 £k	2012/13 £k	2013/14 £k	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k
Achieved	2,766	2,927	4,112	2,599					
Planned					2,203	2,503	2,521	2,531	2,539

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

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

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

The Board is aware that the majority of acute providers are in deficit and therefore it is a considerable achievement to be in surplus and with plans to develop services further.

Impact

The plan for 2015/16 (shown in table 2) includes an expansion in trauma and orthodontic services and a growth in activity in elective inpatient services comparable to the planned levels in 2014/15. The main impact of a reduction in the surplus by £1.5m is the opportunity cost of having less surplus to invest. However in 2015/16 the Trust plans to spend £2.1m of its accumulated surplus for strategic investment in IT and the estate. Furthermore the Trust has accumulated surpluses over a number of years so that cash balances currently stand at over £8m which is considerably in excess of its cash requirements.

We have assessed the potential impact on the Continuity of Service Risk Ratings (CoSRR) and the forecast is that the rating would remain at 4.

Income

Contract negotiations are taking place with CCGs, NHS England and Sussex MSK Partnership. These have focused to date on activity reconciliation and completion of the non-financial schedules due to the delays to the final decision on national tariff. The Trust sent out a forecast outturn position to all commissioners back in December and again in February as a baseline for negotiations. Currently only one CCG has responded and their plan has been agreed. We are expecting the co-ordinating Commissioning Support Unit to follow the CCG plans up by 20th March. Sussex MSK Partnership plan to send us an indicative plan by 20th March. NHS England has indicated that they are currently not in a position to send plans out.

The national contract documentation remains draft as final documents have yet to be published

The income plan for 2015/16 is £62.03m. This includes income from the new developments in trauma and orthodontics and income from growth in activity particularly in elective inpatient services. This would be put the Trust at the position it had planned to achieve in 2014/15 but was temporarily diverted.

Expenditure

Expenditure budgets have been prepared in collaboration with budget holders and reflect a review of all current pay and non-pay budgets and are based on the forecast outturn of the current financial year, adjusted for significant non-recurring issues.

Reserves

The Trust has the following reserves:

- Inflation - £0.66m – it is possible that not all of the inflation reserves will be required
- General - £0.30m – Monitor guidance is that Trust should hold contingency reserves of 0.5%. The general reserve would equate to about 0.48% but could be topped up from the inflation reserve if required.

Cost Improvements

The CIPs planned for 2015/15 are shown in table 3 and total £1.66m. The CIPs have been reviewed by the Medical Director who is satisfied that they would not impact negatively on the quality of patient care. The CIP has been built up from budget holders rather than centrally driven.

Cost pressures

Cost pressures totalling £1.23m have been kept to a minimum by the Directorates. The key areas of pressure are:

- Additional Clinical Staff - £357k
- Additional Clinical support staff - £116k
- Take up of Macmillan initially funded posts - £45k
- Continued rental of OT6 - £53k
- Increased PDC & depreciation - £340k

Table 2

	Income		Pay		Non-Pay		Financing Costs		Surplus	
Directorate	**Forecast Outturn 2014/15**	**Budget 2015/16**	**Forecast Outturn 2014/15**	**Budget 2015/16**	**Forecast Outturn 2014/15**	**Budget 2015/16**	**Forecast Outturn 2014/15**	**Budget 2015/16**	**Forecast Outturn 2014/15**	**Budget 2015/16**
	£,000	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**
Plastics	(30,212)	-31,669	5,123	5,085	1,270	1,306			(23,819)	(25,278)
Oral	(12,732)	-13,263	4,632	4,892	1,936	1,974			(6,164)	(6,397)
Eyes	(5,216)	-5,282	1,442	1,579	941	920			(2,833)	(2,783)
Sleep	(3,737)	-3,927	759	782	1,089	1,040			(1,889)	(2,105)
Clinical Support	(3,525)	-3,490	3,923	4,051	1,735	1,734			2,133	2,295
Operational Admin	(769)	-777	165	156	389	397			(215)	(224)
Nursing	(3,212)	-3,509	17,328	18,253	5,511	5,533			19,627	20,277
Corporate	(1,955)	-119	6,067	5,966	4,144	3,548	3,466	3,806	11,722	13,201
Operating Surplus									**(1,437)**	**(1,014)**
Prior year					(943)				(943)	
Total Surplus									**(2,380)**	

Capital programme

The capital programme in 2015/16 will be £4.5m. The key schemes are:

Medical Devices -£690k

- Ongoing new and replacement equipment programmes

Estates - £880k

- Jubilee Building Refurbishment
- Corneo Plastic Department electrical distribution panel

IT - £2,950k

- Infrastructure Improvement Programme
- Electronic Patient Record

CIP as at 11th Mar 2015			Table 3
Division	**Final Accounts Line**	**Text**	**Sum of CIP £**
1 Anaesthetics and Surgery	Non Pay	Propofol saving	-108,000
	Non Pay Total		**-108,000**
	Pay	5 PA reduction from existing cons to part offset new L Newman cons	-50,000
		Employers pension saving from Venn retirement	-20,733
		Keith Cullen retirement	-34,765
		Steve Squires retirement	-30,000
		Reduce banding of registrars as per JM	-50,000
		Theatres staff retirements	-39,000
		Theatres pay protection ended	-31,596
	Pay Total		**-256,094**
1 Anaesthetics and Surgery Total			-364,094
2 Clinical Support	Non Pay	Histo: Prof Fees: reduction in costs as accreditation now achieved	-50,000
		Pathology: Reduce pathology drugs as per PG. Line not used.	-1,476
		Histo: Other Clinical Costs: Svc provided by 'Backlogs' repatriated in house as per FL 13.2	-10,000
		Therapies: Sterile Products: CSSD saving ref. disposable scissors	-2,000
		Histo: Pathology - BSUH: Remove unused budget	-1,596
		Radiography: Xray eqpt mtc: PACS contract with Philips as per KH	-17,000
		Radiography: X ray film: External storage of xray films no longer needed as films being disposed of as	-2,000
		Psychotherapy: Other Clinical Costs: Renegotiation of psychotherapy contract from £12k to £9k as per J	-3,000
		Therapies: Eqpt and materials: reduce splinting materials budget in line with usage	-1,000
	Non Pay Total		**-88,072**
	Other Income	Radiography: Based on 14/15 activity - BSUH chest xrays @ £400pw as per KH	-20,800
		Clean Room: Cornea charge incr to £1,200 per cornea as per P Gable 13.2	-53,200
	Other Income Total		**-74,000**
	Pay	Histo: Reduction in agency fees in line with reduced usage as per FL	-25,550
		Therapies: B5: Reduce pressure garment technician hours as per JM	-1,800
		Radiogrphy: Agency PAMS: Out of Hours svc changes as per KH 13.2	-10,000
	Pay Total		**-37,350**
2 Clinical Support Total			-199,422
3 Nursing	Non Pay	CNST: £4.9k CIP as per 15-16 contract costs.	-4,900
		CNST: £470 CIP as per 15-16 contract costs.	-470
		CNST: £49k CIP as per 15-16 contract cost.	-49,000
	Non Pay Total		-54,370
	Pay	0.80 B7 CIP (C-Wing)	-35,500
		Banding change B7 to B6 for compliance post	-14,000
		Reduced Sunday working (Paeds) as per JT	-5,000
		Remove 1 x B5 ITU post as per JT	-27,000
		Reduce Deputy Director of Nursing budget to mid point	-3,939
	Pay Total		**-85,439**
3 Nursing Total			**-139,809**
4 Estates and Hotel Services	Non Pay	Sewerage - reduce with usage	-1,000
		Full year effect of OT 6 lease termination based on Outturn	-202,000
	Non Pay Total		**-203,000**
	Pay	B6 Programme Office post	-21,467
	Pay Total		**-21,467**
4 Estates and Hotel Services Total			-224,467
5 Human Resources	Non Pay	Intrepid Database licence 14/15 £750	-250
	Non Pay Total		**-250**
5 Human Resources Total			-250
6 Finance	Non Pay	Procurement CIP to be reallocated	-400,000
		Stationery - reduction in line with actual	-1,800
		External Consultancy Fees - reduction in line with actual	-4,351
		Reduction in CHKS contract	-6,000
		IT Licence fees - reduction in line with actual	-25,000
	Non Pay Total		**-437,151**
	Pay	Reduce Deputy Director of Finance budget to mid point	-12,000
	Pay Total		**-12,000**
6 Finance Total			-449,151
7 Corporate	Non Pay	ASHN fee	-36,000
	Non Pay Total		-36,000
	Pay	Temp staff target reduction as per KM	-250,000
	Pay Total		-250,000
7 Corporate Total			-286,000
Grand Total			**-1,663,193**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26th March 2015
Reference number:	73-15
Report from:	Graeme Armitage, Director of HR & Organisational Development
Author:	Graeme Armitage, Director of HR & Organisational Development
Report date:	18th March 2015
Appendices:	A: 2014 Staff Survey Results

QVH Staff Survey Results - 2014

Key issues

1. Attached at Appendix A is the summary report compiled by the Picker Institute on behalf of the NHS. The report indicates where our results have improved or worsened since 2013 and therefore forms a basis for actions to be taken forward during 2015/16. The 2014 Staff Survey results continue to show QVH to be one of the top performing Trusts based on the feedback from our staff through the survey. Whilst this is the case, there are sufficient areas where our results need to improve if we are to achieve greater levels of staff satisfaction within the organisation.

2. The national context with regard to the 2014 results also needs to be taken into consideration as across the NHS results have deteriorated in the following areas:-

   - Staff recommending there Trust as a place to work
   - Staff experiencing an increase in in work pressures
   - More staff saying they have suffered work related stress
   - Staff experiencing bullying, harassment and abuse from work colleagues

   With regard to other areas little has changed with the exception of an increase in the number of staff feeling safe about raising concerns about clinical practice and knowing how to raise those concerns within their organisation.

3. In addition, the 2014 results are reflective of a number of other external factors namely, 3 years of pay freeze (this has been addressed in 2015 and likely to have a positive impact for the 2015 survey), the first Francis report and the Saville report. The latter have spurned later reports and recommendations which are intended to improve patient care by developing a more open culture within the NHS however, they have also caused a short term negative impact on staff moral with all Trusts being required to examine their practices.

4. The areas for immediate consideration for QVH are:

   - Appraisals and their effectiveness
   - Improvements in team working
   - Health and Safety training *

- Managing work related stress **

*NB: * this is due to the impact of the changes to mandatory training refresh rates.*

*** since the survey in October 2014 sickness related stress has dropped significantly.*

5. HR/OD will be developing an improvement action plan however, in order to move ahead a more detailed review of the survey results over the last 5 years is necessary. This will include more analysis of staff responses by service and staff group over that period and will provide a more accurate assessment of the changes in approach we need to take. As an example, the wide ranging staff engagement sessions associated with the recent management restructure were well received by all staff and were used to demonstrate their opinion is genuinely taken into account.

Implications of results reported

6. The staff survey results have an impact on the quality of patient care and so effective action planning for improvement is seen as a priority.
7. Staff survey results are available nationally and may be used by commissioners.

Action required

8. The Director of HR/OD will be responsible for developing an action plan based on the last 5 years surveys to support the organisation to achieve year on year improvements in staff survey results.

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

Implications for BAF or Corporate Risk Register

9. The issues raised at paragraphs 1 – 5 above where they impact on the delivery of care and staff moral/effectiveness are already included in the Corporate Risk Register and Board Assurance Framework. The mitigations are currently felt to provide assurance that these issues are not impacting negatively on the Trust's overall performance.

Regulatory impacts

10. Although there is always a potential for staff survey results to be an indicator of potential compromises on quality of care and have a detrimental impact on the experience of other staff, it is not felt that the 2014 results are a threat to regulatory compliance.

Recommendation

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

2014 National NHS staff survey

Brief summary of results from Queen Victoria Hospital NHS Foundation Trust

BoD March 2015

Table of Contents

1. Introduction to this report

This report presents the findings of the 2014 national NHS staff survey conducted in Queen Victoria Hospital NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 29 Key Findings.

These sections of the report have been structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus three additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.
- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.
- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- Additional theme: Staff satisfaction
- Additional theme: Equality and diversity
- Additional theme: Patient experience measures

Please note that the NHS pledges were amended in 2014, however the report has been structured around 4 of the pledges which have been maintained since 2009. For more information regarding this please see the “Making Sense of Your Staff Survey Data” document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2014 survey results for Queen Victoria Hospital NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q12a - 12d and the un-weighted score for Key Finding 24. The percentages for Q12a – Q12d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

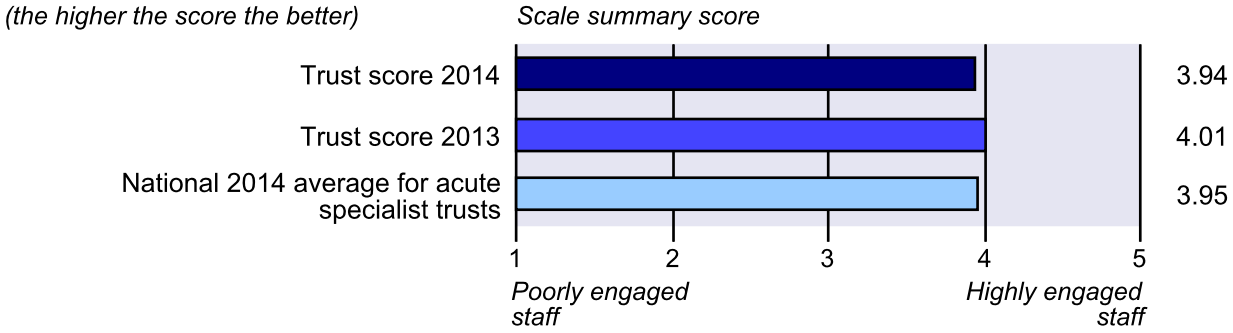
Q12a, Q12c and Q12d feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”.

		Your Trust in 2014	Average (median) for acute specialist trusts	Your Trust in 2013
Q12a	"Care of patients / service users is my organisation's top priority"	84	84	88
Q12b	"My organisation acts on concerns raised by patients / service users"	85	83	87
Q12c	"I would recommend my organisation as a place to work"	74	73	81
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	91	89	94
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	4.16	4.12	4.26

2. Overall indicator of staff engagement for Queen Victoria Hospital NHS Foundation Trust

The figure below shows how Queen Victoria Hospital NHS Foundation Trust compares with other acute specialist trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.94 was average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 22, 24 and 25. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 22); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 24); and the extent to which they feel motivated and engaged with their work (Key Finding 25).

The table below shows how Queen Victoria Hospital NHS Foundation Trust compares with other acute specialist trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2013 survey.

	Change since 2013 survey	Ranking, compared with all acute specialist trusts
OVERALL STAFF ENGAGEMENT	• No change	• Average
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	• Average
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	• No change	✓ Above (better than) average
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	• Average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

3. Summary of 2014 Key Findings for Queen Victoria Hospital NHS Foundation Trust

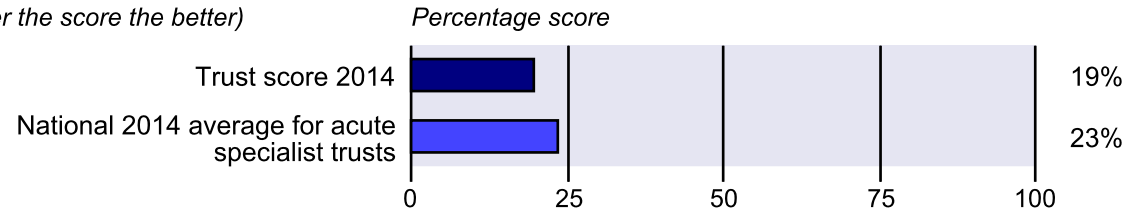
3.1 Top and Bottom Ranking Scores

This page highlights the five Key Findings for which Queen Victoria Hospital NHS Foundation Trust compares most favourably with other acute specialist trusts in England.

TOP FIVE RANKING SCORES

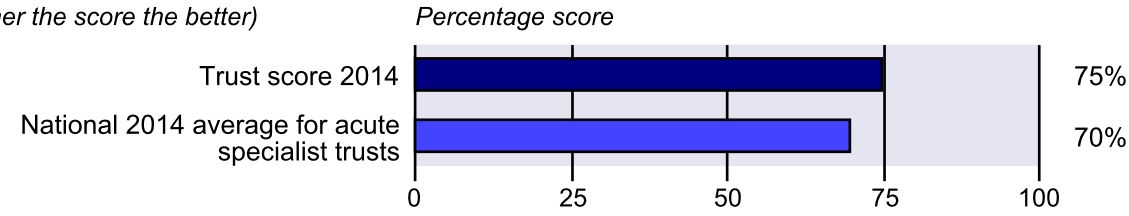
✓KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



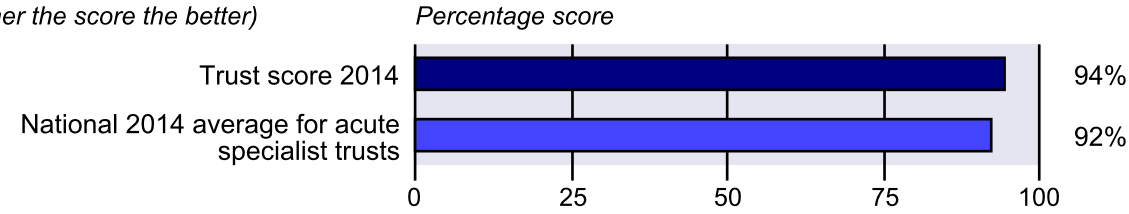
✓KF15. Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice

(the higher the score the better)



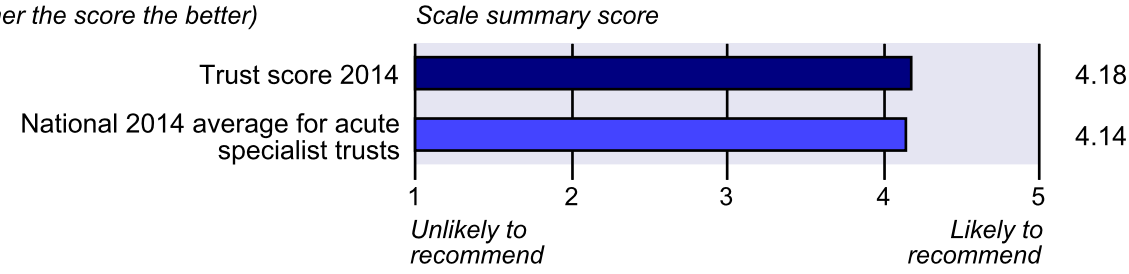
✓KF13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



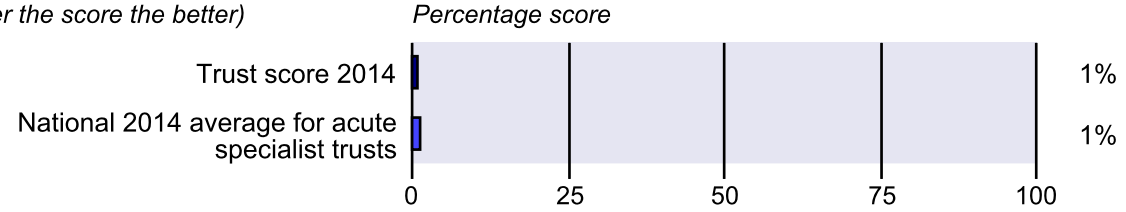
✓KF24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



✓KF17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)

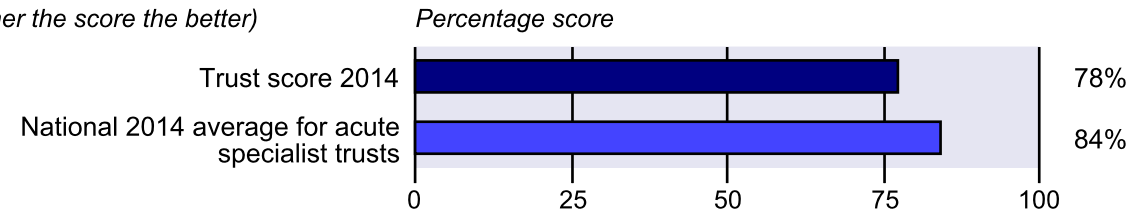


This page highlights the five Key Findings for which Queen Victoria Hospital NHS Foundation Trust compares least favourably with other acute specialist trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

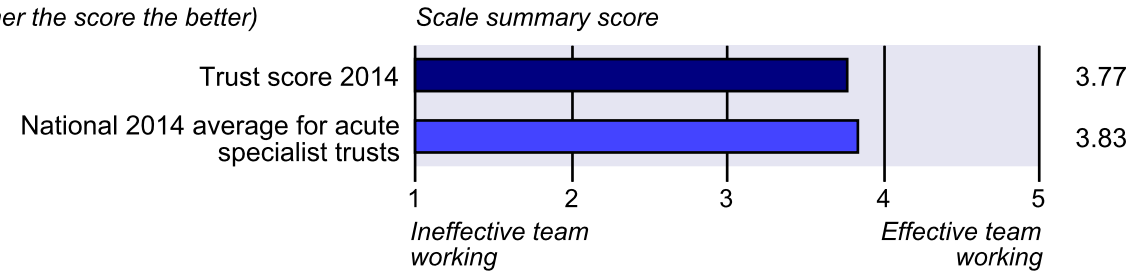
! KF7. Percentage of staff appraised in last 12 months

(the higher the score the better)



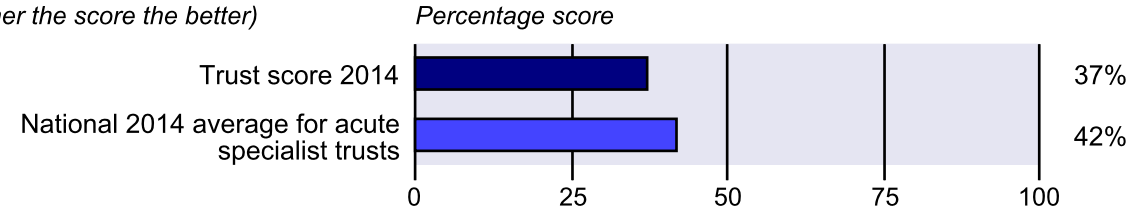
! KF4. Effective team working

(the higher the score the better)



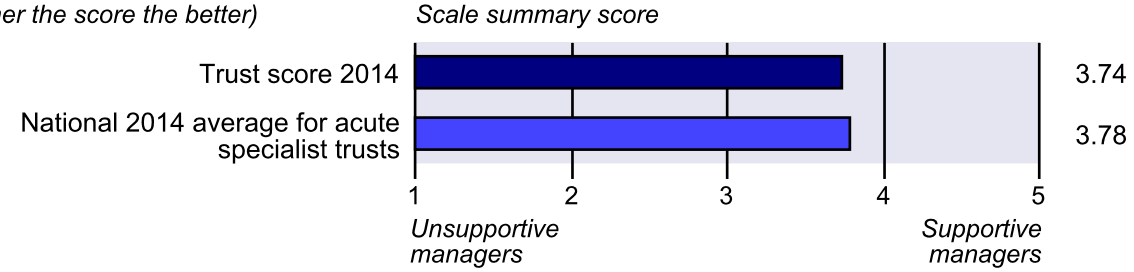
! KF8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



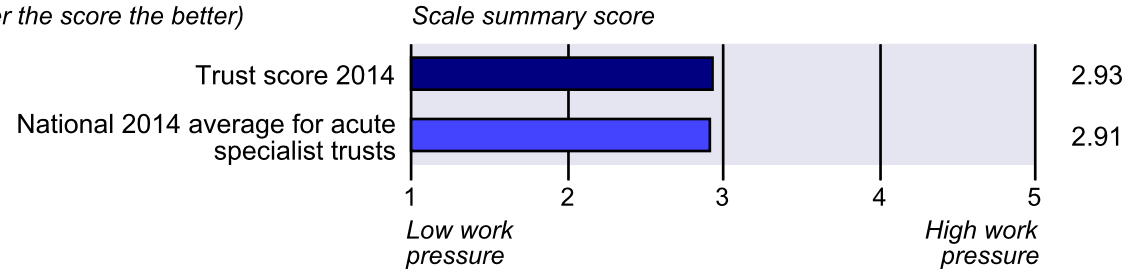
! KF9. Support from immediate managers

(the higher the score the better)



! KF3. Work pressure felt by staff

(the lower the score the better)



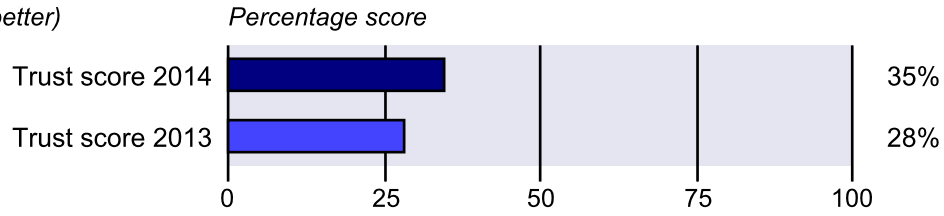
3.2 Largest Local Changes since the 2013 Survey

This page highlights the two Key Findings where staff experiences have deteriorated since the 2013 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

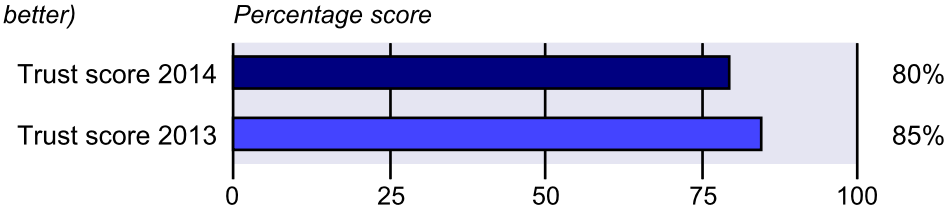
! KF11. Percentage of staff suffering work-related stress in last 12 months

(the lower the score the better)



! KF10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)



3.3. Summary of all Key Findings for Queen Victoria Hospital NHS Foundation Trust

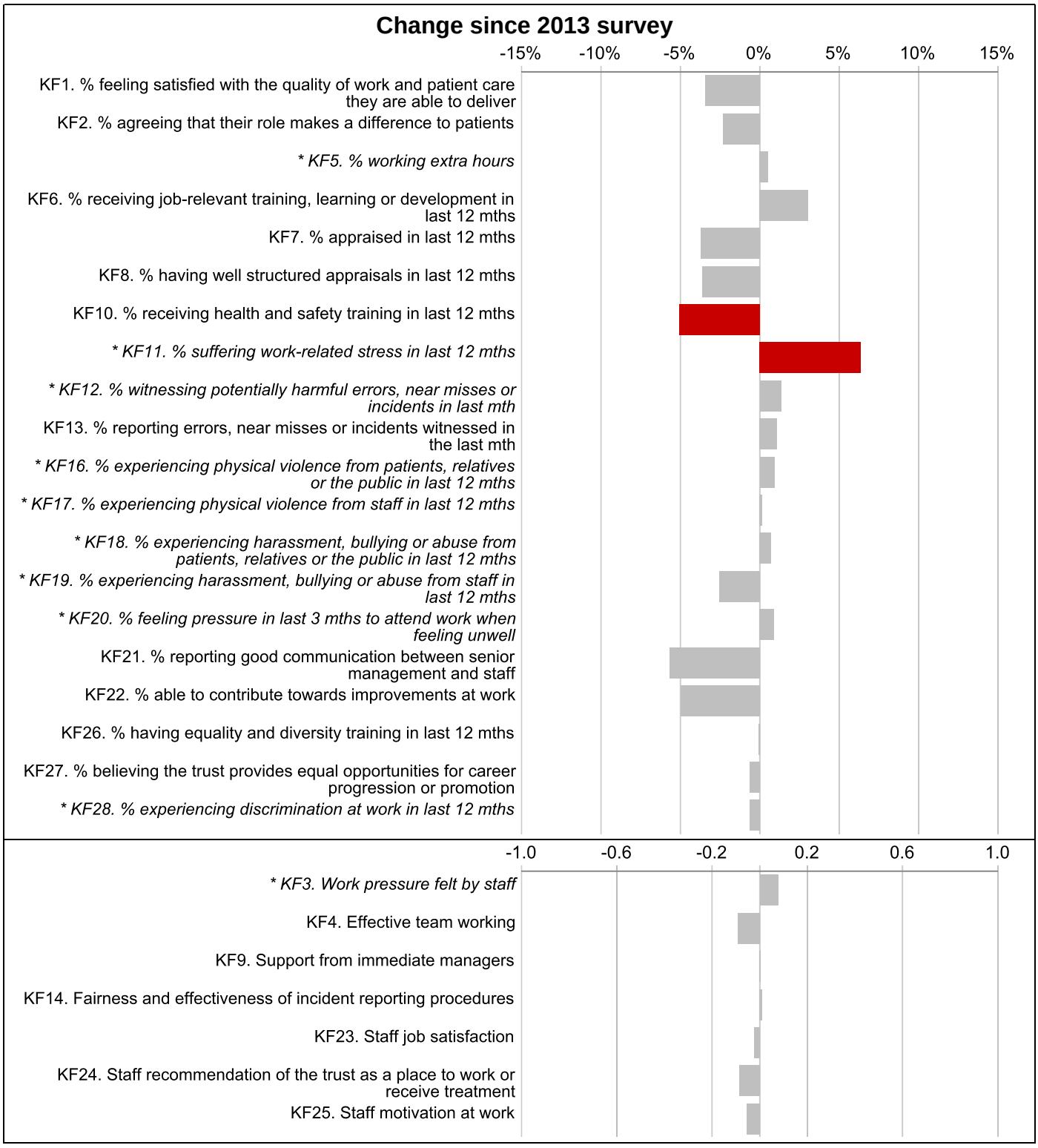
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2013 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2013 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2013 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Queen Victoria Hospital NHS Foundation Trust

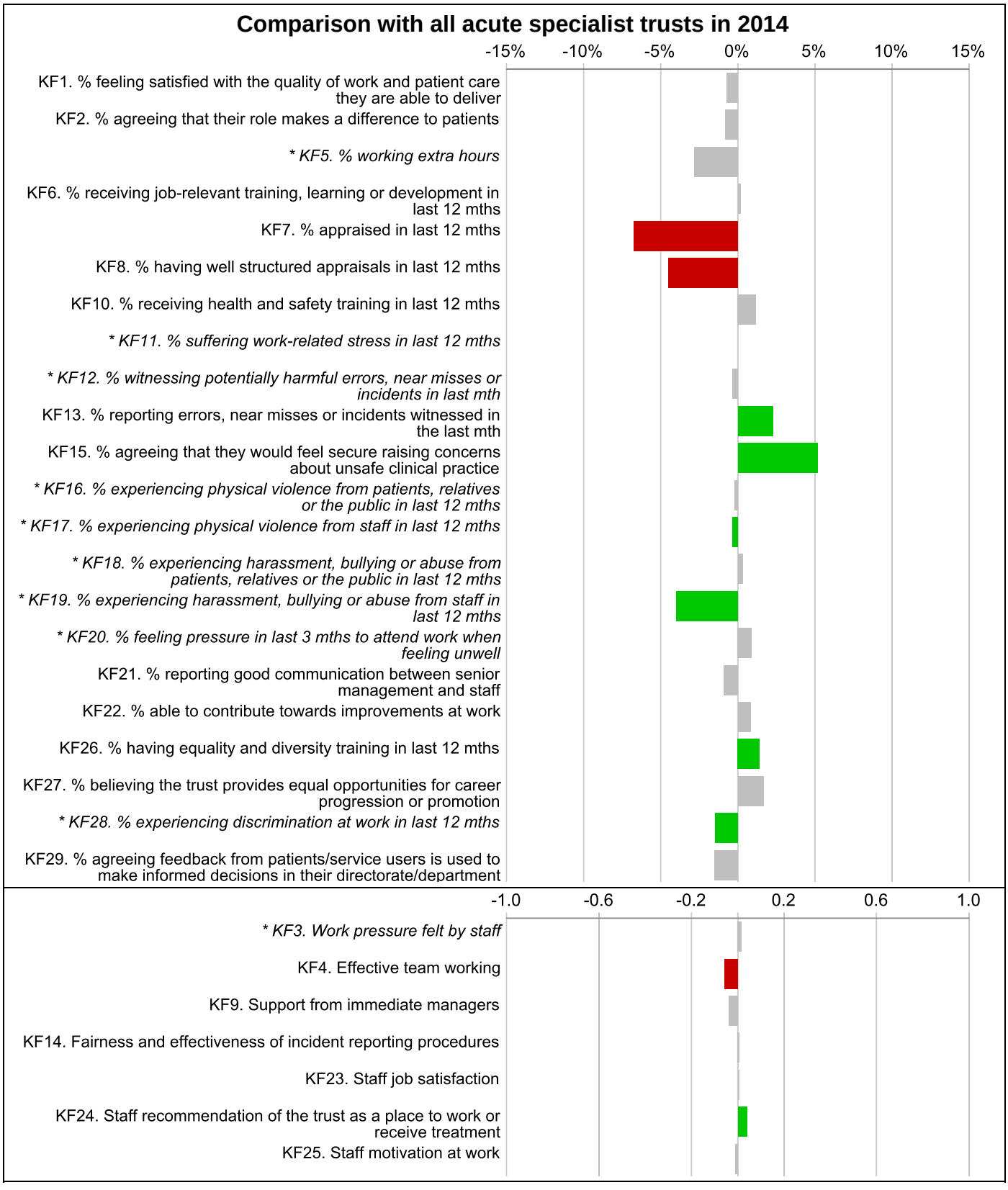
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than avearge.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.4. Summary of all Key Findings for Queen Victoria Hospital NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2013.

! Red = Negative finding, e.g. worse than average, worse than 2013.

'Change since 2013 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2013 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2013 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2013 survey	Ranking, compared with all acute specialist trusts in 2014
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	• No change	• Average
KF2. % agreeing that their role makes a difference to patients	• No change	• Average
* *KF3. Work pressure felt by staff*	• No change	• Average
KF4. Effective team working	• No change	! Below (worse than) average
* *KF5. % working extra hours*	• No change	• Average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	• No change	• Average
KF7. % appraised in last 12 mths	• No change	! Below (worse than) average
KF8. % having well structured appraisals in last 12 mths	• No change	! Below (worse than) average
KF9. Support from immediate managers	• No change	• Average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	! Decrease (worse than 13)	• Average
* *KF11. % suffering work-related stress in last 12 mths*	! Increase (worse than 13)	• Average
Errors and incidents		
* *KF12. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF13. % reporting errors, near misses or incidents witnessed in the last mth	• No change	✓ Above (better than) average
KF14. Fairness and effectiveness of incident reporting procedures	• No change	• Average
KF15. % agreeing that they would feel secure raising concerns about unsafe clinical practice	--	✓ Above (better than) average

3.4. Summary of all Key Findings for Queen Victoria Hospital NHS Foundation Trust (cont)

	Change since 2013 survey	Ranking, compared with all acute specialist trusts in 2014
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF17. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Below (better than) average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	• Average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	• No change	• Average
KF22. % able to contribute towards improvements at work	• No change	• Average
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	• No change	• Average
KF24. Staff recommendation of the trust as a place to work or receive treatment	• No change	✓ Above (better than) average
KF25. Staff motivation at work	• No change	• Average
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	• No change	✓ Above (better than) average
KF27. % believing the trust provides equal opportunities for career progression or promotion	• No change	• Average
* *KF28. % experiencing discrimination at work in last 12 mths*	• No change	✓ Below (better than) average
ADDITIONAL THEME: Patient experience measures		
Patient/Service user experience Feedback		
KF29. % agreeing feedback from patients/service users is used to make informed decisions in their directorate/department	--	• Average

4. Key Findings for Queen Victoria Hospital NHS Foundation Trust

503 staff at Queen Victoria Hospital NHS Foundation Trust took part in this survey. This is a response rate of 56%[1] which is above average for acute specialist trusts in England, and compares with a response rate of 61% in this trust in the 2013 survey.

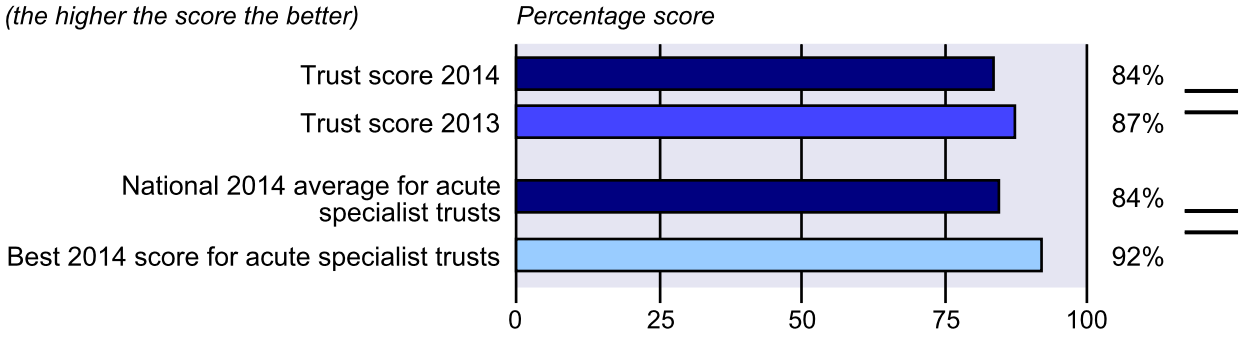
This section presents each of the 29 Key Findings, using data from the trust's 2014 survey, and compares these to other acute specialist trusts in England and to the trust's performance in the 2013 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the three additional themes of staff satisfaction, equality and diversity and patient experience measures.

Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2013). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2013). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

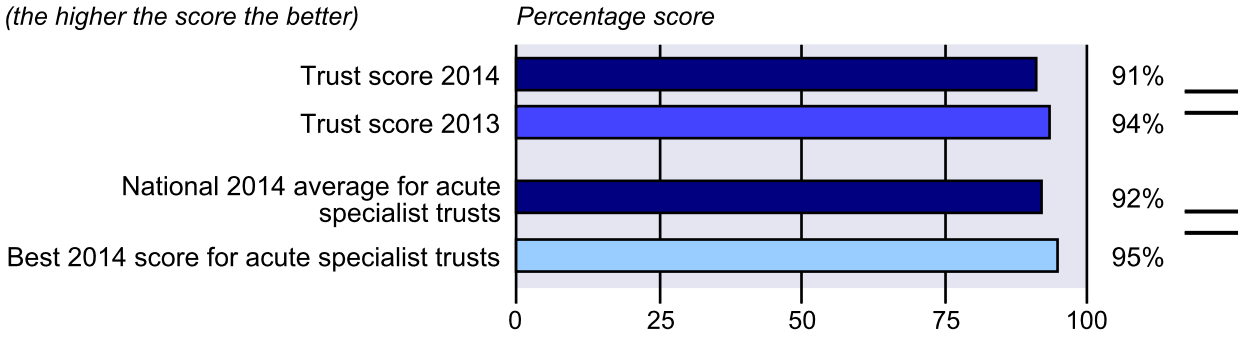
KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



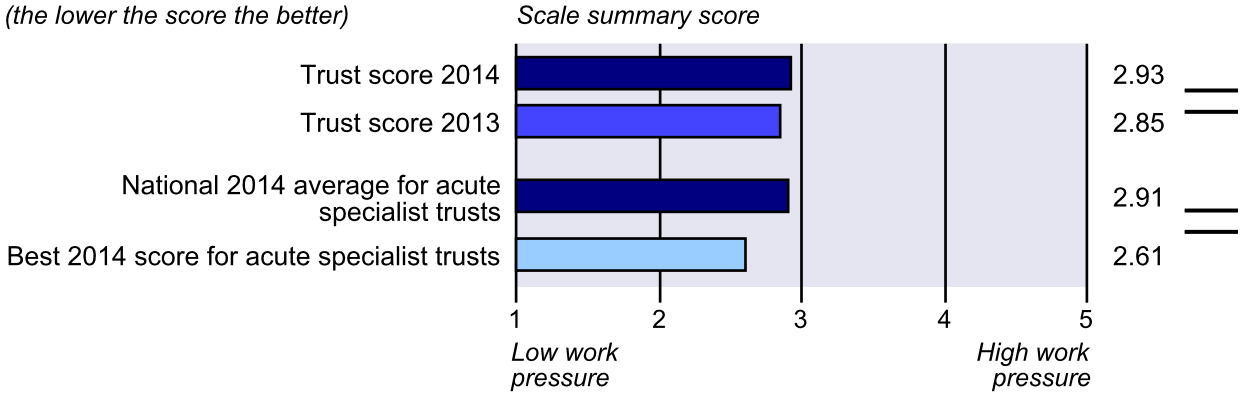
KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

(the higher the score the better)

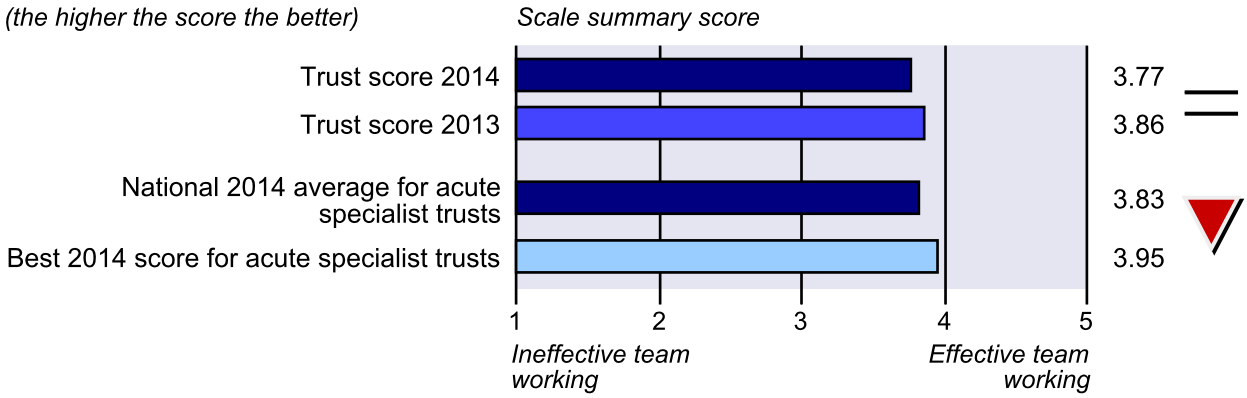


[1]Questionnaires were sent to all 904 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

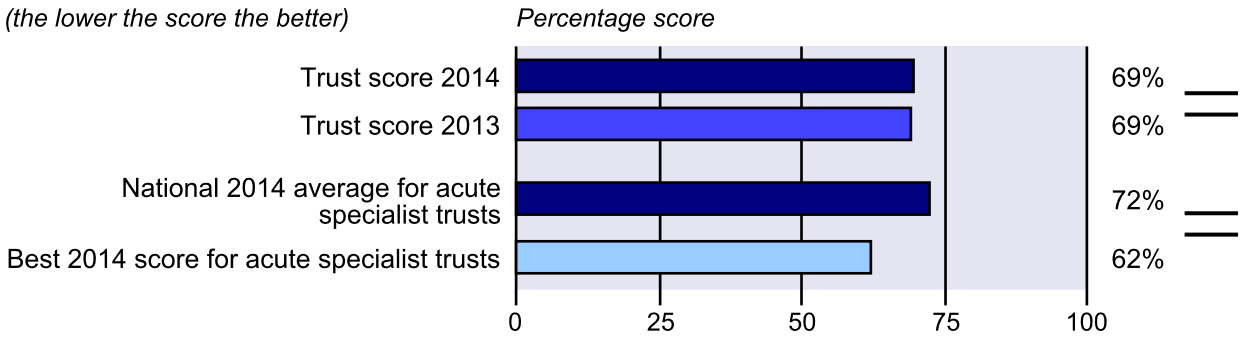
KEY FINDING 3. Work pressure felt by staff



KEY FINDING 4. Effective team working

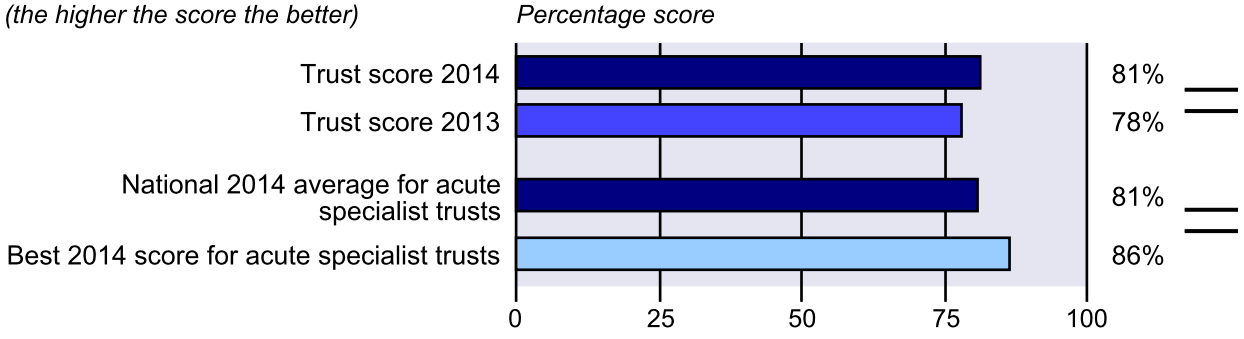


KEY FINDING 5. Percentage of staff working extra hours



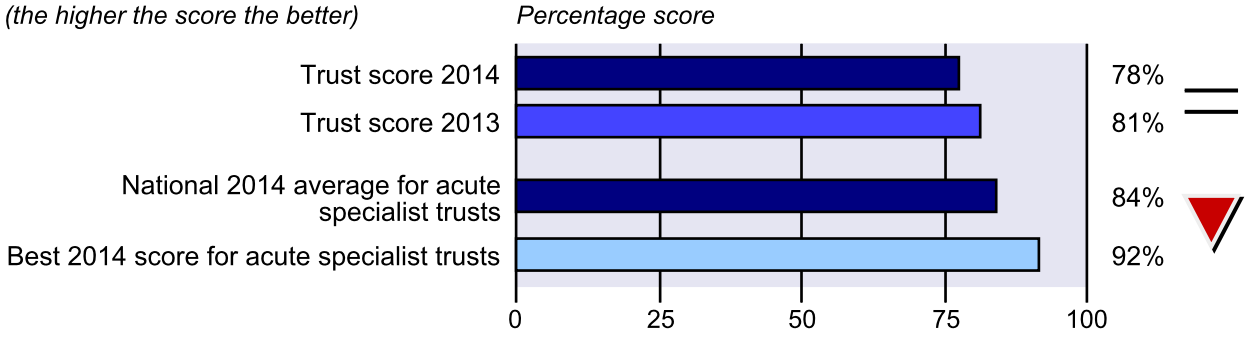
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

KEY FINDING 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months



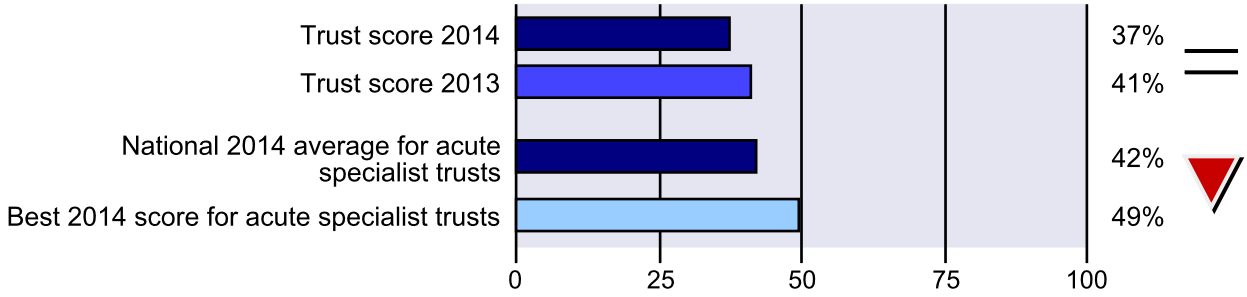
KEY FINDING 7. Percentage of staff appraised in last 12 months

(the higher the score the better)



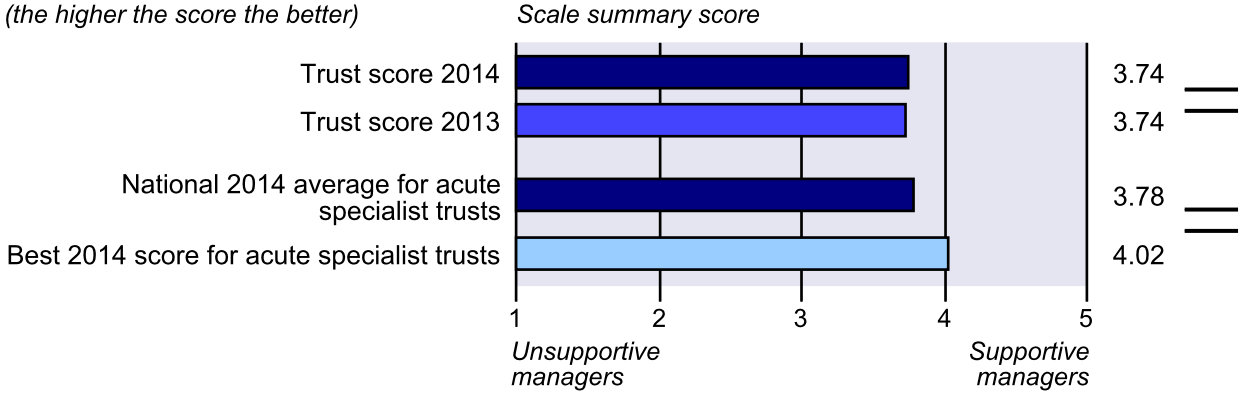
KEY FINDING 8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



KEY FINDING 9. Support from immediate managers

(the higher the score the better)

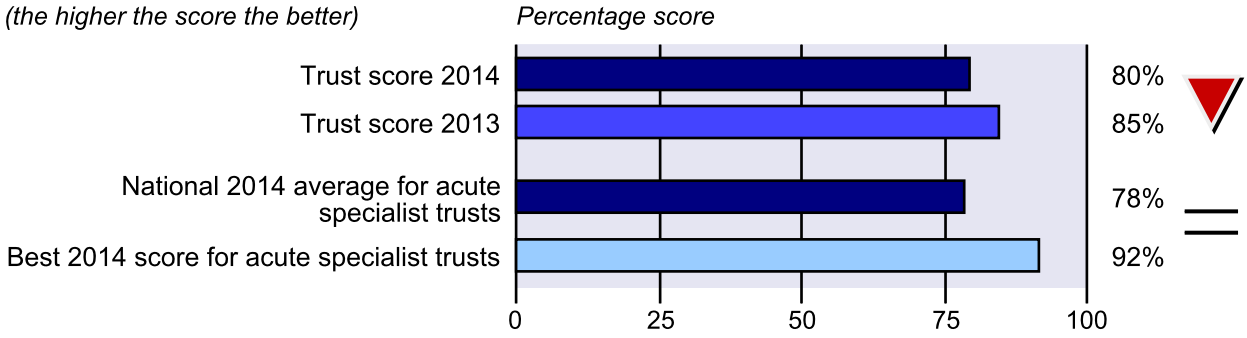


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

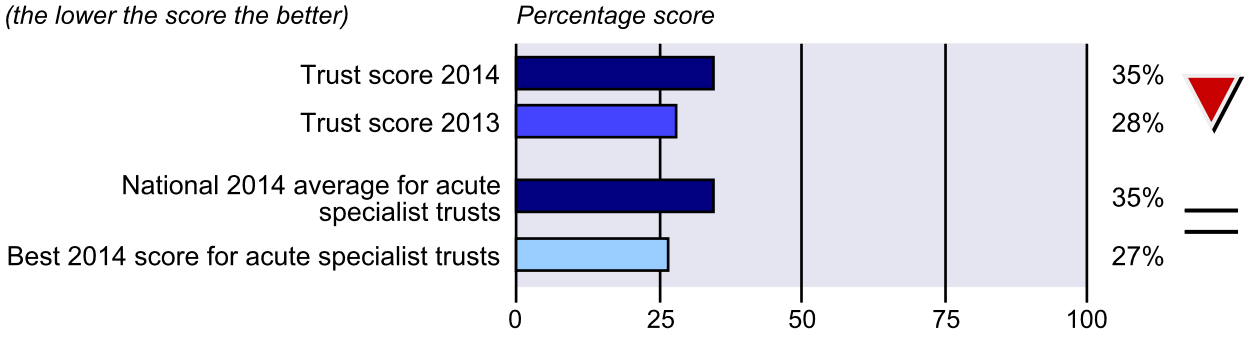
Occupational health and safety

KEY FINDING 10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)

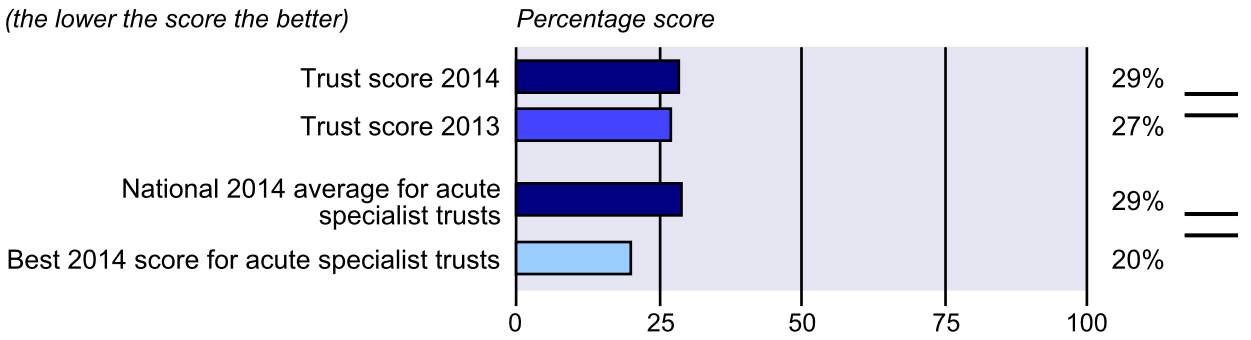


KEY FINDING 11. Percentage of staff suffering work-related stress in last 12 months

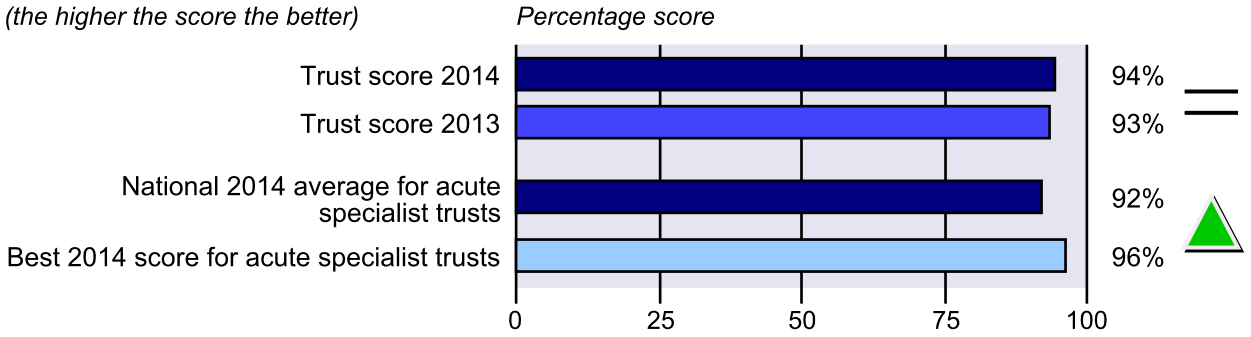


Errors and incidents

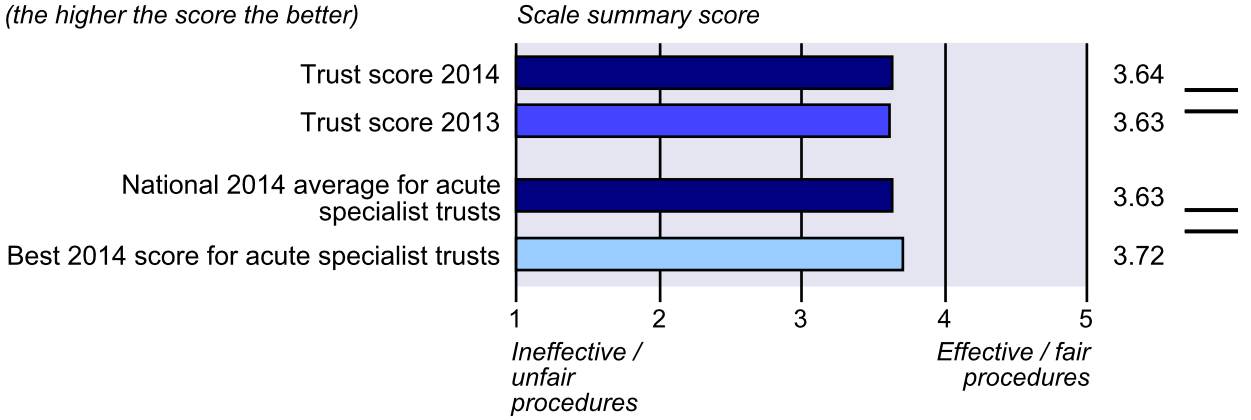
KEY FINDING 12. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



KEY FINDING 13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

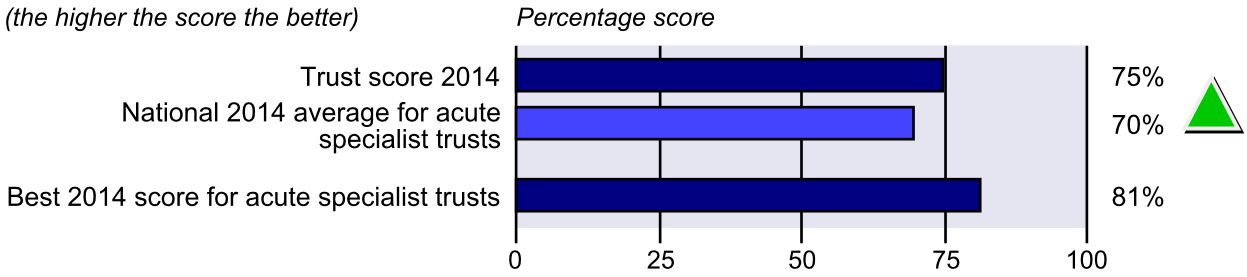


KEY FINDING 14. Fairness and effectiveness of incident reporting procedures



KEY FINDING 15. Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice

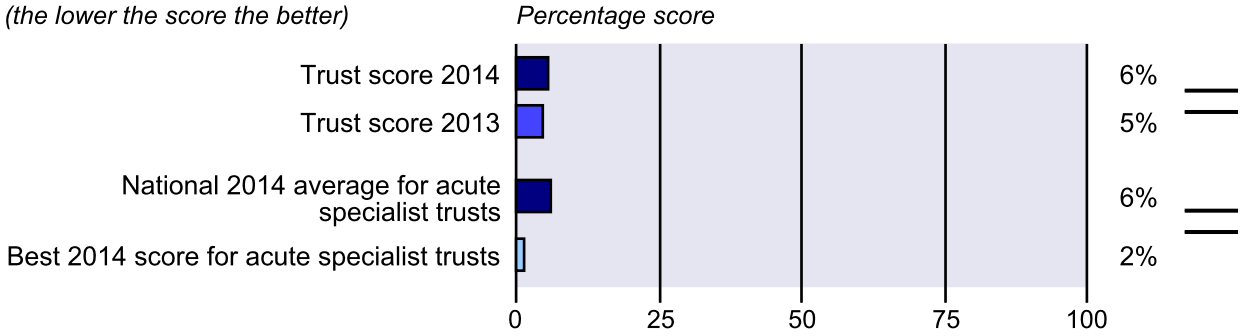
(the higher the score the better)



Violence and harassment

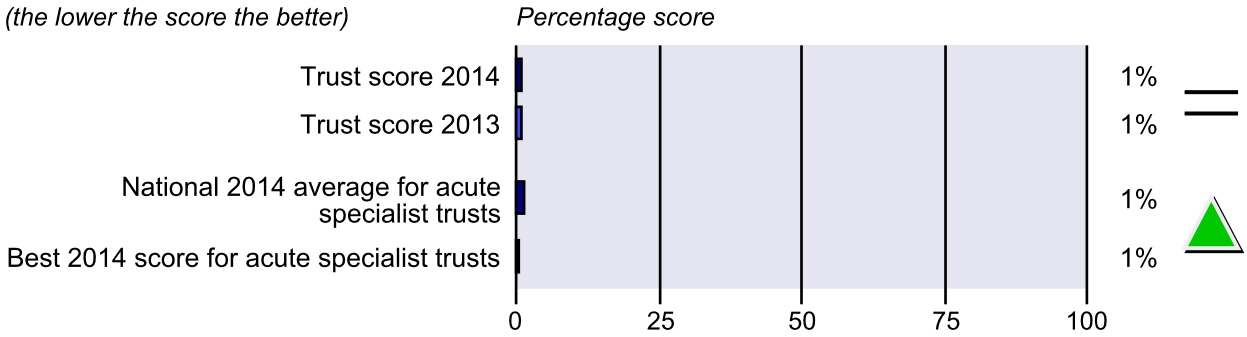
KEY FINDING 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



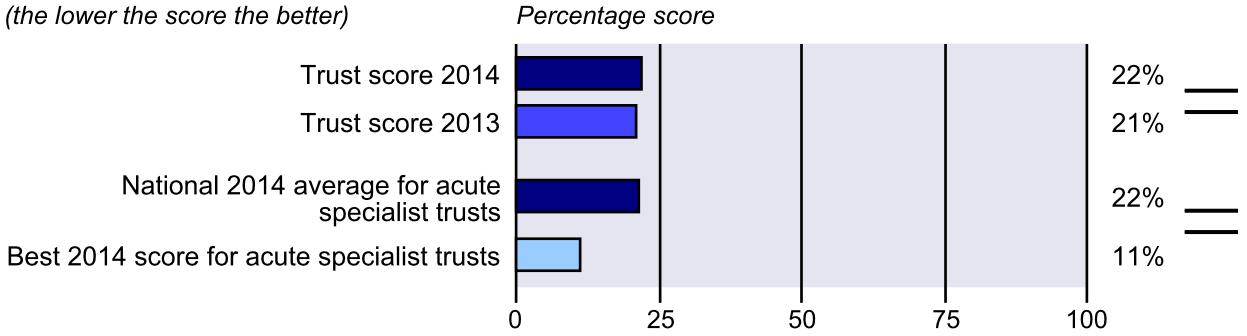
KEY FINDING 17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



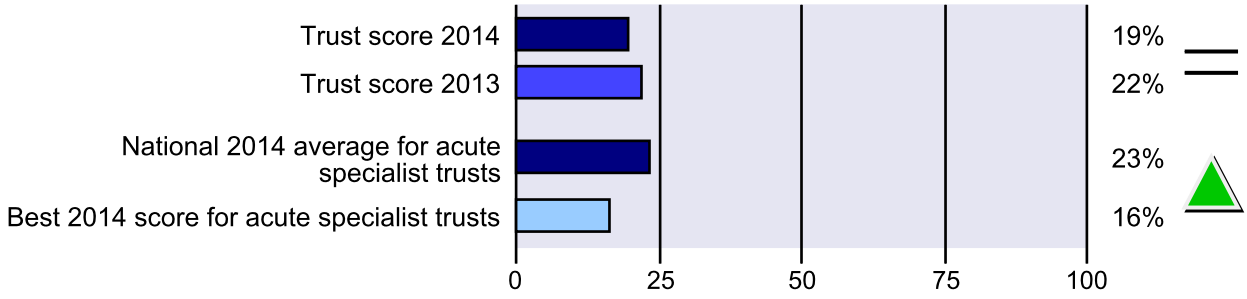
KEY FINDING 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



KEY FINDING 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

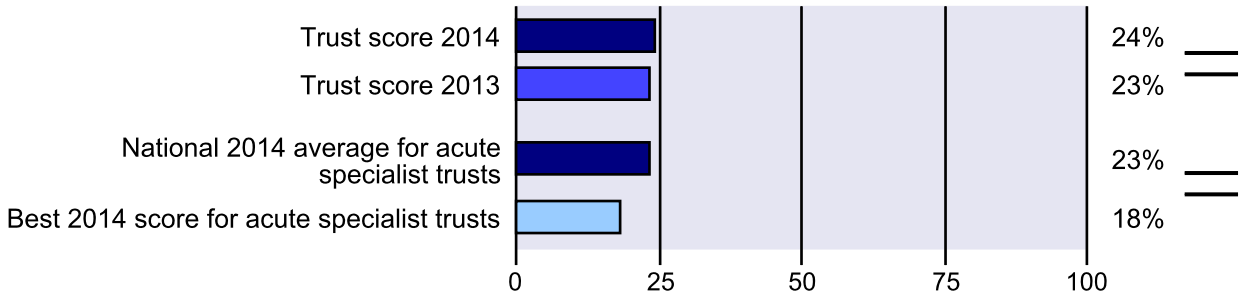
(the lower the score the better) *Percentage score*



Health and well-being

KEY FINDING 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

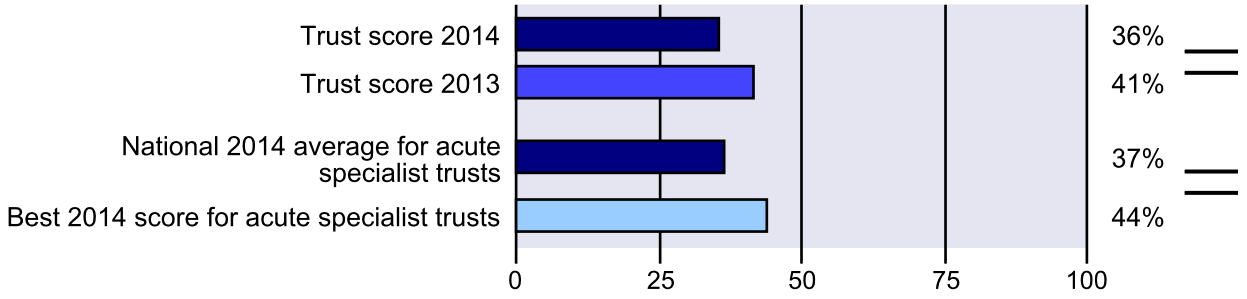
(the lower the score the better) *Percentage score*



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

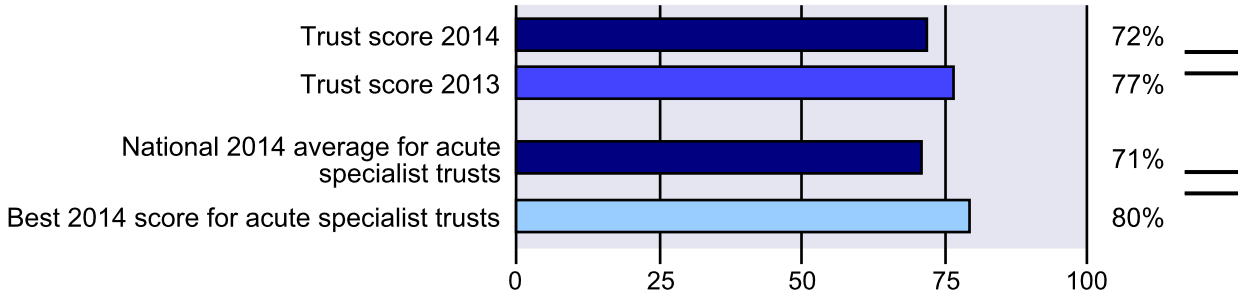
KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better) *Percentage score*



KEY FINDING 22. Percentage of staff able to contribute towards improvements at work

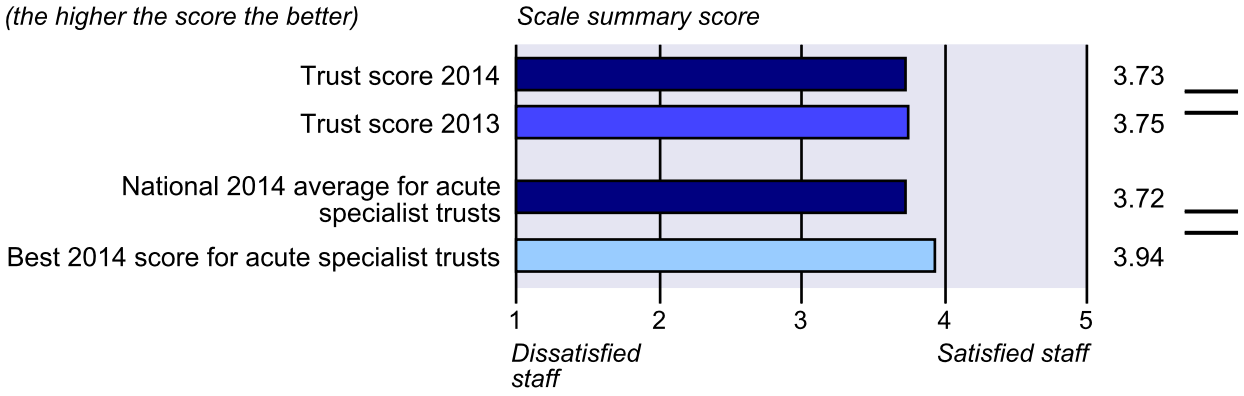
(the higher the score the better) *Percentage score*



ADDITIONAL THEME: Staff satisfaction

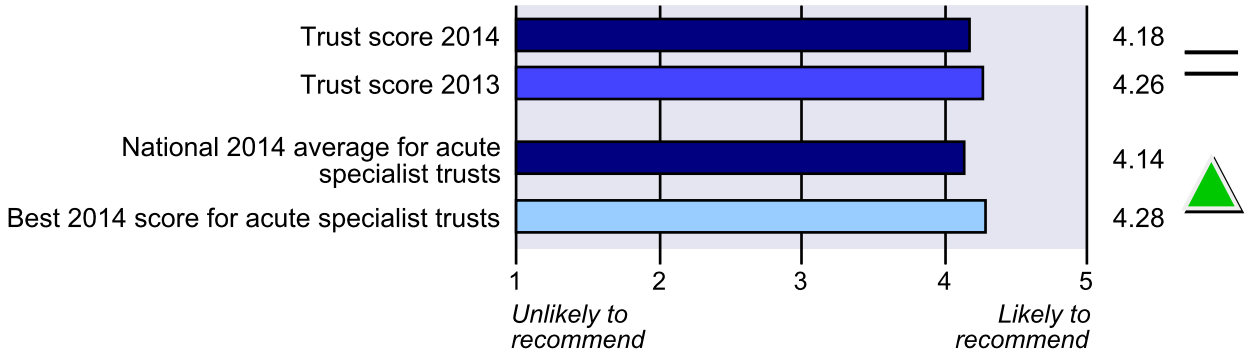
KEY FINDING 23. Staff job satisfaction

(the higher the score the better)



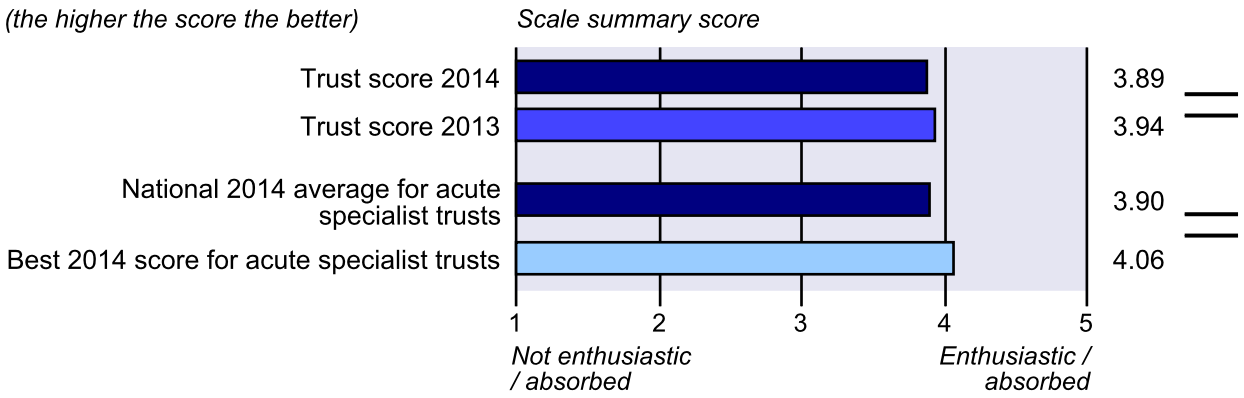
KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



KEY FINDING 25. Staff motivation at work

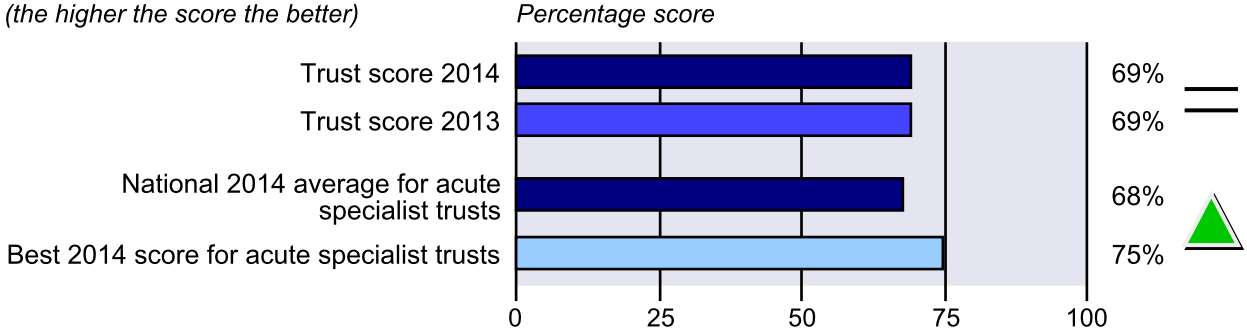
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

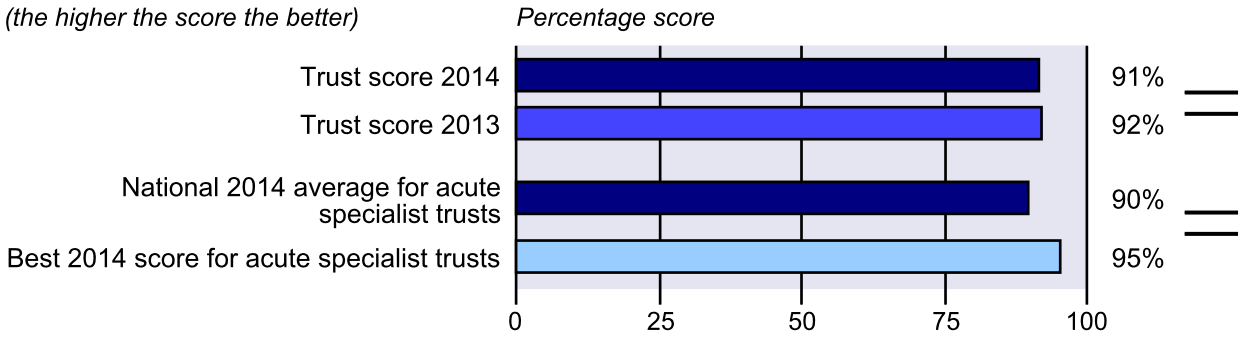
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



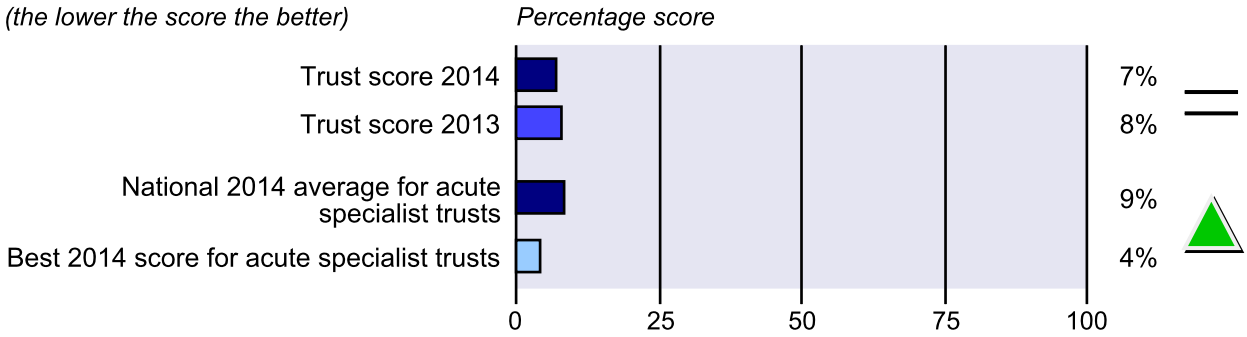
KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)

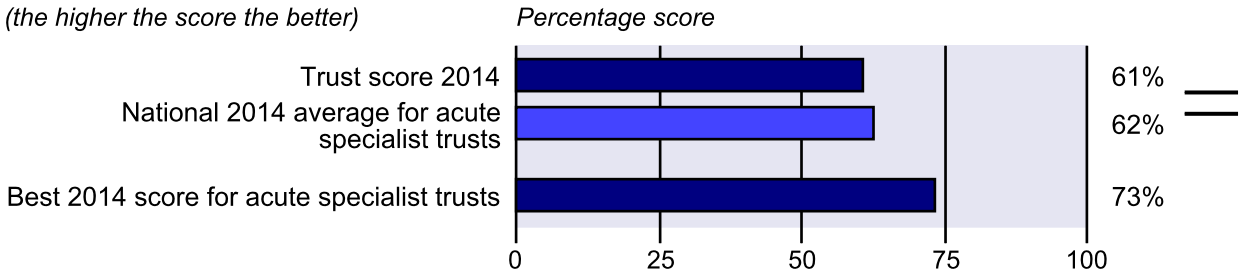


ADDITIONAL THEME: Patient experience measures

Patient/Service user experience Feedback

KEY FINDING 29. Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department

(the higher the score the better)



Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26th March 2015
Reference number:	74-15
Report from:	Jo Thomas, interim Director of Nursing
Author:	Jo Thomas, interim Director of Nursing
Report date:	17th March 2015
Appendices:	Corporate Risk Register

Corporate Risk Register

Key issues

1. The trusts top four risks are, risk of;
   - ability to meet RTT18 targets (risk escalated to 20).
   - breaching cancer targets.
   - failing to maintain continuous Estates services due to staff shortages e.g. sickness and recruitment.
   - impact on the Trusts decontamination services due to relocation of core surgical services at Synergy healthcare.

2. One new risk was rated as a 12 – impact caused by vacancy of Medical Device Officer role.

3. No risks scored 12 and above were closed during February.

4. Three risks in this category had their scores reduced during the month.

Implications of results reported

1. The register demonstrates that the trust is aware of key risks that affect the organisation and that these are reviewed by owners.
2. No specific group/individual with a protected characteristic are affected issues identified within the risk register.
3. Failure to address risks or to recognise the action required to mitigate them would be key concerns to our commissioners, the Care Quality Commission and Monitor.

Action required

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

Link to Key Strategic Objectives (delete those not applicable)

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

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

Implications for BAF or Corporate Risk Register

6. Significant corporate risks have been cross referenced with the trusts Board Assurance Framework.

Regulatory impacts

7. The attached risk register would inform the CQC but does not have any impact on our ability to comply our CQC authorisation and does not indicate that the Trust is not:
   - Safe
   - Effective
   - Caring
   - Well led
   - Responsive

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

Recommendation

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

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

February 2015 data (01/02/2015 – 28/02/2015)

For the period of 01/02/2015 – 28/02/2015 there were 42 open risks scoring 12 and above,

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The Trusts top four risks are given below (*all were reviewed in December 2014, January or February 2015*):

- RTT18 – Risk ID 159 - Ability to operationally meet 18 week target for all Directorates (Score=12)*
- Cancer – Risk ID 474 – Cancer target breaches (Score=12)*
- Estates services - Risk ID 670 - Failure to maintain estates service due to continued staff shortages (Score 15)
- Decontamination provider relocation - Risk ID 756 - Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilisation unit (Score 12)*

**It is proposed to monitor these three risks for a further month in this section of the risk summary, and then de-escalate. These risks will then be monitored routinely within the standardised risk reporting process unless they are identified as featuring within the Trusts top risks.*

New Risks added between 01/02/2015 and 28/02/2015 – One new risk was added scoring 12 and above during January 2015.

Risk register	Risk Score (C/L)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
Corp	4x3=12	786	Impact of the vacancy for the role of Medical Devices Liaison Officer. Remit being covered by the remainder of the Risk Management Department. Potential impact upon medical device purchase applications and recording of medical device training/competencies.	09/02/2015 Clinical Governance Group

Risks Closed between 01/02/2015 and 28/02/2015 – No risks were closed scoring 12 and above during February 2015.

Changes to Risk Scores for February 2015 – Three risks scoring 12 or above were given a reduction in risk scores:

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
Corp	540	Risk of Diagnostic tests involving Pathology	3x4=12	↓ 3x2=6	Proposed Change from Pathology	Agreed by HoR – 03/02/2015

					Clinical Director following improved Controls	
Corp	159	Ability to operationally meet 18 week target for all directorates	4x5=20	↓ 3x4=12	December 2014 targets met, with a positive forecast for January 2015	As part of monthly BAF reviews – JM Also discussed at March 2015 Q&RC
Corp	474	Cancer target breaches	4x5=20	↓ 3x4=12	December 2014 targets met, with a positive forecast for January 2015	As part of monthly BAF reviews – JM Also discussed at March 2015 Q&RC

Committee Key:

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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
670	17/12/2013	Failure to maintain estates service due to continued staff shortages.	Failure to maintain estates service due to continued staff shortages. Continued staff shortages due to un planned absences and long term vacancies which we have been unable to find suitable candidates and annual leave entitlement, has put pressure on the service.	• Unable to maintain a full on call cover 24/7 • Increased stress in the work place leading to potential sickness absences. • Insufficient staff to cover annual leave. • Potential breeches in compliance work being carried out. • Loss of reputation. • Loss of business.	• Recruitment to temporary staff authorised by CEO • Staff volunteering for additional on call duties. • Use of external contractors and agency staff to cover staff shortfalls e.g. lighting, storm damage and electrical failure Use of external contractors for March 2014 to provide additional cover. 24/02/2015: Review recommended: * Upskilling existing workforce * Undertaking more works in-house * Expand Workforce	PRODIR	John Trinick	Estates Infrastructure & Environment	15	6	" HoE to explore the possibilities of a Restructure - Draft paper to be prepared Up-skilling of existing staff (Currently B3s On-Call), Undertake more works in-house (Reduce costs of outsourcing), Expand Workforce (funded by above) Estates review action completed 24/02/2015: HoE to explore the possibilities of a Restructure June 2014-Company commissioned to undertake a review of the Estates Service - Draft Report due end of September 2014	04/03/2015
602	10/02/2013	Business continuity risk to the organisation due to failure of IT network infrastructure - *Proposed that this risk is closed and incorporated in to ID 481 - for agreement at next IGG*	1: Inability for the organisation to function and provide services 2: Delay/inability to provide patient care 3: Financial loss and reputational damage	1: Failure of organisational IT network infrastructure 2: Lack of access to data/patient information i.e PACs, Clinical and business systems. 3: Lack of immediate replacement/back-up hardware/system	1: Available support from an external company to repair if failure occurs. 2: Limited support available on-site 3. A full network review has been carried out and awaiting budget approval. Funding approved for new infrastructure - Budget approved	Dominic Tkaczyk	Nasir Rafiq	Information Governance	12	8	Looking to procure new network (by 31/03/2016) IT Capital bids programme for 2014/15 monitored at Information Management and Governance Committee IT annual plan for 2014/15 in place to monitor progress on IT renewal Purchase and install 2nd core switch which is connected to all edges and other core switch New equipment to be rolled out within 12 months covered by life time warranties - Proposal that risk is closed and incorporated into ID 481	05/03/2015
748	03/10/2014	Field safety notice FSN83000189 patient data may not be updated when exporting to 3rd party devices using the auto export featur	Patient identifiable information on x-rays may not be updated in the VNA (vendor neutral archive. Studies pulled back from the VNA or pushed into a new PACS will potentially contain incorrect patient demographics.	Philips Healthcare released an FSN regarding their implementation of a PACS/Ris solution dated 27/07/2014 stating that when a study requires patient informaion be updated the updated informaion is not always passed to the VNA. There is no fix for for our current version of PACS but there is a solution in the next release of software (Kona). However the release of Kona has been delayed due to desktop intergration issues.	We await the following from Philips: -An explanation as to what workflow causes this miss match in patient data between PACS and VNA. -A description of a workflow to reduce/remove the risk of miss- matched patient data between the PACS and VNA -Implement Kona across Surrey and Sussex to correct this error -Identify studies that have miss-matched data -Produce and implement a fix for the identified miss-matached data	Paul Gable	Paul Gable	Information Governance	12	6	Range of information awaited from Phillips (as per controls column)	02/12/2014
623	19/07/2013	Failure to meet CQUIN requirements for 2014/15 therefore incurring a loss of CQUIN funds £1.4M	1. Financial penalty and loss of CQUIN funds	1. Failure to meet CQUIN requirements set for 2013/14	1. VTE risk assessments within each patient drug chart - VTE policy in place 2.Dementia - process in place to identify trauma patients >75 years of age.Clinical lead identified. 3. Dementia training in place 4. Patient experience group in place reviewing and ensuring actions implemented and linked to OPD experience. Family and friends test score. 4.NHS safety thermometer completion is linked within deputy director of nursing job role and harm score reported to the Board. 5. Organisational performance against CQUIN measures are monitored and reported to Trust board on a monthly basis. 6. High impact intervention CQUINS reports produced each quarter and reviewed by Q&R Committee.	Jo Thomas	Jo Thomas	Compliance (Targets / Assessments / Standards)	12	3	Risk to be updated for 2014/15 CQUINS and 2014/15 BAF Ongoing audit reports to demonstrate CQUIN compliance e.g. WHO checklist and MaPSaF Provide Q3 update to quality and Risk Committee and Board	08/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
742	12/09/2014	Limited ability to disseminate information on criminal sanctions	Non-Compliance to NHS Protect Security Standards due to ilimited ability to disseminate information on successful convictions due to infrequent occurrences	No criminal sanctions brought to date to demnstrate compliance	Head of Risk added reference to disseminating information on successful convictions to the Draft Comms Strategy in Sept 2014. Use of newletters e.g. Connect, and new Risk newsletter. Induction, mandatory training and other traingin sessions Dissemination of LSMS leaflets and information	Jo Thomas	Alison Vizulis	Compliance (Targets / Assessments / Standards)	12	12	NHS Protect approached for advice on utilising a historic case to demonstrate compliance with processes - Completed Discussed with the LSMS - Completed Identification of a local case/incident that may be relevant - completed	08/12/2014
689	25/04/2014	Potential to adversely affect statutory and mandatory training due to increasing number of vacancies (3mths and over)	Risk to patient safety if staff are not up to date with their statutory and mandatory training.	Staff would be unaware of latest updates relating to key clinical and non-clinical areas including infection control, M&H, risk management and governance arrangements.	1. Statutory and mandatory training reviewed monthly and reported to Board. 2. Departmental feedback from above. 3. Utilisation of bank and agency staff to release others to attend training. 4. Risk monitored as part of BAF risks 5A & 5B	Richard Tyler	Graeme Armitage	Compliance (Targets / Assessments / Standards)	12	6	Training frequency under review to ensure match with NHS education passport Continue with utilisation of agency/bank staff to release others for training Review being completed of training matrix and adjustment of profiles as part of KSF skills passport Implementation of more elearning options Overseas recruitment initiative being taken forward Erostering review being undertaken to utilise staff efficiency/availability	08/12/2014
743	09/09/2014	Reputational damage to the Trust as a result of the occurrence of Never Events	Reputation damage to the Trust as a result of the occurrence of Never Events		Risk Management and Incident Reporting Policy Completion of RCAs Never Event reporting and notification process that includes internal and external notifications Internal incident reviews and analysis undertaken via meetings/committees etc Monitoring via dashboards External publishing of Never Event occurrence via NHS England	Jo Thomas	Alison Vizulis	Compliance (Targets / Assessments / Standards)	12	8	Revisions scheduled for CQC regulations in 2015 Governance reporting review underway	08/12/2014
728	29/07/2014	Risk of non-compliance with best practice and regulatory requirements at spoke sites	Risk of compliance with regulatory and best practice requirements e.g. CQC, HSE, CiP assessments and audit etc at spoke sites offering QVH services		Annual H&S assessments programme (monitored by quarterly H&SC) Annual infection control/decontamination reviews CQC/HSE notifications of queries relating to service provision	Jo Thomas	Alison Vizulis	Patient Safety	12	8	Annual CiP assessments to continue at spoke sites revised programme of infection control and decontamination annual assessments	08/12/2014
639	10/10/2013	Support and access from supplier to ORSOS will cease 03/16 leaving Trust without electronic theatre record	Unable to record data for operations. - impact on scheduling - effect on live theatre management - ORSOS reporting including management reports.	Source company withdrawn support.	Discussed at ICAG monthly and theatre user group. Paper back up	Jane Morris	Mr Mark Savage	Information Governance	12	4	Agree on the preferred solution before sourcing the new supplier Source the new supplier Demo of ORSOS completed in Sept 2014 Specification being drawn up to procure new/replacement system ICAG reviewing progress of replacement each month; also Theatre User Group	08/12/2014
732	11/08/2014	Use of Long Term Model Box Store for Maxfacs	Identification of alternative storage for Maxillofacial models on a long term basis		Existing model storage can be accessed by authorised staff using appropriate PPE Risk assessment in place for use of existing location Email sent to owners of materials found in area asking for clearance to enable resiting of model boxes	Stephanie Joice	Alison Vizulis	Staff Safety	12	6	HoR to meet with new Records Manager (SJ) and Matron for Elective Services to agree action plan for documentation belonging to Department that is retained there to be reviewed as per retention guidelines	08/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
727	21/07/2014	Limited on site Physician cover and non compliance with NCEPOD standards	Limited on site Physician cover and non compliance with NCEPOD standards		Cover arrangements managed by Consultant Plastic Surgeon Onsite cover available on Monday, Wednesday and Thursdays (Part BSUH, part agency locum) Telephone cover provided as part of SLA with Brighton. Geriatrics Clinic covered by Locum Geriatrician from SASH Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Mr Asit Khandwala	Paul Gable	Patient Safety	12	6	Explore GPSI option and cover from London Trusts SLA proposal from East Surrey Hospital Arrangements agreed in principal with ESH Meeting between QVH Medical Director and Head of Geriatrics at ESH	09/12/2014
750	12/12/2014	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national gu	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national guidance includes additional recruitment to post of Head & Neck Oncology Consultant.	Single consultant surgeon operating	Clinical audits undertaken on key outcome data on a monthly basis Data submission to DAHNO Consultant Outcomes Publication (COP) database Local review undertaken to identify options for resolution e.g. appointment of a second surgeon and review of job planning. Major Oncology H&N cases to only be run with 2 x surgeons from Jan 2015	Steve Fenlon	Nicola Reeves	Patient Safety	12	8	Actions identified from completed review Major Oncology H&N cases to only be run with 2 x surgeons from Jan 2015 - Completed Major cases moved to Monday for joint sessions	08/01/2015
745	09/09/2014	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources From Risk ID 744 (Closed 02/12/2014 to combine with Risk ID 745): Recent vacancy of Head of Radiology and RPS have led to there being a vacant RPS post within Radiology.		Provision of an additional day included in the BSUH Radiology SLA. Radiation Protection Committee reporting and governance structures and reporting Positive outcome of 2014 IRMER inspection From Risk ID 744 (Closed 02/12/2014 to combine with Risk ID 745): Nominated RPC in place Extended SLA with MTW physics for on-site presence and support on half day a month RPS role is written into the job description of the new band 6 role. Until this person is in post the service manager, operational lead and existing band 6 will share this role. Physics to provide a course for these staff members.	Steve Fenlon	Kirsty Humphry	Patient Safety	12	8		10/01/2015
779	21/01/2015	Inadequate emergency alarm system (sirens and lights) to direct staff to where the emergencies are occurring.	Inadequate emergency alarm system (sirens and lights) in place to direct staff to where the emergencies are occurring.		Ward grade system currently in place (incorrect level of alert given). Staff attend as required (where available)	Dr Ken Sim	Jo Davis	Patient Safety	12	8	Full Estates review and replacement of system Emergency alert drill to be developed and put in place Estates Dept reviewed current system - Completed - increased level of sirens (slightly)	21/01/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
711	30/05/2014	Reliability of Theatre Doors	Defective doors to theatre areas are affecting entry for both staff and patients - Please note this affects ALL automatic doors	Musculoskeletal injury to staff Restricts high levels of privacy and dignity for patients Inconsistency across a range of Theatre doors could lead to staff applying inappropraite pressure when opening doors	Risk Assessment completed and Risk added to the Theatre Risk Register on staff musculoskeletal injury. Two year "Willmott Dixon" agreement for repair of new build includes Theatre Doors Regular meetings to monitor situation takingplace Doors currently being reset by Estates and Theatre staff when faults occur Willmott Dixon visit on 5th and 6th July to fully service all doors Work schedule to upgrqde the doors to correct standard has been agreed with Wilmott Dixon and a financial framework has also been agreed. Timetable to be agreed.	Steve Fenlon	John Trinick	Staff Safety	12	6	Affected staff to use alternative access to Theatres one Theatre door to be replaced to "test" if issue could be resolved by replacing the door - Completed Ongoing updates at Theatre User Group Meeting regarding this risk Willmott Dixon agreed to replace doors - Date to be agreed Work schedule to upgrqde the doors to correct standard has been agreed with Wilmott Dixon and a financial framework has also been agreed. Timetable to be agreed. Trial of replacement door-motors on doors on Theatre 1 and Theatre 4 Increased follow-up with Estates & Willmott Dixon Notices to be put up in Theatres to alert staff of defective doors - Completed Staff utilised to retain privacy and dignity - in affecetd areas - Completed Raise staff awareness at team meetings - completed	21/01/2015
733	12/08/2014	restricted access to blood fridge/cross infection from staff movement	due to the recent restrictive access status of the burns unit there is a potential for delay for both obtaining units of blood and blood gas analysis	delays to treatment for patient burns staff diverted from patient care to manage theatre requests cross infection between burns and theatres	controlled access by burns staff who retrieve blood units and process blood gas cost and introduce a seperate blood fridge and blood gas anaylsis machine for theatres	Dr Ken Sim	Jo Davis	Patient Safety	12	2	Idneitifation of funding for additional blood fridge in Theatres Review of Blood Fridge arrangements to be undertaken-to include exploration of the purchase of an additional fridge	21/01/2015
627	19/07/2013	Failure to embed safer surgery checklist process due to lack of engagement	1. Patient harm due to incorrect procedure 2. Lititigation 3. damage to reputation	1. Key safety checks not undertaken for each individual patient such as correct patient, operation site and side and procedure. 2, Not all staff engaged in process so vital members could be missing	1. 1st stage consent by experienced surgeon in out patients. 2. 2nd stage consent on admission (check with patient) 3. Surgical safety checklist-sign in and time out stages. 4. Patient marking policy changed, presentations to all medical staff and directorates by MD. 5. Consent working group set up to improve consent before day of operation. 6. Pre list brief in place and effective prior to full list starting 7. Safer surgery checklist in place - (WHO Checklist) 8. Information and awareness sent to all theatre staff and clinicians 9. Audit of checklist quality in place 10. operating surgeon is now responsible for timeout 11. training in place for all staff 12. patient safety forum in place to review practice. 13. Addition of WHO checklist compliance as a 2014/15 CQUIN - Q1 & Q" audit reports submitted. 14. WHO checklist audit developed for 2014/15 CQUIN and reporting commenced 15. WHO checklist audits x 2 reviewed at monthly Theatre User Group and Patient Safety Forum.	Steve Fenlon	Jo Davis	Patient Safety	12	4	Ongoing monitoring at Patients Safety Forum and reporting as an indicator on the Quality Metrics dashboard - Completed Audit tool amended following pilot to improve robustness - Completed WHO CQUIN audit reports fro Q3 & Q4 to be submitted Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting - Completed and ongoing	30/01/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
629	19/07/2013	Inadequate health records storage	1. Staff injury from increased moving and handling for staff 2. Staff injury from slip,trip / fall over notes/boxes 3. Lack of storage space for paper records for Trust 4. Delay to obtain health record 5. Lack on budgetary allocation for ongoing storage costs from mid June 2014	1. Kings House near capacity 2. Delay in procurement of electronic patient record system 3. Failure for departments to follow archiving and storage proccess 4. Destruction of records less than 10% of new records created 5. Departments following different storage methods 6. Existihg tender for transport and storage requires renewal	1. Health records policy includes process for managing records off site 2. Bags used for transporting notes changed to fit within boxes therefore reducing handling 3. Regular destruction of notes in place. 4. Increased racking in place in Commonwealth house 5. Missing notes procedure in place Paper to Clinical Cabinet with costs of more packaging and moving records to free additional space 6. Regular transport runs between Kings House and QVH 7. Tracking system for notes in place 8. Outsourcing scanning of 10000 sets of notes to increase capacity completed 9. Tender renewal process underway. 10.Regular meetings between Head of Procurement, Head of RM, HR Manager and Matron (commenced 09/04/2014)to monitor progress 11. Action plan developed and monitored at above meetings	Jane Morris	Nicola Reeves	Patient Safety	12	3	new group in place to monitor the progress of finding suitable a location and renewal of contract Paper to April Clinical Cabinet summarising the costs associated with packaging,moving and storage of medical records as space limited to mid June 2014 Transport tender renewal to include transport and storage of medical records (est costs of transport 2.5-3k) Continue collaborative procurement for EDN Review in 3 months whether further permanent notes need to be scanned to release more space Review on site storage and archive to ensure space utlilised appropriately Develop report showing audits and monitoring of compliance to discuss at Patient Documentation Committee Implement 5 S's lean approach to keeping Health records tidy and that trip hazards are kept to a minimum Provide training sessions for staff to raise awareness of correct filing system - Completed Review staffing on a regular basis to ensure all processing kept up to date including destruction as per policy	03/02/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
159	29/11/2006	Ability to operationally meet 18 week target for all directorates	Failure to meet referral to treatment time of 18 weeks (RTT18)for a second month could result in reduced Monitor rating and a financial loss of 1.2 million. This could be for the trust aggregate failing to meet target which could be more than two specialties failing in one month.	1. Failure to update booking system on changes during pathway - administration errors 2. Failure to update system on patients declining treatment dates 3. Increased number of patients requiring treatment 4. Inadequate number of surgeons or Consultant absence 5. Lack of theatre space (capacity) 6. Poor validation of data.	1. RTT18 PTL established and now circulated daily. 2. Weekly escalation process now established via clinical specialties managers, OPG meeting twice a week to ensure all capacity is fully utilised. 3. 18 week steering group, each specialty highlighting capacity issues in issues log. 4. RTT 18 action plan being reviewed at steering group. 5. Additional theatre lists provided on Saturdays 5. RTT18 clinical outcome recorded on PAS 6. Additional data analyst post to provide cover for DH returns. 7. Clinical outcome forms revised for each specialty. 8. Develop reports to monitor specialty performance, planned w/l with expected TCI, backlog and open pathways monthly. 9. Validation of PTL lists weekly including admitted, non admitted and open pathways. 10. Amended policy incorporates new guidance re planned cases. 11. Training and guidance issued. 12. Monthly review of planned cases without date for attendance at QVH. 13. Develop early warning systems to track increased demand and mismatch with future capacity 14. Proactively discuss W/L each week at OPG for patients 10 weeks plus who do not have TCI date to avoid breach in each speciality 15. Review and validate all pending TCI's for Apr, May, June to ensure patients booked within 18 weeks 16. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably 17. Introduce new LA DC facility by July to increase capacity in main theatres for more complex work.	Dominic Tkaczyk	Jane Morris	Compliance (Targets / Assessments / Standards)	12	8	Centralise all referrals through one access point - Completed Plans and agreements in place until the end of November 2014 to enable compliance from December 2014 Restructure of appointments and admissions teams to achieve consistent Trust wide approach to management of elective pathway bookings Training and guidance to be issued to all relevant staff - Completed Review to take place in January 2011. - Completed 3. Ensure all Planned cases have estimated TCI's when placed on list - Ongoing Implement daily ptl - completed Ensure all future TCI's are validated in relation to 18 weeks- completed 6. Introduce a new automated 6 month administrative WL validation - Completed Agree business case for increasing capacity in sleep studies - completed Explore locum for Ocular plastics - completed 1. Expediate Medway hub 2. Develop matrix of planned cases seen at QVH - Completed Policy being redrafted, to launch May, with associated training package. - completed Clinic outcome forms being revised within specialities - Completed 5. Clinical pathways for top 3 procedures within specialities with clock stops being devised with CD's - agreed, being put into trust format Appointment of Access and Performance	11/02/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
474	10/03/2011	Cancer target breaches	Breach in any quarter for an Oncology treatment targets for 31 and 62 day pathways resulting in delay to patient care and reduction in Monitor rating. This could also result in financial loss to Trust.	1.Administration Staff for plastics and maxfacs failing to follow alerts on potential breaches identified by cancer data coordinator. 2.Lack of theatre capacity. 3. Lack of outpatient capacity. 4. Delays in recieving referals from other trusts. 5. Patient choice to wait longer for surgery however the clock continues to run. Small numbers at QVH cause this to be an issue.	1 - Cancer Data Co-coordinator issues reviewed monthly by Directorate Manager 2 - Patient tracking list for the specialties in place and produced twice a week. 3 - Cancer Data Co-coordinator communicates with staff on potential breaches. 4 - Secretaries respond to requests to bring patients forward wherever possible. 5 - Off site team leader in place to contribute and reconcile breaches. 6 - Appointments team allocate 2 week wait referrals to avoid delay. 7 - All breaches reviewed weekly by Directorate Manager. 8 - Project team established to integrate the cancer pathway. 9 - Action plan for skin cancer performance devised and implemented including process mapping sessions 10 - Cancer Outcomes Dataset report reviewed on a monthly basis by cancer team	Dominic Tkaczyk	Jane Morris	Compliance (Targets / Assessments / Standards)	12	8	Introduce and use cancer network databases within QVH for all MDT's.- Completed Streamline current referral pathwaysfor all types of cancer Establish Cancer Group and Cancer Data Management/MDT team for QVH. Proposals in development - Completed Setting up of 2 week skin cancer clinic - Completed Setting up of central referral management - No longer required Implementation of infoflex and Somerset cancer databases on site - completed Introduce same day see and do LOPA slots - Completed Expand use of infoflex system across Trust Establish business continuity cover in the absence of the data co-ordinator - completed - restructure being agreed and implemented from 22nd April - Completed Create local access policy for the Trust- completed Establish project team to integrate the cancer pathway- Completed Process mapping of skin cancer pathway and cancer data - Completed Action plan specifically focused on skin cancer performance to be devised and implemented including process mapping sessions. - Completed Set up QVH cancer improvement steering group - completed Review COSD data completeness and agree action plan to improve % - Completed Employment of data entry clerk to support	11/02/2015
786	23/02/2015	Impact arising from the vacancy for the role of Medical Devices Liaison Officer	Impact of the vacancy for the role of Medical Devices Liaison Officer. Remit being covered by the remainder of the Risk Management Department. Potential impact upon medical device purchase applications and recording of medical device training/competencies.		1. Risk Management and Procurement Depts covering remit of role on an interim basis. 2. No change to CAS alert receipt and dissemination procedures 3. MHRA notified of vacancy and curent arrangements	Alison Vizulis	Alison Vizulis	Patient Safety	12	8	Assistance provided by redeployed staff	23/02/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
584	23/11/2012	Potential harm from medical devices due to inadequate training	1: Harm to patient from incorrect use of medical devices 2: Financial loss due to litigation 3: Reputational damage from complaints	1: Staff operating devices without training	1. Training and competencies for high risk devices 2. Meetings with medical device co-ordinators to develop action plans for above. 3. Training compliance monitored by medical device officer quarterly. 4. Junior doctors familiarisation session incorporated into induction. 5. Speciality training assessment forms available for ad hoc junior doctor starters. 6. Incident reports used to identify and monitor trends that would highlight training as an issue 7. Monitoring at quarterly Medical Device Committee (with actions) 8. High risk and moderate risk competencies to be completed by Medical Devices Officer 9. Risk rescoring amended to reflect L&D Strategy Group output 10. Dermatome related incident review and business case completed due to number of incidents reported and purchase of devices 11. Elearning completed for dermatomes	Steve Fenlon	Alison Vizulis	Patient Safety	12	6	Elearning options being utilised e.g. dermatomes Medical Devices Officer to review all medical device related incidents from 01/09/2014 High risk and moderate risk competencies to be completed by Medical devices Officer Risk rescoring amended to reflect L&D Strategy Group output Interim arrangements in place to support MDLO vacancy	23/02/2015
756	02/12/2014	potential impact on core service delivery	Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilsation unit. Possible delays/cancelations to patient care Damage to QVH reputation Financial impact	Trustwide disruption to the processing of sterile equipment during the relocation of the sterile service facility	Contingency plans in service contract to provide an on going service Quarterly Synergy contract meetings in place to include discussions on these areas.	Jo Thomas	Jo Davis	Finance	12	6	Peripoperative Matron to meet with the Synergy regional Operational Manager in @ 2 wks potential impact on QVH	23/02/2015
648	06/11/2013	Cross infection resulting in an outbreak and closure of services	1. Infection to patients causing harm and delay in recovery. 2. Closure of department resulting in loss of activity 3. Potential for this bacteria to spread to other patients 4. Following deep clean, decant area, Rycroft has again been used for unauthorised storage.	1.Spread of Multi Resistant Infections to burns patients 2.Unable to contain bacteria/outbreak	- Hand hygiene (failure to achieve 90% compliance in any staff group leads to action plan/ matron audit) - Robust implementation of gowning procedure - Strict universal precautions - Review of patients requiring admission on individual basis with consultant microbiologist and clinician - Regular outbreak review meetings to discuss other actions required. - Monitoring via Datix reporting - Internal inspections undertaken e.g. PLACE inspections and Hotel Services cleaning audits - Reporting of outbreaks as required e.g. Health Protection Agency, CCG, PHE. - Mandatory training of all staff and awareness raising sessions. - Implementation of trust policies.	Jo Thomas	Emma Kerr	Patient Safety	12	4	Dept training as required Abx review by microbiologist Complete RCA / PIR / outbreak report / SUI Specific interventions depend on risk identified. Prepare Rycroft Ward as possible decant area (patients to be transferred in, not enough equipment to be set up as an additional ward).-NB Since action completed, area continually used for storage by person(s) unknown.	26/02/2015
753	27/11/2014	Inaccurate search results for specimens	V number searches do not always highlight the results; searches required both on V number and names. Not all results on Winpath are on ICE (and vice versa).		1. Two searches have to be carried out. 2. Staff reminded to accurately complete request forms.	Jo Thomas	Emma Kerr	Compliance (Targets / Assessments / Standards)	12	2	BSUH to devise new electronic reporting system for ICNs - ongoing issue	26/02/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
27	07/01/2005	Infection risk to individual patients due to poor systems and practice of control	Increased risk of patient(s) contracting a HCAI such as MRSA, C.diff, MRAB or Norovirus.	1. Unknown infection to patients admitted to hospital. 2. Infected patients not isolated on admission. 3. Poor hand hygiene / environmental cleaning.	1. Mandatory training of all staff and awareness raising sessions. 2. Implementation of trust policies - isolation, screening, treatment including root cause analysis for all C Diff / MSSA/Ecoli bacteraemia cases and PIR review for all MRSA bacteraemia. 3. Routine audit of practice, and monthly PLACE inspections. 4. Cleaning strategy implemented including deep clean arrangements 5. Monitoring of trajectory targets for MRSA bacteraemia, MSSA, E Coli and C.diff. 6. Monthly monitoring and Board reports from DIPC to inform organisation of acquisition of infection 7. Failure to achieve 90% or more in any staff group for hand hygiene leads to action plan and matron auditing. 8. Decant arrangements include wider involvement of matrons regarding single room use, with advice from IPACT. 9. Specific interventions depends on risk identified i.e. staff undertake an MRSA protocol treatment 10: Training completed for IPAC Team re: access to BSUH IT System. Awaiting ICNet. 11. Review of investigation processes completed 12. Follow up actions from current infections completed 13. Infection control nurses have direct IT access to BSUH Microbiology system 14. Antibiotic policy reviewed to ensure best practice use and reduce risk of C.diff 15. Departmental training provided as and when required	Jo Thomas	Emma Kerr	Patient Safety	12	6	Awaiting ICNet computer system access 5. Provide direct IT access to BSUH Microbiology system - complete 3. Follow up actions from current infections - Completed 4. Review of anti-biotic policy to ensure best practice use and reduce risk of C.diff - completed 2. Review of investigation process - Completed 7. Complete actions from RCA/PIR investigations as required. Complete actions from MRAB SI report 6. Monitor microbiologist attendance on site to ensure antibiotic prescribing reviewed	26/02/2015
513	04/01/2012	Potential failure to act on infection concerns due to unavailability of Microbiologist	1. Delay in updating policies 2. Reduced patient care due to review not conducted by microbiologist on site 3. Delay in reporting on specimens 4. Reduced attendance on site by Microbiologist	1. Problems recruiting consultants at BSUH 2. No regular microbiology consultant cover on-site 3. Failure for BSUH to fulfil contract requirements	1.Daily lab sheet of positive specimen results however, not all positive specimen are listed on this sheet. 2. Presence of microbiologist during week back to 2 days/wk, remainder of cover provided via telephone (24/7) 3. Trust policies and procedures. 4. Staff mandatory training 5. Access to ICE system winpath for ICNs to review organism resistances 6. Daily visits to wards by ICNs. 7. New consultant and Locum Microbiologist employed from Sept 2014	Jo Thomas	Emma Kerr	Patient Safety	12	6	QVH to review BSUH contract to ensure appropriate microbiolgy service and consultant cover is available on site - BSUH issued with performance notice regarding the microbiology service provided to the QVH. Identify BSUH ability to deliver increased on site attendance Waiting feedback from BSUH	26/02/2015
604	26/03/2013	Breach of information security due to use of unsecure email accounts to transfer person identifiable data (patient and staff)	1: Breach of data protection act 2: Loss/accidental disclosure of patient identifiable data 3: Reputational damage to the organisation 4: Information Commissioner's Office (ICO) investigation and fines 5: Complaints and litigation	1: Failure to follow Trust policy, legislation and confidentiality 2: Lack of responsibility from staff to adhere to IG standards 3: Potential for private email accounts to be subject to hacking 4. Emails containing patient identifiable data sent to non secure address	1: Mandatory information governance training available for all staff and compliance rates increased. 2: Datix incident reporting and investigation procedure in place. 3: Trust information governance manager to oversee and advise regarding information governance standards. 4: The following solutions are in place for accessing and transferring information securely. 4.1 NHS mail 4.2 Good e-mail app 4.3 Remote access 4.5 encrypted memory sticks 5 IT & IG lead to review new security restrictions (soft ware applications) 6. Compatibility review in preparation for Windows 7	Dominic Tkaczyk	Nasir Rafiq	Information Governance	12	6	Monitoring of compliance with IG Toolkit Implement data leakage prevention software Data test to be completed using Data leakage prevention software by 31/03/2015 Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	02/03/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
681	13/02/2014	Failure of cleanroom air handling unit due to wear and tear and age of unit - ongoing issues	Repeated failure of the cleanroom air handling unit is occuring due to the age of the plant equipment leading to cancelled internal and external grafts, loss of income and harm to reputation (unit was installed in 2004 and it has a life expectancy of 10 years)	cancelled internal and external grafts, loss of income and harm to reputation	Ad hoc repairs. Unit on quarterly maintenance contract (as recommended) Company last attended site on 13/02/2014 to fix the bearings Reporting of breakdowns on Datix (on 13/02/2014 ID 11705, On 28/03/2014 ID11878, and on 03/06/2014 ID12119).	Steve Fenlon	Nigel Jordan	Estates Infrastructure & Environment	12	8	28/10/2014: Head of Estates to recommend to Finance Director that a 'reduced scheme' be agreed to the value of £30K as per Clinical Scientists submission. Case to the Estates & Facilitaties Steering Group on 08/09/2014 with quotes for decision 24/02/2015: Orders Raised to enable repair to existing system as per Business Plan by Eyebank Manager and Interim General Manager - Clinical Support Services (works to commence subject to agreement with Eyebank Manager) 24/02/2015: Consideration for relocation of Cleanroom and combining with Hispopatologay proposals Business Case/options appraisal being drafted by General Manager for 3 Options	04/03/2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	26 March 2015
Reference number:	75-15
Report from:	Jo Thomas, Director of Nursing
Author:	Jo Thomas, Director of Nursing
Report date:	17 March 2015
Appendices:	QVH status report on the compliance with the 14 Recommendations from the Kate Lampard Review

QVH status report on the compliance with the 14 Recommendations from the Kate Lampard Review

Key issues

1. The Kate Lampard independent review was undertaken to provide assurance of the investigations that were undertaken at the four NHS Trusts and the matters of the late Jimmy Savile.

2. On 26 June 2014, twenty-eight reports and a separate assurance report were published including fourteen recommendations, thirteen of which were accepted in principle.

3. A review has been undertaken to assess the current position of QVH against these fourteen recommendations. The associated RAG ratings have been defined as follows:

RAG Rating	Number of Recommendations
Red	0
Amber	7
Green	5
Various	2

Implications of results reported

4. This review has highlighted that a sub-set of policies need to be prioritised to demonstrate compliance with the recommendations.

5. Ongoing approval and ratification of the policies mentioned above will be undertaken by the Quality and Risk Committee.

6. No specific group/individual with a protected characteristic are affected.

7. Failure to address any risks or to recognise the action required to mitigate them would be key concerns to our commissioners, the Care Quality Commission and Monitor.

Action required

8. The main areas identified related to the update of a range of policies and procedures, as below:

    - Volunteers Policy
    - Recruitment and Staff Selection Policy
    - Induction Policy
    - Information Security Policy
    - Risk Management Policy

9. Work is to continue on monitoring training compliance levels, and recruitment initiatives are to be implemented.

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

1. Reference has been made to risks already recorded in the Board Assurance Framework within the report. The addition of a new risk to the Corporate Risk Register will be discussed at the April 2015 Clinical Governance Group, this will be to reflect the policy revisions highlighted by this review.

Regulatory impacts

2. The attached report would inform the CQC but does not have any impact on our ability to comply our CQC authorisation and does not indicate that the Trust is not:
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

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

Recommendation

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

QVH status report on compliance with the 14 Recommendations from the Kate Lampard Review

In October 2012, the Secretary of State for Health appointed Kate Lampard, a former barrister, to undertake an independent review of the investigations that were undertaken by the Department of Health and the NHS into the matters relating to four NHS Trusts and the late Jimmy Savile. This was to provide assurance that all investigations had established the truth and had robustly protected the interests of the patients concerned.

On 26 June 2014, twenty-eight reports and a separate assurance report were published including fourteen recommendations, thirteen of which were accepted in principle. The fourteen recommendations are included within this report, with the current position of compliance at QVH. Remedial actions have been identified where required and for future monitoring.

Report Recommendation	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
RECOMMENDATION 1. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.	• QVH has a Volunteers policy and a protocol on ceremonial and VIP visits has been drafted	Amber	Ratification of the ceremonial and VIP visits protocol and incorporation in to the Volunteers Policy	31/05/2015	Company Secretary (K Dalby)	• Protocol has been developed and previously presented to the Trust Board for comment (November 2013). • The Kate Lampard Report is to be discussed at the 26/03/2015 Charitable Funds Committee.
RECOMMENTATION 2. All NHS trusts should review their voluntary services arrangements and ensure that they are fit for purpose; volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and all voluntary services managers have development	• The Volunteers Policy was ratified at the July 2014 Clinical Cabinet. • All volunteers follow strict recruitment procedures that include disclosure and barring checks, along with relevant training commensurate with their role/area of work. • All volunteers are line managed by either the Charity Co-ordinator or the relevant departmental manager who is supported as per routine Trust	Amber	Inclusion of safeguarding in to the volunteers local induction checklist	31/05/2015	Company Secretary (K Dalby)	• Discussed with Charity Co-ordinator.

opportunities and are properly supported.	Procedures. • A local induction checklist is in place but this excludes reference to safeguarding. • Volunteers are offered attendance at the Trusts induction (attendance is not mandatory)					
RECOMMENDATION 3. The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.	The QVH Charity Co-ordinator manages the volunteer process and links in to the: • Local Council for Voluntary Services, and attends Volunteer Management Events • NHS Charities Forum and attends regular events	Green	N/A	N/A	QVH Charity Co-ordinator (Clare Charman)	• Action for the Department of Health and NHS England
RECOMMENDATION 4. All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.	• Mandatory training includes adult safeguarding and child protection Level 1 training for all staff on a 3 yearly basis. Child protection Level 2 training is undertaken 3 yearly for all staff having face-to-face contact with patients, and Level 3 training is completed for all staff who may contribute to a child protection plan. • The level of Training is determined by the needs identified within the Safeguarding children and young people: roles and competences for Health care staff. Intercollegiate document 2014. • Volunteers do not complete safeguarding training as part of the local induction, however this is	Green	See recommend-ation 2	N/A	Safeguard-ing Lead (M Brown)	• See recommendation 2

	included in the Trust induction which is offered to all volunteers (see recommendation 2).					
RECOMMENDATION 5. All NHS hospital trusts should undertake regular reviews of their safeguarding resources, structures and processes (including their training programmes), and the behaviours and responsiveness of management and staff in relation to safeguarding issues - to ensure that their arrangements are robust and operate as effectively as possible.	• The Trust meets the requirements of Section 11 of the Childrens' Act. • A two yearly audit is undertaken by West Sussex Coastal CCG to monitor the provision of safeguarding arrangements at QVH and this includes a review of training and responsiveness. The most recent audit produced an outcome of very good. • Bimonthly safeguarding reports are submitted to West Sussex Coastal CCG.	Green	N/A	N/A	Safeguard-ing Lead (M Brown)	• None – Ongoing audit
RECOMMENDATION 6. The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.	• Enhanced DBS checks are carried out on all clinical staff e.g. nurses, doctors, therapists and health Care Assistants.	Green		Completed	Director of HR (G Armitage)	Current practice is correct and action is being taken to update the policy document to reflect this.

Report Recommendation	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
RECOMMENTATION 7. All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers. **Not accepted, instead the Department of Health will carry out a review of current practices, and use of the DBS Update Service.**	• QVH has a Recruitment and Selection of Staff Policy in place that refers to the completion of CRB checks for staff and volunteers. In practice these are now DBS and enhanced DBS checks therefore the policy requires updating to reflect current practice within Recruitment.	Amber	• The Recruitment and Selection of Staff Policy requires amendment to include reference to DBS and enhanced DBS checks.	31/04/2015	Director of HR (G Armitage)	• Policy is due for review in March 2015
RECOMMENDATION 8. The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.	• QVH alerts are received and appropriately escalated by the Human Resources Department (K Goldsmith and G Harrington)	Green	N/A	N/A	Director of HR (G Armitage)	• None - Ongoing

Report Recommendation	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement-ation Lead	Progress/ comments
RECOMMENDATION 9. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	• QVH currently has an Information Security Policy in place – This policy is under revision to ensure compliance with the latest guidance.	Amber	• Review of the Information Security Policy	31/08/2015	Finance Director (D Tkaczyk) (Information Governance and IT Managers)	• Update of the main Information Security Policy has begun, and this has included collation of various supporting policies e.g. mobile devices, internet and email usage. Policy to be finalised and then to Information Governance Committee and Quality and Risk Committee for ratification.
RECOMMENDATION 10. All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	• QVH has a Recruitment and Selection of staff policy in place that relates to permanent, agency and contract staff. • The Induction Policy includes information on education, training and study leave and is under review • Bank staff, military personnel and contractors undertake the mandatory induction as per permanent staff • Staffing checks on training etc are completed as part of the Recruitment Policy for agency medical • A Learning and Development Strategy is in place	Amber	• Update of the Recruitment and Selection of staff, and Induction Policies	31/04/2015	Director of HR (G Armitage)	• Policies currently under review

Report Recommendation	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement -ation Lead	Progress/ comments
RECOMMENDATION 11. NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	• Review of HR arrangement currently being undertaken • Four high level HR risks (on training, recruitment and retention, staff compliance, and education requirements and provision) contained within the Board Assurance Framework (BAF) monitored monthly by Executive level lead. • Recruitment Processes are being Audited during Q1 2015/16	Amber	• Ongoing reporting for monitoring and remedial work to meet training requirements. • Introduction of Safercare module. • Ongoing recruitment initiatives	30/06/2015	Director of HR (G Armitage)	• Annual TNA completed • MaPSaF sessions completed and Q4 and annual reports being compiled • Additional elearning opportunities provided to staff. • Bank and agency being utilised to establishment levels • Training compliance levels increasing
RECOMMENDATION 12. NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	• QVH has a Risk Management and Incident Reporting Policy, Risk Management Strategy and Communications Strategy in place • The Trusts Board Assurance Framework (BAF) (High level risk register) includes a risk on adverse publicity and damage to reputation Departmental and corporate risk registers are reviewed regularly via committees and monthly meetings (as with the BAF)	Green	The Risk Management and Incident Reporting Policy is currently under review to reflect the Trusts revised governance structure	30/06/2015	Head of Risk (A Vizulis)	• Risks are identified, reviewed and escalated appropriately in relation to this area. • Once the governance restructure has been completed in May 2015, the Risk Management and Incident Reporting Policy will be revised to reflect this.

Report Recommendation	QVH initial assessment	Rating (RAG)	Action Required	Timescale	Implement -ation Lead	Progress/ comments
RECOMMENDATION 13. Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.	As previously stated	Various	As previously stated	As previously stated	As previously stated	As previously stated
RECOMMENDATION 14. Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.	As previously stated	Various	As previously stated	As previously stated	As previously stated	As previously stated

In summary, ongoing actions and monitoring are to continue in relation to human resources e.g. training compliance and recruitment initiatives, with the remaining actions mostly focussing on the review and update of the following policies and associated processes:

- Volunteers Policy
- Recruitment and Staff Selection Policy
- Induction Policy
- Information Security Policy
- Risk Management Policy

Alison Vizulis, Head of Risk

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Trust Board
Meeting date:	26th March 2015
Reference number:	76-15
Report from:	Clinical Cabinet
Author:	Richard Tyler
Report date:	13th March 2015
Appendices:	None

Report from meetings of the Clinical Cabinet held on 16th February & 2nd March 2015

Key issues and Actions

Cabinet **endorsed** the following;

1. Research Strategy Review: Cabinet was updated on progress on the existing research strategy and endorsed future proposals for development.
2. 15/16 Quality Account: Cabinet agreed five priorities for the 15/16 quality account:
    a. Trauma
    b. Catering
    c. Outpatients (subject to further discussion)
    d. Consent
    e. Scheduling of elective surgery
3. Serious Untoward Incident: Cabinet signed off the root cause analysis (RCA) arising from the recent decontamination incident.

Cabinet received **updates** on the following;

1. Hub & Spoke Review
2. Education & Simulation Centre
3. Electronic Patient Record
4. 15/16 tariff proposals
5. Monthly quality & risk update
6. Monthly operations report
7. Monthly finance report
8. Key Strategic Objective 5 – organisational excellence
9. Quarterly strategy & sustainability report
10. February Trust Board

Link to Key Strategic Objectives
Link 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:	26th March 2015
Reference number:	77-15
Report from:	Ginny Colwell, NED
Committee meeting date:	5th March 2015
Appendices:	NA

Report of the Chair of the Quality and Risk Committee
NB Draft minutes not available

Key issues discussed

1. The quality and risk report showed an increase in incidents however 77 out of the 480 related to a temporary administrative system. A new section of the report is now reporting incidents by reporter Staff Nurse, ODP, etc. It was noted that Medical reporting remains low and the MD has taken it to the JHCA meeting.
2. An updated report was received on CQC preparedness, Whilst Compliance in Practice audits play an important role in this area they do not cover all the activities we need to undertake and CIP inspections do not take place in all clinical areas. An action plan is being developed to develop the tool to enable it to be extended to all patient centred areas. Fiona Long is also working on the overall plan, which has some overlap with the governance review and needs to feed through to the Board.
3. It was agreed that whilst we will not receive CQUIN monies this year that we will formalise an internal CQUIN/Quality target process
4. The Raising Concerns Policy was ratified; however it was noted that it will require updating soon to incorporate the recent Francis Report and will also need to ensure that it incorporates all the recommendations within the C Wing report.

Additional information or assurance sought

5. The Committee asked for the First Aid at work Policy to be taken back to the Health and Safety Committee for further clarification.
6. An out of date policies update was received. It was requested that this was updated and represented.
7. Following discussion at the last meeting a report was presented- Deep Dive Risk- Falls. Whilst no particular area for action was identified- it was agreed that we need to ensure more meaningful benchmarking- both internal and external for our reporting overall

Implications for BAF or Corporate Risk Register

8. Main areas of concern are already fed through to the Corporate Risk Register or Board Assurance Framework

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Proposed Schedule March Board of Directors

Thursday 30th April 2015

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

BOARD SUB-COMMITTEE		
09.00 – 10.00	**Nomination & Remuneration Committee**	
INFORMAL SEMINAR		
10.00 – 11.00	**Board Development Programme**	Chair
11.00 – 12.00	**Board Assurance Framework workshop**	Interim Director of Nursing & Quality and Head of Risk
12.00 – 12.30	**Presentation: Breast Surgery**	Martin Jones, Consultant Plastic Surgeon
13:00	**FORMAL BOARD AGENDA**	
	PATIENT STORY	
	Experience	Interim Director of Nursing & Quality
	RESULTS AND ACTIONS	
	Patients	Interim Director of Nursing & Quality
	Operational Performance	Interim Head of Operations
	Financial Performance	Interim Director of Finance & Commerce
	Contract update	Interim Director of Finance & Commerce
	Workforce	Director of HR & Organisational Development
	STRATEGIC PRIORITIES	
	Quarterly update on delivery of KSO3: Operational Excellence	Interim Director of Operations
	Quarterly update on delivery of KSO4: Financial Stability	Interim Director of Finance & Commerce
	QVH Charity	Head of Corporate Affairs
	GOVERNANCE	
	Corporate Risk Register	Interim Director of Nursing & Quality
	Monitor Q4 return	Interim Director of Finance & Commerce
	Annual Declaration of Interest/FPPT statement	Head of Corporate Affairs
	Board Governance Review – interim report	Chair
	Whistleblowing update	Director of Human Resources and Organisational Development
	***Freedom to Speak up* update**	Interim Director of Nursing & Quality
	SUB-COMMITTEE REPORTING	
	Audit	Committee Chair
	Charitable Funds Advisory	Committee Chair
	Clinical Cabinet	Chief Executive