Queen Victoria Hospital NHS
NHS Foundation Trust

BUSINESS MEETING OF THE BOARD OF DIRECTORS

Thursday 22 May 2014

Session in public at 13:00

Session in private at 16:00

Indus Room, Jubilee Community Centre, Charlwoods Road,
East Grinstead, West Sussex RH19 2HL

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: MAY 2014

Members (voting):

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

In full attendance (non-voting):

Interim Company Secretary	-	Lois Howell
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode

In part attendance (non-voting):

Head of Human Resources	-	Graeme Armitage
Directorate Manager Clinical Specialties	-	Jane Morris
Programme Director	-	Heather Bunce

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors (BoD)

Thursday 22 May 2014
Session in public at 13:00

Indus Meeting Room, Jubilee Community Centre, Charlwoods Rd, East Grinstead, West Sussex RH19 2HL

PUBLIC AGENDA			
No.	**Item**	**Time**	**Papers**
WELCOME			
109-14	**Welcome, apologies and declarations of interest** Peter Griffiths, Chairman	13:00	
STANDING ITEMS			
110-14	**Draft minutes of the meeting session held in public on 24 April 2014 for approval** Peter Griffiths, Chairman	13:05	1
111-14	**Matters arising and actions pending** Peter Griffiths, Chairman	13:10	2
112-14	**Update from the Chief Executive** Richard Tyler, Chief Executive	13:15	verbal
113-14	**Update from the Medical Director** Steve Fenlon, Medical Director	13:20	verbal
SAFETY AND QUALITY			
114-14	**Quality and Risk Exception Report: (monthly update)** Ali Strowman, Deputy Director of Nursing and Quality	13.25	3
115-14	**Patient Experience Annual Report** Ali Strowman, Deputy Director of Nursing and Quality	13:30	4
116-14	**Safe Staffing Report: (monthly update)** Ali Strowman, Deputy Director of Nursing and Quality	13:35	5
117-14	**Board Assurance Framework 2013/14** Ali Strowman, Deputy Director of Nursing and Quality	13:40	6
BUSINESS PERFORMANCE AND DELIVERY			
118-14	**Workforce performance report: (monthly update)** Graeme Armitage, Head of HR and Workforce Development	13:45	7
119-14	**Operational performance reports: (monthly update)** Jane Morris, Directorate Manager Clinical Specialties	13:55	8
120-14	**Financial performance report: (monthly update)** Stuart Butt, Interim Director of Finance and Commerce	14:05	9
GOVERNANCE			
121-14	**Annual Report, Quality Accounts and Financial Accounts 2013/14** Lois Howell, Interim HoCA and Company Secretary	14:10	10

122-14	**Executive Level Assurance Structure** Richard Tyler, Chief Executive	15:05	11
STRATEGY			
123-14	**Delivering excellence: QVH 2020 (monthly update)** Richard Tyler, Chief Executive	15:15	verbal
124-14	**Site re-development programme: (monthly update)** Richard Tyler, Chief Executive	15:20	12
125-14	**Capital programme: (monthly update)** Richard Tyler, Chief Executive	15:25	13
126-14	**Sustainable Development: (annual report)** Richard Tyler, Chief Executive	15:30	14
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD			
127-14	**Clinical Cabinet** Richard Tyler, Chief Executive	15:35	verbal
128-14	**Audit Committee** John Thornton, Non-Executive Director	15:40	verbal
GOVERNOR REPRESENTATIVE AND NON-EXECUTIVE DIRECTORS			
129-14	**Report from the Governor Representative** Brian Goode, Public Governor	15:45	verbal
130-14	**Observations from the Chairman and Non-Executive Directors** Peter Griffiths, Chairman		verbal
QUESTIONS FROM OBSERVERS			
131-14	Peter Griffiths, Chairman	15:50	verbal
MOTION TO EXCLUDE THE PRESS AND MEMBERS OF THE PUBLIC			
132-14	*Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss confidential information concerning the trust's finances and corporate governance* Peter Griffiths, Chairman	15:55	verbal
PRIVATE AGENDA			
COMMERCIAL-IN-CONFIDENCE			
133-14	**Draft minutes of the meeting session held in private on 24 April 2014** Peter Griffiths, Chairman	16:00	15
134-14	**Financial Service Line & Operational Performance reports (monthly update):** Stuart Butt, Interim Director of Finance & Commerce	16:05	16
135-14	**Theatre Rebuild: Final Account** Stuart Butt, Interim Director of Finance and Commerce	16:15	17

136-14	**Board Governance Review Action Plan** Lois Howell, Interim Head of Corporate Affairs	16:30	18
137-14	**Market Report** Richard Tyler, Chief Executive	16:50	19
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIRMAN)V			
138-14	Peter Griffiths, Chairman	16:55	

DATES OF THE NEXT MEETINGS

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: Thursday, 26 June 2014, 13:00 CCEC	**Q&R:** Thurs, 29 May, 09:00, JMR **Audit:** Wed 4 June 2014, 14:00. OT6 **N&R:** TBA **CFAC:** Thurs 26 Jun, 09:00, CCEC	**Public**: Thurs 12 June 16:00 ATH

Document:	**Minutes (draft & unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **24 April 2014, 13:00 – 16:00, Council Chamber, East Court, College Lane, East Grinstead, West Sussex RH19 3LT**	
Present:	Peter Griffiths (PAG)	Chairman
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Amanda Parker (AP)	Director of Nursing & Quality
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
In attendance	Caroline Haynes (CH)	Deputy Head of Human Resources
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Directorate Manager: Clinical Specialities [item: 091-14]
	Bill Stronach (BS)	Deputy Director of Finance [item: 090-14]
	Lois Howell (LH)	Interim Head of Corporate Affairs & Co Sec
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Richard Hathaway (RH)	Director of Finance & Commerce
Public gallery:	None	

WELCOME

080-14 **Welcome, apologies and declarations of interest**

The Chairman opened the meeting. Apologies had been received from Richard Hathaway. In addition GA was on leave and had arranged for CH to present the monthly workforce report in his absence.

GC asked the board to note that as part of her existing declaration as NED for CSH Surrey, she was currently Acting Chair.

STANDING ITEMS

081-14 **Draft minutes of the meeting session held in public on 27 March 2014 for approval**

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

082-14 **Matters Arising & Actions Pending**

The board reviewed the current record of Matters Arising and Actions Pending; it was agreed that all complete actions would be removed from the log with effect from next month. Actions for which a date had been agreed, but which were still outstanding, would also be removed from the log and transferred to the board work programme.

LP queried the accuracy of item 14, relating to capital expenditure. RT reminded the board that the operational budget had been approved at its meeting last month but acknowledged this had not included a detailed breakdown and undertook to circulate this. **[Action: RT]**
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083-14 **Update from the Chief Executive**

- RT reminded the board of the impact the Specialist Commissioning Group's revised strategy could have on the trust's burns services; he confirmed any changes were being closely monitored;
- The FTN had established a group to inform a review of sustainability of small hospitals. RT had been invited to join this group and would apprise the board of developments;
- The remaining four theatres became fully operational at the beginning of April; as an aside, it was reported that Mike Bennett would be retiring in May and accordingly, RT would be implementing an interim operational restructure.

	▪ A procurement exercise was currently underway for an external review of the Estates Department; its brief was how best to establish and maintain a robust estates function. This review would focus on only hard FM at this stage. The board **NOTED** the contents of the update
084-14	**Update from the Medical Director** ▪ The revalidation process was continuing, however, SF asked the board to note the challenging timescales associated with the governance framework; ▪ Excellent progress had been made in respect of consent targets this month, with huge improvement in Plastics, (thanks predominantly to surgeon Mark Pickford); ▪ Recruitment for a project manager for the Outcomes work was underway. In the meantime, it was anticipated that the first outcome results would be published in May. Feedback from the Patient Experience Group suggested that age, experience and training were relevant to patient choice and a consultant profile would be developed with this in mind; ▪ As part of the Clinical strategy, it was acknowledged that demand for services was good, although there were concerns as to how high levels of activity would be managed, particularly in trauma; ▪ SF reminded the board of the 7/7 (weekend working) national agenda and asked it to take time to consider how this should be defined at QVH - whether in terms of elective or emergency cover, or both. There was no assumption this would be introduced at QVH, but if it were, consideration would be required as to how it could be managed within standard contractual terms and conditions. GC observed that there was evidence to suggest 7/7 working provided a more robust model from a clinical perspective; ▪ SF observed that the model of CQC Specialist Trust inspections required adjustment for trusts such as QVH. AP advised that CQC teams would shortly begin visits to specialist trusts, but there was still little to indicate what these would entail; RT suggested that reference to the standard data-book might assist in identifying any gaps; In reference to recent national press reports, the Chairman asked SF if QVH should have concerns regarding patients vulnerable to dehydration and associated kidney failure. SF assured him QVH had policies in place, although this issue wouldn't apply to the majority of our patients. AP concurred that the trust wouldn't even have a sufficient cohort of patients with which to undertake such a study. The chairman thanked SF and the board **NOTED** the contents of the update
SAFETY & QUALITY	
085-14	**Quality & Risk Exception Report** AP reminded the board that this report provided information on an exceptional basis, against national and local targets. ▪ **Infection & Prevention Control** AP highlighted concerns regarding the high number of vacancies within the Domestic Services team, which could impact to the detriment of IP&C within the trust. Whilst RT had been advised recently that a recruitment drive was underway in this area, CH agreed to clarify the detail and to expedite the process to ensure the department was recruiting to its full establishment figures. CH would also investigate why these posts were currently restricted to internal applicants only **[Action: CH]** ▪ **Safety Metrics** Investigation into a recent incident of a patient acquiring a pressure ulcer had identified lapses in nursing care; this was being followed up with the staff member concerned.

	WHO compliance, under patient safety, had been agreed as a CQUIN for 2014-15 and would be removed from this metric to avoid duplication of reporting; ▪ **Incidents** No serious incidents reported in April. A previously reported spinal fracture had been identified as deterioration rather than as a result of acute injury. ▪ **Risks** The board reviewed a list of risks which had been rated 12 or above. RT identified several risks that had already been addressed; AP reminded the board that the risk register was a live document it was likely these changes had already been taken into account but agreed to double check. The Chairman asked how easy it was to identify teams which were persistently non-compliant in respect of the WHO checklist. AP responded that reporting would be adapted from 2014-15 to facilitate this. RT reminded the board that he intended to bring Core Standards to the board for discussion next month. ▪ **Patient Experience** The Chairman expressed concern at the low rate of F & F responses in certain areas. AP assured the board that improvements would be seen shortly as this now formed part of the 2014-15 CQUIN targets. ▪ **CQUINS** Results for 2013-14 had now been agreed and confirmation from the CCGs was due shortly. The board **NOTED** the contents of the update
086-14	**National Inpatient Survey Results** Results of the National Inpatient survey demonstrated the trust continues to be rated as one of the best hospitals in the country, achieving the highest scores of any trust in England in respect of quality of nursing care. RT asked the board to note the link between these results, and a recommendation from the recent C-Wing action plan whereby the it had reaffirmed its commitment to the highest standards of nursing care and behaviour as part of its wider commitment to excellence in patient care. The Chairman asked AP to undertake an exercise which would enable a trust comparison of these results against other specialist hospitals. **[Action: AP]**
087-14	**CQUINS 2014-15** AP presented the proposed CQUIN framework for 2014-15 which had been agreed with lead commissioners. Locally mandated requirements included The Catering Mark which would be implemented in an attempt to raise food standards and improve patient experience. JT asked if accountability for each measure had been made clear to leads; AP gave this assurance and stressed that these measures were non-negotiable.
088-14	**Safe Staffing** AP presented a timetable of actions drawn up by the CQC and reminded the board that it was now mandated to receive and publish staffing for each inpatient ward on a monthly basis. In addition, a six-monthly staffing summary, including establishment data, was also required. A model, developed to meet requirements for board reporting of staffing capacity and capability data, was also presented. In addition, a Staff Escalation Plan was also submitted for approval. GC queried if the monthly and bi-annual reports could be combined; AP explained the logistics of why this would not be feasible but gave assurance that there would be adequate cross-referencing

	between the two. After due consideration, the board **APPROVED** the proposed reporting process.
BUSINESS PERFORMANCE & DELIVERY	
089-14	**Workforce Performance Report (monthly update)** CH was in attendance to present the Workforce Performance Report for April which focused on exceptions and actions being taken to address areas of under-performance. It was highlighted that turnover at the trust was still higher than the NHS target but there was no perceivable trend. All exit questionnaires were reviewed and the situation closely monitored. Sickness absence had reduced again this month, showing a downward trend which was a positive sign of support being given to managers by HR in addressing sickness absence issues. CH outlined some of the new initiatives to be introduced to assist with work related stress. A new electronic ECF had been launched which improved efficiency of the recruitment process, while establishing tighter controls. CH reminded the board of the national shortage of nurses and advised that, in line with other trusts, recruitment drives would be extended to Ireland and other parts of Europe. A further potential source being investigated included ex-service personnel. CH reported that measures in place to address the Trust's financial position continued to take effect, with significant reduction in pay and an overall decrease in the use of bank and agency staff. AP concurred this was a positive outcome, and observed that whilst this was more cost effective to the trust, it also provided a safer nursing environment. GC sought clarification in respect of an employee relations case; CH advised that whilst the process followed by the trust had been robust and transparent, it was always difficult to predict the likely outcome of such cases. The Chairman thanked CH for her update and the board **NOTED** the contents of the report.
090-14	**Financial Performance Report (monthly update)** BS attended the meeting on behalf of RH and tabled the March 2014 update. Due to time constraints it had not been possible to circulate this report in advance. BS outlined the technicalities of reporting of the PCT bad debt. NHS England was engaging in the process to resolve the legacy debt issues national and in the meantime, the trust would continue to pursue late payments. BS assured the board that auditors were fully cognisant of the trust legacy debt issues. This month's surplus was £138k behind plan; the year end surplus was just under £2.1m (£419k below plan). This was however the worst case scenario as any debts received in respect of ERT before May could only improve the situation. The 2014-15 had a planned surplus of £2.2m, which this year included all CQUINs money. Whilst Pay was overspent by £177k, this included £89k of research costs released to match income released therefore leaving a net of £88k which was encouraging. The Sleep Services overspend of £294k was highlighted, with the board asking if this

	amount was reflected in income elsewhere in the report; BS explained that due to the reporting format it was difficult to show a direct correlation. It was noted that continued overspends had led to the financial performance being below plan. JT asked if the 2014-15 budget was realistic and one which managers could be held accountable for. The Chairman observed that with the introduction of tighter management controls, there would be no excuses for exceeding the non pay budget in the next financial year. BS reported that overall capital spend was below the phased plan. The costs for Phases 1 and 2 of the theatre project had been calculated but were still subject to final agreement; the concluding report was scheduled for the May board meeting. BS also reported that £800k would be carried forward into 2014-15 in respect of uncompleted projects. BS noted that debt was increasing and was currently higher than previously reported. He set out the issues for 2014-15 and was hopeful that some payments received this month, should reduce the debt from April onwards. LP repeated an earlier request for financial reporting to include previous year figures for comparative purposes. **[Action: BS]** The Chairman thanked BS for his presentation and the board **NOTED** the contents of the report.
091-14	**Operational Report (monthly update including RTT18)** JM attended to present the Month 12 performance report. As predicted earlier, the trust had failed its RTT18 target for March, however there was now an Early Warning tracking system in place to monitor peaks in referrals and conversion rates and to assist capacity planning. Weekly monitoring by the senior management and the operations teams, and bi-monthly monitoring by the Clinical Cabinet was also undertaken. JM set out the reasons for failure last month but assured the board of a series of proactive actions which would be implemented going forward. Following the recent visit by the Intensive Support Team, the trust would be undertaking a further review of its administrative function and waiting list management; the formal report from the IST was due at the end of April. JT asked JM how confident she was that the trust would achieve its targets in April. JM responded that it was anticipated the trust would achieve both outpatient and inpatient aggregate targets. However she believed there is still a risk that the trust aggregate for inpatients in Q1 could be missed due to cancellations, trauma demand, shortages of theatre staff and continued reductions in backlog, particularly in Plastics and Corneo. A planned shutdown for the following weekend also presented risks. It was clearly important that the trust achieved its targets in Q1 to prevent intervention by Monitor; however, RT asked the board to note that trust inpatient aggregate target for Q2 would fail as backlog clearance was expedited in order to achieve a long term sustainable 18-week position. He assured the board that the trust would be working closely with Monitor throughout this process. JT commended JM on the revised style of reporting which had shown greater clarity than in previous months. The Chairman thanked JM for her input and the board **NOTED** the contents of the report.

GOVERNANCE	
092-14	**Declaration of Interests 2014-15** LH asked that all members of the board of Directors complete a new Declaration of Interest form for 2014-15, in line with the attached DoI Guidelines, and return to the Deputy Company Secretary by Friday 15 May 2014 for inclusion on the 2014-15 trust register. The board **NOTED** the contents of the report and associated request.
093-14	**Monitor Declaration: Q4 2013-14** BS reminded the board that the trust was required to submit its Q4 monitoring return by the end of April; he presented a report setting out the proposed Governance Statement which was to be submitted by the board. In addition, to a self-certification framework providing supporting evidence for the declaration was circulated. After due consideration, the board confirmed the following: • Finance: The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months • The Continuity of Service risk ratings (COSRR): 4 - No evident financial concerns • The Governance Rating for Q3 was Green: No evident concerns. • The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework). However, in view of recent RTT18 failures, the board concurred it was unable to confirm that sufficient plans were in place to ensure ongoing compliance with all existing targets (as set out in Appendix A of the Risk Assessment Framework) AP highlighted sections of the self-certificate which required further updating. Notwithstanding these changes, the Board **NOTED** the contents of the schedules and **APPROVED** the declarations to be submitted to Monitor.
094-14	**Equality & Diversity Annual Report** CH presented the annual Equality & Diversity report which included an analysis of the activities the Trust carried out in 2013 to meet the requirements of the Equality Act 2010. It set out objectives for 2014 and also provided an analysis of workforce information across protected characteristics, (with detailed source data for reference) Key points the board was asked to note included: • By the end of 2013, the trust had achieved 63% of its actions and made progress towards 28% of actions (11% and 75% respectively the previous year) set out in its Equality Objective Scheme. Outstanding actions were linked to the use of PAS, which was a national issue, and outside the trust's internal control. • 76% of employees are female. RT noted that whilst this was an over-representation, it was in line with other NHS organisations. • In contrast, the trust employs 12% BME staff, whilst the Mid-Sussex BME population is 5%. CH reported that the Equality, Diversity and Human Rights steering group, (comprising the Executive and Deputy Directors of Nursing and Quality, Head and Deputy of Human Resources, two public Governors and representatives from departments across the trust) ensures QVH complies with all relevant legal requirements and delivers its strategy. The board was assured that this group would lead on key findings of the report. The Chairman thanked CH for the update and the board **NOTED** the contents of the report.

STRATEGY	
095-14	**Delivering Excellence QVH 2020: Key Strategic Objectives 2014-15** As part of the Delivering Excellence strategy, and in an effort to establish the overall accountability framework within which the board would operate during the current financial year, RT presented the trust's key strategic objectives (KSOs) and the work programme for 2014-15. The work programme was being developed into a series of individual action plans which would be cascaded throughout the organisation through an effective communications strategy including announcements through *Connect*. LP raised concerns that the KSOs and work programme did not include a longer term agenda with planning for the sustainability. GC concurred that objectives appeared to be operational rather than strategic. RT responded that the clinical strategy had been addressed, but conceded that the transformational agenda could be more explicit. He did note, however, that the organisation required momentum around smaller operational issues. The Chairman noted that in June the QVH 2020 strategy would be transformed into the 5-7 year plan which would inevitably flush out the strategic direction. JT suggested that the section relating to Trust Board Responsibilities could be removed but LP argued this document was still operational, lacking sufficient reference to strategy. RT reminded the board that the hypothesis he had been working to, which had been approved last September and revisited in December and March, was that QVH would survive by being excellent; this would be delivered by the KSOs and the growth strategy was defined within clinical strategy. LP concurred that the clinical strategy was the driver but needed to be more explicit. The Chairman suggested that it would be helpful to capture the timings of the strategy in a schematic form; however, the board would need to review the clinical strategy first. RT noted the hypothesis would not change fundamentally, but that delivery of the strategy would. Longer term sustainability depended upon ascertaining which areas might be affected by CCG and LAT policies. The Chairman agreed the trust needed to create a vision which would deliver quality of care with a strategy that was viable to commissioners. To this end it was agreed that the document would be approved in its current format and reviewed at a later date in view of the emerging clinical strategy. JT asked that reference to ensuring sustainability be made explicit within the strategy; notwithstanding this amendment, the board **APPROVED** the report.
096-14	**Site Redevelopment (monthly update)** There were no further changes to report and RT reminded the board it would receive the final account for the Theatres project at its meeting in May. The board **NOTED** the contents of the report
097-14	**Capital Programme (monthly update)** RT presented the Capital Programme on behalf of HB and asked the board to note that the RAG rating had reverted from Red to Green for the new financial year. He also asked the board to be aware of potential risks to MIU and Sleep Services during the Jubilee Heating works. AP observed that refurbishment of C-Wing was not specifically referenced in the 2014-15 programme, but agreed to take this up directly with HB.

	The board **NOTED** the contents of the report
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
098-14	**Clinical Cabinet** As part of reviewing cabinet's effectiveness, RT advised he would be raising board level concerns with the Clinical Cabinet at the beginning of each month. The board **NOTED** the contents of the update.
099-14	**Nomination & Remuneration Committee** The Chairman asked the board to note that the minutes of the recent Nomination & Remuneration Committee were still to be finalised and would be submitted to the board next month; in the meantime he advised that the committee had met to discuss the executive leadership of the finance function, and changes pertaining to this. The Chief Executive had been asked to consider proposals to take account of these changes. The board **NOTED** the contents of the update.
100-14	**Board Outcomes Committee** LP reported that, as previously requested by the Chairman, the Terms of Reference of the Board Outcomes Group had now been expanded. These had been circulated to all members of the group. The board **NOTED** the contents of the update.
GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
101-14	**Report from the Governor Representative** BG had no further comments to add
102-14	**Observations from the Chairman and Non-Executive Directors** The board concurred with JT's observation that reporting of Operational Performance had greatly improved this month. There were no further comments and the Chairman closed the meeting with a motion to move to a private session to consider matters of a commercially sensitive nature.

Chairman…… Date…….....

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
April 2014 meeting						
1	**082-14**	Detailed breakdown of capital expenditure to be circulated to board.	**RT**	~~**May**~~ **June** **TBC**	**29.04.14:** 20114/15 capital plans are subject to phasing. **1.** The estates programme to be considered at June audit committee as part of the wider response to the KPMG capital projects audit. Chair of Audit Committee to report to June BoD **2.** Detailed business case in respect of proposed IT expenditure to be submitted to board in Q2. Date of board meeting to be confirmed	**Re-dated**
2	**085-14**	Recruitment of domestic staff to be expedited, whilst ensuring that the trust is recruiting to full establishment figure. In addition, explanation to be provided as to why posts are currently restricted to internal applicants only.	**GA**	**May**	**29.04.14**: CH confirmed 3 WTE to be advertised with immediate effect; further vacancy for 7.5 hours was advertised internally in order to give current staff an opportunity to increase their current hours. GA to provide verbal update at May board.	**Complete**
3	**086-14**	Following recent National Inpatient Survey results, further analysis to be undertaken to determine how QVH compares against other specialist hospitals.	**AP**	**May**	**06.05.14**: Circulated to BoD 06 05 2014	**Complete**
4	**090-14**	Future financial reporting to include previous year figures for comparative purposes	**BS**	**May**	**29.04.14:** Format to be revised in time for next board meeting in May	**Complete**
April 2013 meeting						
	076-13	Provide evidence to BoD that finance team has seen and interrogated complete analysis of costs for Phase 1 theatres, once final account is available	**RH/HB**	**May 2014**	**24.04.14:** On agenda for May BoD	**Complete**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22 May 2014**
Agenda item reference no:	**114-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 May 2014**

QUALITY AND RISK EXCEPTION REPORT: MAY (MONTHLY UPDATE)

1. The attached information was provided to the Clinical Cabinet on 19 May 2014.

2. Areas of note are:
    - Explanations are made against any metrics that are not rated green
    - No significant concerns are noted

3. The Board is asked to **NOTE** the contents of the reports.

Quality and Risk Management Report
May 2014

Introduction

1. The purpose of this report is to bring to the trust board's attention the quality performance of QVH. The report brings together key national and local indicators on quality and safety.

2. The paper provides information on an exceptional basis against national and local targets. A rating scale has been applied and where there is indication that a target or metric is below the expected standard (green), further information is provided. The report provides current information on the trust's performance for 2013/14 with the latest information available from April 2014.

Infection prevention and control

Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	—	0	0												0
	Clostridium Difficile acquired at QVH post 72 hours after admission	—	0	0												0
	E-coli bacteraemia	—	0	0												0
	MSSA bacteraemia	—	0	0												0
	MRSA screening - elective	—	>95%	97%												97%
	MRSA screening - trauma	—	>95%	95%												95%
	Trust hand hygiene compliance		>95%	99%												99%

3. During April the infection control team has maintained a presence in both the clinical and non-clinical areas supporting the undertaking of audit related to infection prevention and control. Activities include:

- *PLACE inspection* – Non clinical – public toilets, corridors, male end of Jubilee.
- *Locker audit* – all lockers checked for cleanliness and all found to be fit for service.

4. Due to the reduced number of cleaners available currently a risk has been raised around our ability to maintain cleanliness around the site. Clinical areas are being prioritised and there is an advert out to recruit to the vacant posts.

Safety metrics

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 -	2013/14 total /	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date
				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	<4	0												
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	—	>95%													
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	—	>95%													
	Patient falls causing harm	16%		4												
	Patient Falls resulting in no or low harm	—		4												
	Patient Falls resulting in moderate or severe harm or death	—		0												
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	—	>95%													#DIV/0!
	Avoidable patient falls identified on the Safety Thermometer	—		0												
	Serious untoward incidents (including Never Events) * SI downgraded following investigation	5		0												
	Total number of incidents involving drug / prescribing errors	—		13												
	No & Low harm incidents involving drug / prescribing errors	—		13												
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	—		0												0.0
	Reduced errors on zero tolerance anti-microbial prescribing audits	—														
	% Medication errors	—														
	Medication administration errors per 1000 spells	1.3		0.7												
	To take consent for elective surgery prior to the day of surgery (Total)	—	75%	84.7%												
	To take consent for elective surgery prior to the day of surgery (Max Fax)	—		68.2%												
	To take consent for elective surgery prior to the day of surgery (Plastics)	—		84.3%												
	To take consent for elective surgery prior to the day of surgery (Corneo)	—		95.0%												1
	Number of outstanding CAS alerts	—		0												
	Number of reported incidents relating to fraud, bribery and corruption	—		0												0%
Staff Safety	Staff incidents causing harm	58		9												
	RIDDOR (Patients & Staff)	4		1												
	Mandatory training attendance	—	80%	82%												0
	Flu vaccine uptake	—	60%	0												0

5. The trust uses a number of metrics to support identifying how safe care is for patients at QVH and a number of additional metrics have been added for 2014/15. Some of the data is missing from the dashboard above as these metrics are still new and data collection processes are being refined to ensure accurate data is captured.

6. Four falls were identified as causing harm. These falls all occurred on Canadian Wing. Two of the falls happened with the same patient and this was due to the patient being confused. All appropriate measures had been taken to assess the risk of falls and to reduce the likelihood of patients falling. All injuries sustained were minor.
7. Overall there has been an improvement in the number of patients who have been consented prior to the day of surgery. The Medical Director and Clinical Lead for Max Fax continue to promote this best practice amongst the team in order to improve in this area.

Incidents

8. Incidents at QVH are rated as serious incidents (SIs); red rated incidents where there was significant harm or the potential for significant harm, amber where there was moderate harm or the potential for moderate harm or green. The trust board is apprised of all SIs, red or amber incidents and updated on actions taken to prevent reoccurrence.

9. No serious incidents were reported in April. There were two amber incidents in April, these will be investigated and information provided back in the June report. No specific trend was identified during the month.

10. During March there were two amber incidents that required investigation. One was where a patient acquired a grade 2 pressure ulcer. The patient had a history of pressure ulcers but inadequate care was provided at QVH to prevent a recurrence of this. The second was regarding a patient who had an ALT flap. Care that was administered overnight from both the nursing and medical staff was inadequate and resulted in the failure of the flap. In both of the stated incidents a full RCA has been undertaken in order to identify lessons to be learnt and disseminated.

Risks

11. The board receives a short summary of all risks rated at 12 or above. Currently is one risk rated as 16, five risks rated as 15 and nine rated at 12. Those rated 16 and 15 are:

- Failure of the clean room air handling unit (16)
- The potential risk of not achieving referral of patients and completion of their treatment within 18 weeks.
- Failure to maintain an estates service due to a continued shortage of staff
- Inadequate health records storage (trip hazards and potential delay to obtain health record has been removed from this risk as they have been resolved)
- Fire doors at the rear of clinics have been repeatedly forced open by public leaving the risk that the department is unsecure at times.
- The potential for misdiagnosis due to additional annotation on PACS viewer that shows anatomical body presentation – this means some images ie left wrist have both an L and R

12. Those rated 12 are;

- Potential loss of referrals due to commissioners moving work to centralised centres.
- The potential for harm to other patients due to spread of infections such as MRSA, clostridium difficile.
- The potential risk of not being able to see and treat patients within the required 31 and 62 day targets.
- The risk that due to our microbiology provider being short staffed there is a risk they are unable to provide sufficient review of our patients.
- Failure to embed the safer surgery check list
- Failure to meet CQUIN targets and thus incurring a loss of CQUIN funding
- The potential risk that information security could be breached due to use of unsecured email accounts; it is identified that the deployment of encryption software would reduce this risk.
- IT infrastructure resilience has been increased to 12 from 8
- The risk of not meeting Statutory and Mandatory training rates due to increased vacancies

All risks have controls identified and actions planned to further mitigate the possibility of the risk outcome occurring.

Patient experience

13. During April there were five complaints received from patients or their relative and two claims. During the month seven complaints were closed with the following actions, these were:

- **Corneo Admin-** Patient placed on the waiting list but due to high blood pressure, required a cardiology review. The patient then received a phone call at 7pm one evening informing her that as she had had her surgery she was now discharged. The patient had not had surgery and would like to know why this phone call was made.
  Outcome *– The patient's surgery was deferred as the patient was not clinically fit. Also QVH has no record that any member of staff telephoned the patient at 7pm to tell her that she had been taken off the waiting list.* ***Unsupported.***

- **Corneo Admin-** The patient had appointments for nurse led and ophthalmic specialist appointments which until recently had been on the same day. The patient was informed that the appointments were now on 2 different days and told that it is too difficult to arrange these on the same day.
  Outcome- *Due to a shortage of visual field test appointments, we have seen longer waiting times for patients to be seen in our Corneo outpatients. We are currently in the process of recruiting a new optometrist who will increase the availability of visual fields to be performed on the same day as the clinic. We will make it clearer to patients who are sent separate appointments that they can contact the department to request a change. Once the optometrist is in post we should only need to send out separate appointments in exceptional cases.* ***Upheld in part.***

- **Nursing 1. -** Concerns were raised by an agency nurse who has been informed that she had acted unprofessionally and broken professional boundaries with patients and can no longer work at QVH
  Outcome- *A full explanation and review of the case was undertaken and the decision that was made was fully upheld by the DoN.* ***Unsupported***

- **Nursing 2. –** A lack of communication and generally a poor service was provided to 91 year old patient.
  Outcome *– It was unacceptable that the patient was allowed to be transferred at this time (member of staff who authorised the transfer was of the understanding that the latest that the ambulance would arrive was at 11:30pm. As a result no patients are to be transferred after 10pm.****Upheld***

- **Nursing 3. –** A patient felt that she was given no support from the Macmillan nurses or therapists.
  Outcome *– Apologies were given, however the patient was contacted on several occasions and visited at home. Although there was some contact made, no contact was made over a seasonal holiday. Expectations from the patient regarding the service appear to be unrealistic.*

- **Plastics-Nursing –** Joint complaint with Kent Social Services and the Queen Elizabeth the Queen Mother Hospital. Concerns were raised by the patients' niece regarding care provided by the Outreach nursing staff. The niece queried why the patient wasn't admitted to hospital upon review of his wounds.
  Outcome: *A reply was sent to the leading hospital informing them that appropriate care had been provided by the QVH outreach team.*

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 -	2013/14 total /	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Experience	Complaints per 1000 spells			3.4												
	Claims per 1000 spells			1.4												1
	FFT Score acute in-patients	—	>75	88												
	% score for likely and very likely to recommend QVH		>90%	99.0%												1
	FFT score MIU	—	>75	76												
	% score for likely and very likely to recommend QVH		>90%	99.0%												
	FFT score OPD	—	>75	82												
	% score for likely and very likely to recommend QVH		>90%	98%												1
	FFT score DSU	—	>75	-100			0	0	0	0	0					
	% score for likely and very likely to recommend QVH		>90%	0												
	FFT score Sleep disorder centre	—	>75	78												78
	% score for likely and very likely to recommend QVH		>90%	99%												99%
	FFT score Therapy	—		0	0	0	0	0	0	0	0	0	0	0%	0%	0%
	Mixed Sex accommodation breach	0	0	0												
	Patient experience - How would you rate the quality of care you received (4&5 score of good and above)	—	>90%	98%												
	Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	—	>90%	92%												#REF!

The Friends and Family Test score for April is 88 and the % score for extremely/likely is 99%. The response rate was 84.97% in March 2014 which compared with 5 other specialist trusts, places QVH with the highest response rate. This has been due to a concerted effort and drive to

encourage patients to complete the survey, and for the clinical areas to return their surveys by month end. However, the red score on the dashboard for DSU indicates that although the FFT surveys were given out to patients, data was not received back from the service by the month end. The team have been reminded of the importance of returning this data in a timely way.

Safeguarding

14. Safeguarding legislation and guidance is in place for children and vulnerable adults and the trust has a responsibility to identify where children or vulnerable adults are at risk of harm and act to protect them. All employees undergo safeguarding training to support them in recognising concerns and in being able to act and report instances.

15. Safeguarding for children activity during February saw involvement in 16 cases. Of these, 6 were referred to Children and Young People Services (CYPS) prior to transfer to QVH and out of 10 internal investigations, 2 were referred on to CYPS.

16. Six adult safeguarding alerts were referred to Social Services during April. Four were reported by the wards and one from outpatients and one from the therapies team. Four cases have been reported with multi-agency involvement and include police investigation. Reasons for reporting to social services included concerns around financial abuse, physical abuse and neglect.

Quality account priorities

1. Our quality account 2013/14 identifies the four main priorities we have set ourselves for 2014/15. Progress against these will be provided each month. These are;

Priority 1 Provision of clinical outcome measures

For 2014/15 we plan to publish outcome measures at consultant or team level as appropriate. They will be made up of both PROMs and clinical outcome measures as decided in consultation with clinicians and patient focus groups. Data collection for most is in progress now and will be validated and uploaded over the year, beginning with orthognathic PROMs in May 2014.

We will publish a total of six outcome measures during the year. They will appear on the trust website and will be updated in accordance with the frequency of data collection.

Progress will be managed by the board sub committee for clinical outcomes that includes both executive and non-executive directors. Quarterly updates will be provided to the Board Outcomes Group, the Quality and Risk Committee and the Board throughout the year.

Priority 2 Scheduling of elective surgery

For 2014/15, we plan to offer 80% of elective surgical patients with dates that allow at least three weeks' notice by the end of March 2015.

We would exclude cancer patients and patients requiring donor tissue from this target as these cases are planned to meet their individual needs. Delivery of this priority will enhance our patients' experience as they will have earlier notice/confirmation of their surgery date.

Our plan is to establish a baseline in Quarter 1 following the introduction of an upgrade to our patient administration system (PAS), with an aim that the percentage of patients booked with at least three weeks' notice increases in a phased manner during Quarters 2 and 3 in order to reach 80% by the end of 2014/15.

We will report on the percentage scheduled with three weeks' notice and we will report on the number of elective surgical cases cancelled and rebooked before admission for the convenience of QVH (i.e. non-clinical hospital cancellations rather than at the request of the patient or for clinical reasons).

Monitoring and reporting will occur monthly, be presented to the management team and included within Board papers.

Priority 3 Increase the number of elective patients receiving treatment on the day of their outpatient appointments for minor skin lesions ('see and do' clinics).

Our aim is to increase the number of elective patients seen and treated on the same day by at least 50%.

Information will be provided monthly on the number of patients with skin lesions that we are treating each month on the day of their appointment as well as the overall length of time from referral to treatment and number of visits per episode. This information will be provided to the management team and included within the trust Board papers.

Priority 4 Introduction of an electronic system to evidence that safe staffing levels are provided on wards

We aim to introduce an additional module to our electronic rostering system by the end of June 2014. Following implementation and training we anticipate that by September we will be able to provide real-time visibility of staffing levels across wards in relation to patient numbers and acuity. This will enable us to redeploy or enhance staffing in real-time and support the delivery of safe care to patients.

Progress on our achievements will be included within the safe staffing reports that will be being provided to the Board of Directors from May 2014.

For this month there is no required update for priority 1 and priority 2. For priority 3, reports are currently being formulated and the main impact is expected in Q2 with the introduction of the additional theatre capacity, the first information will be provided on conclusion of Q1. For priority 4, the Board has been provided with the Safe Staffing report as a separate Board item.

Commissioning for Quality and Innovation (CQUINs)

2. CQUINs for 2014/15 have been agreed with our commissioners. Below is the final summary information in regard to the achievement of quarter 4 CQUINs that has been provided to the CCG.

Reduce avoidable death, disability and chronic ill health from Venous-Thromboembolism (VTE)

During quarter 4, QVH has maintained a VTE assessment rate 100% for each month. Information is collected each month via the Safety Thermometer data tool and we have exceeded the 95% requirement for the quarter.
No Deep Vein Thrombosis or Pulmonary Embolisms have been reported during quarters three or four so no Root Cause Analysis has been required.
QVH view – Q4 CQUIN met

To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.

The Friends and Family test has been instigated since the beginning of 2013. Information has been submitted through the Unify system as required. The return rate for QVH has exceeded the required 15% each month (range 18-85%) and information is made public via our website. QVH scores remain in a consist range of 86-94.
QVH view – Q4 CQUIN met

Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting.

There are three key aspects to dementia diagnosis initial assessment – here we have scored an average of 96% for the quarter. Patients may then require further assessment and or referral in to their GP – for these two aspects we have scored an average of 100% for each during the quarter.
QVH view – Q4 CQUIN met

Improve collection of data in relation to pressure ulcers (if applicable), falls, urinary tract infection in those with a catheter, and VTE.

All Safety Thermometer data has been collected and reported as required. We are expected to maintain a harm free score in excess of 95%. An overall average of 100% has been achieved for quarter 4. To balance this information we now provide the 'no new harm' score from the Safety Thermometer and for quarter 4 this has achieved an average of 100%.
QVH view – Q4 CQUIN met

Intraoperative fluid optimisation

A plan was required with trajectories set for the year – this was provided by the April 30th date as mandated.
Plan - Confirm Q4 12/13 numbers of major head and neck procedures and number of LiDCO uses. Arrange head and neck team meeting to discuss haemodynamic monitoring and share baseline data. Agree common data set for 13/14 patients to include monitoring and outcome measures. Agree realistic target for IOFM use in current year, understanding variable case mix and numbers. Initial expectation is to increase LiDCO use in complex reconstruction head and neck patients to minimum of 50% of cases by end Q4.
Progress - We are auditing the use of flow directed haemodynamic monitoring in major head and neck reconstructive surgery. We have again reviewed our other major cases to identify others who might benefit from IOFM and still consider that no others fit the criteria.

Audit of major head and neck cases.
19 prolonged procedures in head and neck patients have been undertaken in Q4 (6 in January, 6 in February, and 7 in March). LiDCO monitoring was used in **8** of these cases – giving a proportion for the quarter having flow directed monitoring of **42%.** Although slightly down on the previous quarter, the small variance can be explained by one episode of LiDCO malfunction and a further missed case when the theatre LiDCO was temporarily misplaced during the new Operating Theatre block commissioning. With our small numbers one or two cases lost in this way affects the overall percentage use, which would otherwise have been over 50%. A number of the other cases were considered for IOFM but expected fluid shifts were small and central venous pressure monitoring not required so LiDCO use was declined.

Review, case management protocols, and outcome measures.
No further progress to report regarding further local teaching sessions. Dr Alison Chalmers presented our experience of the use of LiDCO for IOFM at the Head and Neck Anaesthetists group meeting in London in early April.
QVH view – Q4 CQUIN met

Digital by default
A plan was required with trajectories set for the year – this was provided by the April 30th date as mandated.
Digital dictation – Q4 plan - Plan implementation of review outcomes
Progress – Digital Dictation: the Paediatric consultants from Brighton are now using G2 in clinic. The Anaesthetic department who currently use G2 only for Consultants who work in the Pre-Assessment clinic, will be rolling it out to all clinicians over the next few months. The % of end user letters which are transcribed from digital dictation is currently 87%. Review has meant we are in the process of recruiting a System Administrator to manage G2, Synertec outsourced mailing and Enlighten self check-in. A key role of this post is to develop the functionality of all three systems with existing users and to facilitate the implementation of these systems into new areas.
QVH view – Q4 CQUIN met

Self check and patient calling system & Jayex Self Check In Kiosks and Patient calling Media Screens – Q4 plan - on going and potential commencement of patient satisfaction data

Progress - Pilot for further roll out of feedback about to commence – to extend into areas not currently using Enlighten. We are in the process of recruiting a System Administrator to manage G2, Synertec outsourced mailing and Enlighten self check-in. A key role of this post is to develop the functionality of all three systems with existing users and to facilitate the implementation of these systems into new areas.
Progress with satisfaction surveys has resulted in a paper that proposes the use of mobile devices as currently the standing kiosks are in use for check-in.
QVH view – Q4 CQUIN met

Appointment reminders – Q4 plan – report on % of clinics suitable for texting against number where texting has commenced

Progress – 100% of clinics suitable for using texting have now commenced using; this has remained constant from Q2.

QVH view – Q4 CQUIN met

Preoperative screening – Q3 plan Q3 4 Roll out of procurement
Progress – Installation of the test environment was completed in February 2014. An evaluation team is working with the supplier to customise the system; it is anticipated that the first pilot will commence by July 2014.
QVH view – Q4 CQUIN met

Assistive Technologies
A plan was required with trajectories set for the year – this was provided by the April 30th date as mandated.
Conversion of trusts on old telemedicine in KSS systems to TRIPS – Q2 plan – Q4 All KSS referrals should now be made via TRIPS.
Progress - All Trust have been using TRIPS since 31/08/13 No referrals via old website since that date. Website now disabled and a confirmation that no referrals have been made via this site since 30th August 2013.
Work with 3 burns hubs to rollout TRIPS outside of Kent Surrey Sussex (KSS) – plan - Q3 and Q4 All KSS referrals should now be made via TRIPS.
Progress - TRIPS Coordinators now employed referral progress can be seen below. Referrals continue increasing through new organisations.
Old website has now been disabled.

Excluding Test Referrals	**2014**												
Hub Name	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Yearly Total**
Broomfield	91	64	117										272
Chelsea and Westminster	29	36	45										110

QVH	720	651	802										2173
St Georges Tooting	53	45	89										187
Stoke Mandeville	32	39	50										121
Monthly Total	**925**	**835**	**1103**										2863

QVH view – Q4 CQUIN met

Shared Decision Making is a process in which patients, when they reach a decision crossroads in their health care, can review the treatment options available to them

A plan was required with trajectories set for the year – this was provided by the April 30th date as mandated.
Q4 Plan – to continue submitting requested information (SURE questionnaires).
Progress - Data collecting and submission have been agreed as; to use the Shared Decision Making tool with all of our osteoarthritis knee patients, this is only about 8-10 patients a month. The only stipulation is that we ask patients to complete a 'SURE' Tool (4 yes/no questions) and pass the completed forms to the CCG. This is occurring, no measurable response to the questionnaire or that we supply details of patients has been stipulated. Q3 has seen submission of data as requested.
QVH view – Q4 CQUIN met

Dementia Carers

Plan – Original plan now complete
Progress – Additional actions are now added routinely to plan and a group formed for monitoring and managing mental capacity / dementia and learning disability patient's experience. This is led by our physician and the group includes our dementia lead, learning disability nurse, physiological therapy lead, and other key staff who are involved with affected patients. This group has continued to meet and address areas of action during Q4.
QVH view – Q4 CQUIN met

Compliance in Practice – roll out of assessments

Plan amended to continue auditing as full roll out achieved in Q2.
Progress – compliance in practice audits were completed in all roll out areas during Q4 and the tool is being revised to reflect new CQC methodology.
QVH view – Q4 CQUIN met

Collaboratives

There is an expectation that trust staff will attend collaborative meetings linked to the above high impact interventions – to date we have attended events we have been aware of, these are minimal.
QVH view – Q4 CQUIN met

Intellectual Property Policy
Completed Q2 no further action required

3. Progress for 14/15 is displayed below.

Source	**Description** (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	**2013/14 total / average**	**Target**	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
CQUIN	VTE prophylaxis		>95%	100%												100%
	VTE in hospital/RCA undertaken	—	0/100	0												
	FFT Score acute in-patients	—	>80	88												88
	Number of responses		30%	25% target												
	FFT score MIU		>80	76												
	Number of responses		20%	15% target												#DIV/0!
	FFT Annual Staff Survey	—	>4	Annual Score												#DIV/0!
	Dementia >75 trauma asked indicative question		90%	80%												80%
	Dementia >75 having diagnostic assessment		90%	100%												
	Dementia > 75 referred for further diagnostic advice		90%	100%												
	Dementia training for non-clinical staff	—	65%	81%												
	Dementia clinical leads identified	—	NA													
	Dementia carers	—	NA													
	Safety thermometer data submission	—	Y/N	Y												
	Harm free care rate	—	>95%	100%												
	No new harm rate (aquired at QVH)		>95%	100%												
	Reducing cancelled operations	—	TBC	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	WHO Checklist compliance - Qualitative	—	90% by end Q2 & >95% by end Q4	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	WHO Checklist compliance - Quantative	—	>95%	96%												
	Assessment against Bronze food chartermark	—		Quarterly report submission			Quarterly report submission			Quarterly report submission			Quarterly report submission			#DIV/0!
	Manchester Patient Safety Framework (MaPSaF) compliance	—		Quarterly report submission			Quarterly report submission			Quarterly report submission			Quarterly report submission			

The Friends and Family Test score for MIU falls just below the target of 80%. The qualitative comments received around areas for improvement were largely around waiting times, and this may have impacted on why 3 respondents to the survey stated they would be unlikely to recommend QVH MIU to friends and family.

The numbers of patients in respect of Dementia screening are very small which easily makes our data appear less favourable. The screening of patients for Dementia continues to be promoted in all clinical areas.

Policy Updates

Policies uploaded in April include:

- Hospital Evacuation Plan – Section 13 of the Emergency Plan (Corporate) (Q&RC)
- Unlicensed and off-label medicines (Medicines Management) MMC

Amanda Parker/Ali Strowman May 2014

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22 May 2014**
Agenda item reference no:	**115-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 May 2014**

PATIENT EXPERIENCE REPORTS

1. Attached is the quarter 4 patient experience report along with the 2013-14 annual patient experience report.

2. The annual patient experience report is provided for information and is required to support information in the quality account 2013/14 and the Department of Health KO41 data reporting on complaints.

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

Queen Victoria Hospital
NHS Foundation Trust

Patient Experience quarterly report

Quarter 4 (January to March 2014)

Nicolle Tadman, Patient Experience Manager
Queen Victoria Hospital

Overview

This report provides an overview of activity between January – March 2014 detailing action taken to improve the patients experience and results of the methods currently in place to obtain patient feedback about their care and our services.

We receive feedback from service users, cares their relatives about Trust services. Complaints, concerns, comments and compliments form a key part of the Trust's mechanisms for seeking continuous improvement in services. We support the Trust in capturing service user and carer experiences and report any learning from this to drive forward service improvements.

Friends and Family

At monthly intervals, the results of the NHS Friends and Family Test for all acute hospital inpatient, accident and emergency and maternity departments are being published by NHS England. The results can also be seen on the NHS Choices website.

Since the test was introduced in April 2013, we scored the highest for inpatient satisfaction of all NHS trusts in the south east. There are 150+ NHS trusts in England and 12+ specialist hospitals. Of these, QVH scored amongst the top ten results for each of the three months since the friends and family test began (a target response rate of 15% (or more) is expected).

How likely are you to recommend our ward to family and friends?

The response to the Friends and Family Test (FFT) question for In-Patients who are 'extremely likely' to recommend us to a friend or family during that period from Margaret Duncombe, Ross Tilley, Burns, Peanut were:

March: +86 based on 373 responses - **a 85% response rate** (99% extremely likely/likely)

February: +93 based on 336 responses - a 37.2% response rate (98% extremely likely/likely)

January: +87 based on 72 responses - a 27.1% response rate (99% extremely likely/likely)

Below is a chart to show how we compare with our FFT score with other specialist hospitals in the country. The figures highlighted in green show the highest scoring and those in red the lowest. At the time of compiling this report the March for the national FFT score had not been published.

Name of Trust	FFT Score Feb 14	FFT Score Jan 14
Christie Hospital NHS Foundation Trust	83	83
Harefield Hospital	86	89
Liverpool Women's NHS Foundation Trust	78	82
Manchester Royal Eye Hospital	69	69
Moorfields Eye Hospital	84	89
National Hospital for Neurology and Neurosurgery	73	74
Nuffield Orthopaedic Centre	86	90
Papworth Hospital NHS Foundation Trust	79	83
Queen Victoria Hospital NHS Foundation Trust	93	86

Royal National Throat, Nose and Ear Hospital	73	67
The Royal Marsden NHS Foundation Trust	91	91
The Royal National Orthopaedic Hospital NHS Trust	78	80

How would you rate the information you were given about your care and treatment?

On average 95.5% of patients rated the information given to them was excellent/good.

Did you feel as involved as you wanted to be in decisions about your care and treatment?

76.5% (average for Qrt) of patients felt that they were involved the decisions regarding their care and treatment. **23%** rated that 'yes, to some extent'.

Overall how would you rate the quality of care you were given?

99% (average for Qrt) scored that the quality of care that they were given was excellent/good.

How would you rate the quality of the food you received?

During this period **82.5%** of patients rated the food as very good/good which is a marked increase from Qrt 3 (58**%)**. However there have been some negative comments and one patient commented:

'*Food is a real let down, you are asked 5-10mins before food is served, it would be nice to have menus for the day'.*

These comments have been fed back to the Matron on Canadian Wing and Hotel Services. Food is monitored each week at ward level and if concerns are directly raised with the staff about food then the Hotel Services Manager is happy to meet with the patient to discuss their concerns further. We are at present changing our menus to take into account food that does not meet the requirement of the patients, following on from our audits. In addition we are looking to place details of the weekly menus within the new patient bedside guide.

We also ask the FFT question from patients who attend the Minor Injuries Unit (on average **+86** based on **615** responses, **98%** were 'extremely likely/likely' to recommend us), and Outpatients Department (on average **+81** based on **762** responses , **98%** were 'extremely likely/likely' to recommend us). This has now been commenced in Day Surgery and will be able to report fully next qtr.

Outpatients and MIU: summary of areas of improvement:

- Professionalism of reception staff
- Communication re: waiting times

Complaints

Open complaints

There were 12 formal complaints received in Qrt 4 which is decrease from the previous Qrt (20).

Complaints during the quarter included the following themes and issues in the chart below.

Complaints by Subject (primary) and Service					
	MEDICAL	NURSING	THEATRE	A&C	Total
Appointment cancelled/changed	0	0	0	2	2
Communication with patients	0	1	2	1	4
Communication failure with other healthcare providers	1	0	0	0	1
Inappropriate comment	0	1	0	0	1
Overall medical care provided	1	0	0	0	1
Overall level of nursing care provided	0	1	0	0	1
Rudeness	2	0	0	0	2
Totals:	**4**	**3**	**2**	**3**	**12**

Looking at trends, the largest category of complaints overall is in relation to communication with patients (4).

The following is summary of the following subjects:

Summary - Patient placed on waiting list but due to high blood pressure required a cardiology review. Patient then received a phone call at 7pm one evening informing her that as had had her surgery she was now discharged. Patient has not had surgery and would like to know why this phone call was made.

Outcome - Patient's surgery was deferred as patient not clinically fit. Also we have no record that any member of staff telephoned the patient at 7pm to advise that they had been taken off the waiting list. In addition we do not have administration staff who work outside of office hours.

Summary – Patient scheduled for first on theatre list but failure to inform on day of surgery that list had been changed.

Outcome – Apologies given for lack of communication. Staff were working from an old theatre list and have been reminded the importance of ensuring that the current list is used and that they effectively communicate with patients at all times.

Summary - Lack of communication and general service provided to 91 year old patient.

Outcome - Apologies given however the course of events differs from that of the third hand information given to complainant by relative who accompanied patient. Considered that patient was made as comfortable as possible and delays were communicated. Issues about care were not raised at the time and if had been could have been acted upon.

Summary - Concerns raised by agency nurse who was informed that for specific reasons should could no longer work at Queen Victoria Hospital. Agency nurse

Summary – Lack of communication by cancer specialist nurse.

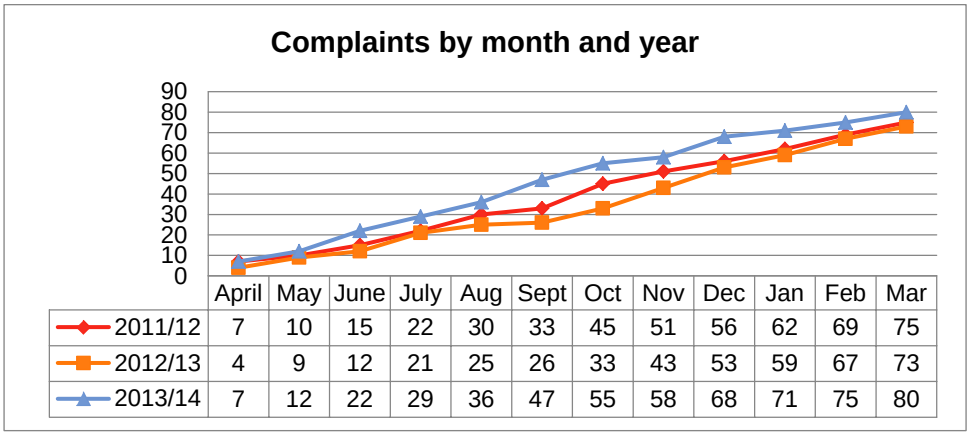
Outcome – Apologies given however patient was contacted on several occasions and visited at home. Although there was some none contact over a seasonal holiday. Expectations appear to unrealistic.

The table below indicates the number of complaints received this Qrt by directorate and division:

Directorate	
Corneo Plastics	3
Head and Neck	1
Plastics	6
Theatres	2
Total:	**12**

Division	
Theatres and Anaesthetics	2
Inpatient Services	2
Outpatients & Community Services	8
Total:	**12**

The following accumulative chart shows how complaints activity to date compares with activity during the two previous financial years.



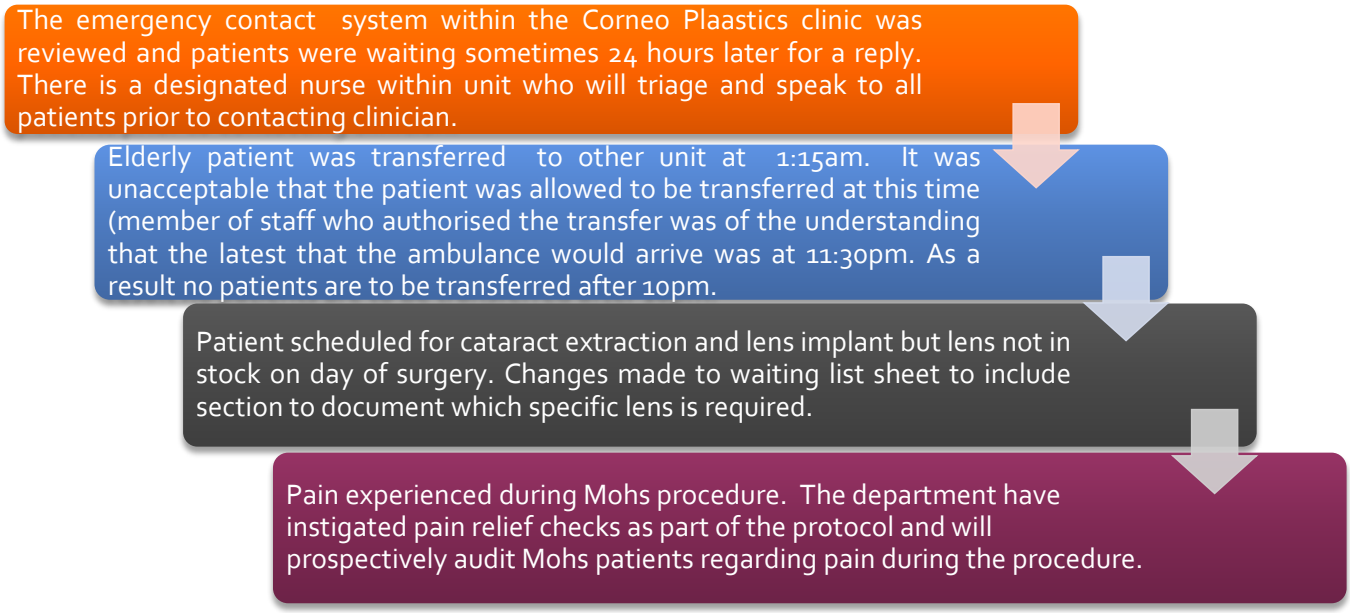
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	7	10	15	22	30	33	45	51	56	62	69	75
2012/13	4	9	12	21	25	26	33	43	53	59	67	73
2013/14	7	12	22	29	36	47	55	58	68	71	75	80

Closed complaints

A total of 13 complaints were closed during this quarter. The Trust triages all complaints in line with the Department of Health guidance to ensure that proportionate investigations take place. As part of the investigation the investigating managers are required to make a decision, after consideration of the evidence, whether or not a complaint should be upheld (supported), partially upheld (supported in part), or not upheld (unsupported).

Of these, 5 were upheld, 5 were partially upheld and 3 were unsupported. If a complaint has several issues raised, it is recorded as partially upheld if one element is upheld even if most elements are found not to be justified.

The complaints resolution process includes identifying and implementing appropriate actions. In response to complaints this quarter, actions have included:



Under the current complaints legislation, Trusts have twelve months in which to endeavour to resolve a complaint to the complainant's satisfaction. If the complainant remains dissatisfied with the response they receive, they can ask the Ombudsman to independently review their complaint.

During this quarter we are pleased to report that no complaints were referred to the Parliamentary & Health Service Ombudsman.

Patient Advice and Liaison Service (PALS)

PALS is a service which offers support, information and help to patients, their families, carers and friends. PALS received 12 enquiries during Qrt 4. 10 enquiries were initial complaints, none of which were referred to the formal complaints procedure at the time of contact.

Legal

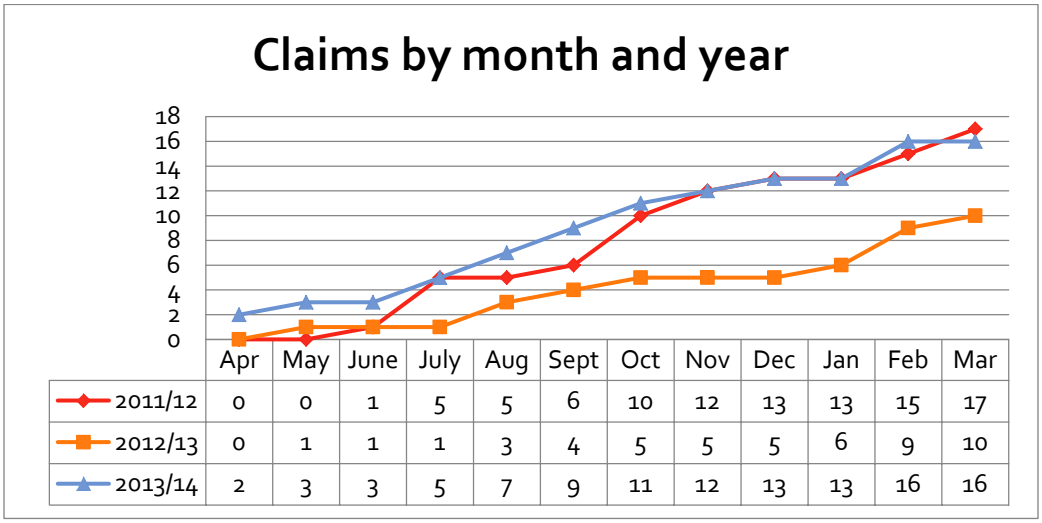
- In Qrt 4, 3 new claims were received, which are summarised below.

1. Intra-operative problems during hand surgery.
2. Failure to prescribe antibiotics following tooth extraction.
3. Failure to perform test for melanoma due to sample not being placed in testing pot.

Overall there are 38 open cases.

No claims were closed during this period.

The following accumulative chart shows how claims activity to date compares with activity during the two previous financial years.



	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	0	0	1	5	5	6	10	12	13	13	15	17
2012/13	0	1	1	1	3	4	5	5	5	6	9	10
2013/14	2	3	3	5	7	9	11	12	13	13	16	16

Queen Victoria Hospital
NHS Foundation Trust

Patient Experience Annual Report

1 April 2013 – 31 March 2014

Nicolle Tadman, Patient Experience Manager
Queen Victoria Hospital

Overview

This report includes an overview of activity for the financial year between 1 April 2013 – 31 March 2014 detailing results of the methods currently in place to obtain patient feedback from our services.

We are committed to improving patient experience and in using complaints and other forms of feedback to better understnad the areas where we perform well and those areas where we need to do better.

We receive feedback from service users, their relatives and carers about Trust services. Complaints, concerns, comments and compliments form a key part of the Trust's mechanisms for seeking continuous improvement in services. We support the Trust in capturing service user and carer experiences and report any learning from this to drive forward service improvements.

This report demonstrates that the trust actively seeks, listens to and acts on feedback from patients and carers. As an organsition the Trust recognises that by improving the patient and carer experience it increases public confidence in the services that we provide.

This report is shared with the Trust Board, Quality and Risk Committee, Patient Experience Group, our stakeholders including Clinical Commissioning Group, Healthwatch and Care Quality Commision.

Friends and Family

At monthly intervals, the results of the NHS Friends and Family Test for all acute hospital inpatient, accident and emergency and maternity departments are being published by NHS England. The results can also be seen on the NHS Choices website.

Since the test was introduced in April 2013, we scored the highest for inpatient satisfaction of all NHS trusts in the south east. There are 150+ NHS trusts in England and 12+ specialist hospitals. Of these, QVH scored amongst the top ten results for each of the three months since the friends and family test began (a target response rate of 15% (or more) is expected).

How likely are you to recommend our ward to family and friends?

The response to the Friends and Family Test (FFT) question for In-Patients who are 'extremely likely' to recommend us to a friend or family during that period from Margaret Duncombe, Ross Tilley, Burns, Peanut were:

March 2014: +86 based on 373 responses - a 85% response rate (99% extremely likely/likely)

February 2014: +93 based on 336 responses - a 37.2% response rate (98% extremely likely/likely)

January 2014: +87 based on 72 responses - a 27.1% response rate (99% extremely likely/likely)

December 2013: +88 based on 159 responses - a 66.6% response rate (97% extremely likely/likely)

November 2013: +81 based on 139 responses - a 36.7% response rate (97% extremely likely/likely)

October 2013: +84 based on 120 responses - a 31.1% response rate (97% extremely likely/likely)

September 2013: +88 based on 159 responses - a 44.9% response rate (98% extremely likely/likely)

August 2013: +81 based on 139 responses - a 38.9% response rate (98% extremely likely/likely)

July 2013: +83 based on 130 responses - a 30.1% response rate (98% extremely likely/likely)

June 2013: +86 based on 186 responses a 76.2% response rate (98% extremely likely/likely)

May 2013: +86 based on 208 responses – a 35.3% response rate (98% extremely likely/likely)

April 2013: +89 based on 165 responses – a 44% response rate (99% extremely likely/likely)

Below is a chart to show how we compare with our FFT score with other specialist hospitals in the country between January 2014 – March 2014.

Name of Trust	FFT Score Mar 14	FFT Score Feb 14	FFT Score Jan 14
Christie Hospital NHS Foundation Trust	85	83	83
Harefield Hospital	83	86	89
Liverpool Women's NHS Foundation Trust	89	78	82
Manchester Royal Eye Hospital	77	69	69
Moorfields Eye Hospital	93	84	89
National Hospital for Neurology and Neurosurgery	76	73	74
Nuffield Orthopaedic Centre	84	86	90
Papworth Hospital NHS Foundation Trust	78	79	83
Queen Victoria Hospital NHS Foundation Trust	87	93	86
Royal National Throat, Nose and Ear Hospital	87	73	67
The Royal Marsden NHS Foundation Trust	94	91	91
The Royal National Orthopaedic Hospital NHS Trust	64	78	80

How would you rate the information you were given about your care and treatment?

On average 95.5% of patients rated the information given to them was excellent/good.

Did you feel as involved as you wanted to be in decisions about your care and treatment?

76.5% (average for Qrt) of patients felt that they were involved the decisions regarding their care and treatment. **23%** rated that 'yes, to some extent'.

Overall how would you rate the quality of care you were given?

99% (average for Qrt) scored that the quality of care that they were given was excellent/good.

How would you rate the quality of the food you received?

During this period **82.5%** of patients rated the food as very good/good which is a marked increase from Qrt 3 (58**%)**. However there have been some negative comments and one patient commented:

'Food is a real let down, you are asked 5-10mins before food is served, it would be nice to have menus for the day'.

These comments have been fed back to the Matron on Canadian Wing and Hotel Services. Food is monitored each week at ward level and if concerns are directly raised with the staff about food then the Hotel Services Manager is happy to meet with the patient to discuss their concerns further. We are at present changing our menus to take into account food that does not meet the requirement of the patients, following on from our audits. In addition we are looking to place details of the weekly menus within the new patient bedside guide.

We also ask the FFT question from patients who attend the Minor Injuries Unit (on average **+86** based on **615** responses, **98%** were 'extremely likely/likely' to recommend us), and Outpatients Department (on average **+81** based on **762** responses, **98%** were 'extremely likely/likely' to recommend us).

Outpatients and MIU: summary of areas of improvement:

- Professionalism of reception staff.
- Communicating with patients the waiting times and whether there are delays in the running of the clinics.

National Inpatient Survey 2013 – Care Quality Commission

Findings from the 2013 national NHS inpatient survey for QVH have been published by the Care Quality Commission (CQC). The survey asked the views of adults who had stayed overnight at QVH as inpatient between June adn August 2013. The questionnaire was sent to 850 patients and the response rate was 48%.

The survey covers all aspects of patients' care and treatment and the findings enable trusts to see how they are doing and how they compare with other trusts.

For the second year in a row we achieved the highest scores of any trust in England for a section of the questions on the quality of nursing care and the support on leaving hospital.

Compared with the other 156 acute and specialist trusts in England, QVH scored better than average on 45 of the 68 questions and about the same as average on the remaining 23. We have also achieved the top scores in the country for (scores out of 10 - the higher the score the better):

The trust did better than mosts trusts in England on the questions relating to single sex accomdation with a score of 9.9, being felt including in conversaitons with the nursing staff and not made to feel as not being there (9.7). High scores were also achieved for the amount of information given to inpatients about their condition and treatment.

Other areas where we were rated as performing better than most trusts including being emotionally supported (8.9), being given enough notice about when being discharged (8.4) and being explained the purposed of medicines that a patient was given to take home (9.4).

Since last year we have improved on our score significantly for the question on whether patients were asked to give their views on the quality of their care. We also improved our score for the question on whether patients were offered a choice of food. This was the only score for which we recieved a worse than average score last year. Hotel Services have already done well to improve on this and have plans to improve the quality and range of food available even further.

There were statistically significant declines in the scores for six questions. However it should be noted that our scores for four og these questions were the best in the country last year, and that all but one of them our scores remain better than average.

- In your opinion, were there enough nurses on duty to care for you in hospital? (8.8 down from 9.3 - top score in the country last year)
- Did a member of staff say one thing and another say something different? (8.8 down from 9.4 - top score in the country last year)
- Were you given enough privacy when being examined or treated? (9.5 down from 9.8 - top score in the country last year - this year's score only 'about the same as average')
- Discharge delayed due to the wait for medicines/to see doctor/for ambulance (7.7 down from 8.6)
- How long was the delay [for discharge]? (8.7 down from 9.2)
- Were you given clear written or printed information about your medicines? (9.0 down from 9.6 - top score in the country last year)

Areas for improvement

We are already looking into how to create a dsicharge lounge away from the ward where patients can wait and their discharged be managed, which should address some of these issues and the Patient Experience Group will be looking at the fidnings in more detail.

Patient Experience Group (PEG)

This group meets bi-monthly and is chaired by the Director of Nursing and Quality. The PEG meeting forms and integral part of the Trust's learning from our patients on their experience of being treated and cared for at the Trust from a wider range of sources including complaints, PALS enquires adn inviting participation from patients in national and local surveys.

The ifnroamtion is vital in helping the group focus on action plans to monitor improvements. Representatives from all areas and levels of the Trust, including Governors, and a representative from Healthwatch come ogether and share information, learning, actions and best practice.

The following are just some of the actions that have come out of PEG in the past year:

- bedside lockers are now in place on the wards
- the patient bedside folders have been updated and in place
- hand rails have been installed within bathrooms on Canadian Wing
- re-launched a Trust induction programme for all new employees to the Trust. This is a 2 day

programme which is made up Care processes and mandatory training.
- Signage under review to ensure corporate image. Signage in place at new 'drop off' area to show 'reached destination'.
- waiting time before appointments - this has impoved greatly, but aspects of communication can be improved upon.
- Work undertaken in hand clinics. Approval was given for therapy led hand therapy clinics and specialist nurse therapists are now able to order x-rays and discharge patients.
- Corneo have brought in nurse led Botox clinics, with a named nurse in charge of clinics.
- The hospital needs to ascertain what patients want to know about consultants in a form of a survey adn this is a piece of work that the group are currnelty undertaking.

Complaints

Complaints received

This part of the report focuses on those complaints received by the Trust which were handled in accordance with the NHS complaints regulations.

We have reviewed and updated the Complaints procedure in accordance with the recommendations that have come out of the Francis Report and the Secretary State for Health report which was published in October 2013. The key recommendations to come out of this most recent report are as follows and some of which the Trust already have in place:

- Board level responsibility - Chief Executives need to take responsibility for signing off complaints. The Trust Board should also scrutinise all complaints and evaluate which action has been taken. A board member with responsibility for whistleblowing should also be accessible to staff on a regular basis. *Recommendation already in place.*

- Transparency - Trusts must publish an annual report in plain English which should state complaints made and changes that have taken place. *Recommendation already in place.*

- Trust complaints scrutiny - patients and communities should be involved in designing and monitoring the complaints system in hospitals. *Recommendation under review.*

- Easier ways to communicate - Trusts should provide patients with a way of feeding back comments and concerns about their care on a ward, including by making sure patients know who they can speak to, to raise a concern. *Recommendation in place and new feedback poster campaign launched in March 2014*.

- Patient services - the Patient Advice and Liaison Service should be rebranded and reviewed so its offer to patients is clearer. *Recommendation in place and Patient Advice and Liaison Service rebranded at QVH to Patient Services in 2012.*

In October 2013 QVH and other neighbouring Trusts were asked by Healthwatch (West Sussex) to provide them with a copy of our Complaints Procedure and complaint leaflets. Their report (Can't complain - An evaluation of information and procedures for handling complaints and gathering feedback) was published in January 2014. The aim of the report looked at: whether clear and accurate information about complaints were easily available; whether complaints procedures were clear and detailed enough to ensure complaints are handled well. The main findings relating to QVH are as follows:

- Criticism was made about the lack of information that QVH place on the website about complaints:
- *Healthwatch* felt that having a single point of contact which is intended to provide a joined up service (PALS and complaints under the heading of Patient Experience) was positive but again the trust should have more information on our website to demonstrate this.

The trust took these matters on board and have added to the website further information about how to feedback and make a complaint. In addition we have created a new 'Feedback' poster and leaflet (launched in March 2014 and located in all clinical areas and wards) which incorporates the various ways that service users can leave feedback also:

i. How to complain to the hospital when things go wrong;

ii. Who to turn to for independent local support, and how to contact them;

iii. How to complain to the Parliamentary Health Service Ombudsman if a patient remains dissatisfied, and how to contact her;

iv. How to contact your local Healthwatch

During 2013/14 we received 80 formal complaints which is an increase from 12/13 (73).

Under the NHS complaints regulations, the Trust is required to acknowledge receipt of complaints within 3 working days. Of the 80 complaints we investigated 63 complied with this requirement. The remaining 17 complaints were acknowledged as soon as possible, however, due to other complexities such as clarifying the address or gaining the necessary patient consent.

In accordance with the Department of Health guidance the Trust has internal review processes to ensure that proportionate investigations take place. As part of the investigation, the investigating managers are required to decide, after consideration of the evidence, whether the complaint should be upheld or unsupported. During this period 51 complaints were upheld, 29 were unsupported.

- Complaints received during 2013/14 included the following themes and service areas.

Complaints received 2013/14 by subject of complaint	Total number of complaints received	Total number of complaints upheld
Admissions, discharge and transfer arrangements	4	2
Appointments delay/cancellation (outpatient)	7	3
Appointments delay/cancellation (inpatient)	1	1

Attitude of staff	18	15
All aspects of clinical treatment	33	19
C**ommunication/information to patients (written and oral)**	13	7
Consent to treatment	2	2
Patients privacy and dignity	1	1
Personal records	1	1
Totals:	**80**	**51**

Looking at trends, there were a large number of complaints in relation to communication with patients and attitude the majority of which were held. The percentage of complaints relating to staff attitude has slightly increased overall.

There have been a disappointing number of complaints stating that patients do not feel they have been listened to and there has been inadequate communication; this applies to patients, carers and relatives who also feel that any changes to care plans etc. are not communicated to either them or the appropriate agencies.

As a means of addressing this issue, we have introduced to the staff induction programme specific training on Care and Compassion together with a session of Customer Care. We also now provide Customer Care training to both clinical and non-clinical front line staff on how to effectively communicate and deal with service users both face to face and over the telephone.

We have summarised in more detail some specific issues of concern.

Attitude

- **Summary:** patient was upset by comments made by junior clinician in relation to the patients breast implants.
- **Outcome:** Following the investigation it was found that the information given by the junior clinician was considered incorrect by the consultant as the junior was not fully aware of the patients history and this matter was discussed fully with the junior. A further appointment was offered to the patient to be seen by the consultant which was accepted.

- **Summary:** patient felt attitude of a member of the Site Practitioner team was uncaring and rude towards them. Patient was waiting for transport and asked the member of staff to provide them with some food whilst they waited.

- **Outcome:** Patient was correctly advised that as an outpatient we would not be responsible for providing patients with food, however a sandwich and some fruit was given to the patient. Apologies given if staff member came across as being ride and staff member accepted that they could have handled this situation differently, which was relayed to the patient.

Communication

- Summary: Carer of child with learning disabilities felt that they were discriminated against whilst

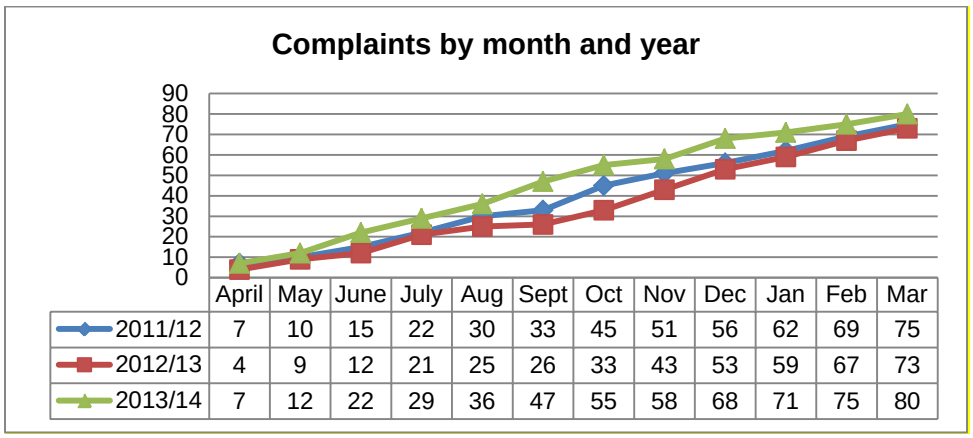
awaiting treatment in our Minor Injuries Unit and were not offered any pain relief whereas another child was.

- **Outcome:** Upon investigation no mention was made to the nurse caring for the child that they were in pain. Other child was given pain relief as this had been asked for. Recommendation was made that additional training in dealing with patients with learning disabilities was provided to all the staff in the unit. It was also recommended that all nurses on the unit were made aware of this complaint in order to highlight the impact that this had on the carer and to reiterate the importance of being understanding and aware of patient's specific needs.

The following chart shows the number of complaints received in 2013/14 by Directorate.

Directorate	
Burns	1
Corneo Plastics	10
Head and Neck	20
Paediatrics	2
Plastics	27
Theatres	4
Total:	**80**

The following accumulative chart shows how complaints activity to date compares with activity during the two previous financial years.



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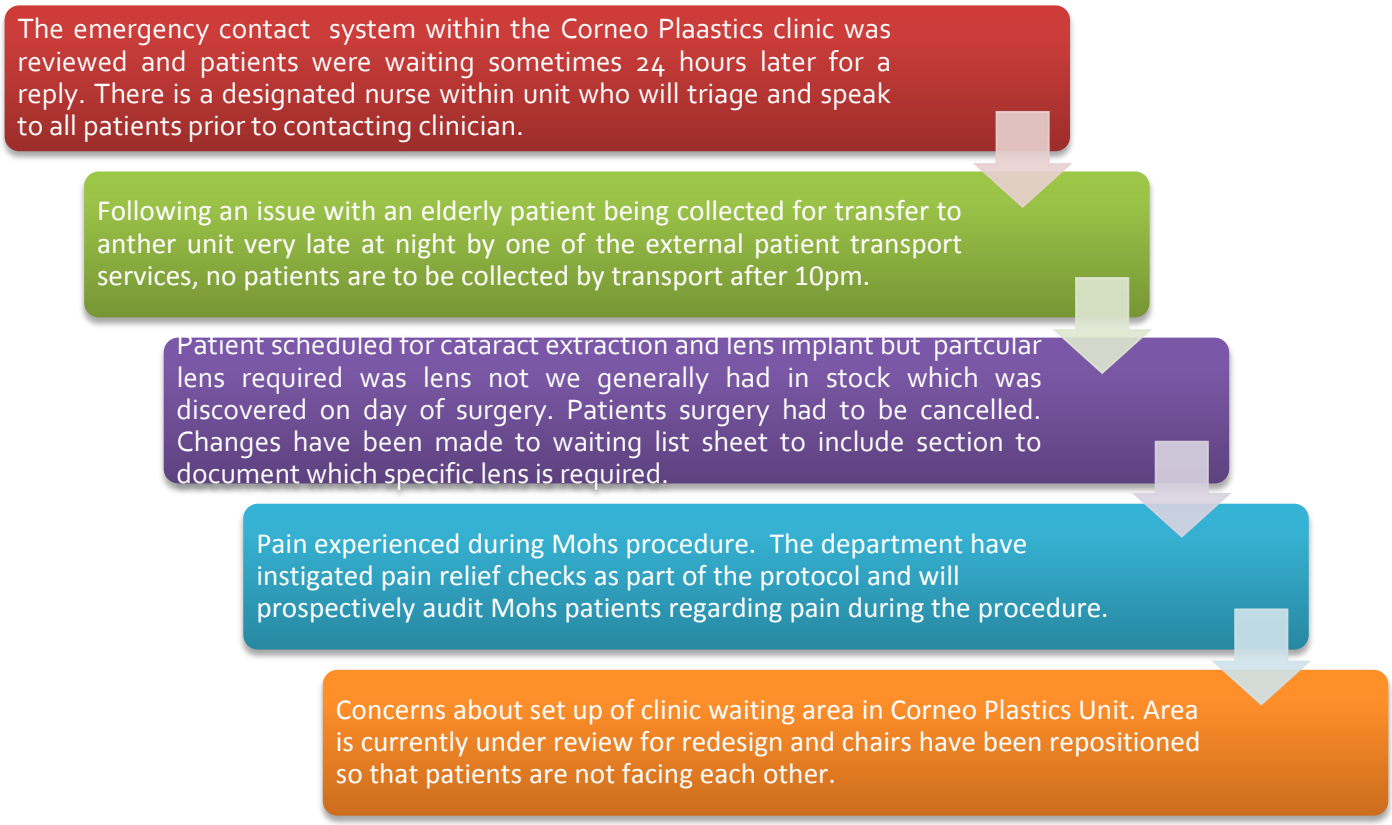
Under the current complaints legislation, Trusts have twelve months in which to endeavor to resolve a complaint to the complainant's satisfaction. If the complainant remains dissatisfied with the response they receive, they can ask the Parliamentary and Health Service Ombudsman to independently review their complaint. During 2013/14 we are pleased to report that no complaints were referred to the Ombudsman.

Closed complaints

In 13/14, 80 formal complaints were closed. Of those, we identified the following improvement opportunities as a result of the investigations:

The complaints resolution process includes identifying and implementing appropriate actions. In response to complaints this year, actions have included:



Patient Advice and Liaison Service (PALS)

PALS is a service which offers support, information and help to patients, their families, carers and friends. During 2013/14 a total of 79 PALS enquiries were received. 40 of these enquiries were initial complaints, however these were dealt with without i being necessary to refer them to the formal complaints procedure at the time of contact.

Compliments

There were 94 formal letters / e-mails / online comments (submitted to the NHS Choices national website) of appreciation were forwarded to the Patient Experience Manager in 2013/14 for collation and

sharing. When acknowledging letters and cards we now ask patients to post feedback onto NHS Choices and also if they would like further information on how to support the Trust.

Examples include:

'I want to commend the staff on Peanut ward for their care of us. I really want this to be recognised as I recognise how busy and stressed medical staff often are, but this treatment was exceptional and really helped us cope with a very traumatic weekend.'

(Patient regarding Peanut ward)

'I wish to thank you all for the wonderful care given to me while a patient, you must be the best hospital in the country. As a sister in 1962 standards were very high but yours were even better than our.'

(Patient regarding Margaret Duncombe ward)

'Thank you for your help & support during my stay in hospital. I appreciated it very much. You are all great nurses.'

(Patient regarding Ross Tilley ward)

'Thank you very much to all the staff that helped me though a terrible time.'

(Patient regarding Burns Unit)

'After treatment in Minor Injuries, the Fracture Clinic and Physiotherapy I have nothing but praise for the kind and professional way in which I was treated throughout. Thank you to all concerned.'

(Patient regarding overall QVH services)

Future developments 2014/15

In order to improve the services provided to patients further, additional developments will be implemented.

- We will continue to work alongside Trust teams to improve the patient and carers experience. As such we believe further developments during 2014/15 will promote this.
- Further improving complaints management process and complaint resolution skills to help improve the quality and timeliness of complaint responses.

- The Patient Experience Manager will continue to work with each of the directorates and teams to ensure a fully collaborative approach is provided regarding improving the patient and carers experience.

- Progress on improving the service will continue to be reported in the quarterly reports that are presented to the Patient Experience Group alongside each service's actions plans for the Commissioning for Quality Innovation (CQUIN) targets.

Nicolle Tadman, Patient Experience Manager April 2014.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22 May 2014**
Agenda item reference no:	**116-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 May 2014**

SAFE STAFFING REPORT: MAY (MONTHLY UPDATE)

1. This provison of information to trust boards on staffing levels by ward and shift is now required following the publication of 'Hard Truths'.

2. The attached report provides information on staffing levels and on metrics which enable the board to judge the effectiveness of care enabling them to formulate a view on; how safe care is, how the patients viewed their care and how well a ward is.

3. This is the first report and as yet not all information is available and the report should be seen as developmental.

4. Areas of note are:
    - Explanations are made against any metrics that are not rated green

5. The Board is asked to **NOTE** the contents of the reports.

Safe Staffing Report

1. The information provided in the following pages includes ward information on safety, activity and staffing. This includes the requirement to provide the board with ward information on daily shift staffing and whether we have been able to provide sufficient staff to provide save care. During April while there were shifts that did not have the expected number of staff on shift when the shift leader reviewed either the acuity or number of patients they were satisfied that patient care was not compromised.

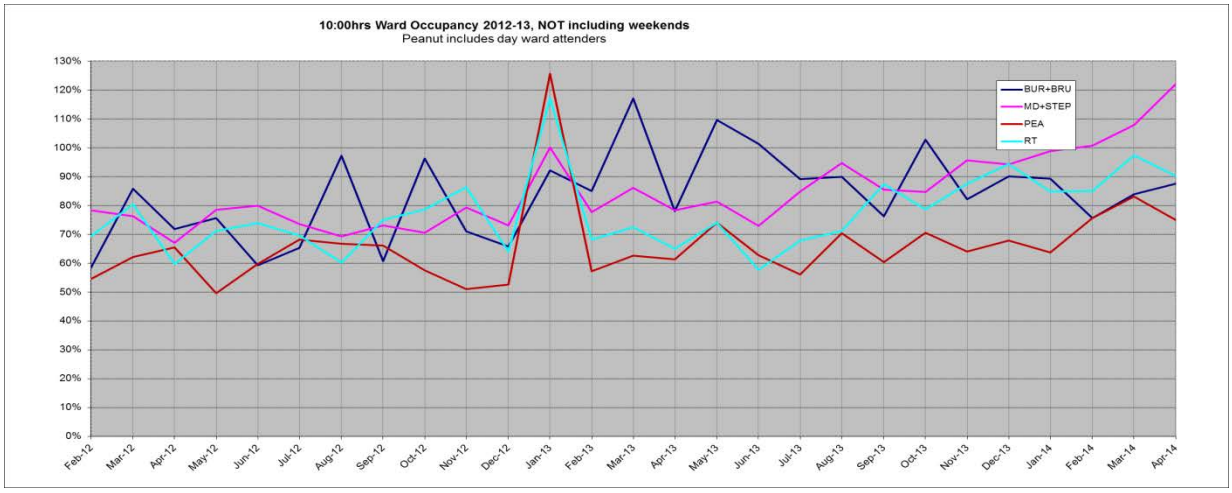
Exception reporting by ward

Canadian Wing

2. Staffing on Canadian Wing is identified as being 10.1 WTE (whole time equivalents) short. Of these 10.1 3 posts are above their required establishment to provide a buffer for recruitment, retirement and maternity staffing gaps. In addition we currently have two military secondees working on Canadian Wing this reduces their actual vacancy gap to 5.1 WTE. 8.6 posts have been recruited to and we are currently awaiting completion of the appointments process.
3. In respect of mandatory training and appraisals the current rate is below the target of >80% and the Manager has been asked to provide a plan that will demonstrate when >80% will be achieved.
4. Other areas highlighted below for the two wards within Canadian Wing will be able to be addressed more proactively following the commencement in post of the second ward manager. This post has been vacant for some time.

Margaret Duncombe Ward (MD)

5. Safe care – feedback to staff will occur at the department meeting on falls and medication errors. The same will occur in respect of VTE assessments – this information is collated from all patients who have been through the ward during the month.
6. Activity – Bed occupancy is reported at 10am for weekdays as this provides the highest occupancy figure for the wards. For April we have seen the highest figure reached for MD at 122% and even when weekends are added in the occupancy figure only drops to 107%. It is unclear whether this is related to the closure of Ross Tilley over the Easter period or whether this is part of a constant rising trend seen over the last months.



Ross Tilley Ward (RT)

7. Safe care – managers have been asked to provide information on actions being taken in regard to pressure ulcer management, falls prevention and medication errors. As noted above a second manager commences in May and additional focus will be on ensuring the quality of care.

Burns Unit

8. Safe care – VTE is to be raised at the department meeting in regard to ensuring that all patients have been assessed and this information documented within patient centre.

9. Staffing – appraisal rates are below the target >80% and the manager has been requested to provide a plan with how and when compliance will be achieved.

Peanut Ward

10. Staffing - Sickness is the only metric rated red and while this is >2% Peanut are a small team and one staff absence for an extended period can impact significantly on their rating. Currently there are no specific concerns regarding sickness on this ward.

CANADIAN WING							
Staff utilisation	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies	10.1 WTE	<5%	?				Vacancies have been advertised and 8.6WTE have been successfully recruited to and waiting clearances
Temporary staffing Exc RMN Bank / Agency	306hrs 745hrs	<10% 588hrs	+157Hrs				
Sickness	4.5%	<2%	+2.5%				
Shifts meeting Est	83%	>95%	-12%				21 shifts out of 120 not meeting establishment - staffing deemed safe due to acuity level of patients or ward closed
Training / Appraisal	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	63.8%	>80%	-16%				Action rquired below target
Appraisals	69.4%	>80%	-11%				Action rquired below target
Drug Assessments	95%	>95%	0%				On track no action required
Friends and Family Test Score MD / RT	84 88	>80	4				On track no action required
Staff Friends and Family Test Score							
Budget							

MARGARET DUNCOMBE		APRIL 2014					
Safe Care	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0				On track no action required
Falls	1	0	1				For discussion at ward meeting
Medication errors	3	0	3				No harm to patients
MRSA/Cdiff	0/0	0	0				On track no action required
VTE assessment	90%	95%	5%				
Nutrition assessment	100%	>95%					On track no action required
Activity	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	122%	<90%	32%				\bed occupacy is excessive, Risk to be raised % reduces to 107% if weekends are included
Bed utilisation							
Patient numbers							
Average acuity							

ROSS TILLEY		APRIL 2014					
Safe Care	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	1	0	1				Grade 2 root cause analysis being undertaken
Falls	3	0	3				For discussion - no harm to patients
Medication errors	5	0	5				To be rasied and discussed at ward meeting
MRSA/Cdiff	0/0	0	0				On track no action required
VTE assessment	93%	95%	-2%				
Nutrition assessment	100%	>95%					On track no action required
Activity	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	90%	<90%	0%				
Bed utilisation							
Patient numbers							
Average acuity							

WARD MARGARET DUNCOMBE/SDU

GREEN Staffing meets planned requirement

AMBER Staffing does not meet planned requirement but

RED Staffing does not meet planned reqirement and the senior nurse

MONT APRIL **When amber or red rationale to be provided below**

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	5	2	6	2	
2	4	2	5	2	
3	4	2	5	2	
4	4	2	4	2	
5	4	2	6	2	
6	4	2	3	2	ITU nurse covering SDU, ITU admission so retu
7	4	2	6	2	
8	4	2	3	2	SDU nurse rotated to RTW to assist their defic
9	4	2	4	2	
10	4	2	5	2	
11	4	2	4	2	
12	4	2	4	2	
13	4	2	4	2	
14	4	2	4	2	
15	4	2	4	2	
16	3	2	3	2	
17	5	3	7	3	Inc x2 super nummary RN's
18	4	2	5	3	
19	4	2	3	2	ward safe as acuity low -bank nurse cancelled.
20	4	2	2	2	ward safe acuity low
21	4	2	3	2	9 pts
22	3	2	3	2	
23	4	2	7	4	
24	4	2	6	4	as rtw shut -staff moved over
25	4	2	6	4	rtw shut- staff moved over
26	4	2	4	4	rtw shut- staff moved over
27	4	2	4	2	rtw shut- staff moved over
28	4	2	5	2	rtw shut- staff moved over
29	4	2	5	2	rtw shut- staff moved over
30	4	3	4	3	
31					

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	1	4	1	
2	4	1	4	1	
3	2	1	2	1	
4	2	1	2	1	
5	2	1	2	1	
6	3	1	2	1	staff sickness. Agency unable to cover.
7	3	1	3	1	
8	3	1	3	1	
9	3	1	3	1	
10	4	1	4	1	
11	2	1	2	1	
12	3	1	3	1	
13	3	1	3	1	
14	3	1	3	1	
15	4	1	4	1	
16	3	1	3	1	
17	2	1	2	1	
18	2	1	2	1	no SDU pt. MDW 14 pt only
19	2	1	2	1	ward safe 9pt
20	2	1	1	1	7 inpatients only
21	2	1	2	1	
22	5	1	5	1	
23	3	2	3	2	
24	3	2	3	2	
25	3	2	3	2	
26	3	1	3	1	
27	3	1	4	2	
28	3	1	3	2	
29	3	1	4	1	
30	5	1	5	1	

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

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	4	3	4	2	
2	4	3	4	3	
3	4	3	4	2	HCA sick. Ward safe as acuity /pt numbers low.
4	4	3	4	2	HCA sick.ward safe.
5	4	3	4	2	HCA not required as pt acuity low ward not full
6	4	3	3	2	1 trained on duty is supernummary, ward safe
7	4	3	4	3	RN sick
8	4	3	4	3	RN sick, SDU nurse in situ with male sdu pt no male bed on MD
9	4	3	3	3	Rn sick
10	4	3	3	3	pt acuity low ward safe
11	4	3	4	3	
12	4	3	4	3	
13	4	3	3	2	pt numbers low (11/24) ward safe
14	4	3	4	3	
15	4	3	4	3	
16	4	3	4	3	
17	4	3	4	3	
18	4	3	3	3	ward safe- Rn from SDU will assist once free
19	4	3	3	2	ward safe as acuity low
20	4	3	3	2	safe as low acuity
21	4	3	3	2	8 pts
22	4	3	4	3	
23	0	0	0	0	no patients till midday
24	4	3	2	1	7 pts
25	4	3	0	0	no pts staff moved to MDW
26	4	3	0	0	no pts staff moved to MDW
27	4	3	0	0	no pts staff moved to MDW
28	4	3	0	0	no pts staff moved to MDW
29	4	3	0	0	no pts staff moved to MDW
30	1	1	1	1	MD helping only 6 patients
31					

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

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	1	3	1	
2	3	1	3	1	
3	3	1	3	1	
4	3	1	3	0	Ward safe pt number low
5	3	1	3	0	ward safe pt numbers low
6	3	1	3	1	
7	3	1	3	1	
8	3	1	3	1	
9	3	1	3	1	
10	3	1	3	1	
11	3	1	3	1	
12	3	1	3	1	
13	3	1	2	0	ward safe 12 pt. HCA MD to help
14	3	1	2	1	ward safe pt number low
15	3	0	3	0	
16	4	3	4	3	
17	3	1	3	1	
18	3	0	3	0	
19	2	1	2	1	ward safe 8 pt.
20	2	1	2	1	
21	2	1	1	1	7 patients only. Safe.
22	0	0	0	0	closed overnight
23	2	0	2	0	6 pts
24	0	0	0	0	closed overnight
25	3	1	0	0	closed overnight
26	3	1	0	0	closed overnight
27	3	1	0	0	closed overnight
28	3	1	0	0	
29	3	1	1	0	5 pt only
30	2	1	2	1	12 pts
31					

Peanut		APRIL 2014					
Safe Care	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0				On track no action required
Falls	0	0	0				
Medication errors	1	0	1				
MRSA/Cdiff	0/0	0	0				
VTE assessment							
Nutrition assessment							
Activity	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	75%	<95%	-20%				
Bed utilisation							
Patient numbers							
Average acuity							

Peanut							
Staff utilisation	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies	1.2 WTE	<5%	?				
Temporary staffing Exc RMN Bank / Agency	12 hrs 149 hrs	<10% (588hrs)	-427hrs				No action required - bank & agency covering annual leave and sickness
Sickness	4.7%	<2%	+2.7%				sickness higher than average due to high sickness with in support staff
Shifts meeting Est							
Training / Appraisal	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	77.1%	>80%	-2.9%				On track no action
Appraisals	93.9%	>80%	+6.1%				On track no action
Drug Assessments	100%	>95%					On track no action
Friends and Family Test Score	83	>80	3				On track no action
Staff Friends and Family Test Score							
Budget							

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

When amber or red rationale to be provided below

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	1	3	1	
2	3	1	3	1	
3	3	1	2	2	R.n x1 Sick. HCA drafted in. Ward safe as acuity low.
4	3	1	4	3	
5	2	2	2	2	
6	2	1	2	1	
7	3	1	3	1	
8	3	2	3	2	
9	3	1	3	1	
10	3	1	3	1	
11	3	1	3	1	
12	2	2	2	2	
13	2	1	2	1	
14	3	1	3	0	
15	3	1	3	1	
16	3	1	3	1	
17	3	1	4	3	
18	2	1	2	1	
19	2	2	2	2	
20	2	1	2	1	
21	2	1	2	1	
22	3	1	3	1	
23	3	1	3	1	
24	3	1	3	1	
25	3	1	3	1	
26	2	1	2	0	no patients
27	2	1	2	0	no patients
28	3	1	3	1	
29	3	1	3	1	
30	4	0	3	0	
31					

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

When amber or red rationale to be provided below

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

Date	**Planned staff**		**Actual staff**		**Rationale if amber or red**
	RN	HCA	RN	HCA	
1	2	0	2	0	
2	2	0	2	0	
3	2	0	2	0	
4	2	0	2	0	
5	2	0	2	0	
6	2	0	2	0	
7	2	0	2	0	
8	2	0	2	0	
9	2	0	2	0	
10	2	0	2	0	
11	2	0	2	0	
12	2	0	2	0	
13	2	0	2	0	
14	2	0	2	0	
15	2	0	2	0	
16	2	0	2	0	
17	2	0	2	0	
18	2	0	2	0	
19	2	0	2	0	
20	2	0	2	0	
21	2	0	2	0	
22	2	0	2	0	
23	2	0	2	0	
24	2	0	2	0	
25	2	0	2	0	
26	2	0	2	0	
27	2	0	2	0	
28	2	0	2	0	
29	2	0	2	0	
30	2	0	2	0	
31					

BURNS WARD		APRIL 2014					
Safe Care	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0				On track no action required
Falls	0	0	0				On track no action required
Medication errors	0	0	0				
MRSA/Cdiff	0/0	0	0				On track no action required
VTE assessment	94%	95%	-1%				
Nutrition assessment	100%	>95%					
Activity	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	88%	<95%	-7%				
Bed utilisation							
Patient numbers							
Average acuity							

BURNS UNIT							
Staff utilisation	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies	WTE	<5%	?				
Temporary staffing Exc RMN Bank / Agency	36hrs 429hrs	<10% 588hrs	-123hrs				No action required below target
Sickness	1.7%	<2%	-0.3%				No action required below target
Shifts meeting Est	90%	>95%	-5%				Saffing identified as safe due to acuity of patients
Training / Appraisal	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	73.2%	>80%	-6.8%				
Appraisals	55.6%	>80%	-24.4%				Action required
Drug Assessments	97%						
Friends and Family Test Score	91	>80	11				
Staff Friends and Family Test Score							
Budget							

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

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	1	3	1	
2	3	1	3	1	
3	3	1	3	1	
4	3	1	3	2	Staff covering Ebac (sickness)and recovering post ops
5	3	1	1	1	pt number low, ITU helping -ward bank cover cancelled
6	3	1	2	1	pt number low ward safe
7	3	1	3	1	
8	3	1	3	2	
9	3	1	2	2	4 pts, level safe
10	3	1	2	1	4 pts, level safe
11	3	1	2	2	4 pts, level safe
12	3	1	2	1	3 pts level safe - pm 1 R/N only therefore ITU to help
13	3	1	2	1	3pts level safe itu to assist pm
14	3	1	2	1	unable to cover shift- manager helping on ward
15	3	2	3	2	
16	3	1	3	1	
17	3	1	3	1	
18	2	1	2	1	
19	3	1	3	1	canc agency ward nurse as itu to help
20	2	1	2	1	
21	3	1	2	1	
22	2	2	2	2	
23	3	1	2	1	assistance from Itu if required ward safe
24	3	1	3	1	
25	3	1	3	1	
26	2	1	2	1	
27	2	1	2	1	
28	2	1	2	1	
29	3	1	3	1	
30	3	1	3	1	
31					

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

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

Date	**Planned staff**		**Actual staff**		**Rationale if amber or red**
	RN	HCA	RN	HCA	
1	2	0	2	0	
2	2	1	2	1	
3	2	0	2	0	
4	2	0	2	0	
5	2	0	2	0	
6	2	0	1	0	itu covering
7	2	0	2	0	
8	2	0	1	0	staff nurse sent home. Itu helping.
9	2	1	2	1	
10	2	1	2	0	only 2 pts
11	2	0	2	0	
12	2	0	2	0	
13	2	0	2	0	
14	2	0	2	0	
15	2	0	2	0	
16	2	0	2	0	
17	2	1	2	1	
18	2	1	2	1	
19	2	0	2	0	
20	2	0	2	0	
21	2	0	2	0	
22	2	0	2	0	
23	2	0	2	0	
24	2	1	2	1	
25	1	1	1	1	
26	2	0	2	0	
27	2	0	2	0	
28	2	0	2	0	
29	2	0	2	0	
30	2	1	2	1	
31					

ITU		APRIL 2014					
Safe Care	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0				On track no action required
Falls	0	0	0				On track no action required
Medication errors	0	0	0				On track no action required
MRSA/Cdiff	0	0	0				On track no action required
VTE assessment	94%	>95%	-1%				
Nutrition assessment							
Activity	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy							
Bed utilisation							
Patient numbers							
Average acuity							

ITU							
Staff utilisation	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies	4.3 WTE	<5%	?				
Temporary staffing Exc RMN Bank / Agency	311hrs	<10% 588hrs	-277hrs				No action required below target
Sickness	8.4%	<2%	+6.4%				Sickness high
Shifts meeting Est	98%	>95%	_3%				
Training / Appraisal	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	77.5%	>80%	-3%				
Appraisals	60.0%	>80%	-20%				
Drug Assessments	97%						
Friends and Family Test Score							
Staff Friends and Family Test Score							
Budget							

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

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	0	3	1	
2	3	1	3	1	
3	3	0	3	0	
4	3	1	3	1	itu staff assisting on ward
5	3	0	2	0	itu staff assisting on ward ,also have x1 itu o/c
6	3	0	3	0	itu staff helped on SDU until burn ref. accepted
7	3	0	3	0	
8	2	0	3	0	1 itu pt. Extra ITU outreaching in external unit
9	2	0	2	0	1 ITU pt
10	3	0	3	0	
11	3	0	4		Covering outreach
12	3	0	3	0	Itu to help on burns ward pm.
13	2	0	2	0	x1 itu nurse o/c - itu to assist ward pm.
14	3	1	2	1	unable to cover -2 hdu pts therefore safe
15	3	0	3	0	
16	2	0	2	0	
17	2	0	2	2	
18	2	0	2	0	
19	2	0	2	0	no itu patients
20	2	0	2	0	
21	2	0	2	0	no itu pts and itu regular shift nurse on call
22	2	0	2	0	only x1 hdu patient.
23	2	0	2	0	only 1 hdu pt.
24	2	1	1		no patients . +1 itu on call
25	3	1	3	1	
26	2	0	2	0	no patients
27	2	0	2	0	no patients
28	2	1	2	1	no patients
29	2	1	2	1	1 itu vent pt.
30	3	0	3	0	
31					

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

When amber or red rationale to be provided below

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

Date	Planned staff		Actual staff		Rationale if amber or red
	RN	HCA	RN	HCA	
1	3	0	3	0	
2	3	0	3	0	
3	2	0	2	0	
4	2	0	1	0	itu staff assisting ward
5	2	0	0	0	itu staff assisting the wards
6	3	0	3	0	helping in burns ward.
7	2	0	2	0	
8	2	0	2	0	
9	4	0	4	0	
10	3	0	3	0	
11	3	0	3	0	
12	3	0	3	0	
13	3	0	3	0	
14	2	0	2	0	
15	2	0	2	0	
16	2	0	2	0	
17	2	0	2	0	
18	2	0	2	0	
19	2	0	2	0	itu staff assisting ward / outreach
20	2	0	2	0	
21	2	0	3	0	I RN holding 400 outreach bleep
22	2	0	2	0	
23	1	0	1	0	no pt. ITU helping ward
24	3	0	3	1	
25	2	0	1	0	1 on call
26	2	0	1	0	1 on call
27	2	0	1	0	
28	2	0	1	0	
29	2	0	2	0	
30	3	0	2	0	day staff stayed on to assist with patient transfer. Also site practiti
31					

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22 May 2014**
Agenda item reference no:	**117-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 May 2014**

BOARD ASSURANCE FRAMEWORK (BAF)

1. The aim of the document is to integrate organisational risks to achieving the key strategic objectives identified from the Trust Risk Register with the risks to achieving the Trust priorities identified in the annual plan submitted to “Monitor”.

2. In addition the document is used to monitor progress in achieving the annual plan.

3. This document is updated quarterly by the Executive leads; this version provides a closing summary of the BAF risks associated with the key strategic objectives for 2013/14.

4. In June the board will be presented the BAF for 2014/15 and its associated risks.

5. This document was reviewed by the Audit Committee in May 2014.

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

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
27	Amanda Parker	Infection risk to patients due to poor systems and practice of control	1. Spread of infection of MRSA, CDiff, MRAB & Norovirus.	1. Unknown infection to patients admitted to hospital. 2. Infected patients not isolated on admission.	1. Mandatory training of all staff and awareness raising sessions. 2. Implementation of trust policies - isolation, screening, treatment including root cause investigation / PIR for all C Diff / MRSA cases . 3. Routine audit of practice, and monthly PLACE inspections. 4. Cleaning strategy implemented including deep clean arrangements 5. Monitoring of trajectory targets for MRSA bacteraemia, MSSA, E Coli and C.diff. 6. Monthly monitoring and Board reports from DIPC to inform organisation of acquisition of infection 7. Failure to achieve 90% or greater in any staff group for hand hygiene leads to matron auditing. 8. Decant arrangements include wider involvement of matrons regarding single room use, with advice from IPACT. 9. Specific interventions depends on risk identified i.e. staff undertake an MRSA protocol treatment 10: Training completed for QVH IPACT Team re: access to BSUH IT System. Awaiting ICNet.	12	6	No	CQC rating. Monitor rating. Infection rates reported in quality dashboard on monthly basis Training attendance figures reported to Board	No	5. Provide infection control nurses with direct IT access to BSUH Microbiology system 3. Follow up actions from current infections - Completed 4. Review of anti-biotic policy to ensure best practice use and reduce risk of C.diff - completed proactive response to recognition of outbreaks to inlcude outbreak meetings that continue past discharge of patient s to ensure additional preventtative mesaures identified 2. Review of investigation process - Completed Complete actions from MRAB SI report 6. Monitor microbiologist attendance on site to ensure antibiotic prescribing reviewed	KSO1

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
388	Amanda Parker	Failure to deliver safe healthcare and breach of targets due to poor governance and staff training/recruitment	1. Poor patient care-potential harm□ 2. Failure to recognise areas of concern□ 3. Damage to reputation and removal of CQC registration	1. Poor employment of new staff.□ 2. Staff not registered with professional bodies.□ 3. Lack of monitoring effectiveness through audit.□ 4. Poor identification of risks.□ 5. Poor learning from incidents.□ 6. Incidents not reported by staff.□ 7. Poor line management of staff.□ 8. Inadequate staff training.□ 9. Poor governance framework□ 10. failure to meet essential targets - Infection control, CQUINs, Quality account targets, 16 core CQC	1. Pre employment checks to ensure that suitably qualified staff are employed.□ 2. Registration checking process in place□ 3. Skill mix review completed and monitored.□ 4. Corporate and local induction and refresher training □ 6. Annual appraisals for all staff.□ 7. Regular review of complaints and incidents□ 8. Pro-active Patient Safety actions.□ 9. Pre testing of doctors on prescribing.□ 10. Mandatory training monitoring in place□ 11. CQC outcome assessment completed and regular compliance in practice□ 13. Annual department risk assessment process to monitor HSE compliance□ 14. Clinical audit process in place with audit team and Joint Hospital Audit Meetings □ 15. Quality and Risk Committee review of CQC action progress and Risk Profile□ 16. Policy monitoring system in place.□ 17. Incident reporting system in	8	1	No	Committee monitoring compliance reported to Audit Committee Annual staff survey results. Annual Complaints return CQC inspections Annual PEAT inspection National Inpatient and Outpatient and Cancer Survey CQC Q&R profile reviewed by Q&RC Quarterly Quality & Risk report to Q&RC and Board	Policy monitoring process for key documents	2. Specific department plans to be actioned. 5. Complete documentation action plan 2. Refine regular review process for each outcome.Completed 3. DoN to receive monthly reports on individuals 3 months over due with mandatory training 4. DoN to receive reports on individuals overdue completion of local induction forms. 1. Monitor mandatory training to achieve 80%. Head of HR reviewing recording process	KSO1

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
484	Steve Fenlon	Burns to patient during surgery from power drill due to poor maintenanc e or technique	1. Patient harm□ 2. Litigation	1. Drill overheating due to excessive use.□ 2. Drill overheading due to poor maintenance.□ 3. Poor technique by surgeon causing friction burn.	1. Continuous maintenance programme in place at TSSU contractors.□ 2. Mouth guards and props used in each cases to protect mouth area.□ 3. Review of maintenance/usage requested from manufacturer.□ 4. Service contract established with Braun for Aesculap drills in Theatre□ 5. Practice reviewed and protocol for actions following a burn completed□ 6. Standard procedure in place for escalation process and isolating drill if a burn arises again. □ 7. Full SUI investigation completed - actions on learning from incidents action plan□ 8. Service contract process revised - Electrical surgical appliances being inputted on Medical device database. Medical; device database adapted to include external service contract data linked to each device.□ 9. Risk team to manage external service contracts for medical devices.□ 10. Agreement with Braun to use 70mm Burr for all cases using the long handpiece by Medical Director.□ 11. Training for junior doctors in place during induction programme□ 12. Now included on the consent form	9	6	No	Reduced incidents of drill burns in monthly board and quarterly Q&R report	No	1. visit TSSU contractor and review maintenance process - Completed 2. review surgical practice at the QVH with usage of power tool- Completed 3. Establish a contract for Epens and Max facs department drills- Completed Confirm all Surgical Drills have been serviced within the last year. Completed Obtain data from synergy re the usage figures for each drill. Completed	KSO1

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513	Amanda Parker	Potential failure to act on infection concerns due to unavailability of Microbiologist	1. Delay in updating policies□ 2. Reduced patient care due to review not conducted by microbiologist on site□ 3. Delay in reporting on specimens□ 4. Reduced attendance on site by Microbiologist	1. Problems recruiting consultants at BSUH □ 2. No regular microbiology consultant cover on-site□ 3. Failure for BSUH to fulfil contract requirements	1.Daily lab sheet of positive specimen results however, not all positive specimen are listed on this sheet.□ 2. Presence of microbiologist during week on site has reduced, remainder of cover provided via telephone (24/7)□ 3. Trust policies and procedures.□ 4. Staff mandatory training□ 5. Access to ICE system training and winpath for ICNs to review organism resistances□ 6. Daily visits to wards by ICNs.	12	6		Infection reporting rates reported in Quality and risk Board report. Quality and Risk report to Q&R Committee Mandatory training compliance reports to Board	No	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	KSO1
609	Steve Fenlon	Lessons not learnt from clinical errors due to the absence of effective specialty morbitiy and mortality meetings	1. Failure to improve practice□ 2. Repeated harm to patients	1. Failure for organisation to learn from mistakes□ 2. Lack of meetings and actions for specialities to review and discuss clinical cases□ 3. Lack of documented evidence of meetings and learning outcomes	1. Specialty meetings happening in some departments□ 2. Clinical Audit team in place produce M&M indicator reports for each specialty□ 3. Incident investigation process and review□ 4. M&M data provided by audit team□ 5. Audit team collect minutes for each specialty and monitor issues□ 6. All of the Directorate meetings minutes will be sent to the Clinical Policy Committee.	8	4			Report on completed mortality and morbidity meeting minutes for Directorates Action plans following meetings to address concerns need to be reported to Clinical Audit and Outcomes Committee	Establish Mortality & Morbidity meetings for each specialty based on information provided by Clinical Audit Team on a quarterly basis to ensure documented discussion on clinical issues	KSO1

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
615	Steve Fenlon	Injury to patient from Dermatome during surgical procedures	1. Full thickness skin graft taken when not required resulting in additional pain,and skin grafts.□ 2. Laceration injury □ 3. Infection risk□ 4. Extended hospital stay□ 5. Litigation	1. Setting too deep prior to use (not checked)□ 2. Dermatome blade incorrectly inserted□ 3. Faulty device□ 4. Guard placed the wrong way round	1. Theatre team hand dermatome to surgeon with setting at zero□ 2. Manufacturer of Dermatome blades purchased to ensure fully compatible□ 3. Service contract for routine maintenance□ 4. All scrub practitioners are trained and aware of how to assemble and check the device □ 5. Reporting and review system in place to ensure learning is shared following dermatome incidents□ 6. Identified issue with incorrect placement of guard raised with staff and reported to MHRA	6	6	Training package for new junior doctors on Dermatome	Reduced Dermatome incidents in quarterly Q&R report (no red or amber incident)	No	Produce dermatome device e-learning package for clinical staff Dermatome summary paper to CPC and Q&RC review of maintenance arrangements Provide key points card for insertion into each dermatome surgical pack - Completed Arrange Dermatome training session for Plastic Surgeons-training by Burns Consultants - Completed	KSO1
622	Amanda Parker	Potential failure to improve patient experience and outcomes due to lack of outcome / experience data	1. Damage to reputation of clinicians and trust.□ 2. Governance rating reduced	1. Lack of clinical reporting databases available□ 2. Clinicians unable to determine clear outcome criteria for specialty□ 3. Family and friends audit not undertaken	1. Family and friends questionnaire in place□ 2. Clinical Audit and Outcomes Group established to determine outcome data□ 3. Included in the outcome measure for the 2013/14 Quality Account	8	6	Outcome data not available for all specialties	Family and friends test results	Specific outcome data for each specialty needs to be available for the Board and to the public	on a monthly basis. Progress monitored through Quality acount. Monitor Francis/Keogh/Cavindish reccommendations covered in report action plan. Berwick recommendations covered within QVH 2020 programme. Develop out come data for each consultant in progress with some information now provided to all Consultants. Monitor francis report action plan Develop outcome data for each consultant Monitor family and friends test	KSO1

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627	Steve Fenlon	Failure to embed safer surgery checklist process due to lack of engagemen t	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	12	4		No never event incidents	Quality audit on time out and sign out required for review and subsequent actions to Theatres and Anaesthetic Directorate	Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting Summary paper of WHO checklist related incidents developed to bring together actions and assurances. Document to next Clinical Policy and Quality and Risk Committees	KSO1

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628	Amanda Parker	Potential harm to patients due to poor clinical record keeping	1. Incorrect /uninformed decision made on patient care□ 2. Failure to provide effective evidence for inquiry□ 3. Failure to comply with CQC Outcome 21	1. Poor design of record administration within the notes □ 2. Combination of electronic and paper records□ 3. Duplication of data recorded□ 4. Multiple professional records not used by whole team□ 5. Miss filing□ 6. Delay in filing of additional information in records□ 7. Failure to document key information in health record	1. Importance of documentation included in induction for all staff. □ 2. Documentation audit completed on a quarterly basis and reported to Patient Documentation Committee.□ 3. Effectiveness and progress of actions following audit monitored by Patient Documentation Committee.□ 4. Health Records Policy includes record keeping standards. □ 5. Departments aware to file reports and additions prior to sending to Health Records wherever possible□ 6. Additional filing Health Record Department responsibility□ 7. Patient Documentation Committee restructured to have senior engagement.	9	6	Electronic health record for all stages of care	Exception report provided quarterly to Patient Documentation Committee CQC Inspection declared compliant Oct 2013	Review / assurance additional filing in health records being undertaken within effective timescale	Monitor exception reporting process Communicate to all staff documentation standards - Completed	KSO1

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
159	Richard Hathaway	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	15	8	Yes - Insufficient staff to manage increased volumes for 18 weeks	Monthly reports to the Board Weekly/monthly reports through unify reviewed by Senior Operational Team Department of Health returns within Monitor Compliance report. Weekly reports to OPG Monitoring by Monitor reported to the Board.	Reporting process to directorates required on time between referal and booking process	Centralise all referrals through one access point - Completed Restructure of appointments and admissions teams to achieve consistent Trust wide approach to management of elective pathway bookings Training and guidance to be issued to all relevant staff - Completed Review to take place in January 2011. - Completed 3. Ensure all Planned cases have estimated TCI's when placed on list - Ongoing Implement daily ptl - completed Ensure all future TCI's are validated in relation to 18 weeks- completed 6. Introduce a new automated 6 month administrative WL validation - Completed Agree business case for increasing capacity in sleep studies - completed Explore locum for Ocular plastics - completed 1. Expediate Medway hub 2. Develop matrix of planned cases seen at QVH - Completed	KSO2

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
474	Richard Hathaway	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	12	8	No	Monitor governance rating Performance reports to Board. Internal audit complete a compliance audit on data quality and timescales and submit to Audit Committee annually	No	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-	KSO2

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
488	Amanda Parker	Breach of infection control national reduction targets due to low threshold set and failure to follow systems in place	National infection reduction targets effectively 0 for 2013/14 (zero tolerance). Failure to achieve these could result in:□ 1. Infection to patient (potential harm)□ 2. Reduced governance target rating□ 3. Financial loss	1. Staff fail to follow policy for testing and isolation□ 2. Policy inefective□ 3. Poor cleaning regime□ 4. Poor hand hygiene□ 5. Poor invasive techniques	1.Infection control policies define standards of practice□ 2. Education and training for all staff groups□ 3. Root cause analysis of any C.diff case and PIR for any MRSA Bacteraemia reported to ICC.□ 4. IPAC team in place to ensure processes followed and monitor cleanliness/hygiene.□ 5. Deep clean programme in place.□ 6. 2013/14 de minimus: C.diff 12, MRSA 6.	9	4	No	Quality dashboard reviewed by Clinical Cabinet and Board Monitor governance rating	No		KSO3
499	Richard Hathaway	Failure to achieve financial targets for the organisation due to changes in external enviroment or increased internal costs	Failure to achieve financial targets resulting in reduced monitor rating and potential financial failure.	1. Failure to achieve cost improvement programme for 2013/14□ 2. Lack of activity resulting in less income□ 3. Increased staffing costs□ 4. Increased non-pay costs□ 5. Reduced payment for procedures□ 6. Incorrect coding for procedures□ 7. Performance financial penalties from commissioners□ 8. Financial penalty from failed CQUIN targets	1. CIP plans for 2013/14 now developed□ 2. Outline plans exist for 2014/16 with Annual Plan 2013/14.□ 3. Monthly reviews of financial performance including CIP at weekly business review and Board□ 4. Service line financial reporting produced monthly□ 5. Monthly finance reports for each department reviewing income, pay and non pay costs.□ 6. Monthly Board report on financial situation.□ 7. Monthly and Quarterly Directorate performance meetings to monitor activity and budget.	10	10	No	Monthly finance reports to the Board Monitor financial risk rating External audit reports CQUIN Compliance	No	Confim fully worked up CIP for 2013/14 - Completed Develop service line management to further improve ownership of performance at service line level Develop more sophisticated cash flow forecasts	KSO3

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587	Amanda Parker	Financial and reputational damage due to breach of Health & Safety legislation	1. Financial loss if HSE find non compliance with Health & Safety Legislation upon inspection due to new payment scheme (Fee for Intervention Scheme)□ 2. Damage to reputation	1: Material breach of health and safety legislation□ 2: Failure to comply with health and safety regulatory requirements□ 3: Inspectors find multiple breaches therefore increased financial penalities	1. Health and Safety and other related Policies□ 2. Regular Health and Safety Training in place for all staff□ 3. Departmental risk assessments and health and safety inspections□ 4. Risk Team with responsibility for ensuring health and safety policy, arrangements and practices are embedded across the organisation□ 5. Datix incident reporting system□ 6. Essential Risk Management Training for managers	6	6	No	DSE compliance audit to H&S Committee Health & Safety department action plan compliance reported to H&S Committee quarterly	Essesntial risk management training attendance compliance report Key policy monitoring compliance report	Gap analysis to Workplace Health and Safety Standards - Completed Gap analysis to Workplace Health and Safety Standards is completed actions to be addressed. Monitored by Health and Safety Committee.	KSO3
613	Richard Tyler	Potential Loss of Burns activity and funding if unable to meet burns facility requirement	1. Loss of income.□ 2. Closure of service or reduction in activity□ 3. Financial loss to organisation and reduction in reputation.	Burns service does not meet the national burns specification for facility (the lowest level of service)in all the required areas. This applies to adult and paediatric services.□ □ QVH does not have all the required infrastructure and resource available on site to deliver burns facility care.	1. SLA with BSUH for provision of paediatric cover and pathology services. □ 2. Policy for management of sick children and thresholds reviewed and robust. □ 3.2 year agreement in place pending further service development.□ 4. Gap analysis completed and action plan being developed to address shortfalls.□ 5. Detailed plan to clinical cabinet 6th Jan gained agreement to proposed service model. Arranging a meeting with area team to discuss the model on 10th Feb.	8	6	Trust reliant on capital developments at Brighton and Sussex University Hospital	Action plan produced to ensure deficiency resolved.	Action plan not reported to specific committee/ group	Arrange meeting with BSUH to determine the way forward to ensure QVH can provide burns facility care	KSO3

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
620	Richard Hathaway	Potential loss of referrals due to commissioners moving work to centralised centres	1. Loss of income affecting financial viability of the organisation 2. Loss of activity	1. Commissioners set up central services such as muscular skeletal services reducing hand services at QVH. 2. Increased number of community based providers established 3. Reduction in national tarrif makes routine work non viable financially	1. Quality of work and reputation of QVH provides a strong position. 2. Identified areas of opportunity - Head and Neck services and breast surgery from other trusts 3. Development of core reconstructive services 4. Contract monitoring meetings, 5. Programme Board overview 6. Review of Service Line reporting 7. Weekly Business meetings reviews of operational issues and referrals 8. Continued dialogue with Health Service Priorities Unit. 9. Business model adapted to cover lost procedures. 10. Engagement with GP's 11. Compliance with low priority procedure policy 12. Education and engagement with CCG leads 13. Engagement with the any qualified provider scheme. 14. 2013/14 reflects potential loss of income	12	6		Finance and performance reports to the board. Referral rate monitoring Service line reports	No	Divest Gynaecology service - Completed Develop relocation of head and neck surgery from Brighton to QVH Develop provision of breast reconstruction surgery to Worthing and Brighton areas - Completed Develop hand surgery services for Surrey residents Develop new maxillo-facial clinics in Horsham - Completed Extend plastic-surgery service into East Kent Review non core services to ensure sustainability Develop referral base through business development plan - Completed annually Develop business intelligence capability	KSO3

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623	Amanda Parker	Failure to meet CQUIN requirements for 2013/14 therefore incurring a loss of CQUIN funds £1.4M	1. Financial penalty and loss of CQUIN funds	1. Failure to meet CQUIN requirements set for 2013/14	1. VTE risk assessments within each patient drug chart - VTE policy in place 2.Dementia - process in place to identify trauma patients >75 years of age.Clinical lead identified. 3. Dementia training in place 4. Patient experience group in place reviewing and ensuring actions implemented and linked to OPD experience. Family and friends test score. 4.NHS safety thermometer completion is linked within deputy director of nursing job role and harm score reported to the Board. 5. Organisational performance against CQUIN measures are monitored and reported to Trust board on a monthly basis. 6. High impact intervention CQUINS reports produced each quarter and reviewed by Q&R Committee.	12	3	No	Quality dashboard reports on CQUIN performance Quarterly progress reports to Q&R Monthly performance report to Trust Board	No	Provide Q3 update to quality and Risk Committee and Board	KSO3

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234	Heather Bunce	Risk of Legionella due to poor testing and control of water systems	1. Harm to patients,staff and visitors□ 2. Litigation□ 3. Damage to reputation	1. Poor water system maintenance□ 2. Poorly installed pipework□ 3. Inadequate testing□ 4. Dormant water supplies	1. Routine sample testing, monitoring and treatment for all areas □ 2. External audit/risk assessment completed and actions 80% complete□ 3. Awing theatre replacement water system completed.□ 4. Pipework lagging completed where identified as at risk (rehab and hotel services).□ 5. HWS from peanut basement plantroom replaced.□ 6. Blending valves in Corneo Plastic department replaced.□ 7. On going maintenance regime in accordance with COP document L8□ 8. Authorised person in place for water safety following the required training.□ 9. New theatre complex water system□ 10.Automatic taps in Peanut PAU replaced to scrubb sink to allow better purging of system and reduce positive counts in water samples.□ 11. Weekly purging of all outlets in empty departments undertaken. (EG. Decomissioned theatres, ricrfot ward, Male end jubilee ward.)	5	5	No	Infection Prevention and Control Committee monitor compliance Legionella sampling results to IPCC	No	1. External audit/risk assessment completed and recommendations to be actioned - Complete 2. Continue Replacement of water systems to Peanut Ward boiler house - Completed 3. lag pipework to rehab and hotel services - completed Training & appointment of Authorised person & competent persons for water safety. 4. Corneo legionella testing at 10 points - completed	KSO4

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
481	Richard Hathaway	Potential total failure of IT systems	1. Delay to treatment through loss of patient information□ 2. Loss of activity	1. Server breakdown / failure □ 2. Damage to server room from fire, flood, vandalism	1. The Trust has two servers located in two separate rooms.□ 2. Data is replicated daily to the second server.□ 3. Back of main server is carried out in second server room.□ 4. Back up tapes stored in fire-proof safe in second server room.□ 5. First server room has fire suppression.□ 6. Information Management and Governance Committee monitor capacity and capability of IT systems and plan future developments.□ 7. Dashboard of IT system and application performance and resilience in place.□ 8. Additional external support provided for server breakdown□ 9. Independent survey completed of whole site infrastructure	8	4		Business continuity plan	Priority list from site survey of resilience actions required to ensure IT system does not fail	Report on resilience actions for IT system following site survey Identify and instigate off-site location for back-up server- Completed	KSO4
624	Richard Hathaway	Failure to invest in IT, estates and medical equipment due to insuficient funds or poor allocation	1. Failure to improve services□ 2. increased maintenance costs for equipment and estate	1. Lack of system in place for capital funding□ 2. No review process for capital funds for the 3 key areas estates, IT and medical equipment	1. IT strategy and site development strategy□ 2. Estates capital programme for 2013/14□ 3. Medical device committee and procurement process□ 4. Procurement software and process to ensure good procurement practice.□ 5. Allocation for capital funding between medical devices, estates and Information Technology to be prioritised on a needs basis rather than the previous process of set amount for each area.	12	4	No	Capital programme report to the Board detailing clear allocation between the 3 key areas and reasons based on risk assessment	No	Complete capital bid / review process - Completed Develop wireless and mobile technology Extend self check in and patient calling system - Completed Implement digital dictation and voice recognition - Completed Progress joint procurement of electronic document management and clinical portal	KSO4

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
629	Richard Tyler	Inadequate health records storage and processing and lack of budgetary allocation for ongoing storage costs from mid June 2014	1. Staff injury from increased moving and handling for staff□ 2. Staff injury from slip,trip / fall over notes/boxes□ 3. Lack of storage space for paper records for Trust□ 4. Delay to obtain health record□ 5. Lack on budgetary allocation for ongoing storage costs from mid June 2014	1. Kings House near capacity□ 2. Delay in procurement of electronic patient record system□ 3. Failure for departments to follow archiving and storage proccess□ 4. Destruction of records less than 10% of new records created□ 5. Departments following different storage methods□ 6. Existihg tender for transport and storage requires renewal	1. Health records policy includes process for managing records off site□ 2. Bags used for transporting notes changed to fit within boxes therefore reducing handling□ 3. Regular destruction of notes in place.□ 4. Increased racking in place in Commonwealth house□ 5. Missing notes procedure in place□ Paper to Clinical Cabinet summarising the costs associated with move packaging and moving records to free additional space as additional storage space will be required from 31/03/2013□ 6. Regular transport runs between Kings House and QVH□ 7. Tracking system for notes in place□ 8. Outsourcing scanning of 10000 sets of notes to increase capacity completed□ 9. Tender renewal process underway.□ 10.Regular meetings commenced between Head of Procurement, Head of RM, HR Manager and Matron (commenced 09/04/2014)to monitor progress□ 11. Action plan developed and monitored at above meetings	15	3	Electronic health record	Patient Documentation Committee minutes Missing notes audit reported to Patient Documentation Committee Destruction audits reported to Patient Documentation Committee	H&S Inspection action plan and re inspection report to Patient Documentation Committee	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	KSO4

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
431	Graeme Armitage	Poor leadership resulting in employees not being treated with fairness and respect	1.Failure to follow up required actions.□ 2.Disengagement of staff.□ 3.Failure to implement required Trust changes.□ 4. Unfair treatment of staff across the organisation□ 5. Lack of motivation and engagement amongst staff	1. Lack of leadership development for managers.□ 2. Lack of direction from senior management team.	1. Appraisal process for all staff.□ 2. Competencies for clinical staff.□ 3. Leadership training in place for staff□ 4. Core values for QVH in place.□ 5. Trust strategic objectives and annual plan in place.□ 6. CEO walk rounds□ 7. Department meetings.□ 8. Clinical leadership programme for clinicians □ 9. Employee Assistance Programme and Occupational Health Service in place to support staff with concerns/issues□ 10. Qualified and professional human resource staff available□ 11. Staff job descriptions clearly specify the roles and responsibilities as well as the Trust's expectation of all staff□ 12. Whistleblowing/confidential avenue for reporting concerns available for staff□ 13. Line management support available for all staff□ 14. Trust's appraisal system in place where staff can discuss and review their personal development plans	6	3	No	Staff survey Review and monitoring by the Wellbeing and Culture Committee	No	training needs analysis. results are very positive indicating a high level of engagement and satisfaction with the organisation. Revised appraisal scheme introduced with effect from Jan 2014 improving the compliance and quality of appraisals. This is linked to the annual Values based recruitment to managers has been updated and approved (Jan 2014) QVH 2020 workstreams includes: Organisational Excellence and within this objective the Head of HR/OD is designing a leadership and management framework. 2013 Staff survey Leadership development programme planned for 2014/15 Integrate culture and values into recruitment and appraisal systems Monitor the impact of licence to lead Develop clinical leadership Implement values based organisational development programme Introduce system for	KSO5

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
477	Graeme Armitage	Inability to fund staff education due financial costs & pressures	1: Lack of current up to date knowledge□ 2: Inability to provide an effective service□ 3: Inability to compete for business with other NHS organisations□ 4: Low staff morale and staff competence□ 5: Difficulty to recruit to vacant posts□ 6. Reduced quality to patient care□ 7. Poorly trained staff providing poor quality of care	1: Reduction of government funding□ 2: Lack of adequate Trust Budget□ 3: Inability to undertake income generation (externally)	1. Bi monthly funding panels ensure robust management.□ 2. Study leave policy amended to include expectations from staff.□ 3. At present essential education funded from SHA; all other applications considered by League of Friends (Rosemary Wooten Bursary).□ 4. Funding allocation from Trust budget□ 5. Funding confirmed for 13/14 from HEEKSS - increase from 2012/13	6	6	No	Inpatient / Outpatient surveys Low harm reporting rates Annual education and training report to Quality & Risk Human Resources Board reports include staff turnover and stability Staff survey results	No	values based recruitment guidence to managers introduced Jan 2014 very positive for the 3rd year running in dicating good engagement with the Trusts workforce. Recruitment of staff hyas not seen any significant deterioration and the quality of candidates is now being tested further before employment through the updated Annual Assessment by Deanary was very positive for 2013 and the relationshiphas improved as a consquence, this will help to manage the downward trend on training places over the next 3 years. Patient feed back survays remain positive and staff survey 2. For 2012 onwards, a commitment both in financial and management terms to support educational training within Trust. - completed 1. Consideration given to increasing Trust educational budget to cover 25% reduction from SHA in 2011/12 - Completed	KSO6

ID	Board Lead	Title	Description (Hazard(s)	Risk Cause(s)	Key Controls	Rating (current)	Rating (target)	Gaps in Controls?	Source of Assurance	Gaps in Assurance ?	Description (Action Plan Summary)	Principal objectives
604	Richard Hathaway	Breach of information security due to use of unsecure email accounts to transfer person identifiable data (patient and staff)	1: Breach of data protection act□ 2: Loss/accidental disclosure of patient identifiable data□ 3: Reputational damage to the organisation□ 4: Information Commissioner's Office (ICO) investigation and fines□ 5: Complaints and litigation	1: Failure to follow Trust policy, legislation and confidentiality□ 2: Lack of responsibility from staff to adhere to IG standards□ 3: Potential for private email accounts to be subject to hacking□ 4. Emails containing patient identifiable data sent to non secure address	1: Mandatory information governance training available for all staff.□ 2: Datix incident reporting and investigation procedure in place.□ 3: Trust information governance manager to oversee and advise regarding information governance standards.□ 4: The following solutions are in place for accessing and transferring information securely.□ 4.1 NHS mail□ 4.2 Good e-mail app□ 4.3 Remote access□ 4.5 encrypted memory sticks□ 5 IT & IG lead to review new security restrictions (soft ware applications)	12	6	NHS.NET account not in use accross Trust	Information Governance toolkit rating Information Governace training attendance compliance reports Incident reporting rates in Q&R report and to Information Management and Technology Committee Internal audit report on information security requirements		Monitor IG training compliance Deploy encryptioin software to manage use of unauthorised email accounts - Not required	KSO6

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22nd May 2014**
Agenda item reference no:	**118-14**
Author:	**Graeme Armitage, Head of HR/OD**
Date of report:	**14th May 2014**

Workforce Performance Report: May 2014 (MONTHLY UPDATE)

1. Introduction:

1.1 The Workforce Performance Report for May focuses on the exceptions and actions being taken to address areas of under-performance and to highlight areas of positive achievement. Additional information is made available to managers underpinning this Board level report to help them to address those areas highlighted as concerns. The information is also used to review service performance on a quarterly basis.

1.2 Sickness absence has risen in April and whilst this is against the previous 3 months downward trend has been highlighted as a concern and a need to focus on with managers. The Trust outturn target for the year is 2% and therefore HR are leading discussions with managers to help and support them to manage more effectively their staff absence.

1.3 Statutory and mandatory training performance continues to improve with compliance rates now at over 79% and just below the Trust target of 80%. This provides the Trust with a stronger baseline for the rest of the year. In addition there is good evidence to support the improving accuracy of the information being provided to managers and the additional reports being made available to them are having an impact. The reports now available to managers include:

a) Staff who did not attend booked courses

b) Staff who are to become non-compliant in the next 3 months

c) Staff who have been non-compliant for more than 3 months

It is a manager's responsibility to review the information provided to them monthly and to take action accordingly. Additionally the Head of HR/OD will be reviewing more specifically the actions taken with those individuals on list c) above. It is expected that in some cases this will result in disciplinary action and potential suspension from duty.

1.4 Bank and agency expenditure is also showing improvements over the previous year albeit with a slight increase over expenditure in March. The controls in place to manage this more effectively remain for the rest of the financial year and closer monitoring will also continue.

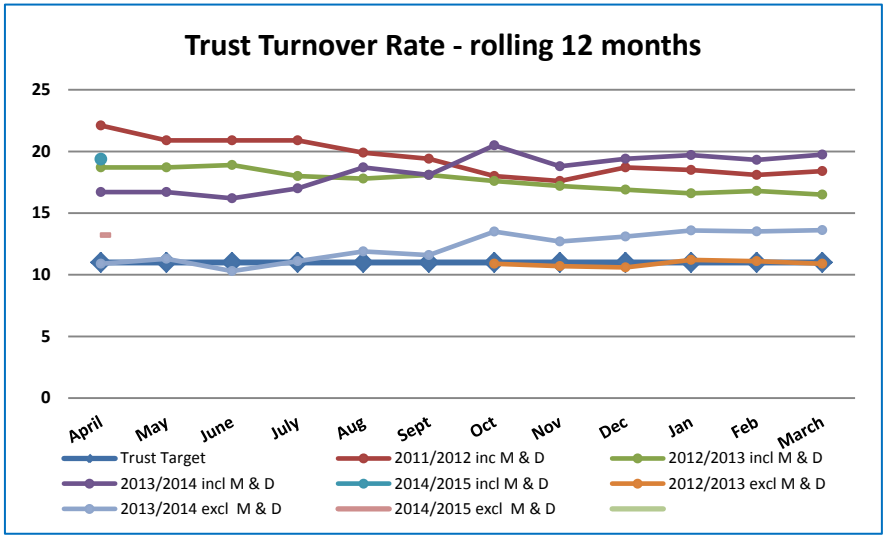
1.5 Appraisals (PDRs) are showing a decrease this month however, this is expected and is as a result of the transition to the new appraisal cycle. Through the year there will be staff whose incremental date and current appraisal dates do not match. Therefore whilst we move through the year aligning incremental progression with appraisals we are likely to see a higher than normal level of staff appearing to be out of date. This will settle

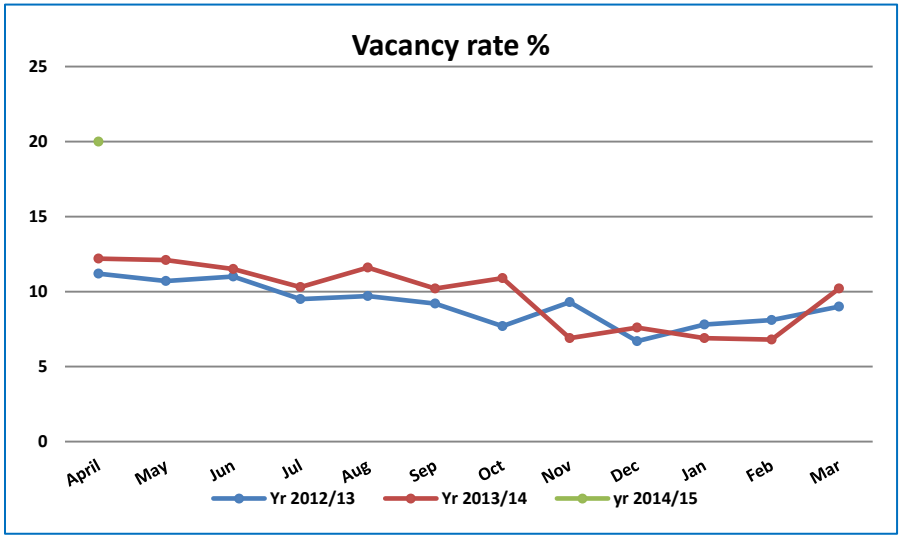
through the next 12 months during which time managers will still be required to undertake 1:1 sessions on a regular basis. The underlying trend will be kept under monthly review to ensure the transitional phase is not covering any other concerns in performance.

1.6 Recruitment timescales have significantly improved from an average of 6 weeks (already good performance in comparison to other Trusts in the southeast) to 5 weeks. This is helping managers to keep additional costs i.e. bank and agency down and improves our external profile with prospective employees.

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

HEADLINE HR KPIs May 2014





	Staff Movements											
	May-13	Jun-13	July 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14
Headcount	926	928	937	930	938	942	960	959	967	978	972	965
WTE in Post	786	790	795	788	789	807	819	820	825	832.36	824.60	816.40
WTE Funded Establishment	867.69	867.69	867.69	867.99	867.99	867.99	867.99	867.99	867.99	867.99	867.99	N/A
New Hires	5	7	15	37	21	33	12	6	16	29	7	10
Leavers	8	6	13	43	12	24	6	14	11	20	16	9
Maternity Leave	10	13	16	15	18	18	19	21	16	17	19	19
Vacancy Rate	11.6%	11.5%	10.3%	11.6%	10.2%	10.9%	6.9%	7.6%	6.9%	6.8%	10.2%	
Turnover Rate	0.76%	0.86%	1.39%	4.62%	1.27%	2.51%	0.73%	1.46%	1.14%	2.05%	1.65%	0.93%

	Rolling 12 Monthly Turnover Figures											
	May-13	Jun-13	July 13	Aug 13	Sep 13	Oct13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14
12 Month Turnover (including Medical & Dental)	16.7%	16.2%	17.0%	18.7%	18.1%	20.5%	18.8%	19.4%	19.70%	19.32%	19.74%	19.38%
12 Month Turnover (Excluding Medical & Dental)	11.3%	10.3%	11.1%	11.9%	11.6%	13.5%	12.7%	13.1%	13.59%	13.51%	13.62%	13.21%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 30th April 2014 decreased slightly by 0.36% to 19.38% (including medical and dental) and by 0.41% to 13.21% (excluding medical and dental).

During April there were 10 new starters to the Trust and 9 leavers (7.65 FTE) with a monthly turnover rate for April of 0.93% (0.94% FTE). Staffing stability is at 94.91%, this indicates that the organisational staffing core is stable.

Medical staffing have the highest turnover for April with 3 WTE post (3– End of Fixed Term Contract), followed by Plastic Surgery Medical Secretaries at 1.40 WTE (2 voluntary resignation – child dependents). Other reasons for leaving in April were 1 - Voluntary Resignation - Health, 1 – Voluntary Resignation – better reward package, 1 - voluntary resignation – promotion.

Vacancies Rates (figures 2 month in arrears)

Vacancy rate for March was at 10.2 % of which 45.4 WTE were actively being recruited to. Bank and agency are being used to the total of 51.77 WTE which is leading to the use of 6.98 WTE above budgeted establishment. The reason for this is the need to cover maternity leave (currently 19 employees on maternity leave) and long-term sickness (20 employees with sick leave of 4 weeks or more)

Vacancies

Activity levels for April currently have 36.8 WTE of active vacancies currently being worked on, of which 19 WTE are Nursing posts, 10.1 WTE currently for Canadian Wing. 30.57 WTE are at interview stage, 5 WTE jobs were not recruited to.

Average recruitment timescales have reduced from 6 weeks to 5 weeks, from advert to conditional offer letter. Further work still remains to be completed to support managers turnaround their shortlisting's within the 5 working day KPI.

Exceptions

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

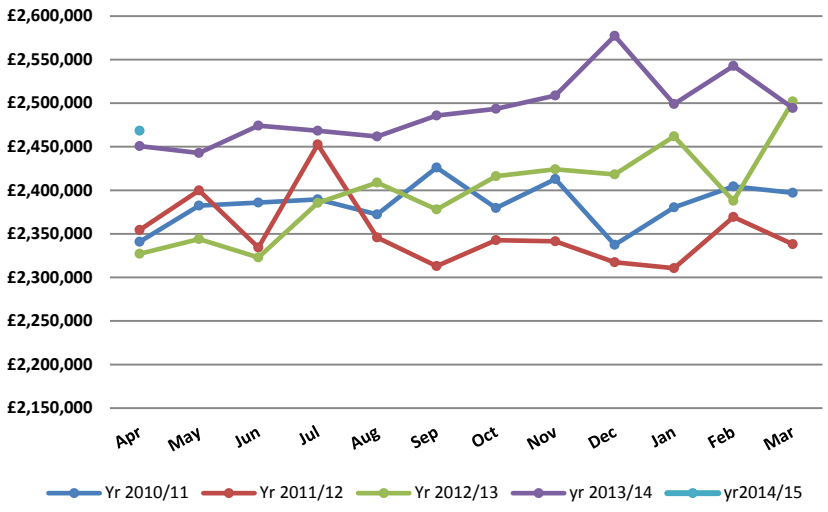
Actions

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

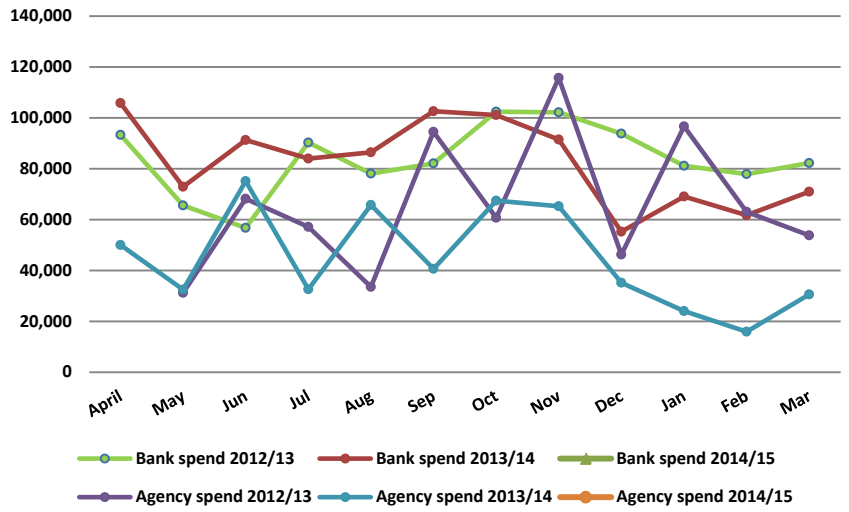
RAG Rating

HEADLINE HR KPIs

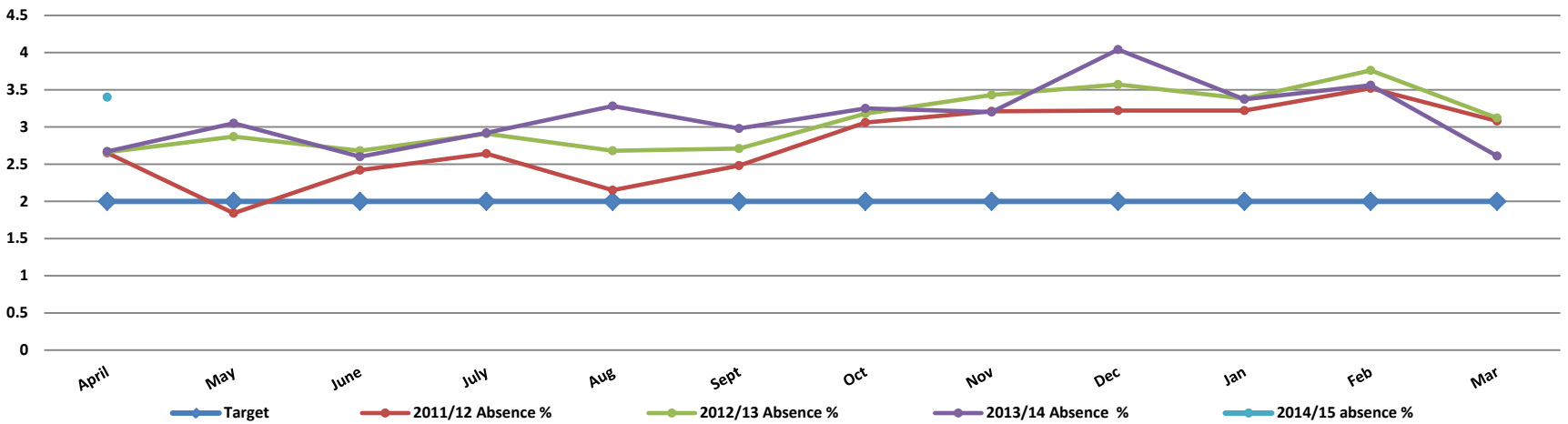
Total Pay Bill per month (excluding on costs)



Bank & Agency Spend



Trust Absence Timeline



HEADLINE HR KPIs

Pay Bill – (1 month in arrears) reported pay does not include on costs.
Pay for April decreased very slightly to £2,468,339, due to tighter monitoring of budgets and robust controls in place for the use of bank and agency workers.

A breakdown of the split between total staff paid WTE and bank/agency and overtime is reported in arrears and for March 14, shows WTE staff in post was 824.6, total WTE paid 881.58 (inclusive of 34.83 Bank WTE, 16.94 Agency WTE and 5.21 over-time WTE).

Bank and Agency usage – (figures are 2 month in arrears)
Bank and agency expenditure for March was £101,500 an increase of £23,926 over last month, due to additional workload, establishment vacancies and high patient activity.

The Bank/agency combined fill rate for March is at 84.5%, in total 6520 hours (66.6%) were filled by bank and 1774 (18.08%)were filled by agency.

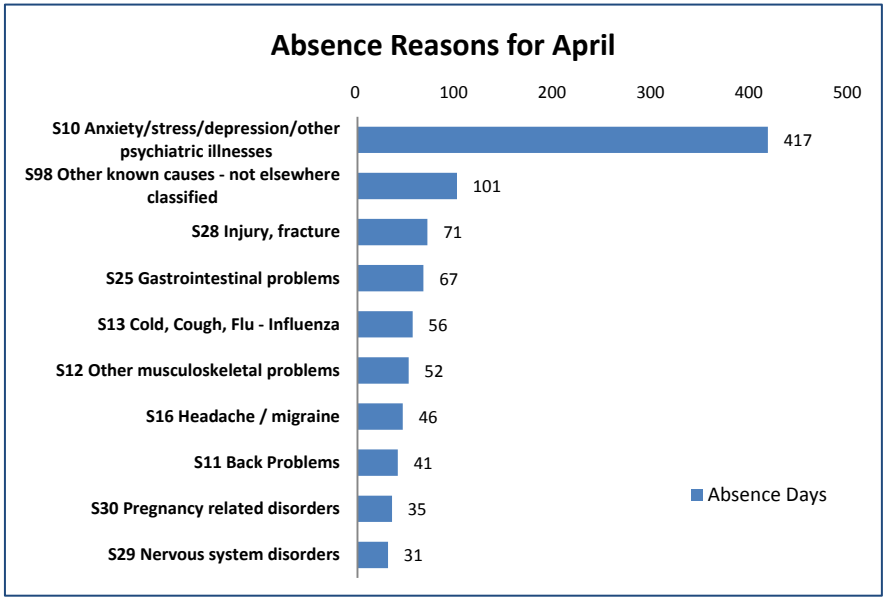
Exception areas
Bank expenditure for March for Canadian Wing was £12,827, an increase of (£4577), agency expenditure was £23,148 an increase of (£14,766) on last month, this is down to vacancies and high patient activity. Burns and Theatres also showed small increases in bank and agency expenditure.

Actions

- Monitor controls put in place and review in May as to whether further steps need to be instigated.
- Senior managers to sign off before any bank or agency agreed to avoid unnecessary use of bank/agency workers.
- Tighter financial controls on departments budgeted establishment

RAG Rating

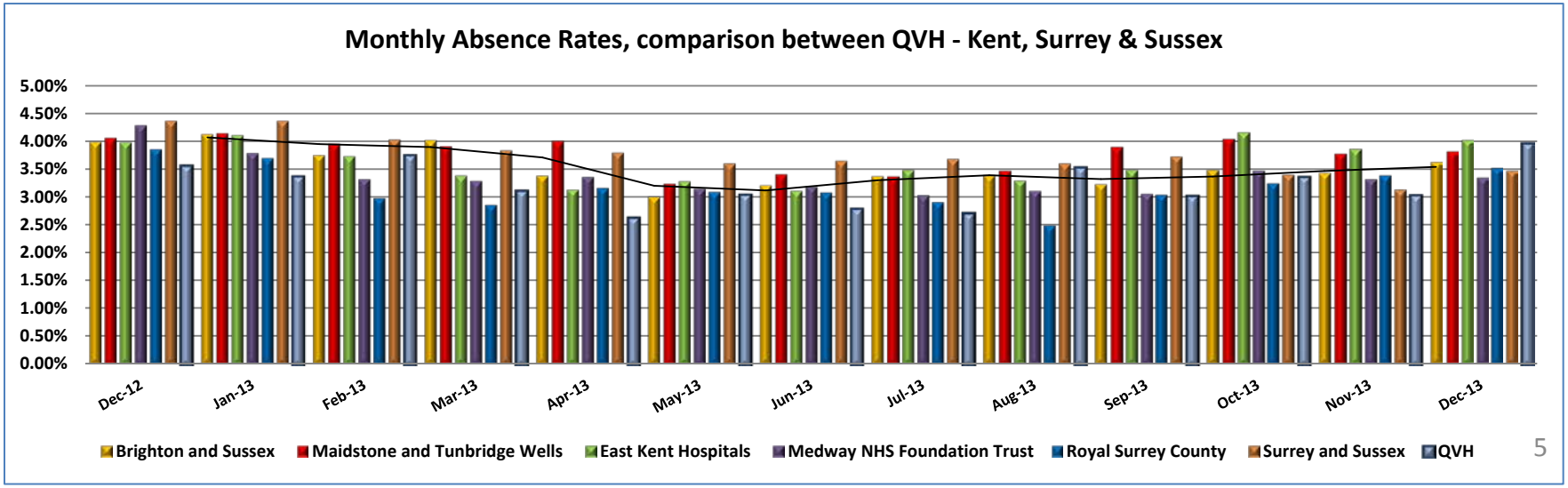
HEADLINE HR KPIs



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

Staff Group	Estimated Cost	FTE Days Lost
Add Prof Scientific and Technic	£5,267	51.5
Additional Clinical Services	£11,303	201.67
Administrative and Clerical	£12,745	218.10
Allied Health Professionals	£3,663	38.53
Estates and Ancillary	£6,210	82.80
Healthcare Scientists	£0	0
Medical and Dental	£1,560	12.0
Nursing and Midwifery Registered	£20,854	227.72
Grand Total	£61,604	838.53

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



HEADLINE HR KPIs

Sickness/Absence

The Trusts reported sickness absence rates for April 2014 stand at 3.40% which is above trust target of 2.0%, an increase of 0.73% over the previous month (April 2.67%), with a current rolling average of 3.32% (2013 rolling average: 3.08%). Efforts to maintain smarter control of absence is being coordinated between HR , with monthly meetings with managers and case reviews in place, increasing the support to staff enabling an earlier return to work. The highest reported sickness for April being 1) anxiety/stress/depression 2)other known causes – not else where classified 3) Injury/fracture.

Exceptions

The main affected areas are Site Practitioners at 13.96% a small department with 4 short-term sickness cases. Building & Engineering Building at 11.46% with 1 long-term and 1 short-term sickness case. Plastic Surgery 4 medical secretaries 2 on long-term sickness with work related stress and 2 short-term sickness. Psychotherapy a small department with 1 employee on long-term sickness and 5 short-term sickness . Burns ITU at 8.4%, 2 long-term sickness cases and 5 short-term sickness. Theatres at 5.43% have 4 long-term sickness cases and 39 short-term sickness cases. Canadian Wing at 4.5% have 2 long-term sickness cases and a number of short-term anxiety/stress/ depression cases.

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

Actions

- A new HR session has been also been added entitled 'Managing Work Related Stress' which is designed to support managers more specifically in understanding and recognising the signs of stress in the workplace and how to make improvements e.g. ensuring staff have their breaks on time.

- A quarterly survey / feedback from managers will be undertaken at the end of Q1 to look at the initiatives in place and determine their effectiveness. The review will also look at further initiatives to support managers to work towards the 2% outturn sickness target.

RAG Rating

HEADLINE HR KPIs

Payroll

All staff were paid on time, there were no new overpayments, the volume remaining at 0 from March. There were 7 interim payments made in April, due to managers error when finalising shifts on healthroster. Payroll errors increased from 0 to 1.

Employee Relations

There were no new cases reported in April 2014.

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

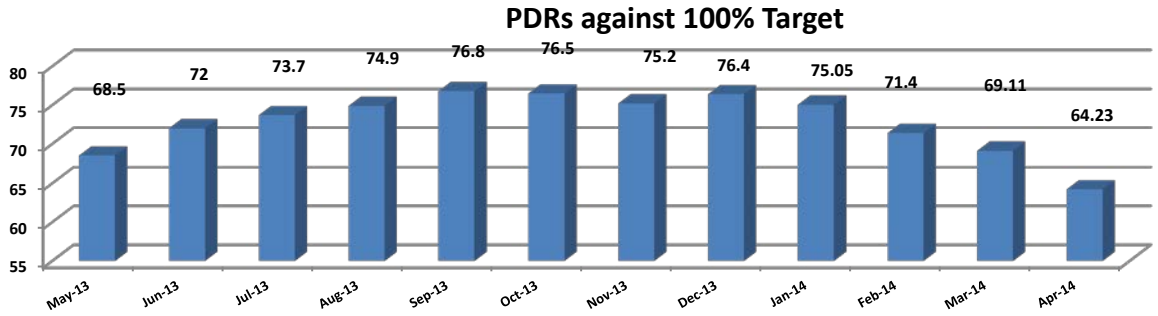
Actions

- Continue to focus on areas above 2% absence rates. Meetings being held regularly with ward managers/matrons/line managers to discuss cases and develop action plans.

- Monitor the short term absence providing monthly reports to managers on staff who have hit trigger points that require intervention.

RAG Rating

PDR's by Directorate



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

Directorate	May 13		Jun 13		Jul 13		Aug 13		Sep 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar 14		Apr 14		
Anaesthetics & Theatres (Dir)	70.15%	↓	67.41%	↓	65.22%	↓	73.19%	↑	70.59%	↓	71.13%	↑	73.10%	↑	60.58%	↓	54.35%	↓	49.28%	↓	48.91%	↓	47.83%	↓	**138**
Head, Neck & Eye (Dir)	50.00%	↑	58.93%	↑	63.16%	↑	72.41%	↑	82.76%	↑	79.66%	↓	79.28%	↓	71.88%	↓	69.23%	↓	56.72%	↓	54.55%	↓	50.00%	↓	**68**
Inpatient Services (Dir)	72.65%	↑	79.31%	↑	77.78%	↓	76.72%	↓	76.52%	↓	76.23%	↓	72.36%	↓	71.43%	↓	71.90%	↑	75.21%	↑	72.41%	↓	63.48%	↓	**115**
MIU (Dir)	70.59%	↑	70.59%	→	88.24%	↑	84.21%	↓	77.78%	↓	83.33%	↑	83.33%	→	83.33%	→	84.21%	↑	84.21%	→	68.42%	↓	63.16%	↓	**19**
Corporate	67.91%	↑	72.04%	↑	61.38%	↓	71.43%	↑	70.62%	↓	72.00%	↑	96.00%	↑	74.75%	↓	91.30%	↑	63.64%	↓	45.83%	↓	33.33%	↓	**24**
Outpatient Services (Dir)	78.48%	↑	81.01%	↑	84.81%	↑	77.63%	↓	80.00%	↑	76.92%	↓	78.21%	↑	75.31%	↓	74.68%	↓	70.00%	↓	77.50%	↑	76.83%	↓	**82**
Paeds & Clinical Support (Dir)	73.15%	↑	79.45%	↑	80.99%	↑	80.54%	↓	79.19%	↓	75.00%	↓	66.88%	↓	80.65%	↑	84.62%	↑	84.08%	↓	84.08%	→	83.23%	↓	**155**
Plastic & Burns (Dir)	80.95%	↑	80.95%	→	82.81%	↑	88.89%	↑	92.06%	↑	92.31%	↑	86.55%	↓	83.33%	↓	81.54%	↓	78.79%	↓	67.19%	↓	39.68%	↓	**63**

Medical & Dental - PDR Achieved against 100%

Directorate	May 13		Jun 13		Jul 13		Aug 13		Sep 13		Oct 13		Nov 13		Dec 13		Jan 14		Feb 14		Mar 14		Apr 14		
Anaesthetics & Theatres (Dir)	51.72%	↑	70.00%	↑	80.00%	↑	83.33%	↑	96.77%	↑	96.88%	↑	93.75%		93.75%	→	90.63%	↓	87.50%	↓	87.10%	↓	80.65%	↓	**31**
Head, Neck & Eye (Dir)	50.00%	↑	54.72%	↑	58.49%	↑	62.75%	↑	67.35%	↑	66.04%	↑	84.91%	↑	84.91%	→	79.25%	↓	74.55%	↓	70.91%	↓	67.27%	↓	**55**
Nursing Management & Risk (Dir)	0.00%	→	100.00%	↑	100.00%	→	100.00%	→	100.00%	→	100.00%	→	100.0%	→	100.0%	→	100%	→	100%	→	100%	→	100%	→	**1**
Paeds & Clinical Support (Dir)	0.00%	→	50.00%	↑	50.00%	→	50.00%	→	50.00%	→	50.00%	→	60.0%	↑	60.0%	→	50.00%	↓	25.00%	↓	33.33%	↑	33.33%	→	**3**
Plastic & Burns (Dir)	50.00%	→	62.75%	↑	64.71%	↑	64.00%	↓	78.00%	↑	74.51%	↓	92.59%	↑	92.59%	→	92.45%	↓	92.45%	→	86.27%	↓	82.69%	↓	**52**

HR KPIs

PDRs

Appraisal rates have continued to decrease for the month of April from 69.11% to 64.23%.

The overall compliance rate for Medical & Dental staff has continued to fall from 79.43% to 75.35%. Nursing Management & Risk has remained the same at 100%. Paeds & Clinical Support have also remained the same but they are only at 33.33%..

Exceptions

Continued areas of under performance are Anaesthetics & Theatres 47.83%, Head, Neck and Eye at 50%, Corporate 33.33%, These areas are chased on an on-going basis to ensure their figures improve.

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

Actions

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

Points to be aware of: Despite the drop in performance this is expected due to the transition to the new appraisal timetable i.e. linking to the individuals incremental date. This has not been adjusted for in the current figures and therefore will be addressed for the June report as this provides for a misleading picture. However if individuals are considerably out of date there is the expectation that managers will give them an interim PDR. It has also been identified that currently there is no electronic system in place to show that PDR's have been booked with staff or that they have actually taken place. HR are therefore reliant upon the paper based information being received in the department to be uploaded. Again this means that the performance at present is under reported and will be addressed for the June report.

The in month figures for April shows the following:

22 appraisals should have been completed by the end of April 2014
4 have been completed
18 are still out of date

RAG Rating

Statutory and Mandatory Training as at 30.4.14

Competence Name	Does not meet requirement	Expired but Booked	Meets Requirement	Grand Total	Trust Overall (Expired + Meets Req)
Adult & Paediatric BLS - annual	11.36%	9.94%	78.70%	100.00%	88.64%
Child Protection Level 1 - 3 yearly	14.04%	2.81%	83.15%	100.00%	85.96%
Child Protection: Level 2 - 3 yearly	35.15%	5.45%	59.40%	100.00%	64.85%
Child Protection: Level 3 - 3 yearly	67.14%	0.00%	32.86%	100.00%	32.86%
Conflict Resolution - 3 yearly	32.01%	10.78%	57.21%	100.00%	67.99%
Dementia Awareness	23.36%	0.00%	76.64%	100.00%	76.64%
Emergency Planning: annual	16.32%	5.65%	78.03%	100.00%	83.68%
Equality, Diversity & Human Rights - once	22.38%	4.39%	73.22%	100.00%	77.62%
Infection Control: annual	11.51%	6.28%	82.22%	100.00%	88.49%
Information Governance - annual	21.13%	3.56%	75.31%	100.00%	78.87%
Manual Handling - Clinical - annual	32.79%	5.91%	61.30%	100.00%	67.21%
Manual Handling - Non-clinical - 3 yearly	19.83%	2.79%	77.37%	100.00%	80.17%
Risk: annual	11.09%	5.54%	83.37%	100.00%	88.91%
Safeguarding Adults - 3 yearly	21.65%	3.97%	74.37%	100.00%	78.35%
Grand Total	20.65%	5.15%	74.20%	100.00%	79.35%

Statutory & Mandatory Training

Statutory and mandatory training Trust figures have risen again from 77.69% to 79.35% (74.20% compliance excluding those who are booked onto another course) but course completions are remaining steady despite the continued high non attendance figure. Whilst performance still remains just below the 80% target there are continued discussions to determine ways to increase the completion rates. The approach taken so far has significantly improved performance and which is now becoming more stable. This initiatives in place will continue with further work still required to maintain a position above the Trust target. **Clinical Specialities remains the area with the largest amount of departments with low compliance rates**

Exceptions

Child Protection level 2 – Despite this remaining red, all areas have increased their compliance rate. 62.11% last month to 64.85%.
Child Protection level 3 – Low completion rate across the Trust. As per CPL2 overall areas have increased this month.
Manual Handling Clinical – those areas below 50% are: **Peanut 37.50% increased from** 25%, Theatres dropped from 49.15% to 47.90%, **Site Practitioners** dropped from 45.45% to 41.67%, **Sleep Studies** - 42.86%
Conflict Resolution **Clinical Specialties remain the main area of concern.**

Actions

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

RAG Rating

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22nd May 2014**
Agenda item reference no:	**119-14**
Author:	**Stuart Butt, Interim Director of Finance**
Date of report:	**15th May 2014**

Performance Report Month 01 (April 2014)

1. Summary

Commissioner income is £306k above plan at April.

Outpatient follow-up activity and Daycases significantly contributes to over performance.

2. Demand

Demand, in the form of referrals, dropped slightly in April but is, overall, a good indicator of stable demand for the Trust's services.

3. Outpatients

Outpatient activity was on, or above, plan across most specialities. Activity is most significantly above plan in follow up attendances.

The number of patients waiting for a new outpatient appointment rose in April after falling for most of the last 8 months.

4. Elective Inpatients

Elective activity and income was above plan in month. Casemix for elective activity was less complex than expected (plan) in April.

5. Non elective

Non-elective income is above plan and the casemix is as expected (planned).

6. Key Performance Indicators

All cancer targets for activity performed in March are met apart from the "Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers" target and the "Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer" target. April is still subject to validation. A residual risk around performance on the cancer targets remains due to the small number of cases.

The Trust is forecasting possible failure of the RTT18 aggregate target for Admitted and non-Admitted Patients in April but achieved the Open Pathways aggregate targets. The final RTT18

submission date is 20th May 2014, when the final figures will be available and reported to the Board.

All other performance indicators (MIU and Diagnostic waits) were met for the month of April.

There were no reportable Healthcare Associated Infections in April.

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

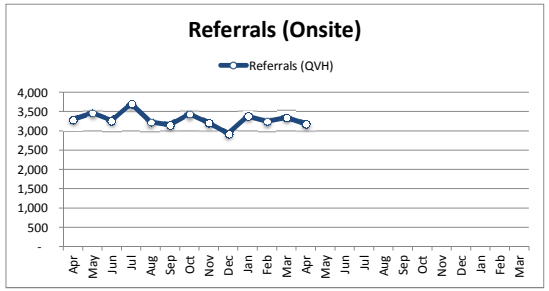
Queen Victoria Hospital NHS
NHS Foundation Trust

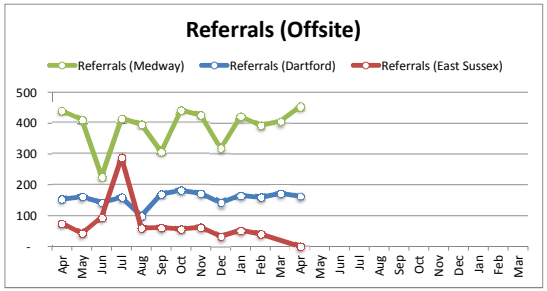
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Stuart Butt

Trust Level Report (All Services)

Period : 2014-15 Month 01 (April)

DEMAND

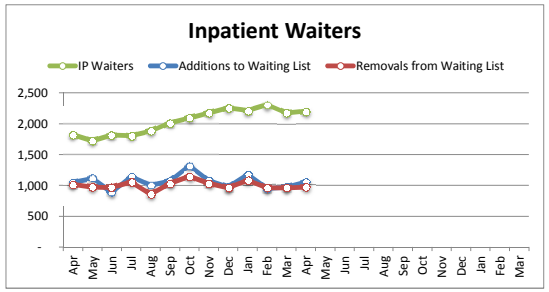


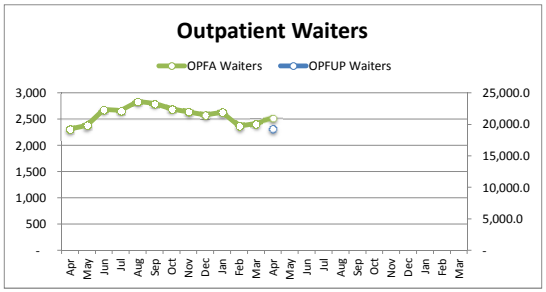


Onsite referrals demonstrating a flat trend from last year

Medway referrals in April 2014 are higher than all of 2013-14
Dartford referrals are steady and unchanged from 2013-14
East Sussex are still to provide us with referral data for Mar/Apr 2014

WAITING LIST

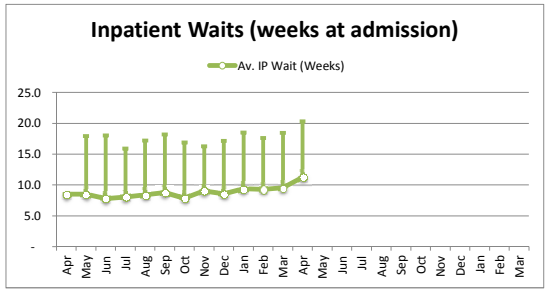


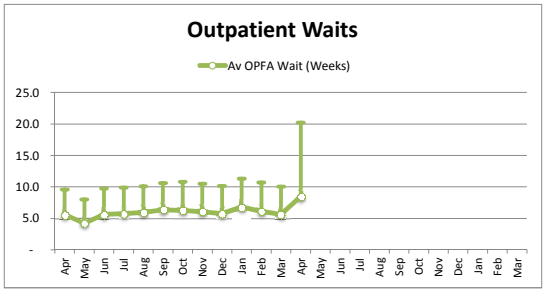


The size of the Inpatient waiting list has grown slightly in April.
Additions to the waiting list (inpatients) outstripped removals in April.
Patients waiting for a new outpatient appointment rose in April.

We started to plot number of patients waiting for a follow-up in April.
(left axis is patients waiting for a new appointment, right is follow-ups)

WAITING TIMES





Average Inpatient wait time rose in April.
This is likely due to no data cleansing done summarily on the dataset.
Av IP Wait Time should be more comparable once May numbers are plotted.

The range of inpatient wait times (error bars) was steady/consistent.

Average outpatient wait time looks much higher in April.
This is likely due to no data cleansing done summarily on the dataset.
Av OP Wait Time should be more comparable once May numbers are plotted.

Queen Victoria Hospital NHS
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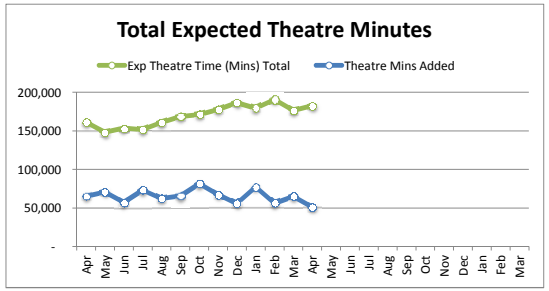
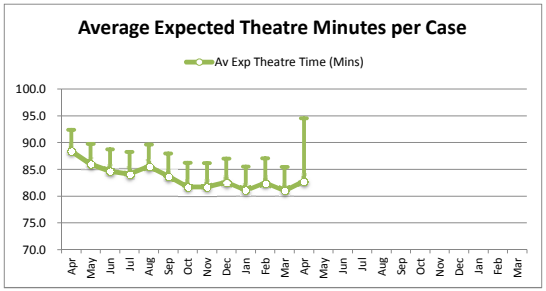
Trust Level Report (All Services)

Period : 2014-15 Month 01 (April)

THEATRE MINS



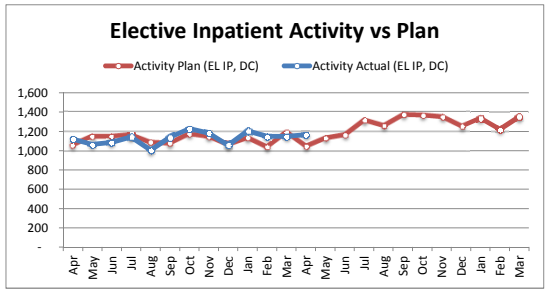


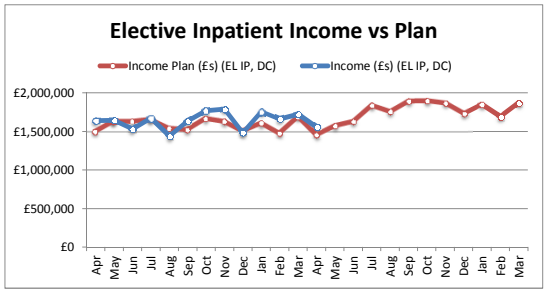
Total Expected Theatre Minutes for April are consistent with the previous month.
Overall theatre minutes are high compared with 2013-14.

Theatre Mins added to waiting lists in April are low and decreasing.
This effect is indicative of treating our backlog for RTT18.

Average expected theatre minutes *per case* remained consistent with the 2nd half of 2013-14.
The range of theatre minutes per case increased significantly in April.

Elective Inpatients





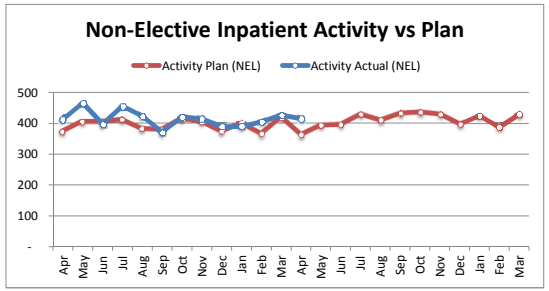
Elective Activity was above plan in April.

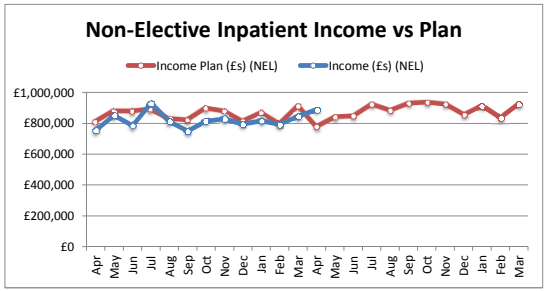
Elective Income was above plan in April.

Income was not as far ahead of plan as Activity was in April - suggesting a less-complex-than-planned casemix for April Elective work.
This casemix hypothesis can be seen later in the casemix charts.

Elective Income was driven by Daycases as we geared up to perform less complex procedures due to the electrical shutdown.

Non-Elective Inpatients





Non-Elective Activity was well above plan in April.

Non-Elective Income was also well above plan in April.

Income surplus was slmost indentical to Activity surplus in April - suggesting Non-Elective casemix was very close to plan in the month.
This casemix hypothesis can be seen later in the casemix charts.

Queen Victoria Hospital NHS
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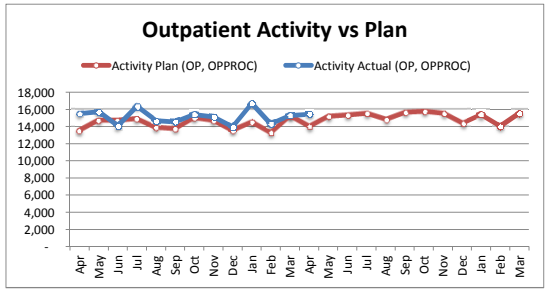
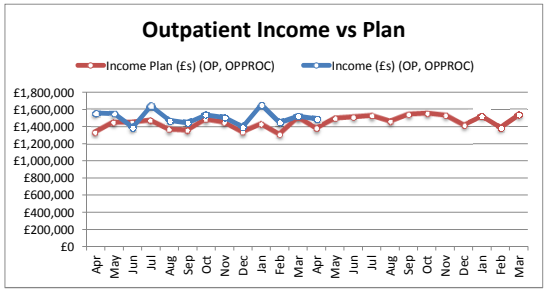
Trust Level Report (All Services)

Period : 2014-15 Month 01 (April)

Outpatients



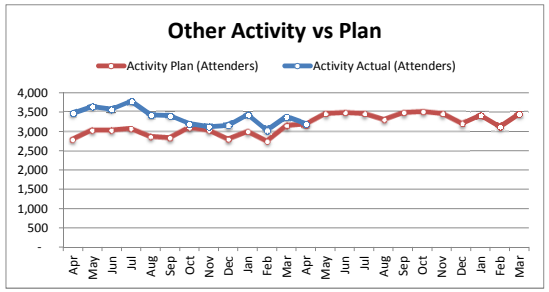


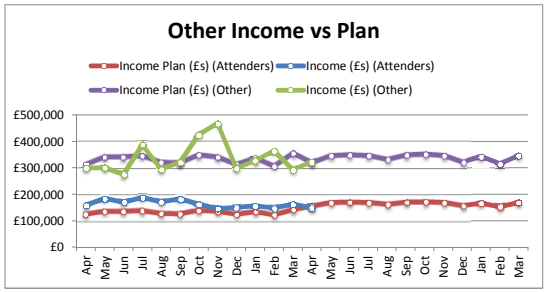
Outpatient Activity and Income was above plan in April

More than half the overperformance (£s) was follow-ups - this could present a residual risk against follow-up ratios.

As we work through our RTT18 backlog there is a likelihood we follow-up more patients in an effort to discharge existing pathways.

Other Activity/Income

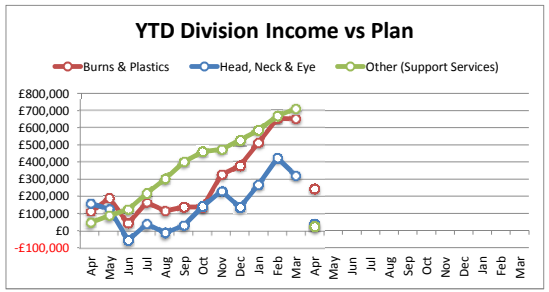


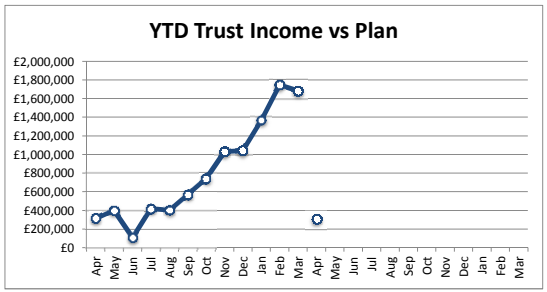


Attenders Activity (Diagnostics, MIU) was on-plan in April
Attenders Income (Diagnostics, MIU) was also on-plan in April

"Other" income (Drugs, Devices and Tariff Exclusions) were on-plan overall for April.

Income vs Plan





Burns & Plastics Division delivered most of the income surplus vs planned income in April.

Overall Income surplus vs plan is the same level as April 2013-14 but it should be noted the overall plan is lower (due to planning assumptions & phasing).

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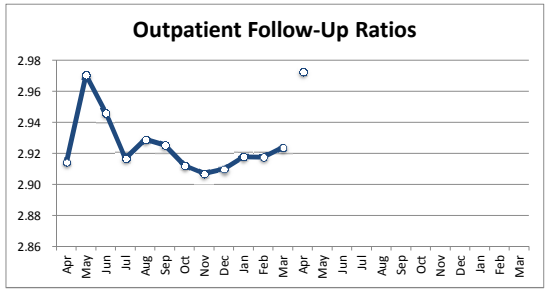
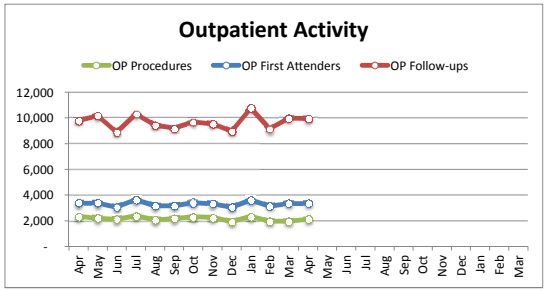
Follow-up Ratios

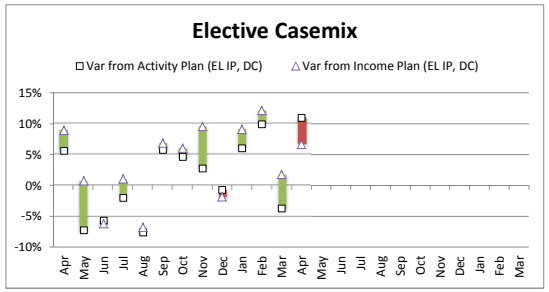


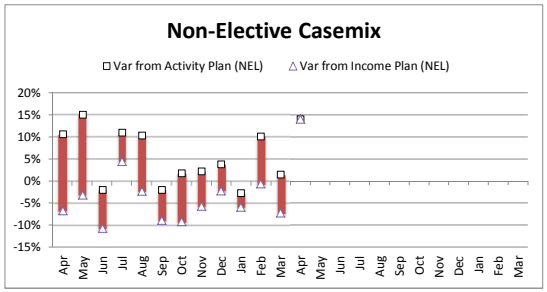


Outpatient follow-up ratios have started higher in 2013-14.
This is a cumulative ratio so is volatile in early months of the year.

The mix of outpatient activity is similar to 2013-14.

Case Mix





Elective casemix was less complex than planned in April most likely due to the electrical shutdown meaning we had to treat a higher volume of low length-of-stay and low income cases.

Non-Elective casemix was as planned.

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

KPIs in-Month

Ref	Operational Standards	Threshold	Score	FINAL?	Consequence of breach	Timing
CB_B1	Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral	90%	90.5%	FINAL	£400 per breach	Monthly
CB_B2	Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	95%	95.1%	FINAL	£100 per breach	Monthly
CB_B3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92%	93.3%	FINAL	£100 per breach	Monthly
CB_B4	Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	99%	TBC		£200 per breach	Monthly
CB_B5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	99.5%	FINAL	£200 per breach. Capped at 8% over target	Monthly
CB_B6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93%	TBC		£200 per breach	Quarterly
CB_B7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	93%	TBC		£200 per breach	Quarterly
CB_B8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%	TBC		£1,000 per breach	Quarterly
CB_B9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94%	TBC		£1,000 per breach	Quarterly
CB_B12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%	TBC		£1,000 per breach	Quarterly
CB_B13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	90%	TBC		£1,000 per breach	Quarterly
CB_B14	Percentage of Service Users waiting no more than 62 days for first definitive treatment following a consultant's decision to upgrade the priority of the Service User (all cancers)	85%	TBC		2% of revenue derived from the provision of the locally defined ser	Quarterly
CB_B18	Operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons not offered another binding date within 28 days (QMCO)	0	0	estimate	Non-payment of costs - cancellation and re-scheduled episode	Monthly
CB_A15	Zero tolerance MRSA	0	0	FINAL	£10,000 in respect of each incidence in the relevant month	Monthly
CB_A16	Minimise rates of Clostridium difficile	0	0	FINAL	£10,000 per case	Monthly
CB_S6	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	0	FINAL	£5,000 per Service User (incomplete RTT pathway waiting over 52	Monthly
DQ1A	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (APC)	99%	TBC		£10 per breach	Monthly
DQ1B	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (OP)	99%	TBC		£10 per breach	Monthly
DQ2	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	95%	TBC		£10 per breach	Monthly
CB_S10	No urgent operation should be cancelled for a second time (Monthly SITREPs)	0	TBC		£5,000 per incidence in the relevant month	Monthly
VTE	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95%	100.0%	FINAL	£200 per breach	Monthly
FORM	Publication of Formulary	TRUE	TRUE	FINAL	Withholding of up to 1% of the Actual Monthly Value per month unti	Monthly
NEVER	Never Events	0	0	FINAL	Cost of Episode	Monthly

KPIs Progression

	Ref	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
90%	CB_B1	92.8%	92.0%	91.9%	91.4%	91.7%	91.6%	92.0%	88.8%	90.9%	89.1%	86.6%	87.6%	90.5%	FINAL										
95%	CB_B2	96.4%	97.4%	95.9%	96.4%	97.1%	95.9%	96.4%	95.6%	95.6%	95.3%	95.0%	95.5%	95.1%	FINAL										
92%	CB_B3	95.6%	95.3%	95.9%	94.3%	95.5%	93.5%	93.8%	92.5%	92.8%	92.6%	90.8%	92.8%	93.3%	FINAL										
99%	CB_B4	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	TBC											
95%	CB_B5	99.7%	99.4%	100.0%	100.0%	99.4%	99.4%	98.5%	99.8%	99.5%	100.0%	99.9%	99.5%	99.5%	FINAL										
93%	CB_B6	96.6%	100.0%	96.4%	94.7%	96.1%	97.2%	94.6%	99.2%	98.2%	93.0%	98.4%	98.3%	TBC											
93%	CB_B7	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	TBC											
96%	CB_B8	96.0%	93.6%	97.8%	97.2%	100.0%	95.8%	96.1%	98.4%	97.2%	98.0%	96.2%	91.7%	TBC											
94%	CB_B9	100.0%	98.1%	100.0%	98.0%	97.2%	97.9%	97.8%	94.7%	96.3%	98.1%	98.0%	97.7%	TBC											
85%	CB_B12	83.3%	96.4%	95.0%	78.3%	92.5%	92.9%	90.2%	84.6%	100.0%	94.9%	81.0%	75.9%	TBC											
90%	CB_B13	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	TBC											
85%	CB_B14	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	TBC											
0	CB_B18	0	0	0	0	0	0	0	0	0	0	0	0	0	estimate										
0	CB_A15	0	0	0	0	0	0	0	0	0	0	0	0	0	FINAL										
0	CB_A16	0	0	0	0	0	0	0	0	0	0	0	0	0	FINAL										
0	CB_S6	0	0	0	0	0	0	0	0	0	0	0	0	0	FINAL										
99%	DQ1A	99.2%	99.3%	99.4%	99.4%	99.4%	99.4%	99.5%	99.5%	99.5%	99.6%	TBC	TBC	TBC											
99%	DQ1B	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	TBC	TBC	TBC											
95%	DQ2	98.0%	98.5%	98.4%	98.1%	98.1%	98.2%	98.1%	98.2%	98.2%	98.3%	TBC	TBC	TBC											
0	CB_S10	0	0	0	0	0	0	5	5	0	0	0	0	TBC											
95%	VTE	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	FINAL										
TRUE	FORM	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	FINAL										
0	NEVER	2	0	0	0	0	1*	2	0	0	0***	0	0	0	FINAL										

We achieved the RTT18 aggregate targets for the month.
Final RTT18 submission date for April data is 20-05-2014. Final figures will be available then. **Current RTT18 scores for April are estimates**
6-week Diagnostic wait times not available at time of publication but expected to achieve target in April.
Cancer wait times for April not available at the time of publication/
VTE assessment score for April not available at time of publication but expected to achieve target in April.
Data Quality metrics only available at the SUS post-reconciliation inclusion date to will be reported in arrears. We are expecting to achieve these metrics.
No Never Events in April.
The target for "No urgent operation should be cancelled for a second time" is to be confirmed at the time of publication. The data source is the monthly SITREPs (summarily published after these papers).

Queen Victoria Hospital NHS
NHS Foundation Trust

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

Trust Level Report (All Services)
Period : 2014-15 Month 01 (April)

14/15 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	Q1 Perf	Q1 Achieved	Q1 Scoring	Q2 Perf	Q2 Achieved	Q2 Scoring	Q3 Perf	Q3 Achieved	Q3 Scoring	Q4 Perf	Q4 Achieved	Q4 Scoring	
M1C	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	90.5%	Achieved		0.0%			0.0%			0.0%			
M2C	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	95.1%	Achieved		0.0%			0.0%			0.0%			
M3C	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	93.3%	Achieved	0	0.0%		0	0.0%		0	0.0%		0	
M4D	A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	99.5%	Achieved	0	#DIV/0!		0	#DIV/0!		0	#DIV/0!		0	
M5E	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	#DIV/0!	Not relevant		#DIV/0!			#DIV/0!			#DIV/0!			deminimis <5 cases per Quarter
M6E	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	1.0		Not relevant	0			0			0			0	deminimis <5 cases per Quarter
M7F	Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	#DIV/0!	Not relevant		#DIV/0!			#DIV/0!			#DIV/0!			
M8F	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0		Not relevant											
M9F	Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0		Not relevant	0			0			0			0	
M10G	Cancer 31 day wait from diagnosis to first treatment	96%	1.0	#DIV/0!	Not relevant	0	#DIV/0!		0	#DIV/0!		0	#DIV/0!		0	
M11H	Cancer 2 week (all cancers)	93%	1.0	#DIV/0!	Not relevant		#DIV/0!			#DIV/0!			#DIV/0!			deminimis <5 cases per Quarter
M12H	Cancer 2 week (breast symptoms)	93%	1.0	DM?	Not relevant	0			0			0			0	deminimis <5 cases per Quarter
M20M	Clostridium Difficile -meeting the C.Diff objective	0	1.0	0	Achieved	0	0		0	0		0	0		0	
M21	MRSA - meeting the MRSA objective	0	N/A	-	Achieved		-			-			-			
						0			0			0			0	

13/14 Monitor Risk Assessment

Ref	Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Weight	Q1 Perf	Q1 Achieved	Q1 Scoring	Q2 Perf	Q2 Achieved	Q2 Scoring	Q3 Perf	Q3 Achieved	Q3 Scoring	Q4 Perf	Q4 Achieved	Q4 Scoring	
M1C	Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	92.2%	Achieved		91.5%	Achieved		88.8%	Not met		86.6%	Not met		
M2C	Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	96.6%	Achieved		96.5%	Achieved		95.9%	Achieved		95.3%	Achieved		
M3C	Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	95.6%	Achieved	0	94.4%	Achieved	0	93.0%	Achieved	1	90.8%	Not met	2	
M4D	A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	99.7%	Achieved	0	99.6%	Achieved	0	99.2%	Achieved	0	99.8%	Achieved	0	
M5E	Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	91.6%	Achieved		87.9%	Achieved		91.6%	Achieved		85.9%	Achieved		deminimis <5 cases per Quarter
M6E	Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	1.0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	deminimis <5 cases per Quarter
M7F	Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	99.4%	Achieved		97.7%	Achieved		96.3%	Achieved		97.9%	Achieved		
M8F	Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0		Not relevant			Not relevant			Not relevant			Not relevant		
M9F	Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0		Not relevant	0		Not relevant	0		Not relevant	0		Not relevant	0	
M10G	Cancer 31 day wait from diagnosis to first treatment	96%	1.0	95.8%	Not met	1	97.7%	Achieved	0	97.2%	Achieved	0	95.3%	Not met	1	
M11H	Cancer 2 week (all cancers)	93%	1.0	97.7%	Achieved		96.0%	Achieved		97.3%	Achieved		96.6%	Achieved		deminimis <5 cases per Quarter
M12H	Cancer 2 week (breast symptoms) *<5 cases in quarter deminimis*	93%	1.0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	DM	Not relevant	0	deminimis <5 cases per Quarter
M20M	Clostridium Difficile -meeting the C.Diff objective	0	1.0	0	Achieved	0	0	Achieved	0	0	Achieved	0	0	Achieved	0	
M21	MRSA - meeting the MRSA objective	0	N/A	-	Achieved		-			-			-			
						1			0			1			3	

2014-15 Q1 Monitor Targets and Indicators
For the 2014-15 QUARTER 1 Monitor Risk Assessment Framework Return we can, currently, only confirm RTT18 scores for April. We achieved the RTT18 aggregate targets for the month but a failure in any month in the quarter means a failed quarter overall.

2013-14 Q4 Monitor Targets and Indicators
For QUARTER 4 of 2013-14 we can now confirm we failed to achieve RTT18 targets for admitted and incomplete pathways.
We also failed the "Cancer 31 day wait from diagnosis to first treatment" target.

Our Q4 Monitor return only noted failure against the RTT18 admitted target thus we scored only 1 point on the mandated date of the return. We commented that figures were estimated and subject to alteration.

2013-14 Q1 Monitor Targets and Indicators
Following retrospective amendment of Cancer wait target scores for Q1 2013-14 we are now showing failure against the "Cancer 31 day wait from diagnosis to first treatment" target for this period
This failure was not reported in the Q1 2013-14 Monitor Return where the score was "96.5%" at the mandated submission date and commented that the M03 (June) score was an estimate.

A key issue is the timing lag between the mandated Monitor quarterly returns submissions date and our ability to confirm cancer scores by this date (for the quarter in question)

Queen Victoria Hospital NHS
NHS Foundation Trust

Cancer waiting times – Board exception report 15/5/2014

Performance Exception Report			
Month	Mar 2014 / Q4 2013-14	**Executive Director:**	Richard Tyler
		Prepared By:	Jane Morris
Indicator	Cancer waiting times - 2 week wait = 93% Cancer waiting times – 31 day First Definitive Treatment (31FDT) = 96% Cancer waiting times - 31 day First Subsequent Treatment (31FST) = 94% Cancer waiting times – 62 Day wait = 85% Cancer waiting times – 62 Day Upgrade (no standard set) Cancer waiting times – 62 day Breast screening = 90% Cancer waiting times – 62 breast symptoms = 93%		
Variation from plan 	**March 2014** – The trust failed to meet the following Cancer Waiting times standards 31 day First Definitive Treatment (31FDT) = **91.7%** against a standard of 96% (4 breaches out of 48 patients) 62 Day wait = **75.9%** against a standard of 85% (3.5 breaches out of 14.5 treatments) 62 day Breast screening = **50%*** against a standard of 90% (0.5 breaches out of 1 treatment) **Q4 2013-14** - The trust failed to meet the following Cancer Waiting times standards 31 day First Definitive Treatment (31FDT) = **95.3%** against a standard of 96% (7 breaches out of 150 patients) 62 day Breast screening = **55.6%(tbc)*** against a standard of 90% 62 breast symptoms = **0%*** against a standard of 93% **Low patient volume so not reportable as numbers below deminimus level*		
Reason for Variation	**March 2014** <u>*31 day First Definitive Treatment (31FDT)*</u> Reasons for breaching standard are • 2 x patients who required immediate breast reconstructions the visiting surgeon who is required to perform the mastectomy was not available • 1 x patient unwell for operation date planned in Feb so rescheduled • 1 x patient breached due to administrative scheduling error		

	62 Day wait Reasons for breaching standard are • 3 x patients had diagnostic delays due to complex pathways (0.5x2 shared across organisations and 1 full breach) • 1 x patient cancelled their surgery on day 59 due to personal transport problems and not able to reschedule before day 62 (0.5 shared breach across organisations) • 1 x patient referred to the Trust from another organisation at day 73 (0.5 shared breach across organisations) • 1 x patient referral was mislaid within QVH (0.5 shared breach across organisations) **Quarter 4 2013 – 2014** *31 day First Definitive Treatment (31FDT)* The Trust was compliant with standard for both January and February. However there were 3 breaches across these two months which when combined with the performance in March caused the Trust to fail this standard for Q4. Reasons for the other 3 patients breaching are • 1 x patient breached due to administrative scheduling error • 1 x patient breached as no record if an earlier date was offered • 1 x patient DNA treatment on day 28 and was not able to reschedule before day 31
Impact	**Patient Outcomes / Experience** Longer patient waits **Financial Position** Financial penalty applied by CCGs is to be confirmed **Monitor Targets / Contractual Requirements** The QVH cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at the Trust, complex multi-organisational pathways and late secondary referrals. The Trust seeks to manage these risks through effective internal monitoring and close working relationships with referring secondary organisations. At the time of preparing the Quarterly Return to Monitor these risks were not considered to be higher than normal and were not therefore flagged as a matter for additional concern. An exception report has now been submitted to CCG and Monitor. The impact on the Monitor risk rating will be discussed directly with them in light of the report and an update will be provided at Board meeting regarding the outcome of this conversation.
Actions to be taken to address variation and ensure Trust	The following immediate actions are being taken • The Trust who was not able to provide a visiting surgeon for immediate breast surgery will be contacted to highlight issue and request they put in some contingency plans to prevent this occurring in the future

continues to maintain performance	• Scheduling issues off site should now be resolved as the staff have recently been TUPE'd across to QVH which will improve information flows and they will receive further training. • Administrative teams within Trust will be reminded again about the importance of scheduling correctly • Process for central referral system will be reviewed again following recommendations from a recent Intensive Support Team visit which suggested improvements were also needed for 18 weeks. • Review the internal reporting mechanisms within the Trust to provide a bi monthly performance report against cancer waiting time standards in addition to PTL. • Review escalation processes when problems incurred with histopathology delays including outsourced testing turnaround times. • Ensure additional staff are brought in to support the cancer team to cover current sickness levels Medium to longer term actions • Increase number of skin cancer patients who are seen and treated on the same day as outpatient clinics with introduction of new theatre from July 2014.
Forecast date to return to plan	It is anticipated for April that the Trust will achieve all cancer targets. It does need to be stressed that an element of risk remains for the reasons given above. However we are confident that our action plan will reduce the likelihood of multiple breaches within any given period.
Forecast outturn	Final out turn for end of year incorporating Mar 2014 figures are as follows Cancer waiting times - 2 week wait = **96.8%** against a standard of 93% Cancer waiting times – 31 day First Definitive Treatment (31FDT) = **96.6%** against a standard of 96% Cancer waiting times - 31 day First Subsequent Treatment (31FST) = **97.8%** against a standard of 94% Cancer waiting times – 62 Day wait = **89.3%** against a standard of 85% Cancer waiting times – 62 Day Upgrade = 97% (no standard set) Cancer waiting times – 62 day Breast screening = **55.6%*** against a standard of 90% Cancer waiting times – 62 breast symptoms = **0%*** against a standard of 93% **Low patient volume so not reportable as numbers below deminimus level*
Monitoring	Clinical Cabinet (bi-monthly) and Senior Management Team (weekly)
Recommendation	The Board is requested to note and endorse the action being taken to improve performance in this area.

Queen Victoria Hospital NHS
NHS Foundation Trust

RTT18 Update
Board report – 22nd May 2014

Performance Exception Report			
Month	Apr 2014	**Executive Director:**	Richard Tyler
		Prepared By:	Jane Morris
Indicator	Referral to Treatment < 18 weeks for Inpatients – Trust level aggregate 90% Referral to Treatment < 18 weeks for Outpatients – Trust level aggregate 95% Referral to Treatment < 18 weeks for Incomplete Pathways – Trust level aggregate 92% Referral to Treatment < 18 weeks for Inpatients for every speciality 90% Referral to Treatment < 18 weeks for outpatients for every speciality 95%		
Variation from plan 	April In patient aggregate = **90.45 %** against target of 90% Specialities failed: • Corneo (25 out of 192 = 86.98%) April out-patient aggregate = **95.11%** against target of 95% Specialities failed: • Max Fac (36 out of 630 = 94.29%) • Sleep (8 out of 116 = 93.10%) April - Incomplete Pathways aggregate = **88.54%** against target of 92% Specialties failed (not subject to individual fines): • Plastics (240 out of 2094 88.54%) • Cardiology (3 out of 37 = 91.89%)		
Reason for Variation	The contributing factors to this in month breach were due to combined effect of three specialties: • Corneo – have concentrated on clearing a significant number of long waiters for specific corneal conditions which requires the surgical equipment only available at Centre for Sight. Further sessions are being secured to continue to reduce the backlog. • Sleep Studies (Other) speciality also has continued to be affected by issues with technician capacity earlier this year. Full establishment is now in place from April. • Max Fac speciality this month has breached in outpatients due to a combination of factors including patient choice, diagnostic delays due to multiple tests and outpatient capacity. The latter point has been caused by shortages of registrar and associate specialists which where possible the loss in activity has tried to be minimised by use of locums.		
Impact	**Patient Outcomes / Experience**		
	Longer patient waits		

	Financial Position
	Financial penalty applied by CCGs is forecast to be circa £ 25K (tbc)
	Monitor Targets / Contractual Requirements
	Exception report submitted to CCG and Monitor Impact on Monitor risk rating – green however it should be noted a third consecutive quarter failure in Q1 of 14/15 would place organisation ' under review'
Actions to be taken to address variation and ensure all specialities continue to maintain performance	**Sleep** • Locum consultant for Sleep Studies is in place providing 4 more clinics a week – now being made substantive. • 7th night opening during Q1 is planned. • Daytime CPAP treatment and fitting is now in place **Corneo** • Extra LA operating sessions have been organised between April through to October on Saturdays (once a month) and likely to continue for 6 months • Extra sessions for complex corneo procedures have taken place and plans are in place to secure further additional capacity in May / June to reduce backlog for these particular procedures • Locum Associate Specialist for 5 sessions a week for 6 months now in place to maintain increase OPD capacity for Corneo (up till recently this was done as ad hoc arrangement). • Full time Orthoptist post has been recruited to and starts in July to further increase outpatient capacity within the specialty **Plastics** • Extra Saturday operating for Plastic Surgery are planned between April and October with all junior doctors in place. • LOPA and DC LA capacity o Move of existing LOPAs / Mohs facility on C wing has now occurred increasing capacity for LOPA's x 2 a week o From June/July (depending on recruitment of additional staff) Trust plans to open up 8x LA DC sessions in a further theatre in the old complex. This in turn would then free up theatre space for complex cases mid-week which would assist in reducing waiting times to a sustainable position without need for Saturday sessions • Replacement for HRB post retirement has been recruited starting in June. • Breast cases being pooled within Plastics to reduce waiting times of other breast consultants • A Blackburn now in place as locum breast consultant providing additional consultant operating for breast cases. • Plans for replacing PMG post in Sept well underway and this will have Burns/Breast component. **Max Fac** • Extra operating sessions have been organised between April through to October on Saturdays (once a month) and likely to continue for 6 months • From July (depending on recruitment of additional staff in Theatres) Trust plans to create one extra IMOS list per fortnight. • Locum being used to minimize reduction in clinic capacity.

	Intensive Support Team (IST) The IST was asked to review our performance in April and they have since made a couple of further visits in early April. The Trust has received a report with a number of recommendations which the team is working through to prioritise into an action plan. A summary of their key findings outlined below. • Review of access policy IST has recommended a number of changes which are being incorporated to tighten up process • Central referral point has been recommended – aim to have this in place by July 2014 • Increase engagement with commissioners to gain support with other providers who cause delays in patient pathways before referring to QVH • Further refine and improve patient tracking especially within OPD and diagnostics to proactively reduce waiting times • Review demand and capacity using IST developed tools with their support • Implement process for booking pre-assessment and surgery date at same time (with 3 weeks apart) • Trust to ensure PAS is primary source for scheduling and should to discontinue medical secretaries using spreadsheets – dependent on upgrade to Patient Centre • Review overall booking processes to ensure consistency and correct application of rules by all secretaries involved in scheduling • Trust to introduce partial booking for follow up appointments – will need to purchase software to make this possible – procurement being commenced **General actions for all areas** • Validation to continue as before each month • Considering proposal to using some of the current vacancies in admin staff to increase hours for pro-active validation • Discussing with theatre about not giving up lists until last possible minute when we know we have a surgeon to allow patients to be booked thus maximizing capacity for each specialty. • Focus on improving Theatre start times in theatres to facilitate adding smaller cases on at start on end of list where possible • Ensure clinics are coded as patient attended more promptly and accurately, particularly with regard to off-sites. • Reinforce with off-site secretaries to send information about additions to waiting list for surgery at QVH within 24 hours. • Continue training of staff on 18 weeks and validation • Early warning tracking system has now been developed to monitor peaks in referrals and conversion rates to assist capacity planning
Forecast date to return to plan	For May and June there is still a risk that the Trust will not achieve both the outpatient and inpatient aggregate target in Q1 due to cancellations, trauma demand, shortages of theatre staff and continued reductions in backlog, particularly in Plastics and Corneo. The Directorates are continuing to proactively manage waiting lists through weekly operational meetings and increasing capacity to reduce waiting times where possible. However once the

	additional LA DC operating sessions are made available in July the Trust is predicting that for Q2 the Trust inpatient aggregate will fail as backlog clearance is expedited in order to achieve a long term sustainable 18 week position. The exact plan and modelling of this is being done in conjunction with the support of the IST and will be made available at the next Board meeting in June.
Forecast outturn	Final out turn for end of year will be available from next month
Monitoring	Clinical Cabinet (bi-monthly) and Senior Management Team (weekly)
Recommendation	The Board is requested to note and endorse the action being taken to improve performance in this area.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22 May 2014**
Agenda item reference no:	**120-14**
Author:	**Stuart Butt, Interim Director of Finance and Commerce**
Date of report:	**14 May 2014**

FINANCIAL PERFORMANCE REPORT: April 2014 (MONTHLY UPDATE)

1. Summary

The financial performance report to the Board this month details the trust's financial performance for April 2014. Because of the timing of the meeting this month the attached report is a summary only but a full report will be produced.

	Plan YTD (£k)	Actual YTD (£k)	Variance to Plan
Turnover	4,432	4,669	236
EBITDA	38	305	266
Surplus	(258)	10	267
Continuity of service risk rating (CoSRR)	3	4	1

NB Table subject to rounding differences.

The financial position is ahead of plan by £267k driven by additional activity provided within budgeted pay and non-pay costs.

2. Income

Patient related income is ahead of plan by £306k

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

The income plan assumes 100% achievement of CQUIN. The actual income assumes 50% achievement and this estimate will be revised once the actual performance against targets is known. This is intended to be a prudent assumption rather than reflecting concern over performance. For month 1 50% of CQUIN is £53k.

Penalties of £25.9k have been accrued for RTT18 weeks breaches.

3. Expenditure

Pay is underspent by £16k..

Non Pay is underspent by £14k.

4. Cash

Cash balance stands at £4,852k. This is an improvement on the year end balance of £3,655k because of reduced debt balances.

5 **Continuity of service rating**

The Continuity of service rating plan of 3 is for the first quarter, and reflects both the planned deficit of £124k for the quarter and the £389k debt repayment due in June. The stated actual of 4 is for April itself. This rating reflects cumulative performance so is adversely affected when the loan repayment is made in June. The forecast for the quarter is the planned rating of 3, assuming surpluses on budget in May and June. Should the current level of overperformance continue the rating would rise to 4.

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report – Public
April 2014
Month 1

14 May 2014

Executive Director: Stuart Butt
Prepared by: Bill Stronach, Stephen Glass

Summary Actual Position – YTD M1 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure Current Month and Year to Date	This Month 13-14 Actual £k	Current Month Actual £k	Current Month Budget £k	Current Month Variance £k	Year to Date Actual £k	Year to Date Budget £k	Year to Date Variance £k
Income	4,645	4,669	4,432	236	4,669	4,432	236
Pay	(3,104)	(3,158)	(3,174)	16	(3,158)	(3,174)	16
Non Pay	(1,242)	(1,205)	(1,220)	14	(1,205)	(1,220)	14
EBITDA	299	305	38	266	305	38	266
EBITDA %	*6.4*	*6.5*	*0.9*	*5.7*	***6.5***	*0.9*	*5.7*
Post EBITDA	(269)	(295)	(296)	1	(295)	(296)	1
Donated assets		-	-	-	-	-	-
Surplus pre exceptionals	**30**	**10**	**(258)**	**267**	**10**	**(258)**	**267**
Surplus Margin %	*0.6*	*0.2*	*-5.8*	*6.0*	***0.2***	*-5.8*	*6.0*
Impairments		-	-	-	-	-	-
Surplus (Deficit)	30	10	(258)	267	**10**	(258)	267

Continuity of Service Risk Rating		Metric	Level 4 threshold		Score	Weighted score	
Liquidity days		33	0		4	50%	2
Debt Service Cover		3.3	2.5x		4	50%	2
Combined Score					1 2	3	**4.0**

Summary

- The surplus of £10k is £267k above plan and is consistent with the surplus achieved in April 2013.

Issues

- The planned income reflected 2 days bank holiday, the opening of the 4 new theatres and the electrical shut down. There was only a 1 day bank holiday in April 2013, the opening of the 6 new theatres in the summer of 2013 saw a significant reduction in activity as did the (longer) electrical shut down in April 2011. Therefore the income variance reflects a real performance gain in the month and is not due to a phasing anomaly.
- The patient related income upside of £306k is largely driven by Hands where income is £232k ahead.
- The income plan reflects 100% CQUIN and the actual income assumes a prudent 50% which is £53k. RTT18 penalties are accrued at £25.9k.
- Pay and non-pay costs are both below plan and this is encouraging. Further analysis will be provided in the detailed report.

Risks

- Generating a surplus when the plan was for a significant deficit, and there was a real risk of a greater deficit, is a positive start to the year. However, the surplus of £10k is only a small step to the planned surplus of £2.2m.
- Key risks are to the achievement of the higher activity plans in future months, cost control and the level of penalties / incentives.

Actions

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22nd May 2014**
Agenda item reference no:	**121-14**
Author:	**Lois Howell, Interim Head of Corporate Affairs**
Date of report:	**14th May 2014**

ANNUAL REPORT, QUALITY ACCOUNTS AND FINANCIAL ACCOUNTS 2013-14

1 Copies of the annual report, quality and financial accounts for 2013-14 were submitted to the board's Audit Committee for review on Wednesday 21st May 2014 and will be tabled at the board meeting.

2. The Board is asked to **APPROVE** the final version of the annual report, quality accounts and financial accounts 2013-14 for submission to Monitor and in preparation for submission to Parliament.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**22nd May 2014**
Agenda item reference no:	**123-14**
Author:	**Richard Tyler, Chief Executive**
Date of report:	**14th May 2014**

EXECUTIVE LEVEL ASSURANCE STRUCTURE

Background

1. One of the key roles of an NHS Trust Board is to set the strategic direction for the Trust and then to hold the organisation to account, through the Chief Executive and Executive Directors, for delivery of both day to day performance and longer term sustainability

2. At its March meeting the Trust Board agreed the 2014/15 work programme and it was noted that the Trust management team was required to focus on both day to day delivery and longer term planning.

3. In this context I have reviewed the existing executive level assurance structures to ensure that sufficient attention is paid to both the management of day to day performance and longer term sustainability.

4. The existing structures provide assurance through the Clinical Cabinet (CC) and the Senior Management Team (SMT). These meet twice monthly with one meeting devoted to operational delivery and the other to longer term strategic developments.

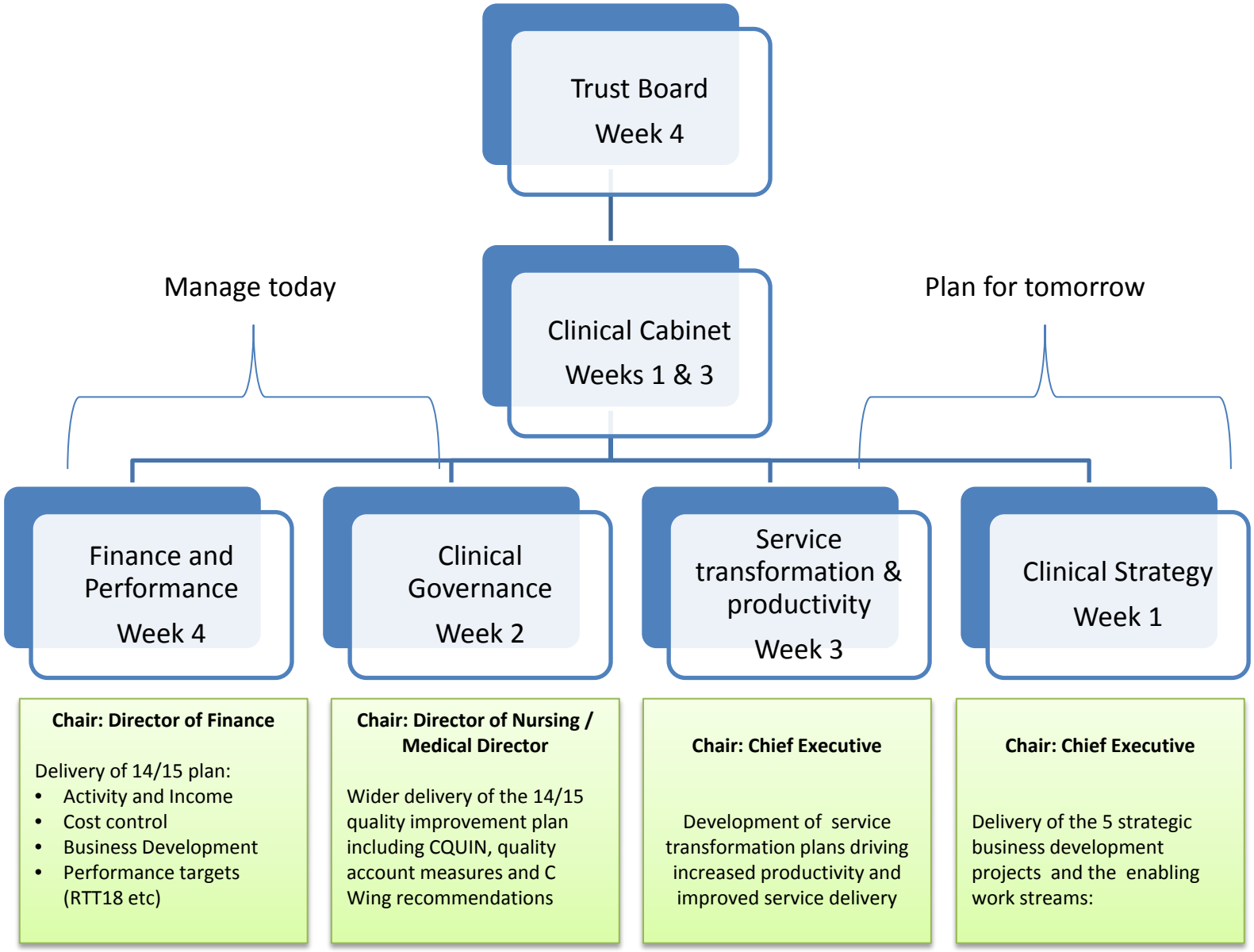
5. On reflection I have decided to amend the SMT meetings to more effectively support both the day to day and longer term agenda. To this end SMT will meet four times a month. Two of the meetings will be devoted to in-year issues, focusing on finance and performance and quality and risk, whilst the other two will focus on our clinical strategy and service transformation and productivity.

6. The outputs from each of these meetings will be reported to the Clinical Cabinet which will continue to meet twice a month and provide the final assurance before reporting to the Trust Board.

7. The revised structure will come into effect from 1st June 2014 to align with the operational and other management changes that are currently being implemented.

The Board is asked to **NOTE** the changes to the Executive level assurance structure.

Revised executive level governance structure incorporating QVH 2020



Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	22 May 2014
Agenda item reference no:	125-14
Author:	Heather Bunce, Programme Director
Date of report:	8 May 2014

Site Redevelopment Programme: Monthly Updates

1. Attached is the final Programme Report showing highlights and activities over the last month in respect of Site Redevelopment. The Final Account for the project will be submitted to this month's Board by the Finance Department.

2. The Board is asked to **note** information contained within the Programme Report.

Theatre Development Scheme Phase 2

Programme Update
13/05/2014

Work Streams & Deliverables.	Programmed Completion	Status Update	Impact on programme	Lead	Handler	RAG	Mitigation
Project Overview							
Programme	17/02/2014	Phase 2 theatre development is now complete with the first patients being treated in this facility on April 7th.		HB	DC		
Finance		Final account is scheduled to be submitted to the May Board. Current budget projections are below approved budget.		HB	DC		
Construction Phase							
Detailed design stage F	03/05/2013	Completed.		HB	DC		
Building construction	17/02/2014	Completed.		HB	DC		
Mechanical and electrical works	10/02/2014	Installation works completed to target programme.		HB	DC		
Technical commissioning	16/02/2014	All commissioning works were completed to the target programme. These works were supervised by our independent Supervising Officer team.		HB	DC		
Handover	17/02/2014	Handover was achieved on Monday 17th February 2014, 4 weeks ahead of the contract programme.		HB	DC		
User Commissioning	31/03/2014	Open date of 7th April achieved.		HB	MB		
Equipment strategy	31/03/2014	Completed		HB	MB		
Project close	08/05/2014	We have achieved a sucessful completion of the project with formal project closure requested of the PSG		HB	HB		
		The Post Project evaluation is planned for Summer 2014.		HB	HB		
		The Customer Service Team's monthly review will continue for two years following each phase hand over.		JT	JT		

Queen Victoria Hospital NHS NHS Foundation Trust	**CONFIDENTIAL** **Phases II and III New Theatres Project Steering Group** **Notes** **Wednesday 26 March 2014** **Jubilee Meeting Room** **1500 - 1600**	

Present:
Richard Tyler (RT) Chief Executive Officer
Richard Hathaway (RH) Director of Finance
Mike Bennett (MB) Divisional Manager, Critical Care
Amanda Parker (Director of Nursing & Risk)
Jane Morris (JM) Divisional Manager, Clinical Specialities (Phase III agenda)

In Attendance:
Heather Bunce (HB) Programme Director
Hilary Twigg (HT) Notes

Apologies:
Steve Fenlon (SF) Medical Director
John Trinick (JT) Head of Estates

Phase III Site Redevelopment		
Item		**Action**
1	**Welcome and Confirmation of Quorum**	
1.1	RT opened the meeting. Apologies noted as above. The meeting was confirmed as quorate.	
2	**Approval of Notes and matters arising from previous PSG**	
2.1	• The Notes of the previous meeting (Phases II and III) held on 20 February were confirmed as a true record. • There were no matters arising not covered under Agenda items.	
3	**Phase III Options /costing**	
3.1	• All of those present had attended the 'Away Day' on 25 March where HB had presented a summary of the options for Phase III site redevelopment with associated costs. Discussion had included the provision of offices for staff in the three options and the possibility that some offices could be relocated off site – HB said that office provision was not in the Project Initiation Document (PID). However, she could refresh previous work on suitability for on/off site location with a view to re-submitting proposals if a more radical approach to the options was supported. • Costings had been discussed at the presentation on 25 March. HB said that timelines had been based on a conservative view that funding would be self-financed, but other options could be explored. RH commented that more detailed information would be required to determine which elements could be self-financed and which financed by loan: at the present time the Trust had a 15 year loan, but there could be a point in the next 5-10 years when a new loan could be considered. The best way if the organisation was keen for work to proceed more quickly was to achieve bigger surpluses! HB pointed out that the costings were very high level, including for example 7.5% of the total construction cost for equipment, 15% for contingency, etc, which left scope for more detailed estimates. However, she proposed that no more external Cost Consultant resources were appropriate at this time. RH concurred and felt that the same applied to further internal resources. JM asked whether the proposals were phased – HB said that they were and would provide JM with the full paper. • RT proposed and it was agreed that the options would be presented to the Board tomorrow. Once the strategic direction was agreed by the Board it would be a question of determining what the funding options were for proceeding with the preferred option more quickly. HB, RH and BS would further scope out at this stage.	**HB** **HB** **HB/RH/ BS**

4	**Site Capacity Development Group**	
4.1	• It was noted that SF had raised some concerns about 'land grab' in relation to the 'old' theatres, and the fact that office staff were not in good quality accommodation. JM said that there had so far been no discussion about utilising space in the 'old' theatres, which HB confirmed was all accounted for in site redevelopment plans. • RH had provided Notes of the most recent SCDG meeting to demonstrate the kind of things that had been discussed. Quality of accommodation had not been an issue so far. The main issues arising had included the PKL building, LOPA Theatre, Meeting Rooms and Discharge Lounge. He said that the SCDG had been set up as a temporary measure, but now the issues were different, and he had some reservations about expanding the remit because of lack of resources. It would be necessary to link with Phase III site redevelopment discussions. It was agreed that there was a need to utilise available space in both the short and longer term and that it was necessary to get information out to the organisation about development plans. JM suggested 'Open Days' could be helpful in engaging people - agreed that this could be linked when the Board had approved the next stage of redevelopment, internal communications to consist of initial time frame, what development would look like etc. SCDG output to feed into Clinical Cabinet (CC) with consultant-led communications from CC. MB suggested possibility of an Estates Control Form: RH agreed to revise the SCDG Terms of Reference to reflect their role in relation to site redevelopment.	**HB/RH**
5	**Any Other Business**	
5.1	• RT advised that a meeting had been arranged with the CCG (Steve Willliams) which could include discussions on Primary Care options. • HB raised the question as to the future of this PSG and whether it should be integrated with the SCDG going forward, as part of the QVH 2020 strategic review. No decision was taken at this meeting. HB confirmed a positive response from one of the Governors in relation to Governor representation on the PSG, and was awaiting a meeting/discussion with him.	**RT** **All**

Phase II New Theatres		
1 & 2	**Confirmation of quorum / Approval of Minutes and Matters Arising from Phase II new theatres PSG 20 February 2014**	
2.1	• The meeting was quorate and the Notes of the meeting on 20 February were confirmed as a true record, as per Phase I above. <u>Matters Arising</u> • Blond McIndoe Roof Canopy – HB reported that this was in hand but there was no start date as yet. • IPS issues – MB reported that these were now resolved. • Doors to the Prep. Room in new theatres – AP reported that there had been some issues with staff sick leave as a consequence of difficulty opening these doors. MB confirmed that the pressures were correct and to install automatic doors would involve expenditure of at least £18K. Simon Wells had reviewed the situation which was being monitored with a view to considering other options if and when necessary. • Letters of thanks – HB had drafted and RT confirmed that these had gone out. • It was agreed that there would be an informal opening of the Phase II new theatres by the Chairman, with attendant local press and a form of celebration for all involved.	**JT** **MB** **RT/MB**

3	**Project Update Client Commissioning**	
3.1	• MB reported that all was on schedule with nothing to prevent opening as planned (would have been ready this weekend). • IT ordering was later than planned but only one non-key item was awaited. • Air samples cultures were excellent and further sampling has been cancelled. • £7.5kg on equipment– need to be able to order for Theatres 8 & 9.Extra 1.5 WTE staff for Theatres 8 & 9 – agreed at SMT. • HB noted that it would be necessary to add cleaning hours to Phase II budget.	
4	**Programme Director's Report**	
4.1	• HB presented the Risk Register, which was unchanged from that presented at the previous PSG meeting. There were no further expenses in the pipeline. • Equipment was still c £2K below budget.	
5	**Final Account Update**	
5.1	• HB reported that a meeting had taken place (Anoop Dhubra of Turner & Townsend, Dave Curzon, Bill Stronach and HB) to agree timescale for the Final Account Report. Most of the required information was already available. • Timescale for Final Account Report: - 9 April: figures to be provided to BS - 14 April – Submission of Final Account Report to BS, RH - 15 April – meeting to agree Final Account Report(BS, RH, HB, DC) • It was noted that BS was to revert as to whether Valuation 31 should be part of the Final Account or an Interim payment.	**HB** **BS**
6	**Mothballing of remaining 4 theatres**	
6.1	• HB reported that JT was working on the mothballing arrangements for the 'old' theatres but this was complicated by keeping Theatres 6, 8 and 9 open.	**JT**
7	**Any Other Business**	
7.1	• Smoking Shelter – AP said that there had been complaints that patients/visitors could see staff Smoking Shelter from the Discharge Lounge. HB suggest Privacy Screening – this was being applied to OPD now and it was agreed that it should also be put on windows in the Discharge Lounge and Stage 3 Recovery. • RT raised an issue regarding signage to the Discharge Lounge which he felt was unclear: it was agreed that HB would investigate. AP raised the issue of signage on the whole site – HB proposed and it was agreed that the way forward would be to invite an outside contractor to advise on signage, then evaluate in relation to cost and phasing. • It was agreed that the next meeting, scheduled for 10 April, would be cancelled unless there were any issues arising from the opening of Phase II new theatres. Date to be kept in diary, email to be sent if meeting to be cancelled.	**HB** **HB** **HB** **HB**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	22 May 2014
Agenda item reference no:	126-14
Author:	Heather Bunce, Programme Director
Date of report:	8 May 2014

Capital Programme Update

1.1. The attached is a status report in respect of the Capital Programme.

1.2. The Board is asked to NOTE the status report.

2013/14 Capital Programme

The following Capital Projects were carried over from 2013/14

CAPITAL PROGRAMME carried over from 13/14				
Project:	**Status**	**Programmed**	**Revised Budget**	**RAG**
Jubilee Centre Heating	• Contractor on site • Work commenced on the ground floor of Jubilee • Project estimated to run for 16 weeks	Originally Programmed for Quarters 1 & 2. Will now run into 1st and Q2 quarter 2014 2015	**£310K**	
Alterations to Burns Heating	• Orders raised • Stakeholder consultation undertaken. • Contractor on site . First phase of this project is Jubilee Centre Heating.	Originally Programmed for Quarters 1 & 2. Will now run into 1st and 2nd quarter of 2014 2015	£100K	
Prosthetics Labs Hot Water System Alterations (split from Jubilee scheme.)	• Orders raised • Stakeholder consultation undertaken. • Contractor on site . First phase of this project is Jubilee Centre Heating.	Originally Programmed for Quarters 1 & 2 Will now run into 1st quarter 2014 2015	**£40K**	
Medical Gas Pipeline Replacement	• No work commenced • Agency project manager appointed but has left after only three weeks to take up a permanent post. Replacement project manager appointed May 6th but will focus on Jubilee heating as contractors are on site.	Originally Programmed for Quarters 3 & 4 Will now run into 1st and 2nd quarter 2014 2015	£30k	
Replacement Radiator Covers	• Agency project manager appointed but has left after only three weeks to take up a permanent post. Replacement project manager appointed May 6th but will focus on Jubilee heating as contractors are on site. • Initial surveys undertaken	Originally Programmed for Quarters 3 & 4 Will now run into 1st @ 2 quarter 2014 2015	£25k	
Refurbishment of Public Toilet (A-Wing)	• No work commenced Agency project manager appointed but has left after only three weeks to take up a permanent post . Replacement project manager appointed May 6th but will focus on Jubilee heating as contractors are on site.	Originally Programmed for Quarters 3 & 4. Will now run into 1st & 2nd quarter 2014 2015	£30k	

2014/15 Capital Programme

CAPITAL PROGRAMME 2014-2015				
Project:	**Status**	**Programmed**	**Budget**	**RAG**
Fire compartmentation (site wide)	Outline case approved.	Quarters 1,2,&3	£160k	
Electrical upgrade to Corneo Plastic Department distribution room and panels.	Outline case approved.	Quarters 2,3,4,And 1 of 2015 2016	£200k	
Carbon Reduction Works to support the Trust's carbon reduction commitments.	Outline case approved.	Quarters 1,2,&3	£50k	
Demolition of the Maud Barclay Room	Outline case approved.	Quarter 2	£30k	
Creation of wet rooms (shower rooms) in Canadian Wing wards.	Outline case approved.	Quarter 3	£24K	
Alterations to Physiotherapy	Outline case approved.	Quarter 2	£8k	
Repair works to A Wing's envelope including brick pointing.	Outline case approved.	Quarter 2	£100k	
Create and upgrade Meeting rooms	Outline case approved	Q3	£50K	
Contingency Sum	No spend.		£100k	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	22 May 2014
Agenda item reference no:	127-14
Author:	Heather Bunce, Programme Director
Date of report:	13 May 2014

Sustainability Annual Report

1.1. Attached is the Annual Sustainability Report.

1.2. The Board is asked to NOTE the report.

Queen Victoria Hospital NHS

NHS Foundation Trust

Sustainable Development

Board of Directors Annual Report

May 2014

Heather Bunce
Programme Director

FINAL

CONTENTS

1 Background

This report presents the Board with an update on statutes, regulations and policies which inform the Trust's Sustainable Development plans. It also provides an update on sustainability initiatives achieved during the financial year 2013/14. Finally, it will propose the Trust's sustainability objectives for the financial year 2014/15.

The NHS has pledged to reduce its carbon emissions in line with the UK Climate Change Act.

January 2014 saw the publication of *A Sustainable Development Strategy for the NHS, Public and Social Care system.* This strategy describes the key principles and opportunities available to enable a more sustainable health and care system. This strategy is aligned with the current policy direction for integrated care closer to home. The strategy was developed following a wide consultation during 2013 in which QVH participated..

The strategy focuses on a number of key areas namely:

- Leadership, engagement and development
- Sustainable clinical and care models
- Healthy, sustainable and resilient communities
- Carbon hotspots
- Commissioning and procurement

June 2014 will see the requirement for all NHS organisations to submit annual sustainability plans via Monitor.

Our statutory and regulatory requirements are therefore to ensure that our Sustainable Development strategy and operational plans are core to our business planning. At the centre of this is The Climate Change Act (2008), whereby the Trust is required to reduce its carbon emissions as follows:

- 10% by 2015 (from the 2007 baseline)
- 26% by 2020 (from the 1990 baseline)

In March 2011, the Trust's Carbon Reduction Strategy was presented to the Board of Directors, followed by interim reports in March 2012 and 2013.

It was recognised that carbon reduction requirements would be extremely challenging for the Trust due to the age and design of its estate as well as its size and geographical location.

The QVH Sustainability Development Group includes representation from Medicine, Nursing, Procurement, Catering and Estates (a full list of members can be found in Appendix 1).

For 2014/15 we hope to strengthen this membership to include representation from Human Resources and Pharmacy, areas where core responsibilities have high carbon footprints.

2 Introduction

The Trust's Sustainable Development Action Plan is aligned to the strategic objectives of its 2011 Carbon Reduction Strategy as follows:

- Energy and Carbon management

- Sustainable procurement
- Catering
- Waste and water
- Travel, transport and access
- Clinical Development
- Education

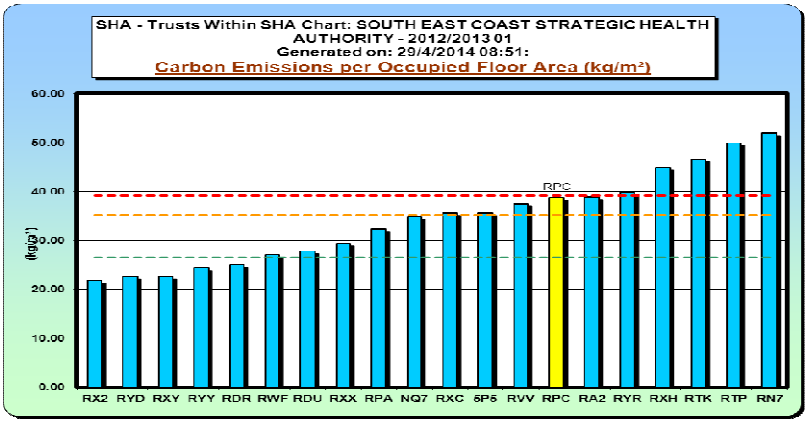
We propose to add **workforce** and the **built environment** as two separate objectives for 2014.

3 Energy & Carbon Management

3.1 Trust Comparisons

Data within this section have been provided by Estates Return Information Collection (ERIC) and based on utility & direct energy usage on site.

3.1.1 Carbon emissions per occupied floor area - Trust Comparison within the former South East Coast (SECSHA) Area

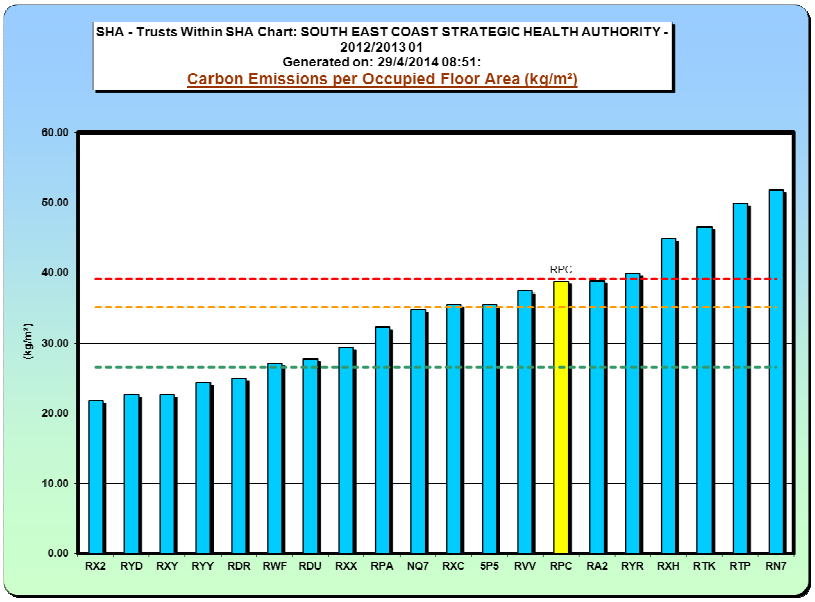


A comparison of carbon emissions between QVH and other Trusts within the (SECSHA) area demonstrates that we are currently within the upper quartile. The results for 2012/13 have been skewed as a result of the demolition of buildings in readiness for the development of the new theatre suite reducing the overall site floor areas, whilst energy consumption has remained the same. Energy consumption has remained unchanged as the energy required for the theatre build is included in our consumption. It is expected that the Trust's carbon omissions per m^2 will fall again when calculated against the new overall floor area next year.

Code	*Organisation Name*	*kg/m²*
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	21.76
RYD	SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	22.60
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	22.61
RYY	KENT COMMUNITY HEALTH NHS TRUST	24.32
RDR	SUSSEX COMMUNITY NHS TRUST	24.96
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	27.13
RDU	FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	27.76
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	29.36
RPA	MEDWAY NHS FOUNDATION TRUST	32.30
NQ7	MEDWAY COMMUNITY HEALTHCARE	34.77
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	35.57
5P5	SURREY PCT	35.57
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	37.42
RPC	**QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST**	**38.77**
RA2	ROYAL SURREY COUNTY NHS FOUNDATION TRUST	38.87
RYR	WESTERN SUSSEX HOSPITALS NHS TRUST	39.91
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	44.84

RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	46.56
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	49.89
RN7	DARTFORD AND GRAVESHAM NHS TRUST	51.86
Total		**34.47**
Lower Quartile		**26.59**
Median		**35.17**
Upper Quartile		**39.13**

3.1.2 Carbon emissions per occupied floor area - Trust Comparison Acute & Specialist



A similar comparison of carbon emissions within the Acute Specialist sector demonstrates that we are currently in the upper quartile.

Code	*Organisation Name*	*kg/m²*
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	21.76
RYD	SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	22.60
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	22.61
RYY	KENT COMMUNITY HEALTH NHS TRUST	24.32
RDR	SUSSEX COMMUNITY NHS TRUST	24.96
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	27.13
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RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	29.36
RPA	MEDWAY NHS FOUNDATION TRUST	32.30
NQ7	MEDWAY COMMUNITY HEALTHCARE	34.77
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	35.57
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RA2	ROYAL SURREY COUNTY NHS FOUNDATION TRUST	38.87
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RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	46.56
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	49.89

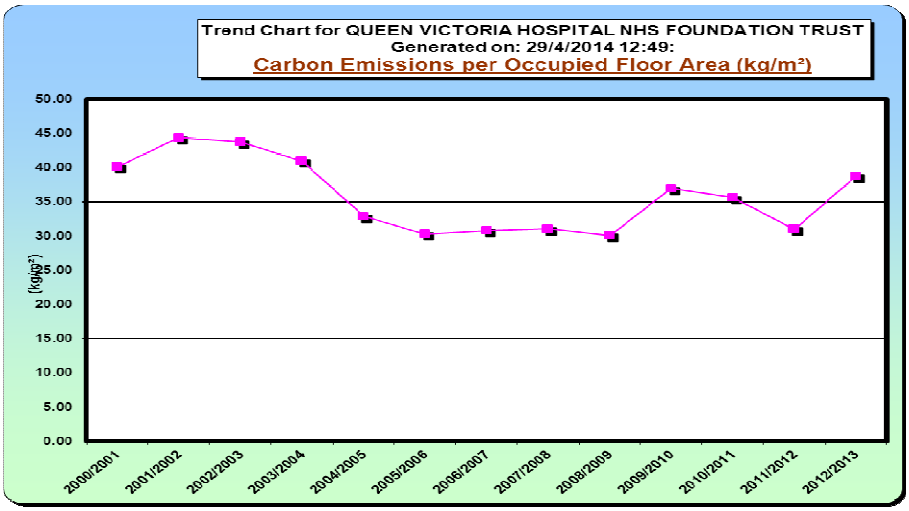
RN7	DARTFORD AND GRAVESHAM NHS TRUST	51.86
Total		**34.47**
Lower Quartile		**26.59**
Median		**35.17**
Upper Quartile		**39.13**

3.1.3 Queen Victoria Hospital Trend Analysis

The table below shows how the Trust's overall carbon emissions per occupied floor area have altered since 2000/2001.

It should be noted that the target of a 10% reduction in carbon foot print from the 2007 baseline figure by 2015 will be unlikely.

QVH Carbon Emission per Occupied Floor Area



Year	*kg/m²*
2000/2001	40.14
2001/2002	44.34
2002/2003	43.74
2003/2004	40.96
2004/2005	32.88
2005/2006	30.27
2006/2007	30.79
2007/2008	31.03
2008/2009	30.07
2009/2010	36.92
2010/2011	35.60
2011/2012	30.98
2012/2013	38.77

3.2 Improvements in Infrastructure

The design of the new theatres building has achieved a BREEAM score of 60%, which translates in to a BREEAM rating of "Very Good." This has been determined by an independent BREEAM assessor.

The design of the theatres has included elements such as high levels of thermal insulation, higher than normal levels of air tightness, thermal wheel heat recovery technology, high efficiency condensing gas boilers and LED theatre lights. This has helped to make the new theatre suite the most energy efficient building on the QVH site.

4 Sustainable Procurement

All procurement across the QVH site is subject to our sustainable procurement policy.

Sustainable procurement is defined as *"the process whereby organisations meet their needs for goods, services works and utilities in a way that achieves value for money on a whole life basis in terms of generating benefits not only to the organisation but also to society and the economy whilst minimising damage to the environment".*

A number of improvements have been achieved during 2013/14 namely:

Local suppliers - achieved by sourcing locally where possible within the legislative framework and encouraging small and medium enterprises to compete for the Trust's business .

New supplier selection - ensuring that sustainable and ethical procurement criteria are built into tendering in OJEU , PQQ and ITT documents.

Suppliers using fuel efficient transportation - encouraging low carbon logistics options for the future, including electric and hybrid vans, by building this into supplier selection criteria.

Consolidated deliveries - achieved by use of NHS Supply Chain.

During the new financial year we will:

- Review the Sustainable Procurement Policy;
- Introduce Sustainability training for the Procurement team;
- Incorporate sustainability into the appraisal process;
- Increase the use of environmental criteria in supplier selection;
- Encourage accreditation to NHS procurement standards.

To date, we have been unable to produce any comparable data to confirm whether adherence to this policy is making a difference.

5 Catering

In 2013/14 the procurement of catering supplies focused on locally grown produce. Contracts have been awarded to local suppliers who produce and source locally where possible the supply of our fruit and vegetables. Our milk is also now provided from this source.

We estimate an annual reduction of 260 deliveries per annum

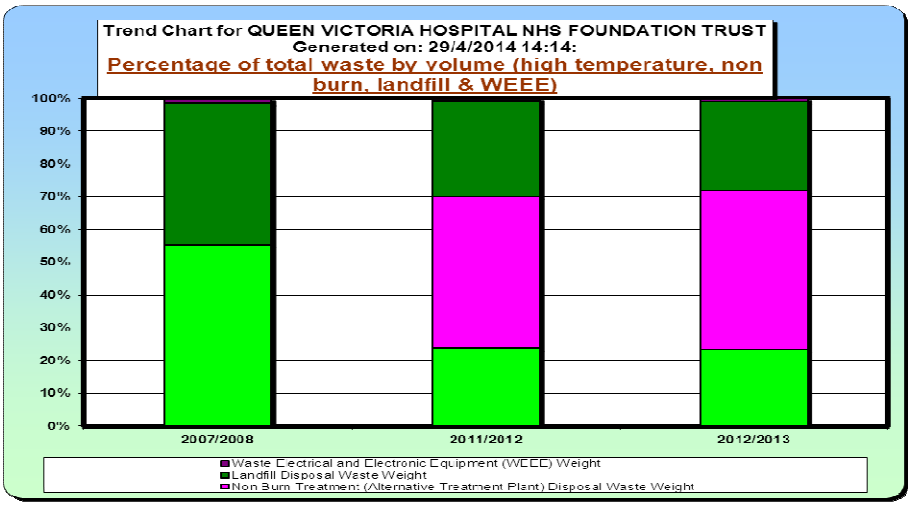
During 2014/15 we will work towards achieving the bronze *Food for Life Catering Mark* standard. By progressing through bronze, silver and gold awards Catering Mark holders demonstrate increasing levels of commitment to these principles.

The Food for Life Catering Mark objectives are to provide fresh food, freshly prepared on site that is environmentally sustainable and ethically sourced. It supports locally produced foods, serving healthy meals free from trans fats and undesirable additives.

In achieving this Charter Mark we will aim to improve the quality of food for patients, visitors and staff while further reducing our carbon footprint for food.

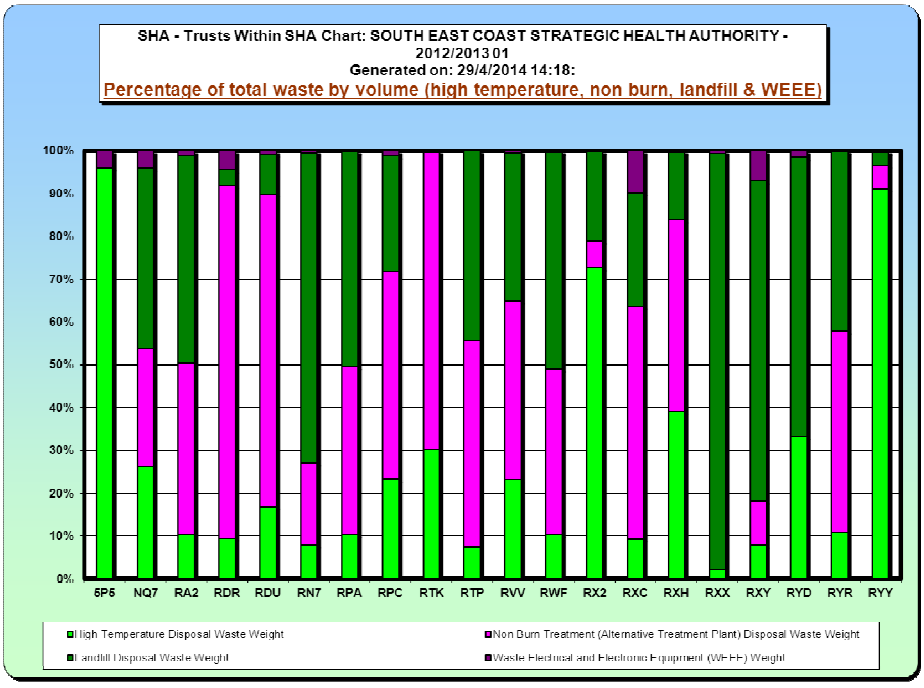
6 Waste

The Trust has continued to reduce the percentage of both waste going to land fill and high temperature disposal of clinical waste.



Year	*High Temperature Disposal Waste Weight*	*Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Weight*	*Landfill Disposal Waste Weight*	*Waste Electrical and Electronic Equipment (WEEE) Weight*
2007/2008	55.29%	0.00%	43.27%	1.44%
2011/2012	23.81%	46.33%	28.96%	0.90%
2012/2013	23.32%	48.43%	27.10%	1.15%

The following chart and table show the benchmark comparison with other Trusts across the South East Region.



Code	Organisation Name	High Temperature Disposal Waste Weight	Non Burn Treatment (Alternative Treatment Plant) Disposal Waste Weight	Landfill Disposal Waste Weight	Waste Electrical and Electronic Equipment (WEEE) Weight
5P5	SURREY PCT	96.00%	0.00%	0.00%	4.00%
NQ7	MEDWAY COMMUNITY HEALTHCARE	26.29%	27.50%	42.13%	4.08%
RA2	ROYAL SURREY COUNTY NHS FOUNDATION TRUST	10.39%	39.96%	48.53%	1.12%
RDR	SUSSEX COMMUNITY NHS TRUST	9.51%	82.41%	3.61%	4.48%
RDU	FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	16.91%	73.02%	9.30%	0.78%
RN7	DARTFORD AND GRAVESHAM NHS TRUST	7.96%	19.19%	72.30%	0.54%
RPA	MEDWAY NHS FOUNDATION TRUST	10.40%	39.21%	50.19%	0.21%
RPC	**QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST**	**23.32%**	**48.43%**	**27.10%**	**1.15%**
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	30.26%	69.49%	0.00%	0.26%
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	7.44%	48.32%	44.24%	0.00%
RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	23.09%	41.89%	34.54%	0.49%
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	10.40%	38.61%	50.65%	0.34%
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	72.67%	6.34%	20.82%	0.18%
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	9.35%	54.37%	26.53%	9.75%
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	39.07%	44.77%	15.78%	0.38%
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	2.31%	0.00%	97.04%	0.64%
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	7.88%	10.34%	74.78%	7.00%
RYD	SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	33.24%	0.00%	65.21%	1.55%
RYR	WESTERN SUSSEX HOSPITALS NHS TRUST	10.87%	47.03%	41.97%	0.14%
RYY	KENT COMMUNITY HEALTH NHS TRUST	91.14%	5.47%	3.01%	0.37%

Total	**22.60%**	**35.07%**	**40.76%**	**1.57%**
Lower Quartile	**9.47%**	**9.34%**	**14.16%**	**0.32%**
Median	**13.89%**	**39.58%**	**38.25%**	**0.59%**
Upper Quartile	**31.00%**	**48.35%**	**50.30%**	**2.16%**

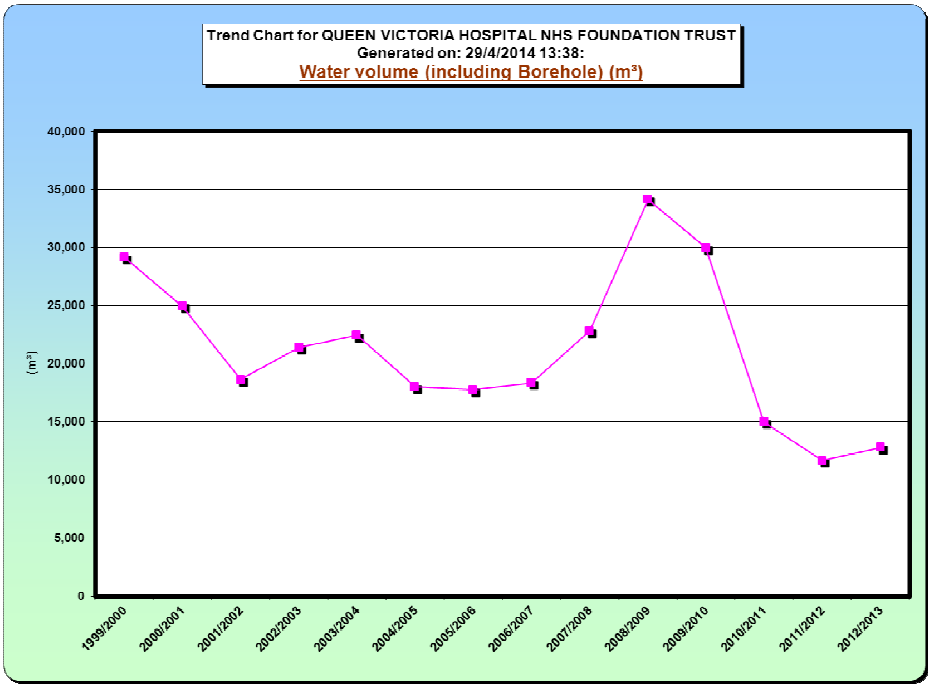
Recycling:

The Trust has continued to reduce the quantity of domestic waste going to landfill by means of co-mingled recycling. The target of 80% recycling by volume has been met.

7 Water

Data within this section have been provided by Estates Return Information Collection (ERIC).

The Trust's water usage has increased slightly since 2011/2012 but is still significantly lower than in previous years.



8 Travel

During 2013/14 we continued to encourage our staff to walk to work by restricting the use of parking permits to staff who live more than a mile away from the Trust.

We have supported the revision of the car parking policy which was launched in April 2014: this policy increases the distance whereby staff are routinely denied a parking permit if living within a radius of 1 mile to a radius of 1 .5 miles. There is an Appeals process in place for those staff living within 1.5 miles of the Trust who are able to demonstrate that they need to use a vehicle to get to work. With the data we keep it would be possible to estimate an average reduction in carbon emission savings as a result of this policy, but resources do not allow us to undertake this work at present.

The Trust operates a year-round tax-free Cycle to Work scheme which enables staff to make large savings on a new bicycle, with easy payback options through Payroll, thus encouraging more staff to cycle to work.

9 Clinical Development

9.1 Telemedicine

In the last financial year the Trust's long established system of Telemedicine has reduced the number of patients having to travel to the East Grinstead site by an estimated 1,200: this represents 15% of patients referred to QVH via this route, a similar number to that in 2013/14.

The estimated 15% of patients who do not have to travel to the QVH for treatment is a historical percentage as resources do not allow for these data to be reviewed and refreshed.

No supporting data is available to calculate the number of miles (and associated volume of carbon reduction) this has saved. We should consider in 2014/15 how we could collect this data, which would then count towards a reduction in our carbon footprint.

9.2 Sterile supplies

Procurement and theatres are currently working on the Synergy contract and will develop a set of KPI/specific targets for sustainability. These will then be included in our 2014/15 objectives. In addition, Synergy as a company can provide us with carbon monitoring data. Procurement are investigating this.

10 Education

During 2012/13 three editions of the QVH Sustainability communication 'Green Vic News' have been produced and circulated to all QVH staff. This newsletter provides, for example, tips on how to save energy, improve recycling and reduce paper consumption, and also updates the Trust on new sustainability initiatives throughout the wider NHS. Feedback from staff to date has been very positive.

We will continue to produce Green News during 2014/15.

We have invited a representative from HR/Education to strengthen our team. Once this new member has joined us we will develop further objectives surrounding education and training.

11 IT

During 2013/14 we have had limited success in introducing software that automatically closes down PCs in non-clinical areas that are not in use during the evening and overnight. The pilots that have been run demonstrate that up to 110 of Trust PCs are left switched on overnight, equating to c £20K wasted electricity usage.

The IT Capital investment for 2014/15 of c£1m will be invested in the network which will provides a more robust infrastructure and will also improve remote access and video conferencing for meetings.

PC hardware will be updated as part of the rolling programme, taking advantage of more efficient hardware and reduced power consumption.

We shall continue to implement software that will automatically trigger a PC to shutdown if it is idle for periods of time (except in clinical areas which are not part of this process).

12 Conclusion

Through this Board update the QVH Sustainability Development Group hopes to have demonstrated that it continues to make a difference to the Trust's Carbon Reduction strategy, albeit working within the usual constraints of time and resources.

The Capital Programme has allocated £50K in 2014/15 and a further £50K per annum in the following two years to support the reduction in our carbon footprint.

The sustainable development agenda is becoming elevated within Health and Social Care. As a group we would wish to raise our profile, and therefore in line with the 2014 Sustainable Development Strategy for the NHS we would request the support of a Non-Executive Director.

Additionally, through the Trust's budget setting process, the Group intends to apply for a small allocated budget to enable it to drive new initiatives.

APPENDIX 1

Sustainability Development Group Membership 2013/14

Chair: Heather Bunce (HB)	Programme Director
Caroline Archer (CA)	Head of Procurement
Nicky Reeves (NR)	Matron
Anita Trinick (AT)	Head of Hotel Services
John Trinick (JT)	Head of Estates
Tim Vorster (TV)	Consultant Anaesthetist

APPENDIX 2: Sustainability Development Objectives as at Year end 2013/14

Initiative/ measure	Action required	Lead	Indicative Costs	Year End Review
Sustainable Procurement				
Review of benchmarks to monitor progress in carbon reduction eg consolidated deliveries	**Local suppliers** - achieved by sourcing locally where possible within the legislative framework. Advertising Trust contracts on Contracts Finder and encouraging SMEs (Small Medium Enterprises) to compete for business. **New supplier selection** - achieved by ensuring that sustainable procurement and ethical procurement criteria are built into tendering-in OJEU and PQQ docs and ITT docs. Also consider the supply chain in its entirety. **Suppliers using fuel efficient transportation -** achieved by encouraging low carbon logistics options for the future, including electric and hybrid vans, building this into supplier selection criteria. **Consolidated deliveries -** achieved by use of NHS Supply Chain where possible negotiating with suppliers to consolidate where possible but still maintaining flexibility around deliveries.	CA	None None Built into contract price. Should lead to a cost reduction as orders are consolidated - fewer orders = fewer invoices	Use of two new food suppliers local to QVH. Use of courier firm based in East Grinstead. Our contract notices are published stating that the contracting authority considers that this contract may be suitable for economic operators that are small or medium enterprises (SMEs). PQQ question around the environment included in PQQ and ITT for relevant tenders. Asked each bidder to outline environmental policy at PQQ stage. This was scored. Question included in sterile services tender on improving environmental impact and reducing carbon in sterilisation and transportation. This was weighted 5% of the total marks available. This was built into the evaluation criteria for the sterile services tender and will be built into the courier tender evaluation criteria and other relevant tenders. Use of Supply Chain where possible Setting up of standing orders for key theatre items - reduces carbon footprint.

Initiative/ measure	Action required	Lead	Indicative Costs	Year End Review
Review of lease options for fuel efficient vehicles	Costs obtained for fuel efficient vehicles. This information is from Lex Autolease on the Crown Commercial framework.	CA	Cheapest- £208.33 ex VAT monthly rental cost - Yaris Hatchback 1.5 Vvt-I Hybrid T3 5dr Cvt Auto-Hybrid, fuel eco combined.	At present our requirement for vehicles is low: this was therefore put on hold with a view to reviewing if our requirements increased.
Catering				
Review of food waste composting options	Speak to present waste provider, check on regulations. Work out weight of waste food generated by Trust.	AT	20 LT container £10 per removal. Central waste store with external water supply required.	We have reviewed this thoroughly: as the volume of food produced as waste by the Trust is small we have been unable to find any product that would be suitable and affordable to compost our food waste.
Review of local provision of specific produce, eg. eggs, meat etc	Meet with local suppliers, send information to Procurement.	AT/ CA	Cost should remain the same.	Have established contracts with local fruit and vegetable farm which is part of the Farm to Table scheme .Our dairy products are now also being delivered via this route, reducing journeys by 260 journeys per year. We have not been successful in procuring meat from a local supplier despite approaching three local independent butchers. .

Initiative/ measure	Action required	Lead	Indicative Costs	Year End Review
Energy & Carbon Management				
Continued reduction in carbon footprint through implementation of Site Master Plan in 2014 and beyond; phasing should prioritise demolition of the worst (and most energy inefficient) parts of the estate.		JT		Site Master Plan Phase 3, with a number of phasing options, has been developed and presented to the March 2014Board. Board has requested more information linked to rationale of these plans - this is now scheduled into the Trust's business cycle for 2014/15.
Smart metering to be introduced to certain areas of the Trust; should budgets permit, system to be linked with BMS enabling further benchmarking and education.		JT		We have had limited success using our BMS system to control the use of additional heating over the winter period. During Q4 we agreed the specification for implementation of an energy monitoring system by building. This will allow us in 2014/15 to target buildings where energy use is considered to be abnormally high.
Waste Management				
Target of achieving 80% recycling		JT		We have achieved this target by volume but not by weight.
Water				
Review use of water across the site		JT		The data for water use has been taken from our ERIC returns which are one year out of date. We believe that with the consolidation of our new theatres and the mothballing of our old theatres our water consumption will decline. These data will not be available until Q3 2014/15.

Initiative/ measure	Action required	Lead	Indicative Costs	Year End Reviews
IM & T				
Implementation of screen savers for all Trust PCs during Q1		NR		Not achieved
Identification of staff who fail to log-off PCs/monitors at end of working day; appropriate action to be taken		NR		Night watchman activated from 18:00hrs in non-clinical areas
Travel, Transport & Access				
Review of 'ad-hoc' transport use for transferring samples, notes etc		NH		Reviewed (objective for next year).
Clinical Development				
Review of options for remote pre-assessment screening		NH		Reviewing the procurement of a Pre-Assessment module, which includes on line pre-screening questions. Some reservations regarding remote pre-assessment being raised by consultant anaesthetists. Off site. Dartford and Medway are starting to do pre –screening of QVH patients with the anticipated outcome that fewer people will need to attend or be telephone assessed.

Initiative/ measure	Action required	Lead	Indicative Costs	Year End Reviews
Education				
Establishment of Sustainable Development award (in conjunction with Staff Awards event) to continue to encourage staff to take responsibility for carbon reduction		HB		Discussed with Corporate Affairs - not part of the staff award brief.
Continue to produce regular communications to staff focusing on ways in which to save energy, improve recycling, reduce use of paper etc.		TV/ HS		Three Green News updates produced during 2013/14.

APPENDIX 3: 2014/15 Sustainability Development Objectives

Initiative/ measure	Action required	Lead	Indicative Costs	Significant Milestones	Q1	Q2	Q3	Q4	Year end Review
Sustainable Procurement									
Review Sustainable Procurement Policy and update if necessary. Sustainability Training for Procurement team - incorporate into Appraisal. Increase use of environmental criteria in supplier selection -encourage accreditation to standards.		CA							
Catering									
Obtain the Food for Life Bronze Charter Mark by March 2015		AT							
Energy & Carbon Management									
Install roof insulation to the Staff Development Centre, targeting a 5% reduction in gas consumption to this building.		JT							
Introduce Smart metering across the trust and target buildings where energy use is considered abnormally high.		JT							
Install permanent engineering changes to the decommissioned theatres to reduce 24/7 energy consumption to a safe level to preserve the fabric of the building.		JT							

Initiative/ measure	Action required	Lead	Indicative Costs	Significant Milestones	Q1	Q2	Q3	Q4	Year end Review
Review the potential to improve the control of the kitchen and catering service.		JT							
Continue to install (as funding allows) zone controls for heating systems.									
IM & T									
Continue to use Nightwatchman to non-clinical areas. Pilot and then roll out as appropriate MSLYNC as we roll out windows 7. Replace old PCs as per the project plan.		NR							
		NR							
Travel, Transport & Access									
Reduce the use of 'ad-hoc' transport for transferring samples, notes etc by 5%		NH							
Clinical Development									
Review of options for remote Pre-Assessment screening		NH							
Establish KPIs for new theatre instrument sterilisation reporting to the Sustainability Development Group on achievements		NH							
Review the medical equipment strategy in respect of sustainability		NH/ TV							

Initiative/ measure	Action required	Lead	Indicative Costs	Significant Milestones	Q1	Q2	Q3	Q4	Year end Review
Education									
Continue to produce regular communications to staff focusing on ways in which to save energy, improve recycling, reduce use of paper etc. Other education targets TBC.		TV							