Queen Victoria Hospital NHS
NHS Foundation Trust

BUSINESS MEETING OF THE BOARD OF DIRECTORS

Thursday 24 April 2014

Session in public at 13:00

Session in private at 16:00

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

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: APRIL 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
Director of Finance and Commerce	-	Richard Hathaway

In full attendance (non-voting):

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

In part attendance (non-voting):

Deputy Head of HR	-	Caroline Haynes
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 24 April 2014 at 13:00

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

PUBLIC AGENDA			
No.	**Item**	**Time**	**Papers**
WELCOME			
080-14	**Welcome, apologies and declarations of interest** Peter Griffiths, Chairman	13:00	V
STANDING ITEMS			
081-14	**Draft minutes of the meeting session held in public on 27 March 2014 for approval** Peter Griffiths, Chairman	13:05	1
082-14	**Matters arising and actions pending** Peter Griffiths, Chairman	13:10	2
083-14	**Update from the Chief Executive** Richard Tyler, Chief Executive	13:15	V
084-14	**Update from the Medical Director** Steve Fenlon, Medical Director	13:20	V
SAFETY AND QUALITY			
085-14	**Quality and Risk exception report: (monthly update)** Amanda Parker, Director of Nursing and Quality	13.25	3
086-14	**National Inpatient Survey Results** Amanda Parker, Director of Nursing and Quality	13.35	4
087-14	**CQUINS 2014-15** Amanda Parker, Director of Nursing and Quality	13.45	5
088-14	**Safe Staffing** Amanda Parker, Director of Nursing and Quality	13.55	6
BUSINESS PERFORMANCE AND DELIVERY			
089-14	**Workforce performance report: (monthly update)** Caroline Haynes, Deputy Head of HR and Workforce Development	14.05	7
090-14	**Financial performance report: (monthly update)** Richard Hathaway, Director of Finance & Commerce	14.15	**To follow** 8
091-14	**Operational performance reports: (monthly update, including RTT18)** Richard Hathaway, Director of Finance & Commerce	14.25	9
GOVERNANCE			
092-14	**Declaration of Interests 2014/15** Lois Howell, Interim Head of Corporate Affairs	14.35	10
093-14	**Monitor Declaration: Q4 2013/14** Richard Hathaway, Director of Finance and Commerce	14.40	11
094-14	**Equality and Diversity Annual Report** Caroline Haynes, Deputy Director of HR	14.50	12

STRATEGY			
095-14	**Delivering excellence: QVH 2020** (To include approval of 2014-15 Key Strategic Objectives) Richard Tyler, Chief Executive	15.00	13
096-14	**Site re-development programme: (monthly update)** Heather Bunce, Programme Director	15.15	14
097-14	**Capital programme: (monthly update)** Heather Bunce, Programme Director	15.20	15
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD			
098-14	**Clinical Cabinet** Richard Tyler, Chief Executive	15.25	V
099-14	**Nomination & Remuneration Committee** Lester Porter, Non-Executive Director	15.30	V
100-14	**Board Outcomes Committee** (to include revised ToRs) Lester Porter, Non-Executive Director	15.35	V
GOVERNOR REPRESENTATIVE AND NON-EXECUTIVE DIRECTORS			
101-14	**Report from the Governor Representative** Brian Goode, Public Governor	15.40	V
102-14	**Observations from the Chairman and Non-Executive Directors** Peter Griffiths, Chairman	15.50	V
QUESTIONS FROM OBSERVERS			
	Peter Griffiths, Chairman	15:55	
PRIVATE AGENDA			
COMMERCIAL-IN-CONFIDENCE			
103-14	**Draft minutes of the meeting session held in private on 27 March 2014**	16.00	16
104-14	**Market report:** Richard Tyler, Chief Executive	16.05	17
105-14	**Monitor Annual Plan** Richard Hathaway, Director of Finance & Commerce	16.10	18
106-14	**Financial Service Line & Operational Performance reports** Richard Hathaway, Director of Finance & Commerce	16.25	19
107-14	**Savile Enquiry Report – Result** Amanda Parker, Director of Nursing and Quality	16.40	**To be Tabled**
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIRMAN)			
108-14	Peter Griffiths, Chairman	16:55	

DATES OF THE NEXT MEETINGS		
Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: Thursday, 22 May 2014, 13:00 **JCC**	**Audit:** 21 May 2014, 14:00. OT6 **Q&R:** Thurs, 29 May, 09:00, JMR **N&R:** TBA **CFAC:** Thurs 26 Jun, 09:00, OT6	**Public**: Thurs 12 June 16:00 ATH

Document:	**Minutes (draft & unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **27 March 2014, 13:00 – 16:00, Council Chamber, East Court, College Lane, East Grinstead, West Sussex RH19 3LT**	
Present:	Peter Griffiths (PAG)	Chairman
	Jeremy Beech (JB)	Non-Executive Director and SID
	Ginny Colwell (GC)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director
	Richard Hathaway (RH)	Director of Finance & Commerce
	Amanda Parker (AP)	Director of Nursing & Quality
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
	Shena Winning (SW)	Non-Executive Director
In attendance	Graeme Armitage (GA)	Head of HR & Workforce Development [item: 060-14]
	Heather Bunce (HB)	Programme Director [items: 063-14 to 079-14]
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Directorate Manager: Clinical Specialities [item: 062-14]
	Lois Howell (LH)	Interim Head of Corporate Affairs& Co Sec
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Public gallery:	3 members of the public	

WELCOME

051-14 **Welcome, apologies and declarations of interest**

The Chairman opened the meeting and welcomed those present, including three members of the public. He reminded the board that this was SW and JB's final meeting after more than eight years as non-executive directors. On behalf of the board, the Chairman thanked them for their enormous support and professionalism, and acknowledged the considerable contribution they had made to the success of the hospital during their tenure.

There were no apologies and no new Declarations of Interest

STANDING ITEMS

052-14 **Draft minutes of the meeting session held in public on 27 February 2014 for approval**

The draft minutes were **APPROVED** as a correct record, subject to the following amendments:

- The minutes to record that BG was in attendance;
- Detail of the discussion held under item [030-14] to be expanded;
- Clarification was sought in respect of provision of consultant level data; however, it was agreed that this month's financial report accurately captured what was required.

053-14 **Matters Arising & Actions Pending**

The Matters Arising log was reviewed and updated as follows:

- **Item 9 [076-13]:** SW requested this be amended now to include an interrogation of costs for both phases of the theatre development, and asked the board to note that KPMG had also been asked to include review of final Phase I and II costs in their Capital report before it was finalised;
- **Item 11 [133-13]:** To be removed;
- **Item 13: [196-13]:** To be removed and instead included as part of strategic priorities for future business planning.

054-14	**Update from the Chief Executive** RT advised the board of the following: • The annual Staff Awards event had been very successful and contributed towards a recent improvement in morale; • The Senior Team had undertaken an away day to agree the new Key Strategic Objectives and the work plan for next year; • As part of the action plan to ensure the efficacy of the generator, a power shutdown had been planned for the weekend of 26 and 27 April; • RT had attended a further LAT burns meeting, and reminded the board that specialist services were currently reviewing all options before deciding the future strategy; • The additional four theatres were scheduled to open on Monday 7 April. The board **NOTED** the contents of the update
055-14	**Update from the Medical Director** SF asked the board to note the following: • Rates of compliance for mandatory training had improved; • Ian Francis had now been now appointed as substantive Radiologist for QVH, an appointment which was aligned to the new clinical strategic aims; • A senior medical workforce manager had now been appointed to the trust; this appointment was timely in that it would support developmental work required in preparation of the KSS Deanery visit. • The opening of the remaining four theatres would be of great benefit to the theatre teams as they would no longer have to work on a split site. SF assured SW that a lessons learned exercise would be undertaken once all ten theatres were fully functioning; • Following on from RT's update, SF advised that the electrical shutdown would extend across the whole site, with the exception of the new theatre buildings; BG sought confirmation there was a comprehensive communication plan for the planned shut down and was assured this was the case; • The trust was currently advertising for a project manager for outcomes programme of work. The Chairman asked for an update in respect of medical manpower planning and asked the board be provided with an update in the near future. **[Action: SF]** The board **NOTED** the contents of the update
SAFETY & QUALITY	
056-14	**Quality & Risk Exception Report** AP advised that further to recent reports in respect of the trust's microbiology contract, the issues raised now appeared to have been addressed. Other highlights included: **Safety Metrics:** • The investigation into a patient acquiring a pressure ulcer had concluded that all necessary steps had been taken to prevent pressure damage occurring; • None of the three patient falls identified could have been predicated, but thankfully all injuries sustained were minor; • Concern was raised at the WHO compliance levels which had dropped recently; this

	issue was being investigated by the Medical Director; • The high level of staff incidents recorded related partly to a problem with the new theatre doors, whose weight was causing issues for those staff members with existing musculoskeletal injuries. Attempts being made to resolve the issue but in the meantime staff have been urged to take extra care. **Incidents** • The serious untoward incident (SUI) reported to the CCG last month had now been downgraded; however, an internal investigation was underway and the outcome would be reported to the board in due course. • Following the recent power failure; generator testing was now undertaken weekly rather than monthly, AP reported that three neighbouring trusts had also experienced failures in power and water during the recent storms. **Risks** • JB noted that the risk relating to inadequate health record storage should be split to reflect two separate issues, ie one relating to a trip hazard (currently under review by the risk manager) and the one to a delay in delivery of health records. • SW asked why the IT infrastructure risk was not rated between 12 and 15; RT advised SW that recent issues had not been internal, but an external issue which he was assured had been described properly and assessed to the correct level of risk. **Patient Experience** • AP assured the board that the Friends & Family red-rated test score for Sleep Studies was a statistical issue rather than a quality one. **Quality Account Priorities 2013/14** • AP reported that there had been an improvement in reporting in respect of consent taken prior to the day of surgery. By speciality, Corneo plastics had achieved 83.3%, MaxFacs 71.4%. It was reported that errors had recently been identified in previous recording of plastic surgery team targets and regrettably had given a misleading picture in recent months. Whilst commending SF and AP for their responsive action in resolving this issue, the Chairman asked what action would be taken against those individuals who remained non-compliant. SF noted that errors in data collection had highlighted the trust's need to be absolutely certain of the facts before applying sanctions. Moreover, it would be necessary to ensure those concerned were fully aware of the implications of non-compliance before instigating any penalties. RT concurred core compliance standards should be agreed and clearly communicated to the organisation and it was agreed this would be discussed as part of a future board seminar **[Action: RT]** **CQUINS** • The CQUINS for 2014/15 had been agreed with commissioners; • On 18 February, the CQC had undertaken a short notice inspection of compliance with the Ionising Radiation regulations. In general, results had been positive, and further details would be provided at the next Quality & Risk Committee; • AP noted that the current F & F response rate requires improvement and reminded the board that next year, there would be a CQUIN target associated with this; • The staff F & F test starts on 01 April and will be reported each quarter. This will also be included as part of next year's CQUINs target. The board **NOTED** the contents of the update
057-14	**Board Assurance Framework** AP reminded the board that the BAF was updated quarterly by Executive leads; this version had been reported to the Quality and Risk Committee in February and the Audit Committee in March; SW noted that historic data still appeared on the current version. RT assured the board

	that AP and LH were currently reviewing the reporting cycle in order to bridge this gap; JT observed these issues had already been identified at last week's Audit Committee. In addition, it had also been agreed that current format was not helpful and would therefore be updated and aligned to the new KSOs. The board **NOTED** the contents of the update
058-14	**Quality Account Priorities** AP summarised the proposals for the Quality Account priorities for 2014/15 as follows: 1. Provision of clinical outcome measures 2. Scheduling of elective surgery 3. Increase in number of elective patients receiving treatment on the day ('see and do' clinics) 4. Introduction of electronic system to evidence staff staffing levels are provided on wards RT asked the board to note that these aligned well with streamlining and operational efficiency, and that the Clinical Cabinet was broadly in agreement with the proposals, with the proviso in respect of elective surgery scheduling. AP stressed the importance in particular of providing evidence relating to safe staffing levels and reminded the board that this was linked to the Francis Inquiry, and further supported by the National Quality Board. The Chairman suggested that this report be made more meaningful for a member of the public. RT concurred and explained that he was currently realigning the new KSOs with QVH 2020; these in turn would be aligned to the Quality Account priorities and a more appropriate document would be developed for the general public. The board **NOTED** the contents of the update
059-14	**C-Wing Report: formal response and action plan** In presenting his formal response and associated action plan, RT stressed the importance of distinguishing between his role as a member of the 'lessons learned' group and his formal role as the trust Chief Executive. He reminded the board that it was in respect of his role as CEO that he had taken responsibility to translate the board's endorsement of the C-Wing report into a detailed action plan. The action plan was reviewed and RT advised updates would be provided to the board on a quarterly basis; moreover, the action plan would be cross-referenced with emerging priorities from QVH 2012 to ensure common themes were identified. BG reminded the board that this should be communicated to governors and was assured this was now in the public domain. With reference to item [10.6a] LP asked that the wording be changed from annual board 'report' to 'discussion'. LH agreed to update and recirculate any changes via email [**Action: LH**] The Chairman commended LH and RT on setting out the requirements with such clarity and the board **NOTED** the contents of the update
BUSINESS PERFORMANCE & DELIVERY	
060-14	**Workforce Performance Report**

	GA tabled several additional reports at the meeting to expand on this month's standard update. Key points were as follows: • Sickness levels had improved but were still not on track. GA reminded the board that a more challenging target of 2% would be implemented next year. GC queried this decision believing it might be deemed too aggressive, although GA was assured that this could be achieved through efficient and effective use of staffing, and noted that this was also the target within KSS. • Measures implemented to address the trust's financial position were now taking effect, with significant reduction in bank and agency costs. These would remain remain in place for the foreseeable future. • The bi-annual safe staffing levels review, undertaken by the Director of Nursing, had been incorporated into this month's report; whilst levels in Burns and Peanut were being maintained, there had been an increase of bank and agency in C-Wing and this would need to be addressed through more effective use of eRostering. • Statutory and mandatory training percentages had increased steadily throughout the year, even taking into account that figures presented didn't include those staff booked to undertake training. Whilst there were still timing issues in the reporting of data, GA asked the board to note that figures were more accurate now than in previous years. The trust was moving towards a greater uptake in online training, which would help address the issue of short notice cancellations and DNAs. The Chairman observed that even in meeting the target of 80% compliance, 20% of staff would remain non-compliant. GA explained why there would always be a small number of staff in this category, for a variety of reasons, but assured the board that action would be taken for any member of staff who remained non-compliant for a period of 3 months. RT concurred 20% was a reasonable level of non-compliance and the trust would manage the risk accordingly; • A presentation tabled at the meeting described a review of workforce productivity reporting, which would encompass both quality as well as financial productivity. GA had been working with AP to develop a scorecard using existing information in a more meaningful way. This report would be introduced initially in the wards, and then rolled out gradually across other areas of the trust. If the board was satisfied with this new approach, the resultant changes would be produced in time for the April board meeting, and continue on a monthly basis and quarterly reporting of trend data. The board commended GA on the model and looked forward to seeing further development in future. The Chairman thanked GA for his update and the board **NOTED** the contents of the report.
061-14	**Financial Performance Report** • RH reported the financial position had improved this month but was still £436k below plan at a surplus of £1.6m. Whilst the trust had taken action to improve the financial position by year end, achieving the planned surplus would remain challenging. • RH drew the board's attention to the cash balance which was lower than had been in the past standing at £4,334k, (and below plan); RH warned that pressure on cash was likely to continue. • SW asked for clarification regarding Pay and Non-Pay and was advised that both were overspent in the month; pay largely within medical staffing and some nurse agency, Non Pay because of general activity related and other overspends • Despite recent difficulties, RH asked the board to note that the new Continuity of Service Risk Rating for the trust was at the top rating, being a 4. The Board **NOTED** the contents of the report.

062-14	**Operational Performance Report:** JM joined the meeting to present on the key issue of RTT18 with RH. RT advised that an exception report had now been submitted to the CCG and to Monitor, advising that the trust would need to fail its corporate target in order to clear backlog; however, he stressed the importance of maintaining the confidence of commissioners and regulators by presenting a structured plan. JM reported that the trust had failed the target in February and explained contributing factors to this breach were due to combined effect of Sleep Studies, Plastics and Corneo, although it was still possible that current figures could change following validation. JM stressed that the Plastics team was striving to get back on track but there was still a significant backlog of patients who had waited longer than 18 weeks following the earlier shortages of junior doctors, coupled with a sharp increase in referrals in July (more than 300 referrals than ever before) 'for consultants to do cases' which were now emerging through the system. Corneo had continued to experience capacity issues particularly surrounding Cataract patients and 'consultant to do only' cases. This had been further compounded by the lack of experience of the current fellows within the speciality. Early warning systems had been developed for the future, and extra sustainable capacity would be provided with the opening of Theatre 11; in the meantime, however, March was likely to fail the target and the shutdown over Easter could exacerbate the situation further, although the trust was planning not to fail the April target. In the meantime, an intensive support team from PWC had been invited into the trust in April to provide support and advice. RH advised that the Monitor risk rating remained green for 2013/14 however, it should be noted a third consecutive quarter failure in Q1 of 14/15 would place organisation ' under review' RT reiterated that whatever the final outcome, the trust still intended to provide Monitor with its action plan to provide continued assurance The board **NOTED** the contents of the update.
063-14	**Site Redevelopment Phase 1: Analysis of Costs** RH advised there that a meeting had taken place on 26th March to discuss the final account for the Theatres project. The format for the final report of costs was agreed but not all subcontractors had yet submitted invoices so final costs were not yet available. It was anticipated this would be brought to the May Board for information. The board **NOTED** the contents of this update.
GOVERNANCE	
064-14	**Information Governance Toolkit Submission** RH reminded the board that the IG toolkit was a self-assessment of compliance against information governance requirements. He reported that the trust had submitted evidence which increase its 2012/13 score from 76% to 81% for 2013/14. This represented a satisfactory score. The board **NOTED** the contents of the report
STRATEGY	
065-14	**Delivering Excellence: QVH 2020 (monthly update)** RT advised that the first phase of the QVH 2020 Clinical Strategy was now concluded and

	had been approved by the Clinical Cabinet. A more detailed update would be provided in the closed session of the meeting. A work programme was being developed and a new project manager had been appointed to start in April. It was anticipated that tangible benefits would start to be seen next year. The board **NOTED** the contents of the update
066-14	**Site Redevelopment Programme:** HB presented the monthly report and confirmed that the Phase II theatres were still on target to open on 7 April. The board **NOTED** the contents of the update
067-14	**Capital Programme:** HB reported that the capital programme for 2013/14 would be carried over to 2014/15. A project manager had been appointed to lead on the Jubilee heating work (including Burns heating and the hot water system in Prosthetics). Work was scheduled to commence on 01 May. The board **NOTED** the contents of the update
068-14	**Business Plan for 2014/15** RH summarised the business plan process which had taken place over the previous few months. Budget setting/business planning had been developed in two stages, ie the two-year operational plan and the five-year strategic plan. A surplus of £2.2-£2.5m was forecast, with investment assigned to improvements in the IT infrastructure and the estate. The Monitor plan would be circulated for information to the Board **[Action: RH]**
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
069-14	**Clinical Cabinet** RT reported that week one of this month's meeting had focused on the clinical strategy, with members of the board in attendance. At the week three meeting, issues relating to performance and quality had been discussed. The board **NOTED** the contents of the update.
070-14	**Audit Committee** • SW advised that the quarterly Audit Committee meeting had taken place on 18 March, with no major issues to report. She did however, wish to draw the board's attention to the draft KPMG report on the trust's capital projects and contract management review which contained significant recommendations; these would need to be implemented to ensure best practice before undertaking the anticipated IT investment programme. • SW confirmed that Internal Audit were on track for the KPMG final account deadline, and also asked the board to note that the existing contract had been extended for this financial year. • Finally, SW noted that PWC would be supporting the trust on the RTT18 review. The board **NOTED** the contents of the update.
071-14	**Charitable Funds Advisory Committee**

	LP updated the board on the committee meeting which had taken place earlier in the day. New legislation had been introduced in respect of Charitable Trusts but he was assured this would not cause significant issues for a trust the size of QVH. The Committee had also received its first quarterly update in respect of the new R & D appointment, which had been very positive. The board **NOTED** the contents of the update.
GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
072-14	**Report from the Governor Representative** BG asked for an update in respect of the Savile report. AP advised she would be meeting with the DoH shortly and confirmed that a final report would be published in June.
073-14	**Observations from the Chairman and Non-Executive Directors** The Chairman reported that, at its meeting on 13 March, the Council of Governors had approved a recommendation for the trust to start the recruitment process for a new Chairman. It was anticipated the new appointment would join the board in June 2014 as a NED and assume the substantive role of Chair in April 2015. The board **NOTED** the contents of the update.
QUESTIONS FROM OBSERVERS	
074-14	One member of the public, (and former governor) asked the board to confirm to what extent it recognised Dr Bull's observation, whilst still in the post of CEO at the trust, that QVH would need to identify new methods of good economic clinical practice in order to advance organisational (and financial) efficiency. He also asked to what extent the trust was moving in the direction of a modified organisational structure in order to promote economic medicine for the benefit of both patients and the wider community. RT responded by concurring with Dr Bull's statement that the trust certainly needed to develop a sustainable model in order to survive in the long term. He provided a synopsis of the QVH 2020 Delivering Excellence strategy which was designed to identify excellent - but sustainable – services whilst joining productivity with growth. SF cautioned that maintaining an appropriate workforce was paramount regardless of any technological advances that might be made and noted there could be no substitute for the human element in patient care. The Chairman thanked those members of the public present. There being no further questions, the meeting was closed at 15:45

Chairman…… Date…….....

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
March 2014 meeting						
1	055-14	Board to discuss long term strategy for medical workforce planning	**SF**	**Sept 2014**	**07.04.14**: Item on board seminar programme for September 2014	**Complete**
2	056-14	Board to agree trust core compliance standards	**RT**	**April 2014**	**24.03.14**: Item on agenda for April Board	**Complete**
3	075-14	Board update on current site and strategic options	**RT/HB**	**July 2014**	**14.04.14:** Board seminar booked for July	**Complete**
February 2014 meeting						
4	029-14	Training updates to be introduced to board workshops to ensure Board compliance	**AP/LH**	**April 2014**	**24.03.14:** Diarised to begin April 2014	**Complete**
5	046-14	Clarity to be sought in respect of clinical support service budgets for corporate areas (and presented as part of overall monthly service line reporting)	**JT/RH**	**June 2014**	**07.04.2014** • Supplementary information in respect of support and corporate budgets now included in board report with effect from March 2014 • RH and JT to review finance reporting format. Item on agenda for June Board	**Complete**
6	048-14	Detailed action plan to be developed following recommendations made within C-Wing report.	**LH**	**March 2014**	**24.03.14:** Action plan on agenda for March Board	**Complete**
7	048-14	RT to respond to C Wing recommendations on behalf of Board	**RT**	**March 2014**	**24.03.14:** Response on agenda for March Board	**Complete**
8	049-14	Board Outcomes Group ToRs to be amended to provide greater clarity to Purpose Statement.	**LP/SF**	**April 2014**	**07.04.14**: Item on agenda for April Board	**Complete**
January 2014 meeting						
9	006-14	Revalidation action plan to be presented to the Board on an annual basis to enable progress to be monitored	**SF**	**Oct 2014**	**30.01.14:** Diarised for October 2014	**Complete**
December 2013 meeting						
10	263-13	Informal business planning meetings to be held during Q4 with NEDs, RH and RT	**RH**	**March 2014**	**24.03.14**: Business Plan approved at March Board	**Complete**
11	264-13	Financial progress updates to be provided to the board on a weekly basis	**RH**	**April 2014**	**24.03.14:** Board to receive update for M12/year end when finalised.	**Complete**
October 2013 meeting						
12	223-13	Phase III Site Redevelopment option appraisal to be presented to BoD March 2014	**RT/HB**	**March 2014**	**24.03.14:** Option Appraisal presented at March Board	**Complete**
September 2013 meeting						
13	196-13	Plan to establish if different elements of streamlining programme can be quantified to demonstrate financial benefits	**RH**	**March 2014**	**24.03.14:** To be removed from matters arising, and instead included as part of strategic priorities for future business planning	**Complete**
June 2013 meeting						
14	133-13	Review of allocation of capital expenditure to be included as part of business planning process	**RH**	**March 2014**	**24.03.2014**: Included as part of business plan approved at March Board	**Complete**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
April 2013 meeting						
15	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**	**24.03.14:** Meeting scheduled 26.03.14 to discuss final account for Phases I and II. Format for final report of costs agreed but still awaiting subcontractor expenses. Final costs to be brought to May BoD.	**On track**
March 2013						
16	058-13	Board to receive consultant level performance data	**RH/AP/ SF**	**March 2014**	**24.03.14:** Now **i**ncluded in Finance SLP with effect from March 2014	**Complete**
February 2013						
17	028-13	Compromise or confidentiality agreements to be subject to approval of Nomination & Remuneration Committee	**GA**	Ongoing	**24.04.14:** Now monitored on an ongoing basis by the Head of HR & WD	**Complete**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**085-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 April 2014**

QUALITY AND RISK EXCEPTION REPORT: APRIL (MONTHLY UPDATE)

1. The attached information was provided to the Clinical Cabinet on 21 April 2014.

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

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

Quality and Risk Management Report
April 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 March 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)	2012/13 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	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
	E-coli bacteraemia	—	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA bacteraemia	—		0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA screening - elective	—	100%	97%	98%	99%	97%	95%	95%	94%	98%	95%	95%	95%	96%	96%
	MRSA screening - trauma	—	100%	100%	99%	99%	99%	97%	98%	98%	96%	97%	97%	96%	98%	98%
	Trust hand hygiene compliance	98%	100%	99%	98%	100%	98%	99%	99%	100%	99%	98%	98%	97%	98%	99%
	Trust mandatory training compliance - IPACT	—	>80%	84%			71%			70%			77%			75%

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 – SDC/anaesthetics; post room; hotel services.
- *Annual PLACE inspection* of all clinical areas the tea included previous patients. No major issues highlighted but noted some areas generally cluttered, pot holes in pathways, need for some high back chairs in waiting rooms. Formal results awaited.

- Main Kitchen/Spitfire/Hurricane annual audit completed – No major issues highlighted, report / action plan sent to Hotel Services Manager. Issues include replacement of old machinery, insufficient cleaning behind hot fryers as permanently on, crack in work surface, chipped paint, removal of out of date herbs and spices.
- *Sink audit* – currently not compliant with guidance in corneo out patients, prosthetic lab and pharmacy. Portable sinks requested for these areas; if not possible risk assessments to be completed. Of in-patient areas, only Sleep and Peanut fully compliant with latest guidance due to change in sink/bed ratio; all side rooms compliant with current guidance. (All areas were compliant when built).
- *Mattress and cleaning chart spot check* – Some areas still not completing ward cleaning checklist; some areas need to edit to make clearer. All mattresses seen were clean / intact. Some treatment couches were damaged and advice given to staff on temporary repairs with a requirement to replace as soon as possible.
- *First part of SSI audit* – 34 elective breast surgery patients audited. In total 11 reported post-operative problems; two were readmitted for IV antibiotics for confirmed SSI. Of the other 9 only 1 was given antibiotics. Readmission rate for SSI = 8%. Total SSI rate when all patients given antibiotic treatment included = 8.8% (decrease from previous audit of 16%).

Safety metrics

4. The trust uses a number of metrics to support identifying how safe care is for patients at QVH.

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)	**2012/13 total / average**	**Target**	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Safety	VTE prophylaxis	92%	>95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Number of Pressure ulcer development Grade 2 or over acquired at QVH	3	<4	1	0	0	2*	0	1	1	0**	1	0	1	1	8
	Patient falls causing harm			0	2	2	1	1	0	2	1	0	4	3	0	16
	WHO compliance	—	>95%	99%	99%	99%	99%	99%	99%	98%	96%	92%	93%	90%	93%	96%
	Percentage of theatre lists starting with a surgical safety briefing	93%	>95%	92%	91%	94%	95%	96%	95%	97%	97%	89%	93%	96%	94%	94%
	Serious untoward incidents (including Never Events) * SI downgraded following investigation	5		2	0	0	0	0	1*	2	0	0	0***	0	0	5
	Medication prescribing errors per 1000 spells	3.4		1.4	3.1	1.5	5.4	2.3	0.7	4.6	3.4	5.2	4.2	2.8	3.8	3.2
	Medication administration errors per 1000 spells	1.6		2.8	1.6	1.5	0.0	0.8	0.7	0.0	3.4	0.7	2.1	0.7	1.3	1.3
Staff Safety	Staff incidents causing harm	7		8	4	8	6	6	9	7	4	3	7	11	5	7
	RIDDOR (Patients & Staff)	4		0	0	0	0	1	0	0	0	0	2	1****	0	4
	Mandatory training attendance	—	80%	72%	66%	69%	70%	74%	68%	68%	66%	66%	74%	77%	78%	71%
	Flu vaccine uptake	—	60%	Not due till October						15.80%	52.20%	54.70%	55%	55%	55%	55%

5. There was one incidence of a patient acquiring a grade 2 pressure ulcer this is being followed up directly involved with this patients care. The current investigation identified lapses in nursing care that may have prevented the development of the pressure ulcer.

6. Lists commencing with a safety briefing is again noted to be lower than 95%. This is discussed regularly with the theatre team and is a focus for the patient safety forum where all aspects of the World health Organisation (WHO) surgical safety checklist and prelist briefing process were reviewed. This measure will form a CQUIN for next year and audit will be both quantitative (the number occurring) and qualitative (who attends).

7. There is a requirement for staff to attend annual mandatory training in risk management, health and safety. QVH sees this as important in providing information to staff on how to prevent harm to themselves and others. All managers have been informed of staff that have not completed their training within the last 15 months and there is a focus on ensuring we achieve above 80% consistently. The Head of Human Resources continues to reviewing the collection and distribution of information to managers.

8. Our flu vaccine rate has not achieved our target of 60%. Although the vaccination programme is now complete, we still have a few vaccines remaining within the trust. 55% did exceed the national average however we will retain a target of 60% for 2014/15.

Incidents

9. 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.

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

11. During February one red rated incident was reported; a patient attending for physiotherapy underwent an x-ray and was identified to have a spinal fracture that was reported three days later. Following a full investigation the decision made on the day were deemed to be appropriate and proportionate as the injury was due to degradation over time rather than an acute injury.

12. During February there were four amber incidents that required investigation. These incidents were related to a pump failure resulting in basement flooding, a pressure ulcer due to extended surgery, minor injury as a result of excess pressure when using a dermatome and a back injury to a staff member after assisting a patient in the car park. Actions taken included;

- Reporting of the back injury as a RIDDOR
- Dermatome taken out of use and checked – no fault, Identified as user error with too much pressure applied.
- Pressure injuries to be reviewed by the patient safety forum as a specific issue for theatres.

Risks

13. The board receives a short summary of all risks rated at 12 or above. Currently is one risk rated as 16, five risks now 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

14. Those rated 12 are;

- Potential risk of confidential information breaches
- 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

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

Patient experience

15. During March there were five complaints received from patients or their relative and no claims. During the month four complaints were closed with the following actions, these were:

- **Medics/Lab –** Aspects of treatment were challenged following removal of squamous cell cancer (SCC) from lip which has resulted in cancer spreading to lung. With a query why the patient was not offered radiotherapy. Concern that delay was caused by biopsies being 'destroyed' by Path lab.
  Outcome *– The patient was not offered radiotherapy as this was not deemed appropriate for his condition. The word 'destroyed' was unfortunately used as due to the size of the specimens they broke down during processing. Although the patient has had to have further specimens taken this has unfortunately had no bearing on him developing secondary cancer.* ***Unsupported.***

- **Nursing/Medics –** Following surgery the patient had stitches removed and claims that acquired an infection from nurse as developed infection in hand. This resulted in an admission of 18 days and only 70% movement in hand. Patient has asked for compensation.
  Outcome *– Patient developed a deep infection in hand following surgery. This is extremely unfortunate however we are unable to determine how the patient got this infection which could be as a result of several factors. Request for compensation declined.* ***Unsupported.***

- **Medics –** Concerns about surgery. Patient felt they were not informed exactly how big or deep the wound would be following excision of SCC. They also when had pain in their leg and were told all would be ok. The graft failed and the leg will take a long time to heal.
  Outcome – Failed communication with patient. Depth of wound should have been fully explained to patient and when she initially contacted the hospital with a concern she should have been made an appointment for review. ***Upheld in part.***

- **Theatres –** Due to waiting and lack of communication patient decided not to wait to have surgery.
  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.* ***Upheld.***

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)	2012/13 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Experience	Complaints per 1000 spells	4.4		5.0	3.1	7.4	4.8	5.4	7.9	5.3	2.1	7.5	2.1	2.8	3.2	4.7
	Claims per 1000 spells	0.7		1.4	0.8	0.0	0.7	1.5	1.4	1.3	0.7	0.7	0.7	2.1	0.0	1.0
	FFT Score acute in-patients	—	>75	89	86	86	83	81	88	84	83	86	87	94	86	86
	% score for likely and very likely to recommend QVH			98.3%	95.0%	98.5%	97.6%	100.0%	97.8%	98.2%	97.0%	97.3%	98.6%	98	99	
	FFT score MIU	—	>75	77	91	90	84	92	90	89	73	76	93	83	87	85
	% score for likely and very likely to recommend QVH			93.0%	100.0%	99.6%	99.4%	98.7%	99.4%	98.5%	98.0%	95.8%	100.0%	99%	99%	
	FFT score OPD	—	>75		80	87	90	84	83	79	80	81	84	80	79	82
	% score for likely and very likely to recommend QVH				98.0%	99.0%	99.1%	97.7%	99.0%	98.2%	97.5%	98.8%	98.9%	98%	98%	
	FFT score DSU	—	>75									86	100	97	87	
	% score for likely and very likely to recommend QVH											98.8%	100.0%	100%	98%	
	FFT score Sleep disorder centre	—	>75	75	80	83	84	87	78	85	72	50	-100	71	76	62
	% score for likely and very likely to recommend QVH			96.0%	99.0%	98.8%	96.6%	100.0%	99.0%	99.0%	94.7%	100.0%	0.0%	92%	99%	
	FFT score Therapy	—														
	Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Patient experience - Would you recommend this hospital to family or friends (indicates a yes response)	99%	>90%	98%	98%	98%	98%	99%	98%	97%	97%	97%	99%	98%	99%	98%
	Patient experience - How would you rate the quality of care you received (4&5 score of good and above)	98%	>90%	99%	99%	99%	98%	99%	99%	98%	96%	98%	100%	98%	97%	98%
	Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	98%	>90%	100%	99%	100%	92%	94%	95%	93%	83%	98%	99%	97%	97%	96%

Safeguarding

16. 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.

17. Safeguarding for children activity during February saw involvement in 20 cases. Of these 7 were referred to Children and Young People Services (CYPS) prior to transfer to QVH and of 13 internal investigations 3 were referred on to CYPS.

18. Four adult safeguarding referrals were made to Social Services during March. Three reported by the wards and one from outpatients, three 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

19. Our quality account 2012/13 identifies the four main priorities we have set ourselves for 2013/14. Progress against these will be provided each month.

20 March has shown an increase in consent taken prior to the day of surgery. The results have been provided back to the clinical leads so they can raise any identified issues with their colleagues and continue to improve in this area. By speciality the corneoplastic team achieved 91.2%. The maxillofacial team achieved 71.9% a further improvement and the plastic surgery team achieved 65.2%. The medical director is working with the lead clinicians and has identified a consultant to look at how consent taking can be improved across the organisation.

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)	**2012/13 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	
Quality Account 2013	Outpatient experience FFT score	—	N/A	Introduce	80	87	90	84	83	79	80	80	84	80	79	82
	*To take consent for elective surgery prior to the day of surgery	33%	75%	44%	47%	57%	49%	54%	42%	48%	57%	67%	68%	60%	72%	72%
	Cancer compliance with outcome data set	—		Phase 1 = 75%			Phase 2 = 85%			Phase 3 = 85%						
	Consultant Outcome Measures	—	N/A	Introduce			In progress			Monthly data available						

21 Our friends and family test score was below 80 for this month but no returns were received from corneo outpatients reasons for this are being investigated.

Commissioning for quality and innovation (CQUINs)

22. CQUINs for 2013/14 have been agreed with our commissioners. We have commenced collecting the required information and will report our progress each month. For some of the measures we have been required to submit plans on what we wish to achieve and how this will be managed. These plans have been submitted for three of the measures; intraoperative fluid management, assistive technology and digital by default as required. A final quarterly update report will be provided to Mid Sussex Clinical Commissioning Group. The director of nursing has met with the CCG to confirm that to the end of quarter three all metrics had been met. Currently we are agreeing measures for 2014/15.

CQUIN	VTE prophylaxis	92.3%	>95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100%	
	VTE in hospital/RCA undertaken	—	0/100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	FFT Score acute in-patients	—		89	86	86	83	81	88	84	83	86	87	94	86	86		
	FFT Annual Staff Survey	—	>4	Annual Score											4.3%	4.3%		
	Dementia >75 trauma asked indicative question	91%	90%	92%	89%	100%	88%	100%	85%	89%	100%	85%	100%	89%	100%	93%		
	Dementia >75 having diagnostic assessment	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Dementia > 75 referred for further diagnostic advice	96%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	89%		
	Dementia training for non-clinical staff	—	65%	64%	66%	67%	65%	70%	61%	61%	70%	74%	65%	72%	75%	67%		
	Dementia clinical leads identified	—		Complete														
	Dementia carers	—		Actions in progress			Actions under way as identified											
	Safety thermometer data submission	—	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Harm free care rate	—	>95%	98%	92%	97%	97%	88.9%	100%	97%	100%	98%	100%	100%	100%	97%		
	No new harm rate (aquired at QVH)			100%	97%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%		
	Intra operative fluid management	—			Submitted		Submitted			Submitted								
	Intermediate commercial activity - intellectual property	—	Policy	Policy ratified			Submitted											
	Assistive Technology - TRIPS	—			Submitted		Submitted			Submitted								
	Digital first enlighten project	—			Submitted		Submitted			Submitted								
	Shared decision making	—		Introduce			submitting information			submitting information								
	Compliance in practice	—	75%	Introduce			Full roll out complete		100%	Full roll out complete		50%			75%			

Policy Updates

23. Policies uploaded in February include:

- Guidelines for the use of IV ketamine.
- Prevention of HAI in urinary catheterisation in acute care.

Care Quality Commission (CQC)

24. Following the short notice announced inspection of compliance with the Ionising Radiation (Medical Exposure) regulations on February 18th 2014. The following action has been provided back to the CQC and will be reported to and followed up by the quality and risk committee.

25. Compliance in practice audit tools used to support assurance of CQC standards have been re written to reflect the new methodology of key lines of enquiry (KLOE's) and the five domains, well led, caring, effective, safe and responsive.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**086-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 April 2014**

NATIONAL INPATIENT SURVEY

1. Attached are the results for the 11th national NHS inpatient survey, 415 patients aged 16 or over who had stayed at QVH for at least one night during June, July or August 2013 completed the survey which was carried out by Picker on behalf of the CQC. The response rate was 50%, the same as last year and in line with the national average of 49%.

2. The survey covers all aspects of patients' care and treatment, including their privacy and dignity, the way they were treated by doctors and nurses, the information they were given, their views on cleanliness, their comfort and quality of food.

3. We have consolidated our excellent results from previous years and continue to be rated as one of the best hospitals in the country in the eyes of patients. For the second year in a row, we achieved the highest scores of any trust in England for the section of questions on the quality of nursing care and the support available on leaving hospital.

4. Comparisons with previous years are shown in the table below:

	2011	**2012**	**2013**
Better than average	47	56	45
About the same	14	10	23
Worse than average	0	1	0
Top scores	27	19	7
Total Qs that year	61	67	68

5. The patient experience group will be reviewing the report and looking for areas where the trust can improve the patients experience in light of their comments.

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

Patient survey report 2013

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

Survey of adult inpatients 2013

Making patients' views count

National NHS patient survey programme
Survey of adult inpatients 2013

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Our purpose is to make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what we find, including performance ratings to help people choose care.

Survey of adult inpatients 2013

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

Information drawn from the survey will be used by the Care Quality Commission as part of our new Hospital Intelligent Monitoring. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The Trust Development Authority will use the results to inform the quality and governance assessment as part of their Oversight Model for NHS Trusts.

The eleventh survey of adult inpatients involved 156 acute and specialist NHS trusts. We received responses from just over 62,400 patients, which is a response rate of 49%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts were given the choice of sampling from June, July or August 2013. Trusts counted back from the last day of their chosen month, including every consecutive discharge, until they had selected 850 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2013). Fieldwork took place between September 2013 and January 2014.

Similar surveys of adult inpatients were also carried out in 2002 and from 2004 to 2012. They are part of a wider programme of NHS patient surveys, which cover a range of topics including maternity, outpatient and A&E services, ambulances, and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing '**about the same**', '**better**' or '**worse**' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S10 in the 'section scores' on page 6. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward,' 'doctors and nurses' and so forth.

This report shows the same data as published on the CQC website (www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better,' 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

Trusts have differing profiles of patients. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of patients.

To account for this, we 'standardise' the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of patients. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing. It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts in any way, for example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q41 "During your stay in hospital, did you have an operation or procedure?"

Graphs

The graphs in this report display the range of scores achieved by all trusts taking part in the survey, from the lowest score achieved (left hand side) to the highest score achieved (right hand side). The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph clearly states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same.' These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The categories described above are based on a statistic called the 'expected range' which is uniquely calculated for each trust for each question. This is the range within which we would expect a trust to score if it performed 'about the same' as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score (no green section) or the lowest possible score (no red section).

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great.

A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs and background information about the patients that responded.

Scores from last year's survey are also displayed. The column called 'change from 2012' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2012. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2012 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if your trust has merged with other trusts since the 2012 survey. Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to applicable trusts.

All trusts

Q11 and Q13: The information collected by Q11 “When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?” and Q13 “After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?” are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as “Did you ever share a sleeping area with patients of the opposite sex?”

Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the questions’ wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q51 and Q52: The information collected by Q51 “On the day you left hospital, was your discharge delayed for any reason?” and Q52 “What was the main reason for the delay?” are presented together to show whether a patient’s discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q52 and is worded as: “Discharge delayed due to wait for medicines/to see doctor/for ambulance.”

Q53: Information from Q51 and Q52 has been used to score Q53 “How long was the delay?” This assesses the length of a delay to discharge for reasons attributable to the hospital.

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/Inpatientsurvey2013

The results for the adult inpatient surveys from 2002 to 2012 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/705

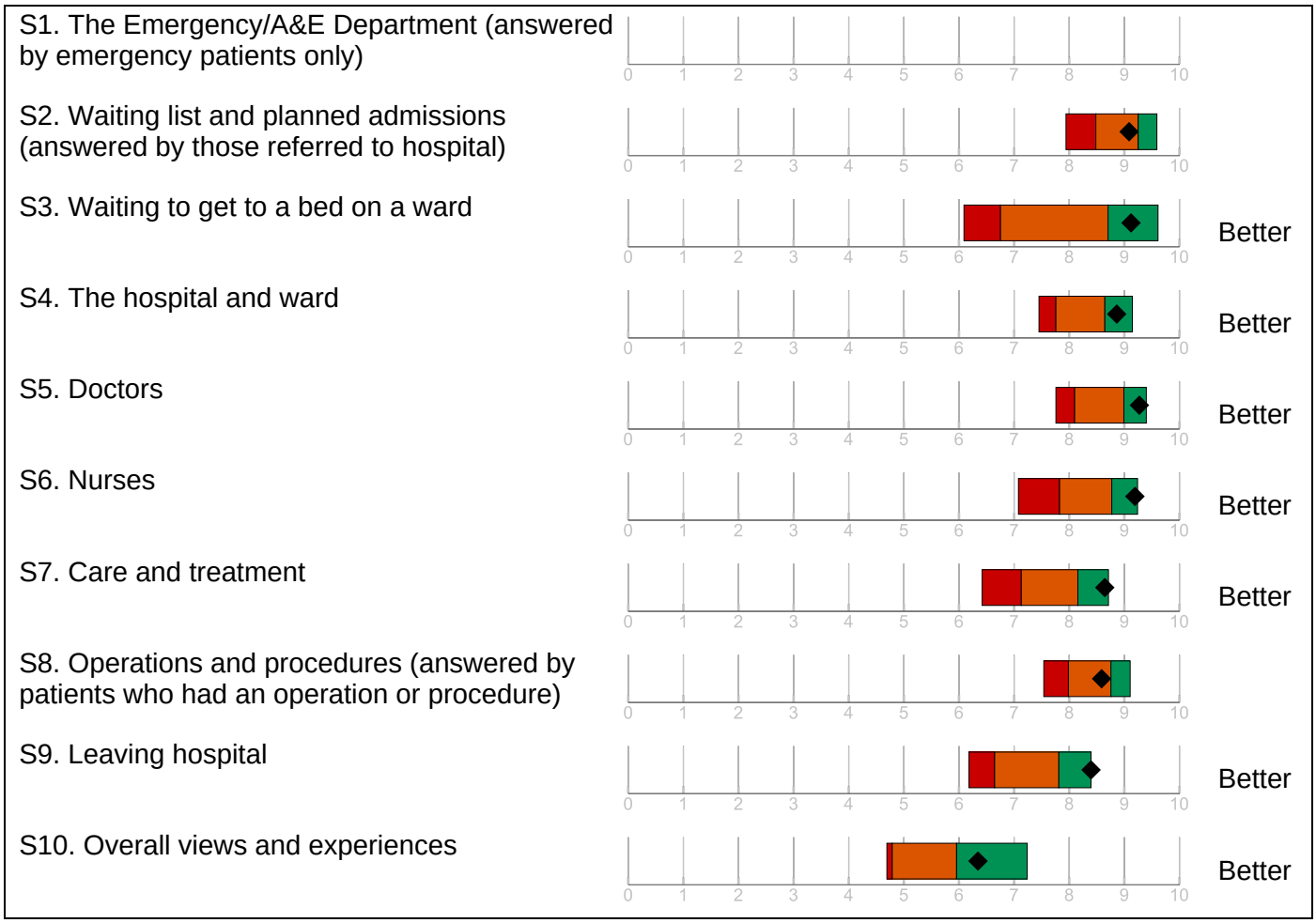
More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/public/hospital-intelligent-monitoring

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

Section scores



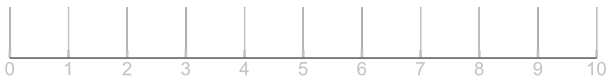
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Waiting list and planned admissions (answered by those referred to hospital)

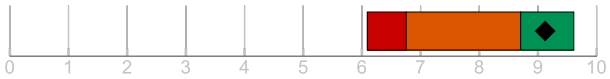
Q6. How do you feel about the length of time you were on the waiting list?

Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



Better

Best performing trusts

About the same

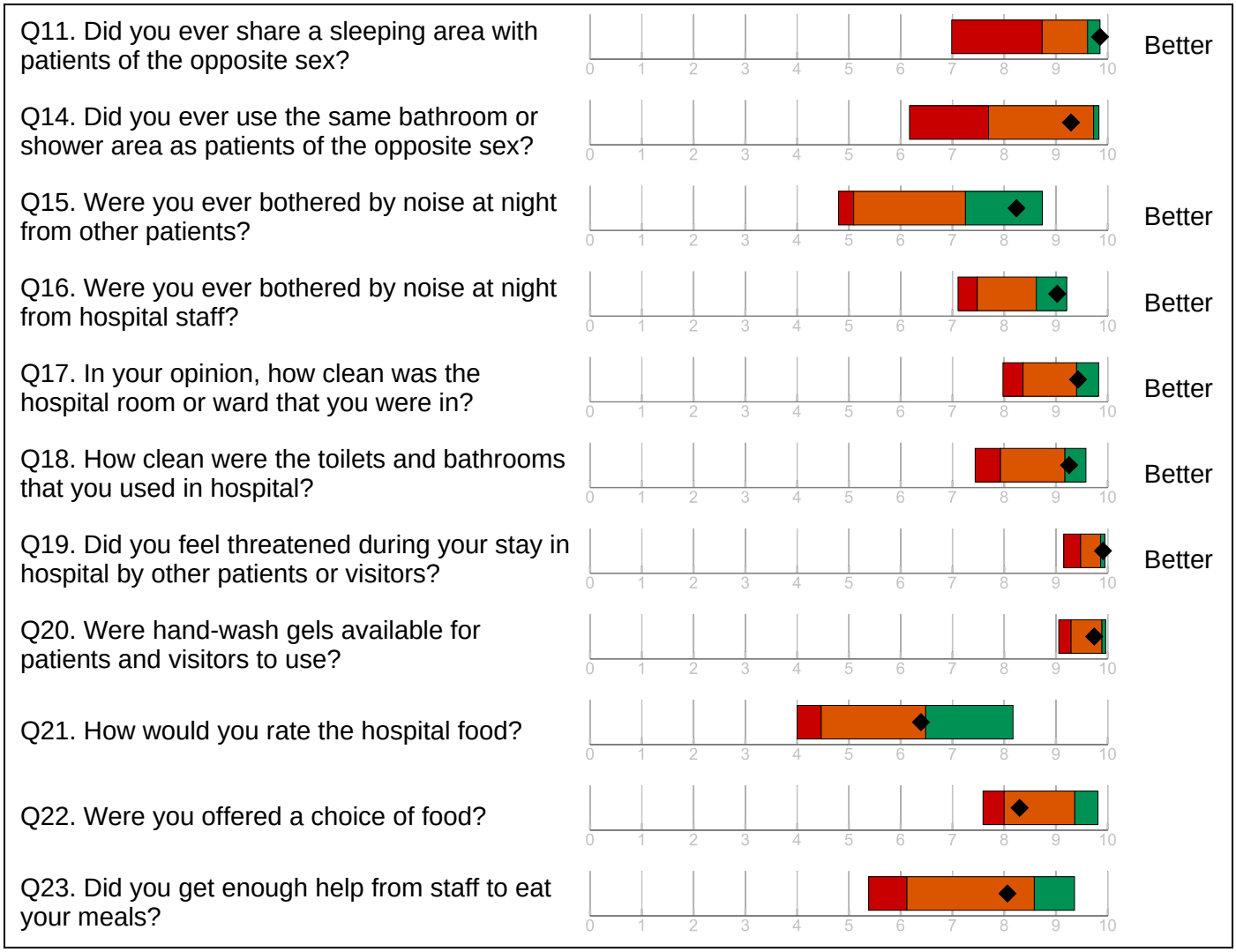
Worst performing trusts

'Better/Worse' Only displayed when this trust is better/worse than most other trusts

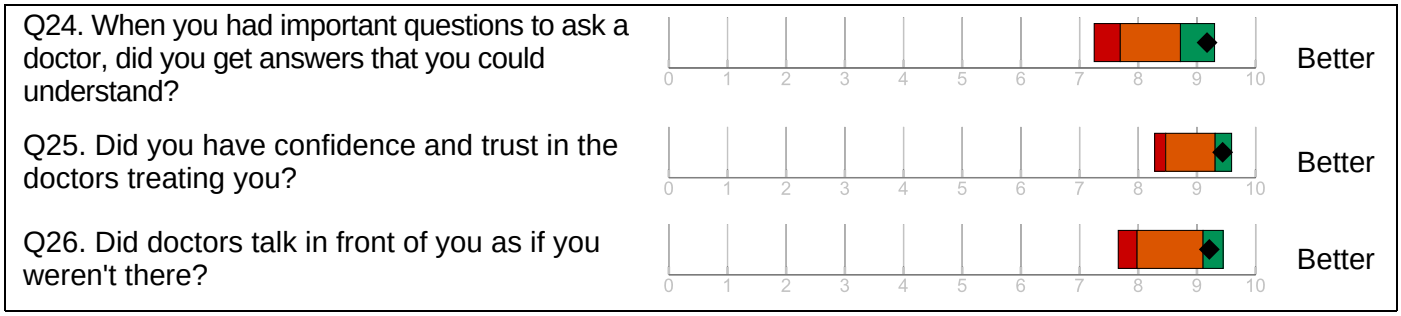
◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

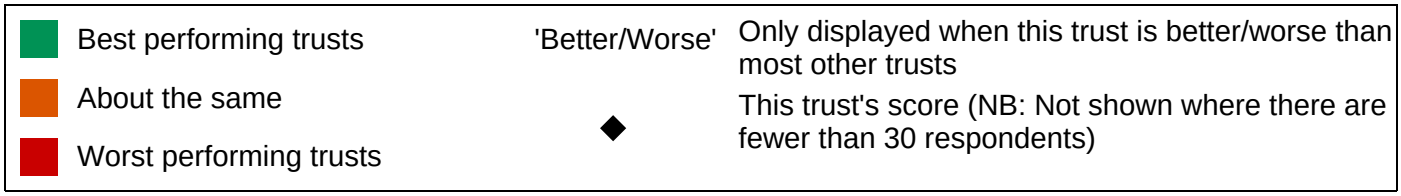
Survey of adult inpatients 2013
Queen Victoria Hospital NHS Foundation Trust

The hospital and ward



Doctors

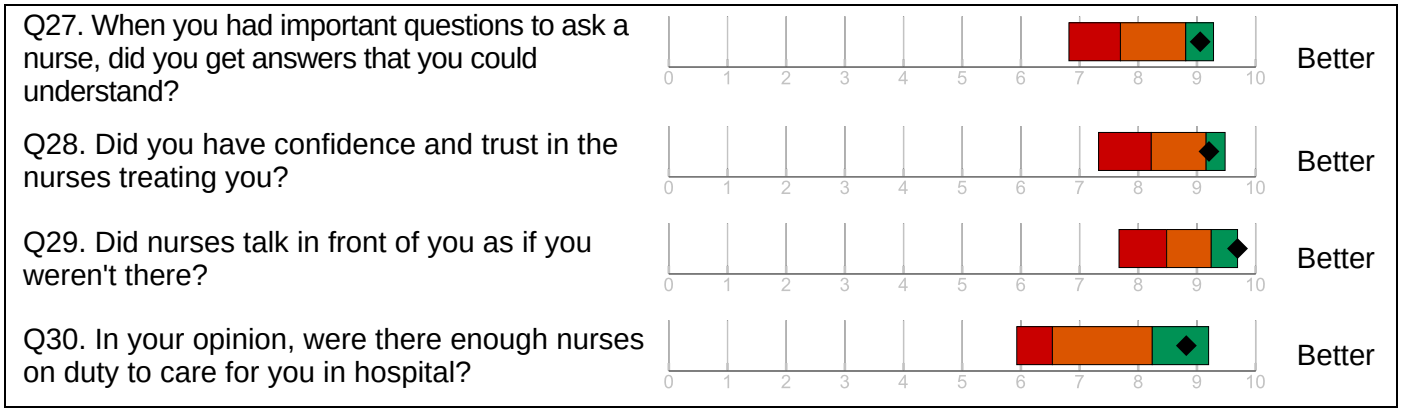




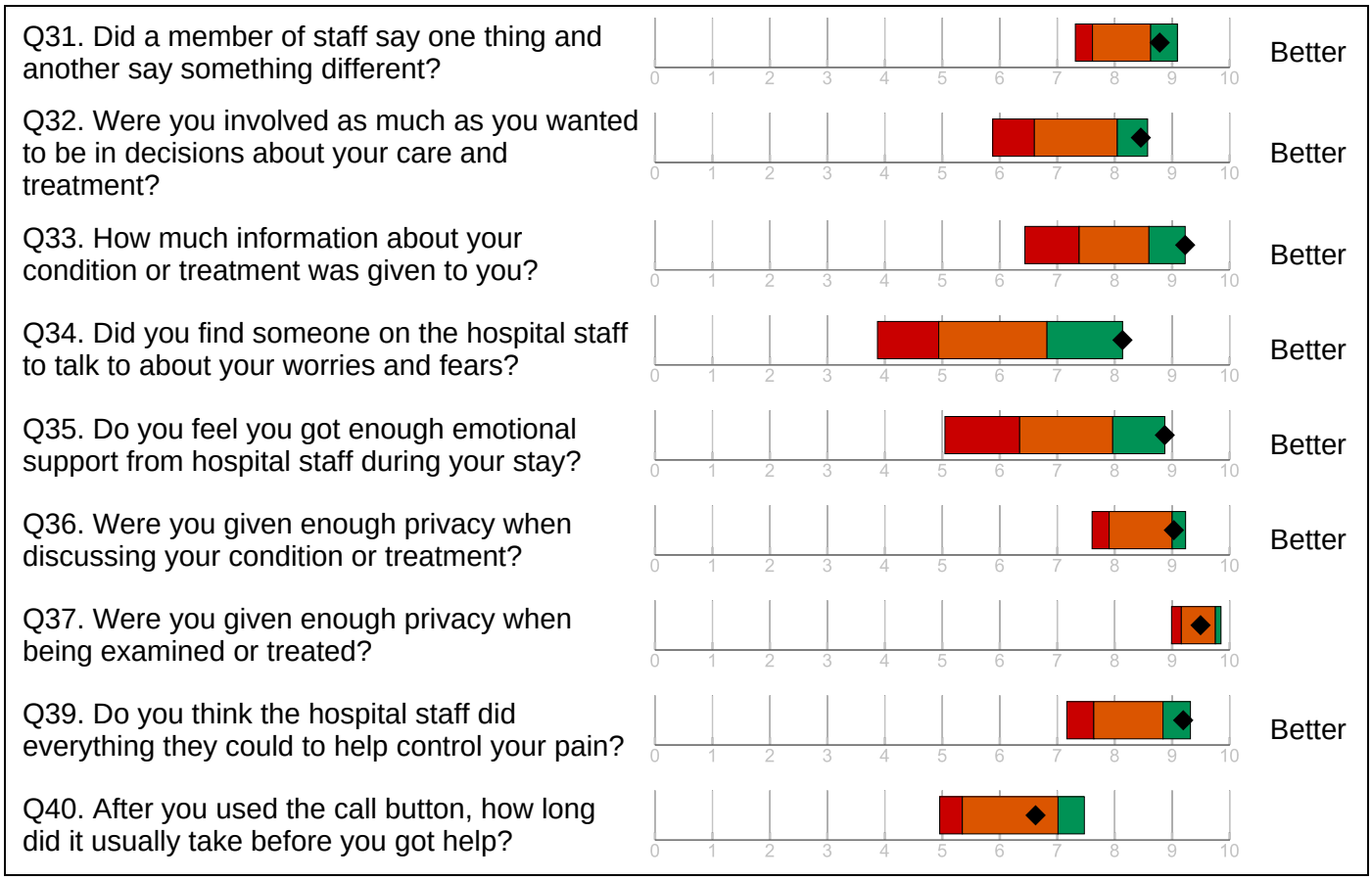
Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

Nurses



Care and treatment



Best performing trusts

About the same

Worst performing trusts

'Better/Worse' Only displayed when this trust is better/worse than most other trusts

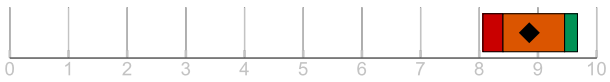
◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

Operations and procedures (answered by patients who had an operation or procedure)

Q42. Did a member of staff explain the risks and benefits of the operation or procedure?



Q43. Did a member of staff explain what would be done during the operation or procedure?

Q44. Did a member of staff answer your questions about the operation or procedure?

Q45. Were you told how you could expect to feel after you had the operation or procedure?

Q47. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

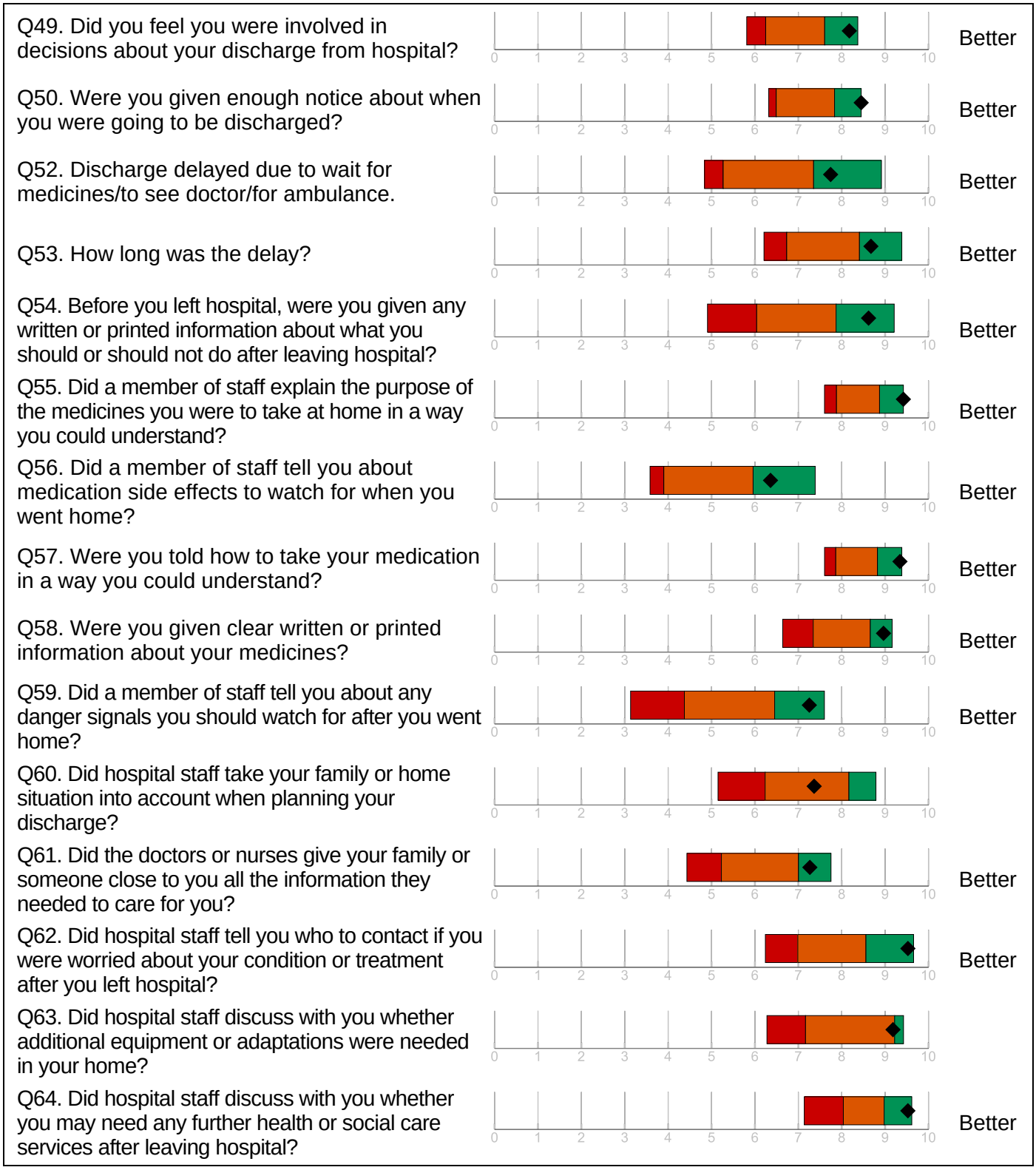
Q48. Afterwards, did a member of staff explain how the operation or procedure had gone?

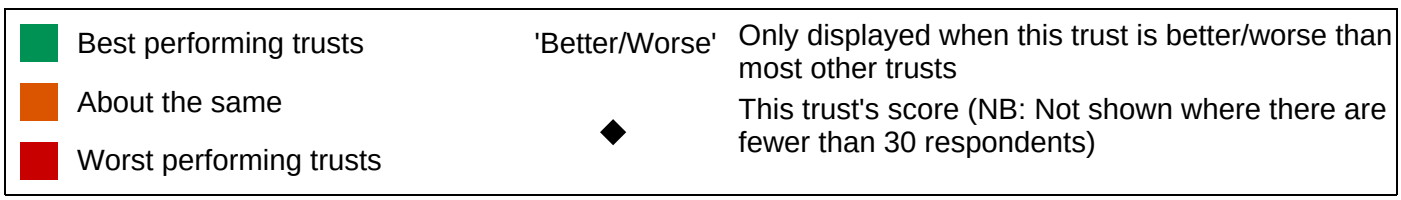
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

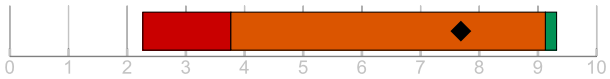
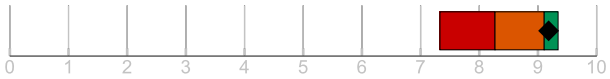
Leaving hospital



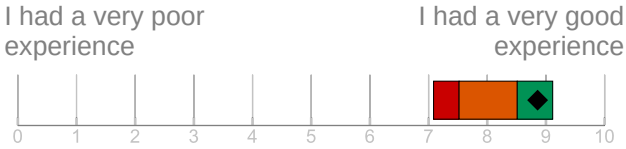
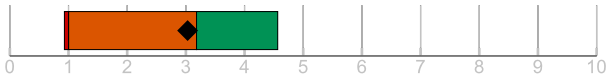


Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?		
Q66. Were the letters written in a way that you could understand?		Better

Overall views and experiences

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?		Better
Q68. Overall...		Better
Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?		
Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?		Better

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	-	7.6	9.5			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	-	7.3	9.4			
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	-	7.7	9.6			
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	9.1	7.9	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.7	6.6	9.7	327	8.9	
Q7	Was your admission date changed by the hospital?	9.5	8.3	9.8	330	9.5	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.1	7.7	9.6	324		
Waiting to get to a bed on a ward							
S3	Section score	9.1	6.1	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	9.1	6.1	9.6	412	9.1	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
The hospital and ward							
S4	Section score	8.9	7.5	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.9	7.0	9.9	363	9.7	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	9.3	6.2	9.8	360	9.5	
Q15	Were you ever bothered by noise at night from other patients?	8.2	4.8	8.7	409	8.4	
Q16	Were you ever bothered by noise at night from hospital staff?	9.0	7.1	9.2	408	9.2	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.4	8.0	9.8	413	9.5	
Q18	How clean were the toilets and bathrooms that you used in hospital?	9.3	7.4	9.6	403	9.2	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.9	9.2	9.9	412	9.9	
Q20	Were hand-wash gels available for patients and visitors to use?	9.7	9.1	10.0	404	9.5	
Q21	How would you rate the hospital food?	6.4	4.0	8.2	335	6.3	
Q22	Were you offered a choice of food?	8.3	7.6	9.8	391	7.8	
Q23	Did you get enough help from staff to eat your meals?	8.1	5.4	9.4	96	8.9	
Doctors							
S5	Section score	9.3	7.8	9.4			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	9.2	7.2	9.3	346	9.3	
Q25	Did you have confidence and trust in the doctors treating you?	9.4	8.3	9.6	401	9.4	
Q26	Did doctors talk in front of you as if you weren't there?	9.2	7.7	9.4	400	9.1	
Nurses							
S6	Section score	9.2	7.1	9.2			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	9.1	6.8	9.3	359	9.3	
Q28	Did you have confidence and trust in the nurses treating you?	9.2	7.3	9.5	409	9.5	
Q29	Did nurses talk in front of you as if you weren't there?	9.7	7.7	9.7	400	9.4	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	8.8	5.9	9.2	404	9.3	↓

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Care and treatment							
S7	Section score	8.6	6.4	8.7			
Q31	Did a member of staff say one thing and another say something different?	8.8	7.3	9.1	413	9.4	↓
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.5	5.9	8.6	407	8.5	
Q33	How much information about your condition or treatment was given to you?	9.2	6.4	9.2	412	9.4	
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	8.1	3.9	8.1	186	7.8	
Q35	Do you feel you got enough emotional support from hospital staff during your stay?	8.9	5.0	8.9	220	8.7	
Q36	Were you given enough privacy when discussing your condition or treatment?	9.0	7.6	9.2	404	9.3	
Q37	Were you given enough privacy when being examined or treated?	9.5	9.0	9.8	406	9.8	↓
Q39	Do you think the hospital staff did everything they could to help control your pain?	9.2	7.2	9.3	202	8.9	
Q40	After you used the call button, how long did it usually take before you got help?	6.6	5.0	7.5	181	7.0	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.6	7.5	9.1			
Q42	Did a member of staff explain the risks and benefits of the operation or procedure?	8.9	8.1	9.7	314	9.5	
Q43	Did a member of staff explain what would be done during the operation or procedure?	9.0	7.7	9.5	311	9.2	
Q44	Did a member of staff answer your questions about the operation or procedure?	9.1	7.8	9.5	274	9.6	
Q45	Were you told how you could expect to feel after you had the operation or procedure?	7.2	6.1	8.1	317	7.1	
Q47	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.2	8.3	9.6	288	9.6	
Q48	Afterwards, did a member of staff explain how the operation or procedure had gone?	8.2	6.9	9.0	316	8.6	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Leaving hospital							
S9	Section score	8.4	6.2	8.4			
Q49	Did you feel you were involved in decisions about your discharge from hospital?	8.2	5.8	8.4	385	8.2	
Q50	Were you given enough notice about when you were going to be discharged?	8.4	6.3	8.4	404	8.6	
Q52	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	7.7	4.8	8.9	397	8.6	↓
Q53	How long was the delay?	8.7	6.2	9.4	397	9.2	↓
Q54	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	8.6	4.9	9.2	397	8.8	
Q55	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.4	7.6	9.4	290	9.5	
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	6.4	3.6	7.4	233	7.0	
Q57	Were you told how to take your medication in a way you could understand?	9.3	7.6	9.4	260	9.5	
Q58	Were you given clear written or printed information about your medicines?	9.0	6.6	9.2	272	9.6	↓
Q59	Did a member of staff tell you about any danger signals you should watch for after you went home?	7.3	3.1	7.6	276	7.5	
Q60	Did hospital staff take your family or home situation into account when planning your discharge?	7.4	5.1	8.8	218	8.1	
Q61	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	7.3	4.4	7.8	224	7.7	
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	9.5	6.2	9.7	379	9.3	
Q63	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.2	6.3	9.4	75	9.3	
Q64	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	9.5	7.1	9.6	141	9.7	
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	7.7	2.3	9.3	384	8.4	
Q66	Were the letters written in a way that you could understand?	9.2	7.3	9.3	303	9.2	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013

Queen Victoria Hospital NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2012 scores for this NHS trust	Change from 2012
Overall views and experiences							
S10	Section score	6.3	4.7	7.2			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.6	7.9	9.7	408	9.6	
Q68	Overall...	8.9	7.1	9.1	402	9.0	
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	3.0	0.9	4.6	348	1.3	↑
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.9	1.3	5.9	281	4.2	

↑ or ↓	Indicates where 2013 score is significantly higher or lower than 2012 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2012 data is available.

Survey of adult inpatients 2013
Queen Victoria Hospital NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	415	62443
Response Rate (percentage)	50	49

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	48	46
Female	52	54
Age group (percentage)	(%)	(%)
Aged 16-35	12	7
Aged 36-50	22	12
Aged 51-65	32	24
Aged 66 and older	34	57
Ethnic group (percentage)	(%)	(%)
White	95	89
Multiple ethnic group	0	1
Asian or Asian British	2	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	1	6
Religion (percentage)	(%)	(%)
No religion	23	16
Buddhist	0	0
Christian	72	78
Hindu	1	1
Jewish	1	1
Muslim	2	2
Sikh	0	0
Other religion	0	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	94	94
Gay/lesbian	1	1
Bisexual	0	0
Other	1	1
Prefer not to say	4	4

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**087-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 April 2014**

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) 2014-2015

1. Attached is the proposed CQUIN framework for QVH to achieve during 2014/15.

2. The CQUINs for 2014/15 have been agreed in conjunction with our lead commissioners and leads of each measure.

3. The board of directors will be provided with a monthly update on progress through the board quality and risk report.

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

CQUIN Negotiations 2014/15

1. Queen Victoria Hospital NHS Foundation Trust

Individual Achievement by Provider
1. Nationally Mandated Requirements (0.5%):

a) Friends and Family Test (0.2%)
b) Safety Thermometer – further 50% reduction from 13/14 data (0.15%)
c) Dementia (0.15%)

2. Locally Mandated Requirements (2.0%)

a) WHO Checklist (0.5%)
b) Elective Surgical Re-Scheduling (0.5%)
c) The Catering Mark (0.5%)
d) MaPSaF (0.5%)

Goals and Indicators

Goal No.	Description of Goal	Quality	Indicator Name	National or [2]	Indicator weighting on total contract value
1a)	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.	Patient experience	Friends and Family Test	Nationally mandated	0.20%
1b)	a. Improve collection of data in relation to patient safety indicators. (Weighting – 0.075%) b. Collaborative working with other providers in relation to patients admitted with pre-existing pressure damage. (Weighting – 0.075%)	Safety	NHS Safety Thermometer	Nationally mandated	0.15%
1c)	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	Safety, effectiveness and patient experience	Dementia screening	Nationally mandated	0.15%
2a)	To improve the compliance and quality of the WHO checklist, within theatres.	Safety, effectiveness and patient experience	WHO Checklist	Locally mandated	0.5%
2b)	To reduce the number of cancellations for patients' admission dates prior to surgery, by 50%.	Safety, effectiveness and patient experience	Elective Surgical Re-Scheduling	Locally mandated	0.5%
2c)	To implement the catering mark within the Provider and implement measures, to improve patient experience, sustainability and health.	Patient experience	The Catering Mark	Locally mandated	0.5%
2d)	To implement the MaPSaF tool. To provide 5 main dimensions relating to areas where attitudes, values and behaviours about patient safety are likely to be reflected in the Provider's working practices.	Patient Safety	MaPSaF	Locally mandated	0.5%

[1] Safety / Effectiveness / Experience / Innovation
[1] Nationally mandated / Regionally mandated/ Regionally suggested/ No

Indicator 1a)
Friends and Family Test

FRIENDS AND FAMILY TEST – IMPLEMENTATION OF STAFF FFT - NHS TRUSTS ONLY	
Indicator number	1a part 1
Indicator name	Friends and Family Test – Implementation of staff FFT
Indicator weighting (% of CQUIN scheme available)	0.05%
Description of indicator	Further implementation of patient FFT and staff FFT, according to the national timetable
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Local provider response to local commissioners
Frequency of data collection	Check on implementation at end of July 2014
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	One off
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	July 2014
Final indicator value (payment threshold)	Provider to demonstrate to commissioner that staff FFT has been delivered across all staff groups as outlined in guidance
Final indicator reporting date	Response from providers to commissioners by 31 July 2014
Are there rules for any agreed in-year milestones that result in payment?	Funding payable once July 2014 indicator achieved
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Not applicable

FRIENDS AND FAMILY TEST: EARLY IMPLEMENTATION	
Indicator number	1a part 2
Indicator name	Friends and Family Test – early implementation
Indicator weighting (% of CQUIN scheme available)	0.05%
Description of indicator	Early implementation
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Local provider response to local commissioners
Frequency of data collection	Check on implementation at end of October 2014
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	One off activity
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	October 2014
Final indicator value (payment threshold)	Full delivery of FFT across all services delivered by the provider as outlined in guidance
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider to demonstrate to commissioner that milestone has been met
Final indicator reporting date	Response from providers to commissioners by 31 October 2014
Are there rules for any agreed in-year milestones that result in payment?	Not applicable
Are there any rules for partial achievement of the indicator at the final indicator period/date?	For acute providers, there will be no payment for partial achievement. For other providers, partial implementation will result in receiving half of the funding available for the indicator (20% of the FFT CQUIN). There will be further guidance on the conditions for partial funding.

FRIENDS AND FAMILY TEST: PHASED EXPANSION	
Indicator number	1a part 3
Indicator name	Friends and Family Test - Phased expansion
Indicator weighting (% of CQUIN scheme available)	0.5%
Description of indicator	Phased expansion
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Local provider response to local commissioners
Frequency of data collection	Check on implementation at end of January 2015
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	One off
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	January 2015
Final indicator value (payment threshold)	Full delivery of the nationally set milestones
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider to demonstrate to commissioner that milestones have been met
Final indicator reporting date	Response from providers to commissioners by 31 January 2015
Are there rules for any agreed in-year milestones that result in payment?	Not applicable
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Not applicable

FRIENDS AND FAMILY TEST: INCREASED RESPONSE RATE FFT IN ACUTE PROVIDERS	
Indicator number	1a part 4
Indicator name	Friends and Family Test – Increased or Maintained Response Rate
Indicator weighting (% of CQUIN scheme available)	0.5%
Description of indicator	Increased or maintained response rate
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Provider submission via UNIFY data collection system
Frequency of data collection	Monthly return
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	See below
Baseline value	See below
Final indicator period/date (on which payment is based)	Q4 in 2014/15
Final indicator value (payment threshold)	A response rate for Quarter 4 that is at least 20% for A&E services and at least 30% for inpatient services
Final indicator reporting date	Data available by end of April 2015 (for Q4)
Are there rules for any agreed in-year milestones that result in payment?	Yes – see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	A response rate for Quarter 1 that is at least 15% for A&E services and at least 25% for inpatient services	31 July 2014	50%
Quarter 4	A response rate for Quarter 4 that is at least 20% for A&E services and at least 30% for inpatient services	30 April 2015	50%

Indicator 1b

NHS SAFETY THERMOMETER – IMPROVEMENT GOAL SPECIFICATION (NOT MANDATORY – ORGANISATIONS CAN SET AN ALTERNATIVE NHS SAFETY THERMOMETER IMPROVEMENT GOAL)	
Indicator number	1b
Indicator name	NHS Safety Thermometer
Indicator weighting (% of CQUIN scheme available)	0.15%
Description of indicator	a. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter. (Weighting – 0.075%) b. Collaborative working with other providers in relation to patients admitted with pre-existing pressure damage. (Weighting – 0.075%)
Numerator	a. The number of patients recorded as having a category 2-4 pressure ulcer (old or new) as measured using the NHS Safety Thermometer on the day of each monthly survey b. n/a
Denominator	a. Total number of patients surveyed on the day b. n/a
Rationale for inclusion	a. National CQUIN scheme b. To reduce the prevalence & improve the management of pressure ulcers
Data source	a. Provider submission to the Information Centre which publishes the data at http://www.hscic.gov.uk/thermometer b. n/a
Frequency of data collection	a. Monthly provided within the Trust's Scorecard b. Q1 to determine the scope and measurement of the CQUIN going forward. Q1 will determine the specifics for Q2-Q4 Q2 – determination of baseline, trajectory and plan of action to be created going forward Q3/Q4 – roll out of the plan and assurance provided
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	a. Median of six consecutive monthly data points up to 31st March 2014 b. n/a
Baseline value	a. M12 2013/14. National pressure ulcer prevalence data from the NHS Safety Thermometer suggests a prevalence of around 5% for all pressure ulcers (old and new) for the 2013/14 year to date. b. n/a
Final indicator period/date (on which payment is based)	a. Median of five consecutive monthly data points up to 31 March 2015. For this median value to count as improvement the 5 consecutive monthly data points have to be below the baseline median value (i.e. demonstrate improvement according to special cause variation rules)

	b. 31st March 2015
Final indicator value (payment threshold)	a. 50% reduction from baseline pressure ulcer prevalence. Note the requirement for the median value to have been re-set following special cause variation rules. This means that for the final indicator value to demonstrate improvement, it must be constructed from 5 consecutive monthly data points up to 31 March 2015 all of which are at a lower level than the baseline median value. b. Evidence of collaborative working with other providers in relation to patients admitted with pre-existing pressure damage, including the identification of the source of the pressure damage (home/ community).
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	a. Achievement of 95% or greater of the agreed improvement goal (shown through special cause[2,3]) will trigger full payment of the CQUIN. b. Evaluation report on findings
Final indicator reporting date	a. NHS Safety Thermometer data for March 2015 will be available on 15 April 2015 b. 31st March 2015
Are there rules for any agreed in-year milestones that result in payment?	a. No. To reduce complexity, organisations should be assessed on their achievement at year end as set out above. b. Q1 to determine the scope and measurement of the CQUIN going forward. Q1 will determine the specifics for Q2-Q4 Q2 – determination of baseline, trajectory and plan of action to be created going forward Q3/Q4 – roll out of the plan and assurance provided
Are there any rules for partial achievement of the indicator at the final indicator period/date?	a. Yes. A sliding scale of payment for partial achievement of the improvement goal should also operate so that improvement from baseline performance (shown through special cause) that does not fully meet the target is still rewarded to some extent: • achievement of 80-95% of target = 40% payment • achievement of 60-79% of target = 30% payment • achievement of 40-59% of target = 20% payment • achievement of 20-39% of target = 10% payment • achievement of <20% of target = 0% payment. b. No.

[2] http://harmfreecare.org/measurement/nhs-safety-thermometer/
[3] http://www.qualityobservatory.nhs.uk/index.php?option=com_cat&view=item&Itemid=28&cat_id=588

1c) Dementia

DEMENTIA – FIND, ASSESS, INVESTIGATE & REFER	
Indicator number	1c) part 1
Indicator name	Dementia – Find, Assess, Investigate and Refer
Indicator weighting (% of CQUIN scheme available)	0.05%
Description of indicator	The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services. Each patient admission can only be included once in each indicator but not necessarily in the same month, as the identification, assessment and referral stages may take place in different months.
Numerator	1) Number of patients >75 admitted as an emergency who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for whom the case finding question cannot be completed for clinical reasons (e.g. coma). 2) Number of above patients reported as having had a diagnostic assessment including investigations 3) Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners
Denominator	1) Number of patients >75 admitted as an emergency, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinical reasons (e.g. coma) 2) Number of above patients with clinical diagnosis of delirium or who answered positively on the dementia case finding question 3) Number of above patients who underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive
Rationale for inclusion	National CQUIN scheme
Data source	UNIFY 2
Frequency of data collection	Monthly

Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	90%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider achieves 90% or more for each element of the indicator for Quarter 4 of 2014/15, taken as a whole.
Final indicator reporting date	30 April 2015
Are there rules for any agreed in-year milestones that result in payment?	Yes – see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Date/period milestone relates to	**Rules for achievement of milestones (including evidence to be supplied to commissioner)**	**Date milestone to be reported**	**Milestone weighting (% of CQUIN scheme available)**
Quarter 1	Provider achieves 90% or more for each element of the indicator for Quarter 1 of 2014/15, taken as a whole	31 July 2014	25%
Quarter 2	Provider achieves 90% or more for each element of the indicator for Quarter 2 of 2014/15, taken as a whole	31 October 2014	25%
Quarter 3	Provider achieves 90% or more for each element of the indicator for Quarter 3 of 2014/15, taken as a whole	31 January 2015	25%
Quarter 4	Provider achieves 90% or more for each element of the indicator for Quarter 4 of 2014/15, taken as a whole	30 April 2015	25%

DEMENTIA – CLINICAL LEADERSHIP	
Indicator number	1c) part 2
Indicator name	Dementia – Clinical Leadership
Indicator weighting (% of CQUIN scheme available)	0.05%
Description of indicator	Named lead clinician for dementia and appropriate training for staff
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme.
Data source	Provider
Frequency of data collection	Annual
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Twice (pre-April 2014, March 2015)
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	Not applicable
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider must confirm named lead clinician and the planned training programme (to be determined locally) for dementia for the coming year. Payment will be made at the end of the year, provided the planned training programme has been undertaken.
Final indicator reporting date	March 2015
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

DEMENTIA – SUPPORTING CARERS	
Indicator number	1c) part 3
Indicator name	Dementia – Supporting Carers of People with Dementia
Indicator weighting (% of CQUIN scheme available)	0.05%
Description of indicator	Ensuring carers feel supported
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Provider report to provider Board
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Bi-annually
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	Not applicable
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider must demonstrate that they have undertaken a monthly audit of carers of people with dementia to test whether they feel supported and reported the results to the Board. Provider and commissioner should work together to agree the content of the audit.
Final indicator reporting date	March 2015
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Indicator 2a

WHO CHECKLIST COMPLIANCE	
Indicator number	2a)
Indicator name	WHO Checklist
Indicator weighting (% of CQUIN scheme available)	0.5%
Description of indicator	To improve the compliance and quality of the WHO checklist, within theatres.
Numerator	Based on the sign out full participation achieving 100% by the end of Q2.
Denominator	N/A
Rationale for inclusion	To improve compliance and quality of the WHO checklist.
Data source	Monthly data report to CCG
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	M1 2014/15
Baseline value	April 2013 – March 2014 monthly quantitative and qualitative WHO checklist audits.
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	0.5%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Monthly provision of audit reports measuring both the quantitative and qualitative perspectives as follows - • Quantitative - 40 WHO surgical safety checklists to be audited monthly to monitor the levels of completion across the five sections of ward handover (sign in, time out, sign out and recovery handover). In addition, the completion of the pre-list brief and debrief to also be audited. • Qualitative - A monthly audit to be undertaken on 20 audit forms to assess compliance with additional aspects of the WHO surgical safety checklist forms. To include compliance % for: • number audited • surgeon led time out • time out including surgeon, anaesthetist and practitioner • time out before skin incision

	• sign out including all key checks • sign out full participation. Based on the sign out full participation to achieve 100% by the end of Q2.
Final indicator reporting date	March 2015
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Indicator 2b

ELECTIVE SURGICAL RE-SCHEDULING	
Indicator number	2b)
Indicator name	Elective Surgical Re-Scheduling
Indicator weighting (% of CQUIN scheme available)	0.5%
Description of indicator	To reduce the number of cancellations or rescheduling of patients' admission dates prior to surgery by 50%.
Numerator	Number of patients provided with confirmation of admission date for surgery.
Denominator	Number of patients with Provider cancelled/rescheduled admission date for surgery, without prior agreement to accept an earlier date
Rationale for inclusion	TBC
Data source	Monthly data report to CCG
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	M1 2014/15
Baseline value	Based on Q1 as the benchmark
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	0.5%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider must demonstrate that they have reduced the number of cancelled/ rescheduled appointments, quarterly: • Q1 – benchmark • Q2 – Q4 payments to be agreed
Final indicator reporting date	March 2015
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

2c)

THE CATERING MARK	
Indicator number	2c)
Indicator name	The Catering Mark
Indicator weighting (% of CQUIN scheme available)	0.5%
Description of indicator	To implement the catering mark within the Provider and implement measures, to improve patient experience, sustainability and health.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	The importance of providing good, nutritious hospital food for patients has been highlighted by NHS England's 2014/15 key guidance for commissioners and care providers. The guidance now includes a new hospital food goal (the Hospital Food CQUIN Exemplar), and cites the Catering Mark as a way to raise food standards. For more information, use the link below: http://www.foodforlife.org.uk/Whatyoucando/Caterers/CateringMark.aspx
Data source	Provider data
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	M1 2014/15
Baseline value	TBC
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	0.5%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider must demonstrate that they have achieved the following: • Q1 – Catering Mark internal assessment against the bronze standards • Q2/ Q3 – Development and introduction of action plans, including how it will be used and managed. • Q3/ Q4 – Implementation /delivery of action plans • Relevant evidence, including timeframes, action plans and any surveys undertaken are to be provided to the CCG.

	• Demonstrate use of seasonal menus with 75% of dishes freshly prepared • Demonstrate comprehensive training for all catering staff on the Catering Mark
Final indicator reporting date	March 2015
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

2d)

MAPSAF TOOL	
Indicator number	2d)
Indicator name	MaPSaF (Manchester Patient Safety Framework) Tool
Indicator weighting (% of CQUIN scheme available)	0.5%
Description of indicator	To implement the MaPSaF tool. To provide 5 main dimensions relating to areas where attitudes, values and behaviours about patient safety are likely to be reflected in the Provider's working practices.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	The safety of both patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. This 'safety culture' is a new concept in the health sector and can be a difficult one to assess and change. The MaPSaF framework has been produced to help make the concept of safety culture more accessible.
Data source	Provider data
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	M1 2014/15
Baseline value	Q1 2014/15
Final indicator period/date (on which payment is based)	April 2014 – March 2015
Final indicator value (payment threshold)	0.5%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider must demonstrate that they have achieved the following: Q1 / Q2 staff training on MapSaF facilitation across the whole organisation. Q2/Q3 Workshops to be undertaken in all Divisions/ Directorates with attendees of all grades and positions. Agenda to include: • Facilitation of reflection on patient safety • Discussions about strengths/ weakness of the patients safety • Reveal the differences in perception between different staff groups

	Q4 Implementation of action plans with specific intervention needed to change the culture of patients' safety to include: • Staff competency assessments on roles • Staff education and training from themes identified by the workshops • Shared learning across the organisation Final report to be provided at the end of Q4. Relevant evidence, including timeframes, action plans, and evidence of workshops within all Divisions / Directorates. Any surveys undertaken are to be provided to the CCG.
Final indicator reporting date	March 2015
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**088-14**
Author:	**Amanda Parker, Director of Nursing and Quality**
Date of report:	**14 April 2014**

SAFE STAFFING

1. Following the publication of the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry and Hard Truths – The Journey to putting the Patients First (Volume Two of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry: Response to the Inquiry's Recommendations), that Trust Boards should receive information on staffing capacity and capability.

2. Reporting should include a six monthly staffing summary that includes full information on establishment and how this is calculated.

3. Each month the board must receive and publish staffing for each inpatient ward to include every shift.

4. Wards must make public each shift the staffing required and those actually available.

5. Attached is a reporting model that is proposed for use. This meets the requirements for the ward and board publication of the required information.

6. The Board is asked to **APPROVE** the proposed reporting process.

Report on the safe staffing for all inpatient wards at Queen Victoria Hospital

1. There is now a greater focus to ensure that Trusts have the correct capacity and capability for its nursing workforce in order to meet the needs and expectations of its patients. Evidence is now available that failings in care and poor staffing levels have a direct impact on mortality, care indicators and increased staff sickness which ultimately reduce staff availability further.

2. There is now a requirement post the publication of the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry and Hard Truths – The Journey to putting the Patients First (Volume Two of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry: Response to the Inquiry's Recommendations), that Trust Boards should receive information on staffing capacity and capability.

3. Information that should be provided includes every six months a report on:

    - the methodology used to determine staffing levels.
    - the allowance within the model for annual leave and statutory and mandatory training.
    - the skill mix review.
    - the details for supernumery/supervisory allowance for ward sisters.
    - evidence of triangulation of professional judgement and scrutiny.
    - details of workforce metrics.
    - information related to key quality and outcome measures.

4. A report providing this information came to the board in March 2014 and has been provided twice a year to the board previously. The current report will be reviewed to ensure it provides all of the required information.

5. In addition the board is should receive a monthly summary position on of the staffing shortfalls in the previous months. Hard Truths requires this information is to be within a separate report to workforce information and is to be published on the trust's internet and on NHS Choices.

6. At ward level there is a requirement that ward staffing information and staffing availability is visible on a daily basis.

7. A summary of the national requirements and time line is provided within Appendix D.

8. The key message from all the recent documentation is that the solution is not totally focussed on numbers but other key factors underpin safe dignified care. The Head of HR and OD proposed presentation of measures by ward at the last board meeting. He and the Director of Nursing have met and agreed how combined reporting can achieve the requirements of Hard Truths and also to provide the Board with an analysis on productivity and the efficient use of resources.

9. It is proposed that the following reports are provided to the board of directors each month to meet the requirement:

   - A summary of safety, staffing and patient experience metrics by ward (Example Appendix C) i.e. productivity and efficient use of resources

   - A monthly summary sheet of staffing by ward indicating staffing for the previous month (Example Appendix A)

10. At ward level staff are already making visible the staffing required and using green / amber / red indicators as to whether this provides safe staffing for that shift. It is this information that supports the information within the monthly summary sheet.

11. To support managers a summary of expectation in how to escalate concerns has been written. This reflects current practice but provides all managers with clarity on expectations (Appendix B).

12. Pending the outcome of discussion at the Board in April it is intended that the first formal report will be provided to the Board in May 2014.

APPENDIX A

WARD	**MARGARET DUNCOMBE**
GREEN	Staffing meets planned requirement
AMBER	Staffing does not meet planned requirement but care is safe
RED	Staffing does not meet planned reqirement and the senior nurse has been informed
MONTH	**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 amber or r
	RN	HCA	RN	HCA	
1	5	2	5	3	
2	5	2	5	2	
3	5	2	5	2	
4	5	2	5	2	
5	5	2	5		
6	5	2	4	2	afe - y acuity and pateitns pre surgery and self caring
7	5	2	5		
8	5	2	5	2	
9	5	2		2	
10	5	2	5	2	
11	5	2	5	2	
12	5	2	5	2	
13	5	2	5	2	
14	5	2	4	2	safe, 3 patients on home leave overnight
15	5	2	5	2	
16	5	2	5	2	
17	5	2	5	2	
18	5	2	5	2	
19	5	2	5	2	
20	5	2	5	2	
21	5	2	5	2	
22	5	2	4	2	safe, 4 empty beds and low acuity patients
23	5	2	5	2	
24	5	2	5	2	
25	5	2	5	2	
26	5	2	5	2	
27	5	2	3	1	unsafe - site practitioner redeployed, Dr taking trauma calls on call manager contacted
28	5	2	5	2	
29	5	2	5	2	
30	5	2	5	2	
31	5	2	5	2	

WARD	**MARGARET DUNCOMBE**	
GREEN		Staffing meets planned requirement
AMBER		Staffing does not meet planned requirement but care is safe
RED		Staffing does not meet planned reqirement and the senior nurse has been informed
MONTH	**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 in 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	1	
5	3	1	3	1	
6	3	1	3	1	
7	3	1	3	1	
8	3	1	3	1	
9	3	1	3	1	
10	3	1	3	1	
11	3	1	3	1	
12	3	1	3	1	
13	3	1	3	1	
14	3	1	3	1	
15	3	1	3	1	
16	3	1	3	1	
17	3	1	3	1	
18	3	1	3	1	
19	3	1	3	1	
20	3	1	3	1	
21	3	1	3	1	
22	3	1	3	1	
23	3	1	3	1	
24	3	1	3	1	
25	3	1	3	1	
26	3	1	3	1	
27	3	1	3	1	
28	3	1	3	1	
29	3	1	3	1	
30	3	1	3	1	
31	3	1	3	1	

Staffing Escalation Plan

- **Ward Managers have responsibility to roster staff to establishment via E-roster.**
- **Bank can be used to fill vacant posts or short notice sickness to meet identified ward staffing template.**
- **Where bank cannot be sourced ward managers are authorized to use agency for established vacancies following discussion with their matron and rationale included on E-roster i.e. sickness/established vacancy.**
- **Where staffing is required in excess of ward template the ward manager should discuss rationale with their matron.**
- **On the day where staffing does not meet ward template the nurse in charge is responsible for accessing the care needs of patients and to reach a decision on is care as safe (amber rating).**
- **Where care is identified as unsafe (red rating) the nurse in charge must call their matron or the site practitioner and complete a Datix.**
- **When care is identified as unsafe to a matron or site practitioner they are responsible for ensuring all staff available across the trust and have the authority to redeploy staff to provide safe care.**
- **Staffing will be discussed on a daily basis at the bed meetings held at 09.30 and 16.00**
- **Actions may include:**
  - **Bringing in more bank/agency staff**
  - **Redeploying site or trauma coordinator staff and using medical staff to support the taking of referrals**
  - **Requesting specialist nurses/DN and DDN/practice educators etc to provide direct care**
  - **Cancellation of elective / trauma activity**
- **Where activity in the form of elective or trauma patients is considered the on call manager must be informed to discuss a plan of action.**
- **Where action has been taken but the impact involves overnight or the weekend the on call manager must be made aware of the plan of action.**
- **If there is the requirement to redeploy staff other than those already in direct care i.e. trauma coordinator etc, then the on call manager must be informed as their presence on site may be required to support the site practitioner/matron.**

MARGARET DUNCOMBE		APRIL 2014					
Safe Care	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	6	8	-2				On track no action required
Falls	1	<3	0				
Medication errors	5	<2	0				
MRSA/Cdiff	0	0	0				
VTE assessment	97%	100%	0				
Nutrition assessment	87%	100%	3%				
Activity	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy		85%	-5%				
Bed utilisation	115%	100%					
Patient numbers	156	125	35				
Average acuity							

CANADIAN WING							
Staff utilisation	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies	6%	<5%	1%				
Temporary staffing Exc RMN Bank / Agency	300hrs 600hrs	<10% (588 hrs)	+45 hrs				
Sickness	3%	2%	1%				
Shifts meeting Est	75%	95%	-20%				
Training / Appraisal	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	78%						
Appraisals		>8 %	-2%				
Drug Assessments	67%	>90%	-5%				
Friends and Family Test Score	80	>80	7				
Staff Friends and Family Test Score	80	>80	-8				

Hard Truths Commitments Regarding the Publishing of Staffing Data

Timetable of Actions

	Action Required by Trusts:	By When:	Periodicity:	National Quality Board Expectation(s):	Further Guidance:
A	The Board receives a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report page 12 and reflects a realistic expectation of the impact of staffing on a range of factors. This report: • Draws on expert professional opinion and insight into local clinical need and context • Makes recommendations to the Board which are considered and discussed • Is presented to and discussed at the public Board meeting • Prompts agreement of actions which are recorded and followed up on • Is posted on the Trust's public website along with all the other public Board papers	June 2014	Every Six Months	1, 3 and 7	NQB pages 12, 18-22 and 42

B	The Trust clearly displays information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. This should be visible, clear and accurate, and it should include the full range of patient care support staff (HCA and band 4 staff) available in the area during each shift. It may be helpful to outline additional information that is held locally, such as the significance of different uniforms and titles used. To summarise, the displays should: • Be in an area within the clinical area that is accessible to patients, their families and carers • Explain the planned and actual numbers of staff for each shift (registered and non-registered) • Detail who is in charge of the shift • Describe what each member of the team's role is • Be accurate	From April and by June 2014 at the latest	Each shift	8	NQB pages 48-51
C	The Board: • Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap • Evaluates risks associated with staffing issues • Seeks assurances regarding contingency planning, mitigating actions and incident reporting • Ensures that the Executive Team is supported to take	From April and by June 2014 at the latest	Monthly	1 and 7	NQB pages 12, 13 and 45

	decisive action to protect patient safety and experience • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website).				
D	The Trust will ensure that the published monthly update report specified in Row C [i.e. the Board paper on expected and actual staffing] is available to the public via not only the Trust's website but also the relevant hospital(s) profiles on NHS Choices. The latter can be achieved either by placing a link to the report that is hosted on the Trust website on the relevant hospital(s)' newsfeed on their NHS Choices webpage or by uploading the relevant document to the relevant hospital(s)' NHS Choices newsfeed. For Trusts with multiple hospital sites that have their own NHS Choices webpages, this will require the separate posting of the Trust Board report to each hospital newsfeed. However, this is likely to reach more patients given that patients tend to review hospital, not Trust, NHS Choices webpages. This approach will also allow you to highlight hospital-specific plans and achievements, which may be of particular interest to a public audience. Given these requirements, the update reports should be written in a form that is accessible and understandable to patients and the public. This is likely to include ensuring that the information on staffing is not embedded within hundreds	By June 2014	Monthly	1 and 7	

	of pages of other Board papers. Your own NHS Choices web editor(s), who already provide your Trust and hospital-specific content to NHS Choices, will be able to advise you further on their preferred mechanism for making these documents available on NHS Choices – either via a link or by uploading a .pdf of the Board paper. NHS Choices will also be liaising directly with each Trust's web editors with further information.				
E	The Trust: • Reviews the actual versus planned staffing on a shift by shift basis • Responds to address gaps or shortages where these are identified • Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care	Immediate	Each Shift	2	NQB pages 16 and 17

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24th April 2014**
Agenda item reference no:	**089-14**
Author:	**Graeme Armitage, Head of HR/OD**
Date of report:	**16th April 2014**

Workforce Performance Report: April 2014 (MONTHLY UPDATE)

1. Introduction:

1.1 The Workforce Performance Report for April focuses on the exceptions and actions being taken to address areas of under-performance. 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 shown another decrease this month and a more substantial one that seen previously. We now have an encouraging 3 month downward trend which is reasonable to attribute to the effective support being given to managers by the HR teams in addressing their sickness absence performance. The year on year trend shows that sickness is usually lower at this time of year therefore to avoid complacency and to manage sickness levels down further, work will continue to support managers through additional training and more up to date reporting.

1.3 Statutory and mandatory training performance continues to improve with compliance rates now at over 77%. There is good evidence to support the improving accuracy of the information being provided to managers and this month has seen 3 further reports being made available to them. These are:

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

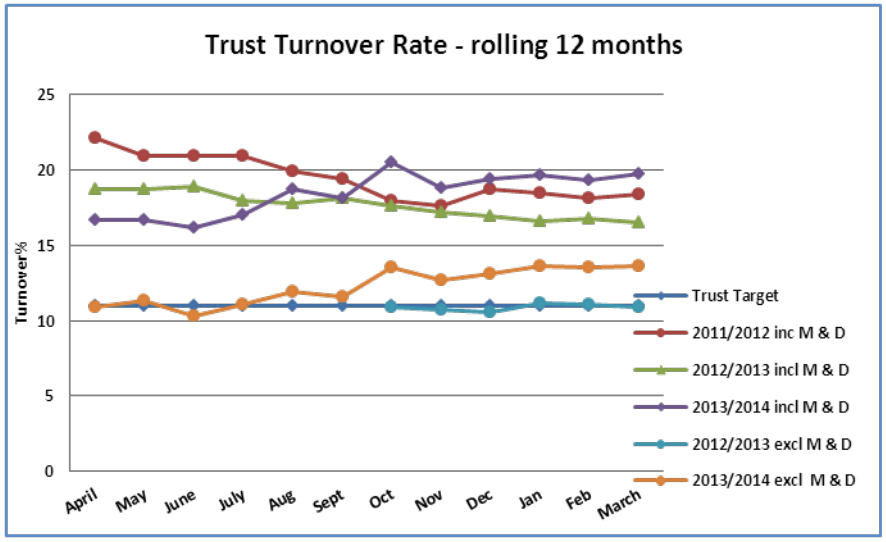
It is a manager's responsibility to review the information provided to them monthly and to take action accordingly. Additionally the Head of HR/OD will be reviewing more specifically the actions taken with those individuals on list c) above. It is expected that in some cases this will result in disciplinary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

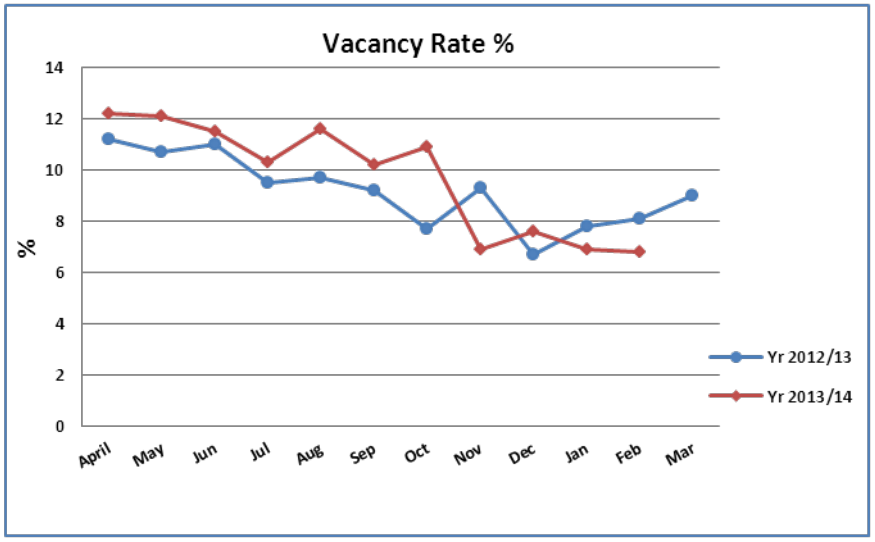
1.4 The measures put in place to address the Trust's financial position continue to take effect with significant reduction in pay and an overall decrease in the use of bank and agency staff. We have also seen a significant and sustained decrease in the amount of bank and agency over the budgeted establishment. This has fallen from over 40 wte in January to 18 wte in March. The additional control measures were initially intended to be a temporary position to improve internal controls and as this has proved successful it has been decided to keep them in place throughout 2014/15.

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.

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

HEADLINE HR KPIs April 2014





	Staff Movements											
	Apr-13	May-13	Jun-13	July 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Headcount	927	926	928	937	930	938	942	960	959	967	978	972
WTE in Post	788	786	790	795	788	789	807	819	820	825	832.36	824.60
WTE Funded Establishment	867.69	867.69	867.69	867.69	867.99	867.99	867.99	867.99	867.99	867.99	867.99	867.99
New Hires	16	5	7	15	37	21	33	12	6	16	29	7
Leavers	13	8	6	13	43	12	24	6	14	11	20	16
Maternity Leave	14	10	13	16	15	18	18	19	21	16	17	19
Vacancy Rate	11.8%	11.6%	11.5%	10.3%	11.6%	10.2%	10.9%	6.9%	7.6%	6.9%	6.8%	
Turnover Rate	1.83%	0.76%	0.86%	1.39%	4.62%	1.27%	2.51%	0.73%	1.46%	1.14%	2.05%	1.65%

	Rolling 12 Monthly Turnover Figures											
	Apr-13	May-13	Jun-13	July 13	Aug 13	Sep 13	Oct13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
12 Month Turnover (including Medical & Dental)	16.7%	16.7%	16.2%	17.0%	18.7%	18.1%	20.5%	18.8%	19.4%	19.70%	19.32%	19.74%
12 Month Turnover (Excluding Medical & Dental)	10.9%	11.3%	10.3%	11.1%	11.9%	11.6%	13.5%	12.7%	13.1%	13.59%	13.51%	13.62%

HEADLINE HR KPIs March 2014

Turnover (12 month rolling turnover)
Trust turnover for the 12 month rolling period ending 31st March 2014 increased slightly by 0.42% to 19.74% (including medical and dental) and by 0.11% to 13.62% (excluding medical and dental). Turnover has remained consistent over the last 4 months.

During March there were 7 new starters to the Trust, and 16 leavers (14.75 FTE) with a monthly turnover rate for March of 1.65% (1.79% FTE) a decrease of 0.40% over last month. **Staffing stability is at 99.31%, this indicates that the core of Trust staffing is very stable**.

Reasons for leaving, 5 voluntary resignations – other/not known, 2 voluntary resignations – child dependents, 2 voluntary resignations – relocation and 2 retirement age.

Vacancy Rate (figures 2 month in arrears)
Vacancy rate for March is 6.8% representing 36 WTE vacancies of which 24 WTE are active in recruitment. Bank and agency remains high at 63.56 WTE which is leading to the use of 18 WTE above budgeted establishment. The reason for this is the need to cover maternity leave (currently there are 19 employees on maternity leave) and long-term sickness (i.e. 20 employees with sick leave of 4 weeks or more).

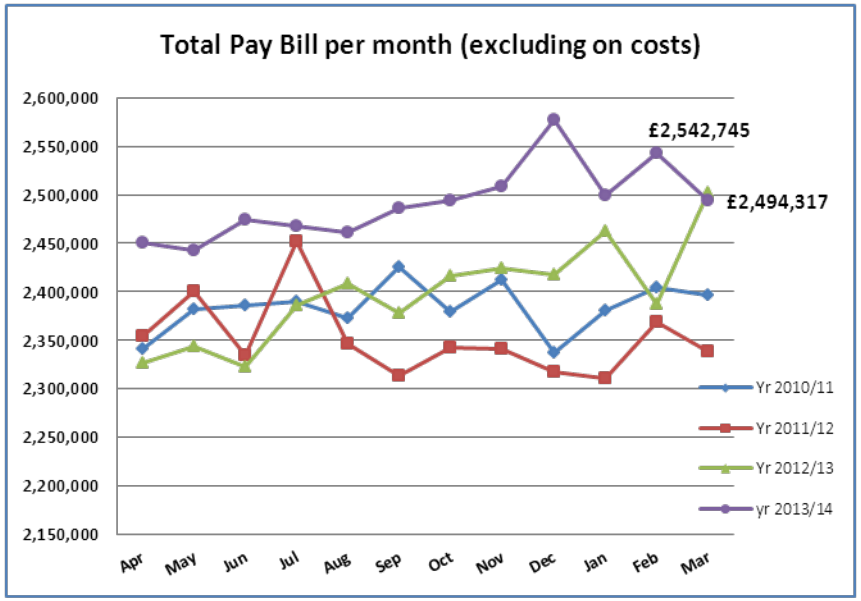
Vacancies
A total of 45.4 WTE jobs were advertised in March, with a further 19.26 WTE due to be advertised in April. 30.57 WTE are currently at the interview stage with a further 18.58 WTE at clearing stage, there were 6 WTE posts not recruited to 1x B7 Maxillofacial Prosthetist and 1 x B6 SALT (fixed term) 1 x B7 Theatre Team Leader (Hand Surgery) 1 x B5 ITU Staff Nurse 1 x B4 Dental Nurse (fixed term) 1 x Junior Orthoplastic Fellow.

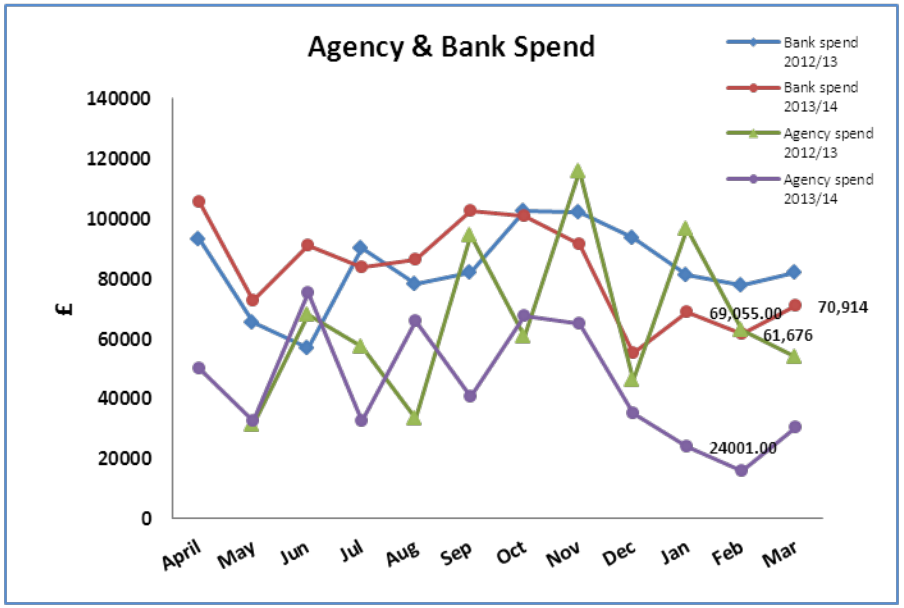
Exceptions
Current recruitment methods have not been successful in appointing to essential posts along with the Trust's location and its lack of High Cost Area Supplement means that it is competing with London and neighbouring Trusts that offer higher salary packages.

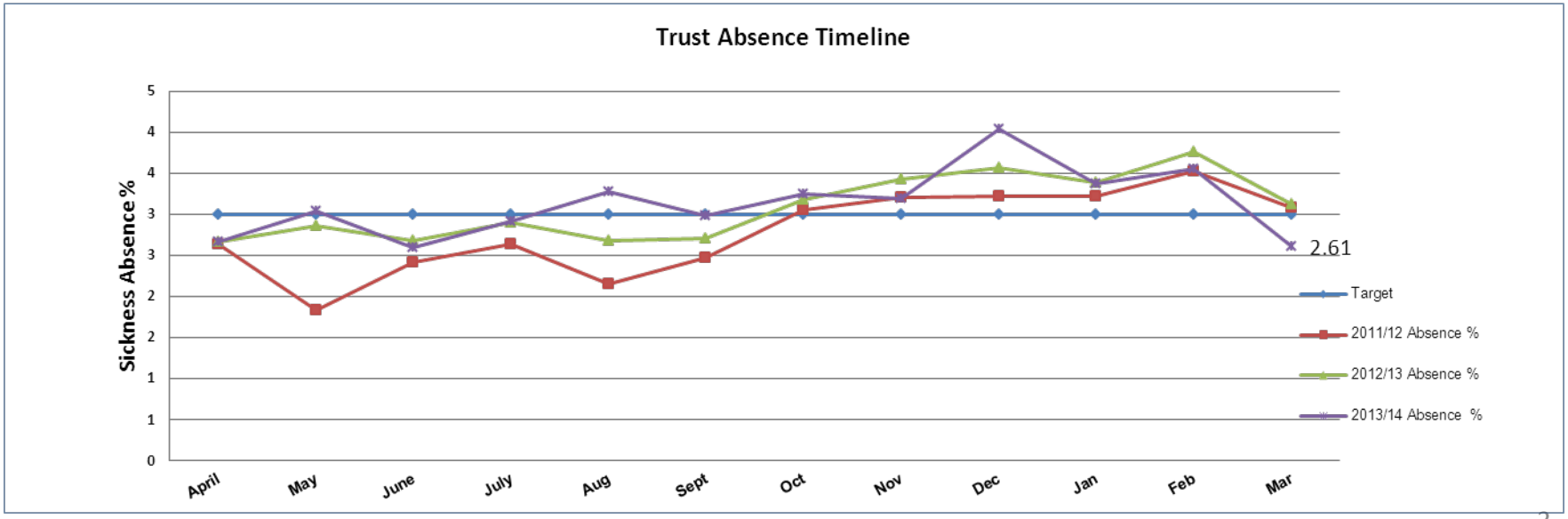
Action
Maintain relationships with universities to continue to employ nurses and build stronger links
Expand our talent pool so that the Trust can successfully recruit to our nursing posts.
Look to recruit from within Europe

RAG Rating

HEADLINE HR KPIs







HEADLINE HR KPIs

Pay Bill – (1 month in arrears) reported pay does not include on costs.
Pay for March has decreased slightly 1.9% to £2,494,37, a decrease of £48,428 on the previous month. This is due to measures put in place to address the Trust's financial position.

Currently, we have a WTE staff in post figure of 832.4 and a total WTE paid figure of 892.73 this is inclusive of 45.59 WTE Bank, 12.56 Agency WTE and 2.22 Over-time WTE.

Bank and Agency usage – (figures are 2 month in arrears)
Bank and agency expenditure for February £77,574 a combined decrease of 16.55% on previous month. Agency and Bank expenditure is likely to increase due to high sickness levels in Canadian Wing, Burns Peanut and Theatres, high establishment vacancies for staff nurses in these areas and the inability to fill these positions (equivalent to 21 WTE)

The Bank/agency combined fill rate for February is 85.8%, in total 5473 hours (72.03%) were filled by bank and 1044 (13.74%) were filled by agency.

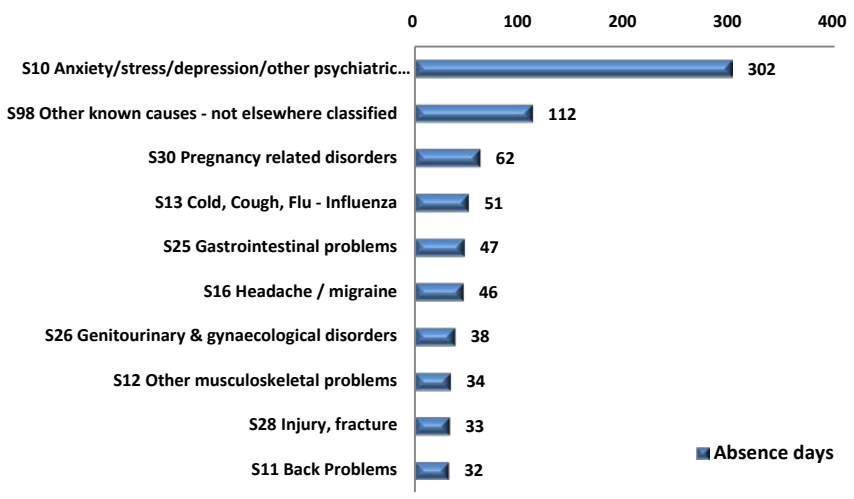
Exception areas
Bank and agency expenditure for February for Burns was £8,903 a substantial decrease of 38% on the previous month. Canadian Wing, ITU, Peanut and Theatres also showed small decreases in bank and agency expenditure.

Actions

- Maintain tight management control over bank and agency and monitor regularly to determine whether further steps need to be instigated.
- Healthroster bank shifts are now being booked against the unfilled shifts before the need for bank is considered.
- Admin and Clerical bank has been stopped unless there are exceptional service provision reasons.
- Vacancies within establishment are being recruited to where this avoids the need for bank / agency.
- All requests outside of Healthroster continue to be agreed by senior managers.
- 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

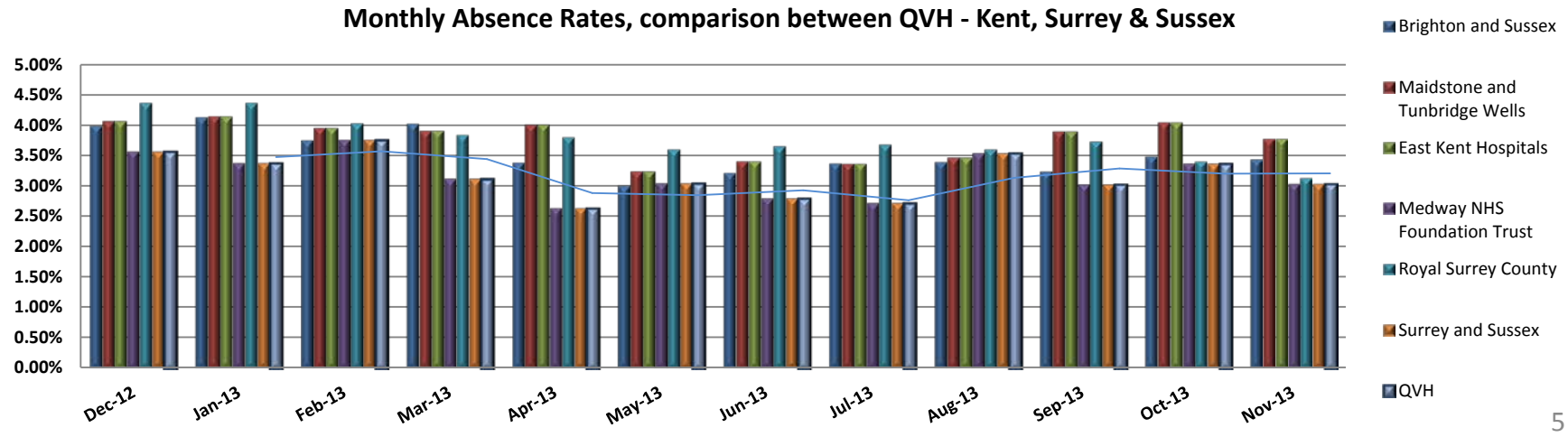
HEADLINE HR KPIs



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

Staff Group	Estimated Cost	FTE Days Lost
Add Prof Scientific and Technic	£4,174	35.44
Additional Clinical Services	£9.693	156.15
Administrative and Clerical	£8,850	153.28
Allied Health Professionals	£2,802	35.20
Estates and Ancillary	£7,960	117.60
Medical and Dental	£675	4.73
Nursing and Midwifery Registered	£13,047	167.56
Grand Total	£47,200	669.95

Current information provided from HSCIC for the period December 2012 and November 2013 (last reported period) shows that QVH sickness absence figures remain below Kent, Surrey and Sussex apart from a slight increase in February and August 2013.



HEADLINE HR KPIs

Sickness/Absence

Sickness absence for March fell below Trust target of 3% to 2.61%. At the same point in 2012/2013 sickness fell to 3.1%.

Stress/anxiety/depression continue to be the most common reason for absence at 40% of all sickness absence days for March. This is followed by 'Other Known causes – not elsewhere classified' (surgery) at 15%.

A Trust target of 2% has been agreed for 2014/2015. The HR Advisors have been focusing on long-term sickness, supporting and guiding managers through the process. Although steady progress is being made we recognise the requirement to reduce sickness absence rate further and therefore, the HR Advisors will now focus their effort on short-term sickness with the aim of producing similar improvements to those seen in relation to long-term sickness.

Exceptions

Across the Trust ITU has the highest rate of sickness at 8.04%. A couple of other wards are also experiencing high absence levels, Peanut at 7.5% and Canadian Wing at 7.31%.

Actions

- Continue to focus on areas above 3% 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.
- 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.

RAG Rating

HEADLINE HR KPIs

RAG Rating

Payroll

All staff were paid on time, overpayments reduced from 2 to 0, the decrease in amount from £1967.36 to £0.00. Interim payments decreased from 4 to 2 and Payroll errors decreased from 2 to 0.

Employee Relations

There were 6 new cases reported in March 2014 - 2 Capability – poor performance, 1 in Canadian Wing (hearing due 31.03.14), 2 Stage 1 formal Sickness Absence cases in Theatres. A further 3 informal meetings took place, 1 Capability – poor performance in Burns, 1 informal grievance meeting and 1 short-term sickness in Canadian Wing, 2 cases under probationary review in IT and Sleep Studies.

On-going cases

1 case of dismissal is now going to tribunal

1 case of long-term sickness has been granted tier 1 ill-health retirement. at tier 12 cases of suspension have now been lifted, one employee has now returned to work, and one employee still remains on Long-term sickness due to stress.

2 employees remain on capability in Radiology and Burns

2 cases of capability in Medical Staffing concerning Doctors from Corneo and Anaesthetics.

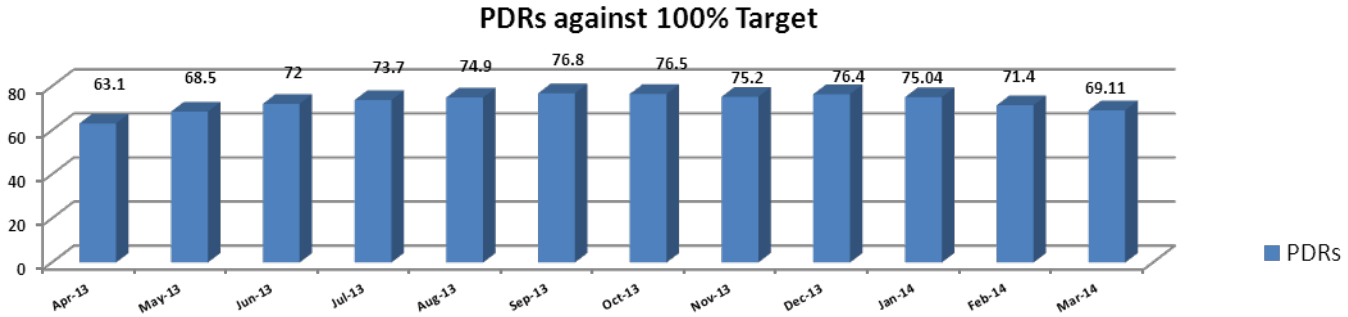
1 case moved from informal sickness absence to first formal

5 informal cases of short-term sickness in Theatres, Therapies, Out-patients and MIU

Long-term sickness

There are 18 cases of long-term sickness (any employee off for more than 28 consecutive days is considered to be long-term sickness) 50% of the long-term sickness cases are stress, anxiety and depression related of which 4 of these cases are due to work-related stress, these employees are being supported by Occupational Health and the HR advisors who are aware of the issues and are looking at a solution to the problem.

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		Dec13		Jan 14		Feb 1 4		Mar 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%	↓	**137**
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%	↓	**66**
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%	↓	**116**
MIU (Dir)	70.59%	↑	70.59%	→	88.24%	↑	84.21%	↓	77.78%	↓	83.33%	↑	83.33%	→	83.33%	→	84.21	↑	84.21%	↑	68.42%	↓	**19**
Corporate (Dir)	67.91%	↑	72.04%	↑	61.38%	↓	71.43%	↑	70.62%	↓	72.00%	↑	96.00%	↑	74.75%	↓	91.30	↑	63.64%	↑	45.83%	↓	**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%	↑	**80**
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%	→	**157**
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%	↓	**64**

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		
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%	↓	**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%	↓	**55**
Nursing Management & Risk (Dir)	0.00%	→	100.00%	↑	100.00%	→	100.00%	→	100.00%	→	100.00%	→	100.0%	→	100.0%	→	100.0	→	100%	→	100%	→	**1**
Paeds & Clinical Support (Dir)	0.00%	→	50.00%	↑	50.00%	→	50.00%	→	50.00%	→	50.00%	→	60.0%	↑	60.0%	→	50.0	↓	25.00%	↓	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%	↓	**51**

HR KPIs

PDRs

There has been an expected decrease in appraisals in March due partly to the transitional arrangements in place for this calendar year. This allows staff to over into the new cycles of annual appraisal linked to their incremental date. Those staff who's current appraisal date is out of step with their incremental date will still be expected to have 1:1 discussions with their manager whilst this transition takes place.

Exceptions

Areas of under performance are Anaesthetics & Theatres 48.91%, Head, Neck and Eye at 54.55%, Corporate 45.83%, 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 but they have increased their PDR completions this month. Head, Neck and Eye and Plastic & Burns are the two areas who have dropped this month.

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

RAG Rating

Statutory and Mandatory Training

Competence Name	Non Compliant	Expired but Booked	Compliant	Grand Total	Trust Overall (Expired + Compliant)
Adult & Paediatric BLS - annual	12.35%	11.74%	75.91%	100.00%	87.65%
Child Protection Level 1 - 3 yearly	15.17%	1.97%	82.87%	100.00%	84.83%
Child Protection: Level 2 - 3 yearly	37.89%	5.09%	57.02%	100.00%	62.11%
Child Protection: Level 3 - 3 yearly	70.42%	0.00%	29.58%	100.00%	29.58%
Conflict Resolution - 3 yearly	35.40%	8.41%	56.19%	100.00%	64.60%
Emergency Planning: annual	16.74%	8.89%	74.37%	100.00%	83.26%
Equality, Diversity & Human Rights - once	23.12%	4.18%	72.70%	100.00%	76.88%
Infection Control: annual	12.34%	9.52%	78.14%	100.00%	87.66%
Information Governance - annual	26.78%	3.77%	69.46%	100.00%	73.22%
Manual Handling - Clinical - annual	35.03%	6.92%	58.04%	100.00%	64.97%
Manual Handling - Non-clinical - 3 yearly	14.80%	6.15%	79.05%	100.00%	85.20%
Risk: annual	12.45%	8.47%	79.08%	100.00%	87.55%
Safeguarding Adults - 3 yearly	25.00%	2.82%	72.18%	100.00%	75.00%
Grand Total	22.31%	6.47%	71.23%	100.00%	77.69%

Statutory & Mandatory Training

Statutory and mandatory training Trust figures have risen slightly to 77.69% (71.23% compliance excluding those who are booked onto another course) but course completions are remaining steady although there continues to be a high non attendance figure. Whilst performance still remains below the 80% target the improvement plan is impacting positively and will therefore continue as planned. **Clinical Specialities as an area have a larger amount of departments with low compliance rates**

Exceptions

Child Protection level 2 – **Clinical Specialties (Plastic Surgery Skin, Sleep Studies both below 35%) and Clinical Support (MIU, Corneo Nursing , SALT & C Wing all showing below 25%) areas showing as 50.49% and 57.93% compliant**.

Child Protection level 3 – Low completion rate across the Trust. **Clinical Support Services** is main area of non compliance (**Canadian Wing** 0%, **MIU** at 7.14%, **Paediatrics** at 51.72%, **Psychotherapy** at 42.86%).

Manual Handling Clinical – those areas below 50% are: **Peanut** 25%, **MIU 10**%, **Peanut** 37.50%, **Theatres** 49.15%, **Site Practitioners** 45.45%

Conflict Resolution **Clinical Specialties main area of concern.** L&D are adding extra courses to try to combat this.

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

Mandatory & Statutory Training by Directorate
As at 1.4.14

Activity	Trust	Corporate	Clinical Specialities	Clinical Support Services
Adult & Paediatric BLS	74.61%	87.50%	67.00%	76.25%
Staff	508	8	100	400
Trained	379	7	67	305
Booked				
Gap	129	1	33	95
Child Protection Level 1	82.14%	85.98%	76.47%	82.72%
Staff	364	164	119	81
Trained	299	141	91	67
Booked				
Gap	65	23	28	14
Child Protection Level 2	57.00%	65.52%	50.49%	57.93%
Staff	586	29	103	454
Trained	334	19	52	263
Booked				
Gap	252	10	51	191
Child Protection Level 3	29.58%	66.67%	NA	27.94%
Staff	71	3	0	68
Trained	21	2	0	19
Booked				
Gap	50	1	0	49
Conflict Resolution	55.80%	75.00%	30.95%	63.96%
Staff	647	24	168	455
Trained	361	18	52	291
Booked				
Gap	286	6	116	164
Emergency Planning	73.50%	77.72%	58.47%	78.45%
Staff	981	202	236	543
Trained	721	157	138	426
Booked				
Gap	260	45	98	117
Equality, Diversity & Human Rights	72.68%	79.70%	58.47%	76.24%
Staff	981	202	236	543
Trained	713	161	138	414
Booked				
Gap	268	41	98	129

Activity	Trust	Corporate	Clinical Specialities	Clinical Support Services
Infection Control	76.76%	76.24%	72.03%	79.01%
Staff	981	202	236	543
Trained	753	154	170	429
Booked				
Gap	228	48	66	114
Information Governance	68.20%	80.69%	55.93%	68.88%
Staff	981	202	236	543
Trained	669	163	132	374
Booked				
Gap	312	39	104	169
Manual Handling - Clinical	56.75%	45.45%	67.35%	54.69%
Staff	504	22	98	384
Trained	286	10	66	210
Booked				
Gap	218	12	32	174
Manual Handling - Non Clinical	77.81%	83.54%	74.11%	71.91%
Staff	365	164	112	89
Trained	284	137	83	64
Booked				
Gap	81	27	29	25
Risk	77.78%	77.23%	72.03%	80.48%
Staff	981	202	236	543
Trained	763	156	170	437
Booked				
Gap	218	46	66	106
Safeguarding Adults	71.05%	81.19%	65.25%	69.80%
Staff	981	202	236	543
Trained	697	164	154	379
Booked				
Gap	284	38	82	164

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**090-14**
Author:	**Bill Stronach, Deputy Director of Finance**
Date of report:	**24 April 2014**

FINANCIAL PERFORMANCE REPORT: March 2014 (MONTHLY UPDATE)

1. Summary

The financial performance report to the Board this month details the trust's financial performance for the twelve months to March 2014.

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report – Public
March 2014
Month 12

24 April 2014

Executive Director: Richard Hathaway
Prepared by: Bill Stronach, Stephen Glass

Contents

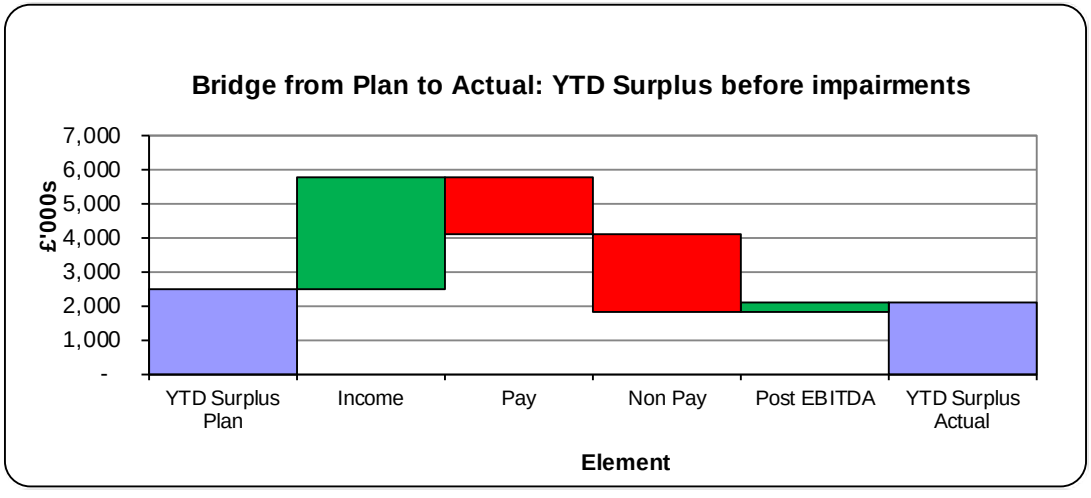
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M12 2013/14

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure Current Month and Year to Date	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	5,812	4,977	835	59,672	56,396	3,277
Pay	(3,233)	(3,056)	(177)	(38,316)	(36,652)	(1,664)
Non Pay	(1,984)	(1,164)	(820)	(16,176)	(13,903)	(2,274)
EBITDA	595	758	(162)	5,180	5,841	(661)
EBITDA %	*10.2*	*15.2*	*-5.0*	***8.7***	*10.4*	*-1.7*
Post EBITDA	(313)	(278)	(34)	(3,309)	(3,337)	28
Donated assets	59	-	59	214	-	214
Surplus pre exceptionals	**342**	**479**	**(138)**	**2,085**	**2,504**	**(419)**
Surplus Margin %	*5.9*	*9.6*	*-3.7*	***3.5***	*4.4*	*-0.9*
Impairments	(1,936)	-	(1,936)	(2,538)	-	(2,538)
Surplus (Deficit)	(1,594)	479	(2,073)	**(453)**	2,504	(2,956)

Continuity of Service Risk Rating	Metric	Level 4 threshold		Score	Weighted score	
Liquidity days	36	0		4	50%	2
Debt Service Cover	3.6	2.5x		4	50%	2
Combined Score			1	2	3	**4**



Summary

- These values are from the unaudited year end accounts.
- The in month values contain year end adjustments and disclosure changes.
- The in month surplus pre impairments is £342k, £138k below plan.
- The year end surplus pre impairments is £2,085k, £419k below plan.

Issues

- Income in March is £835k ahead of plan split
  - Patient activity £38k, RTT18 penalty -£37k
  - Release of credit note provision £396k (see non-pay)
  - Research income recognised £112k (see pay and non-pay)
  - Other £326k (see non pay)
- Pay is £177k overspent split
  - Research pay costs recognised £89k
  - Other £88k
- Non-pay over by £820k
  - Bad debt provision £467k (see release of credit note provision and other income)
  - Other £353k
- Impairments relate to revaluations of theatres phase 2, American Wing, Day Surgery Unit and land.
- Continuity of Services Risk Rating is 4 which is on plan and the highest score possible.

Actions

- Material estimates in these unaudited values are around the bad debt provision against legacy debt of £820k and the ERT penalty of £1,151k where no immediate payments or agreements are anticipated.

Summary Trend Position – YTD M12 2013/14

Queen Victoria Hospital
NHS Foundation Trust

Forecast 2013/14

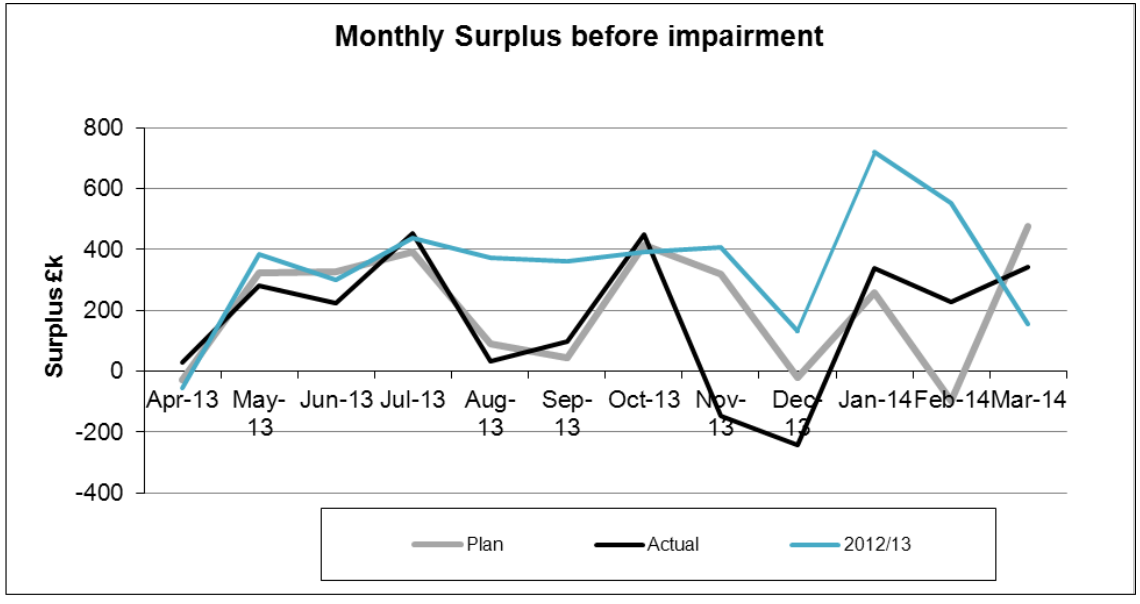
- The year end forecast at month 11 was for a surplus of £2,300k so there was a shortfall of £215k against this.
- The reasons for the shortfall are income only marginally above plan rather than being above by the trend level, pay and non-pay costs higher than anticipated and the performance penalty.

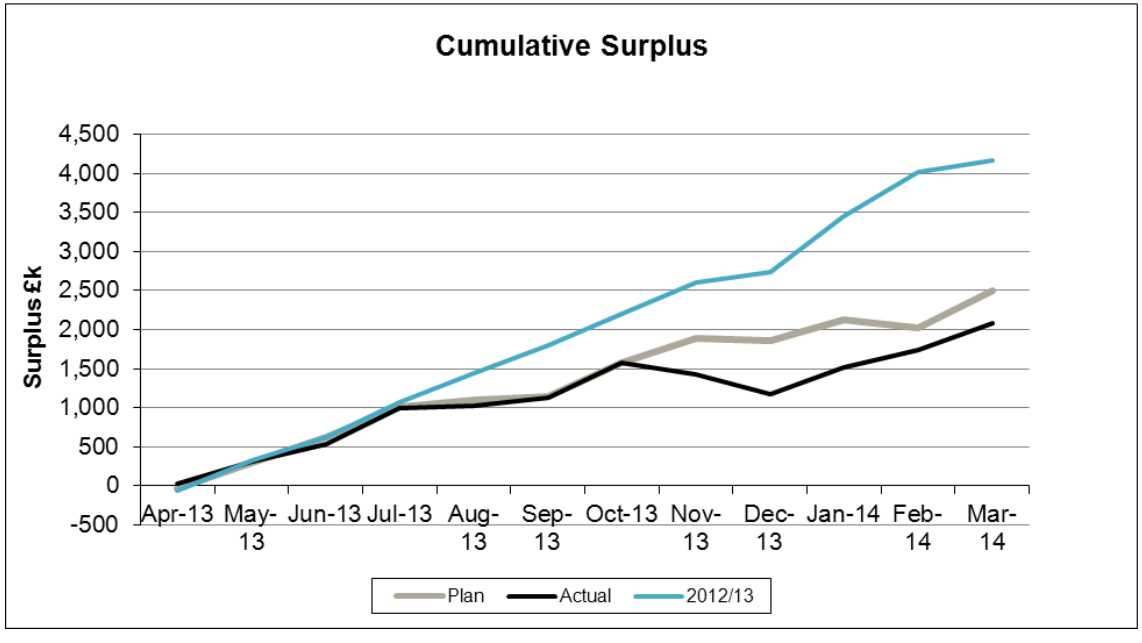
Forecast 2014/15

- The plan for 2014/15 is a surplus of £2,203k, consistent with the planned and actual level of surplus achieved in 2013/14.
- The risks around delivery of this plan – income, pay, non-pay and cash – are being managed through a number of new processes.
- The forecast at this stage is that the planned level of surplus will be achieved.
- Future reports will contain greater detail around forecasts, risks and actions.

Summary Trend Position – YTD M12 2013/14

Queen Victoria Hospital
NHS Foundation Trust





Pay Analysis – YTD M12 2013/14

Queen Victoria Hospital NHS Foundation Trust

Pay Costs By Staff Group	Current Month Variance	YTD Month 12 Actual £'000	Budget £'000	Variance £'000
Clinical Staff				
Consultant (Including locum)	(29)	8,187	7,779	(408)
Junior medical (Including locum)	(58)	5,066	4,648	(418)
Nursing (including bank)	10	8,463	8,677	214
Scientific, therapeutic and technical	(46)	5,957	5,885	(71)
Healthcare assistants	(1)	1,539	1,602	62
Agency:				
Agency other medical	(13)	294	60	(234)
Agency nursing & HCA	(12)	479	7	(472)
RMN agency (for recharge)	(7)	250	102	(148)
Agency scientific, T&T	(7)	98	46	(51)
Salary recharged out	(24)	(436)	(632)	(196)
TOTAL CLINICAL STAFF	**(187)**	**29,897**	**28,174**	**(1,724)**
Non-Clinical Staff				
Chair & Neds	(0)	114	117	4
Executives	(0)	392	426	33
Admin & clerical	24	6,521	6,603	82
Maintenance & support	(3)	1,373	1,332	(42)
Agency non-clinical	(10)	18	-	(18)
TOTAL NON-CLINICAL STAFF	**10**	**8,419**	**8,478**	**60**
TOTAL STAFF COSTS	**(177)**	**38,316**	**36,652**	**(1,664)**

Summary

- Pay is overspent by £177k with Clinical overspends only marginally offset by Non-Clinical savings.

Issues

- £177k overspend in month but this includes £89k of research costs released to match income released leaving a net £88k.
- Non-clinical costs, 23% of the pay budget, are underspent.
- Nursing costs, 24% of the budget, are materially on budget in month.
- There remain pressures on the other pay categories.

Risks

- Continued overspends in overspending areas.

Actions

- Revised controls for additional staff and ad-hoc payments.

Non Pay Analysis – YTD M12 2013/14

Queen Victoria Hospital NHS Foundation Trust

£k Non Pay Overspends YTD M12 2013/14		
Transport	**197**	Ambulance services, under discussion
Sleep Services	**294**	Medical devices which are expected to attract corresponding income.
Drugs	**176**	Mainly in Corneo, Plastics, Anaethestics & Burns
Other Clinical	**889**	Clinical supplies (esp. theatres), disposables, travel, professional fees, records, pathology, SLA's.
Clinical	**1,556**	
Corporate Services	82	Branding etc.
Investment Fund	37	
Building & Engineering	135	Maintenance work done
Building & Engineering	102	Energy
Hotel Services	21	Postage
Domestics	18	Laundry
Net Other	323	Bad debt expenses partially offset with various in-year savings
Non Clinical	**718**	
Total	**2,274**	year to date

Summary

- Non pay overspend is now £2,274k year to date.

Issues

- Clinical overspend is £1,556k and this reflects increased activity, income mix and a number of challenging areas.
- Non clinical overspend is £718k across a number of areas. Last month the cumulative overspend was £271k. The increase relates to year end bad debt movements of £467k that are matched by income increases.

Risks

- Continued overspends lead to financial performance below plan.

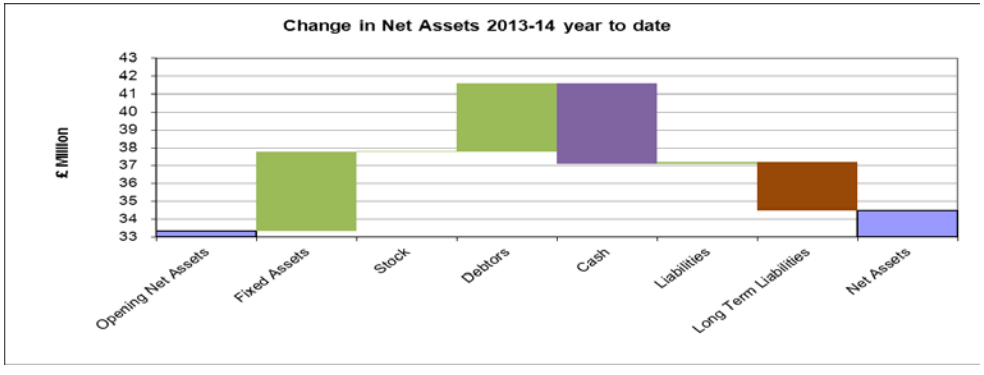
Actions

- Tighter management controls.

Balance Sheet – M12 2013/14

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet	2012/13 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	33,623	38,060	38,318
Other Receivables	-	-	-
Sub Total Non-Current Assets	33,623	38,060	38,318
Current Assets			
Inventories	390	415	375
Trade and Other Receivables	3,534	7,345	6,267
Cash and Cash Equivalents	8,137	3,655	4,334
Current Liabilities	(5,549)	(5,466)	(5,313)
Sub Total Net Current Assets	6,512	5,950	5,662
Total Assets less Current Liabilities	40,135	44,010	43,981
Non-Current Liabilities			
Provisions for Liabilities and Charges	(549)	(582)	(582)
Non-Current Liabilities >1 Year	(6,250)	(8,933)	(8,933)
Total Assets Employed	**33,337**	**34,495**	**34,466**
Tax Payers Equity			
Public Dividend Capital	12,212	12,237	12,212
Retained Earnings	14,859	14,618	16,001
Revaluation Reserve	6,266	7,640	6,253
Total Tax Payers Equity	**33,337**	**34,495**	**34,466**



Summary

- Net current asset position continues to be strong.

Issues

- Fixed assets have declined with net impairments.
- Debtors remain at a high level due to delays in CCG payments for over performance.
- Cash balance has reduced with the increase in debtors and reduced surplus achievement.
- The internal funding of the phase 2 theatre project is materially complete.

Risks

- Continued balance sheet strength relies on surplus performance.

Actions

- NHS England engaging in process for resolving legacy debt issues nationally.
- Pursue late payments.

Capital – M12 2013/14

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	2013/14 Plan £000s	2013/14 Approved budget £000s	YTD Spend £000s	2013/14 Total Spend £000s
Internal Funded Programme:				
Estates projects				
Site development:				
Theatres Phase 1	2,619	2,619	2,839	2,839
Theatres Phase 2	4,332	4,332	3,926	3,926
12/13 Projects:				
OPD entrance	85	85	30	30
13/14 Projects:				
Car Park resurfacing	150	150	145	145
Jubilee/Burns heating	410	410	26	26
Prosthetics hot water system	40	40	2	2
Other projects	200	200	39	39
Medical Equipment	600	600	374	374
IT Equipment	600	600	317	303
Grand Total	9,036	9,036	7,698	7,684

Summary

- Overall capital spend is below the phased plan.

Issues

- Phase 1 and 2 final theatre costs have been calculated subject to final agreement.

Risks

- There will be a carry forward of uncompleted projects into 14-15 of £800k.

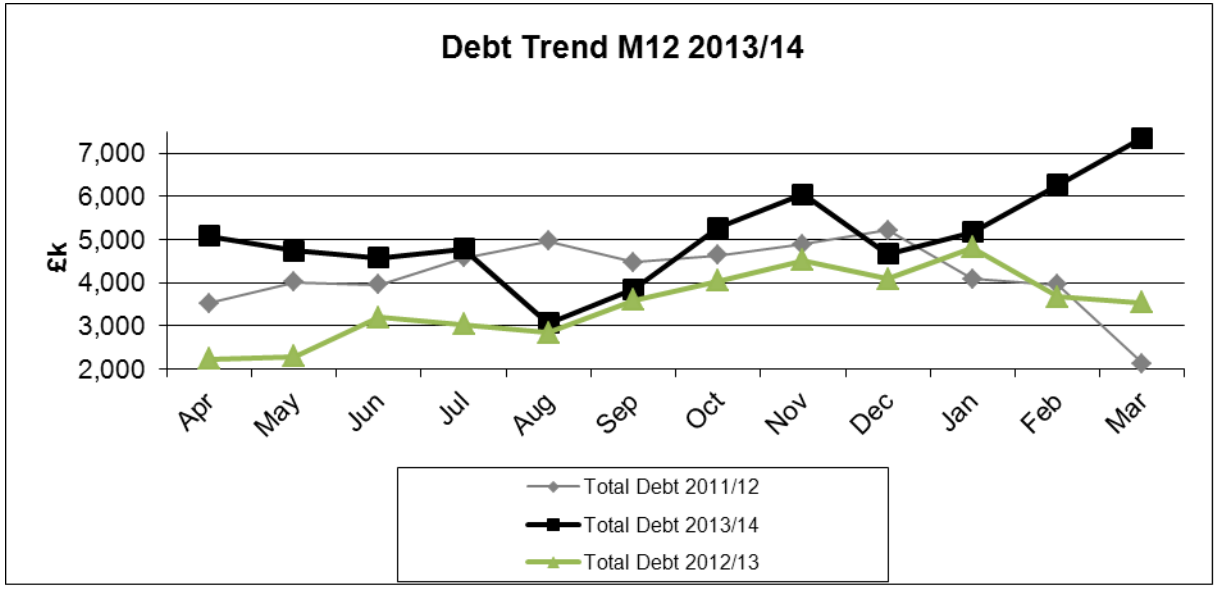
Actions

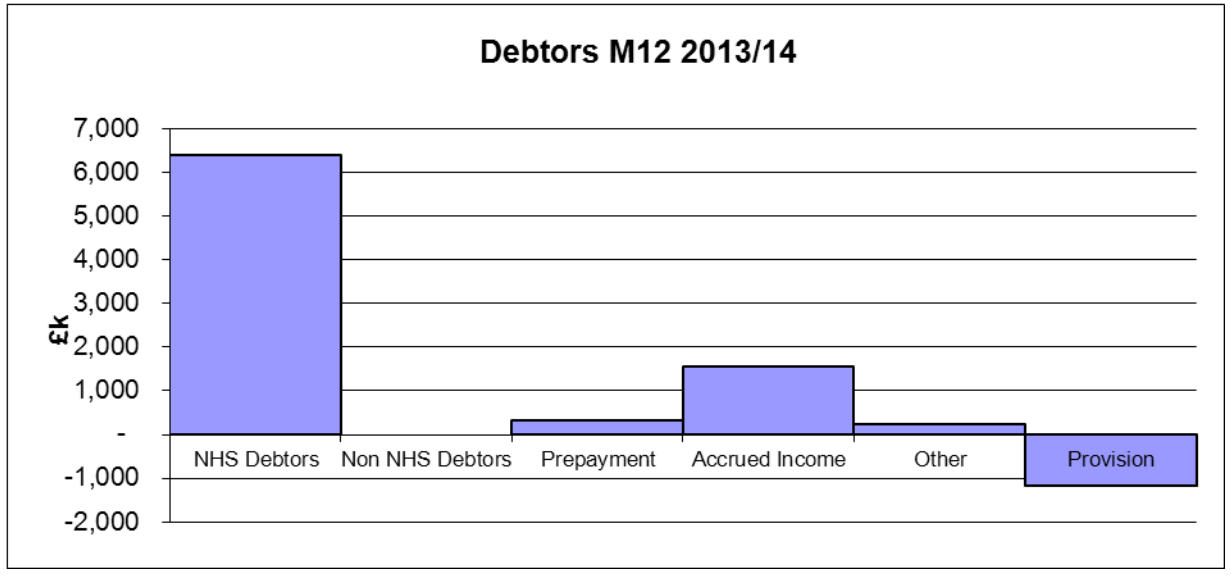
- Finalise theatres projects outturn with Willmott Dixon.

Site Redevelopment	Theatres Phase 1	OPD	Department Moves	Total
Pre- 13/14 spend	9,070	544	296	9,910
13/14	2,839	-	-	2,839
Post-13/14	-	-	-	-
Total	11,909	544	296	12,749
Budget	12,053	490	315	12,858

Debtors – M12 2013/14

Queen Victoria Hospital NHS
NHS Foundation Trust





Summary

- Debt balances are above historic levels for March.

Issues

- Contracts for 14/15 don't include the expected growth so any growth will be subject to delayed payment.
- CCGs with smaller activity levels are becoming non contracted activity and this delays payment too.
- Payments received so far in April mean that balances should reduce from April onward.

Risks

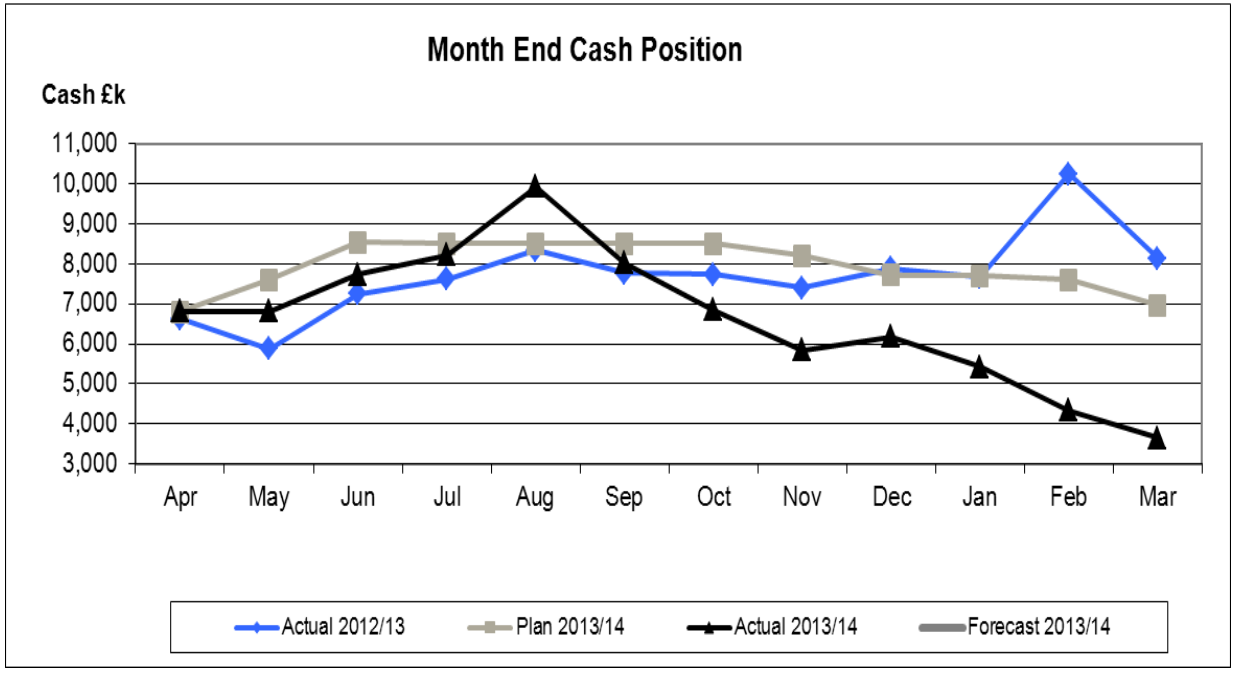
- Payment of older NHS invoices.
- Payment of over performance invoices.

Actions

- Overdue debt is being chased.

Cash – M12 2013/14

Queen Victoria Hospital NHS
NHS Foundation Trust



Summary

- Cash at M12 is below plan because of the pay and non pay overspends and the time lag around payment for additional activity.

Issues

- The Trust is behind the surplus plan, the pattern of the surplus increases the impact on cash flow. Overspends on pay and non-pay have an immediate cash impact but the cash from overachievement on income is delayed whilst agreement is reached
- ERT of £1.15m is being invoiced, and provided against, but disputed so this is leading to delayed payment of invoices.
- Receipts improved in April so the cash balance is expected to be above £4m at the month end.
- A full forecast will be provided separately.

Risks

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

Actions

- Overdue debt is being chased.

Creditors – M12 2013/14

Queen Victoria Hospital NHS Foundation Trust

Better Payment Practice Code March 2014	2012/13 Outturn # Inv's	2012/13 Outturn £000s	Current Month # Inv's	Current Month £000s	YTD Month # Inv's	YTD Month £000s
Total Non-NHS trade invoices paid	13,407	17,956	1,100	1,368	15,071	21,255
Total Non NHS trade invoices paid within target	9,731	14,983	793	1,004	9,386	15,087
Percentage of Non-NHS trade invoices paid within target	**73%**	**83%**	**72%**	**73%**	**62%**	**71%**
Total NHS trade invoices paid	1,363	6,945	54	285	1,082	4,544
Total NHS trade invoices paid within target	873	5,424	22	137	624	2,858
Percentage of NHS trade invoices paid within target	**64%**	**78%**	**41%**	**48%**	**58%**	**63%**

Summary

- Creditor payment performance dipped in August due to the implementation of the new finance ledger but has recovered.

Issues

- Payment performance is measured when payment is made. Therefore during a catch up period performance appears to worsen although it is improving.
- Performance is against a 30 day target and late payment of invoices that aren't disputed is usually only a few days late.

Risks

- Payment delays leading to supply problems.

Actions

- Increased resource in place to correct performance.
- Daily meetings to go through volumes of invoices on hold.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24th April 2014**
Agenda item reference no:	**091-14**
Author:	**Richard Hathaway, Director of Finance**
Date of report:	**16th April 2014**

Performance Report Month 12 (March 2014)

1. Summary

Commissioner income is now £1.70m above plan at March. This has risen from £1.67m above plan at February. Commissioner income was above plan in March.

Outpatient follow-up activity and Diagnostics significantly contributes to both the in-month and year-to-date over performance.

2. Demand

Demand, in the form of referrals, rose slightly in March, is higher than 2012-13 levels, and is 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 has fallen consistently for around 6 months (based on trend).

4. Elective Inpatients

Elective activity was slightly below plan and income was on plan in month. Casemix for elective activity was more complex than expected (plan) in March.

5. Non elective

Non-elective income remains under plan year to date because casemix has been lower than anticipated. The casemix effect is most pronounced for Orthopaedic Trauma cases from Kent Commissioners. In month the non-elective income was lower than planned. The non-elective casemix in March was less complex than expected (plan) so, despite admitting the planned number of patients, we still experienced a shortfall in income.

6. Key Performance Indicators

All cancer targets for activity performed in February are met apart from the "1st Definitive Treatment in 62 days" target. March is still subject to validation. A residual risk around performance on the cancer targets remains due to the small number of cases.

The Trust failed to achieve the RTT18 aggregate target for Admitted Patients in March but achieved the Outpatient and Open Pathways aggregate targets.

At speciality level, the Trust failed to meet the RTT18 targets for Ophthalmology, Plastics and Other (mainly Sleep Studies) against Inpatients Pathways and also failed to meet the target for Plastics against Outpatient and Incomplete Pathways.

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

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

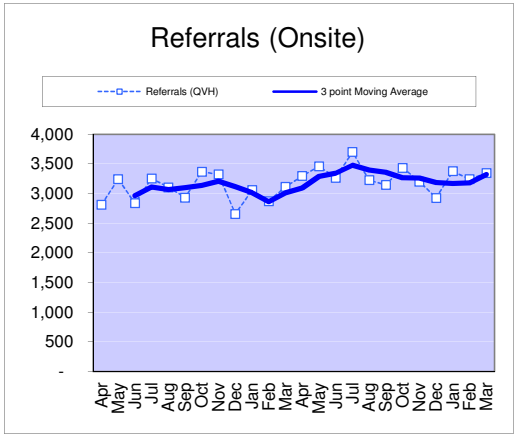
Queen Victoria Hospital NHS
NHS Foundation Trust

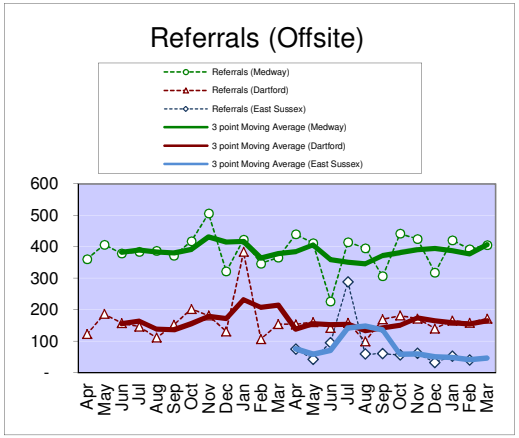
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Richard Hathaway

Trust Level Report (All Services)

Period : 2013-14 Month 12 (Mar)

DEMAND



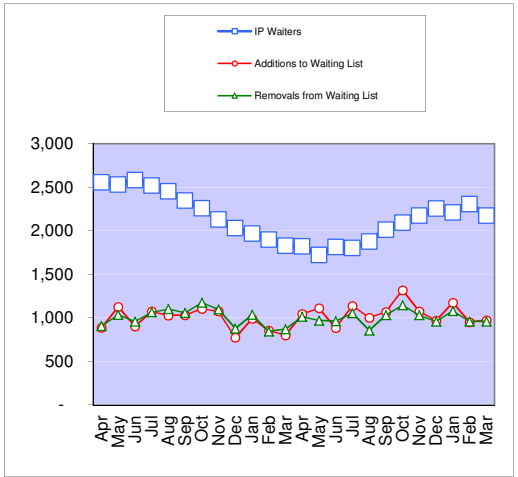


March referrals were high although, across our various service lines, referrals have been flat. The overall rise in referrals is driven by a large increase in referrals into MIU - which suggests more referrals into MIU Trauma clinics (up from 225 referrals in Feb to 363 in March).

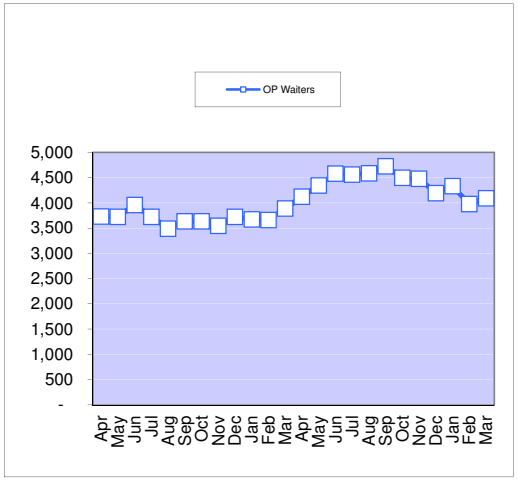
All referrals into offsite spokes are steady (Plastics and Maxillofacial). East Sussex referrals for March are not available at the time of publication.

WAITING LIST

INPATIENT WAITERS



OUTPATIENT WAITERS



The number of patients waiting for an admission/daycase has fallen in March.

Hands, Breast, Maxillofacial and Corneo Plastics all saw significant reductions in their inpatient waiting lists in March. Sleep Studies, Oculoplastics and Cataracts waiting lists rose slightly. Removals from the waiting list kept pace with Additions to the waiting list in March due to a combination of additional Saturday lists every week, during the month, as well as validation.

The size of the Outpatient Waiting List (patients waiting for a first outpatient appointment) was slightly higher in March than in February but 100 additional patients (in March) are in Physiotherapy (this may be a timing/processing issue) - without this the outpatient waiting list is at the same level as February.

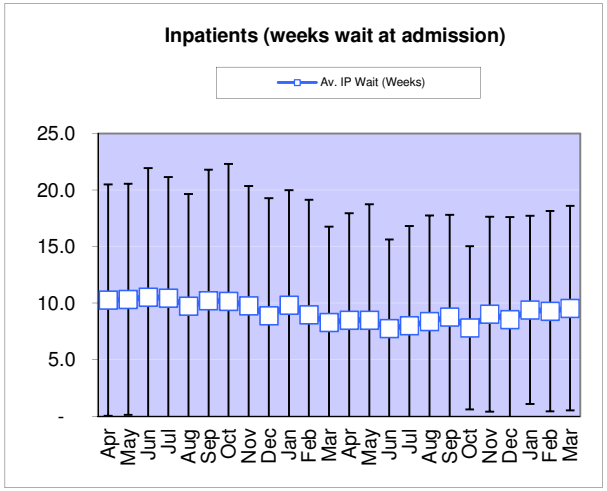
Queen Victoria Hospital NHS
NHS Foundation Trust

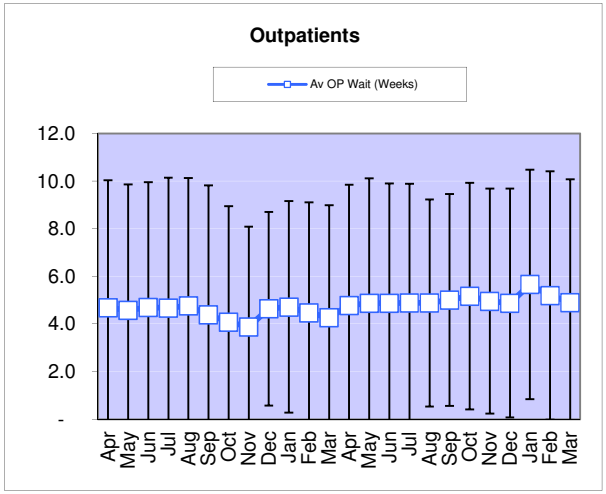
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Richard Hathaway

Trust Level Report (All Services)

Period : 2013-14 Month 12 (Mar)

WAITING TIMES

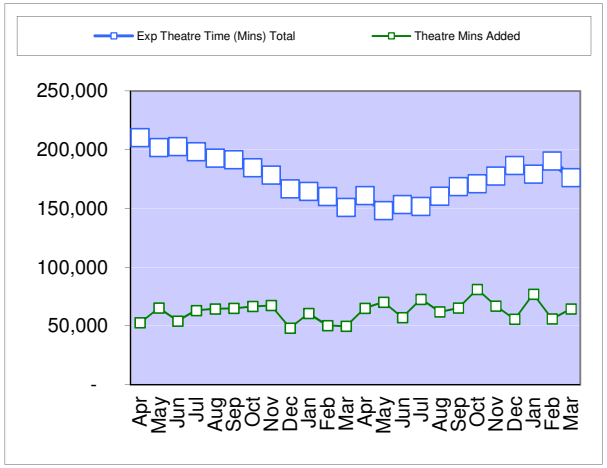


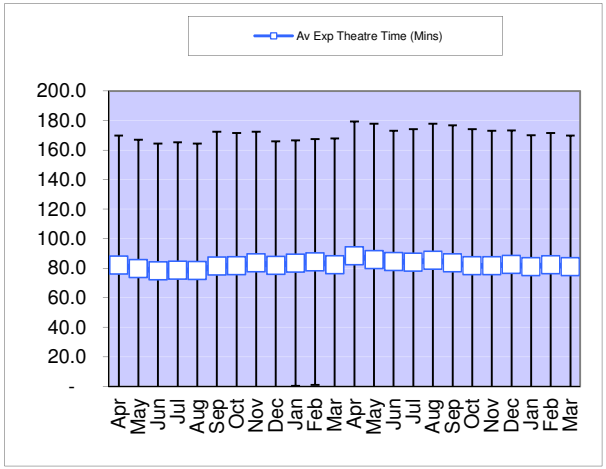


Average Inpatient waiting times are steady in March but the range of waits increased slightly. Average inpatient wait times have returned to the higher levels we saw at the start of 2012-13. A factor in this rise may be the increasingly complex casemix we've encountered in elective admissions in May, November and March 2013-14 (see Ratios reports).

Outpatient average wait times fell sharply again in March to 4.9 weeks, noting that Radiology waits have only been included since October (which is pushing the average up overall).

THEATRE MINS





Expected Theatre Minutes per month is following the trend of the Inpatient Waiting List, although Theatre Minutes added to our waiting lists in March are low compared to the highest months in 2014 (October and January).

Average Expected Theatre time per case has been largely unchanged since April 2012 although the range of values has been slightly falling in 2013-14.

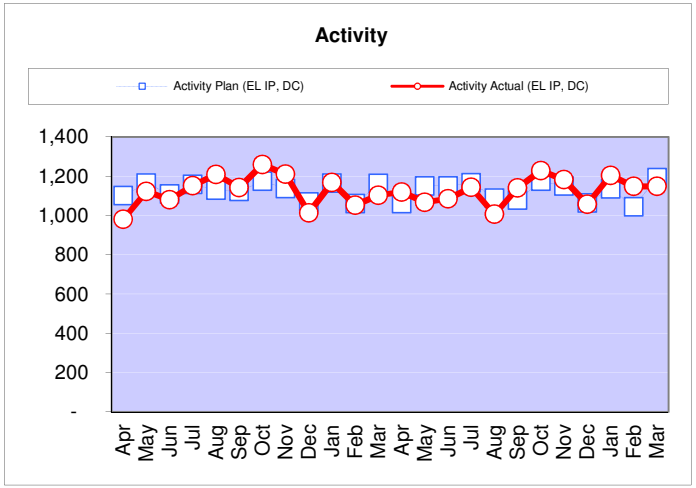
Queen Victoria Hospital NHS
NHS Foundation Trust

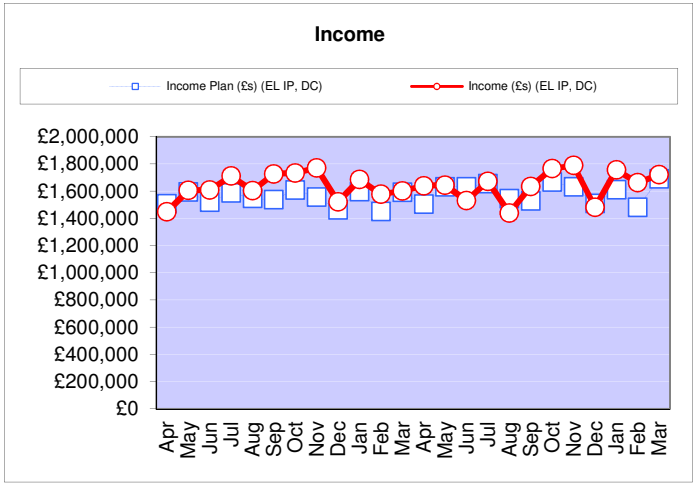
Author: Dean Janes (Contracts & Coding Manager)
Executive Director: Richard Hathaway

Trust Level Report (All Services)

Period : 2013-14 Month 12 (Mar)

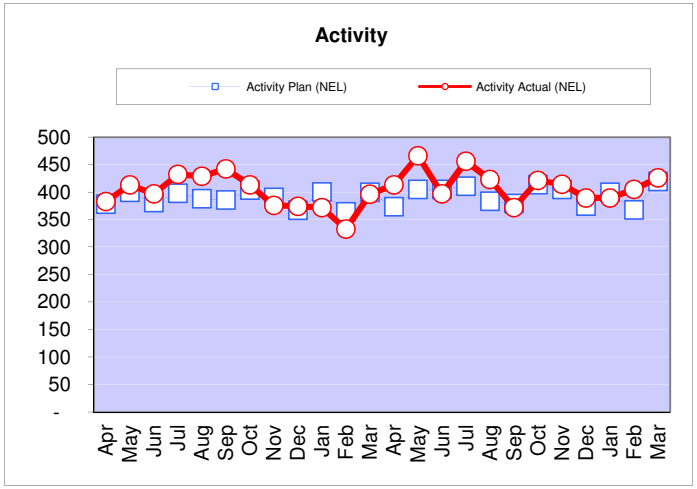
Elective Inpatients

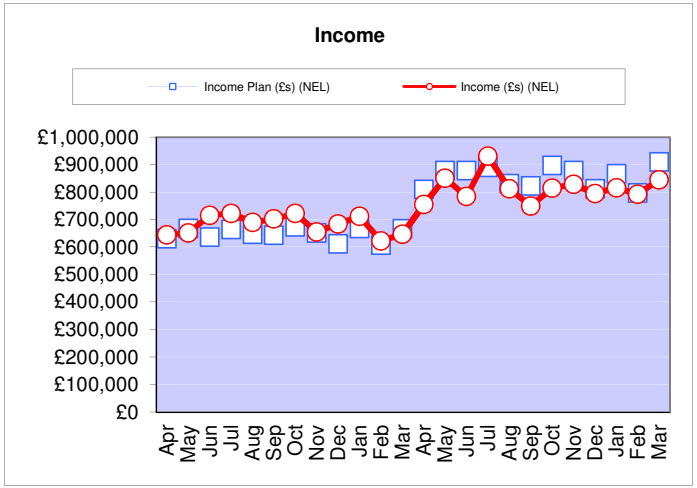




Elective/Daycase activity was slightly behind plan in March (44 cases behind plan) but the income for this activity was above plan (£+30k) as a result of a more complex than planned casemix encountered in the month.

Non-Elective Inpatients





Non-Elective Income is £-65k below plan in March, although activity was on-plan we experienced a less complex than planned casemix in the month leading to the income shortfall.

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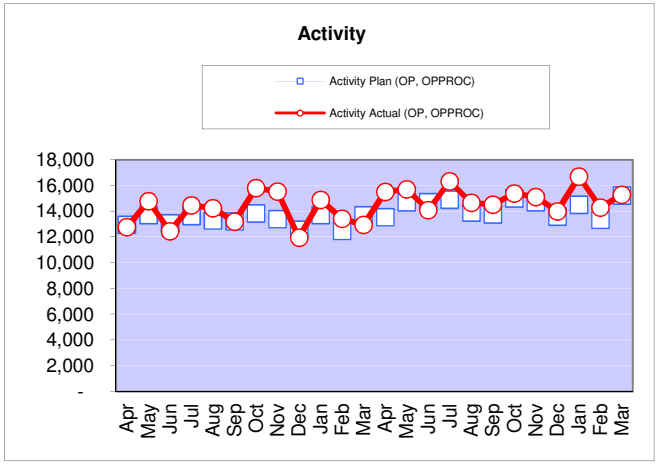
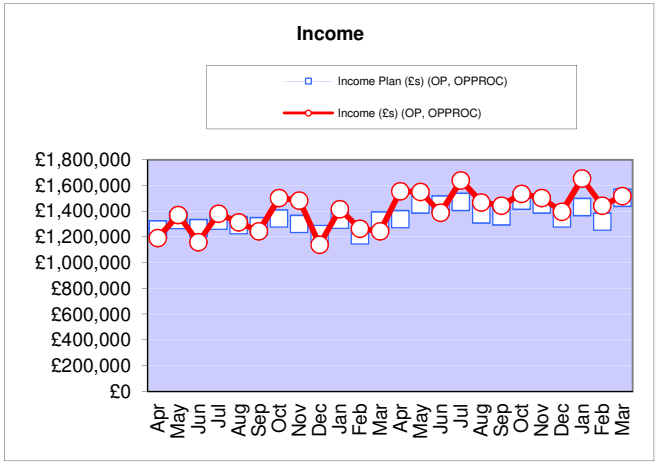
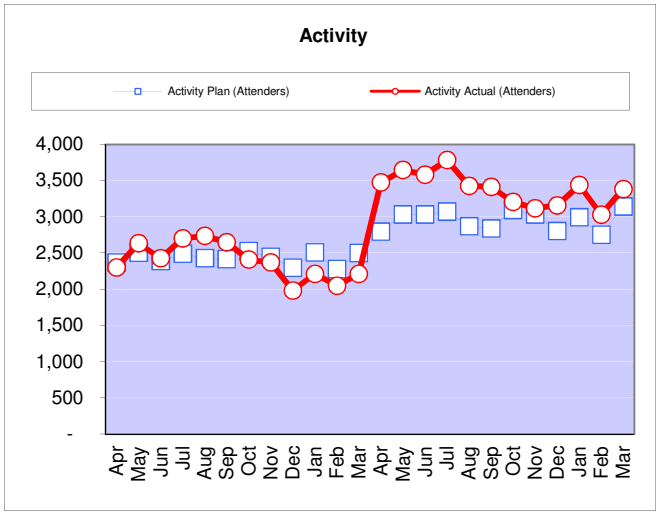
Outpatients

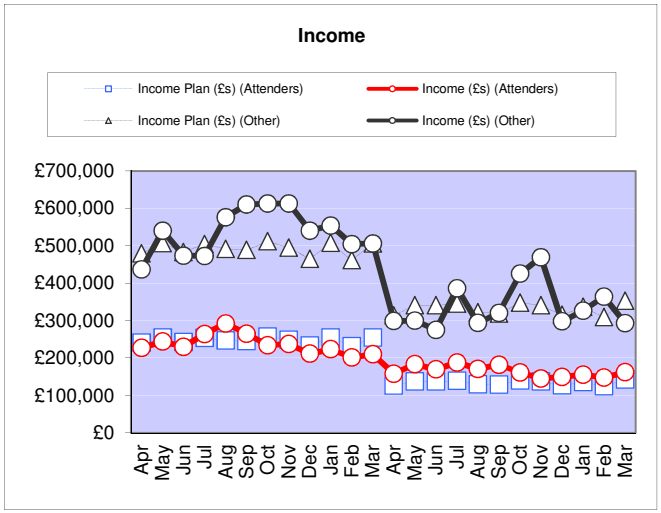




Outpatient Activity and Income are on plan in March although we continue to perform many more Outpatient Follow-Ups than planned and there may be a future, associated risk to our follow-up ratios (in terms of penalties). Individual Service Line reports (published internally) will show performance versus target ratios for each service. Consultant Activity Reports also show individual performance against outpatient follow-up ratio targets for most consultants.

Other Activity/Income





Radiology attenders are above planned *income* in March (£+21k), mainly Unbundled Outpatient Diagnostics, but this is offset my MIU Attenders being slightly below plan (£-2k). Direct Access Diagnostics are on-plan. The Diagnostics overperformance should be considered alongside the 50% marginal rate risk-share mechanism (which is not included here) and will dampen the gains.

Critical Care was low in March (£-35k). Total "Other" Income was therefore slightly below plan in the month.

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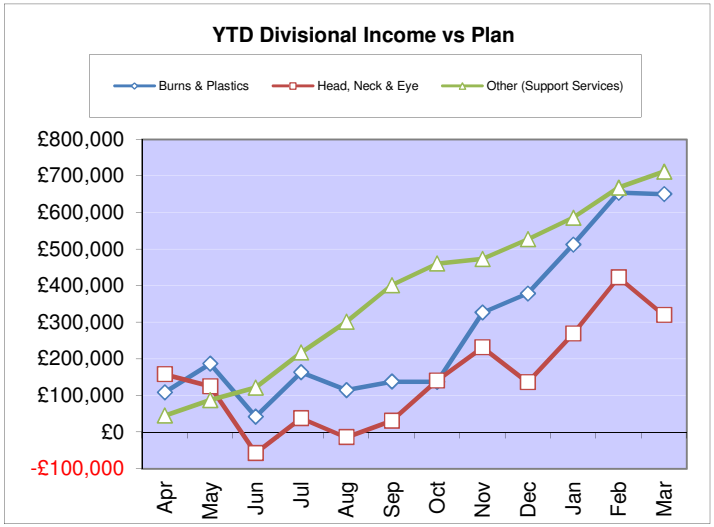
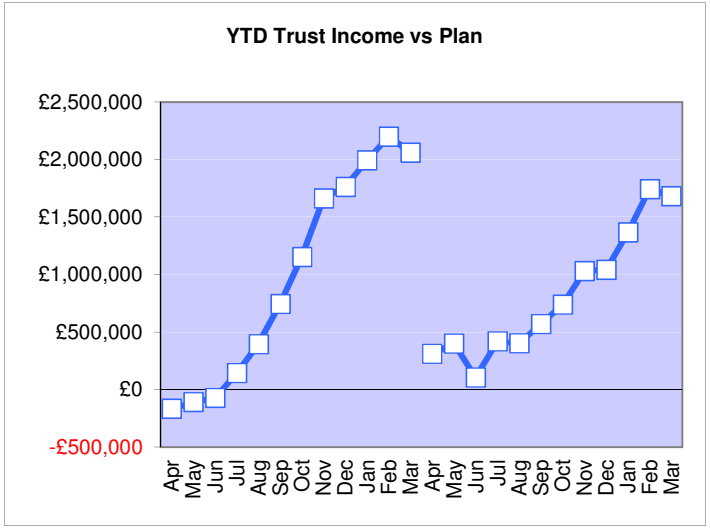
Trust Level Report (All Services)

Period : 2013-14 Month 12 (Mar)

Income vs Plan





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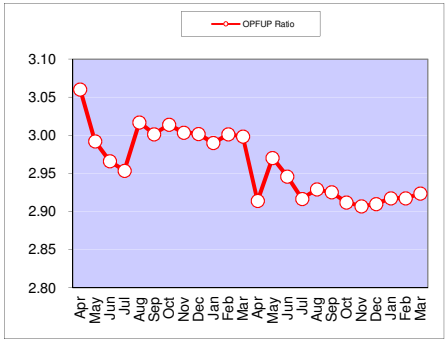
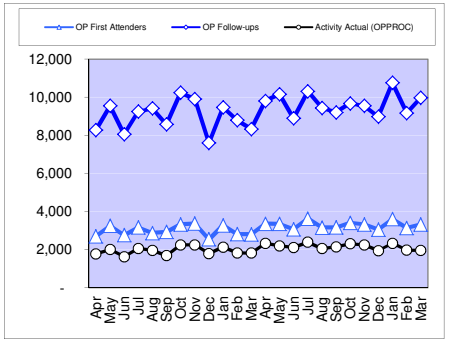
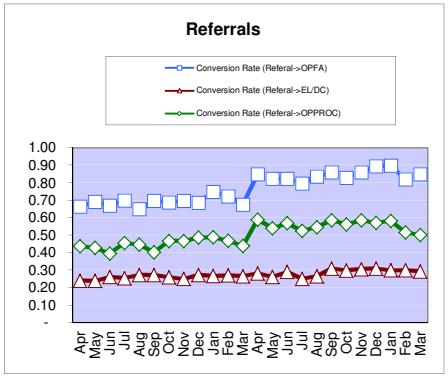
Follow-Up Ratios

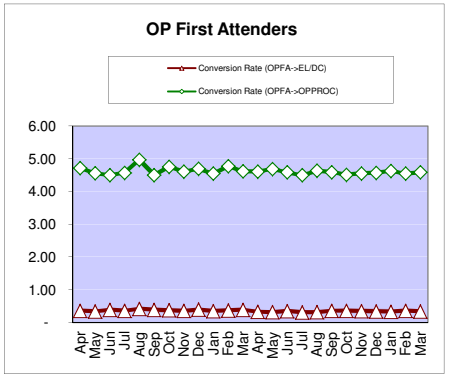




Outpatient Activity is increasing and the overall Trust follow-up ratio is lower than last year. We managed to negotiate no penalty for New To Follow-up Ratios with our host commissioner for Q2 but potential risk remains for Q3-Q4.

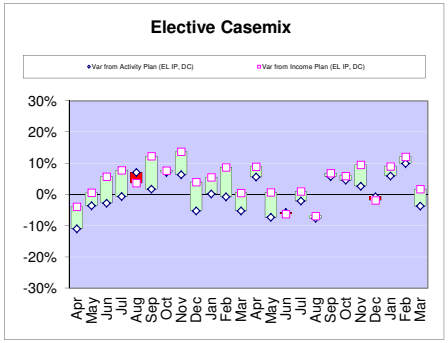
Conversion Rates

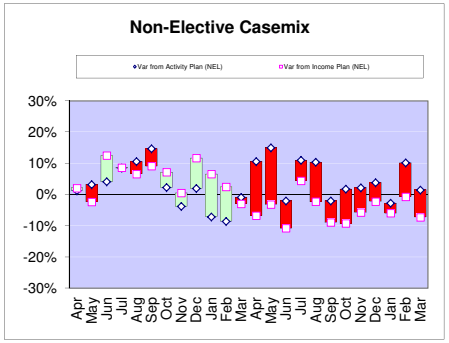




Activity Ratios suggest we are slower to move patients from Referral to Outpatient Procedures in the last two months.

Case Mix





Elective casemix was more complex than planned in March and, although we admitted less patients than planned, we achieved our income plan for Elective Admissions in the month.

The casemix shift in Non-Elective Admissions is mainly in Non-Elective Orthopaedic Trauma cases from Kent commissioners. The weaker casemix in Non-Elective admissions, that we experienced all year, was prevalent in March. The number of admissions was as planned but the lower complexity meant an income shortfall.

Queen Victoria Hospital NHS
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Trust Level Report (All Services)

Period : 2013-14 Month 12 (Mar)

KPIs

Performance	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	13-14 Av	13-14 Av	Target
MIU															
% Attdrs within 4 hours of Total Attenders	99.7%	99.4%	100.0%	100.0%	99.4%	99.4%	98.5%	99.8%	99.5%	100.0%	99.9%	99.5%	**99.6%**	Target Met	**95%**
18 weeks															
18ww Admitted	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%**	Target Not Met	**90%**
No of failing specs (Adm)	0	0	0	1	1	0	0	3	1	2	2	3	**n/a**	Not Applicable	**n/a**
18ww Non Admitted	96.4%	97.4%	95.9%	96.4%	97.1%	95.9%	96.4%	95.6%	95.6%	95.3%	95.0%	95.5%	**96.0%**	Target Met	**95%**
No of failing specs (Non Adm)	0	1	0	0	2	1	0	1	1	1	2	1	**n/a**	Not Applicable	**n/a**
% incomplete pathways within 18 weeks	95.6%	95.3%	95.9%	94.3%	95.5%	93.5%	93.8%	92.5%	92.8%	92.6%	90.8%	92.8%	**93.8%**	Target Met	**92%**
% receiving diagnostic test within 6 weeks	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%**	Target Met	**99%**
Cancer															
Cancer - TWR	96.6%	100.0%	96.4%	94.7%	96.1%	97.2%	94.6%	99.2%	98.2%	93.0%	98.4%	TBC	**96.8%**	Target Met (Feb)	**93%**
Cancer - 1st definitive 31 day	96.0%	93.2%	97.8%	97.2%	100.0%	95.8%	96.1%	98.4%	97.2%	98.0%	96.2%	TBC	**96.9%**	Target Met (Feb)	**96%**
Cancer - 2nd/sub (surgery)	100.0%	98.1%	100.0%	98.0%	97.2%	97.9%	97.8%	94.7%	96.3%	98.1%	98.0%	TBC	**97.8%**	Target Met (Feb)	**94%**
Cancer - 1st definitive 62 day	83.0%	96.4%	95.0%	73.8%	92.5%	92.9%	90.2%	84.6%	100.0%	94.9%	81.0%	TBC	**89.5%**	Target Not Met (Feb)	**85%**
Cancer - 1st definitive 62 day (upgrades)	100%	100%	100%	100%	100%	100%	100%	75%	100.0%	100%	100.0%	TBC	**97.7%**	No Target	**N/A**
Cancer Screening - 62 day				100%	100%	0%	0%	n/a	0%	n/a	100.0%	TBC	**50.0%**	Not Applicable	**N/A**
Cancelled ops and HCAI															
Cancelled operations	3	2	2	2	1	3	3	2	5	1	1	13	**38**	No National Target	**N/A**
MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	**0**	Target Met	**<1**
cDiff cases	1	0	0	0	0	0	0	0	0	0	0	0	**1**	Target Met	**<1**

(TBC) = Estimated Figure - subject to further work

- The 4-hour MIU wait target has been achieved, on average, over the course of 2013-14. The target was achieved in March.
- RTT18 wait target for admitted patients was achieved, on average, over the course of 2013-14. The March RTT18 target was not met
- RTT18 wait target for non-admitted patients was achieved, on average, over the course of 2013-14. The March RTT18 target was met
- RTT18 wait target for open/incomplete pathways was achieved, on average, over the course of 2013-14. The March RTT18 target was met
- The target for diagnostics tests within 6 weeks was achieved, on average, over the course of 2013-14. The target was achieved in March.
- The Cancer Two Week Rule target was achieved, on average, over the course of 2013-14. The March Cancer position is subject to validation at his time.
- The Cancer 1st definitive 31 day target was achieved, on average, over the course of 2013-14. The March Cancer position is subject to validation at his time.
- The Cancer 2nd or subsequent treatment target was achieved, on average, over the course of 2013-14. The March Cancer position is subject to validation at his time.
- The Cancer 1st definitive 62 day target was achieved, on average, over the course of 2013-14. The March Cancer position is subject to validation at his time.
- The Cancer 1st definitive 62 day (upgrades) was achieved, on average, over the course of 2013-14. The March Cancer position is subject to validation at his time.
- The Cancer Screening 62 day target was not applicable for most of 2013-14 due to small numbers of patients. The March Cancer position is subject to validation at his time.
- We achieved our MRSA target (no cases for the contract year)
- We failed our cDiff target (1 case in April vs target of 0 for the year) but there were no additional cases all year
  We will not be penalised for the April breach (cDiff) since the case was not clinically avoidable (as per our contract agreement with Commissioners).
- At the time of reporting the cancer target numbers are still subject to a number of validations for March and outstanding histopathology reports.
- The final position (Cancer) will be available for March imminently but was not available at the time of publication

Queen Victoria Hospital NHS
NHS Foundation Trust

RTT18 Update
Board report – 24th April 2014

Performance Exception Report			
Month	Mar 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 	February In patient aggregate = **86.6%** against target of 90% Specialities failed: • Plastics (63 out of 558 = 88.71%) • Corneo (35 out of 166 = 78.92%) • Sleep (8 out of 71 = 88.73%) February out-patient aggregate = **95.4%** against target of 95% Specialities failed: • Plastics (26 out of 423 = 93.90%) February Incomplete Pathways aggregate = **92.75%** against target of 92% Specialties failed (not subject to individual fines): • Plastics (259 out of 2280 = 88.64%)		
Reason for Variation	The contributing factors to this in month breach were due to combined effect of three specialties: • Sleep Studies (Other) speciality also has continued to be affected by issues with technician capacity since Christmas due to the delay in recruiting to a vacant Band 6 post and the departure of the Band 7. Where possible the loss in activity has tried to be minimised by use of agency staff. Full establishment will be in place from April. • The speciality of Plastic Surgery is continuing to focus efforts for the remainder of the year (Q4) on addressing the backlog of patients who have waited longer than 18 weeks The scheduling of LOPA's has been completely reviewed and whilst the new system embeds there have been some patients who have still experienced slightly longer waits. Both these issues have resulted in Plastics failing all three targets for March 2013. • Corneo – have continued to experience capacity issues particularly surrounding Cataract patients and patients requiring consultant to do only cases. This has been further compounded by the lack of experience of the current fellows within the speciality.		

Impact	**Patient Outcomes / Experience**
	Longer patient waits
	Financial Position
	Financial penalty applied by CCGs is forecast to be £-36,588
	Monitor Targets / Contractual Requirements
	Exception report submitted to CCG and Monitor Impact on Monitor risk rating – remains green for 13/14 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. • Recruitment of Band 6 has been successful and is starting in early April which will result in 7th night opening during Q1. • 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 been organised for the end of April and plans are in place to secure further additional capacity in May 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 advertised 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 Immediately moving any LOPAs cases that are over 60 mins into day case theatres and or to fill last minute cancellations for and transfer to day case. o Existing LOPAs / Mohs facility on C wing moved at the beginning of April into part of the old retained theatre block 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 likely to start in June. In the meantime sessions are being used by senior registrars to assist capacity. • Breast cases being pooled within Plastics to reduce waiting times of other breast consultants • Increased demand for immediates has resulted in backlog of planned delayed reconstructions. Directorate plan to use A Blackburn as locum breast consultant from April (will not fill senior micro fellow post) once CTC back from deployment. This will not gain extra Theatre capacity but will provide additional consultant operating for breast cases.

	• Longer term started planning for PMG retirement in Sept which will have Burns/Breast component. **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 • Further review administrative function and waiting list management systems with support from IST following their visit in early April. The Trust is expecting to receive written feedback on the 30th April.
Forecast date to return to plan	It is anticipated for April that the Trust will achieve both the outpatient and inpatient aggregate target. However it should be noted that there is still a risk that the Trust aggregate for inpatients in Q1 maybe missed due to cancellations, trauma demand, shortages of theatre staff and continued reductions in backlog, particularly in Plastics and Corneo. The Directorates are introducing additional waiting list management systems alongside extra capacity to reduce waiting times in order to achieve aggregate performance for Q1. Once the additional LA DC operating sessions are made available in July the Trust is anticipating 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.
Forecast outturn	Final out turn for end of year incorporating Mar 2014 figures are as follows • Inpatient Trust aggregate = 90.52% against target of 90% • Outpatient Trust aggregate = 96.04% against target of 95% • Open Pathways aggregate = 93.77% against target of 92%
Monitoring	Clinical Cabinet (bi-monthly) and Senior Management Team (weekly)
Recommendation	The Board is requested to note and endorse the action being taken to improve performance in this area.

Glossary

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

Data Area	Chart Name	Detail
Demand	Referrals (Onsite) Referrals (Offsite)	These charts indicate overall demand for our services from external sources i.e. referrals into QVH East Grinstead (onsite) and referrals into Dartford, Medway and East Sussex (offsite). N.B. Dartford does not provide referral data therefore first outpatient is used as a proxy for referral data. The charts use a 3-point moving average to smooth out peaks and troughs associated with number of working days in the month. Included in the data are referrals from: • GPs • General Dental Practitioners (GDPs) • Other A&E departments • Direct Access referrals e.g. to therapy • Consultants at other hospitals • QVH Minor Injuries Unit • Other external health professionals – optometrists, practice nurses etc. Excluded from the data are: • Referrals from our own QVH departments or Consultants – this would not necessarily indicate 'new' demand For context, the specialities that receive the highest number of referrals in order are: maxfac, hands, physio, burns, skin, sleep, breast.
Waiting List	Inpatient Waiters	The purpose of this chart is to show the total elective 'order book'. This chart is not intended to be used to measure the management of waiting lists or waiting times – it simply represents the totality of the work the Trust has committed to undertake. IP waiters = In Patient waiters: the number of patients waiting for an elective procedure irrespective of whether they have a To Come In (TCI) date or not. This chart includes planned patients. It is a snapshot taken monthly. Additions to Waiting List = the number of patients who were added to the waiting list in the month, again irrespective of whether they have a TCI date or are planned.

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

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

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

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

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

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**092-14**
Author:	**Lois Howell, Interim Head of Corporate Affairs**
Date of report:	**8 April 2014**

BOARD OF DIRECTORS
ANNUAL DECLARATION OF INTEREST 2014-15

Introduction:

1 The trust has a duty to have in place principles and procedures to minimise, manage and register potential conflicts of interests, which could be deemed, or assumed, to affect the decisions made by those involved in the business of the Trust. Paragraph 40 (and Annex 8) of the Trust's Constitution describe conflicts of interests of Directors and how they should be declared and managed. When first appointed to the Board of Directors, Directors are required to complete and sign a *Director Declaration of Interests Form*

2 At every meeting, Directors are asked to declare any new interests and to remind other board members of existing interests relevant to other items on the board agenda through a standing agenda item entitled "Declaration of Interests".

3 At the beginning of each financial year, the trust requires each Director to complete a new Declaration of Interest form through the annual declaration process. This report initiates this process for the year 2014/15.

4 A Register of Interests of the Directors is held by the Trust to record disclosures, both annually and during the course of a Director's duties. The Secretary maintains the Register of Interests of the Directors and will arrange for it to be reviewed by the Board of Directors annually. The Register of Interests of the Directors is available for inspection by the public and will be published on the Trust's website.

The Board is asked to:

5 note that all members of the board of Directos are required to 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.

Queen Victoria Hospital NHS
NHS Foundation Trust

Director Declaration of Interests Form

NAME:	**DESIGNATION:**
NATURE OF INTEREST IN FULL: **(please write "none" if applicable)**	
Office use only: Authorised □ YES DATE: □ NO □ NOT APPLICABLE	
Office use only: Authorised □ YES DATE: □ NO □ NOT APPLICABLE	
Office use only: Authorised □ YES DATE: □ NO □ NOT APPLICABLE	
SIGNATURE:	**NATURE OF DECLARATION** □ **On Appointment** □ **Annual Declaration** □ **At a Meeting** **Date:** **Participated in Discussion: YES / NO** □ **Change in Circumstances**
DATE:	

Office use only

Date recorded on Register of Interests of the Directors:	

Guidance Notes for the Completion of the Director Declaration of Interests Form

1.0 INTRODUCTION

1.1 This guidance note is intended to support Directors in the completion of the *Director Declaration of Interests Form.*

2.0 BACKGROUND

2.1 Queen Victoria Hospital (QVH) NHS Foundation Trust (the Trust) has a duty to have in place principles and procedures to minimise, manage and register potential conflicts of interests, which could be deemed, or assumed, to affect the decisions made by those involved in the business of the Trust.

2.2 Members of the Board of Directors shall be aware of the standards of conduct that are required from a publicly funded body that carries out public functions. Directors shall follow the Seven Principles of Public Life as set out by the Committee on Standards in Public Life (the "Nolan Principles"), as well as operating in line with the Trust's Constitution and Code of Conduct for Directors. Declaring interests should also be seen in the context of the wider regulatory framework that governs the policies and operations of the Trust, including the *Code of Conduct: Code of Accountability in the NHS* (DH 2004), the *Code of Accountability for NHS Boards* and the *Code of Conduct for NHS Managers* (DH 2002), *Governing the NHS: A Guide for NHS Boards* and *The NHS Foundation Trust Code of Governance* as well as *The Bribery Act 2010.*

2.3 Board members must be, and be seen to be, honest and objective in the exercise of their duties and should understand fully their terms of appointment, duties and responsibilities.

3.0 QVH CONSTITUTION

3.1 Paragraph 40 and Annex 8 of the Trust's Constitution describes conflicts of interests of Directors and how they should be declared and managed.

3.2 The Constitution states that, by virtue of being a Director of a Foundation Trust, a Director has a duty to:

i. avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust;
ii. not to accept a benefit from a third party by reason of being a Director, or doing (or not doing) anything in that capacity.

3.3 The duty referred to in 3.2(i) is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or the matter has been authorised in accordance with the Constitution.

3.4 The duty referred to in sub-paragraph 3.2(ii) is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest. "Third party" in this instance means a person other than the Trust, or a person acting on its behalf.

3.5. If a Director has in any way a relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors. Any such declaration must be made before the Trust enters into the proposed transaction or arrangement.

3.6 Interests which should be regarded as “relevant and material” for Directors are:

i. directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies); or
ii. ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust; or
iii. significant or controlling share in organisations likely or possibly seeking to do business with the NHS or the Trust; or
iv. a position of authority in a charity or voluntary organisation in the field of health or social care; or
v. any connection with a voluntary or other organisation contracting for NHS or the Trust's services or commissioning NHS or the Trust's services; or
vi. any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders of banks.

3.7 A "family interest" is an interest of a Close Family Member of a Director which, if it were the interest of that Director, would be a personal or pecuniary interest of his. A "Close Family Member" means a person who is related to a Director in any of the following ways:

i. spouse;
ii. status of a "Civil Partner" as defined in the Civil Partnerships Act 2004 or a co-habitee;
iii. child, step child or adopted child;
iv. sibling;
v. parent; or
vi. nephew, niece or cousin.

3.8 If a Director makes a declaration under these arrangements, which subsequently proves to be, or becomes, inaccurate or incomplete, the Director must make a further declaration before the Trust enters into the transaction or arrangement.

3.9 A Director need not declare an interest in the following circumstances:

i. it cannot be reasonably regarded as likely to give rise to a conflict of interest;
ii. to the extent that the Director is unaware of the interest, or the transaction or arrangement in question;
iii. to the extent that the Directors are already aware of the interest;
iv. to the extent that the interest concerns terms of the Director’s appointment that have been, or are to be, considered by the Board of Directors or a designated committee of the Directors appointed for that purpose under the Trust's Constitution.

3.10 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than immediacy of the relationship is more important in assessing the relevance of an interest.

4.0 DECLARING AN INTEREST

4.1 When first appointed to the Board of Directors, Directors shall be asked to complete and sign a *Director Declaration of Interests Form*. Also at every meeting, Directors are asked to declare any new interests through a standing agenda item entitled “Declaration of Interests”.

4.2 The *Director Declaration of Interests Form* requires the Director to provide his name and designation as well as details of the interest, and whether the interest was declared:

i. on appointment;

ii. during the usual course of his duties;
iii. through the annual declaration process; or
iv. at a meeting (including the date of the meeting and if the Director participated in the relevant part of the meeting).

4.3 A *Register of Interests of the Directors* is held by the Trust to record disclosures, both annually and during the course of a Director's duties.

4.4 Directors who appear on the Register shall be required to ensure that entries relating to them in the *Register of Interests of the Directors* are accurate, complete and up to date. If there are any changes in a Director's interests, these should be declared to the Secretary immediately or at the earliest opportunity following any change in circumstances; the Director shall be required to complete and sign a new *Declaration of Director Interests Form* if relevant. When a declared interest ceases to be relevant, the Director should inform the Secretary so that it can be removed from the *Register of Interests of the Directors*.

4.5 If a Director has a declared interest in a matter under discussion or consideration by the Board of Directors, he should comply with the arrangements for excluding Directors from participation in these circumstances unless the matter has been authorised as referred to in paragraph 5 below.

5.0 AUTHORISING AN INTEREST

5.1 In certain circumstances, the Board of Directors may authorise a Director with a declared Conflict of Interest ("Interested Director) to continue to be involved in that matter. In such circumstances, the Interested Director may be subject to terms and conditions relating to his attendance and involvement at any meetings where the matter may be discussed and shall be obliged to conduct himself in accordance with these.

5.2 The Board of Directors may revoke or vary the authorisation at any time.

5.3 If a conflict of interest has been authorised, this shall be recorded in the *Register of Interests of the Directors.*

6.0 REGISTER OF INTERESTS OF THE DIRECTORS

6.1 The *Register of Interests of the Directors* sets out the names of the Directors and details of their interests, including the date of their declaration.

6.2 The Secretary maintains the *Register of Interests of the Directors* and arranges for it to be reviewed by the Board of Directors annually. The *Register of Interests of the Directors* is available for inspection by the public and is published on the Trust's website.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**093-14**
Author:	**Bill Stronach, Deputy Director of Finance**
Date of report:	**16 April 2014**

MONITOR DECLARATION: QUARTER 4 OF 2013/14

1. The Trust is required to submit its Quarter 4 (Q4) monitoring return by the end of April.

2. This paper confirms the In Year Governance Statement from the Board contained in the Q4 return. An updated self-certification framework is attached, which gives the sources of supporting evidence for our Monitor declarations.

3. For finance the declaration that "The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the the next 12 months" is **confirmed**.

   The Continuity of Service risk ratings (COSRR) within the Risk Assessment Framework are described as follows

   1. Significant risk
   2. Material risk
   2* Level of risk is material but stable
   3. Emerging or minor concern
   4. No evident concerns

   In Q4 the COSRR is 4: No evident financial concerns

   In the Monitor annual plan the COSSR is planned as 3 in Q1 and 4 in the remaining seven quarters to the end of 2015/16. The reduced rating in Q1 reflects the combination of the planned deficit and the scheduled debt repayment. These ratings are maintained in the downside scenario included in the annual plan.

4. For governance the declaration that "The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forward" is **not confirmed.**

   In the Q3 return there was a breach of the Referral to treatment time, 18 weeks in aggregate, admitted patients target leading to a trust overall score of 1 (where zero is the best score). Each breach is assigned a score and these are summed into a trust total. This was the first breach of the year.

   In the Q4 return there are breaches of the Referral to treatment time, 18 weeks in aggregate targets for admitted patients, (January, February and March) and non-admitted patients (February). These breaches lead to a trust score of 2. Performance against the other targets in the Framework is to be confirmed.

   In the Monitor annual plan the following three targets are declared as at risk leading to a trust score capped at 2.0

   Referral to treatment time, 18 weeks in aggregate, admitted patients

Referral to treatment time, 18 weeks in aggregate, non-admitted patients
Referral to treatment time, 18 weeks in aggregate, incomplete pathways

For Q1 the operational team is anticipating achievement of these targets

However it should be noted that there is still a risk that the trust aggregate for admitted patients in Q1 may be missed due to unplanned cancellations, trauma demand, shortages of theatre staff and continued reductions in backlog in specific specialities. The Intensive Support Team have been called in to review the systems in place and trajectories and are due to report formally at the end of April which will be fed into a detailed action plan. The trust is introducing additional waiting list management systems alongside extra capacity to reduce waiting times in order to achieve aggregate performance for Q1.

5. The Governance Ratings within the Risk Assessment Framework are described as follows

Green: No evident concerns
Issues identified
Red: Subject to enforcement action

Monitor summarises the Issues identified category as “Where we have identified a concern at a trust but have not yet taken action, we will provide a written description stating the issue at hand and the action we are considering”.

Concerns are triggered by either scoring more than 4 in any one quarter or by breaching a specific target in 3 consecutive quarters. The trust has not scored more than 4 in any quarter and is not declaring a risk that it will. The Trust has not breached any target for 3 consecutive quarters. If the Referral to treatment time, 18 weeks in aggregate, admitted patients target is breached in Q1 2014/15 then this target will have been breached for 3 consecutive quarters.

The Governance Rating for Q3 was Green: No evident concerns.

6. For Otherwise the declaration “The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 21“ is **confirmed.**

7. The Board asked to **NOTE** the contents of the schedules and **APPROVE** that the above declarations should be made to Monitor.

QUEEN VICTORIA HOSPITAL NHS FT
Self Certification Framework

NHS Foundation Trusts must confirm compliance with their Authorisation in relation to the items on this list. Items have been included, for instance regarding clinical quality, to ensure that the Board of Directors can track the quality performance of the Trust on clearly identified performance metrics

FOR 3 MONTH PERIOD - January 2014 – March 2014

LEAD	ITEM COVERED BY SELF CERTIFICATION	SOURCE OF ASSURANCE [To avoid duplication, the overarching Assurance Framework supports this document]	GAPS IN ASSURANCE (Y/N)	Latest Evidence for Quarterly Declaration
	Finance			
• The Board anticipates that the Trust will continue to maintain a financial risk rating of at least 3 over the next twelve months • The board is satisfied that the Trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.				
RH	Financial performance this year	Finance reports to each Board	**N**	Finance reports to Board in January, February and March 2014. Subsequent action plan meetings with Chair and NED. Additional financial performance meetings to monitor impact of controls whilst off plan.
RH	Planned future financial performance demonstrates going concern basis	Business Planning process, including reports to Board	**N**	Board budget workshops held in December, January and February 2014. Budget approved by Board March 2014 Annual Plan to Monitor shows 2 year position to 15/16.
RH	Issues raised by external auditors/assessors resolved or are being resolved in a timely manner	i) Standing item at Audit Committee ii)Auditors' Report iii) Recommendation Follow up covered at each Audit Committee	**N**	Audit Committee minutes, last meeting March 2014. KPMG audit report Head of Internal Audit opinion.
RH	Audit Committee recommendations implemented	i) See above ii) Minutes and actions reviewed at each Audit Committee and copied to Board	**N**	Audit Committee minutes, last meeting March 2014. KPMG audit report. Head of Internal Audit opinion.
RH	Processes able to deliver annual plan for the next three	i) Performance framework in place ii) Finance & performance reports to every Board with activity	**N**	Annual Plan approved March

	years	against the plan monitored ii) Regular reporting of the financial position to the Clinical Cabinet and Senior Managers Meeting, in addition to a monthly Business Review meeting with the Chief Executive to manage the delivery of the plan iii) Clinical Directorates and other departments involved in annual planning to improve process iv) Business Plan approved by Board v) Annual Plan discussed and agreed with Monitor		2014. 14/15 Business Plan discussions October 2013 to March 2014 Finance, performance and quality reports monthly Annual Plan submitted to Monitor. Minor questions received so far, await fuller response.
AP	Key risks identified, analysed and addressed (1B: Is the board sufficiently aware of potential risks to quality? - MQGF)	i) Risk Register populated within Clinical Directorates and by Risk Management Team. ii) Reviewed at Clinical Directorate meetings and organisationally at the Quality & Risk Committee which is chaired by a non-executive director. iii) Exception report at each Board meeting iv) Level 1 NHSLA v) Business Continuity Plan aligned to BS25999 vi) Board Assurance Framework to BoD vii) Quarterly Quality & Risk Committee – minutes to BoD viii) Risk Management Strategy approved by Board ix) Emergency Plan approved by Board Compliant with annual emergency / business continuity testing requirements	**N**	Risk register to Board Minutes directorate meetings Quality and Risk paper to Board. Plans in place and routinely updated and tested. Testing programme in place.
	Performance (targets) • The Board confirms that all targets and indicators have been met (after application of thresholds) over the period and that sufficient plans are in place to ensure that all known targets and indicators which will come into force during 2011-12 will also be met.			
	Trust achieving all targets ands indicators	Performance targets covered in monthly Board report	**N**	Issues in service line compliance noted and action plans in place (Monthly Board papers) Q3 return rated Green by Monitor.
	Quality • The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patters of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. • The Board is satisfied that, having used its own processes and having assessed against Monitor's Quality Governance Framework (supported by relevant information from the Trust and third parties such as the Care Quality Commission), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. • The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.			

AP	Monitor's Quality Framework objectives (1A: Does quality drive the trust's strategy? - MQGF) (3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? - MQGF)	i) KSO 1 ii) Board briefed on quality initiatives - CQUINS iii) Nursing Strategy released Nov 10 Vision iv) Care Quality Commission QRPs v) Ongoing audit and inspection vi) Trust uses risk management knowledge to mitigate risks and improve quality (complaints/claims/incidents etc) vii) Policy on responses to national guidance/findings in place. Would include Healthcare Commission reports, NICE guidelines etc viii) Pro-active and continuous corporate learning from complaints and patient experience generally (via PALS Co-ordinator) with Executive Director and Chief Executive involvement in handling responses. ix) Clinical Governance & Quality Annual Report to Q&R Committee and on to Board annually x) Child Protection Annual Report to BoD annually xi) Quality Accounts published annually xii) Corporate objectives, purpose, mission and vision reviewed as part of Business Plan annually xiii) Director of Nursing & Quality in post xiv) CQC inspections	**N**	Quality & Risk Board paper monthly CQUINs update October 2013 Q&R confirmed monthly to the Board IPACT reports to Board Risks › to Board each month QA to Board May 2013, Q2 update to Board October 2013. CQC unannounced visit September 2013 gave full assurance.
AP	Metrics identified to monitor quality in terms of clinical outcomes, patient/service user safety and experience, and the expected levels of performance	i) Clinical Indicators developed and reported on. ii) Claims, Complaints and Compliments reported on iii) Quality Accounts	**N**	Monthly board report Monthly board report
AP	Compliance with relevant legislation: Code of Practice for the Prevention and Control of Health Care Associated Infections – the Hygiene Code	i) Annual Core Standards assurance processes in place ii) Action plan for Hygiene Code with evidence iii) DIPC report to Board iv) DIPC Annual Report to BoD iv) Saving Lives Campaign v) Monthly report to Board from Matrons and clinicians vi) CQC Infection control inspection January 2011 vii) Registration with Care Quality Commission viii) Board walkabouts commenced to ensure ward to Board information	**N**	1. Feb Board report 2. ICC committee reviewed 3. Monthly report to Board 4 Audits reported within monthly board report
AP/HB	Systems to monitor and report on improving cleanliness	i) PEAT action plan and 'mini' PEATs conducted throughout year ii) Visits by Governors iii) Annual PEAT inspection v) Environmental Risk & Hygiene Compliance Group	**N**	IPC reports Patient Experience reports
AP	Demonstrate learning from Patient Surveys (3C: Does the board actively engage patients, staff and other key stakeholders on quality? - MQGF)	i) Action plan generated and incorporating verbatim comments from survey responses ii) PALS / Patient Experience reports to PPI Committee and Clinical Governance & Quality Committee iii) PPI Strategy iv) National surveys inpatients/outpatients/cancer v) Family and friends test	**N**	Within Q&R monthly board report National Inpatient Survey Board report Feb 2013 Family and friends test results provided each month.
AP	Establish and develop procedures to review and challenge performance on an ongoing basis (4A: Is appropriate quality information being analysed and	i) Regular executive led performance reviews based around Quality & Risk Committee and sub committees eg Infection Control Committee, Medicines Management Committee, PPI Committee, Clinical Policy Committee, Audit	**N**	Q&R minutes to board. Service line activity with monthly

	challenged? - MQGF)	Committee, Health & Safety Committee ii) Board agenda has separate section for "Clinical Quality & Service Performance" with standing items being discussed by Board, including DIPC reports iii) Quality & Risk Committee reports to Board and led by NED iv)Governance and Management reporting structures in place v) Service Line reports developed for each area		board report
AP	Maintain a programme of internal audit review that supports the self certification process (4.B: Is the board assured of the robustness of the quality information? - MQGF) (4C: Is quality information used effectively? - MQGF)	i) Self certification framework ii) Monitored by Audit Committee/internal audit	**N**	Internal Audit programme agreed for 2013/14. Audit Committee minutes

Governance

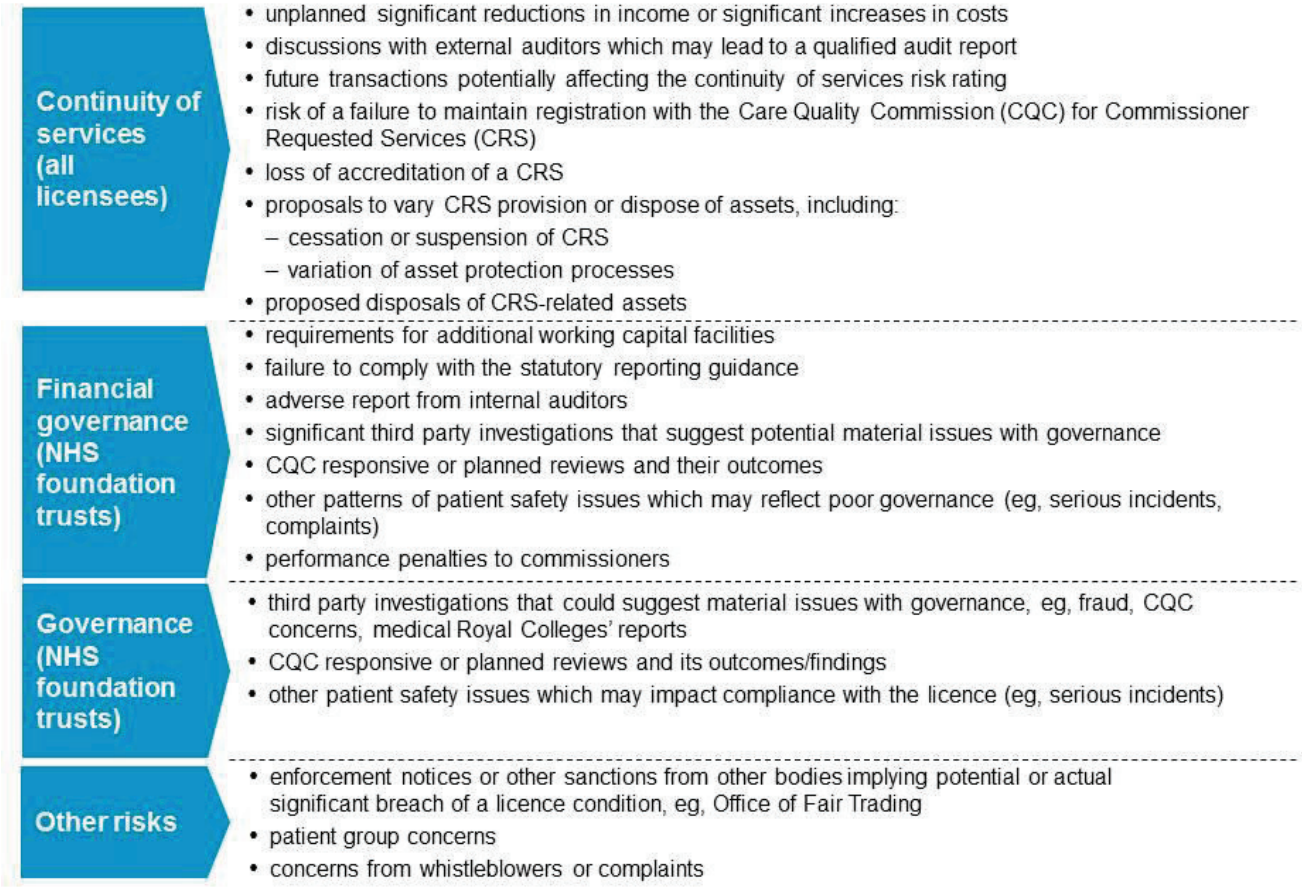
- The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.
- An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).
- The Board will ensure that the Trust remains at all times compliant with its terms of authorisation and has regard to the NHS Constitution.
- All current key risks to compliance with the Trust's Authorisation have been identified (raised either internally or by external audit and assessment bodies) and addressed in a timely manner.
- The Board has considered all likely future risks to compliance with its Authorisation and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.
- The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.
- The Board is satisfied that the management team has the capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.
- The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations are implemented satisfactorily to the Board.
- The Board will ensure that the Trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; that all Board positions are filled, with plans in place to fill any vacancies; and that all elections to the Board of Governors are held in accordance with the election rules.

AB	Annual Governance Statement in place and the Trust compliant with guidance from Treasury/DH/ Monitor	i) SIC in place and compliant with guidance	**N**	Annual Governance Statement in 12/13 Accounts.
KD	Register of conflicts maintained and no material conflicts	i) Maintained for Board of Directors, Board of Governors and all staff. (September 2010 e-mail to BoD/BoG refers). ii) Included on Board agenda (and other committees) iii) Weekly Briefing item 18/1/08 remind staff re declarations of interest plus sponsorship, gifts and hospitality registers iii) Included at induction	**N**	New Governors info added in January 2012
PG/AB	Directors qualified to discharge board functions, including setting strategy, monitoring and managing performance and ensuring management capacity and capability	i) Board effectiveness review undertaking annually and monitored by Nomination & Remuneration Committee ii) Yearly appraisal of NEDs by Chairman ii) Yearly appraisal of NEDs by Chief Executive	**N**	Board effectiveness reviewed August 2013 Appraisals undertaken in June /

	(2B: Does the board promote a quality focused culture throughout the trust? – MQGF)			July 2013.2012.
PG/AB	Selection and training in place	i) Individual board member development opportunities identified at yearly appraisal ii) Board development identified by Nomination & Remuneration Committee following effectiveness review and incorporating monthly feedback following each Board.	**N**	Appraisals undertaken Board effectiveness review completed August 2013.
AB	Management team has experience to deliver annual plan and deliver corporate objectives (2A: Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? - MQGF)	See above	**N**	Performance tracked through monthly Board reports
AB	Management structure can deliver forward plan (3A: Are there clear roles and accountabilities in relation to quality governance? – MQGF)	i) Responsibility of Chief Executive ii) Executive team recruitment complete iii) Management structure realignment following corporate restructuring almost complete	**N**	New CEO commenced July 2013. NED recruitment completed and commenced October 2013.
	EXCEPTION REPORTING REQUIRED			
	Finance			
RH	Unplanned significant reduction(s) in income or significant increase(s) in costs	i) Finance & Performance report a standing item on Board agenda, monitoring activity against plan ii) Monitored also by Clinical Cabinet and Weekly Business Review Meetings iii) Service Line and Off Site reporting increasingly detailed	**N**	Monthly Board reports Service Line reports produced monthly
RH	Requirement for working capital in breach of Prudential Borrowing Limit	i) Finance & Performance reports to Board ii) Robust financial processes	**N**	Working capital loan not required
RH	Failure to comply with the NHS FT Accounting and Reporting Manual (FT ARM)	i) Monitored by Audit Committee and internal/external audit ii) Attendance at annual updates held by external audit/Monitor	**N**	Audit Committee minutes May 2013
RH	Discussions with external auditors which may lead to a qualified audit report	i) Audit Committee discussion ii) Additional meetings held with Chair of Audit Committee / Director of Finance / external audit partner, as required. Iii) 2011/12 Accounts given unqualified report	**N**	Audit Committee May 2013
AB/KD	**Governance** Events suggesting material issues with governance processes and structures eg	i) Established Governance and Management reporting structures in place	**N**	No issues identified
PG/AB	Removal of Director(s) for abuse of office	i) Declaration of interests process in place and promoted via each Board agenda and weekly briefing ii) Weekly meetings between Chief Executive/Executive Directors	**N**	No issues identified
AB	Significant non contractual dispute with NHS body	i) Regular meetings with NHS stakeholders ii) Legal support now formally appointed with regular client care meetings iii) Good communication links	**N**	No issues identified
AB	Relevant third party investigations eg fraud, Healthcare Commission reports of “significant failings”	i) Regular meetings with LCFS / Director of Finance ii) Any incidents requiring LCFS investigation, reported to Audit Committee	**N**	Audit Committee updated June 2013.

		iii) Policy on responses to national guidance/findings in place. Would include Healthcare Commission reports, NICE guidelines etc iv) CQC unannounced visit re Dignity and Nutrition gave very positive feedback, discussed at Board June 2011		
	Mandatory Services			
AB	Proposals to vary mandatory service provision or dispose of assets	i) Would be raised when service redesign is planned ii) Discussed with Relationship Manager (Monitor) at Quarterly reviews by Director of Finance and Chief Executive	**N**	No current issues identified
AB	Loss of accreditation of a mandatory service	i) Finance & Performance Reports to Board ii) Would discuss with Monitor	**N**	No current issues identified
	Other			
RH	Explanations for qualified or missing self-certifications for any item above	i) Self certification framework	**N**	No current issues identified
AB	Breach of any authorisation requirement	i) See Above ii) Regular reporting to Board	**N**	No current issues identified

Diagram 6: Examples of exception reporting



Actions on receiving an exception report

On receiving an exception report, Monitor may require additional information from the licence holder to assess the effect on compliance with its licence. Where the exception represents a material risk to the licence holder's ability to carry on as a going concern, Monitor will consider applying an override to the licence holder's continuity of services risk rating (see Chapter 3).

Reporting transactions and other exceptional financial events

Licence holders should report to Monitor details of:

- any planned UK health care investments or other transactions worth more than 10% of their assets, revenue or capital; and
- any planned changes in capital structure representing a change of more than 10% in their capital employed over a 12-month period.

On receiving these reports, we may conduct our own risk assessment of the transaction. The level of scrutiny will be proportionate to: the nature and volume of

Table 2: targets and indicators with thresholds for 2013/14

Area		Indicator	Threshold (A)	Weighting (B)	Monitoring Period
Access	1	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted **(C)**	90%	1.0	Quarterly
	2	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted **(C)**	95%	1.0	Quarterly
	3	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway **(C)**	92%	1.0	Quarterly
	4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge **(D)**	95%	1.0	Quarterly
	5	All cancers: 62-day wait for first treatment **(E)** from:			
		urgent GP referral for suspected cancer	85%	1.0	Quarterly
		NHS Cancer Screening Service referral	90%		
	6	All cancers: 31-day wait for second or subsequent treatment **(F)**, comprising:			
		surgery	94%	1.0	Quarterly
		anti-cancer drug treatments	98%		
		radiotherapy	94%		
	7	All cancers: 31-day wait from diagnosis to first treatment **(G)**	96%	1.0	Quarterly
	8	Cancer: two week wait from referral to date first seen **(H)**, comprising:			
		all urgent referrals (cancer suspected)	93%	1.0	Quarterly
		for symptomatic breast patients (cancer not initially suspected)	93%		
	9	Care Programme Approach (CPA) patients **(I)**, comprising:			
		receiving follow-up contact within seven days of discharge	95%	1.0	Quarterly
		having formal review within 12 months	95%		
	10	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams **(J)**	95%	1.0	Quarterly
	11	Meeting commitment to serve new psychosis cases by early intervention teams **(K)**	95%	1.0	Quarterly
	12	Category A call – emergency response within 8 minutes **(L)**, comprising:			
		Red 1 calls	75%	1.0	Quarterly
		Red 2 calls	75%	1.0	
	13	Category A call – ambulance vehicle arrives within 19 minutes **(L)**	95%	1.0	Quarterly
Outcomes	14	Clostridium (C.) difficile – meeting the C. difficile objective **(M)**	DM*	1.0	Quarterly
	16	Minimising mental health delayed transfers of care **(N)**	≤7.5%	1.0	Quarterly
	17	Mental health data completeness: identifiers **(O)**	97%	1.0	Quarterly
	18	Mental health data completeness: outcomes for patients on CPA **(P)**	50%	1.0	Quarterly
	19	Certification against compliance with requirements regarding access to health care for people with a learning disability **(Q)**	N/A	1.0	Quarterly
	20	Data completeness: community services **(R)**, comprising:			
		referral to treatment information	50%	1.0	Quarterly
		referral information	50%		
		treatment activity information	50%		

*DM – a *de minimis* applies

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24th April 2014**
Agenda item reference no:	**094-14**
Author:	**Caroline Haynes, Deputy Head of HR and OD**
Date of report:	**4th April 2014**

EQUALITY, DIVERSITY AND HUMAN RIGHTS ANNUAL REPORT 2013

Introduction:

Under the specific duty of the Equality Act 2010, the Trust "must publish sufficient information to demonstrate that (it) has complied with the general equality duty...annally. The information to be published must include: information on the effect that (the Trust's) policies and practices have had on employees and people from the protected groups; evidence of the analysis undertaken to establish whether (its) policies and practices will (or have) furthered the three equality aims in the general equality duty; details of the information used in that analysis, and details of the engagement (it) undertook" (Equality and Human Rights Commission, 2011).

The enclosed report provides an analysis of the activities the Trust carried out in 2013 to meet the requirements of the Equality Act 2010 and sets out the objectives for 2014. It also provides an analysis of workforce information across the protected characteristics and includes detailed source data for reference.

1. Key points to note:

    - The Trust had by the end of 2013, 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. 2013 was the second year of a 3 year scheme.

    - The 2013 staff survey, which had a return rate of 61%, showed the percentage of staff experiencing discrimination at work in the last 12 months remained below the acute specialist trust average of 9%.

    - In line with last year's findings, the percentage of staff believing the trust provides equal opportunities for career progression or promotion was 92%, just above the average for acute specialist Trusts.

    - The percentage of staff having equality and diversity training in last 12 months rose by 7% to 69%, above the average for acute specialist Trusts.

    - The monitoring data showed that 4% of staff consider themselves to have a disability.

    - The Trust employs 12% BME staff, 1% less than in 2012, whilst the Mid-Sussex BME population is 5%.

    - 76% of employees are female. Although this is an over-represetnation, it is in line with other NHS organisations.

    - 35% of Trust employees are aged 51 or over, the same as in 2012.

2. The Equality, Diversity and Human Rights Steering group will lead on the key findings of the report however the Board is asked to **NOTE** its contents.

Queen Victoria Hospital NHS
NHS Foundation Trust

Equality, Diversity and Human Rights Annual Report 2013

Published April 2014

This document is available in alternative formats upon request. Please contact the HR department on 01342 414430

Introduction

The Queen Victoria Hospital NHS Foundation Trust has been publishing an annual Equality and Diversity report since 2006. The report meets the requirement to publish data across the 9 protected characteristics.

Between November 2011 and December 2012, the Trust had a Service Level Agreement (SLA) with Sussex Partnership NHS Foundation Trust to support the Trust with all aspects of Equality, Diversity and Human Rights. Since January 2014, that support is now provided by the Human Resources department working in partnership with other departments and the Trust's Equality Links.

During 2012, the Trust produced its Equality Objectives Scheme which includes an action plan. Key achievements against the action plan in 2013 and key objectives for 2014 are shown in the report.

The Queen Victoria Hospital NHS Foundation Trust is a major employer and service provider in the East Grinstead area. The Trust recognises that the preferences and choices of its patients and staff about service provision or employment at the Trust must not be disadvantaged by race, disability, gender and gender identity, age, sexual orientation, marriage and civil partnership, pregnancy and maternity, gender reassignment or by religion or belief.

There are a number of national drivers and legal imperatives that have influenced the content of this report:

- Reducing inequalities
- Meeting the legal duties imposed on all public bodies
- Monitoring requirements
- Meeting the Care Quality Commission standards, especially on governance, patient focus, accessible and responsive care
- Equality and Human Rights Commission (EHRC) Codes of Practice (and codes issued by predecessor organisations)
- Monitor
- The NHS Equality Delivery System
- Equality Act 2010
- CQUINN
- Friends and Family patient experience test

Over the last few years, the NHS and the Trust have been operating in a less financially secure environment. Changes to the NHS architecture offer new challenges for the Trust; however as a public institution it will continue to screen for any negative outcome of any decisions which could unfairly affect any particular group of patient, patient relative, carer, employee or volunteer. The Trust will ensure that it meets the requirements of the Equality Act 2010.

This report summarises extensive data analysis, indicating points of progress and enabling the Trust to identify and respond to key challenges. It demonstrates that the Trust views Equality, Diversity and Human Rights as core to its mission and key to its future business success and is deemed to meet the requirements of the Equality Act 2010 Public Sector Duties with regards to the publication of information and key outcomes over the past 12 months. It follows the 2012 Annual Equality and Diversity Report, published in May 2013. It covers the period between January and December 2013 and contains four parts: A review of the progress made to date, a review of the workforce information, the source data and patient information.

Contents

Part I

Review of progress to date

1. Governance and Scrutiny

1.1 Equality Objective Scheme

The scheme runs from 2012 to 2015 and describes how the Trust will fulfil its legal duties, demonstrating due regard and has a tenet beyond legal compliance to put equality at the heart of everything it does.

Our Equality Objective Scheme provides us with a unified governance structure for tackling discriminatory practice but more importantly to design in positive approaches to people in the first instance and demonstrates our commitment to the ethos of promoting equality and human rights for all.

This scheme enables us to achieve our intentions by ensuring that our policies, services and functions meet the needs of all our staff, patients and stakeholders. We are committed to ensuring quality in our service provision and to becoming a model employer.

This Scheme sets out how the Trust intends to reinforce this commitment by ensuring that Equality, Diversity and Human Rights is at the heart of its work. The scheme covers the period 1st April 2012 to 31st March 2016 and is closely linked to the way the Trust develops its business and strategic plans.

The key achievement in 2013 was the huge progress made against the Equality Objective Scheme action plan. The Trust achieved 63% of its actions and made progress towards 28% of actions (11% and 75% respectively the previous year). 2013 was the second year of a three-year plan and the Trust is therefore on track to meet the remainder of its objectives by the end of year three.

1.2 Equality, Diversity and Human Rights Steering Group

The Equality, Diversity and Human Rights steering group provides strategic direction, governance and scrutiny to the development and achievement of our Equality, Diversity and Human Rights culture in the Trust. The membership of the group includes the Executive Director and Deputy Director of Nursing and Quality, the Head and Deputy Head of Human Resources and Organisational Development, two Governors and representatives from departments across the Trust.

The role of the group is to ensure that the Trust complies with all relevant legal requirements and that we deliver our Equality and Diversity strategy (set out in the Equality Objective Scheme). The group usually meets four times a year.

Its achievements in 2013 were:

- Monitored, measured, enforced and scrutinised progress against the EOS action plan
- Kept abreast of changes to legislation, NHS guidance and case law to ensure Trust compliance
- Identified the key objectives for equality, diversity and human rights for 2014

From January 2014, the work of the Steering group will be supported by a new Equality, Diversity and Human Rights (ED&HR) Operational Group. The operational group will lead on the delivery of the EOS action plan as well as actions arising from the Staff Survey and Staff Friends and Family Test (SFFT) relating to ED&HR. There is no obligation to record monitoring information as part of the SFFT however the Trust recognises the importance of that information and monitoring questions will therefore be included in the test. It will also lead on actions arising from this report and continue to support the development of

ED&HR resources for staff. The Operational Group will be chaired jointly by the Deputy Head of HR and Deputy Director of Nursing and include a Governor and the Equality Links and will report to the Steering group.

1.3 Equality Links

The Trust historically had 15 Equality Champions across the Trust. Their role was to champion equality, diversity and human rights in clinical areas, to identify any issues and agree actions to ensure a positive approach, to undertake impact assessment and analysis and to train others to undertake impact assessment and analysis (EHRIA). In 2013, this group of staff was refreshed and developed into departmental link staff for Equality, Diversity and Human Rights. The Links have received training on equality, diversity and human rights issues to become a source of information for their department, attend the steering group meetings and help organise and participate in equality, diversity and human rights activities in the Trust. The Links have also participated in the EHRIA process, becoming a source of advice for managers undertaking EHRIAs on policies or services.

2. Workforce

2.1 Annual Staff Survey

The staff survey was completed by 61% of staff in 2013, a slight decrease from the year before.

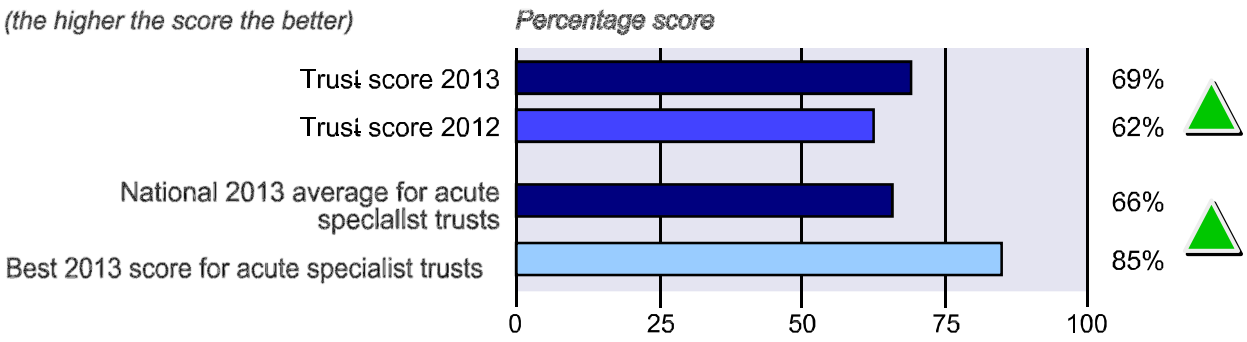
The key findings relating to Equality, Diversity and Human Rights are shown below. They show that more staff are reporting to have received ED&HR training than in 2012, and the score is higher than the average for specialist Trusts. ED&HR training is part of the Trust's statutory and mandatory training requirement and close monitoring of the compliance rate across the Trust is on-going.

There has been an increase in the number of staff believing the Trust provides equal opportunities for career progression or promotion, and the Trust remains above average.

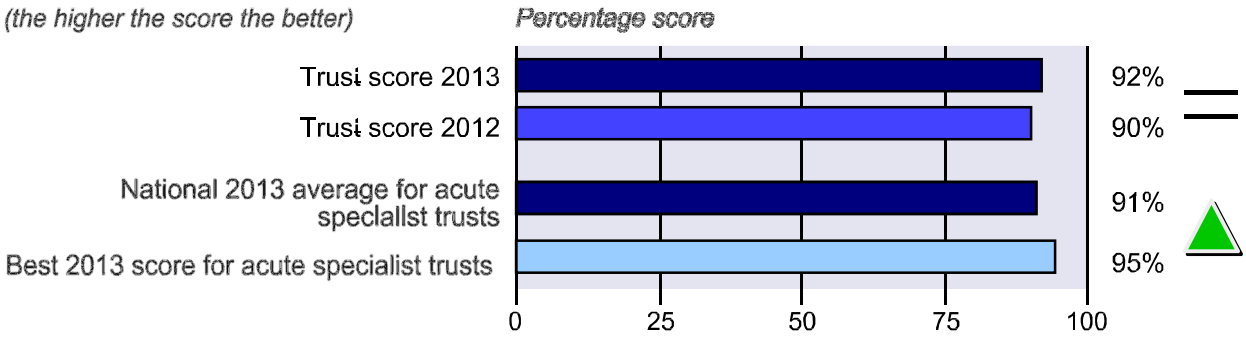
There has been a small increase in the number of staff experiencing discrimination at work in the last 12 months; however the Trust's score remains below average. Staff are encouraged to raise concerns using the relevant HR policy or through "Tell Amanda" on the Intranet.

The staff survey results are in the process of being analysed more thoroughly by the Trust and an action plan will work to address any issues identified.

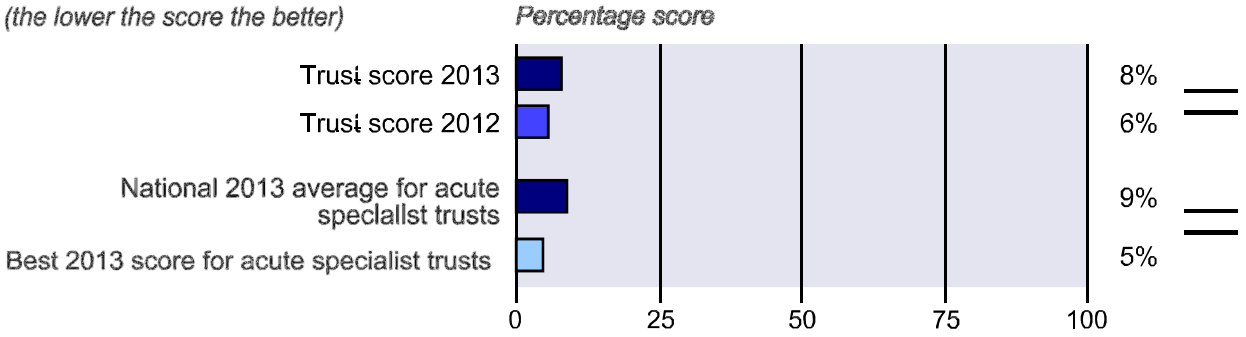
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months



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



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



2.2 Training

The Trust continues to offer face-to-face and e-learning courses on equality, diversity and human rights. 75% of staff are trained and the training is mandatory for all in line with last year's compliance rate. In addition a large number of managers have received training in EHRIA which are completed when policies are written or reviewed and when service decisions are made.

3. Trust Membership

The Trust has 9,143 public members and 760 staff members. In 2013 a new more comprehensive online membership form was launched that asks enrolling members more about their characteristics in order to comply with equality, diversity and human rights legislation.

This new form will enable us to undertake an Equality Impact Analysis of the election process and results in order to help us ensure that the makeup of the public governor body is representative of the trust, patient and local population

In April 2014, Survey monkey will be used to engage those members who have provided an email address (28%) to disclose their data across the protected characteristics in order to improve ESR data quality.

3. The Year Ahead

The Trust is continuing to work towards delivering all objectives set out in the Equality Objective Scheme action plan and further developing link staff to champion Equality, Diversity and Human Rights across the Trust and create in-house expertise. In addition in 2014:

The face-to-face training for ED&HR will be reviewed and refreshed in 2014.

The EHRIA process will be in-house and will go through approval by a panel. The panel will consist of three members including the Deputy Head of HR or the Deputy Director of Nursing, one Link and the Staff Experience Coordinator.

Findings from the Staff Survey and the new Staff Friends and Family Test, as well as findings from the Compliance in Practice Assessments will be used to identify further actions required to enhance staff and patient experience with regards to Equality, Diversity and Human Rights.

The delivery of those actions will be led by the Operational group and monitored by the Strategy group.

Finally in 2014, the Trust will start reviewing its EOS action plan and with a view to aligning it to the new NHS Equality Delivery System (EDS2).

4. Conclusion

Since the introduction of the 2010 Act, the Trust has taken steps to ensure it not only meets the requirements of the legislation but also embeds a culture of equality, diversity and human rights in all that it does.

The Trust has made significant progress towards achieving what it set out to do in the EOS action plan and is on track to deliver the rest of the action plan in time. The Trust is also using feedback from staff and patients on their experience to identify further areas of improvements so that those can also be addressed.

The Equality Objective Scheme is a statement of the Trust's commitment to Equality, Diversity and Human Rights and its action plan enable us to achieve our objectives through a structured approach.

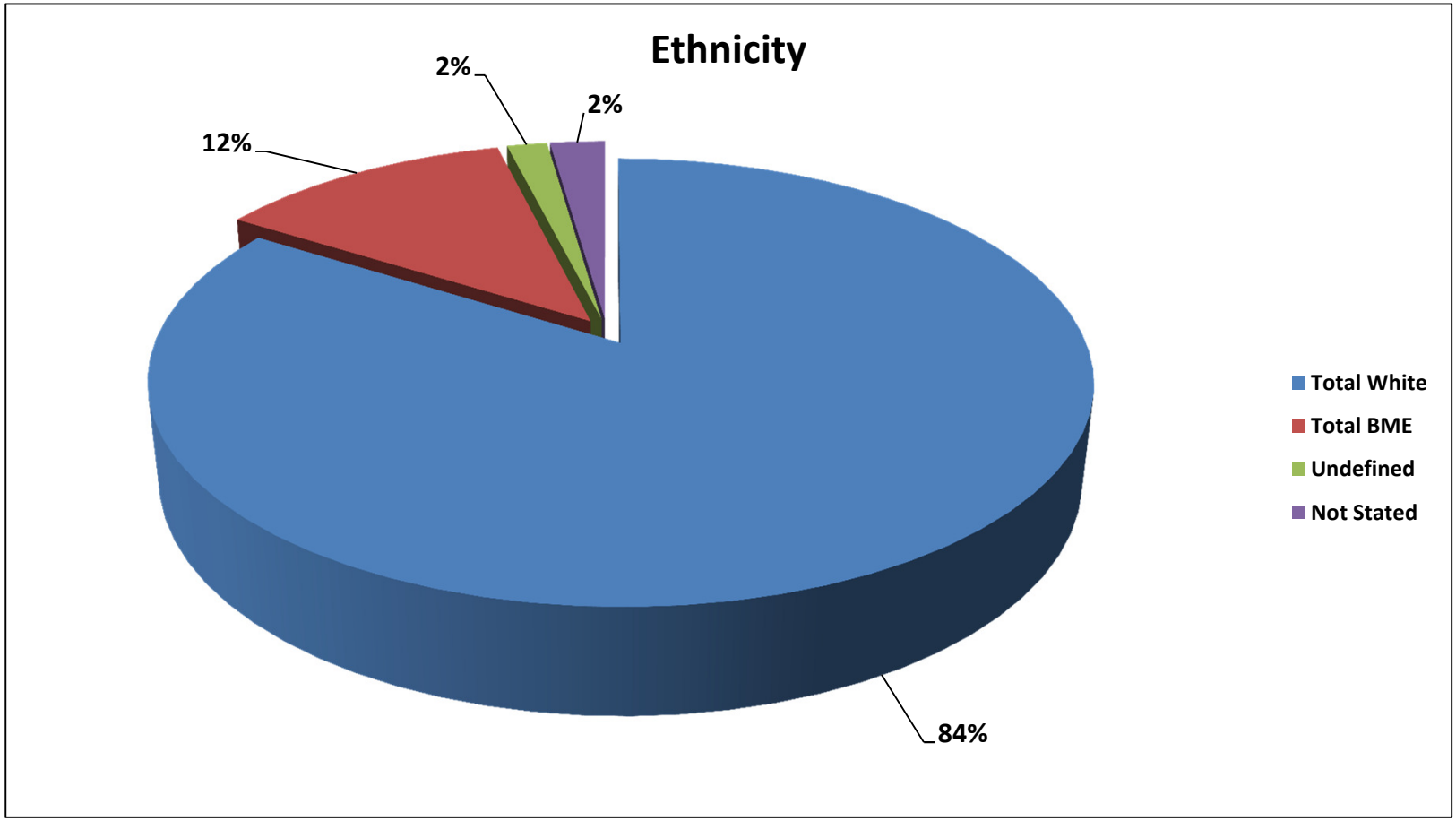
Part 2

Workforce Information

1. Workforce profile

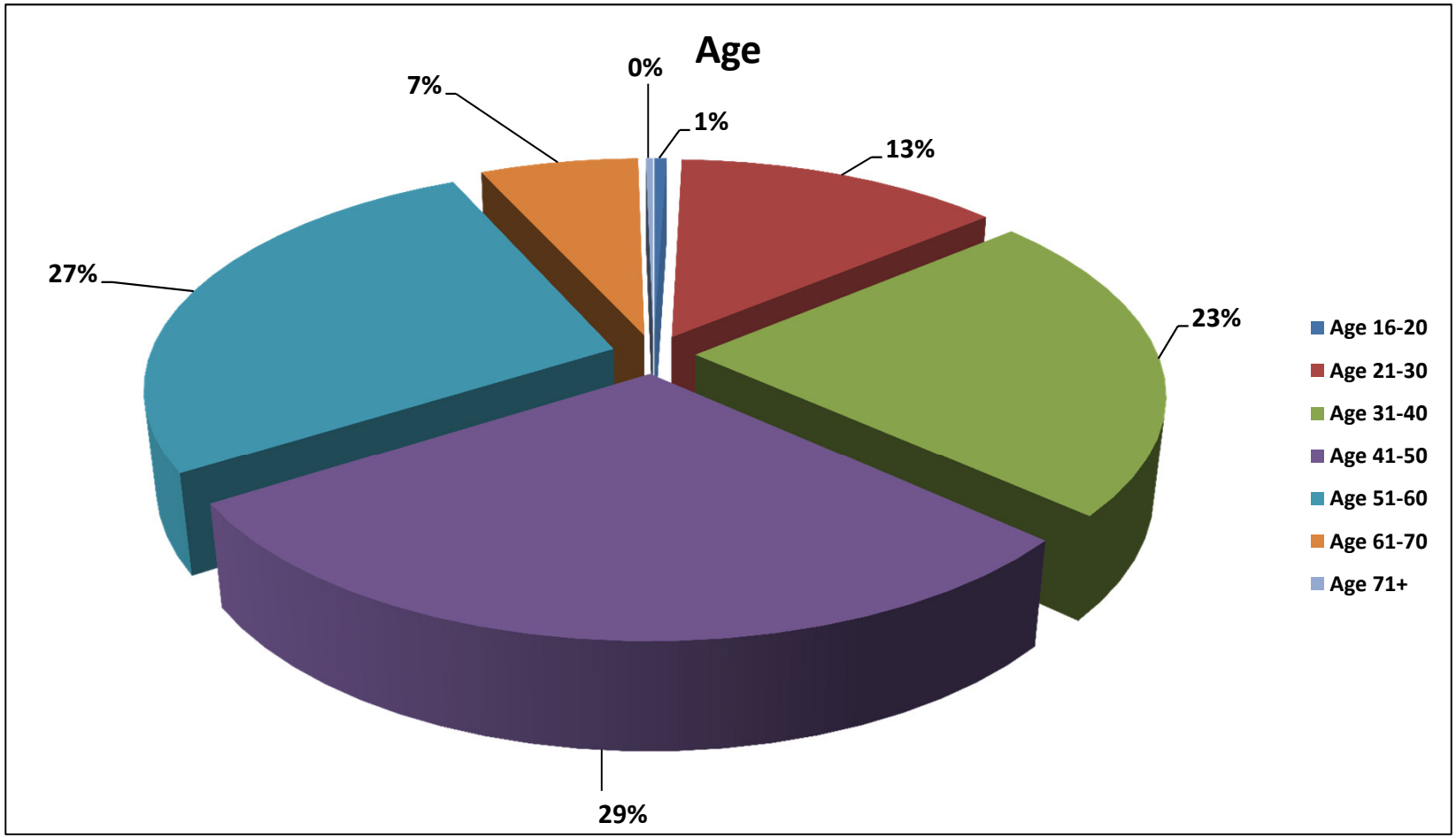
1.1 Ethnicity

The Trusts workforce profile shows that the ethnic representation is in line with the Trust population of Mid-Sussex. There is a strong representative of BME staff as the population of Mid-Sussex is 5% whilst the Trust's BME representation is currently 12%, a 1% decrease from the previous year. The Trust employs people from 40 different nationalities including British.



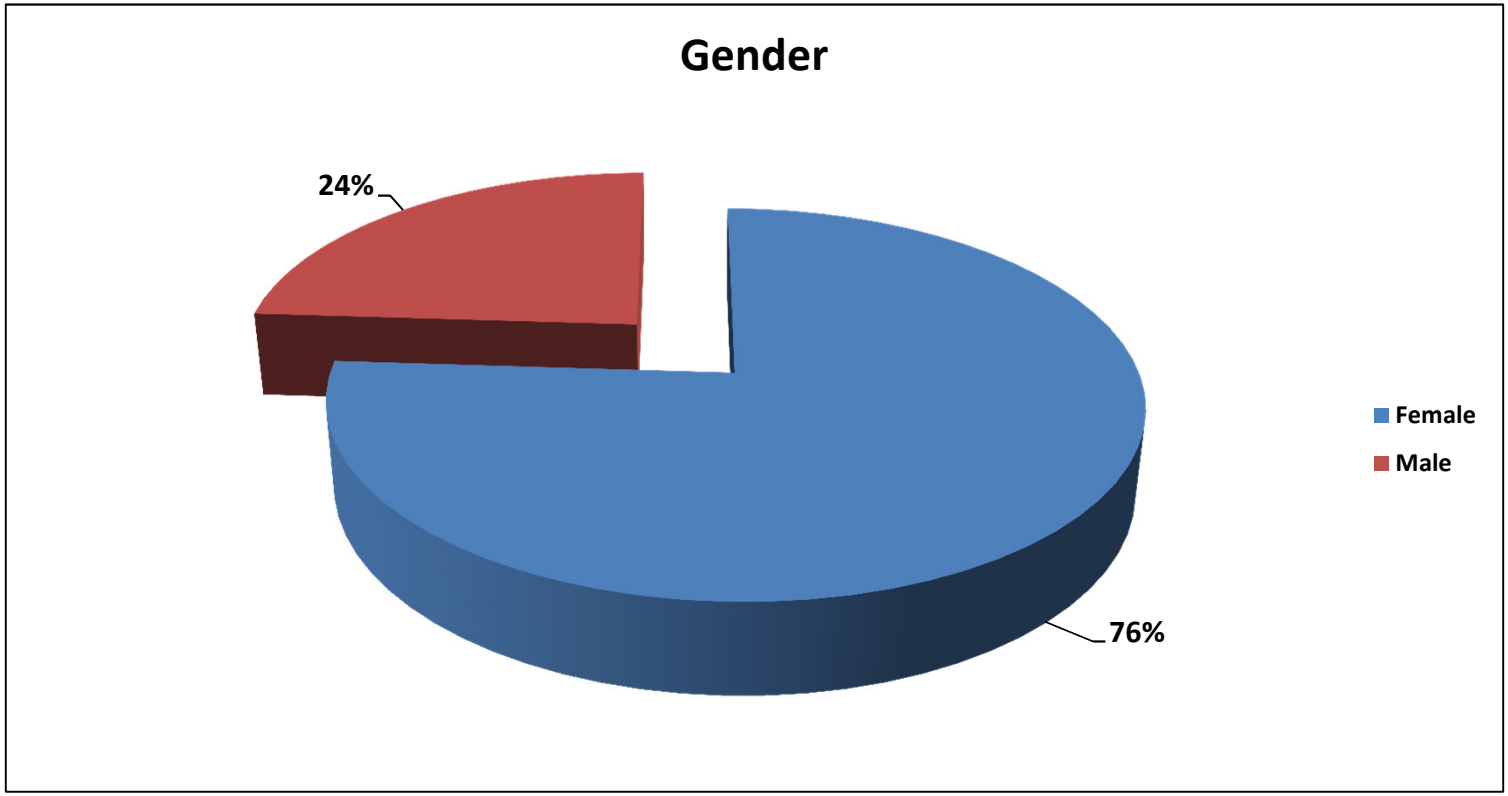
1.2 Age

There has been no significant changes in the age split from the previous year; The majority of Trust employees are aged 41-50 , this reflects the Mid-Sussex population



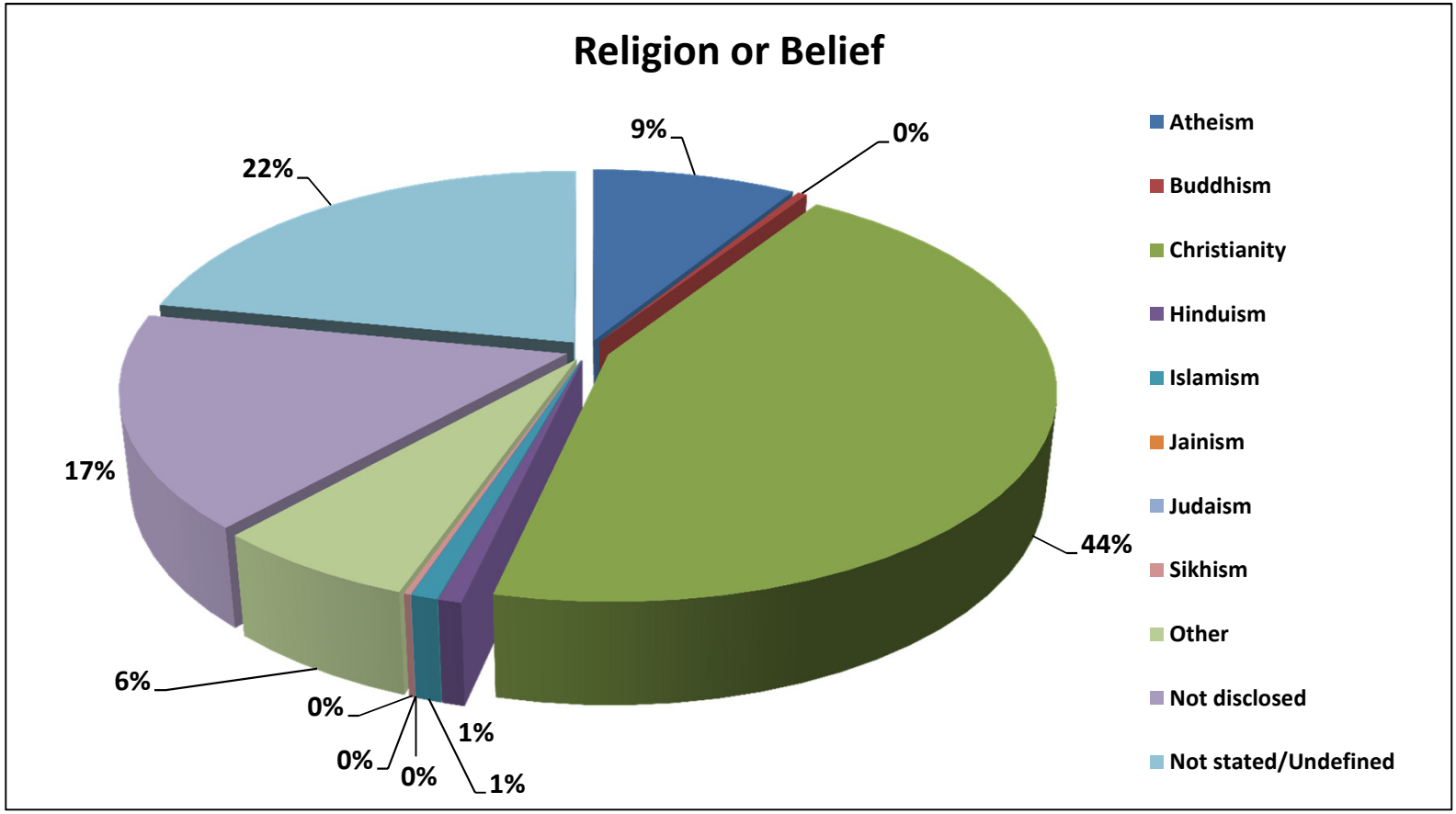
1.3 Gender

There are no changes in the gender split from the previous year; 76% of the Trust employees are female and whilst this is higher than the demographic for Mid-Sussex, this is in line with other NHS organisation.



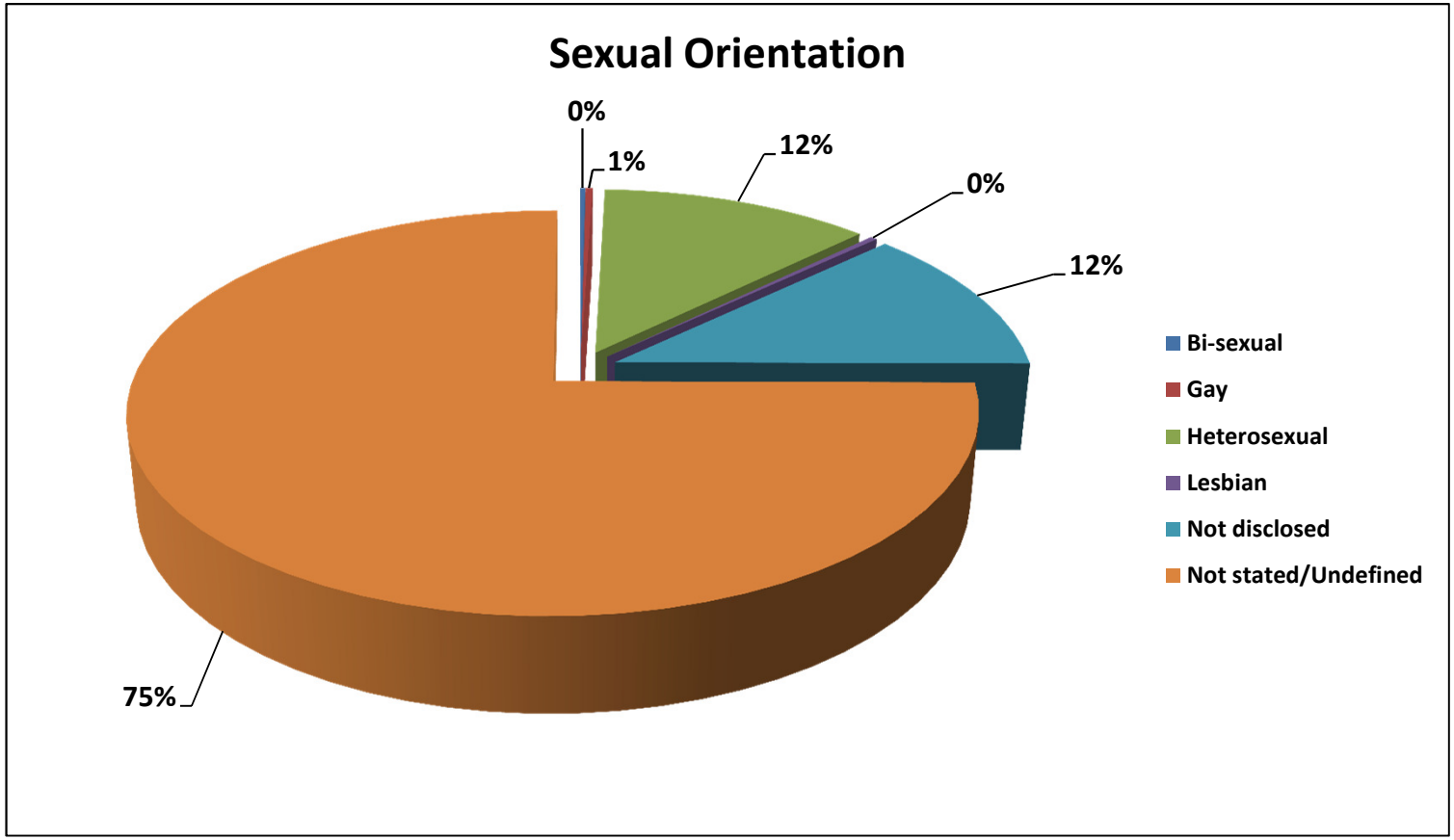
1.4 Religion and Belief

The Trusts religion and belief remains very much the same as last year; with a slight increase in the number of Christians to 44% and Atheism to 9%. This is lower than Mid-Sussex area; however it is reflective of the demographics of East Grinstead and surrounding areas.



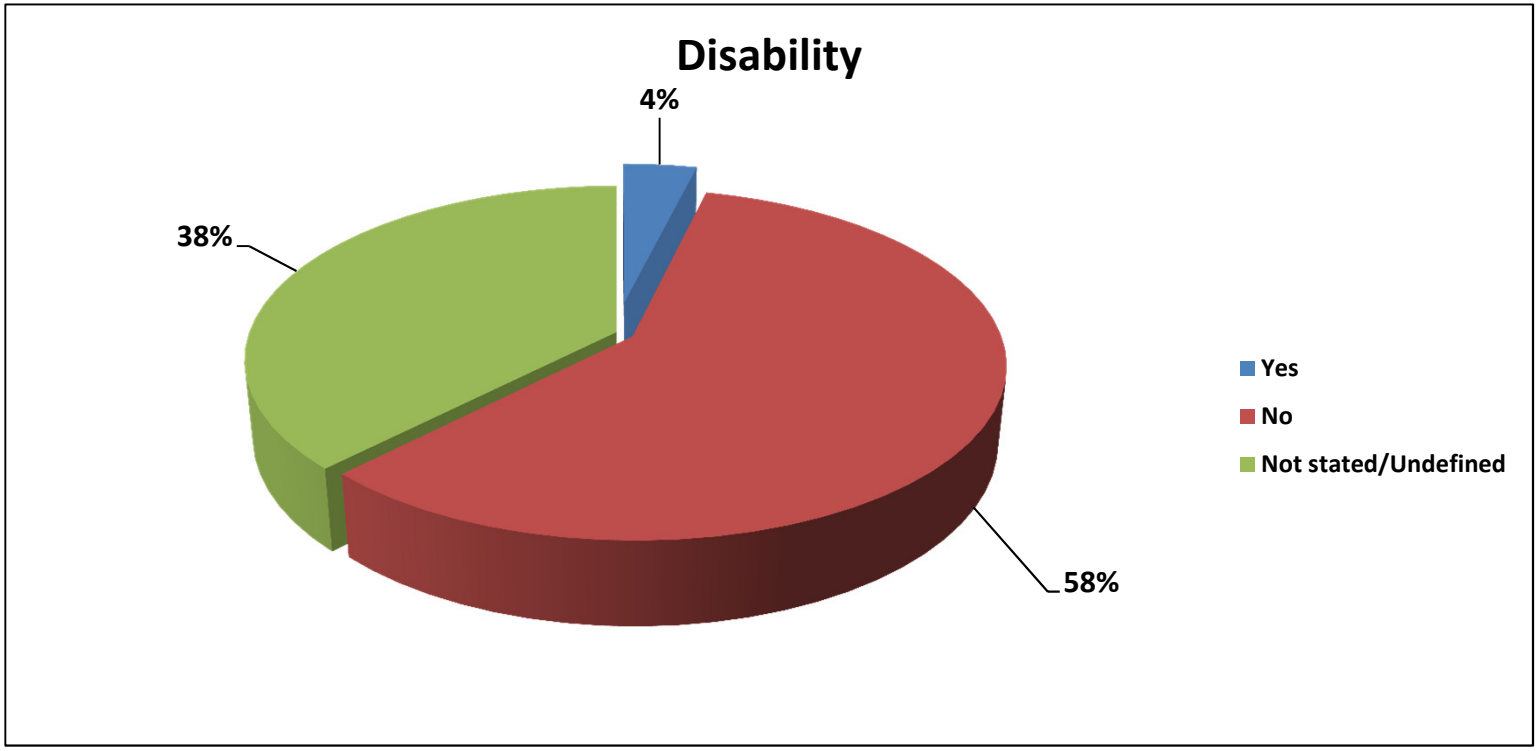
1.5 Sexual Orientation

The Trusts has seen a significant drop in the overall recording of information for sexual orientation. The census does not provided information about sexual orientation so comparison with Mid-Sussex demographics is not currently possible.



1.6 Disability

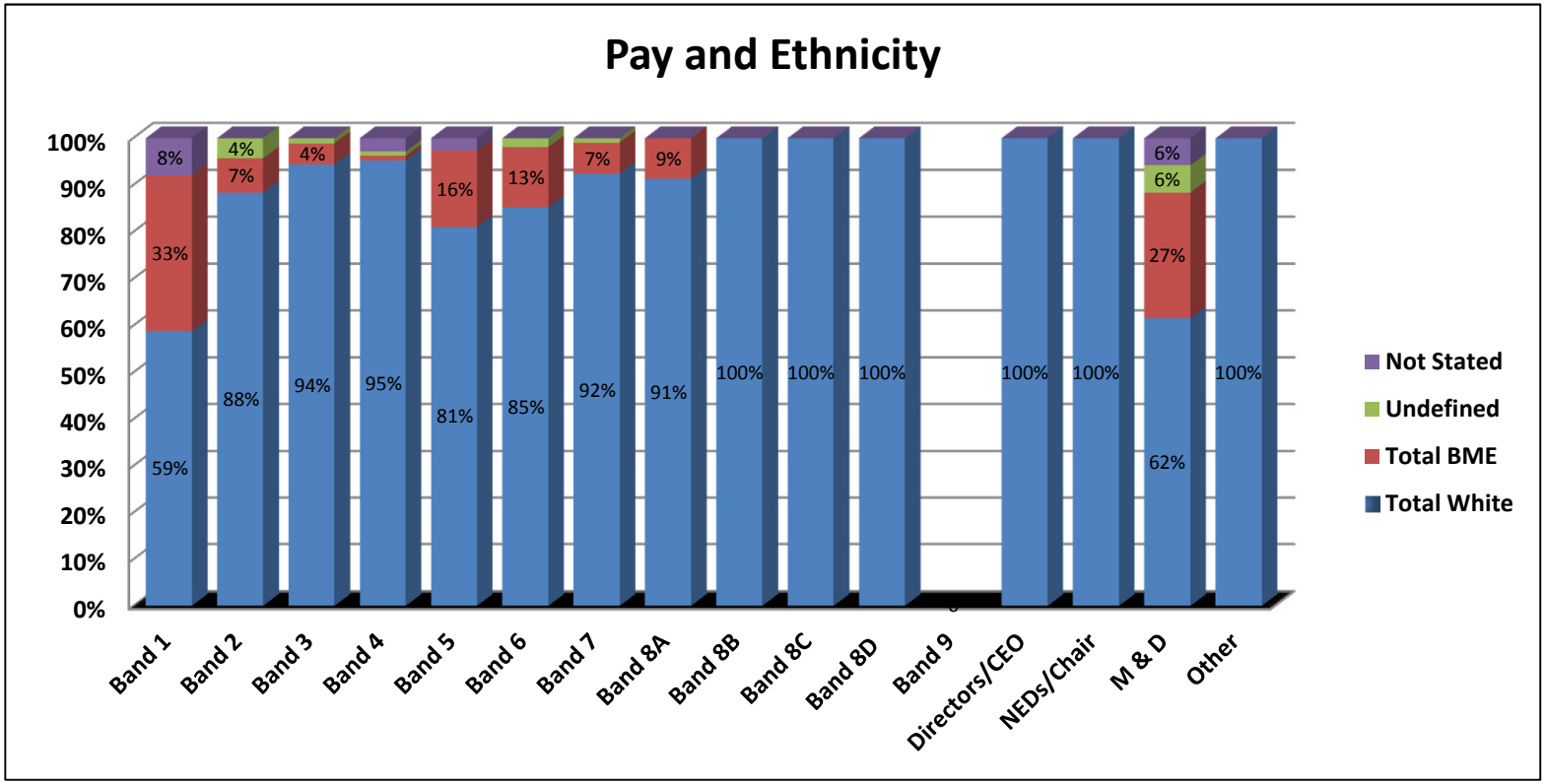
There has not been any significant changes with Disability from the previous year, with 4% of the Trust considering themselves disabled and 58% of the Trust do not. This is below the Mid-Sussex 2011 census but remains important information for the Trust when making decisions that affect staff.



2. Pay analysis by protected characteristic

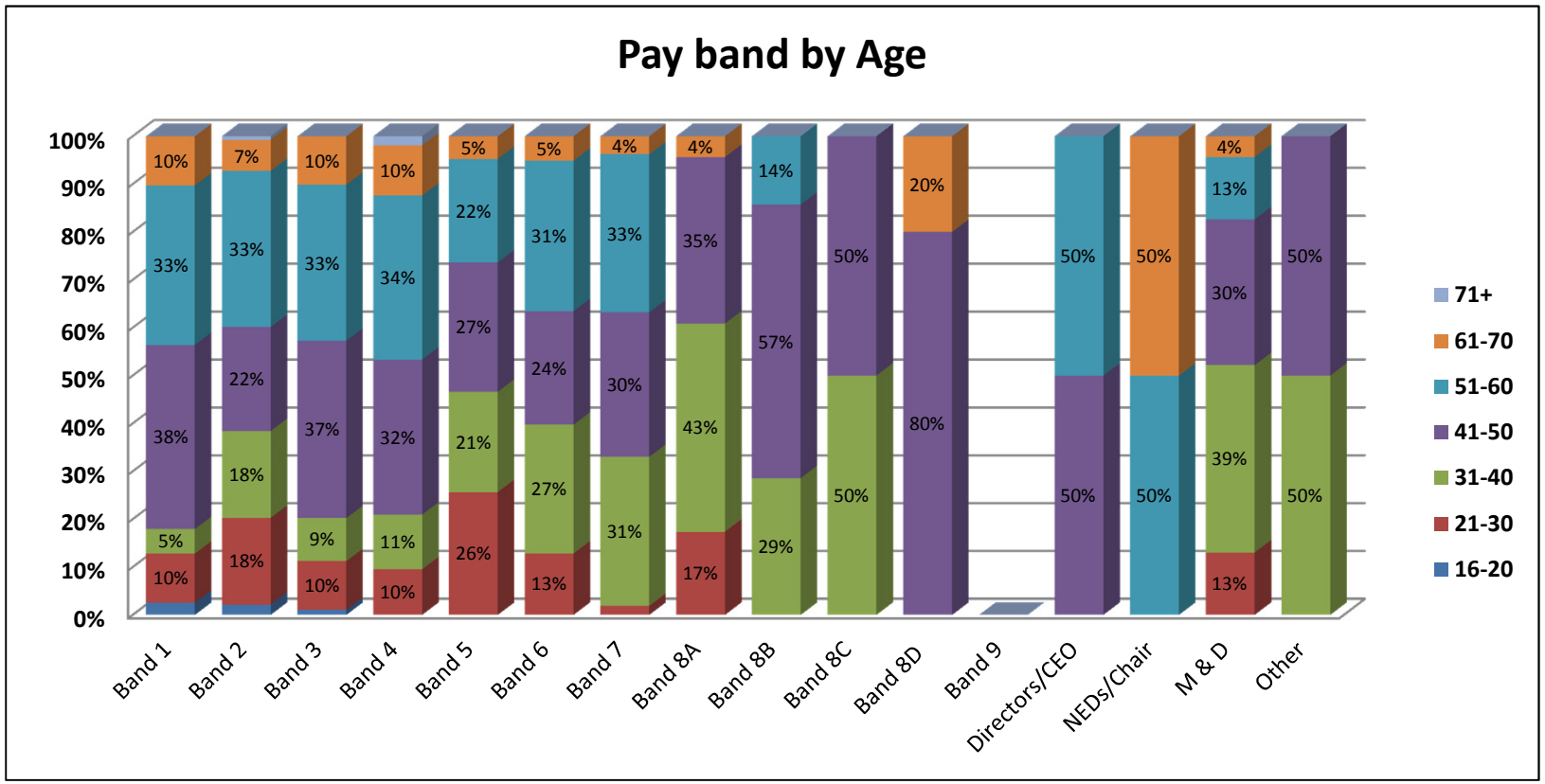
2.1 Pay and Ethnicity

There has been no real change to the BME representation across the pay band from the previous year, with the majority of staff being in Bands 1 and Medical and Dental, with further representation being in Bands 2 to 6. There is no BME representation in Bands 8b and above (14 staff) or in Other (2 staff).



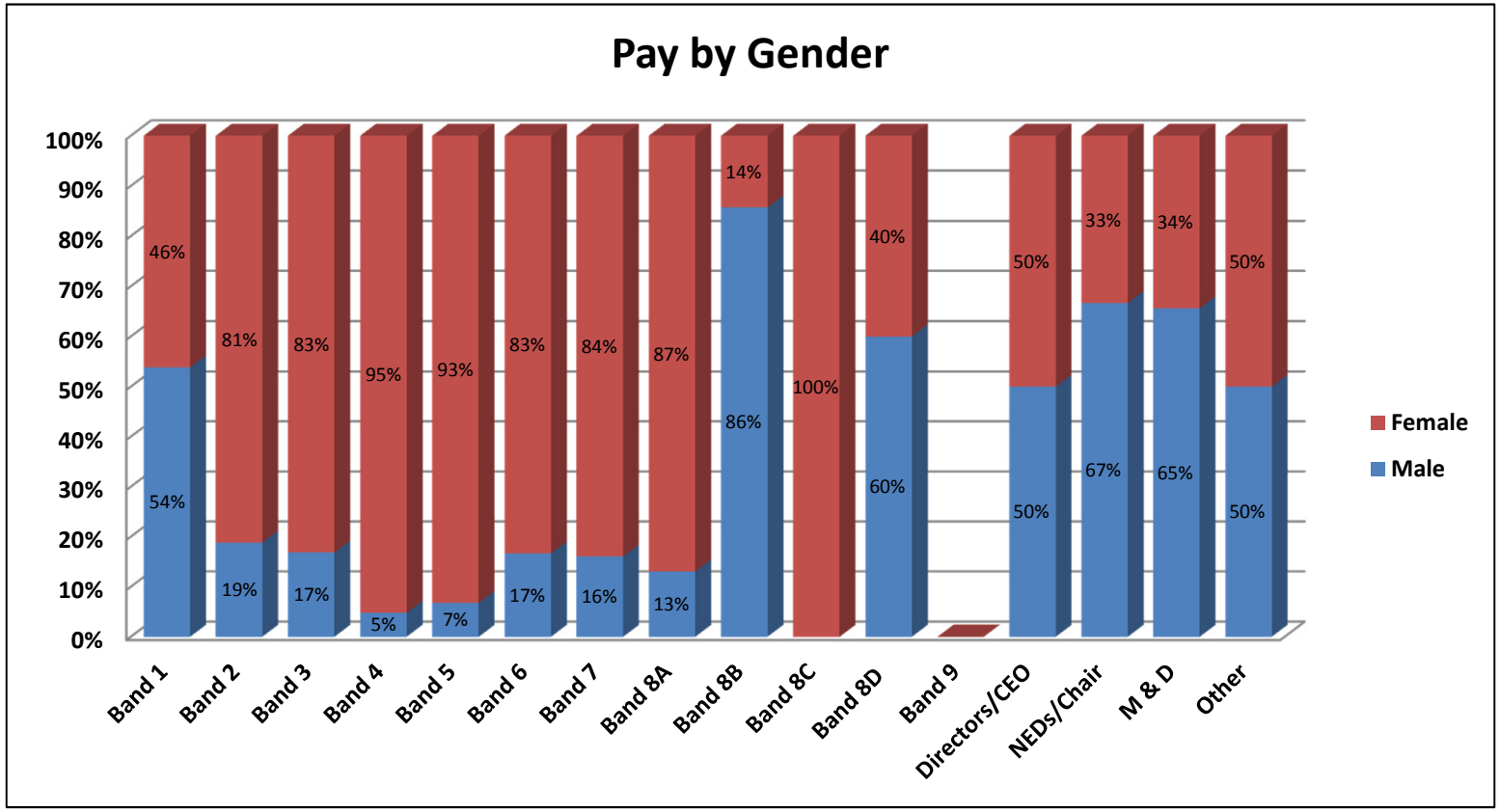
2.2 Pay and Age

The age split remains consistent across the bands, with an over representation of staff aged 41-50 in bands 8b and above.



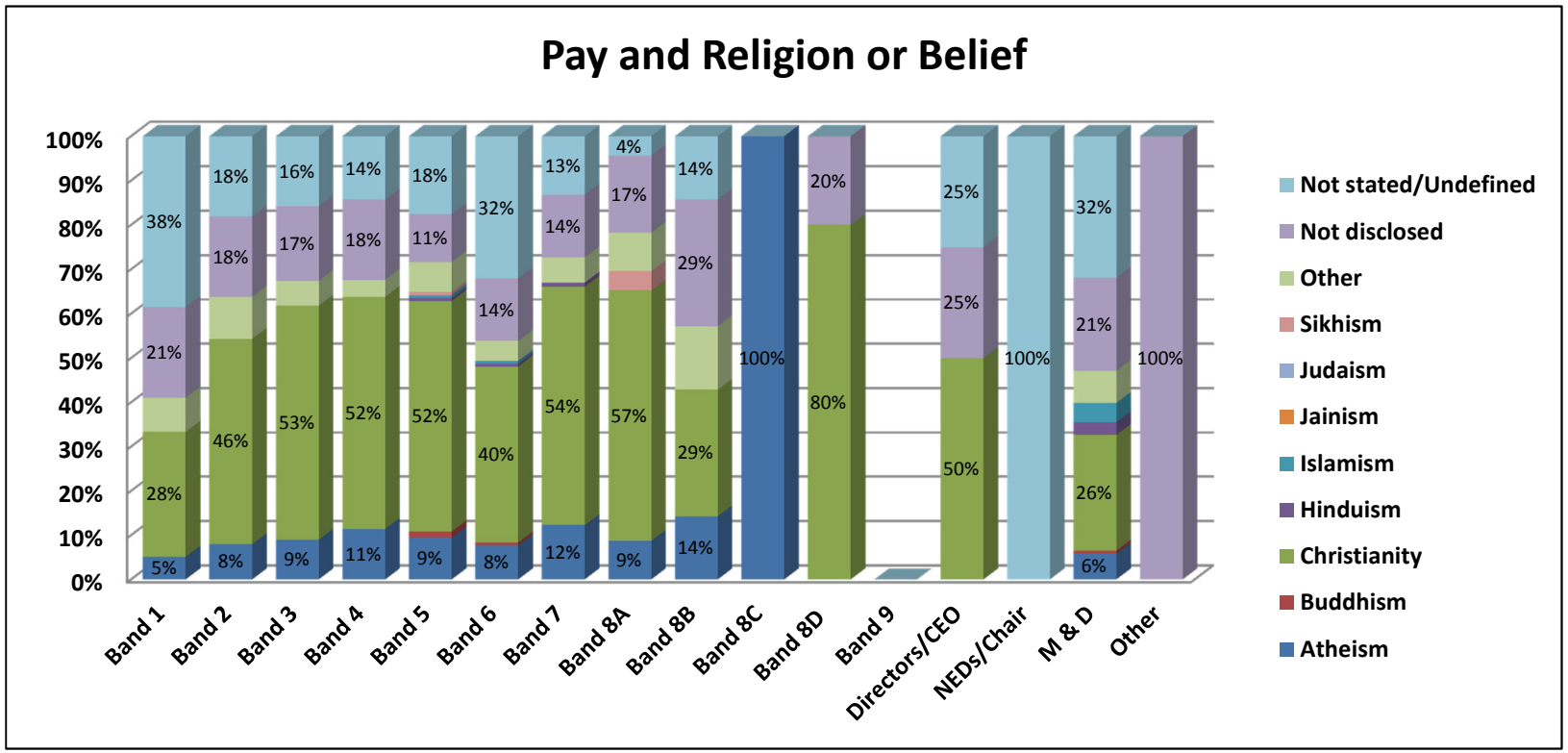
2.3 Pay and **Gender**

Pay and Gender split do not differ much from the previous year. There remains an over representation of male staff in Bands 1 and 8b and an under representation in bands 2 to 8a. There is also an over representation of male staff in Medical and Dental and more senior roles, which is consistent with other NHS organisations.



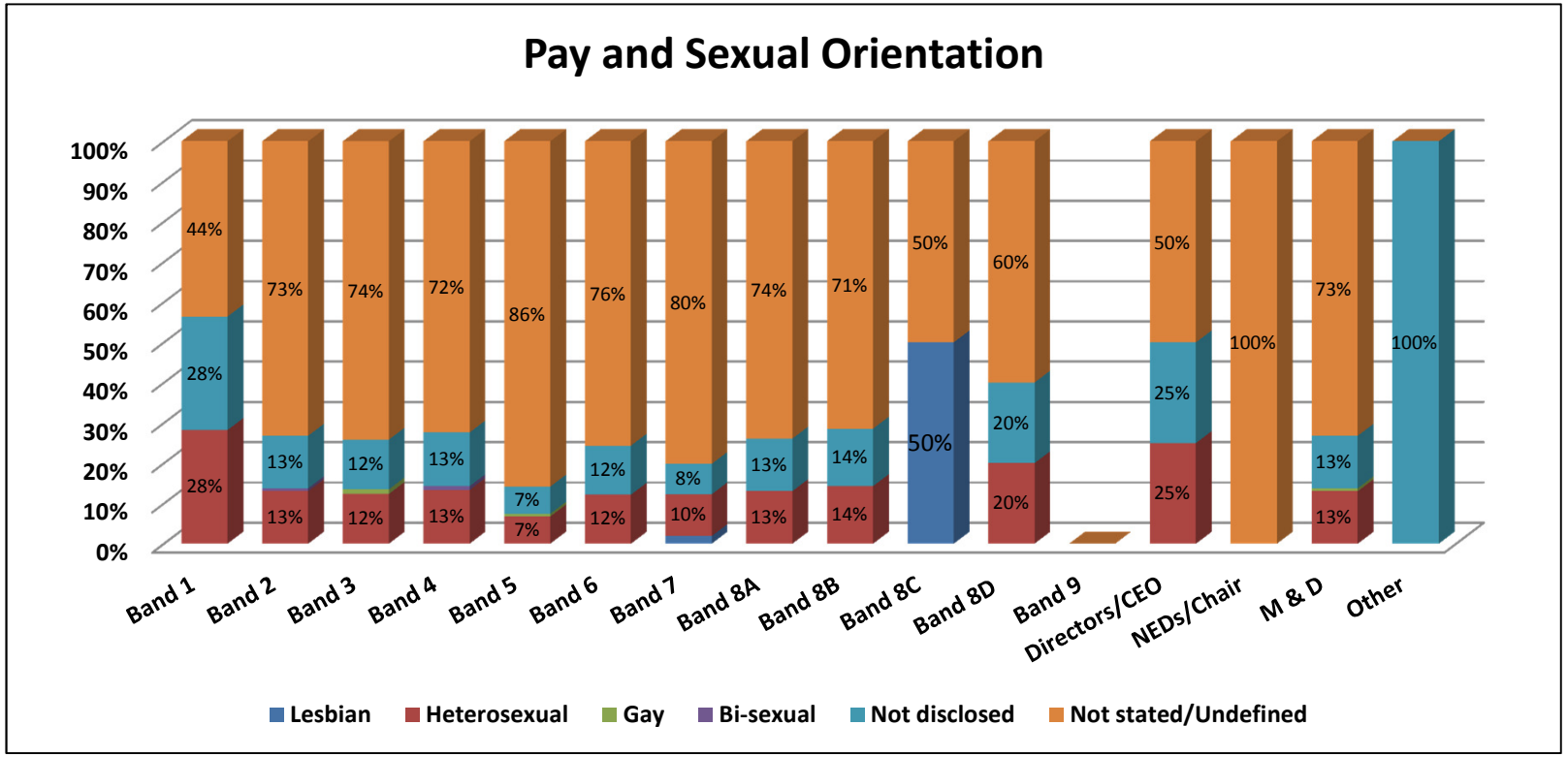
2.4 Pay and Religion or belief

There is a higher representative of Christianity recorded over the majority of the pay bands. This is representative of the demographics of the area, and with no data being recorded for Non-Executive Directors/Chair and Other.



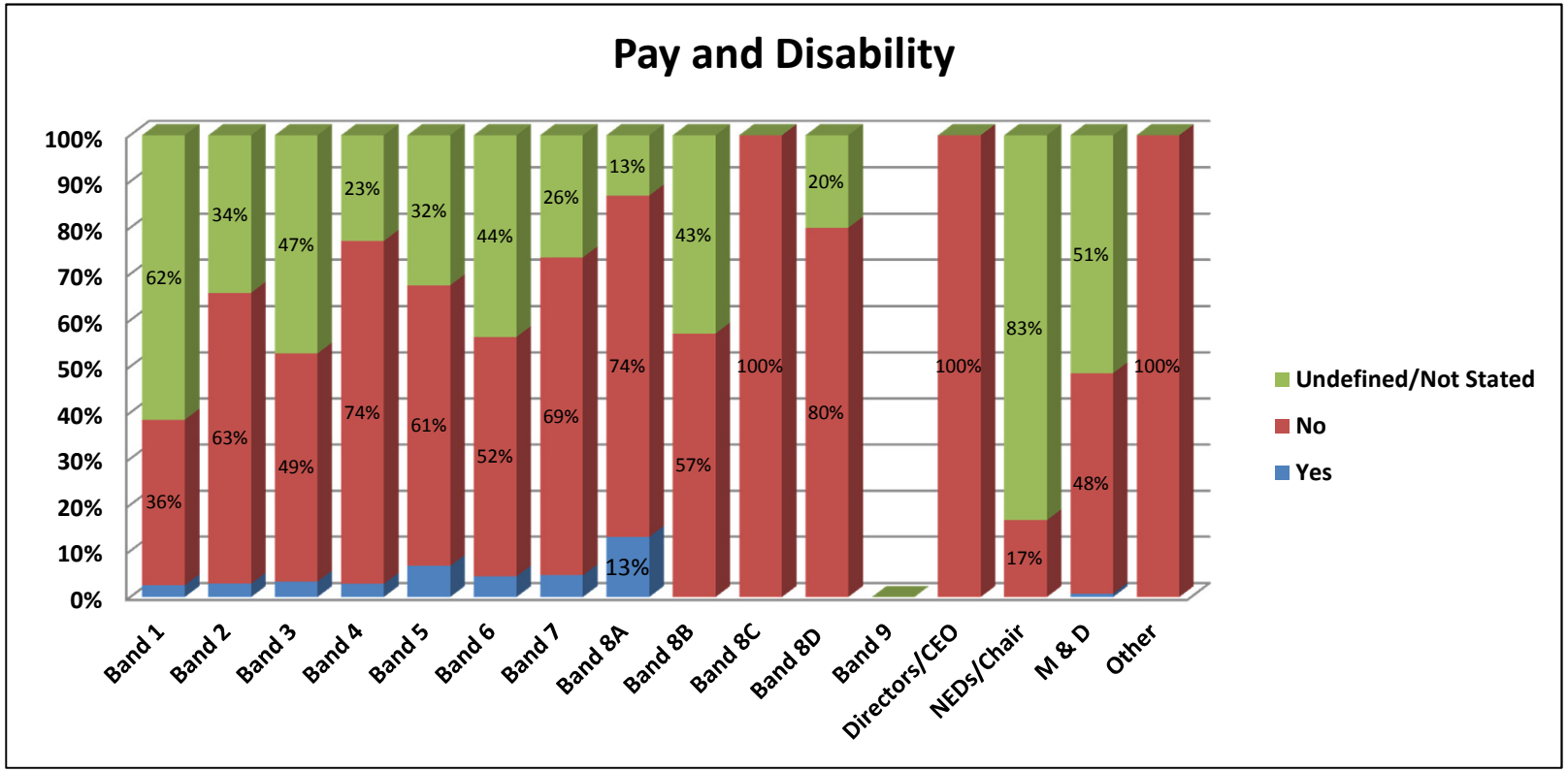
2.5 Pay and Sexual Orientation

There still remains a high number of Not stated/Undefined and Not disclosed responses, however the vast majority of staff consider themselves to be heterosexual.



2.6 Pay and Disability

Data remains more or less the same as the previous year, with the largest number of disabled staff being recorded in bands 5 and an over representation in Band 8a due to the small number of staff in that pay band.



3. Leavers and Recruitment

There is an over representation of BME leavers due to the rotational nature of some of the medical and dental posts; however the overall BME representation in the Trust is not reducing. The 21-40 age group has more leavers than is representation in the Trust; however this is due to rotational medical and dental posts and the mobile nature of that age group. There were more female leavers (however more are employed) and 3 leavers had a disability.

Whilst there has been an increase in the number of BME applicants, the number of BME staff employed by the Trust has not reduced. The percentage of BME applicants is much higher than the local demographic; however the representation of BME decreases through the recruitment process with only 18.7% of appointments from BME candidates as opposed to 33.2% of applicants. Some applicants cannot be progressed through the recruitment process because of their right to work in the UK status, in particular as a result of recent changes to immigration legislation.

The decrease in representation is reflected in male applicants with 23.7% of appointments made to male candidates from 29.7% of applicants.

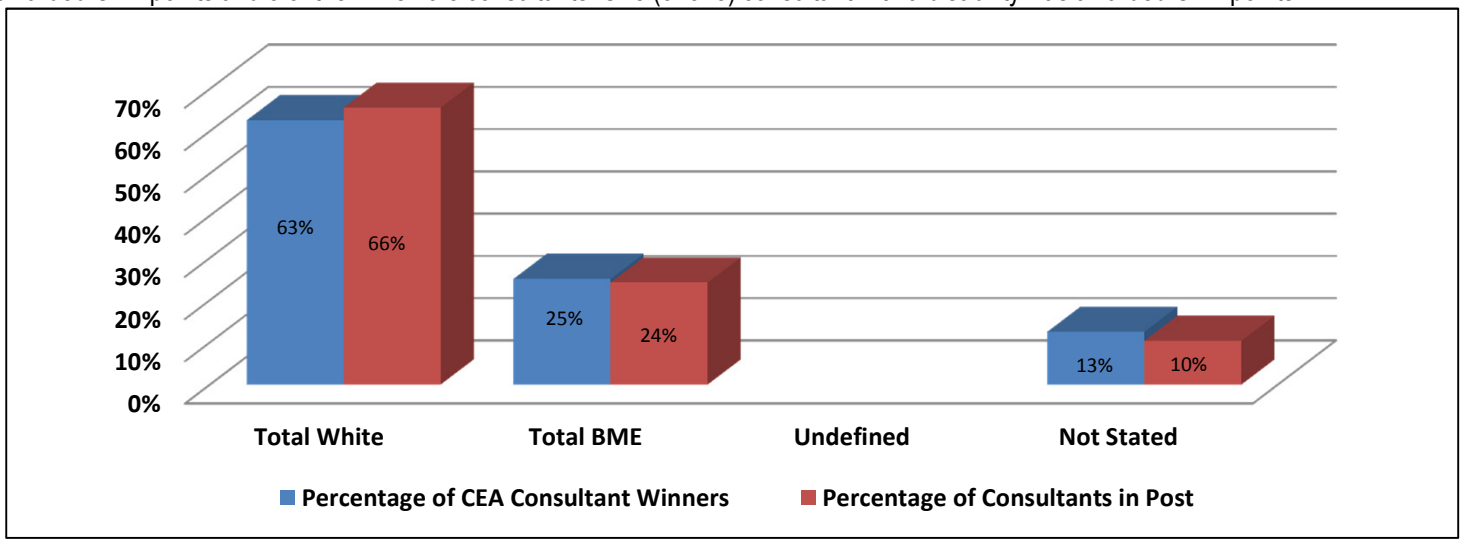
The proportion of shortlisted applicants with a disability is higher than the proportion of disabled applicants from 3.0% to 4.1%; however there is then a decrease with only 3.8% of candidates with a disability appointed. The proportion of staff with a disability in the Trust is 4%.

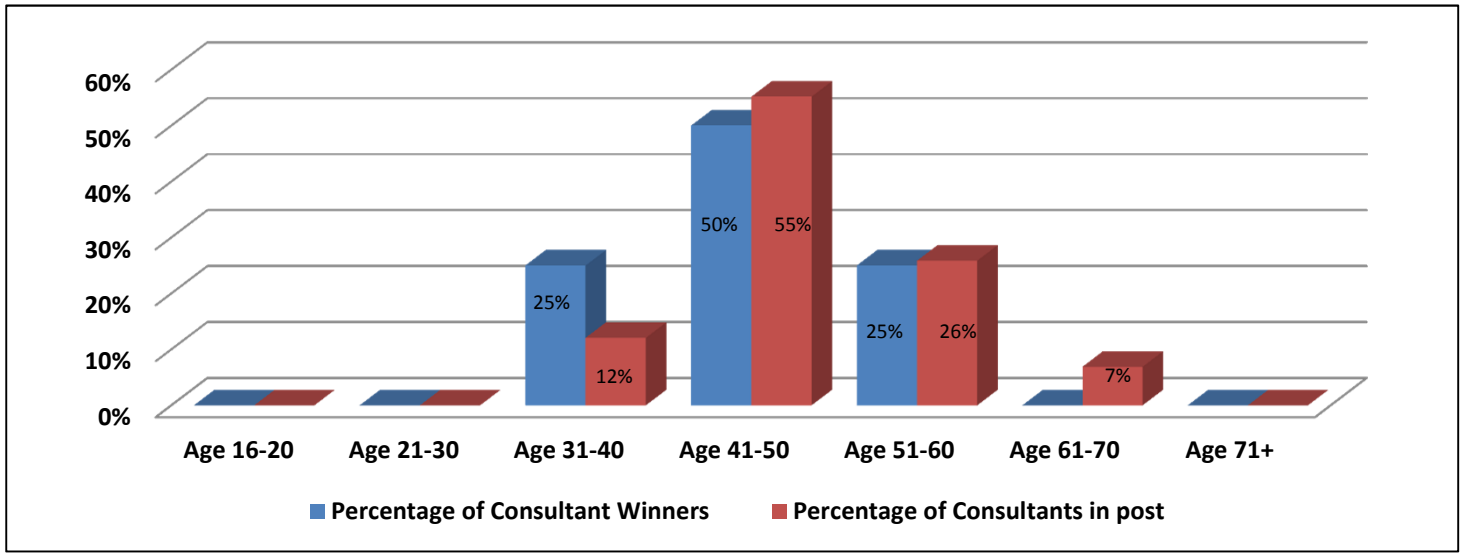
4. Clinical Excellence Awards

Clinical Excellence Awards (CEAs) were awarded to 8 Consultants in 2013 out of a possible 58.

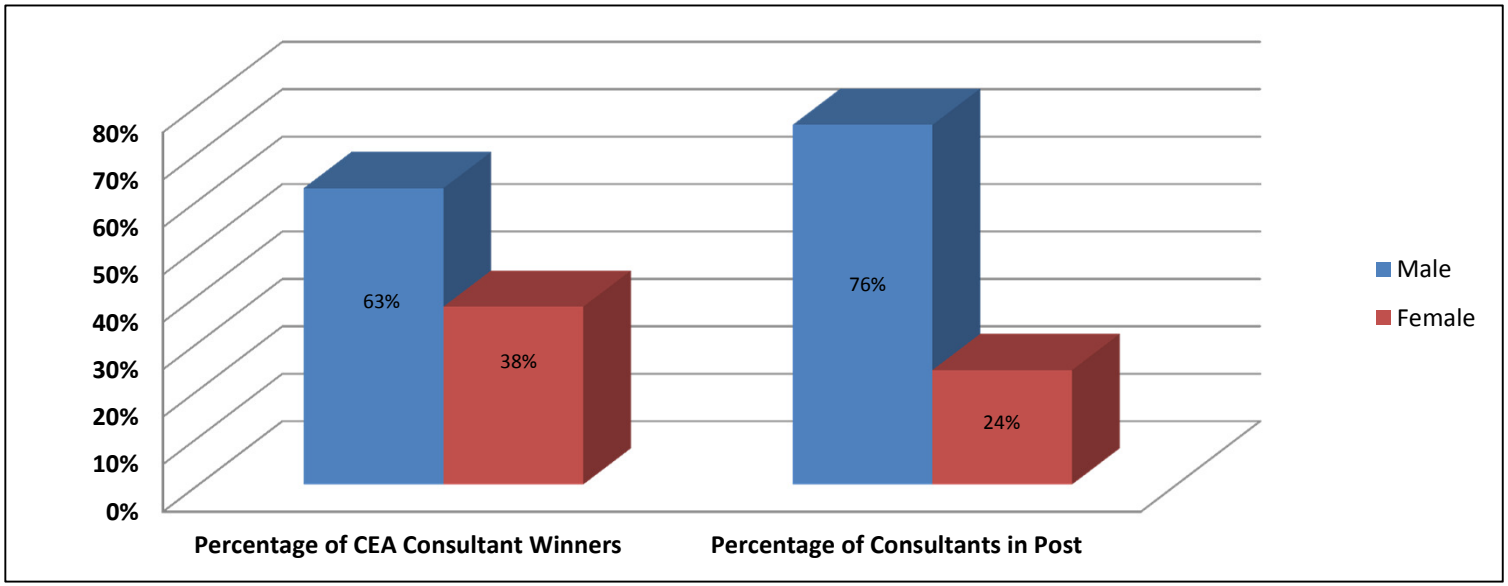
4.1 Clinical Excellence Awards by Ethnicity and by Age

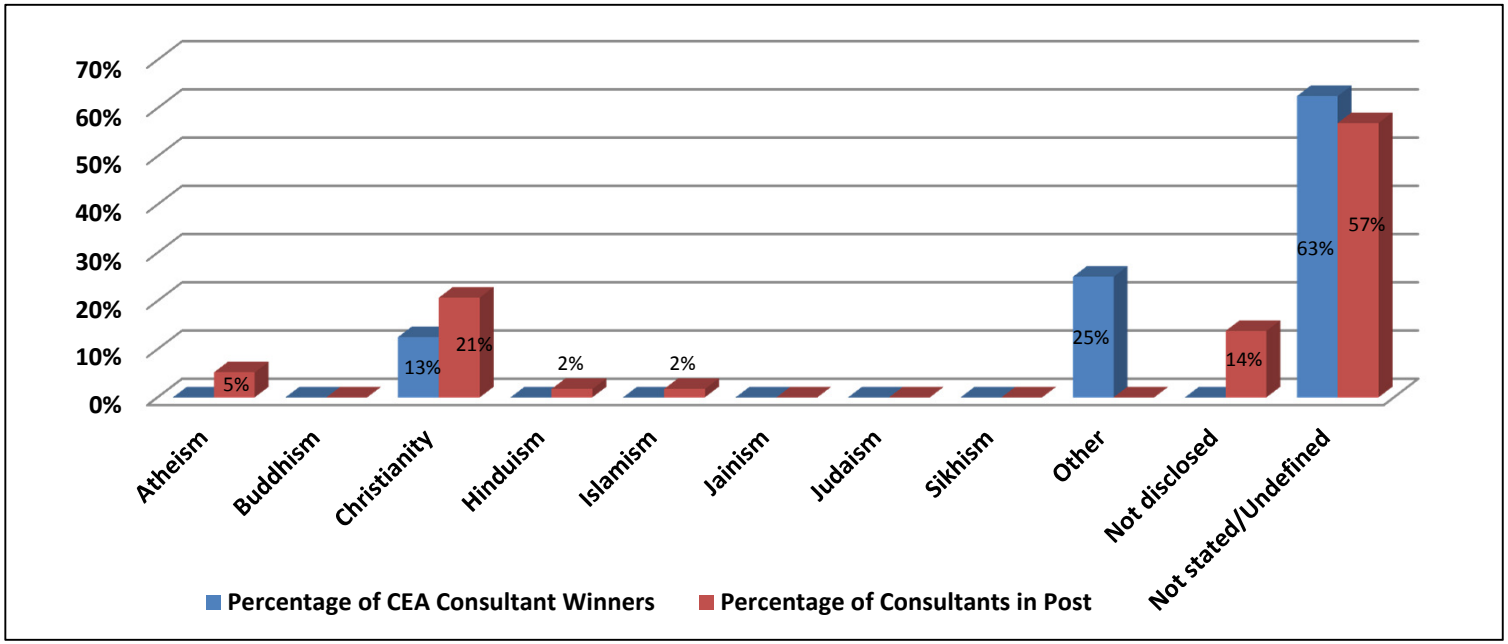
5 of consultants awarded are defined as White and 2 as BME against a total number of 38 and 14 employed respectively. 5 of the 44 male consultants were awarded CEA points and 3 of the 14 female consultants. One (of one) consultant with a disability was awarded CEA points.



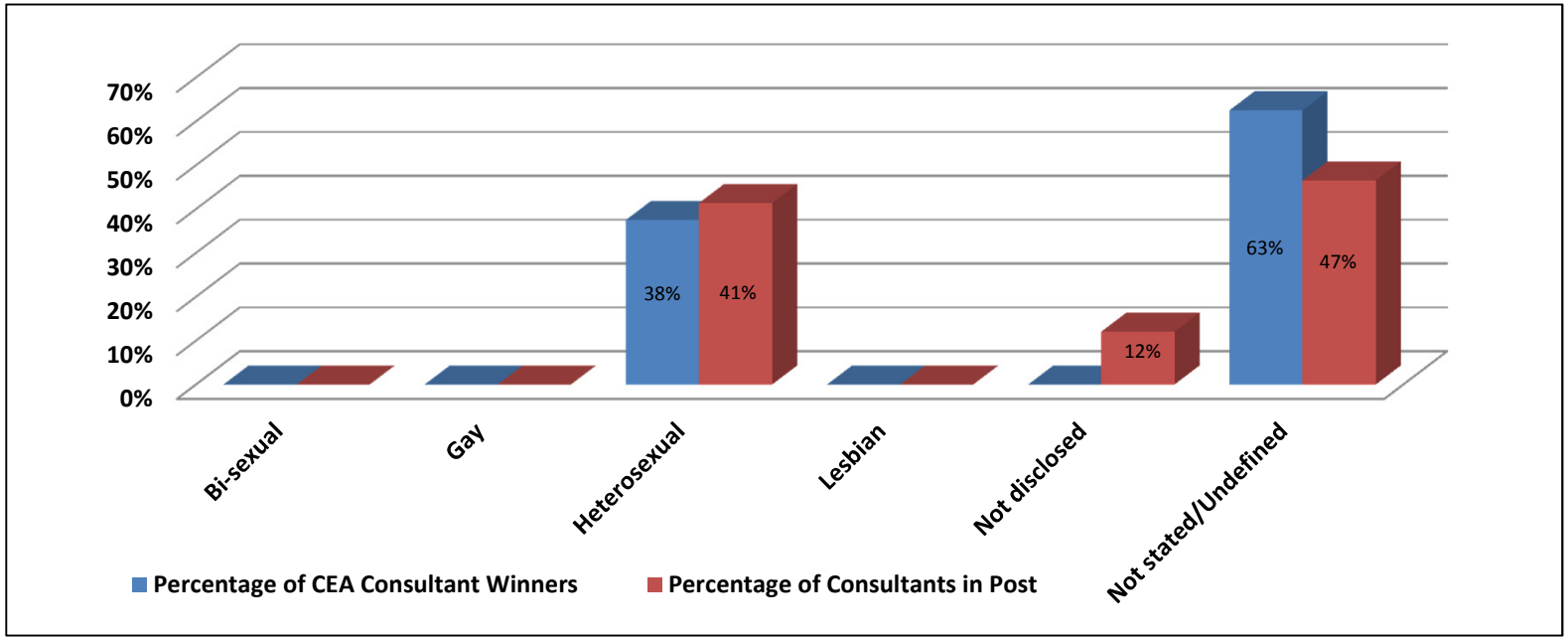


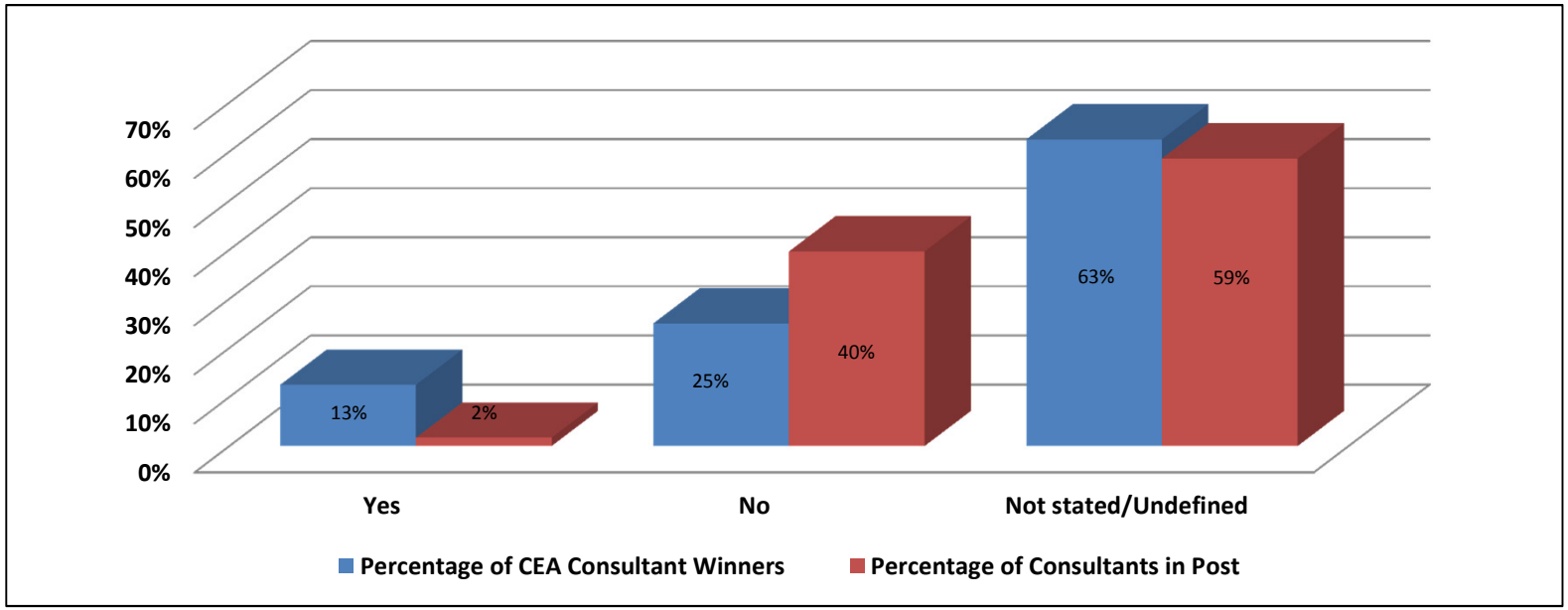
4.2 Clinical Excellence Awards by Gender and Religion or Belief





4.3 Clinical Excellence Awards by Sexual Orientation and by Disability



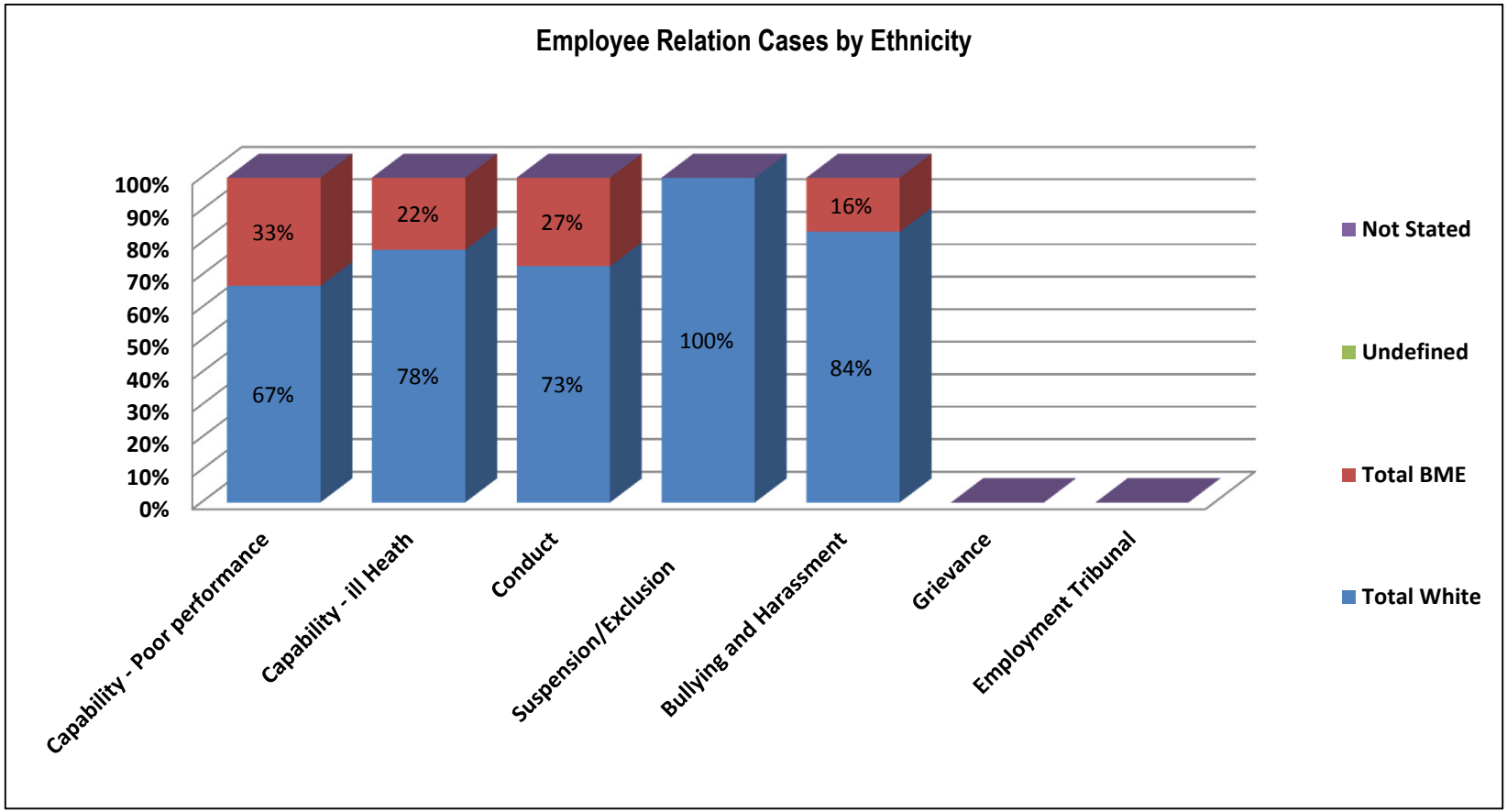


5. Employee Relation Cases

There were 6 cases of capability due to poor performance and 18 due to ill health. There were 11 cases of conduct and 3 suspensions. 6 cases were for bullying and harassment.

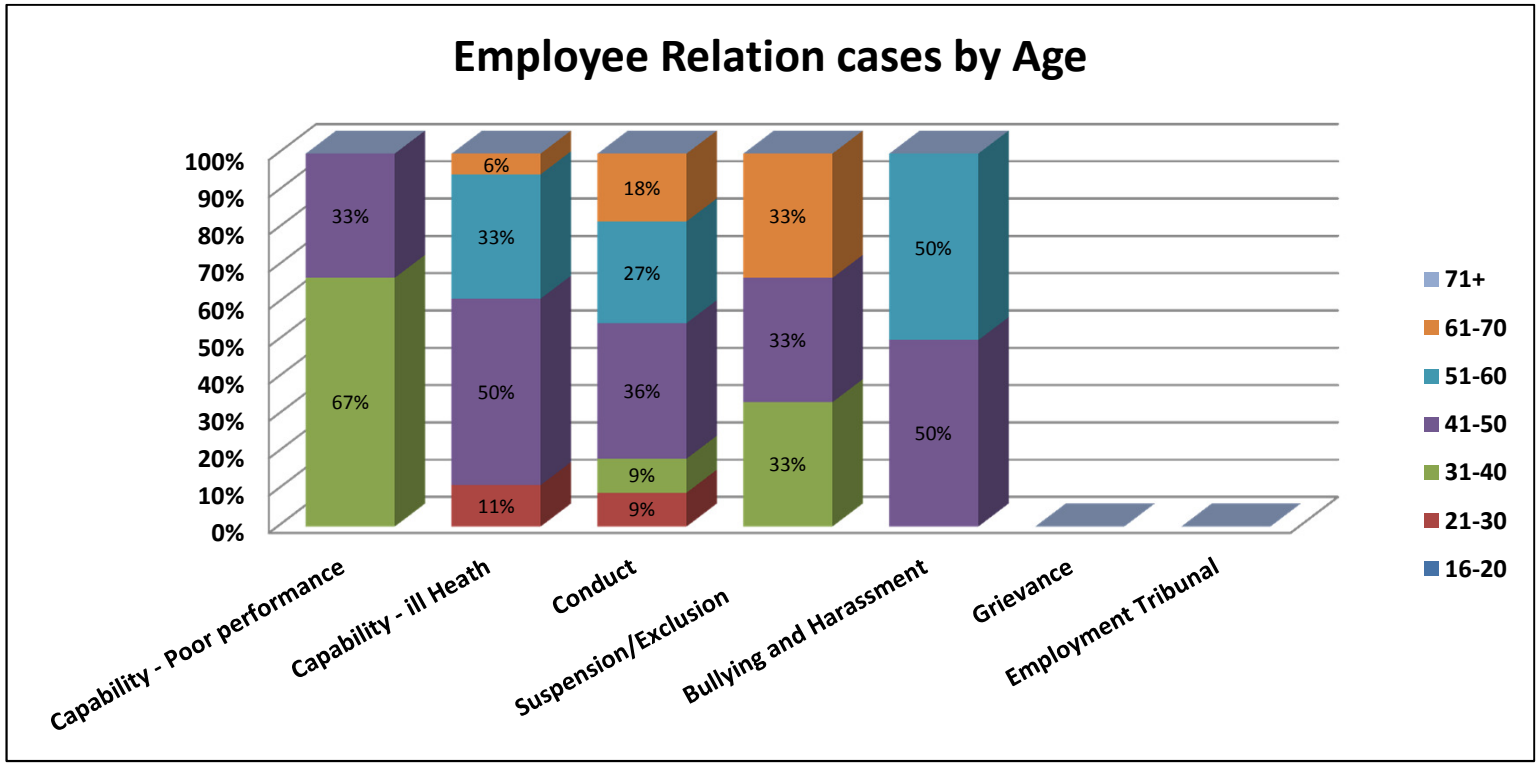
5.1 Employee relation cases by Ethnicity

There were less formal cases involving BME staff, however the highest number of BME staff were reported cases of Capability due to poor performance.



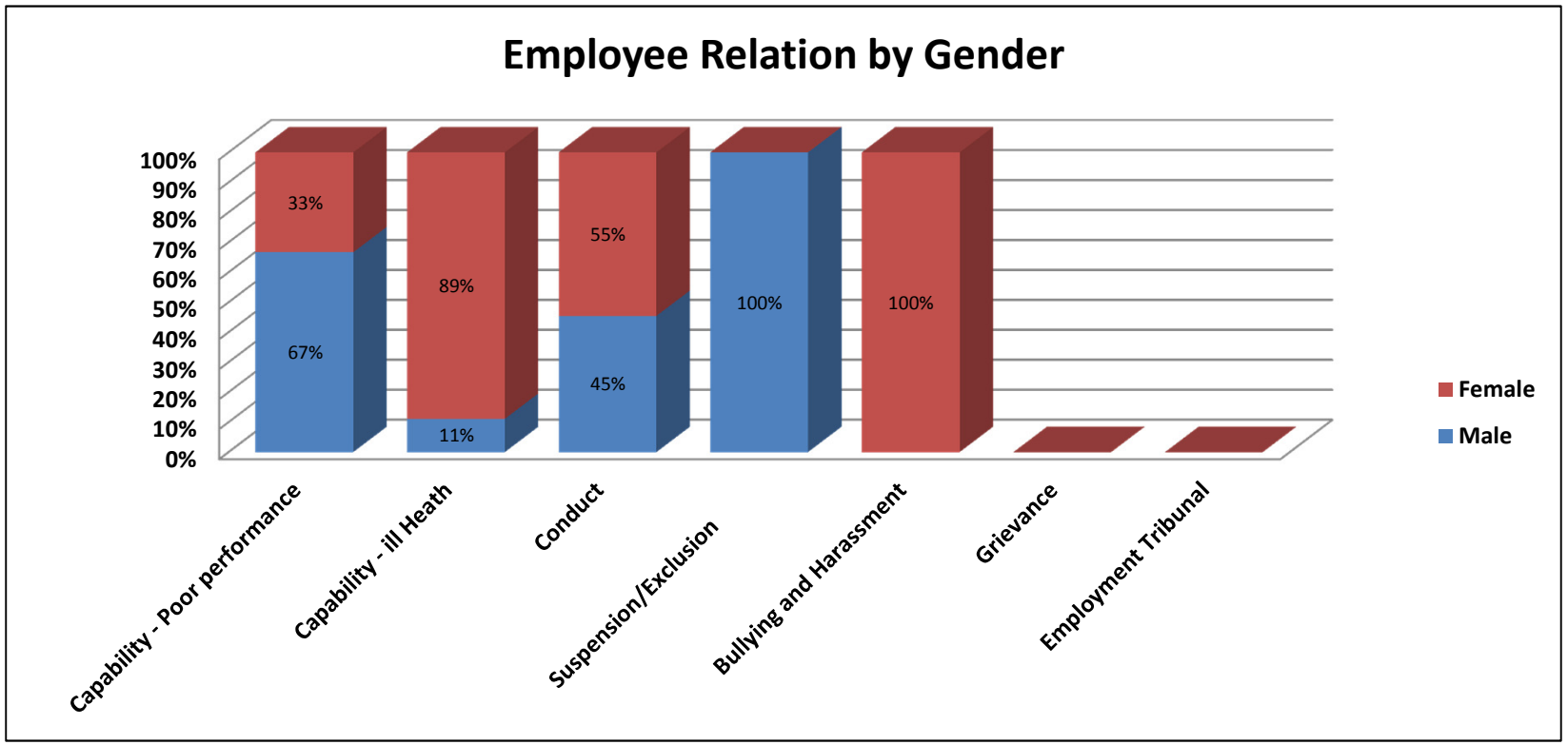
5.2 Employee relation cases by Age

The largest number of capability due to poor performance were in the 31 to 40 age group, with capability due to ill health and Bullying and Harassment highest in the 41-50 age group.

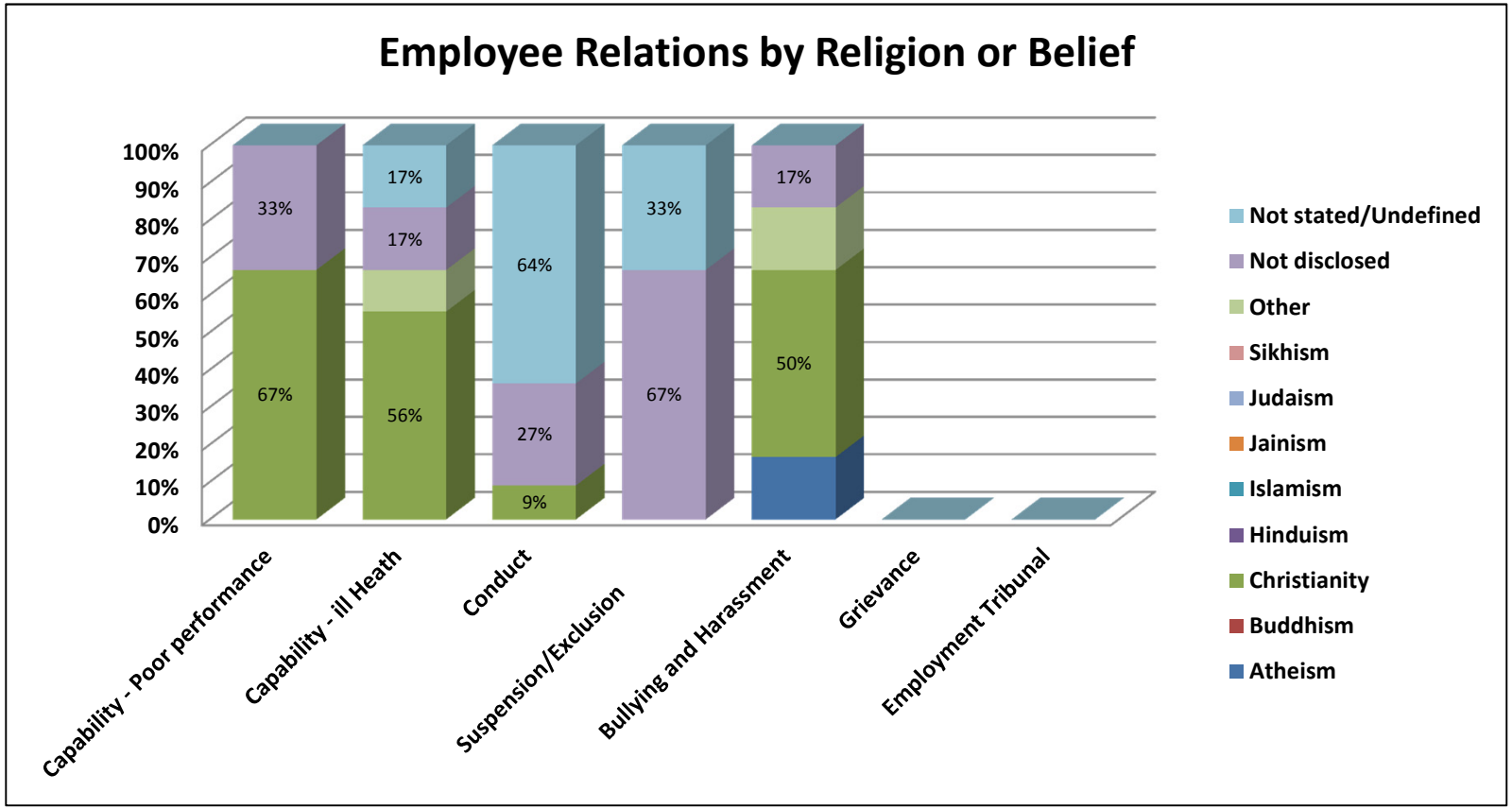


5.3 Employee relation cases by Gender

The largest number of cases reported for Bullying and Harassment were female, followed by Capability due to ill health.; cases reported of Suspension/Exclusion and Capability due to poor performance were male.

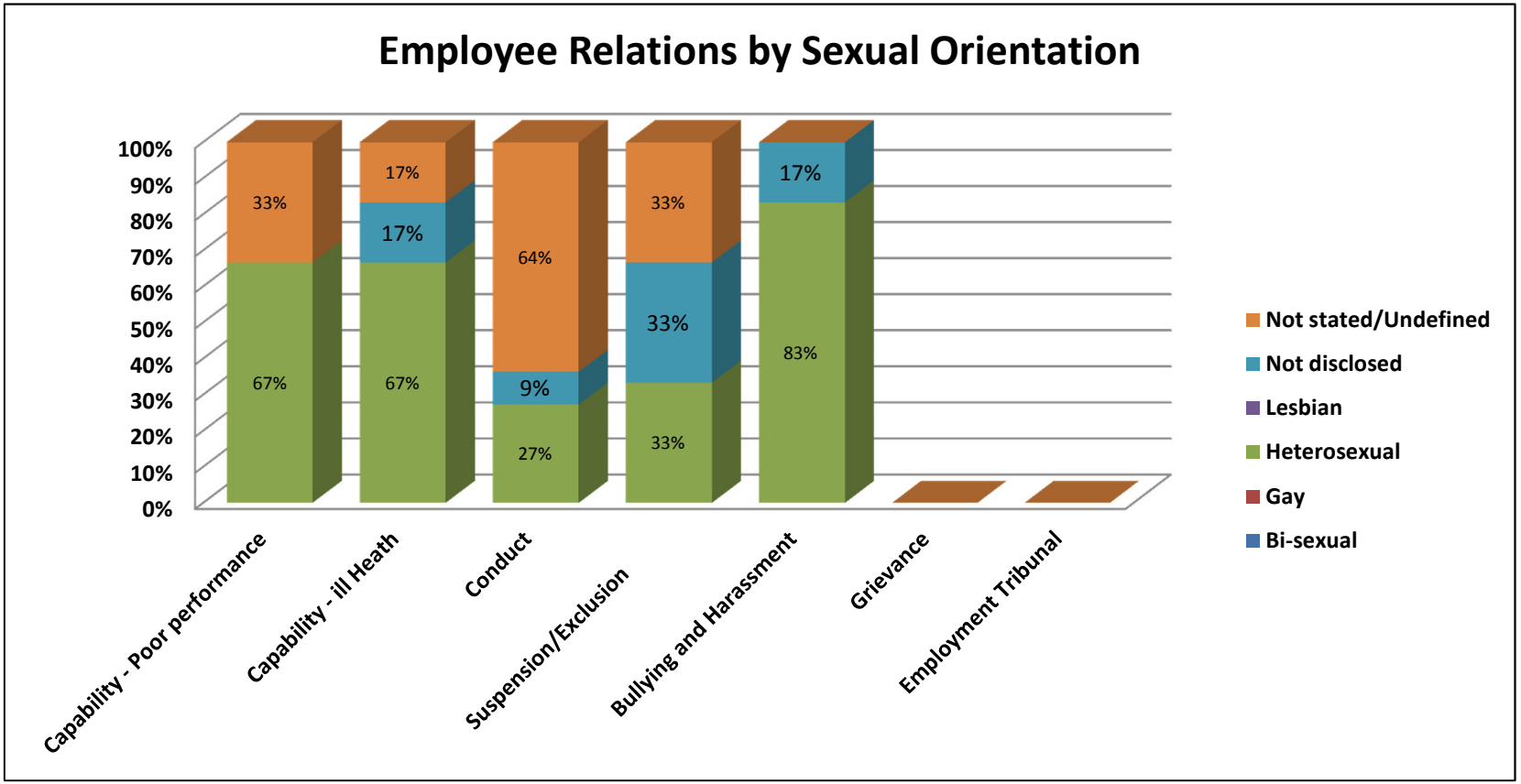


5.4 Employee relation cases by Religion or Belief



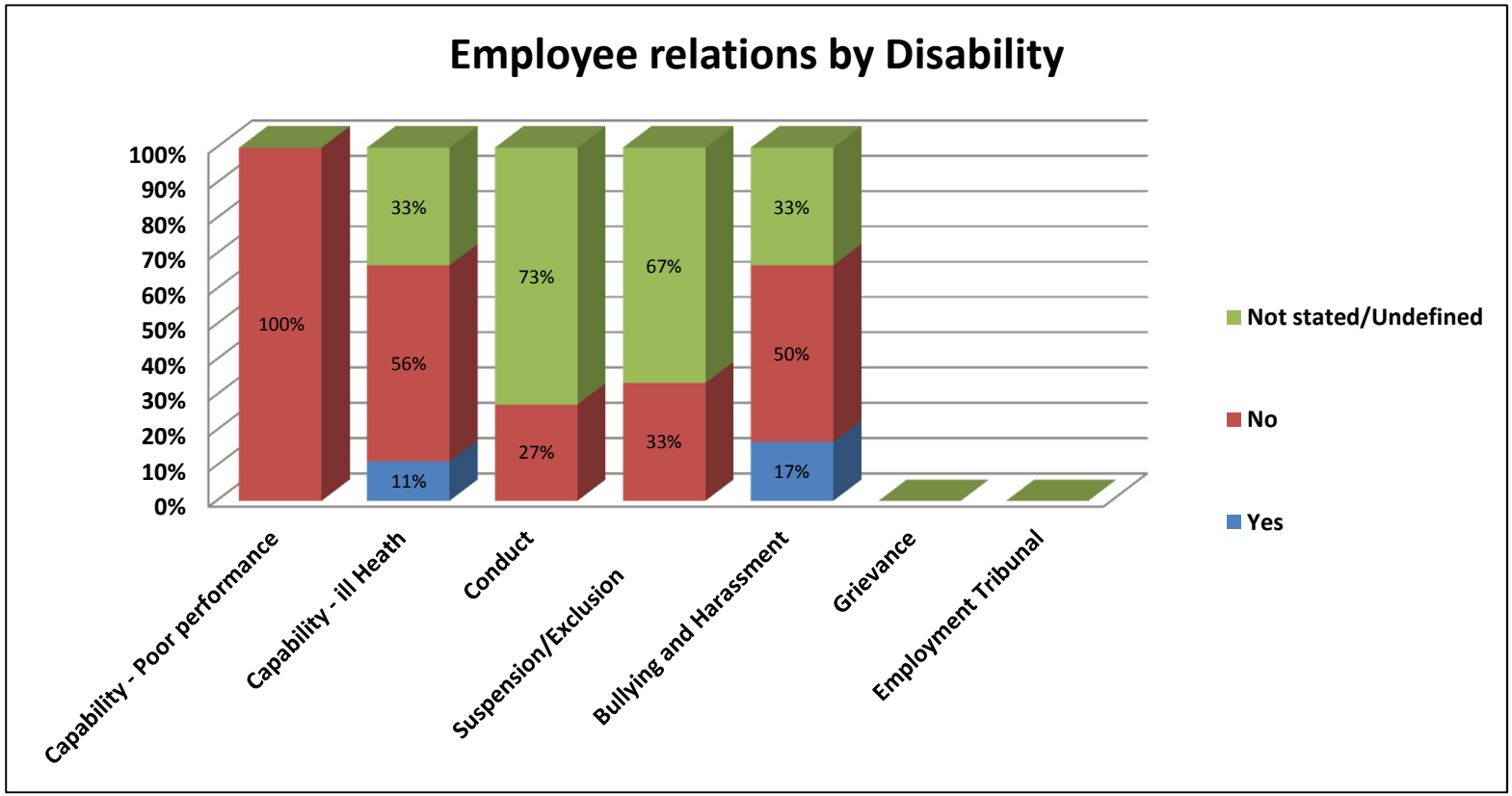
5.5 Employee relation cases by Sexual Orientation

A significant proportion of the data is from Not stated/Undefined and Not disclosed, this does not allow for a meaningful interpretation of the data.



5.6 Employee relation cases and disability

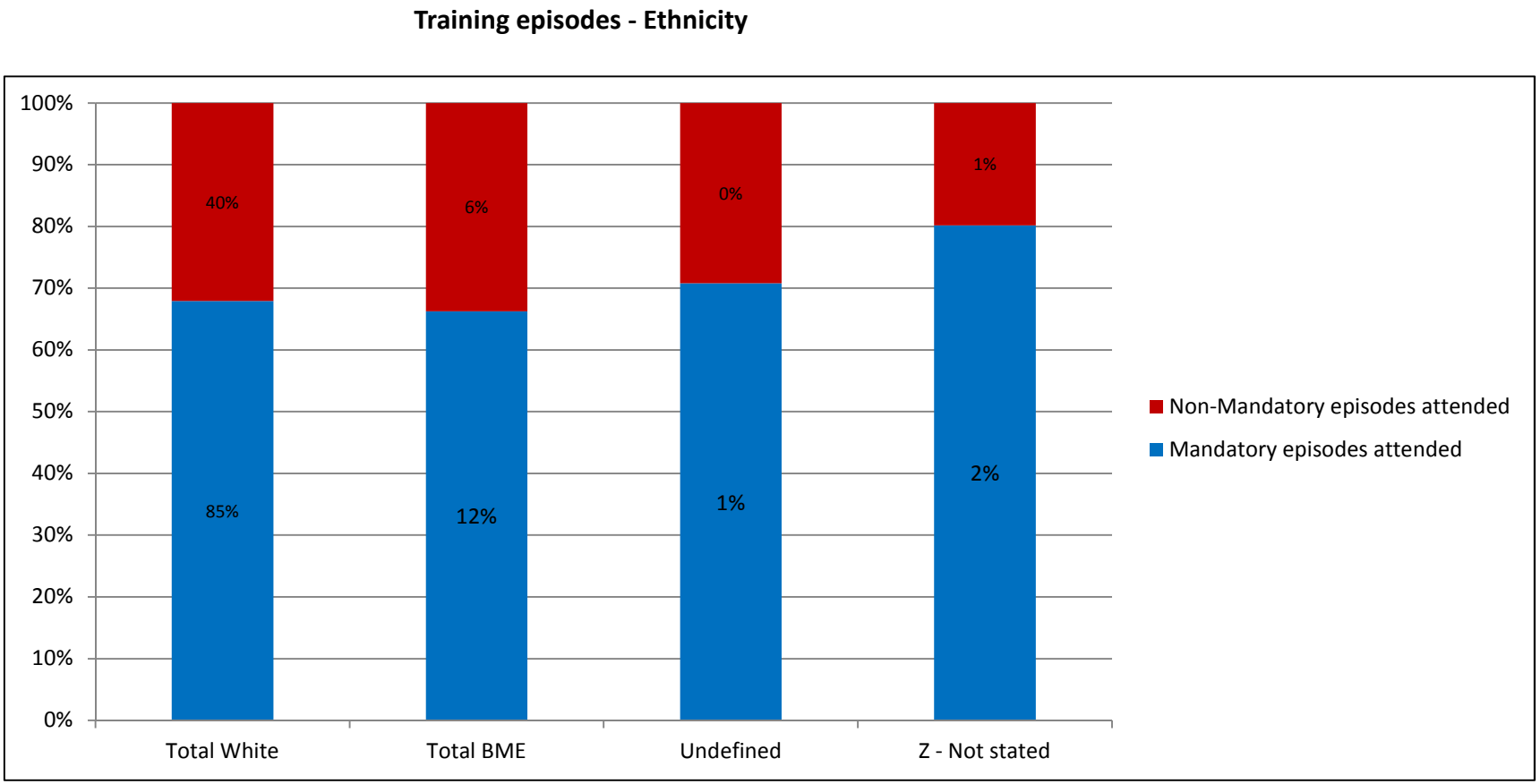
The largest number of recorded cases with a reported Disability are Bullying and Harassment and Capability due to ill health. Staff suffering from a long-term medical condition which is being dealt with by the Trust as part of a capability process may consider themselves to have a disability.



6. Training Episodes

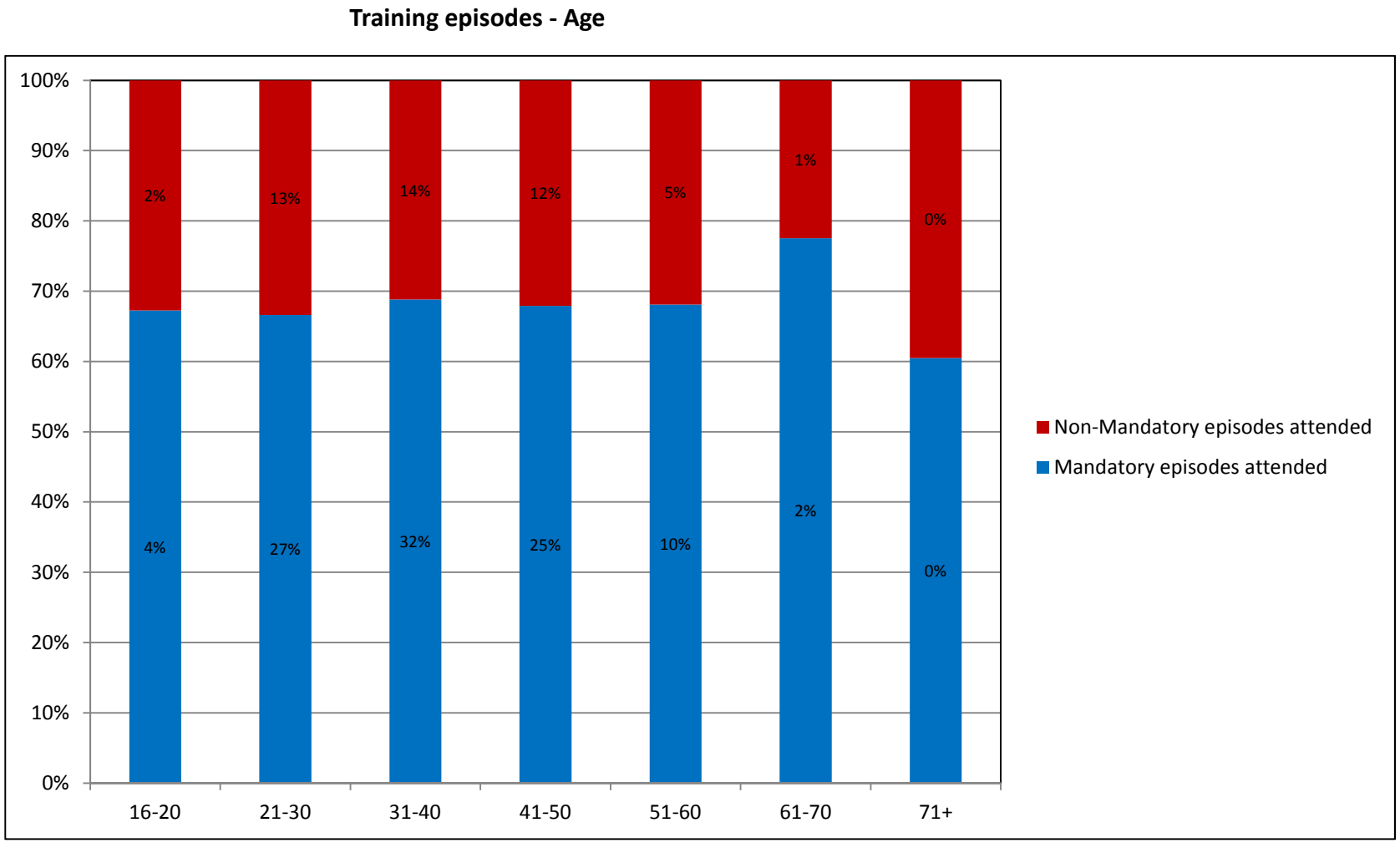
6.1 Training episodes by Ethnicity

There has been a change from the previous year and BME staff have had proportionally less non-mandatory (development) training episodes than mandatory ones.



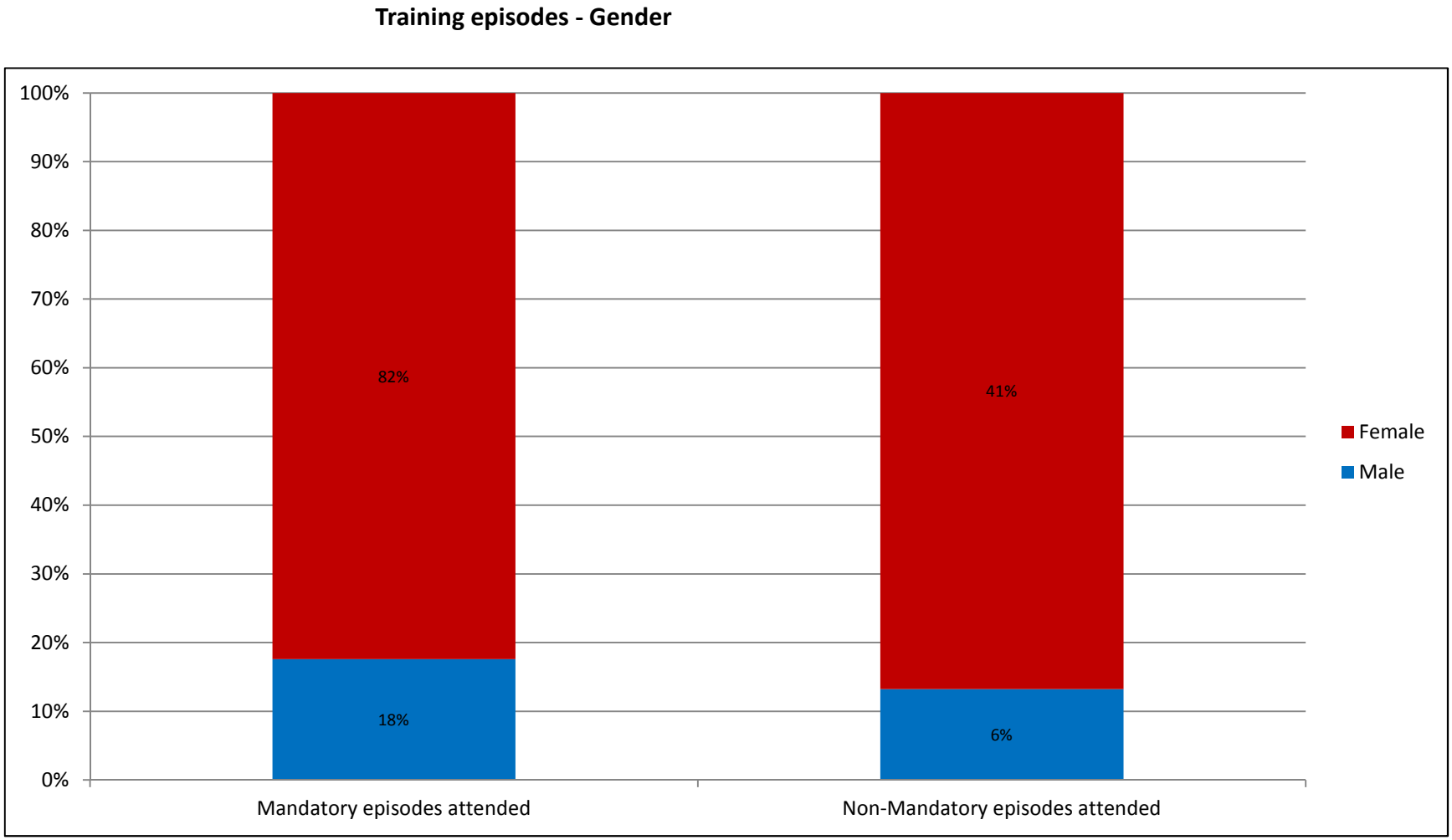
6.2 Training episodes by Age

There has been a further change from the previous year and the number of training episodes is now much more evenly distributed across all the age groups for both mandatory and non-mandatory training.



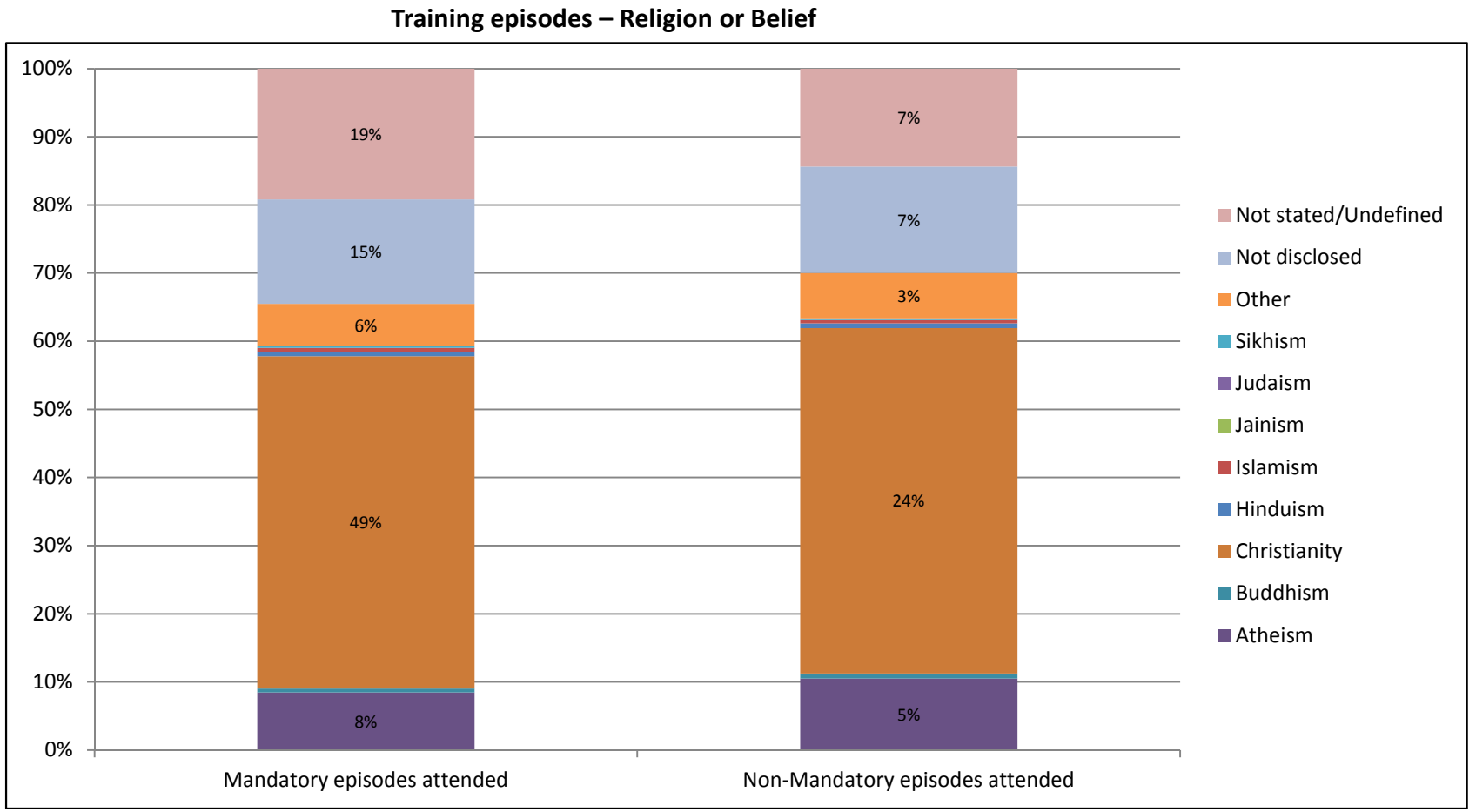
6.3 Training episodes by Gender

There is still under-representation of male staff attending training with no change to the previous year.



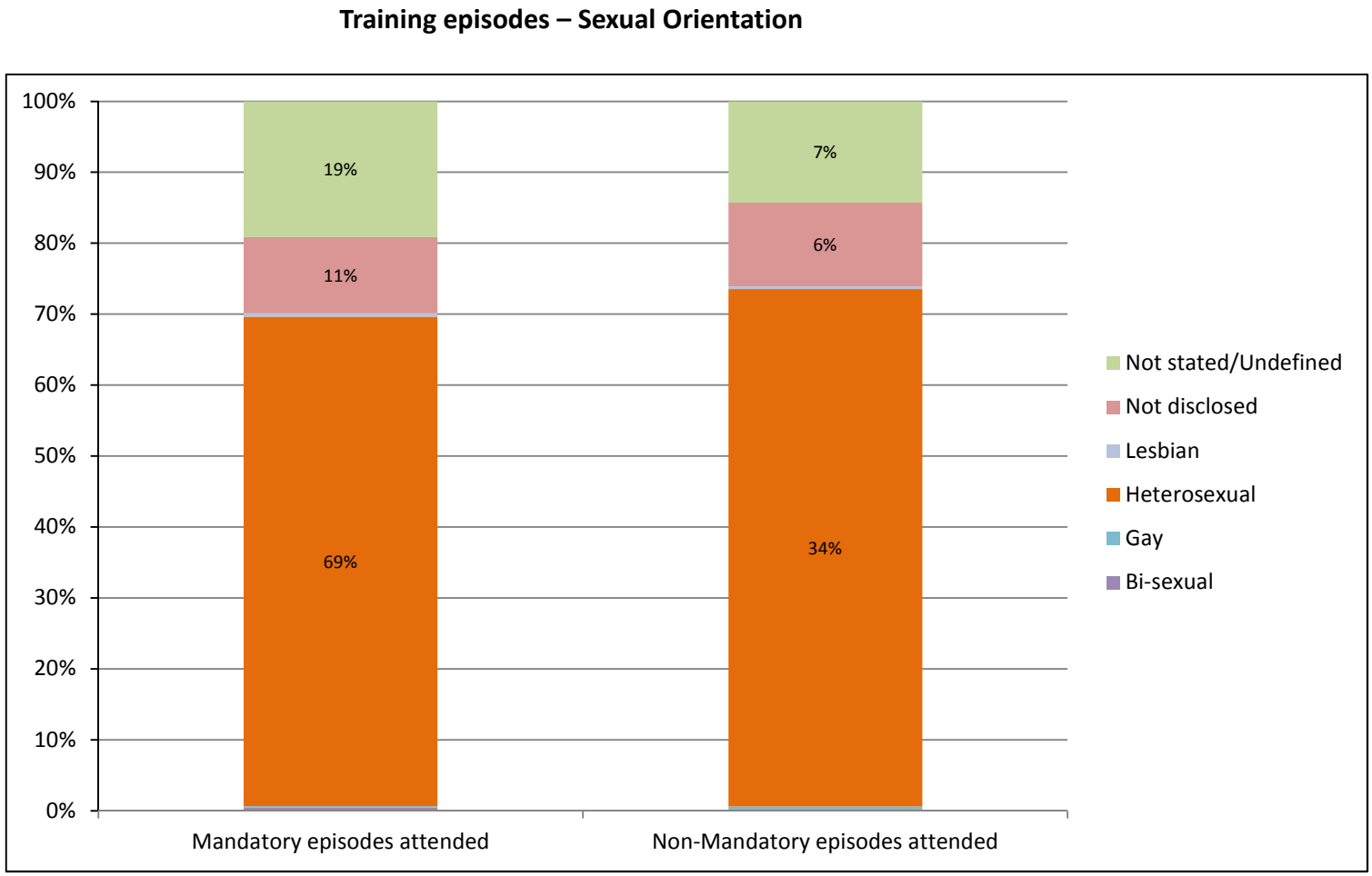
6.4 Training episodes by Religion or Belief

The data remains similar to the previous year. The high proportion of Christian staff reflects the high representation of this group in the Trust.



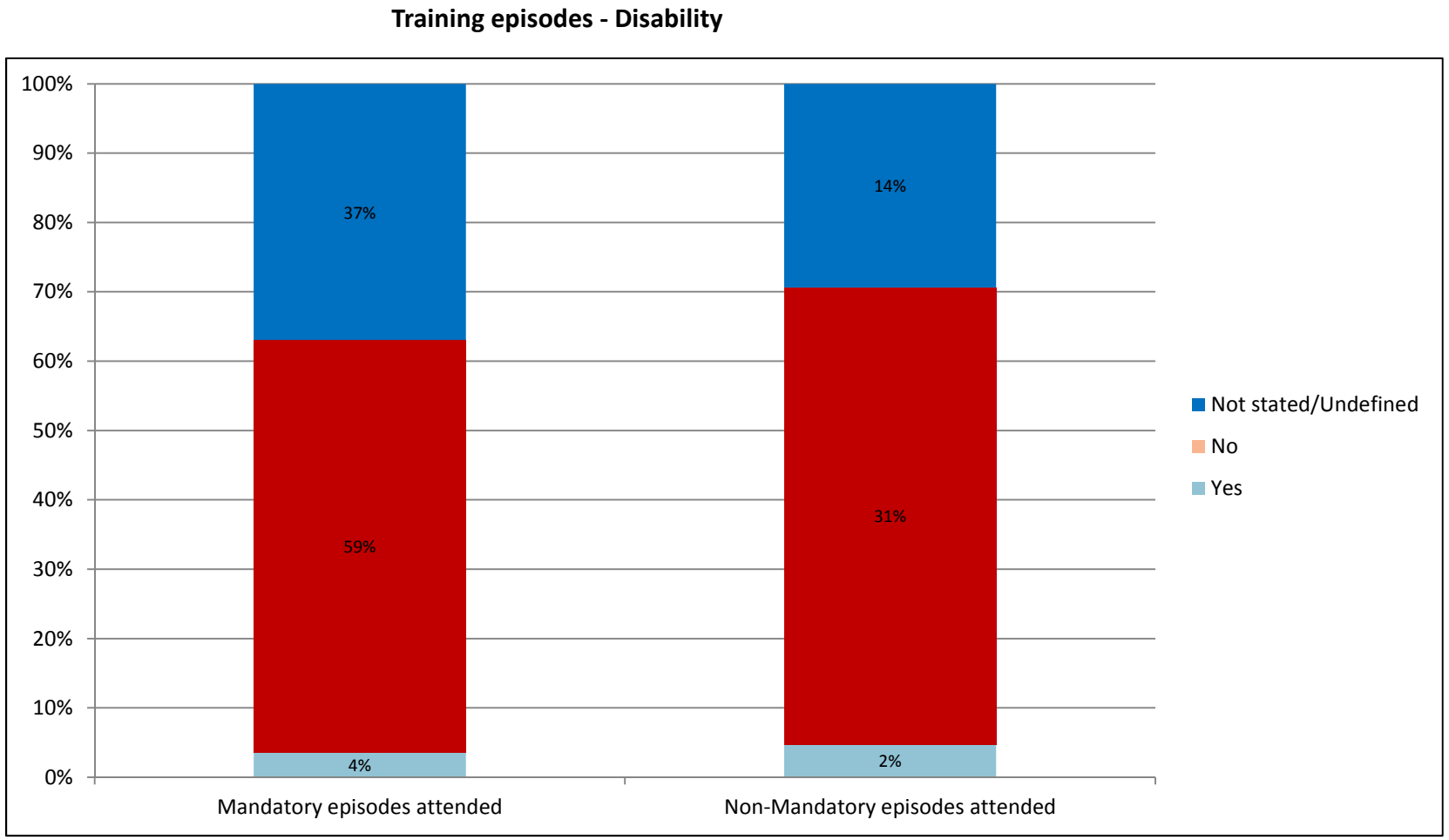
6.5 Training episodes by Sexual Orientation

The data remains similar to the previous year. The low representation from Lesbian, Gay and Bi-sexual staff reflect the low number of staff in those groups in the Trust.



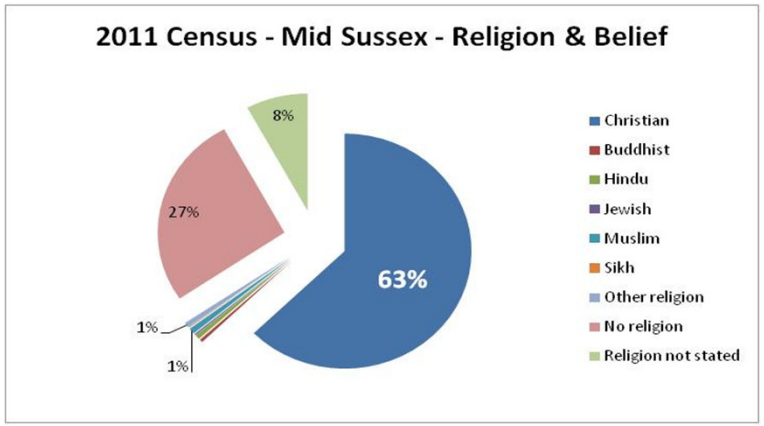
6.6 Training episodes by Disability

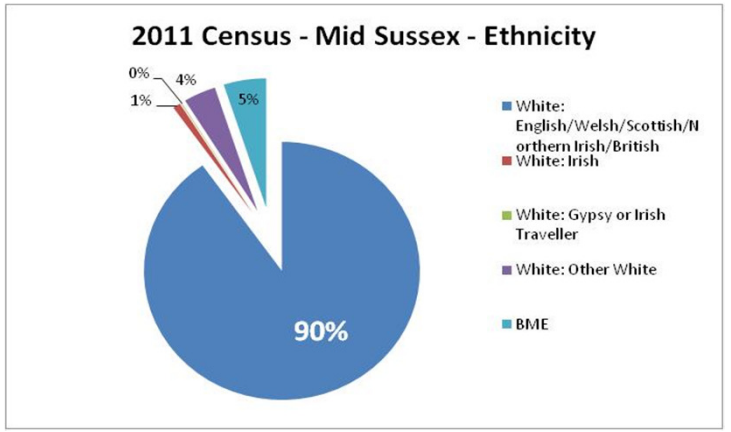
There is an under-representation of disabled staff attending training and access to training for those staff group.

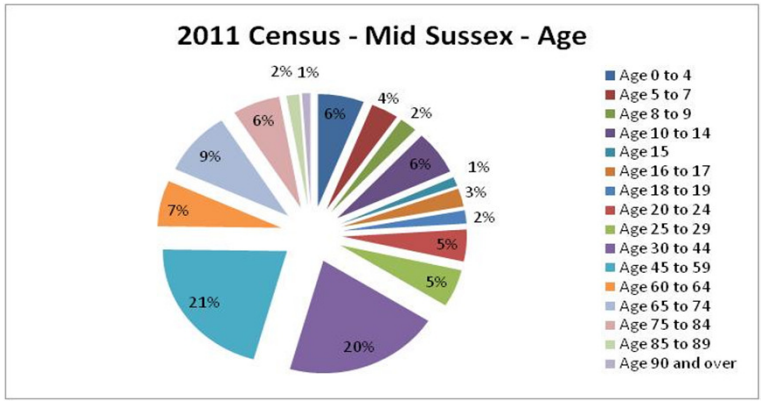


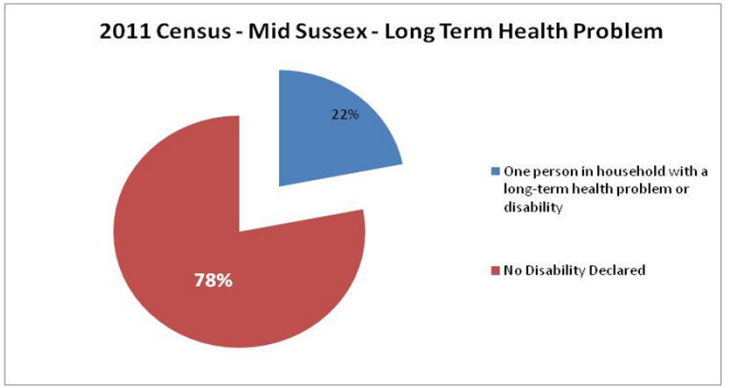
Part 3
Source data

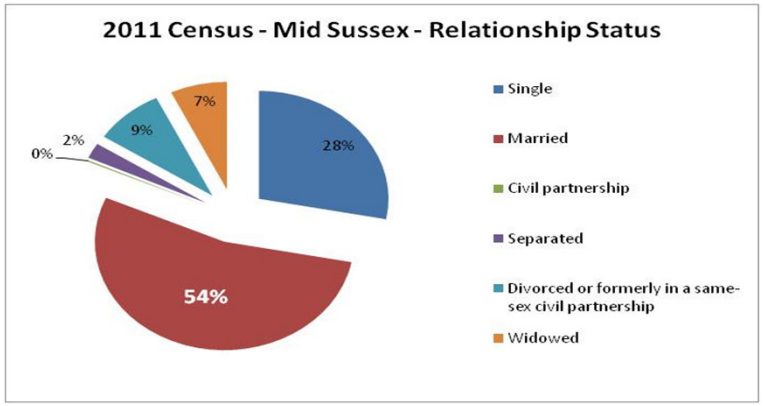
Mid Sussex Population Data (2011 census)

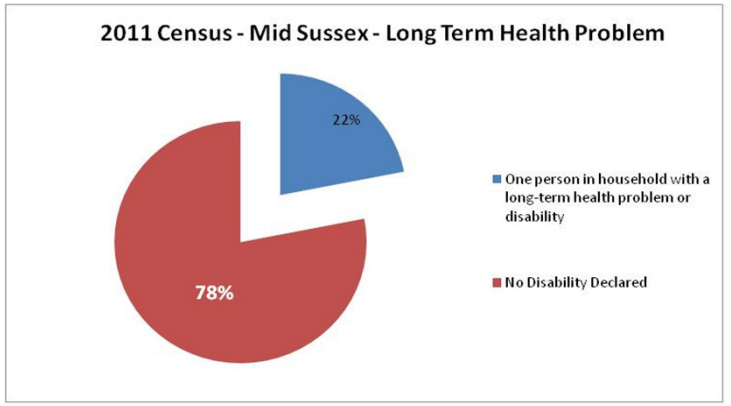












Workforce Profile

Protected Characteristic	Group	Number	Trust Representation
Ethnicity			
	A - White – British	726	75.00%
	B - White – Irish	14	1.45%
	C - White – Any other white background	72	7.44%
	Total White	**812**	**83.88%**
	D - Mixed – White and Black Caribbean	3	0.31%
	E - Mixed – White and Black African	4	0.41%
	F - Mixed – White and Asian	1	0.10%
	G - Other Mixed	4	0.41%
	H - Indian	25	2.58%
	J - Pakistani	5	0.52%
	L - Other Asian	21	2.17%
	M - Caribbean	4	0.41%
	N - African	5	0.52%
	P - Other Black	6	0.62%
	R - Chinese	4	0.41%
	S - Other	36	3.72%
	Total BME	**118**	**12.19%**
	Undefined	16	1.65%
	Z - Not stated	22	2.27%
	Grand total	**968**	**100.00%**
Age	16-20	5	0.52%
	21-30	130	13.43%
	31-40	221	22.83%
	41-50	283	29.24%
	51-60	263	27.17%
	61-70	63	6.51%
	71+	3	0.31%
	Grand total	**968**	**100.00%**
Gender	Male	230	23.76%
	Female	738	76.23%
	Grand total	**968**	**100.00%**

Workforce profile

Protected Characteristic	Group	Number	Trust Representation
Religion or belief	Atheism	85	8.78%
	Buddhism	4	0.41%
	Christianity	430	44.42%
	Hinduism	7	0.72%
	Islamism	8	0.83%
	Jainism	0	0.0%
	Judaism	0	0.0%
	Sikhism	2	0.21%
	Other	61	6.30%
	Not disclosed	159	16.43%
	Not stated/Undefined	212	21.90%
	Grand total	**968**	**100.00%**
Sexual orientation	Bi-sexual	2	0.21%
	Gay	3	0.31%
	Heterosexual	118	12.19%
	Lesbian	3	0.31%
	Not disclosed	117	12.09%
	Not stated/Undefined	725	74.90%
	Grand total	**968**	**100.00%**
Disability	Yes	37	3.82%
	No	567	58.57%
	Not stated/Undefined	364	37.60%
	Grand total	**968**	**100.00%**

Pay

Protected Characteristic	Group	Band		Band 2		Band 3		Band 4		Band 5		Band 6		Band 7	
Ethnicity		**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**
	A - White – British	22	2.27%	111	11.47%	80	8.26%	92	9.50%	108	11.16%	124	12.81%	86	8.88%
	B - White – Irish	0	0.00%	2	0.21%	1	0.10%	3	0.31%	2	0.21%	1	0.10%	2	0.21%
	C - White – Any other white background	1	0.10%	9	0.93%	3	0.31%	5	0.52%	10	1.03%	8	0.83%	10	1.03%
	Total White	**23**	**2.38%**	**122**	**12.60%**	**84**	**8.68%**	**100**	**10.33%**	**120**	**12.40%**	**133**	**13.74%**	**98**	**10.12%**
	D - Mixed – White and Black Caribbean	0	0.0%	2	0.21%	0	0.00%	0	0.00%	0	0.00%	1	0.10%	0	0.00%
	E - Mixed – White and Black African	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	0.21%	0	0.00%	0	0.00%
	F - Mixed – White and Asian	0	0.00 %	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	G - Other Mixed	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.10%	0	0.00%
	H - Indian	1	0.10%	2	0.21%	0	0.00%	0	0.00%	6	0.62%	1	0.10%	1	0.10%
	J - Pakistani	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.10%	1	0.10%	1	0.10%
	L - Other Asian	5	0.52%	2	0.21%	0	0.00%	0	0.00%	2	0.21%	7	0.72%	3	0.31%
	M - Caribbean	0	0.00%	2	0.21%	1	0.10%	0	0.00%	1	0.10%	0	0.00%	0	0.00%
	N - African	0	0.00%	0	0.00%	1	0.10%	0	0.00%	3	0.31%	0	0.00%	0	0.00%
	P - Other Black	1	0.10%	0	0.00%	0	0.00%	1	0.10%	1	0.10%	0	0.00%	0	0.00%
	R - Chinese	0	0.0%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.10%	0	0.00%
	S - Other	6	0.62%	2	0.21%	2	0.21%	0	0.00%	8	0.83%	8	0.83%	2	0.21%
	Total BME	**13**	**1.34%**	**10**	**1.03%**	**4**	**0.41%**	**1**	**0.10%**	**24**	**2.48%**	**20**	**2.07%**	**7**	**0.72%**
	Undefined	0	0.31%	6	0.62%	1	0.10%	1	0.10%	0	0.00%	0	0.00%	0	0.00%
	Z - Not stated	3	0.31%	0	0.00%	0	0.00%	3	0.31%	4	0.41%	3	0.31%	1	0.10%
	Grand total	**39**	4.03%	**138**	**14.26%**	**89**	**9.19%**	**105**	**10.85%**	**148**	**15.29%**	**156**	**16.12%**	**106**	**10.95%**
Age	16-20	1	0.10%	3	0.31%	1	0.10%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	21-30	4	0.41%	25	2.58%	9	0.93%	10	1.03%	38	3.93%	20	2.07%	2	0.21%
	31-40	2	0.21%	25	2.58%	8	0.83%	12	1.24%	31	3.20%	42	4.34%	33	3.41%
	41-50	15	1.55%	30	3.10%	33	3.41%	34	3.51%	40	4.13%	37	3.82%	32	3.31%
	51-60	13	1.34%	45	4.65%	29	3.00%	36	3.72%	32	3.31%	49	5.06%	35	3.62%
	61-70	4	0.41%	9	0.93%	9	0.93%	11	1.14%	7	0.72%	8	0.83%	4	0.41%
	71+	0	0.00%	1	0.10%	0	0.00%	2	0.21%	0	0.00%	0	0.00%	0	0.00%
	Grand total	**39**	4.03%	**138**	**14.26%**	**89**	**9.19%**	**105**	**10.85%**	**148**	**15.29%**	**156**	**16.12%**	**106**	**10.95%**
Gender	Male	21	2.17%	26	2.69%	15	1.55%	5	0.52%	10	1.03%	26	2.69%	17	1.76%
	Female	18	1.86%	112	11.57%	74	7.64%	100	10.33%	138	14.26%	130	13.43%	89	9.19%
	Grand total	**39**	**4.03%**	**138**	**14.26%**	**89**	**9.19%**	**105**	**10.85%**	**148**	**15.29%**	**156**	**16.12%**	**106**	**10.95%**

Protected Characteristic	Group	Band 1		Band 2		Band 3		Band 4		Band 5		Band 6		Band 7	
		Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %
Religion or belief	Atheism	2	0.21%	11	1.14%	8	0.83%	12	1.24%	14	1.45%	12	1.24%	13	1.34%
	Buddhism	0	0.00%	0	0.00%	0	0.00%	0	0.0%	2	0.21%	1	0.10%	0	0.00%
	Christianity	11	1.14%	64	6.61%	47	4.86%	55	5.68%	77	7.95%	62	6.40%	57	5.89%
	Hinduism	0	0.00%	0	0.00%	0	0.0%	0	0.0%	1	0.10%	1	0.10%	1	0.10%
	Islamism	0	0.00%	0	0.00%	0	0.0%	0	0.0%	1	0.10%	1	0.10%	0	0.0%
	Jainism	0	0.00%	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Judaism	0	0.00%	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Sikhism	0	0.00%	0	0.00%	0	0.0%	0	0.0%	1	0.10%	0	0.0%	0	0.0%
	Other	3	0.31%	13	1.34%	5	0.52%	4	0.41%	10	1.03%	7	0.72%	6	0.62%
	Not disclosed	8	0.83%	25	2.58%	15	1.55%	19	1.96%	16	1.65%	22	2.27%	15	1.55%
	Not stated/Undefined	15	1.55%	25	2.58%	14	1.45%	15	1.55%	26	2.69%	50	5.17%	14	1.45%
	Grand total	**39**	**4.03%**	**138**	**14.26%**	**89**	**9.19%**	**105**	**10.85%**	**148**	**15.29%**	**156**	**16.12%**	**106**	**10.95%**
Sexual Orientation	Lesbian	0	0.00%	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	0.21%
	Heterosexual	11	1.14%	18	1.86%	11	1.14%	14	1.45%	10	1.03%	19	1.96%	11	1.14%
	Gay	0	0.00%	0	0.00%	1	0.10%	0	0.0%	1	0.10%	0	0.0%	0	0.0%
	Bi-sexual	0	0.00%	1	0.10%	0	0.0%	1	0.10%	0	0.0%	0	0.0%	0	0.0%
	Not disclosed	11	1.14%	18	1.86%	11	1.14%	14	1.45%	10	1.03%	19	1.96%	8	0.83%
	Not stated/Undefined	17	1.76%	101	10.43%	66	6.82%	76	7.85%	127	13.12%	118	12.19%	85	8.78%
	Grand total	**39**	**4.03%**	**138**	**14.26%**	**89**	**9.19%**	**105**	**10.85%**	**148**	**15.29%**	**156**	**16.12%**	**106**	**10.95%**
Disability	Yes	1	0.10%	4	0.41%	3	0.31%	3	0.31%	10	1.03%	7	0.72%	5	0.52%
	No	14	1.45%	87	8.99%	44	4.55%	78	8.06%	90	9.30%	81	8.37%	73	7.54%
	Not stated/Undefined	24	2.48%	47	4.86%	42	4.34%	24	2.48%	48	4.96%	68	7.02%	28	2.89%
	Grand total	**39**	**4.03%**	**138**	**14.26%**	**89**	**9.19%**	**105**	**10.85%**	**148**	**15.29%**	**156**	**16.12%**	**106**	**10.95%**

Pay

Protected Characteristic	Group	Band 8A		Band 8B		Band 8C		Band 8D		Band 9		Directors/CEO	
Ethnicity		**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**	**Number**	**Trust %**
	A - White – British	21	2.17%	6	0.62%	2	0.21%	4	0.41%	0	0.0%	3	0.31%
	B - White – Irish	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	C - White – Any other white background	0	0.0%	1	0.10%	0	0.0%	1	0.10%	0	0.0%	1	0.10%
	Total White	**21**	**2.17%**	**7**	**0.72%**	**2**	**0.21%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.41%**
	D - Mixed – White and Black Caribbean	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	E - Mixed – White and Black African	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	F - Mixed – White and Asian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	G - Other Mixed	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	H - Indian	1	0.10%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	J - Pakistani	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	L - Other Asian	1	0.10%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	M - Caribbean	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	N - African	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	P - Other Black	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	R - Chinese	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	S - Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Total BME	**2**	**0.21%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
	Undefined	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Z - Not stated	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Grand total	**23**	**2.38%**	**7**	**0.72%**	**2**	**0.21%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.41%**
Age	16-20	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	21-30	4	0.41%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	31-40	10	1.03%	2	0.21%	1	0.10%	0	0.0%	0	0.0%	0	0.0%
	41-50	8	0.83%	4	0.41%	1	0.10%	4	0.41%	0	0.0%	2	0.21%
	51-60	0	0.0%	1	0.10%	0	0.0%	0	0.0%	0	0.0%	2	0.21%
	61-70	1	0.10%	0	0.0%	0	0.0%	1	0.10%	0	0.0%	0	0.0%
	71+	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Grand total	**23**	**2.38%**	**7**	**0.72%**	**2**	**0.20%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.42%**
Gender	Male	3	0.31%	6	0.62%	0	0.0%	3	0.31%	0	0.0%	2	0.21%
	Female	20	2.07%	1	0.10%	2	0.20%	2	0.21%	0	0.0%	2	0.21%
	Grand total	**23**	**2.38%**	**7**	**0.72%**	**2**	**0.20%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.42%**

Protected Characteristic	Group	Band 8A		Band 8B		Band 8C		Band 8D		Band 9		Directors/CEO	
		Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %	Number	Trust %
Religion or belief	Atheism	2	0.21%	1	0.10%	2	0.21%	0	0.0%	0	0.0%	0	0.0%
	Buddhism	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Christianity	13	1.34%	2	0.21%	0	0.0%	4	0.41%	0	0.0%	2	0.21%
	Hinduism	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Islamism	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Jainism	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Judaism	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Sikhism	1	0.10%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Other	2	0.21%	1	0.10%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Not disclosed	4	0.41%	2	0.21%	0	0.0%	1	0.10%	0	0.0%	1	0.10%
	Not stated/Undefined	1	0.10%	1	0.10%	0	0.0%	0	0.0%	0	0.0%	1	0.10%
	Grand total	**23**	**2.38%**	**7**	**0.72%**	**2**	**0.21%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.41%**
Sexual Orientation	Lesbian	0	0.0%	0	0.0%	1	0.10%	0	0.0%	0	0.0%	0	0.0%
	Heterosexual	3	0.31%	1	0.10%	0	0.0%	1	0.10%	0	0.0%	1	0.10%
	Gay	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Bi-sexual	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Not disclosed	3	0.31%	1	0.10%	0	0.0%	1	0.10%	0	0.0%	1	0.10%
	Not stated/Undefined	17	1.76%	5	0.52%	1	0.10%	3	0.31%	0	0.0%	2	0.21%
	Grand total	**23**	**2.38%**	**7**	**0.72%**	**2**	**0.21%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.41%**
Disability	Yes	3	0.31%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	No	17	1.76%	4	0.41%	2	0.21%	4	0.41%	0	0.0%	4	0.41%
	Not stated/Undefined	3	0.31%	3	0.31%	0	0.0%	1	0.10%	0	0.0%	0	0.0%
	Grand total	**23**	**2.38%**	**7**	**0.72%**	**2**	**0.21%**	**5**	**0.52%**	**0**	**0.0%**	**4**	**0.41%**

Protected characteristic	Group	NEDs/ Chair		M&D		Other		Total	Total
Ethnicity		Number	Trust %	Number	Trust %	Number	Trust %	Number	%
	A - White – British	6	0.62%	59	6.10%%	2	0.21%	726	75.00%
	B - White – Irish	0	0.0%	3	0.31%	0	0.0%	14	1.45%
	C - White – Any other white background	0	0.0%	23	2.38%	0	0.0%	72	7.44%
	Total White	**6**	**0.62%**	**85**	**8.78%**	**2**	**0.21%**	**812**	**83.88%**
	D - Mixed – White and Black Caribbean	0	0.0%	0	0.0%	0	0.0%	3	0.31%
	E - Mixed – White and Black African	0	0.0%	2	0.21%	0	0.0%	4	0.41%
	F - Mixed – White and Asian	0	0.0%	1	0.10%	0	0.0%	1	0.10%
	G - Other Mixed	0	0.0%	3	0.31%	0	0.0%	4	0.41%
	H - Indian	0	0..0%	13	1.34%	0	0.0%	25	2.58%
	J - Pakistani	0	0.0%	2	0.21%	0	0.0%	5	0.52%
	L - Other Asian	0	0.0%	1	0.10%	0	0.0%	21	2.17%
	M - Caribbean	0	0.0%	0	0.0%	0	0.0%	4	0.41%
	N - African	0	0.0%	1	0.10%	0	0.0%	5	0.52%
	P - Other Black	0	0.0%	3	0.31%	0	0.0%	6	0.62%
	R - Chinese	0	0.0%	3	0.31%	0	0.0%	4	0.41%
	S - Other	0	0.0%	8	0.83%	0	0.0%	36	3.72%
	Total BME	**0**	**0.0%**	**37**	**3.82%**	**0**	**0.0%**	**118**	**12.19%**
	Undefined	0	0.0%	8	0.83%	0	0.0%	16	1.65%
	Z - Not stated	0	0.0%	8	0.83%	0	0.0%	22	2.27%
	Grand total	**6**	**0.62%**	**138**	**14.26%**	**2**	**0.21%**	**968**	**100.00%**
Age	16-20	0	0.0%	0		0	0.0%	5	0.52%
	21-30	0	0.0%	18	1.86%	0	0.0%	130	13.43%
	31-40	0	0.0%	54	5.58%	1	0.10%	221	22.83%
	41-50	0	0.0%	42	4.34%	1	0.10%	283	29.24%
	51-60	3	0.31%	18	1.86%	0	0.0%	263	27.17%
	61-70	3	0.31%	6	0.62%	0	0.0%	63	6.51%
	71+	0	0.0%	0	0.0%	0	0.0%	3	0.31%
	Grand total	**6**	**0.62%**	**138**	**14.26%**	**2**	**0.21%**	**968**	**100.00%**
Gender	Male	4	0.41%	91	9.40%	1	0.10%	230	23.76%
	Female	2	0.21%	47	4.86%	1	0.10%	738	76.24%
	Grand total	**6**	**0.62%**	**138**	**14.26%**	**2**	**0.21%**	**968**	**100.00%**

Protected characteristic	Group	NEDs/ Chair		M&D		Other		Total	Total
		Number		Number		Number		Number	%
Religion or belief	Atheism	0	0.0%	8	0.83%	0	0.0%	85	8.78%
	Buddhism	0	0.0%	1	0.10%	0	0.0%	4	0.41%
	Christianity	0	0.0%	36	3.72%	0	0.0%	430	44.42%
	Hinduism	0	0.0%	4	0.41%	0	0.0%	7	0.72%
	Islamism	0	0.0%	6	0.62%	0	0.0%	8	0.83%
	Jainism	0	0.0%	0	0.0%	0	0.0%	0	0.00%
	Judaism	0	0.0%	0	0.0%	0	0.0%	0	0.00%
	Sikhism	0	0.0%	0	0.0%	0	0.0%	2	0.21%
	Other	0	0.0%	10	1.03%	0	0.0%	61	6.30%
	Not disclosed	0	0.0%	29	3.00%	2	0.21%	159	16.43%
	Not stated/Undefined	6	0.62%	44	4.55%	0	0.0%	212	21.90%
	Grand total	**6**	**0.62%**	**138**	**14.26%**	**2**	**0.21%**	**968**	**100.00%**
Sexual orientation	Lesbian	0	0.0%	0	0.0%	0	0.0%	3	0.31%
	Heterosexual	0	0.0%	18	1.86%	0	0.0%	118	12.19%
	Gay	0	0.0%	1	0.10%	0	0.0%	3	0.31%
	Bi-sexual	0	0.0%	0	0.0%	0	0.0%	2	0.21%
	Not disclosed	0	0.0%	18	1.86%	2	0.21%	117	12.09%
	Not stated/Undefined	6	0.62%	101	10.43%	0	0.0%	725	74.90%
	Grand total	**6**	**0.62%**	**138**	**14.26%**	**2**	**0.21%**	**968**	**100.00%**
Disability	Yes	0	0.0%	1	0.10%	0	0.0%	37	3.82%
	No	1	0.10%	66	6.82%	2	0.21%	567	58.57%
	Not stated/Undefined	5	0.52%	71	7.33%	0	0.0%	364	37.60%
	Grand total	6	**0.62%**	138	**14.26%**	2	**0.21%**	**968**	**100.00%**

Leavers

Protected characteristic	Group	Redundancy	% Split	Other reason for leaving	Leavers Percentage Split
Ethnicity					
	A - White – British	2	100%	107	61.14%
	B - White – Irish	0	0.00%	2	1.14%
	C - White – Any other white background	0	0.0%	21	12.00%
	Total White	**2**	**100.0%**	**130**	**74.29%**
	D - Mixed – White and Black Caribbean	0	0.0%	1	0.57%
	E - Mixed – White and Black African	0	0.0%	0	0.00%
	F - Mixed – White and Asian	0	0.0%	0	0.00%
	G - Other Mixed	0	0.0%	1	0.57%
	H - Indian	0	0.0%	10	5.71%
	J - Pakistani	0	0.0%	1	0.57%
	L - Other Asian	0	0.0%	9	5.14%
	M - Caribbean	0	0.0%	0	0.00%
	N - African	0	0.0%	3	1.71%
	P - Other Black	0	0.0%	1	0.57%
	R - Chinese	0	0.0%	6	3.43%
	S - Other	0	0.0%	4	2.29%
	Total BME	**0**	**0.0%**	**36**	**20.57%**
	Undefined	0	0.0%	5	2.86%
	Z - Not stated	0	0.0%	4	2.29%
	Grand Total	**2**	**100.0%**	**175**	**100.00%**
Age	16-20	0	0.0%	3	1.71%
	21-30	0	0.0%	52	29.71%
	31-40	0	0.0%	59	33.71%
	41-50	0	0.0%	23	13.14%
	51-60	2	100.0%	20	11.43%
	61-70	0	0.0%	17	9.71%
	71+	0	0.0	1	0.57%
	Grand Total	**2**	**100.0%**	**175**	**100.00%**

Protected characteristic	Group	Redundancy	% Split	Other reason for leaving	Leavers Percentage Split
Gender	Male	1	50.0%	67	38.29%
	Female	1	50.0%	108	61.71%
	Grand Total	**2**	**100.0%**	**175**	**100.00%**
Religion or belief	Atheism	0	0.0%	21	12.00%
	Buddhism	0	0.0%	2	1.14%
	Christianity	0	0.0%	60	34.29%
	Hinduism	0	0.0%	6	3.43%
	Islamism	0	0.0%	3	1.71%
	Jainism	0	0.0%	0	0.00%
	Judaism	0	0.0%	0	0.00%
	Sikhism	0	0.0%	2	1.14%
	Other	0	0.0%	10	5.71%
	Not disclosed	0	0.0%	43	24.57%
	Not stated/Undefined	2	100.0%	28	16.0%
	Grand Total	**2**		**175**	**100.00%**
Sexual orientation	Bi-sexual	0	0.0%	0	0.00%
	Gay	0	0.0%	1	0.57%
	Heterosexual	0	0.0%	111	63.43%
	Lesbian	0	0.0%	0	0.0%
	Not disclosed	0	0.0%	35	20.0%
	Not stated/Undefined	2	100.0%	28	16.0%
	Grand Total	**0**	**100.0%**	**175**	**100.00%**
Disability	Yes	0	0.0%	3	1.71%
	No	0	0.0%	98	56.00%
	Not stated/Undefined	2	100.0%	74	42.29%
	Grand Total	**2**	**100.0%**	**175**	**100.00%**

Recruitment

Protected characteristic	Group	Applicants			Shortlisted			Appointed			Workforce profile		
Ethnicity		Number	%	% shift from 2012	Number	%	% shift from 2012	Number	%	% shift from 2012	Number	%	% shift from 2012
	A - White – British	2248	54.2%	5.80%	806	65.5%	3.40%	180	68.7%	-12.40%	726	75.00%	0.27%
	B - White – Irish	40	1.0%	-0.40%	16	1.3%	-0.50%	4	1.5%	-0.90%	14	1.45%	0.17%
	C - White – Any other white background	427	10.3%	-0.60%	112	9.1%	0.50%	28	10.7%	-3.10%	72	7.44%	-0.02%
	Total White	**2715**	**65.5%**	**4.80%**	**934**	**75.9%**	**3.40%**	**212**	**80.9%**	**-16.40%**	**812**	**83.88%**	**0.42%**
	D - Mixed – White and Black Caribbean	15	0.4%	-0.10%	11	0.9%	0.60%	1	0.4%	0.40%	3	0.31%	-0.01%
	E - Mixed – White and Black African	32	0.8%	0.20%	1	0.1%	-0.20%	1	0.4%	-0.40%	4	0.41%	-0.02%
	F - Mixed – White and Asian	27	0.7%	0.20%	9	0.7%	0.30%	1	0.4%	0.40%	1	0.10%	0.10%
	G - Other Mixed	38	0.9%	0.40%	12	1.0%	0.60%	5	1.9%	1.90%	4	0.41%	0.09%
	H - Indian	423	10.2%	-1.50%	71	5.8%	-1.50%	8	3.1%	1.50%	25	2.58%	-0.41%
	J - Pakistani	127	3.1%	-0.90%	21	1.7%	-0.40%	5	1.9%	1.90%	5	0.52%	0.20%
	L - Other Asian	245	5.9%	-0.60%	64	5.2%	1.60%	15	5.7%	1.80%	21	2.17%	-0.39%
	M - Caribbean	33	0.8%	-0.10%	16	1.3%	0.40%	3	1.1%	1.10%	4	0.41%	0.20%
	N - African	262	6.3%	-1.80%	42	3.4%	-3.70%	5	1.9%	-0.50%	5	0.52%	-0.01%
	P - Other Black	22	0.5%	0.00%	4	0.3%	0.00%	0	0.0%	0.00%	6	0.62%	0.09%
	R – Chinese	24	0.6%	-0.20%	5	0.4%	-0.40%	2	0.8%	0.00%	4	0.41%	-0.44%
	S – Other	130	3.1%	0.00%	25	2.0%	-0.40%	3	1.1%	0.30%	36	3.72%	0.20%
	Total BME	**1378**	**33.2%**	**-4.40%**	**281**	**22.8%**	**-3.10%**	**49**	**18.7%**	**8.40%**	**118**	**12.19%**	**-0.40%**
	Undefined	0	0.0%	0.00%	0	0.0%	0.00%	1	0.4%	0.00%	4	0.41%	-0.02%
	Z - Not stated	54	1.3%	-0.40%	15	1.2%	-0.20%	0	0.0%	-0.48%	34	3.51%	-0.01%
	Grand total	**4147**	**100.0%**		**1230**	**100.0%**		**262**	**100.0%**		**968**	**100.00%**	

Protected characteristic	Group	Applicants			Shortlisted			Appointed			Workforce profile		
Age	16-20	145	3.5%	0.70%	29	2.4%	0.30%	6	2.3%	-0.10%	5	0.52%	-0.12%
	21-30	1474	35.5%	-2.70%	344	28.0%	-0.70%	73	27.9%	-1.20%	130	13.43%	0.53%
	31-40	1085	26.2%	-1.80%	295	24.0%	-4.50%	75	28.6%	1.80%	220	22.73%	-0.51%
	41-50	866	20.9%	1.60%	335	27.2%	2.70%	69	26.3%	-2.00%	284	29.34%	0.77%
	51-60	500	12.1%	1.90%	196	15.9%	1.60%	35	13.4%	0.00%	263	27.17%	-0.23%
	61-70	77	1.9%	0.30%	31	2.5%	0.60%	4	1.5%	1.50%	63	6.51%	-0.31%
	71+	0	0.0%	0.00%	0	0.0%	0.00%	0	0.0%	0.00%	3	0.31%	-0.13%
	Grand total	**4147**	**100.0%**	**0.00%**	**1230**	**100.0%**	**0.00%**	**262**	**100.0%**	**0.00%**	**968**	**100.00%**	**0.00%**
Gender	Male	1232	29.7%	-0.50%	279	22.7%	-1.30%	62	23.7%	8.00%	230	23.76%	-0.23%
	Female	2911	70.2%	0.50%	951	77.3%	1.40%	200	76.3%	-8.00%	738	76.24%	0.23%
	undisclosed	4	0.1%	0.00%	0	0.0%	0.10%	0	0.0%	0.00%	0	0.00%	0.00%
	Grand total	4147	100.0%	0.00%	1230	100.0%	0.00%	262	100.0%	0.00%	968	100.00%	0.00%
Religion or belief	Atheism	474	11.4%	1.70%	158	12.8%	1.60%	32	12.2%	-2.00%	85	8.78%	0.68%
	Buddhism	46	1.1%	0.20%	15	1.2%	0.80%	2	0.8%	0.80%	4	0.41%	-0.12%
	Christianity	2226	53.7%	-1.60%	730	59.3%	-1.00%	158	60.3%	-6.60%	430	44.42%	2.31%
	Hinduism	291	7.0%	0.00%	40	3.3%	0.10%	4	1.5%	1.50%	7	0.72%	-0.03%
	Islamism	307	7.4%	-2.50%	48	3.9%	-3.20%	12	4.6%	3.00%	8	0.83%	0.62%
	Jainism	9	0.2%	0.10%	2	0.2%	0.20%	1	0.4%	0.40%	0	0.00%	0.00%
	Judaism	8	0.2%	-0.10%	1	0.1%	-0.30%	0	0.0%	-0.80%	0	0.00%	0.00%
	Sikhism	28	0.7%	-0.20%	11	0.9%	0.30%	1	0.4%	-0.40%	2	0.21%	0.00%
	Other	381	9.2%	1.10%	102	8.3%	1.00%	18	6.9%	-1.00%	61	6.30%	0.22%
	Not disclosed	377	9.1%	1.30%	123	10.0%	0.50%	34	13.0%	5.10%	159	16.43%	0.23%
	Not stated/Undefined	0	0.0%	0.00%	0	0.0%	0.00%	0	0.0%	0.00%	212	21.90%	-3.91%
	Grand total	**4147**	**100.0%**	**0.00%**	**1230**	**100.0%**	**0.00%**	**262**	**100.0%**	**0.00%**	**968**	**100.00%**	**0.00%**
Sexual Orientation	Bi-sexual	44	1.1%	-0.20%	6	0.5%	-0.70%	0	0.0%	-1.60%	2	0.21%	0.00%
	Gay	30	0.7%	0.20%	7	0.6%	0.00%	0	0.0%	-0.80%	3	0.31%	-0.01%
	Heterosexual	3739	90.2%	0.70%	1114	90.6%	-0.60%	244	93.1%	1.00%	118	12.19%	-48.90%
	Lesbian	12	0.3%	-0.20%	5	0.4%	-0.10%	0	0.0%	-1.60%	3	0.31%	0.20%
	Not disclosed	322	7.8%	-0.50%	98	8.0%	1.40%	18	6.9%	3.00%	117	12.09%	-0.38%
	Not stated/ Undefined	0	0.0%	0.00%	0	0.0%	0.00%	0	0.0%	0.00%	725	74.90%	49.09%
	Grand total	**4147**	**100.0%**	**0.00%**	**1230**	**100.0%**	**0.00%**	**262**	**100.0%**	**0.00%**	**968**	**100.00%**	**0.00%**
Disability	Yes	124	3.0%	-1.00%	51	4.1%	-1.50%	10	3.8%	3.00%	37	3.82%	-0.96%
	No	3993	96.3%	0.90%	1169	95.0%	1.90%	252	96.2%	-2.20%	567	58.57%	3.56%
	Not stated/ Undefined	30	0.7%	0.10%	10	0.8%	-0.40%	0	0.0%	-0.80%	364	37.60%	-2.60%
	Grand total	**4147**	**100.0%**	**0.00%**	**1230**	**100.0%**	**0.00%**	**262**	**100.0%**	**0.00%**	**968**	**100.00%**	**0.00%**

Clinical excellence Awards

Protected characteristic	Group	Consultant Numbers	CEA Winners	Percentage of CEA Consultant Winners	Percentage of Consultants in post
Ethnicity					
	A - White – British	30	3	37.50%	51.72%
	B - White – Irish	1	0	0.00%	1.72%
	C - White – Any other white background	7	2	25.00%	12.07%
	Total White	**38**	**5**	**62.50%**	**65.52%**
	D - Mixed – White and Black Caribbean	0	0	0.00%	0.00%
	E - Mixed – White and Black African	1	0	0.00%	1.72%
	F - Mixed – White and Asian	0	0	0.00%	0.00%
	G - Other Mixed	0	0	0.00%	0.00%
	H - Indian	7	2	25.00%	12.07%
	J - Pakistani	0	0	0.00%	0.00%
	L - Other Asian	0	0	0.00%	0.00%
	M - Caribbean	0	0	0.00%	0.00%
	N - African	1	0	0.00%	1.72%
	P - Other Black	1	0	0.00%	1.72%
	R - Chinese	1	0	0.00%	1.72%
	S - Other	3	0	0.00%	5.17%
	Total BME	**14**	**2**	**25.00%**	**24.14%**
	Undefined	0	0	0.00%	0.00%
	Z - Not stated	6	1	12.50%	10.34%
	Grand total	**58**	**8**	**100.00%**	**100.00%**
Age	16-20	0	0	0.00%	0.00%
	21-30	0	0	0.00%	0.00%
	31-40	7	2	25.00%	12.07%
	41-50	32	4	50.00%	55.17%
	51-60	15	2	25.00%	25.86%
	61-70	4	0	0.00%	6.90%
	71+	0	0	0.00%	0.00%
	Grand total	**58**	**8**	**100.00%**	**100.00%**

Protected characteristic	Group	Consultant Numbers	CEA Winners	Percentage of CEA Consultant Winners	Percentage of Consultants in post
Gender	Male	44	5	62.50%	75.86%
	Female	14	3	37.50%	24.14%
	Grand total	**58**	**8**	**100.00%**	**100.00%**
Religion or belief	Atheism	3	0	0.00%	5.17%
	Buddhism	0	0	0.00%	0.00%
	Christianity	12	1	12.50%	20.69%
	Hinduism	1	0	0.00%	1.72%
	Islamism	1	0	0.00%	1.72%
	Jainism	0	0	0.00%	0.00%
	Judaism	0	0	0.00%	0.00%
	Sikhism	0	0	0.00%	0.00%
	Other	0	2	25.00%	0.00%
	Not disclosed	8	0	0.00%	13.79%
	Not stated/Undefined	33	5	62.50%	56.90%
	Grand total	**58**	**8**	**100.00%**	**100.00%**
Sexual orientation	Bi-sexual	0	0	0.00%	0.00%
	Gay	0	0	0.00%	0.00%
	Heterosexual	24	3	37.50%	41.38%
	Lesbian	0	0	0.00%	0.00%
	Not disclosed	7	0	0.00%	12.07%
	Not stated/Undefined	27	5	62.50%	46.55%
	Grand total	**58**	**8**	**100.00%**	**100.00%**
Disability	Yes	1	1	12.50%	1.72%
	No	23	2	25.00%	39.66%
	Not stated/Undefined	34	5	62.50%	58.62%
	Grand total	**58**	**8**	**100.00%**	**100.00%**

Employee Relations

Protected characteristic	Group	Capability - Poor performance	Capability - ill Heath	Conduct	Suspension/ Exclusion	Bullying and Harassment	Grievance	Employment Tribunal
Ethnicity								
	A - White – British	1	12	7	3	5	0	0
	B - White – Irish	0	0	1	0	0	0	0
	C - White – Any other white background	1	2	0	0	0	0	0
	Total White	2	14	8	3	5	0	0
	D - Mixed – White and Black Caribbean	0	0	0	0	0	0	0
	E - Mixed – White and Black African	0	0	0	0	0	0	0
	F - Mixed – White and Asian	0	0	0	0	0	0	0
	G - Other Mixed	0	0	0	0	0	0	0
	H - Indian	0	0	0	0	0	0	0
	J - Pakistani	0	0	0	0	0	0	0
	L - Other Asian	0	0	3	0	0	0	0
	M - Caribbean	0	0	0	0	0	0	0
	N - African	1	0	0	0	0	0	0
	P - Other Black	0	2	0	0	1	0	0
	R - Chinese	0	0	0	0	0	0	0
	S - Other	0	2	0	0	0	0	0
	Total BME	**1**	**4**	**3**	**0**	**1**	**0**	**0**
	Undefined	0	0	0	0	0	0	0
	Z - Not stated	0	0	0	0	0	0	0
	Grand total	**3**	**18**	**11**	**3**	**6**	**0**	**0**
Age	16-20	0	0	0	0	0	0	0
	21-30	0	2	1	0	0	0	0
	31-40	2	0	1	1	0	0	0
	41-50	1	9	4	1	0	0	0
	51-60	0	6	3	0	3	0	0
	61-70	0	1	2	1	3	0	0
	71+	0	0	0	0	0	0	0
	Grand total	**3**	**18**	**11**	**3**	**6**	**0**	**0**
Gender	Male	2	2	5	3	0	0	0
	Female	1	16	6	0	6	0	0
	Grand total	**3**	**18**	**11**	**3**	**6**	**0**	**0**

Protected characteristic	Group	Capability - Poor performance	Capability - ill Heath	Conduct	Suspension/ Exclusion	Bullying and Harassment	Grievance	Employment Tribunal
Religion or belief								
	Atheism	0	0	0	0	1	0	0
	Buddhism	0	0	0	0	0	0	0
	Christianity	2	10	1	0	3	0	0
	Hinduism	0	0	0	0	0	0	0
	Islamism	0	0	0	0	0	0	0
	Jainism	0	0	0	0	0	0	0
	Judaism	0	0	0	0	0	0	0
	Sikhism	0	0	0	0	0	0	0
	Other	0	2	0	0	1	0	0
	Not disclosed	0	3	3	2	1	0	0
	Not stated/Undefined	1	3	7	1	0	0	0
	Grand total	**3**	**18**	**11**	**3**	**6**	**0**	**0**
Sexual Orientation	Bi-sexual	0	0	0	0	0	0	0
	Gay	0	0	0	0	0	0	0
	Heterosexual	2	12	3	1	5	0	0
	Lesbian	0	0	0	0	0	0	0
	Not disclosed	0	3	1	1	1	0	0
	Not stated/Undefined	1	3	7	1	0	0	0
	Grand total	**3**	**18**	**11**	**3**	**6**	**0**	**0**
Disability	Yes	0	2	0	0	1	0	0
	No	3	10	3	1	3	0	0
	Not stated/Undefined	0	6	8	2	2	0	0
	Grand total	**3**	**18**	**11**	**3**	**6**	**0**	**0**

Trust mandatory training, classroom courses:

AED - INITIAL	Equality, Diversity & Human Rights	Manual Handling Clinical INITIAL
AED - UPDATE	Equality Impact Assessment Training	Manual Handling Clinical Update
Basic Life Support - INITIAL	Essential Risk Management Study Day	Manual Handling Non Clinical - INITIAL
Child Protection Level 1 Update	Fire Evacuation & Safety Awareness	Manual Handling Non Clinical Update
Child Protection Level 2	Fire Team Training	Medical Gases
Clinical Mandatory Training	Hospital Immediate Life Support (HILS)	Non Clinical Mandatory Training
Conflict Resolution INITIAL	Immediate Life Support (ILS)	Paediatric Intermediate Life Support (PILS)
Conflict Resolution Update	Information Governance Initial	Paediatric Hospital Immediate Life Support (PHILS)
Defibrillation Pacing Cardioversion	Information Governance Update	Safeguarding Adults Update
Dementia Awareness Training	IT Log On Training	Trust Induction
Doctors Clinical Mandatory Training	Junior Doctors Induction	

Non-mandatory training classroom courses:	Approximately 50 different course titles for clinical and non-clinical staff. Categories include Leadership, Personal development, Information Technology and clinical skills

OTHER TRAINING:

PTD	PTD (Personal Training Day) post registration funded continuing professional development PTD training is linked to the clinical workforce and most directly through clinical knowledge and skills development sessions. Trust staff access this training at the University of Brighton. Some PTD funds are ring-fenced for essential training and eligible staff are automatically booked to attend by virtue of their role or position.
PTDe	PTDe (Personal Training Day elsewhere) funded continuing professional development PTDe training is commonly linked with clinical knowledge and skills development but sometimes through management and leadership development in the clinical context; all at post registration level. It enables staff to access training and development not available through the PTD contract with the University of Brighton.
RW	RW (Rosemary Wootton Fund) The League of Friends created an educational bursary intended to assist all grades of non-medical staff in the hospital who wish to attend educational courses, seminars and conferences. The fund does not apply to mandatory training activities as these are the remit of the Trust. Staff submit an application form to the Funding Panel which meets bi-monthly.
L&D	L&D (Learning & Development) Mandatory and non-mandatory courses are funded from this budget as well as 'train the trainer' courses for QVH staff who deliver mandatory training. Some Funding Panel applications are also met from this budget
WPL	WPL (Widening Participation for Learning) for Bands 1-4 Includes NVQs, Skills for Health, Key Skills training run by FE colleges and other providers.

NB: Training data records episodes of training, not headcount, as staff attend multiple training events throughout the year.

Training episodes

Total episodes Jan to Dec 2013: 6045

Protected characteristic	Group	Mandatory episodes attended	Non-Mandatory episodes attended	Trust representation
Ethnicity				
	A - White – British	76.23%	36%	57.32%
	B - White – Irish	1.57%	1%	1.21%
	C - White – Any other white background	7.14%	3%	5.28%
	Total White	84.94%	40%	63.80%
	D - Mixed – White and Black Caribbean	0.31%	0%	0.26%
	E - Mixed – White and Black African	0.25%	0%	0.43%
	F - Mixed – White and Asian	0.06%	0%	0.03%
	G - Other Mixed	0.19%	0%	0.18%
	H - Indian	2.19%	1%	1.62%
	J - Pakistani	0.41%	0%	0.35%
	K - Asian or Asian British - Banladeshi	0.03%	0%	0.02%
	L - Other Asian	2.51%	1%	1.97%
	M - Caribbean	0.19%	0%	0.13%
	N - African	0.75%	0%	0.53%
	P - Other Black	0.56%	0%	0.38%
	R - Chinese	0.34%	0%	0.26%
	S - Other	4.26%	2%	3.28%
	Total BME	**12.06%**	**6%**	**9.26%**
	Undefined	0.60%	0%	0.43%
	Z - Not stated	2.41%	1%	1.56%
	Grand total	**100.00%**	**47%**	**75.05%**
Age	16-20	4%	2%	3.11%
	21-30	27%	13%	20.60%
	31-40	32%	14%	23.49%
	41-50	25%	12%	19.01%
	51-60	10%	5%	7.34%
	61-70	2%	1%	1.21%
	71+	0%	0%	0.31%
	Grand total	**100%**	**47%**	**75.07%**

Protected characteristic	Group	Mandatory episodes attended	Non-Mandatory episodes attended	Trust representation
Gender	Male	18%	6%	12.24%
	Female	82%	41%	62.83%
	Grand total	100%	47%	75.07%
Religion or belief	Atheism	8%	5%	6.80%
	Buddhism	1%	0%	0.48%
	Christianity	49%	24%	37.04%
	Hinduism	1%	0%	0.48%
	Islamism	1%	0%	0.41%
	Jainism	0%	0%	0.00%
	Judaism	0%	0%	0.00%
	Sikhism	0%	0%	0.20%
	Other	6%	3%	4.76%
	Not disclosed	15%	7%	11.56%
	Not stated/Undefined	19%	7%	13.33%
	Grand total	**100%**	**47%**	**75.07%**
Sexual orientation	Bi-sexual	0%	0%	0.26%
	Gay	0%	0%	0.20%
	Heterosexual	69%	34%	52.69%
	Lesbian	0%	0%	0.33%
	Not disclosed	11%	6%	8.30%
	Not stated/Undefined	19%	7%	13.28%
	Grand total	**100%**	**47%**	**75.07%**
Disability	Yes	4%	2%	2.93%
	No	59%	31%	46.09%
	Not stated/Undefined	37%	14%	26.05%
	Grand total	**100%**	**47%**	**75.07%**

Training - source of funding

Total episodes Jan to Dec 2013: 79

Protected characteristic	Group	L&D	PTD	PTDe	RW	WPL	TOTAL	Trust representation
Ethnicity								
	A - White – British	2.53%	2.53%	18.99%	58.23%	0.00%	82.28%	57.32%
	B - White – Irish	0.00%	0.00%	0.00%	1.00%	0.00%	1.00%	1.21%
	C - White – Any other white background	2.00%	0.00%	2.00%	0.00%	0.00%	4.00%	5.28%
	Total White	4.53%	2.53%	20.99%	59.23%	0.00%	87.28%	63.80%
	D - Mixed – White and Black Caribbean	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.26%
	E - Mixed – White and Black African	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.43%
	F - Mixed – White and Asian	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%
	G - Other Mixed	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.18%
	H - Indian	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.62%
	J - Pakistani	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.35%
	K - Asian or Asian British - Banladeshi	0%	0%	0%	0%	0%	0.00%	0.02%
	L - Other Asian	0.00%	0.00%	0.60%	0.00%	0.00%	0.60%	1.97%
	M - Caribbean	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.13%
	N - African	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.53%
	P - Other Black	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.38%
	R - Chinese	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.26%
	S - Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.28%
	Total BME	**0.00%**	**0.00%**	**0.60%**	**0.00%**	**0.00%**	**0.60%**	**9.26%**
	Undefined	0.00%	0.00%	0.00%	1.27%	0.00%	1.27%	0.43%
	Z - Not stated	0.00%	0.00%	0.00%	5.06%	0.00%	5.06%	1.56%
	Grand total	**4.53%**	**2.53%**	**21.59%**	**65.56%**	**0.00%**	**94.21%**	**75.05%**
Age	16-20	0.00%	0.00%	0.00%	1.27%	0.00%	1.27%	3.11%
	21-30	0.00%	0.00%	0.00%	2.53%	0.00%	2.53%	20.60%
	31-40	1.27%	0.00%	10.13%	29.11%	0.00%	40.51%	23.49%
	41-50	2.53%	0.00%	8.86%	13.92%	0.00%	25.32%	19.01%
	51-60	1.27%	2.53%	3.80%	20.25%	0.00%	27.85%	7.34%
	61-70	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.21%
	71+	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.31%
	Grand total	**5.06%**	**2.53%**	**22.78%**	**67.09%**	**0.00%**	**97.47%**	**75.07%**

Protected characteristic	Group	L&D	PTD	PTDe	RW	WPL	TOTAL	Trust representation
Gender	Male	0.00%	0.00%	8.86%	11.39%	0.00%	20.25%	12.24%
	Female	5.06%	2.53%	16.46%	55.70%	0.00%	79.75%	62.83%
	Grand total	**5.06%**	**2.53%**	**25.32%**	**67.09%**	**0.00%**	**100.00%**	**75.07%**
Religion or belief	Atheism	1.27%	0.00%	8.86%	7.59%	0.00%	17.72%	6.80%
	Buddhism	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.48%
	Christianity	2.53%	2.53%	7.59%	43.04%	0.00%	55.70%	37.04%
	Hinduism	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.48%
	Islamism	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.41%
	Jainism	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Judaism	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Sikhism	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.20%
	Other	0.00%	0.00%	3.80%	2.53%	0.00%	6.33%	4.76%
	Not disclosed	0.00%	0.00%	1.27%	12.66%	0.00%	13.92%	11.56%
	Not stated/Undefined	1.27%	0.00%	1.27%	1.27%	0.00%	3.80%	13.33%
	Grand total	**5.06%**	**2.53%**	**22.78%**	**67.09%**	**0.00%**	**97.47%**	**75.07%**
Sexual orientation	Bi-sexual	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.26%
	Gay	0.00%	0.00%	2.53%	0.00%	0.00%	2.53%	0.20%
	Heterosexual	3.80%	2.53%	17.72%	59.49%	0.00%	83.54%	52.69%
	Lesbian	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.33%
	Not disclosed	0.00%	0.00%	1.27%	6.33%	0.00%	7.59%	8.30%
	Not stated/Undefined	1.27%	0.00%	1.27%	1.27%	0.00%	3.80%	13.28%
	Grand total	**5.06%**	**2.53%**	**22.78%**	**67.09%**	**0.00%**	**97.47%**	**75.07%**
Disability	Yes	0.00%	0.00%	1.27%	2.53%	0.00%	3.80%	2.93%
	No	2.53%	1.27%	13.92%	35.44%	0.00%	53.16%	46.09%
	Not stated/Undefined	2.53%	1.27%	7.59%	29.11%	0.00%	40.51%	26.05%
	Grand total	**5.06%**	**2.53%**	**22.78%**	**67.09%**	**0.00%**	**97.47%**	**75.07%**

A Summary of our Community Equality Profile

The information below sets out broadly what we know about the profile of different groups of people in Mid Sussex, and helps us to understand better the equality issues which may impact on the people who may use our services.

Disability

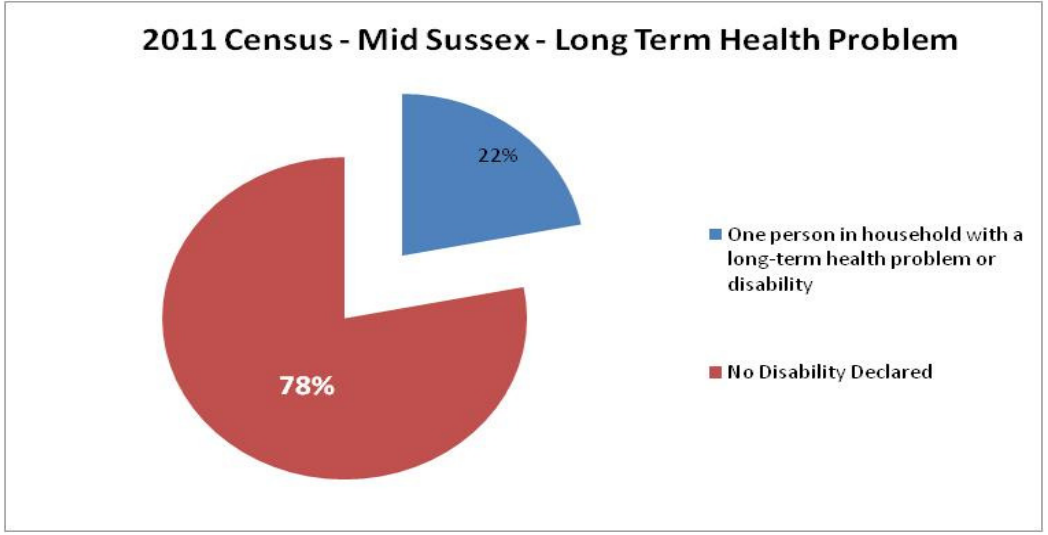
In relation to the Equality Act, a person has a disability if they have “a mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities”.
According to some definitions there are currently around 11 million disabled adults and 770,000 children in the UK, equivalent to 24% of the adult population and 7% of all children[1].

The population of disabled people includes wheelchair users, blind people and deaf people – these are an important minority of the total, but the majority of disabled people have other (often less visible) impairments.

Among adults, trends show increasing numbers of people reporting mental illness and behavioural disorders, while the number of people reporting physical impairments is decreasing.

The chart below shows that in the 2011 Census, 78% of the residents of Mid Sussex stated that they did not have a disability.

[1] Office for National Statistics (2004) “Living in Britain: Results from the 2002 General Household Survey”



In QVH we do not currently capture data related to disability of our patients. This is because our Patient Administration System has not been set up to capture this data. In 2014 we intend to address this issue so that we are able to understand more fully how we are meeting the needs of patients who identify as being disabled. This will be looked at by the Strategy Group in 2014.

Gender

The gender profile of Mid Sussex broadly reflects the national picture. This is shown in Table 1:

Table 1 **Gender Statistics (Census 2011)**

Area	Total Population	Male	%	Female	%
Mid Sussex	33,403	16,467	49.3%	16,935	50.7%
England	53,012,500	26,069,200	49%	26,943,300	51%

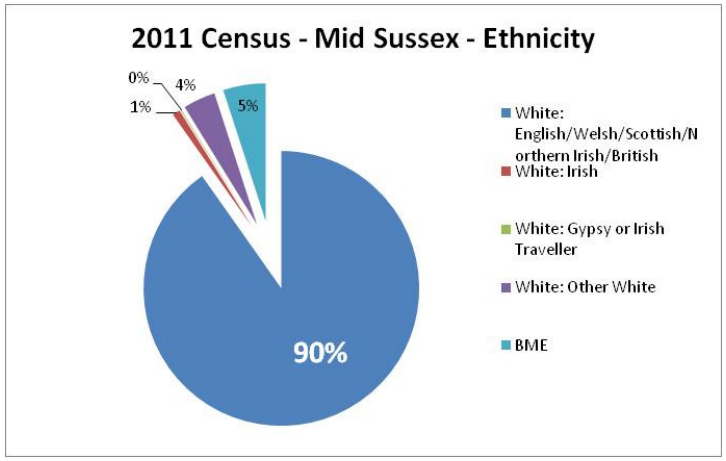
The number of transgender people is not accurately known. Because of the social stigma attached to this, arising from a widespread lack of awareness of the true nature of the condition, it is something that is often kept hidden. Therefore it is only possible to collect statistics on the numbers of declared transsexuals and such figures undoubtedly represent only a proportion of those affected. We do not yet have the means to gather reliable data on the numbers or needs of our transgender residents. However we are working to improve the data available to us.

Race

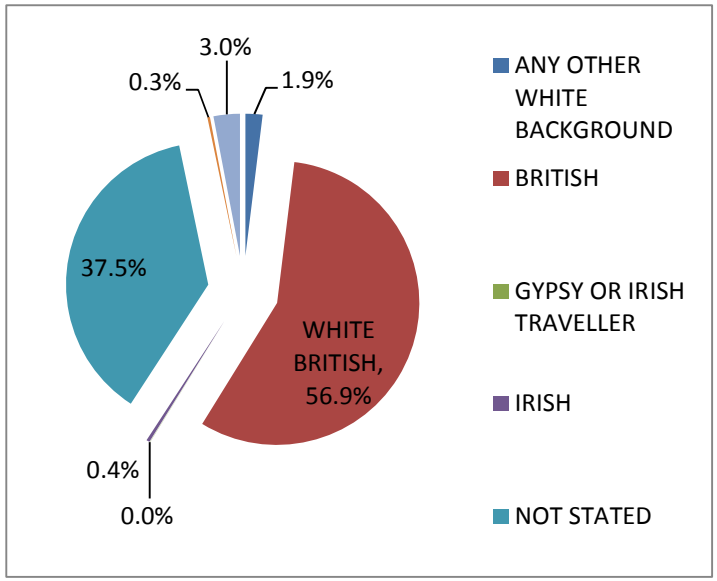
Ethnic Group

According to the 2011 census, most residents of Mid Sussex belonged to the White ethnic group (95%). The data codes used to capture patient information at QVH does not compare easily to the Census data. Essentially 3% of patients treated in QVH in 2013 identified at non-white, 59.5% identified as white and 37.5% did not state their ethnicity. As a trust we need to look to improving capturing our ethnicity data of our patients

Ethnic Group (Census 2011)



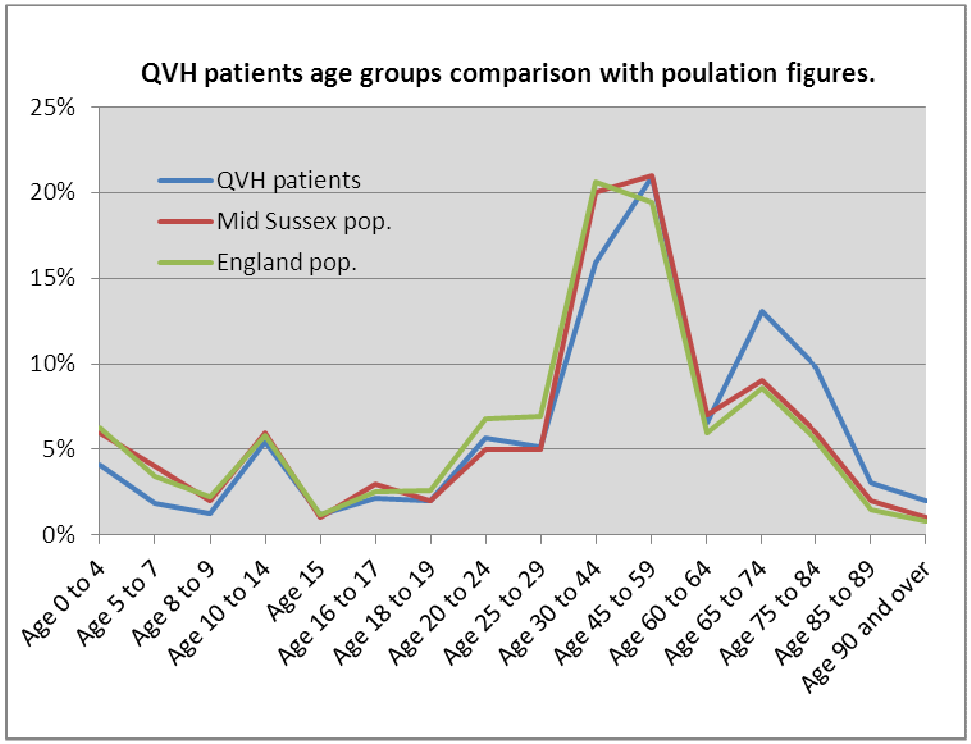
Ethnic Group (QVH Patients 2013)



Mid Sussex has a relatively small black and ethnic minority population. Gypsies and Travellers, including those identifying themselves as Gypsy Romany or Irish Travellers, were separately identified for the first time in the 2011 Census. In England and Wales 56,000 people identified themselves as Gypsy/Irish traveller, with 142 living in Mid Sussex. Of the 45,617 patients treated in QVH in 2013, just 13 patients identified as Gypsy/Irish Traveller.

Age

The age profile of the patients treated in QVH in 2013 broadly reflects that of both the local and national population. The only slight deviation in this number appears to be in the older population, which may reflect the work QVH does with skin cancer patients as this tends to affect older people more.



Sexual Orientation

Although there is no hard data on the number of lesbians, gay men and bisexuals in the UK as no national census has ever asked people to define their sexuality, government actuaries estimate that 6% of the population is lesbian, gay or bisexual (LGB). This represents around 3.6 million people – or 1 in 16 Britons.

Unfortunately there is a lack of data documenting sexual identity at a District level.
However, a recent ONS[2] survey suggests that sexual identity in the South East is similar to that of the UK. There were a higher proportion of people who identified themselves as gay/lesbian/bisexual in the South East – 1.5 per cent compared to 1.0 per cent across

the UK as a whole. In QVH we do not capture data on sexual orientation. Until there is a national requirement to do so, the software manufacturer will not upgrade their system to enable us to capture this.

Religion / Belief

The question on religion affiliation in the census was introduced in 2001 and is voluntary. In the 2011 Census, 75.9% of Mid Sussex residents affiliated with the Christian religion. The table below indicates that a large proportion of QVH patients in 2013 did not state their religion. This may be as they were not asked the question on admission to QVH services and this is an area for improvement.

	Christian	Buddhist	Jewish	Hindu	Muslim	Sikh	Other religion	No religion	Not stated
QVH patients 2013	**25.7%**	**0.10%**	**0.06%**	**0.29%**	**0.7%**	**0.17%**	**0.5%**	**16.7%**	**55.82%**
Mid Sussex	75.9%	**0.2%**	**0.3%**	**0.2%**	**0.6%**	**0.1%**	**0.6%**	**15.3%**	**6.8%**
West Sussex	**74.5%**	**0.2%**	**0.6%**	**0.2%**	**1.0%**	**0.1%**	**0.4%**	**15.6%**	**7.4%**
South East	**72.8%**	**0.3%**	**0.6%**	**0.2%**	**1.4%**	**0.5%**	**0.4%**	**16.5%**	**7.5%**
England	**71.7%**	**0.3%**	**1.1%**	**0.5%**	**3.1%**	**0.7%**	**0.3%**	**14.6%**	**7.7%**

Interpreting and translation services

Communication

Across all Trust services there are specific issues around ensuring accessibility of information and communication particularly for people with certain disabilities and people who do not speak or read English.

While it is our aim to support all those moving into our area to learn to speak English so as to be able to participate fully, it is also important to make sure that the Trust can make information available in a range of languages for those who cannot yet understand English.

There are some particular challenges in Mid Sussex, because, while our population does include groups of people for whom English is not a first language, these are generally small, diverse and geographically scattered, so that requirements for translation and interpretation require individualised responses. Access to telephone interpretation is available, and face to face and British Sign Language interpretation can be arranged.

During 2013, 53 face to face translations, including 6 for British Sign Language were used within QVH services, and 36 telephone interpretations were required. This is demonstrated below:

Language	No. of Face to Face Sessions	Telephone interpretation
Bulgarian	2	1
Russian	1	6
Polish	6	14
Tamil	2	
Czech	1	2
Turkish	8	3
Arabic	1	2
Gujurati	2	
Hindi	1	1
Spanish	2	3
Cantonese	6	
Romanian	4	
Hungarian	2	1
Nepalese	3	1
Slovak	2	
Mandarin	4	2
British Sign Language	6	

Total	**53**	**36**

Learning from Complaints

In 2013 there were 88 complaints in total. Of these 88 complaints, 2 related to equality issues. One patient was partially sighted and felt that their needs were not fully understood and accommodated for by staff. This complaint was upheld. Competency training for dealing with patients who are visually impaired has been introduced. A new colour coding for visually impaired patients on the Patient Status Board has also been introduced so that from a glance, staff are aware that additional requirements are needed. The other patient was a child with learning disabilities and the mother of the child felt that the patient was treated differently due to their disability. This complaint was upheld in part and although it was not found that this patient was treated any differently it was recommended that further Learning Disability training be provided to the staff in the unit. It was also recommended that all the nurses on the unit receive feedback regarding the complaint in order to highlight the impact that this had to the carer and to reiterate the importance of being understanding and aware of patient's specific needs.

Complaints are an important way of learning more about the equality issues that impact on different groups of people in our community. We have looked at the complaints we have received over the last year, and have incorporated themes into our planned improvements. We will continue to review how we can best make use of the complaints we receive from the public to improve our services and promote equality.

Learning from Incidents

In 2013 there were a total of 755 incidents recorded. No theme or trend was identified in relation to equality issues but this will continue to be monitored by the trust.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	**Board of Directors**
Meeting date:	**24 April 2014**
Agenda item reference no:	**095-14**
Author:	**Richard Tyler, Chief Executive**
Date of report:	**24th April 2014**

DELIVERING EXCELLENCE
QVH 2020

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. As a Foundation Trust the Board is directly accountable to its Board of Governors for delivery against its agreed responsibilities and results areas, as well as being accountable more widely for its overall performance.

2. Against this backdrop it is important that the Board can see a clear alignment between its key areas of responsibility and organisational delivery. Similarly it is important that there are clear lines of accountability from the Board to individual directors for agreed areas of responsibility.

3. The aim of this paper is to establish the overall accountability framework within which the Board will operate during 2014/15 and in doing so to clarify both the Board and organisational responsibilities and key results areas.

4. The Board is asked to **APPROVE**;
   a. The overall accountability framework
   b. The Board's key responsibilities and priorities as set out in section 3.
   c. The key strategic objectives and annual work plan as set out in sections 4 & 6
   d. The individual director responsibilities as set out in section 5.

QUEEN VICTORIA HOSPTIAL – NHS FOUNDATON TRUST
KEY STRATEGIC OBJECTIVES AND WORK PROGRAMME 2014/15

1.0 Introduction

One of the key roles of an NHS Trust Board is to set the strategic direction for the Trust and then to hold the organisational to account, through the Chief Executive and Executive Directors, for delivery of both day to day performance and longer term sustainability. As a Foundation Trust the Board is directly accountable to its Board of Governors for delivery against its agreed responsibilities and results areas, as well as being accountable more widely for its overall performance.

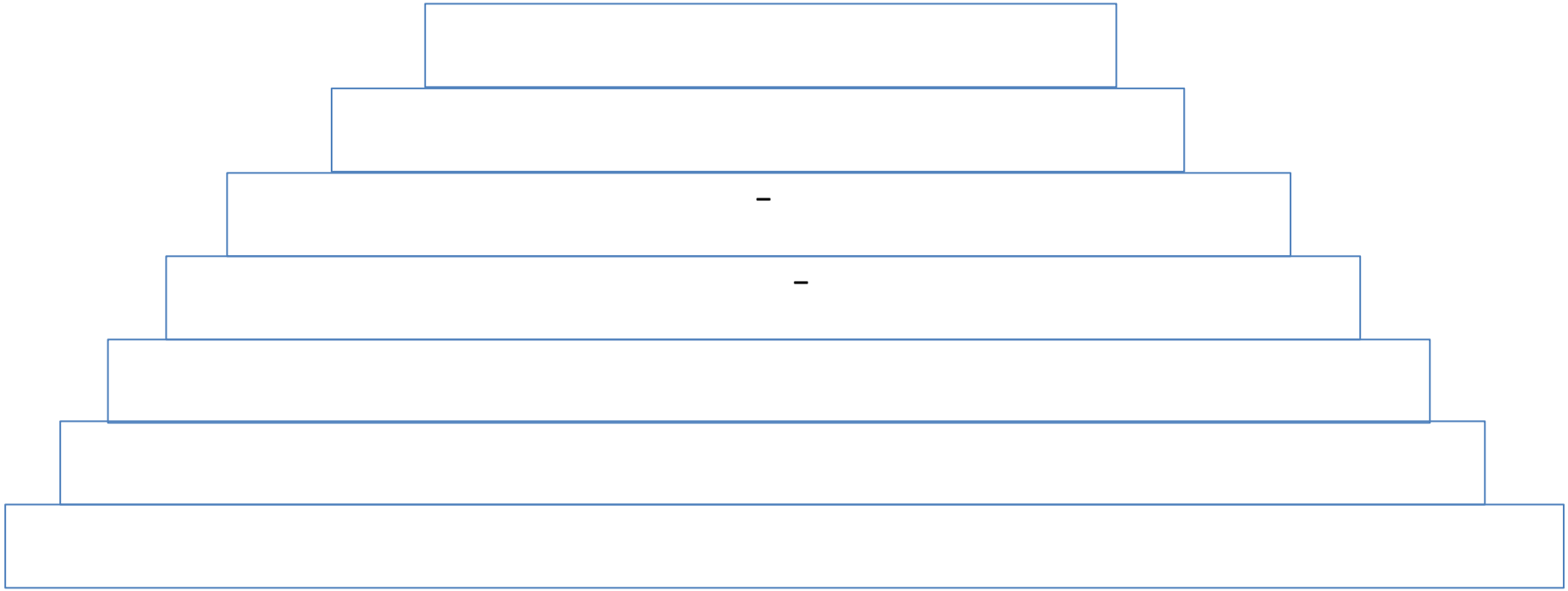
Against this backdrop it is important that the Board can see a clear alignment between its key areas of responsibility and organisational delivery. Similarly it is important that there are clear lines of accountability from the Board to individual directors for agreed areas of responsibility. The aim of this paper is to establish the overall accountability framework within which the Board will operate during 2014/15.

Richard Tyler
Chief Executive
April 2014

2.0 Aligning Board and Organisational Objectives.

Figure one sets out the proposed alignment between the Board's responsibilities and operational delivery. It will be seen that this consists of seven key steps, the detail of which is set out below;

Figure 1: Cascade of accountabilities



3.0 Trust Board responsibilities, key results areas and strategic priorities

It is proposed that the Board has five main responsibilities:

i. A responsibility to **patients:** to provide safe, effective and efficient care and treatment for patients delivered in a friendly and professional manner;
ii. A responsibility to ensure **sustainability**: to put plans in place to maintain and develop new and existing services in order to ensure the longer term sustainability of the Trust;
iii. A responsibility to **stakeholders**: to achieve high levels of satisfaction and ratings from patients, staff, commissioners, regulators and governors;
iv. A responsibility for **money**: to have sound finances that support stability in service provision and employment and provides for regular investment in essential improvements;
v. A responsibility for **staff**: to be a good employer and have sufficient numbers of skilled, experienced and well managed staff to meet the required levels of service.

The Board has identified seven strategic priorities for 2014/15 which align with its main responsibilities as follows;

i. Improving the patient experience
ii. Improving the estate
iii. Increasing patient referrals and income
iv. Establishing patient outcomes and clinical results
v. Improving productivity and reducing costs
vi. Improving information
vii. Improving leadership

4.0 Operational Delivery – Key Strategic Objectives

In September 2013 the Trust initiated a strategic review entitled *Delivering Excellence: QVH 2020*. The aim of the review was to determine the strategic direction of the Trust for the next 5-10 years and was based on the straightforward belief that delivering excellence was the most effective way of ensuring the Trust would both survive and thrive.

We sought originally to define excellence across three domains; outstanding patient experience; world class clinical services; and operational excellence. During the course of the review we have widened to the scope to include; organisational excellence, the quality of care being only as good as the quality of those delivering it; and financial sustainability, the need to ensure our services remain affordable and profitable, as well as of the highest quality, being central to our long-term future. These five domains form the basis of a revised set of key strategic objectives (KSOs) which are shown in table 1 below.

Table 1 – Key Strategic Objectives 2014/15

Key Strategic Objectives (aligned with QVH 2020)	KSO1 - Outstanding patient experience (AP)	KSO2 - World class clinical services (SF)	KSO3 - Operational Excellence (JM)	KSO4 - Financial Sustainability (RH)	KSO 5 - Organisational excellence (GA)
	We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of patients and their families.	We provide a portfolio of world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education & training and innovative research & development.	We provide streamlined services that ensure our patients are offered choice and are treated in timely manner.	We maximise existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services.	We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership.

Focus areas (aligned with QVH 2020)	Superior care & outcomes Exceptional environment Outstanding personal service	Clinical Strategy Clinical Outcomes R&D Education & Training	Pathway redesign Capacity review Delivery annual operational plan	Delivery of annual financial plan CIP programme 15/16 - 19/20 Business development programme 14/15 – 19/20	Leadership development Performance Management Innovation & Learning

4.0 Aligning Board responsibilities and priorities with KSOs

Table 2 below demonstrates how the KSOs are aligned with the Board's main responsibilities and priorities as set out above;

Board focus & main responsibilities		Board strategic priorities 14/15	Organisational delivery - key strategic objectives		Lead Director
Patients	To provide safe, effective and efficient care and treatment for patients delivered in a friendly and professional manner.	i) Improving the patient experience ii) Improving the estate	KSO 1 Outstanding Patient Experience	i) Superior Care & Outcomes ii) Exceptional Environment iii) Outstanding personal service	Director of Nursing & Patient Experience
Sustainability	To put plans in place to maintain and develop new & existing services in order to ensure the longer term sustainability of the Trust.	i) Increase in patient referrals and income ii) Establishing patient outcomes and clinical results	KSO 2 World Class Clinical Services	i) Clinical Strategy ii) Clinical Outcomes iii) Research & Development iv) Education & Training	Medical Director

Stakeholders	To achieve high levels of satisfaction and ratings from patients, staff commissioners, regulators and governors	Improving productivity and reducing costs	KSO 3 Operational Excellence	i) ii) iii)	Pathway Redesign Annual operational plan Increase productivity	Head of Operations
Money	To have sound finances that support stability in service provision and employment and provides for regular investment in essential improvements.	Improving information	KSO 4 Financial Sustainability	i) ii) iii)	Annual financial plan 5 year financial planning Capital investment programme	Director of Finance
Staff	To be a good employer and have sufficient numbers of skilled, experienced and well managed staff to meet the required levels of service.	Improving leadership	KSO 5 Organisational Excellence	i) ii) iii)	Organisational leadership & development Performance Management Innovation & Learning	Head of HR & OD

6.0 2014/15 Work Programme

Each of the 5 KSOs have been assigned to an individual lead. Each lead has then determined the key actions for 2014/15 which are shown in table 3. These actions are derived from a number of sources:

i) **QVH 2020** – unless otherwise stated the actions have emerged from the work carried out as part of the strategic review.

ii) **C wing enquiry** – recommendations arising from the C wing enquiry have been included where relevant. These are indicated by (C & number) which provides a cross-reference to the C wing action plan.

iii) **Board review of financial controls** – recommendations arising from the review have been included where relevant. These are indicated by (JT & number) which provide a cross-reference to the review.

iv) **KPMG review of capital projects** – recommendations arising from the review are indicated by (KPMG & number).

v) **Quality Accounts** – actions indicated by (QA) are included in the 14/15 Quality Account

vi) **CQUINs** – actions indicated by (CQUIN) are included in the 14/15 CQUINS.

vii) **External reports** – The Berwick, Frances and Keogh reports make a number of significant recommendations regarding the overall patient experience. Our response to these is picked up with the relevant section of the *Outstanding Patient Experience* domain.

These actions have then formed the basis of individual objective setting for the Chief Executive and his direct reports.

Table 3 – 2014/15 Trust Action Plan

KEY STRATEGIC OBJECTIVE	FOCUS AREA	KEY ACTIONS 2014/15
KSO1 – Outstanding Patient Experience (AP)	Superior Care & Outcomes *Care is safe, compassionate, competent and provided by a well led team*	**Leadership & Values** The Trust Board to reaffirm its commitment to the highest standards of nursing care and behaviour as part of its wider commitment to excellence in patient care. (C8.1) The Trust Board to take the lead in creating a culture of openness and transparency throughout the organisation through an increased programme of board visits, 'back to the floor' sessions and involvement in existing programmes such as 'Compliance in Practice'. (C6.1) The Trust Board to re-emphasise to all senior management having responsibility for, or interaction with, nursing staff or patients that, under no circumstances, should they, or staff reporting to them, be deflected from a focus on these core responsibilities as a result of involvement in other projects or as a result of a shortage of resources. Any concerns by individuals related to this must be raised by them, and discussed and resolved with the Chief Executive. (C6.2) Ensure that all Directors, Governors and Clinicians undertaking visits within the clinical areas are

		encouraged to feed back any comments or concerns relating to staff attitudes/morale or the quality of patient care directly to the Chief Executive. (C6.4) Ensure that the Trust takes appropriate robust action against any individual whose behaviour is not consistent with the core values of the Trust regardless of other positive aspects of their performance. (C6.5) The Executive Directors to incorporate in their monthly updates for the Board any negative feedback they have received or concerns they have, relating to staff behaviour including the action taken to address the issues raised. (C6.6) Support staff in taking a zero tolerance to poor attitude towards colleagues / patients Increased visibility of the Director of Nursing (DN) in clinical areas. When considering management structures below, consideration should be given to the existing balance of the DN role between her responsibility for the improvement of nursing standards and her lead role in governance and compliance matters. (C6.3) The DN to work with the matrons and other senior nursing staff to develop a clear set of QVH nursing standards and behaviours that can be incorporated into recruitment, appraisal and performance management. (C8.2) Review role of trauma coordinators leading to increased recruitment & retention, **March – July 2014** **Safe Care, Safe Staffing** Monthly publication of staffing data. Making use of e-rostering and other workforce data to provide assurance to the Board, staff and patients as to the provision of safe and competent levels of staffing throughout the Trust. (C8.3) i) Meet with Allocate to introduce the Safer Care module to the e-roster system, May 2014 to enable monthly reporting of staff vs. acuity patients: **June – August 2014**. (QA) **Strategic Investment Fund (SIF)** ii) Introduction of Vital Pac – IT system for identification of deteriorating patient (QA). **Dependent on successful bid to Nursing Technology Fund.**

		Develop an action plan to reduce the use of agency staff – exact level to be recommended by the DN taking into account benchmarked data from similar organisations. (C8.4) Build on the work already started by the Head of Human Resources to establish an integrated scorecard (monthly) for C wing and other clinical areas that makes use of both the existing indicators and the outputs from e-rostering highlighted above. Integrating these reports will provide a much fuller picture of both the day to day management and the longer term trends which would provide an improved system of early warning. (C14.1) Develop a weekly 'flash report' to provide early warning of challenges to staffing levels relative to patient numbers and acuity and inappropriate use of temporary staffing. (C14.2) Chief Executive to charge the Head of Human Resources with taking responsibility for developing and monitoring relevant and timely early warning data. (C14.3) Head of Human Resources to provide a quarterly update to the Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system (C14.4) Monthly reporting of safety thermometer 'harm-free care' (CQUIN) Monthly collection of compliance with WHO checklist (CQUIN) **Governance** Whilst we are confident about the effectiveness of both the Quality & Risk and Audit Committees it would seem appropriate, both in the light of the *Frances*, *Keogh* and *Berwick* reports, and in *Monitor's* growing focus on formal governance processes, to review our Board level governance structures. We understand that the interim Director of Corporate Affairs has been tasked with reviewing the Board systems of both corporate and clinical governance. (C16.1) As part of a wider review of Trust governance systems, the interim Director of Corporate Affairs to consider how best we can incorporate behavioural and cultural concerns within our governance systems. (C6.7)

		Establish a monthly executive level Quality & Safety Committee to be chaired by the CE, and review and amend the remit of the existing directorate quality & risk committees and other committees dealing with quality, risk and safety issues to align governance structures and reporting across the Trust. (C16.2) Trend analysis to be included in monthly reporting to the Quality & Safety Committee. (C16.3) Quality & Safety Committee to define trend reporting requirements to be provided by the Risk Team. (C16.4) Quality & Safety Committee to review the Trust risk registers to ensure it is a 'live document' with risks appropriately identified, graded and escalated. To agree a unified approach for the different registers. (C16.5) Monitoring of incidents, including follow up on action plans to be included in monthly agendas for Quality & Safety Committee. (C16.6) Qualitative audit of implementation of WHO 'checklist' – (CQUIN)
	Exceptional Environment *An environment that provides accommodation and facilities that meet the needs of patients and their families*	Liaise with corporate affairs and review volunteer cover for reception desk ideally covering 0800-1800 July **2014** Support provision of a discharge lounge / transport waiting area **June 2014.** Ward re fresh – painting, removal of arjo baths and replacement with showers etc. **2014/15 capital programme** Refurbishment Physio/OT reception area. **2014/15 capital programme** Work with hotel service team to review food charter mark guidance and develop actions to work towards gaining a charter mark **March 2015** (CQUIN)
	Outstanding personal service	Provide programme of engagement to patient experience group **May 2014**

	All interactions with patients and their family/carers are caring and compassionate putting the patient at the heart of care.	Act on negative feedback and monitor actions to improve experience. **Ongoing** Make available drinks for family within ward area **July 2014** Provide wider availability of information on how to access personal items / newspapers etc. **July 2014** Take a zero tolerance to avoidable late start clinics initially identifying the causes August 2014 developing actions to address identified issues **March 2015** Wifi access for patients. **2014/15 capital programme**
KSO2 – World Class Clinical Services (SF)	Clinical Strategy	Appoint clinical lead for strategy – **April 2014** Increase 14/15 activity through incremental growth sustained into future years **– On-going** Prioritise opportunities identified for additional growth in years 1 & 2, implementation plans produced by **May 2014** Produce outline business cases for 5 strategic projects – **phased through 2014 (Additional resource requirement SIF)** Develop a clear communications strategy that aligns with the needs of the clinical strategy.
	Clinical Outcomes	Appoint Project Manager – **April 2014. SIF** Appoint outcomes administrator – **April 2014. SIF** Clinical leads agree measures – **May 2014** Publication schedule (QA) **i)** May 14: Orthoganthic PROMs published **ii)** July 14: Common database for consultant safety metrics **iii)** Sept 14: Consultant or team level PROMS all possible SL

		iv) November 14: Consultant level COMS in limited SL Collate governance database – **IT resource identified**
	Research & Development	Close defunct trials; review **May 14** and then **December 14** Increase portfolio recruitment or studies by 25% Enrol QVH nurse(s) on MRES course by **September 14** Set up tissue bank with BMRF/UOB by **December 14**
	Education & Training	Funding for simulation /education centre (theatre 6) – **April 14 14/15 Capital programme** Gap analysis of Plastics, MF, Anaesthetics against curricula and deanery visits. Determine extent of shortfall. Address trainee shortfall by recruitment of trust grade doctors – completion of GAP analysis and plan – **September 2014** Options appraisal for future medical workforce **– October 2014** Joint education and professional development to follow All recruitment to follow consultant level recruitment. Re-write PS/JP
KSO3 – Operational Excellence (JM)	Pathway redesign *To ensure value is added to every step of the patient pathway for both elective & trauma care*	Implement IT pre-assessment system – **complete by Oct 2014 IT resource identified** Introduce electronic referrals – **by Dec 2014 IT resources identified** Introduce dedicated LA DC / See and Do unit **– from 1st of July 2014** Review and implement revised theatre scheduling systems – **pilot to be completed by Oct 2014**

		Introduce internal service improvement training modules – **from Sept 2014**
	Deliver annual operational plan *To achieve sustainable performance with reduced waiting times*	Deliver annual operational targets as agreed by Trust Board - **ongoing** Delivery of streamlined pathways of care for cancer patients particularly off site **– throughout 14/15** Capacity review – **every quarter**
	Increased productivity *To maximise capacity from existing resources to increase throughput*	Productive Theatre / OPD Internal review of theatre productivity and effective use of medical workforce 7/7 80% of elective operating lists to be scheduled at least 3 weeks in advance of operating list, excluding cancer and those requiring donor tissue (QA) Review of clinic templates for all services and implementing alternatives to FU's to release capacity Off -site spoke review (cross reference clinical strategy) Introduce one stop services for trauma Review options around centralised referrals / appointments / scheduling function Review collocation of departments to reduce duplication or delay in processes
KSO4 Financial Sustainability (RH)	Annual plan delivery for 2014/15	Set budget which enables agreed level of investment Maintain in-year cash flow Establish monthly finance and performance meetings to hold budget holders to account for I&E

		Establish initiation plan for Information Strategy Implement recommendations from the Board Financial Review. Specifically implement the recommendations contained in the sections noted below: 1. Budgetary ownership (JT 14 – 20) 2. Communications (JT 28-31) 3. Controls (JT 36-37)
	5 year financial plan including CIP programme 15/16 – 19/20(align Monitor planning cycle)	CIP Programme – establish CIP programme board with brief to develop longer term CIP programme in line with Monitor requirement for increasing level of *transformational* savings. Service development and growth – develop detailed business plans for each of the five strategic projects contained within the Trust's clinical strategy (cross reference World Class Clinical Services)
	Capital programme 14/15 – 19/20 (align QVH 2020)	Estates Phase III Development – 1. Produce initial set of proposals in line with requirements of emerging clinical strategy 2. Produce affordability analysis and funding options Annual capital programme – 1. Deliver 14/15 capital programme against agreed budget and project plan 2. Ensure successful delivery of IT infrastructure project 14/15 3. Prepare plan for 15/16 priorities Capital Projects & Contract Management Review – implement KPGM recommendations 1 – 9, ensuring immediate focus on areas identified as red (KPMGH 1-3)
KSO5 – Organisational Excellence (GA)	Organisation and Leadership Development	Chief Executive to review operational management structures to ensure sufficient focus and resource provided to delivery of key performance and productivity targets. (C12.3)

	Leaders adopting innovation in practice to support staff in attaining greater performance.	Chief Executive to review existing structures to create a more consistent structure with clearer reporting lines for roles of doctors, nurses and especially operations. (JT 28) Chief Executive to consider creation of a small number of leadership teams (2 or 3) including aligned Lead Clinicians, Matrons and Operations staff supported by finance and HR. Between them these teams would own their joint budgets. It would be their responsibility to monitor the performance of all aspects of their unit including financial performance. (JT 29) Chief Executive, in discussion with the Director of Nursing, to review the line management of matrons, site practitioners and clinical nurse specialists. (C12.1) In light of recommendation C12.1, review the respective roles and responsibilities of both the Director and Deputy Director of Nursing. (C12.2) Chief Executive to review Trust Estates function in line with KPMG *Report Capital Projects and Contract Management Review* (KPMG 7) Set up QVH 2020 programme board – **May 2014** Appoint QVH 2020 programme manager – **April 2014 SIF** Introduce a system of 'talent management' designed to identify existing and potential high performers as well as those with significant development needs. (C10.5) Ensure that the Board is involved in the annual review of talent management for the top tier of trust leadership. (C10.6) Revised leadership / management development programme drafted and consulted upon across the Trust - **January to March 2014** **New programme running from May /June 2014**. Entry point will be based on experience and appraisal. The programme will be for all staff. Leadership modules will be multidisciplinary and will provide access to externally supported KSS / national programmes. Talent management will be incorporated and will be

		focussed towards developing greater leadership capacity. Additional leadership development activities in 14/15 will include: i) Developing the learning into action culture: ii) Assessments: 360-Degree, leadership potential. iii) Development and career path planning: Identify strengths and developmental areas. iv) Align development with career interests. v) Executive Coaching/ Mentoring: Confidential support to help improve leadership effectiveness. vi) Action learning: Focus on driving change; improving quality and implementing innovation. Recruitment to leadership and management roles reviewed and revised to incorporate values / culture based assessments – new process implemented across the Trust - **July 2014** Head of HR to review whether sufficient emphasis in management training and development is given to identifying and dealing with inappropriate behaviour by supervisory staff towards their team members which does not reflect the core values of the Trust. (C6.8) Introduce 360 feed-back for all managers. (C10.2) Communication and commercial awareness module will be part of the programme or can be accessed as part of an individual training activity – **September 2014**
	Performance Management A consistent and clearly communicated strategy outlining the Trust's direction, values	Review of existing systems of individual performance management; ensure that all managers are competent to performance manage staff and that action is taken promptly to manage underperformance. (C10.1) Continued implementation of new appraisal system. **'Go Live' is January 2014** and provides direct link to incremental progression. Allowing greater involvement of staff in decision making through the business planning process, improvements in workforce planning (designing the services for the future). Introduction of workforce

	and philosophies with mirrored performance measurements.	planning template to dovetail with business planning process – **January / February 2014** Effective 3 year workforce plans detailing the expected changes in service delivery over that timeframe and matching the skills, experience and capability of staff. This will be drawn from the completed workforce planning templates in 2) and will be refreshed annually - **April 2014** Reviewing management structures across the Trust speeding up decision making and enabling decisions at local level – **April to June 2014** Linking to changes in the meetings structure, Senior team (Executive and Senior leaders) to develop portfolio management arrangements to lead the implementation of the 7 work-streams of QVH 2020 – **August/September 2014** Reward strategy developed to consider options for pay and remuneration. Staff and managers to be involved in working through options and will be aimed at rewarding excellent performance in all staff groups – **Task and Finish Group established in April 2014, first draft October 2014, staff / manager engagement Nov/Dec 2014, Final proposals Feb/March 2015** Ensure all leavers are strongly encouraged to take up the opportunity of an exit interview. (C10.3)
	Innovation and learning *Integration of best practice in service delivery and patient care with cutting edge clinical innovation.*	Bring together Learning and Development with R&D and Medical Education.- Establish task and finish group in March 2014 to work up proposal with management options to SMT / CC in **July 2014** Establish an on-site Education and Innovation Centre providing strategic direction for all learning and development across the Trust and building relationships with other centres (private and public sector health). This will become a focal point for training, learning and practice and feeds into Trust services – Outline to SMT/CC September 2014 linking closely with both the Technology and Estates strategic enablers, final proposal **January 2015** Integrate planning and implementation of the simulation suite with 1) and2) above Market regular clinical practice seminars, accessible by webinars and other media promote the QVH@ branding and invite/engage specialist and local commissioners – **Review current activity in 4th Quarter**

		2013/14, undertake market assessment September 2014, establish 3 targeted sessions to run in Q4 2014/15 and Q1/2 2015/16

7.0 Key Performance Indicators

The Trust Board receives currently a wide range of performance indicators which provide evidence of performance against key targets. It is proposed that these are reviewed at a Board workshop in May as part of developing a set of core compliance measures alongside more developmental indicators. These will then form a revised balanced scorecard that is more clearly aligned with the priorities set out above.

8.0 Board Assurance Framework

The Board Assurance Framework (BAF) will be amended to reflect the revised KSOs. The wider process of BAF development and review forms part of the corporate governance review being led by the interim Head of Corporate Affairs. Individual directors have been tasked with identifying the key risks for the respective KSOs.

9.0 Board Leadership & Accountability

Executive members of the Board have a dual responsibility for both their functional area and delivery of the relevant KSO. As will be seen, individual directors have been identified as leads for each of the KSOs identified above and will be held to account by the Trust Board for delivery in these areas.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 April 2014
Agenda item reference no:	096-14
Author:	Heather Bunce, Programme Director
Date of report:	16 April 2014

Site Redevelopment Programme: Monthly Updates

1. Attached are reports showing highlights and activities over the last month in respect of Site Redevelopment.

2. The Board is asked to **note** information contained within these reports.

Planning Contingency - Phase II

15th April 2014

Allocation by PSG	Original Date Agreed	Trust Risk Costs At GMP	Risk Actioned or Cleared	PSG Approval Date	Possible Total Outturn Cost	Notes	CE No.	Timescales For Decisions
1. Programme delays under direct control of Trust.	22/05/2013	£17,500			£0			
2. Programme delays that are contractual responsibility of Trust.	22/05/2013	£15,000						
3. Insufficient Equipment budget.	22/05/2013	£15,000			£0			
4. Impact of regulatory or legislative change generally.	22/05/2013	£10,000			£0			
5. Trust IT Involvement.	22/05/2013	£5,000			£0			
6. Access to the site entrance and staff car park.	22/05/2013	£5,000			£0			
7. Unforeseen Local Authority works in immediate area affects access.	22/05/2013	£12,000			£0			
8. Change in client brief, including changes introduced following alterations to Trust Model of Care	22/05/2013	£25,000			£8,412	Previous CE Report (up to CE 108)		
					£400	Electrical Room AC controller	CE111	Instructed
					£2,140	Wall protection	CE112	Instructed
					£850	BREEAM Registration	CE113	Instructed
					£600	Relocate DSU drugs cupboard	CE115	Likely
					£2,893	In-Patient doors	CE116	Instructed
					£200	Filter Change	CE117	
					£280	Revisions to Data Cabinet	CE118	
					£300	Legionella Testing	CE119	
					£450	Temperature Sensor Electrical Plant Room	CE120	
9. Disruption to Phase 1 during construction	22/05/2013	£10,000			£0			
TOTAL		£114,500			£16,525			

NO CHANGE FROM 18th MARCH 2014 REPORT

Theatre Development Scheme Phase 2

Programme Update
15/04/2014

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		

Queen Victoria Hospital NHS NHS Foundation Trust	**CONFIDENTIAL** **Phases II and III New Theatres Project Steering Group** **Notes** **Thursday 20 February 2014** **OT6 Meeting Room** **0900 - 1000**	

Present:
Richard Tyler (RT) Chief Executive Officer
Steve Fenlon (SF) Medical Director
Mike Bennett (MB) Divisional Manager, Critical Care
Richard Hathaway (RH) Director of Finance

In Attendance:
Heather Bunce (HB) Programme Director
Dave Curzon (DC) Project Manager
Hilary Twigg (HT) Notes

Apologies:
Amanda Parker (AP) Director of Nursing
Jane Morris (JM) Divisional Manager, Clinical Specialities
John Trinick (JT) Head of Estates

Item		Action
1	**Welcome and Confirmation of Quorum**	
1.1	RT opened the meeting. In view of the fact that JM was not present but might attend later on it was agreed to reverse the Agenda order and take Phase II New theatres first. 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 held on 16 January were confirmed as a true record. The following were matters arising not covered under Agenda items: • Final Account: RH reported that he proposed to provide a written update combining Phases I and II to the May Board. This remained the case. • Call Bell: DC confirmed that a Call Bell had been purchased but had not yet been installed pending erection of external signage. • Blond McIndoe Roof Canopy: DC reported that 3 quotes had been obtained for replacement of the Blond McIndoe Roof Canopy – one for £1800, one for £2600 and one for £6K (which had been disregarded). It was agreed that the lowest quote should be accepted and the work proceed. RT asked for confirmation that the issue of the Blond McIndoe Fire Door had been addressed – DC confirmed that it had: the Trust did not have responsibility in the matter but in the case of this Fire Door we had been of assistance as it had been replaced as part of the theatre development work. Following inspection by the Fire Safety Advisor the door was found to be swollen because of recent rain and work had been undertaken to correct this. There were other fire exits from the area. • KPMG Audit Report: RH reported that the first draft report had been received.	**RH** **DC** **RH**
3	**Project Manager Update**	
3.1	**Phase I** DC reported as follows: • Electric In-patient doors to be installed this Saturday – the work had been planned for the previous weekend but in the event there was no appropriate power supply. SF asked whether there would be access for patients to theatres in this area during these works – DC confirmed that they would. • Floor painting had now been completed to proper standard. • There was an issue with repeated IPS alarms in Phase I Recovery, arising from equipment plugged into the (predominantly anaesthetic) pendant. The proposal was that a group including Estates and theatre staff assemble on a Saturday and systematically test every appliance to try and identify the fault. In the event that no appliance demonstrated any fault then Starkstrom would be called in to assess the IPS system.	

	MB commented that some appliances had been returned to the manufacturer for testing and were reportedly functioning correctly. SF questioned whether this might be a wasted exercise if the fault lay in the IPS system – DC said that if Starkstrom were called out before testing had been carried out the Trust would incur a charge. It was agreed that systematic testing should be undertaken before Starkstrom were contacted. • Simon Wells (Moving & Handling Advisor) had raised concerns about doors to the Prep Room in the new theatres being too heavy for smaller members of staff to push open. The issue was to do with air pressures, which had been checked by the manufacturer and found to be correct. SW had been advised that installation of an automatic system of door opening could be considered. - estimated cost £18K. It was agreed that MB would continue to monitor the situation closely – HB to write to SW explaining the position, and advising that it was not currently proposed to change the door operating system.	**MB/DC** **MB** **HB**
	Phase II DC reported as follows: • Handover to the Trust had taken place as planned on 17 February, four weeks ahead of schedule. • There was a small list of outstanding works to be undertaken, but nothing impactful. • The contractor had commenced clearance of the site, which with some exceptions (eg some hoarding at the back of Blond McIndoe and a small Contractor's office in the woodland pro tem) should be clear and there should be no signs of construction by the end of February. • Seeding to take place in April-May. • WD were putting Joe Conway (Site Manager) forward for the Chartered Institute of Building 'Manager of the Year' award. A Citation had been written and forwarded in support of this. • Architects P+HS had also asked permission to submit an article to the Architect's Journal, which had been approved RT raised the question of internal communications, thanking and informing people (eg through Connect). HB said that she had drafted a letter from the Chairman to WD and Mott MacDonald at his request. It was agreed that HB would draft letters of thanks for RT to send. RT said that, as agreed previously, we would now plan something around the formal opening of the theatres. DC confirmed that this would be his last PSG. He would be contracted for a further 10.5 days (off site) to finalise project accounts. RT thanked DC very much for his contribution to the project.	**HB/RT**
4	**Programme Director's Report**	
4.1	Risk Register The Risk Register was tabled by HB. There were no questions.	
5	**Project Cost Summary**	
5.1	Cost Control Summary DC tabled and presented the Cost Control Summary together with a projected 'Actual Cost' out turn cost for Phases I and II combined. The Phase II Cost Control Summary showed a £2K reduction from the January report. The Energy Usage costs were now included as agreed at the January PSG. DC had also included £2900 for a replacement porch. These costs have been balanced out by a reduction in the remaining Contingency Sum. This balance was £45K, with little risk of expenditure at this stage.	

	The second Cost Control Summary presented identified the individual Phase I and II GMP Approval costs and Forecast Out Turn costs. This demonstrated that the project has been delivered well below the approved sums. The final column was a projection of the likely final Actual Cost of the building project. This would potentially generate a further saving to the Trust of £200K. These costs did include a 'Gain' sum payable to Willmott Dixon under the terms of the P21+ Framework. HB said that she had little to add to DCs report, except to say that this had been a highly successful project, undertaken by a small team of people and resulting in a quality product.	
6	**Commissioning Programme**	
6.1	• The Commissioning Programme is ongoing and now being managed by MB. • Air sampling results should be available by Friday 1 March. • Carpenter booked for fitting out for 5/6 March. • 85-90% of equipment is currently on site - all that remains is for the equipment to be moved into place.	
7	**Mothballing of Old Theatres**	
7.1	It was planned to shut power to the decommissioned theatres for the summer months and then commence greatly revised air exchange in the winter months to preserve the fabric of the building. In light of plans to keep Theatres 8/9 these plans will have to be revisited.	**JT**
8	**Any Other Business**	
	There were no further items for discussion.	

Phase III Site Redevelopment

1	**Phase III Options**	
1.1	HB provided a site Block Drawing (originated in support of the Phase III Site Redevelopment Option Appraisal OBC in 2013) to assist in orientation of the three Options which had previously been circulated. The proposed relocation in all options had been considered against the criteria: - Will this move enhance Clinical Pathways? - Is this department on a build-critical pathway? It was clarified that the Jubilee Building would remain in each option, with clinical functions removed in two of the options. <u>Option 1 – Centralise all clinical services: assume no Primary Care on site</u> HB explained that in this option it was assumed that there would be no Primary Care on site and there would be centralisation of all clinical services. It was effectively simply moving clinical services to more appropriate locations. The various proposed moves were presented in detail. This option would include new build, with a number of options to allow phasing in line with affordability. It would be necessary to include an expansion footprint in new build for theatres (Discharge area). New wards were located in front of Blond McIndoe, opposite the new theatres. The issue of centralisation would also depend upon the long term futures of 'old' theatres 8 and 9. <u>Option 2 – Primary Care services on site: Relocate all departments on the east of the site to support this objective.</u> This option assumed Primary Care on the east of the site which would require the relocation of all departments currently in that area. The option does little to enhance clinical pathways and there is no 'pick and mix' option, but has to happen if the site is to be cleared.	

	Option 3 – Clear East of site to provide primary care services and relocate key clinical services to support pathway design. This option represents a mix of Options 1 and 2. SF raised a query regarding 'old' Theatres 8 and 9 with reference to suitability and condition of fabric. HB said that as the floor in Theatre 8 did not have a concrete base it was not possible to use for surgical procedures which required the use of a microscope. The air exchange was good but the flat roof needed replacing in the near future. SF also asked about the future of the PKL building: HB said that the option existed for the Trust to rent for 5 years at £5.5K per month, with the building belonging to the Trust at the end of that period. However, the Trust has recently asked for details of the option to purchase the building. If the building were removed the cost would be £185K plus c £50K to make good the ground vacated. If the building were retained one option would be to use OT6 for a theatre simulation unit. The issue of funding was discussed at length – RH felt that it would be very difficult to forecast when any of the options would be affordable by whatever means, and it was necessary to be realistic about what was achievable. It was agreed that before proposals could be put to the Board it would be necessary to agree phasing/potential cost/ realistic funding possibilities and day to day pressures in order to determine how quickly and in what phasing we could move forward given the projected costs. It was agreed that HB would cost the different proposals and draft a high level milestone plan and a Site Master Plan which was essential to avoid repeating mistakes of the past where departments etc were located inappropriately. SF said that there must be things that could happen now, eg to address issues of office space / Meeting Rooms. He felt that we needed some kind of forum for decision making in the next 1-2 years while we determine the longer term plan. It was noted that RH was Chair of the Site Capacity Development Group – RH said that responsibility for current accommodation issues could lie with this group or with the Phase III Site Redevelopment group – he did not mind which, though this had not been part of the SDCDG's remit. It was agreed that RH as the Chair of the SCDG would present the output of the latest meeting (due to be held this afternoon) to the next PSG. RT said that there may be a requirement to adjust the Capital Programme for next year to address the issue of Meeting Room provision.	**HB** **RH**
2	**Any Other Business**	
2.1	It was agreed that the date of the next meeting, scheduled for 13 March, would be delayed to week beginning 24 March, the week of the Board Meeting to enable time for RH and HB to meet – HB to discuss outlines of cost and staging and funding possibilities with a view to getting Board agreement on the preferred way forward. There were no further items for discussion and the meeting was closed.	**RH/HB**

Next meeting: Wednesday 26 March 2014, 1500hrs, OT6 Meeting Room
Apologies to Heather Bunce, please.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 April 2014
Agenda item reference no:	097-14
Author:	Heather Bunce, Programme Director
Date of report:	16 April 2014

Capital Programme Update

1.1. The attached is a status report in respect of the Capital Programmes for 2013/2014 and 2014/2015.

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

2011-13 Capital Programme

CAPITAL PROGRAMME 2011- 2013		
Peanut Ward Refurbishment	• Settlement agreed with Bondsman for performance guarantee bond against the original Vector Build Ltd contract. • Payment of £110,000 received in full and final settlement.	

2013/14 Capital Programme

CAPITAL PROGRAMME 2013 2014				
Project:	**Status**	**Programmed**	**Revised Budget**	**RAG**
Jubilee Centre Heating	• Orders raised • Stakeholder consultation undertaken. • Contractor developing programme with late April start date target.	Originally Programmed for Quarters 1 & 2 Will now run into 1st quarter 2014 2015	£310k	
Alterations to Burns Heating	• Orders raised • Stakeholder consultation undertaken. • Contractor developing programme with late April start date target.	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 developing programme with late April start date target.	Originally Programmed for Quarters 1 & 2 Will now run into 1st quarter 2014 2015	£40k	
Resurfacing of Visitor Car Park	• Work completed		£150k	
Replacement of Catering Equipment	• New ovens installed.		£50k	
External Corridor Refurbishment.	• Completed.		£50k	
Medical Gas Pipeline Replacement	• No work commenced • Project Manager appointed • Pre contract meeting to be held.	Originally Programmed for Quarters 3 & 4 Will now run into 1st quarter 2014 2015	£30k	
Replacement Radiator Covers	• Project Manager appointed • Initial surveys undertaken.	Originally Programmed for Quarters 3 & 4 Will now run into 1st quarter 2014 2015	£25k	
Refurbishment of Public Toilet (A-Wing)	• No work commenced • Project Manager appointed • Pre contract meeting to be held.	Originally Programmed for Quarters 3 & 4 Will now run into 1st & 2nd quarter 2014 2015	£30k	
Estates contingency	**NOT SPENT AT END OF MARCH 14**		£100k	
		TOTAL	**£885k**	

2014/15 Capital Programme

CAPITAL PROGRAMME 2013 2014				
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	
Contingency Sum	No spend.		£100k	