Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 25 September 2014

Session in public at 13.00
Session in private at 16.00

Dove Suite
The Ark
Mount Lane
Turners Hill
West Sussex
RH10 4RA

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: September 2014

Members (voting):

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

In full attendance (non-voting):

Head of Human Resources	-	Graeme Armitage
Interim Head of Operations	-	Jane Morris
Interim Company Secretary	-	Lois Howell
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode (apologies)
Deputy Director of Nursing	-	Ali Strowman

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 25th September 2014 at 13:00
The Dove Suite, The Ark, Turners Hill, West Sussex RH19 4RA

PUBLIC AGENDA			
No.	**Item**	**Time**	**Page no**
WELCOME			
225-14	**Welcome, apologies and declarations of interest** Peter Griffiths, Chairman	13:00	-
PATIENT STORY			
226-14	**Patient Safety** Ali Strowman, Deputy Director of Nursing and Quality	13.02	-
STANDING ITEMS			
227-14	**Draft minutes of the meeting session held in public on 28 August 2014 for approval** Peter Griffiths, Chairman	13.10	1
228-14	**Matters arising and actions pending** Peter Griffiths, Chairman	13.15	10
229-14	**Update from the Chief Executive** Richard Tyler, Chief Executive	13.20	-
RESULTS AND ACTIONS			
230-14	**Patients: safe staffing and quality of care** Ali Strowman, Deputy Director of Nursing and Quality	13.30	13
231-14	**Operational performance: targets, delivery and key performance indicators** Jane Morris, Interim Head of Operations	13.40	53 (remainder to follow)
232-14	**Financial performance: monthly update** Stuart Butt, interim Director of Finance & Commerce	13.50	67
233-14	**Workforce** Graeme Armitage, Head of Human Resources and Organisational Development	14.00	90
STRATEGIC PRIORITIES			
234-14	**Quarterly update on delivery of Key Strategic Objective One:** ***Outstanding patient experience*** Ali Strowman, Deputy Director of Nursing and Quality	14.10	102

235-14	**Quarterly update on delivery of Key Strategic Objective Two:** ***World class clinical services*** Steve Fenlon, Medical Director	14.20	117
236-14	**Stakeholder Engagement Strategy** Lois Howell, interim Head of Corporate Affairs and Company Secretary	14.30	135
GOVERNANCE			
237-14	**Corporate Risk Register** Ali Strowman, Deputy Director of Nursing and Quality	14.40	237
238-14	**2014 Emergency Preparedness Resilience and Response (EPRR) board assurance** Ali Strowman, Deputy Director of Nursing and Quality	14.50	153
239-14	**Canadian Wing Action Plan update** Lois Howell, interim Head of Corporate Affairs and Company Secretary	15.00	161
240-14	**Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation** Stuart Butt, interim Director of Finance & Commerce	15.05	181
241-14	**Safeguarding Annual Report** Ali Strowman, Deputy Director of Nursing and Quality	15.20	255
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD (AND COUNCIL OF GOVERNORS)			
242-14	**Clinical Cabinet** Richard Tyler, Chief Executive	15.25	266
243-14	**Quality & Risk Committee** Ginny Colwell, Committee Chair	15.30	267
244-14	**Council of Governors** Lois Howell, interim Head of Corporate Affairs and Company Secretary (on behalf of Brian Goode, Governor Representative)	15.35	268
STAKEHOLDER AND STAFF ENGAGEMENT			
245-14	**Feedback from events and other engagement with staff and stakeholders** All board members	15.40	-
GOVERNOR REPRESENTATIVE AND NON-EXECUTIVE DIRECTORS			
246-14	**Observations from the Chairman, Non-Executive Directors & Governor Representative** Peter Griffiths, Chairman	15.45	-
MEMBERS OF THE PUBLIC			
247-14	**Observations from members of the public** Peter Griffiths, Chairman	15.50	-

248-14	Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature. Peter Griffiths, Chairman	15.55	-
PRIVATE AGENDA			
COMMERCIAL-IN-CONFIDENCE			
249-14	**Draft minutes of the meeting session held in private on 28th August for approval** Peter Griffiths, Chairman	16.00	267
250-14	**Contract Update** Stuart Butt, Interim Director of Finance & Commerce	16.05	272
251-14	**Project Initiation Document: Review of Hub and Spoke Arrangements** Richard Tyler, Chief Executive	16.10	277
252-14	**Project Initiation Document: Growth and New Business** Richard Tyler, Chief Executive	16.25	282
253-14	**Business Case for new Anaesthetic Machines** Steve Fenlon, Medical Director	16.40	289
NEXT MONTH'S AGENDA			
254-14	**Draft agenda for next month's meeting** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	16.50	292
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIRMAN)			
255-14	Peter Griffiths, Chairman	16.55	-

DATES OF THE NEXT MEETINGS

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 30 October2014 at 13:00	**N & R:** 30 October 2014 at 09:00 **Q & R**: 04 November 2014 at 09:00 **Audit**: 03 December at 14:00 **CFAC:** 18 December at 09:00	**Public**: 11 December 2014 at 16:00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft & unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 28 August 2014, 13:00 – 16:00, Council Chamber, East Court, College Lane, East Grinstead, West Sussex RH19 3LT**	
Present:	Peter Griffiths (PAG)	Chairman
	Stuart Butt (SB)	Interim Director of Finance
	Ginny Colwell (GC)	Non-Executive Director
	Beryl Hobson (BH)	Non-Executive Director and Chair Designate
	Amanda Parker (AP)	Director of Nursing & Quality
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
In attendance:	Graeme Armitage (GA)	Head of Human Resources & Organisational Development
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Interim Head of Operations
	Lois Howell (LH)	Interim Head of Corporate Affairs & Co Sec
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Steve Fenlon (SF)	Medical Director
	Richard Tyler (RT)	Chief Executive
Public gallery:	Ali Strowman, Deputy Director of Nursing	

WELCOME

199-14 **Welcome, apologies and declarations of interest**

The Chairman opened the meeting and welcome Ali Strowman who was attending today's public session.

Apologies had been received from the Chief Executive and the Medical Director.

There were no declarations of interest.

PATIENT STORY

200-14

AP apprised the board of an issue raised by one of the Site Practitioners concerning a patient treated recently at the hospital. Whilst commending the excellent care she had received, the patient had raised concerns in respect of the behaviour of another patient which she had found to be very intimidating. Staff had attempted to address the situation themselves without recourse to the on-site Security officer which might have meant that dealing with the issue was easier. Accordingly a reminder of this resource, and how it should be used, was now emphasised within the Risk training module.

The Chairman thanked AP for her update and the board **NOTED** its contents.

STANDING ITEMS

201-14 **Draft minutes of the meeting session held in public on 31 July 2014 for approval**

JT asked that Item 187-14 be amended to read: 'only extend' and not 'extend only'. Subject to this revision, the minutes of the meeting were **APPROVED** as a correct record.

202-14 **Matters Arising & Actions Pending**

The board reviewed the current record of Matters Arising and Actions Pending and the document was updated as appropriate. The following items were highlighted:

	Under item 12 (151-14) JT asked the board to note that whilst the Board Assurance Framework (BAF) had indeed been presented at its meeting in July, the document was still a work in progress and as such, he queried whether the status should be shown as 'complete'; however, LH assured him that the BAF was on a rolling programme of quarterly board updates to the board and would continue to be reviewed on a regular basis. In respect of item 22 (082-14), LP expressed concern that the original reasons for raising the issue had become blurred. In order to clarify his original concerns, he suggested Capital Expenditure proposals be included as part of overall budget setting for the new fiscal year. SB assured him that this would be the case in the future; in the meantime, he would be providing additional detail on the capital programme during the closed session of the board meeting. Accordingly, it was agreed that this item could now be removed from the Matters Arising document.

203-14	**Update on behalf of the Chief Executive**
	
	AP had been asked by the Chief Executive to provide a monthly update in his absence. Highlights included the following:
	
	• A 'Never Event' had occurred within the Orthodontic Department; appropriate action had been taken and a full investigation was underway. The Chairman reminded the board that in June the Chief Executive had agreed to undertake a review into 'never events' to determine if there were underlying concerns regarding the current level. Findings were due to be reported to the board at its meeting in September but in the meantime, AP advised of several initiatives being introduced to mitigate associated risks which included the Medical Director writing to all medical staff informing them of the trust's expectations of them; inclusion of medical staff in the Manchester Patient Safety Framework programme; and the joining the Trust to the 'sign up to safety campaign'. JM reported that the Ops team was also reviewing 'never events' and a paper around risks and compliance would be submitted to the next Quality and Risk Committee;
	• A patient being treated within the Burns Unit had received insufficient overnight care from an agency nurse. AP was assured that this incident had been highlighted by a substantive member of staff and the appropriate action taken. In the meantime, the nurse in question had been reported to the Nursing and Midwifery Council under the 'Fitness to Practice' regime.
	• Safeguarding concerns had been raised in respect of a doctor working for the trust under a Service Level Agreement; a full investigation was currently underway.
	• AP and SB had undertaken the quarterly telephone update with Monitor at which the following issues were discussed:
	  ◦ The trust's continued difficulties in meeting all RTT18 targets; AP advised the board that Monitor was assured by the actions which the trust was taking to address this.
	  ◦ The recent MRSA outbreak within the Burns Unit; again, AP felt Monitor was satisfied with the course of action the trust was following;
	  ◦ Formal notification of the recent 'never event';
	  ◦ Current slippage of the Capital Expenditure programme; and
	  ◦ The trust's strategic plan, including its Cost Improvement Programme.
	
	Following the phone call, Monitor would be writing to formalise its responses.
	
	The Chairman thanked AP and the board **NOTED** the contents of the CEO's update.

RESULTS AND ACTIONS	

204-14	**Patients: safe staffing and quality of care**
	
	AP presented the monthly update on Patient care, highlighting the following issues:
	
	• <u>Safe Staffing</u>
	Safe staffing levels were achieved throughout July; however, there were areas of concern regarding vacancy rates within the Burns ward as a result of staff on long term sickness. AP was working closely with the HR team in reviewing recruitment opportunities. (AP asked the board to note that the low appraisal rate reported within the Intensive Treatment Unit (ITU) was a data anomaly).
	
	• <u>Quality & Risk</u>
	  • Investigations into the recent 'never event' and Serious Incident (SI) recently reported to the board had now been carried out; summary reports were provided, (and it was noted these had also been submitted to the Clinical Commissioning Group).
	  • An additional SI had been declared recently following the outbreak of hospital acquired MRSA. JT and GC queried if this could have been partly as a result of current staffing issues; AP did not believe this to be the case but the review was ongoing and results reported back to the board in October. AP highlighted concerns that vacancies within the hotel services department were impacting on the capability to clean; whilst HR was supporting a recruitment drive for this area, an external company would be appointed to decontaminate the burns unit. AP asked the board to note that the risk score for Hospital Acquired Infection (HAI) had been raised from 12 to 16 on the Corporate Risk Register (CRR) due to the infection outbreak, and would impact on the burns ward non pay budget and ITU temporary staffing use.
	  • The Care Quality Commission (CQC) raised a concern in respect of infection control practices for QVH patients at Darent Valley Hospital. The Head of Risk, infection control nurse specialist and decontamination lead visited a QVH clinic at Darent Valley hospital in July to undertake a review of infection control and health and safety aspects related to QVH patients and staff; findings have been communicated back to Dartford & Gravesham NHS Trust at Darent Valley Hospital and the Trust's Chief Nurse will be providing an action plan to QVH to provide assurance that concerns raised have been addressed, (which will include actions for QVH to fulfil).
	
	• <u>Patient Complaints</u>
	  • Eleven complaints were acknowledged during July; these are under investigation and progress is reviewed monthly by the Chief Executive and Director of Nursing. (AP reminded the board that all complaints that are signed personally either by the Chief Executive or Director of Nursing). AP noted that patient feedback remained positive with a good response rate to the friends and family test (FFT); however, this was now a requirement for all outpatient areas (including off-site locations) and with limited resources, careful consideration was required as to the most effective way of collecting data.
	  • LP raised concerns at the increased level of complaints this month. Although there were no clear trends emerging, the Chairman suggested reporting could be honed to triangulate this information and it was agreed that AP would work with LH to develop a score card which would enable the board to better correlate the data provided [Action: AP]
	  • On page 57 of the report, it was noted that the comment/action for Peanut had been duplicated in error for Canadian Wing; this should have read '*Still undergoing investigation and awaiting comments'.*

	The Chairman thanked AP for her update, the contents of which were **NOTED** by the board.
205-14	**Operational performance: targets, delivery and key performance indicators** JM reported that trust income from patient activity was above plan in Month 4. As predicted, as a result of a determination to clear the backlog of long waiting patients (and complete validation of open pathways), the trust had failed to meet all three aggregate 18-week targets as a consequence of failing to meet the following service level targets: • The admitted target in Ophthalmology, Oral Surgery and Plastics; • The non-admitted target in Oral Surgery, Plastics and Cardiology, and • The open pathway target in Oral Surgery, Plastics and Ophthalmology. However, the trust was now introducing additional waiting list management systems alongside extra capacity to reduce the backlog, and anticipated achieving aggregate compliance with all 18-week targets from the beginning of October (Q3). JM was also pleased to report that an internal solution to the issues within Ophthalmology had been identified; JM assured the board that the trust continued to work with commissioners and the Intensive Support Team (IST) in monitoring trajectories to ensure compliance by the end of September. GC raised concerns that increased workload to reduce backlog may not be sustainable in the long term; JM assured her that within the Plastics directorate, additional activity had been achieved through the reallocation of caseloads, and also as a result of extra capacity gained by opening Theatre 11; supplementary sessions within Ophthalmology would be undertaken as a one-off exercise until the a gap between demand and capacity had been addressed. Moreover, JM was confident that the IST action plan now enabled better forecasting. JM reported that the trust had also failed its 31-day first definitive treatment (FDT) and 62-day wait for cancer patients in June, and the 31 FDT for Quarter 1. There was concern that whilst the numbers involved were small, these failures would impact on the reputation of the trust and there was a need to ensure that operational arrangements with third parties were more robust. SB suggested that the trust should be looking to reduce its maximum waiting time to 15- weeks, rather than just aiming to achieve the minimum target. Whilst noting that trust income was above plan, JT sought assurance that budget phasing would allow for more activity from July. SB was assured there was no need for a separate business case; additional funding would be required, and whilst this would be outside routine budgets, he was confident the plan was affordable. SB was also optimistic that with better information on demand and capacity, the trust would be in a much stronger position in the future. In summarizing, the Chairman emphasised the need for the trust to return to a sustainable, fully compliant position from October. He thanked JM for her update, and the board endorsed the actions being taken to improve performance where required.
206-14	**Financial performance: monthly update** SB reminded the board that as agreed last month, all financial reporting was now contained within the public section of the board report. SB opened by reporting that the trust remained significantly ahead of the surplus plan (just under £1.1m) for the year, with additional income only marginally offset by additional costs. pay and non-pay spend was also closer to the budget than in the previous year, with any variances reflecting activity and non-recurrent costs. However, he warned that pay costs

	would be under pressure due in part to agency cover and sickness. SB referred the board to the Month 4 forecast, noting that the downside position was for a surplus of £2,174k, (with the upside at £4,481k), giving a midpoint of £3,328k. He was confident that the planned surplus budget of £2,203k was consistent with the downside, providing for a strong financial forecast. Re-iterating last month's comments, SB emphasised the need for the board to consider how best it should utilise improved surplus for investment in future years. JT noted that whilst the current financial position was gratifying, the trust had set a cautious budget this year. BH raised concerns regarding conveying these details to the organisation whilst at the same time attempting to implement the 2015/16 Cost Improvement Programme. SB concurred and emphasised the need to impart such information within an accurate context to avoid any distortion. SB reported that cash balances were significantly above plan because of reduced debtor balances and delays to capital expenditure. However, this in turn meant that capital expenditure was significantly below the phased plan. Currently, the original plan was being subjected to a more comprehensive review, and SB reminded the board that a detailed update would be provided during the closed session of today's meeting. The Chairman thanked SB for his comprehensive update the contents of which were **NOTED** by the board.
207-14	**Workforce** GA presented the Workforce report for the month, highlighting areas of significance as follows: Turnover had increased to 16%, although there was no overall trend emerging and core stability remained good. GA noted that whilst issues on Canadian Wing were improving, there continued to be concerns within Hotel Services. There did not appear to be any obvious trends in the high level of turnover, although this was being monitored closely with the aim of reducing levels closer to 11%. GA assured the board that the Workforce Information Team continued to focus on vacancy levels (and associated reasons for leaving); in addition, improvements in the exit interview process were underway. June saw a very large number of leavers, although numbers for July had returned to a more reasonable level. However, whilst the vacancy level was falling, turnover remained an issue at present which would not be resolved by oversees recruitment. SB noted significant variances within different areas of the hospital, with some departments not working to full establishment, and reminded the board that underspend was as much a concern as overspend. GA reported that bank and agency levels remain lower than in previous years whilst vacancies and overall pay had increased from last year. He advised that he was working closely with SB to ensure future reporting between the two directorates was more consistent, with fewer anomalies. Sickness absence in the Trust rose in July however this did not appear to be linked to incidents of stress or anxiety which had remained static. As requested by the board last month, GA had undertaken further research into the high levels of stress and anxiety reported. He confirmed that all sickness was reviewed on a weekly basis. Out of a total of 30 cases of stress and anxiety, only nine were work related.

	These were predominantly due to increased workload, although some were linked to capability. However, of the nine cases examined, seven had now returned to work with only two outstanding. The Chairman asked GA what plans were in place to reduce the current rate; GA responded that the aim was to return to the target of 2% by year end through careful use of resources and better planning. GA assured the board that managers were now better equipped to deal with episodes of long term sickness than in the past, through proactive collaboration between line managers, Human Resources and Occupational Health. The Chairman thanked GA for his update which had been very helpful, particularly with regard to the issues of stress and anxiety and asked that this remain a component of future board reporting. The board **NOTED** the contents of the update.
STRATEGIC PRIORITIES	
208-14	**Quarterly update on delivery of Key Strategic Objective (KSO) 5: Organisational Excellence** GA presented the board with the first of the quarterly updates against the objectives / actions associated with KSO 5, Organisational Excellence. GA explained that the report was designed to provide assurance against the workforce elements of the Trust strategy (mainly relating to the current fiscal year). However, whilst providing progress updates on main objectives, it also linked actions to overall aims associated both with the QVH 2020 strategy (Delivering Excellence) and the emerging Workforce Strategy. GA reminded the board that the initial vision for QVH had led to the development of the QVH 2020 strategy; once vision and aims were established it had then been possible to develop the Key Strategic Objectives (KSOs) to ensure the trust achieved a sustainable future for the organisation. The Workforce Strategy had been developed from the KSOs and was built around six key themes, namely: • Developing staff (improving flexibility of the workforce); • Improving business (driving up quality and value for money); • Being accountable (strengthening leadership capability); • Sharing the journey (engaging with staff, patients and their carers); • Managing the change (workforce planning and effective change management); • Designing our future (working with staff / external stakeholders on future of delivery of services) Having reiterated the link between the KSOs and Organisational Excellence, GA explained that initial projects to deliver organisational excellence included leadership development, performance management and innovation and apprised the board of progress to date. GC queried how the board could be assured that the trust was on track. GA suggested there might be a number of indicators including Friends and Family Test result; however, he reminded the board that a series of open staff engagement sessions would be launched shortly to discuss how best to take the organisation forward, and staff feedback would be considered prior to the formal consultation. The Chairman commended GA for the excellent framework in which the update had been presented which gave a clear picture of how this connected overall to the trust's 2020 vision. He suggested it would be helpful to the board to receive regular progress updates, with

	enhanced data where appropriate. In the meantime, the Chairman noted the need to allocate a dedicated NED to support development of this work; he noted that Organisational Excellence would impinge on the wider sub-committee review and was equally as important as Audit and Quality and Risk. The board agreed this merited careful consideration. The board **NOTED** the contents of the quarterly update.
GOVERNANCE	
209-14	**Corporate Risk Register (CRR)** AP presented the quarterly Corporate Risk Register (CRR) and asked the board to note that two new risks, rated above 12, had been identified. She assured the board that mitigating actions had been taken and further actions to further reduce risk identified. After consideration it was suggested that one of the newly identified risks (ID732 relating to storage of long term model boxes) did not warrant a rate of 12+; AP agreed to review and adjust as necessary. The Chairman thanked AP for her update the contents of which were **NOTED** by the board.
210-14	**Annual Seal Register Report** LH reminded the board that, in line with the Trust's Standing Orders, it was required to receive a report of all sealings on an annual basis. Accordingly, an report had been prepared; this stated that a resolution to apply the trust seal was last brought to the board in September 2012 and confirmed there had been no further requests to apply the seal since that time. The Chairman thanked LH for her update and the board **NOTED** its contents.
211-14	**Statutory Duties of Co-operation/Stakeholder Engagement** LH reminded the board that during the self-assessment against the Board Governance Assurance Framework model conducted earlier in the year, it was highlighted there was no definitive statement in the trust of how its various statutory duties of cooperation were fulfilled. Accordingly, LH had prepared a report which provided assurance to the board the these duties were understood and appropriately met. The board **NOTED** the contents of the report and accepted the assurance contained therein.
212-14	**Audit Committee Terms of Reference and Work Plan** LH presented the revised Terms of Reference for the Audit Committee, together with a draft Audit Work programme. Both documents had been revised to reflect Healthcare Financial Management Association (HFMA) guidelines and best practice. JT asked the board to note that, with the exception of Whistleblowing (which was a recent addition), headings for the new ToRs remained the same as in previous versions, (whilst containing greater detail); however, it was likely these could be subject to further changes, depending on the outcome of the current wider review of sub-committees. Likewise it was noted that the work plan could change and JT advised he was working closely with GC, (as Chair of the Quality and Risk Committee) to minimise overlap.

	JT reminded the board of its responsibility to identify areas requiring additional scrutiny, rather than delegating this to the Audit Committee as was current practice. The Chairman noted the need for clarity around the correlation between the Quality and Risk (Q&R) and Audit Committees. He hoped this would emerge from the current review and proposed that in the meantime, both the ToRs and work programme be approved, pending the review outcomes. Accordingly the board **APPROVED** the current ToRs and associated work programme.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
213-14	**Clinical Cabinet** On behalf of the Chief Executive, AP apprised the board of matters which had been considered by the Clinical Cabinet over the last month. These included: • 18-week performance targets; • Finance (including the 2015/16 Cost Improvement Programme); • The proposed Education Centre (with agreement to undertake an options appraisal to determine options for location). In the meantime, a short term location for a simulation suite would be determined, pending a longer term decision; • Signing off two serious incidents (previously reported to the board) which included wrong tooth extraction and histopathology late reporting; • A 'never event' relating to wrong tooth extraction; • A successful bid to support the development of Schwartz rounds; • An update on the current MRSA situation, with agreement to engage external company to undertake deep clean of the unit due to the lack of internal resources at present, and • An update on progress against Key Strategic Objectives 3 & 4 The Chairman was assured that the contents of the Clinical Cabinet update reflected issues raised at today's board meeting; he also commended the Chief Executive on the succinct and clear reporting format.
214-14	**Nominations & Remuneration Committee** LP presented an update following last month's Nomination and Remuneration Committee, of which he was Chair. In echoing JT's comments, he asked the board to note that the Committee's work plan was a document which would evolve as part of the overall review of the trust's committee structure. The Chairman asked the board to note that the appraisal process for the Chief Executive was now complete.
STAKEHOLDER AND STAFF ENGAGEMENT	
215-14	**Feedback from events and other engagement with staff and stakeholders** • GC reported she had undertaking a Compliance in Practice session in August and had received very positive feedback from patients. • AP had visited theatre staff and was encouraged by staff awareness of the trust's culture and values.

GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
216-14	**Observations from the Chairman, Non-Executive Directors and Governor Representatives** There were none
MEMBERS OF THE PUBLIC	
217-14	**Observations from members of the public** There were none
218-14	Further to paragraph 39.1, and annex 6 of the Trust's Constitution, it was agreed that members of the public should be excluded from the remainder of the meeting in order to enable the board to discuss confidential information concerning the trust's finances and matters of a commercially sensitive nature

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
August 2014 meeting						
	223-14	Board to be apprised of planning timetables for two-year and five-year annual plans.	**LH**	**30.09. 14**	**Update 15.09.14:** Details to be circulated by email	**On track**
July 2014 meeting						
	175-14	Occupancy and staffing levels to be reviewed to ensure no direct correlation with recent infection issues on Burns Ward.	**AP**	**Oct**	**Update 07 08 2014** Review to be undertaken on conclusion of current outbreak and completion of action plan and Root Cause Analysis	**On track**
	178-14	Board to attend Safeguarding training	**AP**	**Sept** **Oct**	**Update 07 08 2014** Board to receive Annual Safeguarding Report **Update 07 08 2014** Safeguarding training to be included as part of October board seminar	**On track** **On track**
	178-14	Additional information regarding safeguarding, and stress and anxiety to be brought to August board.	**GA**	**Aug**	**Update 29 August** GA presented update to August board	**Complete**
	181-14	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**	**Oct**	This will form part of the wider organisational review which will start in October 2014	**On-track**
June 2014 meeting						
	144-14	Details of organisational restructure within Estates Department to be provided to board.	**RT**	**Oct**	Pending outcome of Green & Kassab review into Estates function **Update 31 07 2014** This will be incorporated into the next quarterly update on KSO4 following review to be undertaken by RT and SB (see items 082-14 & 157-14) **Update 25 09 2014** This will form part of the wider	**On-track**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
					organisational review which will start in October 2014	
	145-14	CEO to lead on discussions with Medical Director and Director of Nursing & Quality to determine if there are underlying concerns regarding current level of SUIs and 'Never Events'.	**RT**	**Sept**	**Update 31 07 2014** Initial discussion scheduled for 4 August; feedback to be provided to September board. (See 157-14 & 082-14) **Update 25 09 2014** Agreement to engage external support to review prevailing culture in theatres in context of compliance with WHO checklist and other quality metrics.	**On track**
	146-14	JM to raise concerns with Programme Board in respect of allocation of accountabilities for breaches.	**JM**	**Sept**	**Update 14 07 2014** Initial concerns raised by QVH at Programme Board beginning of July. Issue will be on-going over the next few months as part of the wider work relating to 18-weeks. JM to provide update after the next Programme Board in September.	**On track**
	150-14	Key headings and RAG status to be incorporated into future KSO quarterly reporting.	**SF**	**Sept**	Next quarterly report on KSO2 due September 2014	**On track**
	157-14	As a result of concerns raised by KPMG in its report into trust's capital projects and processes, final report to be circulated to board at its meeting in July.	**SB**	~~**July**~~ **Sept**	**Update 31 07 2014** This will be incorporated into the next quarterly update on KSO4 following review to be undertaken by RT and SB (see 145-14 & 082-14)	**Pending**
	159-14	Further to request made by Governor Representative, RT to provide updates to full Council of Governors regarding the QVH 2020 strategy and the Estate strategy.	**RT**	**Sept**	**Update 12 09 2014** On agenda for September meeting of the full Council of Governors	**Complete**
May 2014 meeting						
	114-14	MIU to be invited to present at future board seminar.	**LH**	~~**June**~~ **Aug**	**Update 26.06.2014** MIU to attend board seminar in August to make a presentation on the work of the department	**Pending**
	117-14	Deputy Director of Nursing to attend future board	**LH**	~~**June**~~	**Update: 26.06.2014**	**Pending**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
		seminar to provide update on Leadership Development.		**Oct**	Dep DoN to attend Board seminar session in October to provide update	
	126-14	Board lead for Sustainable Development agenda to be identified	**RT**	~~**July**~~ **Aug**	**Update 18 06 2014:** RT to circulate to Board members requesting expressions of interest Update 25 09 2014: Circulated w/b 22.09.2014	**Complete**
	136-14	Monitor's "Well-Led" assessment framework to be implemented as part of the governance review. LH to liaise with RT regarding next steps, and board to be updated accordingly.	**LH**	~~**Aug**~~ ~~**Oct**~~ **Dec**	Update: 08.07.2014 Presentation to be made to October Nomination & Remuneration Committee Update 15.09.14: Well Led Review template to be used as framework for Board self-assessment commencing at December away day	**Pending**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	230-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	16 September 2014
Appendices:	A: Safe Staffing B: Quality & Risk C: Infection Prevention & Control D: Patient Experience, Complaints and Claims

Patients: safe staffing and quality of care

Key issues

1. This report provides information on;

    - Safe staffing and whether safe staffing levels are being achieved as per national recommendations and information on how safe and well led each ward is. (Appendix A).
    - Quality and risk management with information provided on quality and safety metrics and incident management (Appendix B).
    - Infection prevention and control issues and actions (Appendix C).
    - Information on new and closed complaints, claims and patient experience feedback. (Appendix D).

Safe Staffing (p1)

2. Safe staffing levels were achieved throughout August.
3. Areas of concern are vacancy rates within the Burns ward, long term sickness of two staff within the burns ward and ITU. These matters have been raised with HR who are reviewing recruitment opportunities and the ward manager for ITU who will be completing appraisals.

Quality and Risk Management (p11)

4. Following a further never event involving the extraction of a wrong tooth in a clinic environment and having undertaken an executive review of the recent never events and serious incidents it has been agreed to invite an external review of theatre practise and to review the process within clinics to ensure all actions to prevent errors occurring are in place and being implemented. Previously identified actions were; Medical Director to write to all medical staff informing them of the trusts expectations of them, inclusion of medical staff in the Manchester patient safety framework programme and QVH to join the sign up to ‘safety campaign’.
5. A serious incident was declared in July following an outbreak of hospital acquired multi resistant MRSA. Full precautions have been taken to protect patients and external advice

sought from PHE, and expert in MRSA and out microbiologist. Further information is available within the infection prevention control report (p33)

6. Complaints have increased during July these are currently being investigated and responded to detail is contained within the patient experience report (p39).
7. Quality metrics that have not achieved their target have been addressed with the relevant staff groups; nursing and theatre personnel involved in the WHO checklist.

Infection Control (p22)

8. Infection control concerns being addressed are;
    - A period of increased incidence of healthcare associated infection (HCAI) MRSA has been managed we are now implementing the maintenance and decontamination programme prior to reopening. This is anticipated to be in early September.
    - Spoke site compliance visits have recommenced following new staff starting and an informal concern raised by the CQC. Processes have been amended to ensure the Health and Safety committee is informed of overdue visits.
    - Vacancies within the hotel services team continue to affect the capacity to clean, HR are involved in supporting recruitment and an external company will be used to decontaminate the burns unit.

Complaints, Claims and Patient Experience (p31)

9. There were four complaints acknowledged during August these are under investigation and progress is reviewed monthly by the chief executive and director of nursing. For all closed complaints letters sent are signed by either the chief executive or director of nursing.
10. Any action identified as the result of a complaint is monitored through the monthly clinical governance group and good progress on closure of actions is reported by the DN.
11. Staff attitude and behaviour is identified by the DN as a continued theme – A number of direct actions are taken and it is raised with staff as a priority at induction, through feedback on incidents/complaints and through other training; customer care, conflict and care and compassion. Managers discuss with staff at their individual appraisal where it is linked to their demonstration of the trust core values.
12. Patient feedback is good with a good response rate to the friends and family test (FFT). An action plan has been developed to meet the newly released guidance on further roll out. This will be monitored by the patient experience group though investment will be required to support data collection. An options appraisal is currently being undertaken as to which products available may support this data collection and national data submission.

Implications of results reported

13. Additional agency and bank staff have been required as a result of vacancies on wards and due to managing the infection control outbreak with ITU located within two areas until mid-August.
14. Closure of the burns unit to adult admissions has meant that to date approximately 3 patients have had to be admitted to alternative burns units.

15. Non pay costs within the burns unit have increased due to the use of additional items to prevent the spread of infection.
16. Failure to further improve WHO checklist compliance for sign out and recovery hand over may impact on the related CQUIN.
17. Investment will be required to support additional staff or technology to collect FFT data.

Action required

18. External review of theatres
19. Review of processes within clinics to prevent errors occurring
20. Increased compliance with patient consent taking
21. Continuation of WHO checklist by nurses and theatre personnel.
22. Roll out of additional FFT areas for completion by end March 2015.
23. A review of how poor staff attitude can be addressed.

Link to Key Strategic Objectives (delete those not applicable)

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

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

Implications for BAF or Corporate Risk Register

25. A risk has been raised relating to the risk of a poor reputation following the number of never events that have occurred. This will also be reflected within the board assurance framework.
26. The corporate risk associated with the recruitment of staff has been raised following a meeting on 18 August.

Regulatory impacts

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

Recommendation

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

APPENDIX A

SAFE STAFFING
Monthly Report – August 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- National recommendations are followed and that wards are provided with sufficient staff to provide safe care.
- The report contains key information on;
    - day by day and shift by shift staffing information
    - safety and quality metrics by ward
    - information to indicate how well led a ward is

Key Points:

The key priority that the board need to be aware of for this month are ;

1. Safe staffing levels were provided throughout the month of August, this achieved while segregating staffing to manage patients due to infection outbreak and by increased use of bank and agency.
2. The key challenge during August has been staff annual leave and the closure of the burns unit that has required the relocation of ITU and burns unit patients. In addition bank and agency staff are more difficult to book during the holiday period.
3. Recruitment concerns have been raised with HR in respect of recruitment and a variety of recruitment approaches are currently under consideration. Sickness is being actively managed and the DN has currently chaired an number of HR hearings as a result of continued staff sickness.
4. One pressure ulcer is noted and this is reported on further within the quality and risk section of the report
5. NICE guidance final recommendations need introducing, one area 'red flags' is outstanding.

Implications:

- The corporate risk related to safe staffing is identified on the risk register and the rating has been raised during August.

Recommendations:

The board is asked to note the actions currently being taken and the raised risk related to recruitment.

Safe Staffing Levels Summary - August 2014

During August there was a staffing requirement for a total of 1336.5 hours. QVH were able to provide 13030.5 hours of nursing care achieving a percentage of 97.5% over the month.

Margaret Duncombe Ward; 59 out of 62 shifts were established as planned, where staffing did not meet the plan patient acuity was identified as lower than anticipated or additional support was provided.

Ross Tilley Ward; 60/62 shifts were established as planned for the 2 shifts where staffing did not meet the plan staff were provided on one day and on the other there were fewer patients and care was deemed safe.

Peanut Ward; 54/62 shifts met the planned staffing establishment. On the days this was not achieved staffing was deemed safe either due to low numbers of patients or a variety of measure used to ensure sufficient staff; moving staff from one area to another or restricting admissions.

Burns Ward; 57/62 shifts met the planned staffing establishment where shifts did not additional RMN staff and internal staff were available to support care.

Burns ITU; 57/62 shifts met the planned requirement. The shifts that did not were supported by site team members and additional nursing staff as per our escalation plan.

NICE guidance on safe staffing has been released and the assessment was provided to the Quality and Risk Committee. The only outstanding actions to fully meet the recommendations is the introduction of red flags, examples of these include failure to administer pan relief and to take observations when required. These will require staff to report and requires amendments within datix and raising of awareness with patients so they can also report.

CANADIAN WING										
Staff utilisation	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies wte/hrs Est = 62.88	7.76 WTE 1288.7hrs	9.21 WTE 1480hrs	6.22 WTE 1033hrs	3.83WTE 636hrs	<5%	6.09%				Action required under established adverts out to recruit
Temporary staffing Exc RMN Bank / Agency hours	530.10 431.30	553.15 360.30	735.15 375.0	836.50 452.30	<10% 235.8 + vacancy	+ 417.0				Additional staffing has been required during August due to the relocation of burns patients to Canadian Wing
Sickness	2.4%	1.2%	1.0%	1.8%	<2%	-0.16				On track no action required
Shifts meeting Est	97.0%	98.0%	100.0%	99.0%	>95%	3%				On track no action required
Training / Appraisal	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	70.2%	70.3%	63.2%	61.6%	>85%	-23.40%				Action required below target
Appraisals	67.7%	70.5%	73.7%	68.9%	>85%	-16.10%				Action required below target
Drug Assessments	96%	98%	100%	100%	>95%	5%				On track no action required
Friends and Family Test Score **MD / RT**	89 85	94 94	87 91	83 82	>80	+3 +2				On track no action required
Staff Friends and Family Test Score		79 17								
Budget (K)	15	6	12.6	-24	>0	-24				Over spend on nursing budget

MARGARET DUNCOMBE	MAY	JUNE	July	Aug	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	1	0	1				Patient had a BMI of 35.7 and had undergone major case surgery so had been on the operating table for a significant period of time.
Falls	0	1	2	1	0	1				For discussion at ward meeting no harm patient slipped on when self transferring
Medication errors	5	2	1	0	0	0				Paracetamol administered against a prescription with no dose specified
MRSA/Cdiff	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	95%	0%				On track no action required
Nutrition assessment MUST/7 day review	100% 30%	94% 100%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	No/%	No/%	No/%		Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy (10am)		73%	67%	82%	<90%	-23%				On track no action required
Bed utilisation	93%				<100%					On track no action required
Patient numbers	158	141	148	132						On track no action required
Average length of stay	32.8Hrs									
Average patient acuity numbers/day		0 = 12 1a = 1.7 1b = 7								the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE

ROSS TILLEY	MAY	JUNE	JULY	AUG	DN Rating					
Safe Care	No/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0	0				On track no action required
Falls	1	0	1	0	0	1				On track no action required
Medication errors	0	15	0	0	0	0				On track no action required
MRSA/Cdiff	0\0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	91%	100%	100%	100%	95%	5%				On track no action required
Nutrition assessment MUST / 7 day	100% 100%	100% 92%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy		67%	64%	67%	<90%	23%				On track no action required
Bed utilisation	107%				<100%					On track no action required
Patient numbers	199	186	207	190						On track no action required
Average length of stay	34.9Hrs									
Average patient acuity numbers/day		0 = 14.3 1a = 0.86 1b = 1.5								Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE

BURNS UNIT										
Staff utilisation	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 30.63	1.6 wte 266hrs	6.40 wte 1028hrs	7.40 wte 1229hrs	6.40 wte 1062.85	<5%	20.89%				Vacancy on establishment
Temporary staffing Exc RMN Bank / Agency	398.15 114	466.30 128.55	400.45 573.0	335.0 216.0	<10% 114.8hrs + vacancy	-626.65				No action required
Sickness	4.1%	4.79%	2.42%	1.98%	<2%	-0.02				no action required
Shifts meeting Est	96%	99%	98%	92%	>95%					Staffing identified as safe due to acuity of patients
Training / Appraisal	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	80.25%	83.60%	77.10%	75.91%	>85%	-9.09%				Below target
Appraisals	58.82%	66.67%	86.21%	80.00%	>85%	-5.0%				action required
Drug Assessments	95%	97%	97%	94%	>95%	-1%				Action required
Friends and Family Test Score	100	94	100	100	>80	20				
Staff Friends and Family Test Score		79 17								
Budget	3	15	-14.6	-90	>0	-90				Non pay remains overspent some of which will be due to increased requirements due to infection outbreak plus activity income has not been achieved. An underspend in nursing equates to non pay overspend.

BURNS WARD	MAY	JUNE	July	Aug	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0				On track no action required
Falls	0	2	3	0	0	0				No patient was harmed as result of their fall
Medication errors	0	0	0	0	0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	78%	68%	77%	29%	<95%	18%				Closed during August
Bed utilisation										
Patient numbers	28	25	38	3						On track no action required
Average length of stay	36.5Hrs									
Average patient acuity numbers/day burns & ITU		0 = 1.2 1a = 0.23 1b = 3 2 = 0.29 3 = 0.1								Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE

ITU	MAY	JUNE	July	Aug	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0				On track no action required
Falls	0	0	0	0	0	0				On track no action required
Medication errors	0	0	0	0	0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	>95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy										
Bed utilisation										
Patient numbers										
Average patient acuity numbers/day burns & ITU		1a = 0.23 1b = 3 2 = 0.29 3 = 0.1								Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE
ITU										
Staff utilisation	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies Est = 16.16	2.40 WTE 386 hrs	0 WTE 0.0	.44wte 73.0	1.76 wte 292.28	<5%	11%				action required
Temporary staffing Exc RMN Bank / Agency	151.30 280.20	238.40 112.30	124.4 426.0	249.30 414.00	<10% 60.6hrs + vacancy	+310.12				ITU was located within two areas during August due to the closure of the burns unit
Sickness	14.59%	7.01%	5.52%	2.30%	<2%	+0.30%				Sickness improved over last month,
Shifts meeting Est	95%	91%	97%	96%	>95%	2%				
Training / Appraisal	**No/%**				**Target**		**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	79.17%	83.60%	76.00%	80.27%	>85%	-4.73%				Fallen slightly below target, action required
Appraisals	50.0%	46.67%	33.33%	37.71%	>85%	-47.29%				Raised directly with manager
Drug Assessments	95%	97%	97%	94%	>95	-1%				Action required
Budget	-7	-25	-48	-62	>0	-62				Activity income is under plan in respect of ITU H&N patients

Peanut	MAY	JUNE	July	Aug	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0	0				On track no action required
Falls	0	0	0	0	0	0				On track no action required
Medication errors	0	0	0	1	0	1				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0/0	0	0				On track no action required
Activity	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy Taken at 10.00 daily excluding weekends	64%	67%	68%		<95%	27%				
Bed utilisation										
Patient numbers										
Average length of stay	5.5Hrs									
Average acuity										
Peanut										
Staff utilisation	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Vacancies Est = 25.00	1.72wte 286hrs	2.2wte 365hrs	2.2wte 365hrs	.63wte 104.62	<5%	3%				No action required
Temporary staffing Exc RMN Bank / Agency	160.15 23.45	289.20 0	328.05 7.30	331.0 35.0	<10% 93.75 + vacancy	+ 167.73				
Sickness	3.8%	4.36%	10.03%	8.43%	<2%	+6.43				Sickness increased, carrying 1 long-term sickness case from 16.06.14. Other sickness in the department relating to stress Anxiety, Back problems
Shifts meeting Est	96%	100%	97%	94%	>95%	2%				No action required
Training / Appraisal	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Stat and Mand compliance	81.3%	85.00%	67.20%	77.69%	>85%	-7.31%				Action required
Appraisals	87.1%	96.77	84.38%	87.10%	>85%	- 0.62%				On track no action
Drug Assessments	100.0%	95.5%	88.0%	100.0%	>95%	-8%				On track no action
Friends and Family Test Score	100	100	66	-100	>80	-14				No data collected from the 8 patients eligible
Staff Friends and Family Test Score		79 17								
Budget	-6	-5	-6.6	-12	>0	-12				

QUALITY &RISK MANAGEMENT REPORT
Monthly Report – July 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- Areas of concern related to patient and staff safety have been identified, assessed and the risks are being prioritised and managed with the lessons learnt disseminated to the organisation.
- The report contains key information on;
  - quality metrics
  - safety metrics
  - incident management
  - policy updates

Key Points:

The key priority that the board need to be aware of for this month are ;

1. During August a never event was declared following the extraction of the wrong tooth in an outpatient clinic.
   - A full investigation has been commenced.
   - The clinician involved is currently not undertaking clinical commitments.
   - As this was a further incident declared as a never event involving medical staff the executive team had previously met to discuss and consider whether there were any cultural aspects that required investigating further. As a result the following actions reported in August will occur;
     - Medical Director to write to all medical staff informing them of the trusts expectations of them.
     - The Manchester Patient Safety Framework programme to include medical staff. This is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture.
     - QVH will join the Sign up to safety campaign launched in July 2014.

   In addition the trust is requesting an external review of theatre processes which it is hoped can commence in October or November and is currently assessing the systems and processes in place to prevent a reoccurrence in any clinic environment.

2. During August two significant incidents were identified and related to poor care received by patients. One has resulted in a safeguarding referral being made and the second in a referral to the Nursing and Midwifery Council under Fitness to Practise
   - For both incidents a full investigation has been commenced
   - Within both incidents involved staff not employed directly by QVH, the issues were identified and could be acted on as a direct result of QVH staffs ability to feel able to raise concerns, take positive action to prevent reoccurrence and to collect evidence in a timely manner.

3. Information on trends is discussed at relevant department meetings and at Clinical Cabinet each month. The DN attended the paediatric meeting in September and was assured of the group's proactive approach having observed the review of incidents involving children.

4. Within the quality and safety metrics issues I would draw to the board attention are;
   - One grade two pressure has occurred review by the DN identifies that this occurred following a long surgical procedure in a patient with a high BMI whose would therefore have been at higher risk of pressure ulcer development. This pressure ulcer is the reason

for the lower harm free care score during August (92%). A review by the DN of the actions taken to prevent harm occurring during the surgical period showed that preventative action had been and was still being taken.

- Ward nurses have been further reminded about their responsibilities in ensuring that all patient risk assessments are completed within 24 hours the score during August had improved on July but remains below the level expected by the DN. Ward visits to review documentation with the ward nurse will be commencing during September.
- Theatre staff have improved compliance with the WHO checklist and this remains a focus of attention with the sign out and recovery handover the areas of current focus at they are not achieving 100%. Though this remains an area of risk for achievement of CQUIN payment.
- The FFT score within the Sleep disorder unit is 73 though their % of extremely likely and likely to recommend is 95%. Review of their feedback comments by the DN identified no negative comments and many very positive comments in particular about staff attitude were provided. A questionnaire return rate of 58% was achieved which is also considered positive.
- Consent documentation for elective surgery has taken a dip during August with a trust score of 68.7% and neither plastic surgery nor maxilla facial surgery teams achieved 75%. This information has been fed back to lead clinicians and to those attending clinical cabinet in September. No specific reason is identified though new doctors commenced during August which may have impacted on scores. This will continue to be closely monitored and specific individuals are identified to the medical director following audits.

Implications:

- Failure to improve the overall WHO checklist compliance score is identified as a risk to gaining the full CQUIN funding.

Recommendations:

The board is asked to note the actions currently being taken.

Clinical Cabinet & Trust Board
Quality & Risk Management Report

September 2014 (August 2014 Incidents)

Quality Metrics

1. **Quality Metrics data (monthly metrics for Clinical Cabinet only, Board receive quarterly Metrics)**
   This includes monthly & quarterly (where appropriate) Quality Metrics data

2. **Patient Safety Data**

Incidents

3. **Incidents open and closed**
   Chart showing the number of complete and incomplete investigations by month

4. **Incident Trend Analysis**
   This series of charts aims to identify unusual reporting activity therefore highlighting possible trends. The focus is on total incidents reported, patient falls and incidents by their severity plus any identified trend / increase in reporting category.

5. **Incidents of concern for <u>July 2014</u>**
   Red (severe) and amber (moderate) incidents - highlighted as potential areas of concern by the risk management team. The content of data has not been changed apart from names removed wherever possible. Please treat as confidential.

Policies

6. **Policies uploaded during the month**

Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
CQUIN	VTE prophylaxis	100%	>95%	100%	100%	100%	100%	100%								100%
	VTE in hospital/RCA undertaken	100%	0/100	0	0	0	0	0%								
	FFT Score acute in-patients	86%	>80	88	86	94	91	83								88
	Number of responses	NEW	30%	72%	37%	47%	48%	35%								
	FFT score MIU	85%	>80	76	77	77	75	86								
	Number of responses	NEW	20%	21%	8%	45%	19%	44%								27%
	FFT Annual Staff Survey	NEW	>4	Annual Score												#DIV/0!
	Dementia >75 trauma asked indicative question	93%	90%	80%	100%	100%	100%	100%								96%
	Dementia >75 having diagnostic assessment	100%	90%	100%	100%	100%	100%	100%								
	Dementia > 75 referred for further diagnostic advice	89%	90%	100%	100%	100%	100%	100%								
	Dementia training for staff	—	65%	81%	77%	85%	85%	85%								
	Dementia clinical leads identified	—	NA	Informatiion sum=bmitted to CCG during June 2014						Reported twice yearly						
	Dementia carers monthly audit	100%	NA	All Q1 carers of patient on the buttefly scheme have been contacted with the butterfly scheme evaluation tool												
	Safety thermometer data submission	100%	Y/N	Y	Y	Y	Y	Y								
	Harm free care rate	100%	>95%	100%	98%	100%	95%	92%								
	No new harm rate (aquired at QVH)	100%	>95%	100%	100%	100%	100%	96%								
	Reducing cancelled operations	—	TBC	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	WHO Checklist compliance - Qualitative (100% compliance is CCG target)	100%	90% by end Q2 & >95% by end Q4	47%	90.50%	89%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	WHO Checklist compliance - Quantative (100% compliance is CCG CQUIN)	96%	>95%	96%	91%	96%	96%	98%								#DIV/0!
	Assessment against Bronze food chartermark	NEW		Quarterly report submitted			Quarterly report submission			Quarterly report submission			Quarterly report submission			
	Manchester Patient Safety Framework (MaPSaF) compliance	NEW		Quarterly report submitted			Quarterly report submission			Quarterly report submission			Quarterly report submission			
Quality Account 2014	Scheduling of elective surgery with 3weeks notice	NEW	80%	Quarterly report submitted			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Number of elective patients receiving treatment on the day of their outpatient appointment	NEW	50% incr from Q1	Quarterly report submitted			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Introduction of safer care module to eroster	NEW	Commence reporting	Quarterly report submitted			Quarterly report submission			Quarterly report submission			Quarterly report submission			
Clinical Indicators (Clinical outcomes reported annually in Quality Account)	Unplanned patient return to theatre within 24 hours (ORSOS Data)	0.36%		0.35%			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			0.35%
	Unplanned patient return to theatre within 7 days (ORSOS Data)	0.92%		0.70%			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			0.70%
	Surgical mortality (excludes Burns)	1		1			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			1
	Burns mortality	1		1			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			1
	Unplanned transfers out (HES Data)	0.28%		0.46%			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			0.46%
	Unplanned re - admission (HES Data) *final figure (includes end of month crossover cases).	1.29%*		1.39%			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			1.39%
Patient Experience	Complaints per 1000 spells	4.7		3.4	2.9	6.9	6.6	2.5								1
	Claims per 1000 spells	1		1.4	0.0	2.7	1.2	0.6								
	FFT Score acute in-patients	86%	>80	88	86	94	91	83								1
	% score for likely and very likely to recommend QVH		>90%	99%	100%	99%	97%	100.0%								
	FFT score MIU	85%	>80	76	77	77	75	86								
	% score for likely and very likely to recommend QVH		>90%	99%	97%	96%	96%	97%								
	FFT score OPD	82%	>80	82	81	80	82	80								1
	% score for likely and very likely to recommend QVH		>90%	98%	98%	98%	98%	98%								
	FFT score DSU	93%	>80	-100	90	88	83	95								
	% score for likely and very likely to recommend QVH		>90%	0	98%	99%	99%	100%								76
	FFT score Sleep disorder centre	76%	>80	78	74	76	78	73								97%
	% score for likely and very likely to recommend QVH		>90%	99%	97%	98%	98.0%	95%								#DIV/0!
	FFT score Therapy	NEW														
	Mixed Sex accommodation breach	0	0	0	0	0	0									
	Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	—	>90%	92%	97%	99%	98%	98%								

Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Safety	Number of Pressure ulcer development Grade 2 or over acquired at QVH	8		0	0	0	0	1								
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	NEW	>95%		100%	97%	100%	100%								
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	NEW	>95%		80%	83%	100%	100%								
	Patient Falls resulting in no or low harm	16	—	4	1	3	6	4								
	Patient Falls resulting in moderate or severe harm or death	NEW	—	0	0	0	0	0								0.9
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	NEW	>95%	100%	73%	82%	85%	88%								
	Avoidable patient falls identified on the Safety Thermometer	—		0	0	0	0	0								
	Serious Incidents	5		0	0	1	1	0								
	Never Events	NEW		0	1	0	0	1								
	Total number of incidents involving drug / prescribing errors	NEW		13	10	19	16	17								
	No & Low harm incidents involving drug / prescribing errors	NEW		13	10	18	16	17								0.4
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	NEW		0	0	1	1	0								
	Medication administration errors per 1000 spells	1.3		0.7	3.6	2.7	1.2	0								
	To take consent for elective surgery prior to the day of surgery (Total)	72.2%	75%	84.7%	69.6%	76.8%	77.1%	68.7%								
	To take consent for elective surgery prior to the day of surgery (Max Fax)	60%		68.2%	69.7%	71.4%	77.8%	57.1%								
	To take consent for elective surgery prior to the day of surgery (Plastics)	46%		84.3%	65.1%	72.9%	72.4%	69.4%								1
	To take consent for elective surgery prior to the day of surgery (Corneo)	81%		95.0%	88.5%	93.9%	87.8%	75.7%								
	Number of outstanding CAS alerts	NEW		0	0	0	0	0								20%
	Number of reported incidents relating to fraud, bribery and corruption	NEW		0	0	1	0	0								
																0
Staff Safety	Staff incidents causing harm	58		9	8	6	10	8								
	RIDDOR (Patients & Staff)	4		1	0	0	0	0								0
	Mandatory training attendance	71%	80%	82%	78%	82%	89%	79%								0
	Flu vaccine uptake	55%	60%	Not due till October												0
																0
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0%								0%
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0%								0%
	E-coli bacteraemia	0	0	0	0	0	0	0%								0%
	MSSA bacteraemia	0	0	0	0	0	0	0%								
	MRSA screening - elective	96%	>95%	97%	97%	97%	95%	94%								
	MRSA screening - trauma	98%	>95%	95%	97%	97%	97%	93%								
	Trust hand hygiene compliance	95%	>95%	99%	100%	96%	99%	97%								

Incidents Open and Closed Data 2014/15

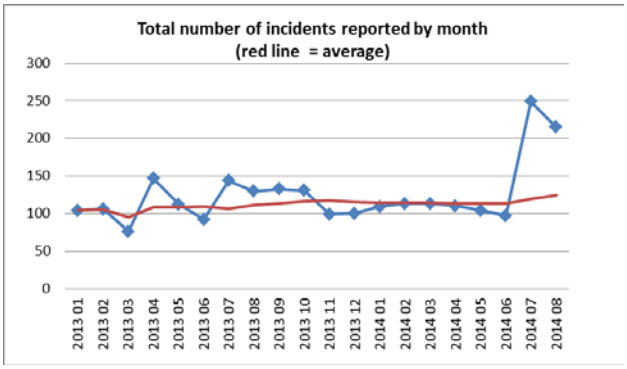
Overview/Summary

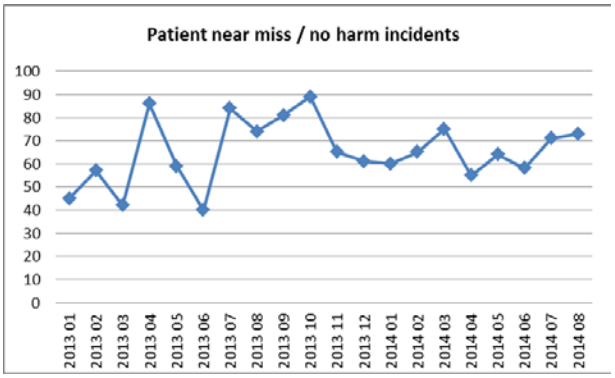
The number of incidents reported for the Trust for 01/08/2014 – 31/08/2014 was 215, with 92 of these being associated with a temporary administration system. The 122 other incidents that were reported is slightly increased from the number of incidents reported in July 2014.

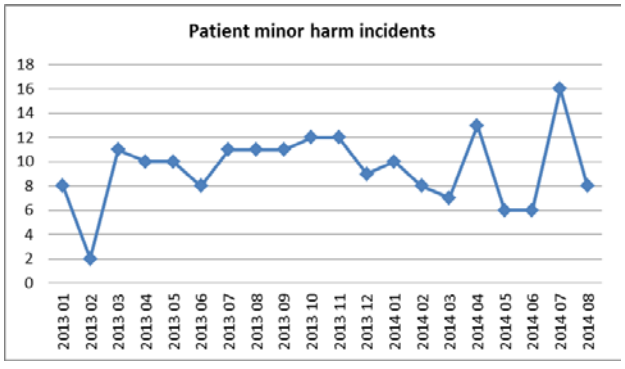
280 incidents were closed during the month of August – 155 of which related to the temporary administration system. The remainder of 125 is another increase compared to 87 in July 2014.

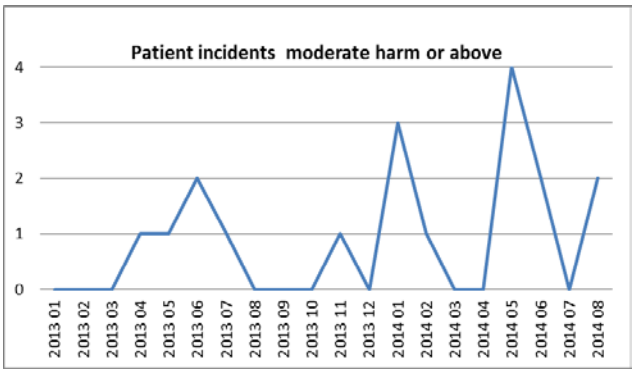
There were 3 “red” incidents (one of which was an SI) and 3 “amber” incidents during August 2014, compared to 2 “red” and 2 “amber” incidents for July 2014. Root Cause Analysis (RCA) reports are routinely completed for these categories.

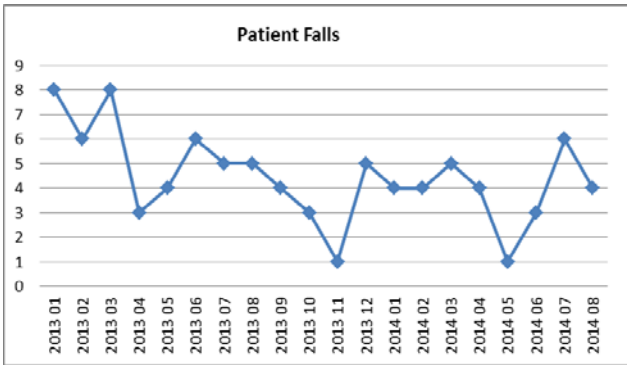
Incident Trend Analysis











Trends / issues following incidents reported in August 2014

Referral system (n=92)

As per the July report, with effect from 14 July 2014 a revised, centralised referral system was implemented within the Trust. Staff were asked to report when incorrectly directed referrals were received in order to monitor the numbers. This monitoring will be used to improve internal systems and the delivery of patient care, for example, timescales.

Drug error (Prescribing) (n=7)

The majority of the drug error incidents reported in August 2014, related to Prescribing Errors (n=7).

Methotrexate (a high risk medication) was excluded from the drug chart/patient clerking process on two occasions when patients were admitted via Main Theatres. This increases the risk of methotrexate toxicity due to the possibility of contraindication with other drugs e.g. nsaids and antibiotics if required at a later stage. These incidents were discussed at the monthly Pharmacy meeting to identify ways of reducing the recurrence and information was also fed back to the Clinical Director for Plastic Surgery.

30mg of Dihydrocodeine was prescribed for a 9 year-old girl on Peanut (weight 32.8kg) by an anaesthetic registrar (unable to decipher signature from drug chart), and it was administered by two trained nurses on the ward – this is the recommended four hourly adult dose. The patient was monitored regularly and suffered no untoward effects. The investigation for this incident is currently underway.

One incident related to eye drops being prescribed for the patient left eye when this should have been for the right. This patient clarified this with the Clinic prior to use and incorrect use was averted.

One internal “amber” prescribing incident was reported that related to a near miss penicillin allergy (see separate section in this report).

The Head of Risk and Medication Safety Officer have put in place a new mechanism to meet with the Lead Consultants for Plastics and Maxillofacial surgery on a 4-6 weekly basis to review all

incidents (with a special focus on medication related errors). This mechanism has been commenced to complement the incident and risk review process undertaken at the Monthly Directorate Review Meetings.

The Head of Risk and The Medication Safety Officer will also be attending the M&M meetings to raise awareness of incident outcomes and to increase the dissemination of learning.

Delay in Investigation, treatment, diagnosis or results (n=4)

Difficulty in contacting the on call Radiographer when a patient required an urgent chest X-ray. The Radiology Manager has investigated and confirmed that an alternative number for the on call Radiologist will be held by Switchboard, and that details of a second on call staff member will also be retained.

A delay was encountered by two patients when oncology referrals were faxed through to the Trauma Co-ordinator on 07/07/2014 and 24/7/14. These should have been categorised as two week waits, and as the consultant did not see the referrals until 7/8/14, this was when the appointments were generated for the patients. The investigation for these incident is underway.

Two other ad hoc incidents were reported for this category, and no trends were identified.

Blood transfusion/Blood Issues (n=4)

The main issue to note in this category was that the blood fridge broke down between 7th and 12th August 2014, and QVH blood was temporarily stored at the McIndoe Centre. Correct procedures were undertaken during this period including:

- All blood products were removed and returned to PRH.
- A circular was sent to staff to inform them of the situation and that QVH blood was temporarily being stored at the McIndoe Centre.
- 6 new units of O neg were placed in the McIndoe fridge.
- Speed of repair increased by the Director of Nursing.

Documentation (n=6)

No trends were identified for this category.

An adult patient had been added to the paediatric waiting list in error as the incorrect form had been placed in the notes, as both operations were similar. Both cases were corrected and staff reminded to be more aware.

Patient information was omitted from the WHO Surgical Checklist, the error was brought to Matron's attention post operatively by the Recovery staff. Staff on shift had check-listed the patient and were reminded to ensure that patient identification is added in the future by the Matron. Two further minor incidents related to missing patient documentation e.g. notes and a missing drug chart and these are under investigation.

New internal “red/amber” incidents and SI’s – 1 SI (also categorised as a Red incident), a total of 3 x “Red” internal incidents (including the SI), and 3 x “Amber” internal incidents.

1 x Serious Incident (ID 12581) was reported on STEIS for August 2014 (reference: 2014/26691). An incorrect tooth (upper left second premolar tooth (UL5)) was extracted by a QVH Dental Surgeon instead of the upper left first premolar (UL4) at Medway Hospital. The investigation and completion of the Root Cause Analysis (RCA) report is underway.

3 x internal “Red” incidents were reported (including the one above)

12569 – An investigation is underway in relation to professional misconduct of an agency nurse and an incident of care provision to a patient who had received failed skin grafts to his back.

12610 – A professional misconduct allegation was made as part of the SLA arrangements with Brighton and Sussex University Hospitals. The correct regulatory processes have been followed and Police action was not required. Appropriate safeguarding action has been undertaken, and the investigation has been commenced.

3 x internal “amber” incidents were reported

12481 – G2 Pressure Ulcer on Margaret Duncombe Ward. Routine RCA underway.

12524 - A near miss penicillin allergy. Tazocin was prescribed for a patient who was documented as having an allergic reaction to penicillin (documented that the reaction would be a rash and confirmed by the patient as a widespread rash and severe vomiting). Tazocin is an antipsuedomonal penicillin, not suitable for penicillin sensitive patients. The medication was not given to the patient and the prescriber was informed. RCA underway.

12687 – Patient admitted to Ross Tilley ward on 5th August 2014 following Right Perienial flap procedure - complained of a throbbing pain. A large haematoma developed and the patient lost sight from the right eye. RCA commenced.

Progress on ongoing incidents

MRSA Outbreak in the Burns Unit - Progress continues and no new cases have been identified. RCA completed and to Clinical Cabinet in August 2014, also submitted to CCG.

Theatre door related incidents including suspected staff injuries – The Finance Director met with Wilmott Dixon representatives and has arranged for a trial of alternative door closers to see if this would resolve the issues raised. The OH Manager has also been asked to provide some statistical data on the numbers of musculoskeletal referrals raised in connection with the Theatre doors.

Incident ID12469 – Discrepancy of 13 x 50mg capsules – RCA underway. The Head of Risk, Medications Safety Officer and the Local Security Management Specialist (LSMS) met on 21/07/2014 to complete the RCA and action plan for this incident. Initial feedback was given to the Pharmacy Department and the RCA is underway. Identified actions have been completed and an update given to the 08/09/2014 Clinical Governance Group.

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

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

ID	Risk	Incident date	Directorate	Service	Incident Summary	Investigation Summary	Category
12408	Red	24/07/2014	Plastics	Theatre Services	Pt booked for Swanson Arthroplasy to two fingers. Only one Swanson joint of the correct size on the shelf. Local anaesthetic block in both fingers before lack of implant identified. The size required was not highlighted in advance or at the time out. Implant not available from elsewhere. Patient offered choice, decided to wait to have both fingers done together at later date.	RCA has been drafted and awaiting final agreement with clinicians concerned. Actions identified.	Lack of resources (staff, equipment, facilities, etc)
12452	Amber	15/05/2014	Not Applicable	Radiology	Right wrist radiograph on 15 May reported normal. Cone-beam CT study of same wrist on 30 May showed fracture. Orignal imaging review does not show the fracture clearly. Case included in discrepancy process meeting for shared learning and RCA commenced.	Original imaging review did not show the fracture clearly. Case included in discrepancy process meeting for shared learning and RCA commenced. Outcome of discussions at discrepancy meeting highlighted that patient had followed correct pathway, therefore no identification of error identified. Radiation Protection Committee to agree downgrading of incident from an amber on 09/09/2014 (also discussed and agreed at Clinical Governance group of 08/09/2014). Only action arising - Ad hoc audit to be undertaken on frequency of occurrence at QVH. Incident recommended for closure at 08/09/2014 Clinical Governance Group.	Delay in investigation, treatment, diagnosis or results
12469	Amber	25/07/2014	Not Applicable	Pharmacy	Part box of 13 x Tramadol found to be missing. Unsuccessful detailed search undertaken, and logs rechecked. Time delay of 1wk had occurred before error identified due to log in book.	All relevant areas re-searched. Accountable Officer informed, incident discussed with Police Controlled Drugs Liaison Officer (West Sussex) on 1.8.14 during visit for CD destruction. RCA underway. The Head of Risk, Medications Safety Officer and the Local Security Management Specialist (LSMS) met on 21/07/2014 to complete the RCA and action plan for this incident. Initial feedback and immediate actions given to the Pharmacy Department and the RCA is being completed.	Drug Error (controlled drug measurement discrepancy)
12261	Red	07/07/2014	Burns	Nursing	Outbreak of hospital acquired MRSA in Burns. Seven patients affected in total	Root cause analysis undertaken. Outbreak declared and reported on STEIS as an SI. Burns Unit closed to admissions from 23/07/2014. Several meetings have taken place. Actions undertaken as per minutes/RCA etc. RCA completed and submitted to August 2014 Clinical Cabinet, followed by submission to CCG.	Hospital Acquired Infection

Policies Uploaded in August 2014

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

- Job planning for consultants (HR) Clinical Cabinet
- Volunteer Policy (Corporate) Clinical Cabinet
- SOP for Porters (Medicines Management) MMC
- SOP for MIU (Medicines Management) MMC
- Legionella and “safe” hot water systems policy and procedures (Risk Management) ICC.

INFECTION PREVENTION & CONTROL
Monthly Report – September 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- Areas of concern related to infection prevention and control have been identified, assessed and the risk are being prioritised and managed.
- The report contains key information on;
  - detail of outbreaks or significant infections
  - surveillance and audit information
  - infection control or prevention risks and mitigation

Key Points:

The key priority that the board need to be aware of for this month are ;

1. Following the outbreak within the burns unit where a number of patients became colonised with MRSA the unit has reopened. A full review of action that could be taken to prevent a reoccurrence has resulted in a number of changes including the the following;
   - All staff entering the main unit must where green scrub uniforms.
   - Once patients are admitted no room changes must occur, if one is considered absolutely necessary then the infection prevention control team and the burns consultant must be included within the discussion.
   - Segregation of ward and out patients, previously some facilities were shared.

   The executive summary and action plan submitted as a part of the root cause analysis investigation is attached for assurance that direct action has and continues to be taken.
2. Patient Led Assessment of the Care Environment (PLACE) results have been released. These incorporate cleanliness, food and hydration, privacy and dignity and condition appearance and maintenance. Our scores were above the national average for cleanliness but below for the other three aspects.

   Immediate action was taken to attend to concerns that could be addressed on the day. Some areas could not be addressed as they are linked to size and shape of building and prevent privacy at the reception desk and behind curtains in MIU as people can over hear due to close proximity. The hotel service lead is providing a summary of actions following the release of the final report.
3. The ability to recruit into the domestic services team is anecdotally related to the time taken to gain DBS and reference checks. This has been raised with HR who are working with the hotel services team to ensure recruitment is as prompt as possible. Two new staff have been appointed since last month's report.
4. Monthly MRSA screening of patients achieved lower than 95%, immediate action has been taken to allow this to be addressed with individual staff members.

Implications:

- Corporate risk (27) remains rated at 16 until a period of time passes with no further infection issues within the buns unit.

Recommendations:

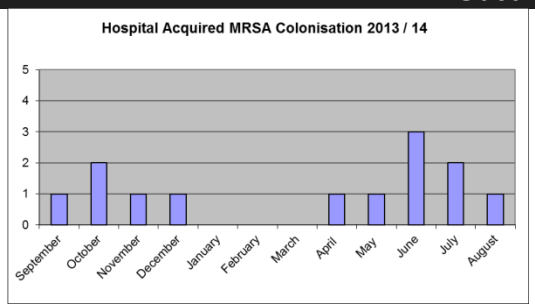
The board is asked to note the actions currently being taken and the raised risk related to hospital acquired infection.

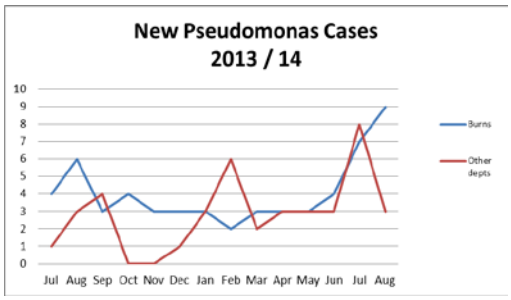
INFECTION PREVENTION & CONTROL
Monthly Report – August 2014

Areas of Concern

- Outbreak of healthcare associated infection (HCAI) MRSA colonisation on the Burns Unit continues. The number of patients involved remains at seven (excluding the index case). The Unit has been closed to new admissions and the last patient was transferred on 22 August. A plan has been devised to protect all future patients and deep cleaning of the Unit will commence on 3 September with a view to reopen on 8 September.
- Monthly MRSA screening figures show below 95% compliance in trauma and elective admissions. Ward Managers to be sent individual patient identification numbers so they can discuss screening with the nurse admitting the patient.
- Antimicrobial prescribing and the potential for over prescribing – A review of the guidelines has occurred and will continue as required, annual audit occurs and reminders are given to staff at clinical mandatory training to discuss antibiotic use with the Microbiologist. Patients are reviewed by the Consultant Microbiologist twice a week, when they are able to meet their contracted hours on site.
- Ability of BSUH to provide electronic reporting in a usable format to the Infection Prevention and Control Team (IPACT). This has been raised as a risk on the risk register and the Director of Infection Prevention and Control (DIPC) is liaising with BSUH. Progress is monitored at the Pathology contract meeting.
- Inaccurate or missing results from the daily laboratory sheet provided by BSUH (eg, MRSA positive results). This has been reported to the DIPC and was discussed at the pathology contract meeting in August. BSUH looking into possibility of providing a new format for the Infection Control Nurses (ICNs).
- Lack of onsite Consultant Microbiology cover –BSUH have been short of Microbiologists therefore unable to meet their onsite commitments at QVH. The risk is recognised on the risk register and is mitigated by provision of 24 hour telephone cover. It is anticipated that in mid-September BSUH will be able to meet their contract commitments as they commence employment of a new Consultant Microbiologist.
- Only one Sterinis machine in working order – This has now been resolved as two new hydrogen peroxide machines have now been received.
- Hotel Services Team is understaffed, this along with additional cleaning required due to the outbreak has reduced their ability to deliver a full cleaning service across the Trust. The lead has met with IPACT and prioritisation of clinical areas agreed. Staff in non-clinical areas have been informed of interim arrangements for cleaning prioritisation. Bank staff requested as short term measure whilst recruitment of permanent staff occurs.

Outbreaks / Significant Infection:





An outbreak was declared on the Burns Unit 7 July and the Unit closed to adult admissions on 25 July. Currently there are no in-patients. Measures implemented include: decolonisation/screening of staff, deep cleaning, review of scrub guidance, management of Intensive Therapy Patients (ITU) patients in an alternative area, burns outpatients (Emergency Burns Assessment Centre, EBAC) process reviewed, screening of patients, management of burns day case patients, cohorting of staff providing care and minimising those attending the Unit. The EBAC service will be relocated to Rycroft during the deep clean. PHE have been informed. Weekly outbreak meetings are being held.

Routine admission MRSA screen confirmed, after discharge, that a patient on Margaret Duncombe Ward had a very sensitive strain similar to the one involved in the Burns Unit Outbreak (not identical). Appropriate departments informed and infection control procedures advised.

Max Fax patient confirmed with a HCAI MRSA acquisition. Root cause analysis (RCA) form to be completed. Infection control precautions were advised.

Risk Register		
Risk	Number	Current situation
Lack of hand wash basins	442 (rated 6)	Portable sinks in situ where risk identified
Carpets in clinical areas	475 (6)	Replacement programme ongoing
Pseudomonas	556 (6)	Testing programme in place.
BSUH microbiology	513 (12)	Not currently providing 5 PA's on site. Telephone cover available. Infection Control Nurse hours increased.
Portable aircon units	631 (6)	Only for use at heatwave level 3 or where room temperatures exceed an acceptable level. Use in clinical areas is done in conjunction with an IPACT discussion.
Pre Sterinis cleaning	630 (3)	Use soap and water prior rather than Chlorclean prior to use of Sterinis (except in Burns)
Sterinis machines broken	688 (6)	Quotes being obtained urgently.

Surveillance					
	New this month	Year to date (target)	IC mandatory training	Overall attendance at 3.9.14: 76.7% (incl booked)	
E.coli bacteraemia	0	0	**Trustwide Quarterly Results – Q1**		
MRSA positive blood cultures	0	0 (0)	MRSA Screening:	Elective: 96.7%	Overall 96.5%
VRE/GRE positive blood cultures	0	0		Trauma: 95.8%	
C.difficile	0	0 (0)	Hand Hygiene / BBE:	Hands: 98.8%	
MSSA positive blood cultures	0	0		BBE: 97.8%	

	All Theatres	Burns/EBAC	Corneo	MD/Stepdown	Maxfax/Ortho	MIU	OPD x2	PAC	Peanut	Recovery	Rehab	RT	Sleep	Therapies	X-ray
Screening – elective	95	n/a		98								98	91		
Screening – trauma	93	n/a		88								95	n/a		
Total new MRSA: 15	1	3		1			3	4				1	2		
Pos on admission: 12	*1*	*1*		*1*			*2*	*4*				*1*	*2*		
Previously positive: 0															
Hospital acquired: 1		*1*													
Unknown: 2		*1*					*1*								
Hand hygiene	100	80	100	100	100	77	100	100	100	100	100	100		100	100
BBE	100	90	100	100	100	87	100	100	100	100	100	100		100	100

Trust Cleanliness

The Trust has to comply with the Patient-Led Assessments of the Care Environment (PLACE) standards. The domestic supervisor undertakes 12-15 cleanliness audits weekly; a score above 80% shows compliance. Results are sent to the Ward/Dept Manager; scores below 80% are provided to the Matron of the area. Areas not achieving 80% in August were MIU (70%) and Max Fax (70%). The domestic for Max Fax is being managed using the capability process. The MIU report was sent to the Manager and Matron for action, the cleaning aspects have been resolved.

The results from the 2014 PLACE programme have been published. The inspections involve a team of QVH staff and ex-patients reviewing areas of the Trust listed below. Cleanliness issues such as levels of dust were addressed on the day and those for example related to privacy and dignity in MIU having only one patient toilet and patients being able to overhear information about another patient in MIU and Out-Patient waiting areas will be discussed at the next Patient Experience Group meeting and the Estates and Facilities Group meeting. An action plan will also be devised.

Area Observed	QVH score	National average
Cleanliness	98.45%	97.25%

Food & Hydration	83.77%	88.79%
Privacy & Dignity	82.66%	87.73%
Condition Appearance and Maintenance	89.85%	91.97%

Training

ICN attended the staff meeting on the Burns Unit, much discussion surrounding the current outbreak situation.

Policies

Uploaded in August: Legionella and "safe" hot water system policy and procedures.

Meeting held to review the processes for Carbapenemase-producing Enterobacteriaceae screening. Policy to be updated to reflect changes.

Complaints

The Patient Experience Manager asked IPACT to investigate a complaint regarding a patient who had been previously admitted for hand surgery. During the patients Out-Patient appointment the Doctor removed the splint to allow examination but did so whilst the blood stained splint from the previous patient was on the same surface. Subsequently the patient developed an infection. IPACT advised this is not best practice and the splint should have been disposed of during the previous patient's appointment and the surface decontaminated. However, the risk of the patient developing an infection is minimal.

Audit Results

PLACE inspections – Clinical – MIU, Burns Non-clinical – Extra walkabouts performed on Burns.

Blood culture audit – 20 forms were received from 56 cultures sent to the laboratory, this is a 36% return rate however, it is an improvement on the last audit (24%). Out of the 20 forms 6 had `no` answers. There were 4 areas of non-compliance, 3 relating to cleaning of the patients skin and 1 to the use of disposable tourniquets. The audit form has now been modified to include an `n/a` column. All areas relating to staff hand washing were 100% compliant.

Monthly Theatre cleaning inspection – Matron, ICN and Domestic Supervisor undertook a walkabout. Issues raised include dust in the specimen room, review of pressure relieving aids in general, wipeable boxes for linen in the anaesthetic rooms. Full report sent to the Matron for action.

Legionella and Pseudomonas Surveillance and Management

New Theatres – One toilet had a second positive count for legionella in July (immediate samples and samples taken after 10 minutes running: 400cfu/l Legionella non pneumophila). It has been confirmed that the pipework is designed and installed in compliance with latest regulations. The UV water treatment system for the theatre complex was checked and it is likely that low use of the outlet has caused the issue. Water is safe to use. Additional purging of the unit undertaken and repeat sampling results returned clear. Further sampling organised 22 August. Estates Lead to meet with the Consultant Microbiologist to review processes and confirm best practice is being followed.

Ongoing issue with the hand washing basin by the Nurses Station in Peanut Ward. Sensor taps changed to lever taps at all sinks in the corridor. However Estates Dept sourcing another type as these are too high for staff. New type to be trialled and then all taps in the Ward to be replaced. Repeat sampling on 22 August.

Legionella Water safety sampling & response
<100.00cfu/l non detectable level (no further action required)
>100.00 - <1000.00 (Instigate flushing regime, investigate possible source, instigate rectification works)
>1000.00cfu/l (Arrange for 2 & 10 minute samples to be taken, investigate possible source, instigate rectification works)

Estates Issues

Area	Issue	Action
Dental lab	Carpet to be replaced with more suitable flooring to allow for cleaning	Delay in requisition being raised due to a procurement problem, now resolved and awaiting date of installation.
Prosthetics	Lack of hot water	Work progressing well; finish due at the end of September.
Jubilee	Heating not functioning	Work progressing well; finish due at the end of September.

Carpets	Carpeted area for replacement in areas in Trust	Estates following the replacement programme prioritised by IPACT. To start in the Burns Unit.
Disposal of waste in pts homes	New guidance states clinical waste created in patient's homes should be returned to QVH for safe disposal	Policy updated. Training delivered. Equipment supplied to staff to ensure safe transportation of waste.
C-Wing	Wards need general repair, painting, holes filled, bumpers on walls added vents and radiators cleaned.	Estates Lead to meet with the Matron to arrange schedule. This has been postponed due to resources being re allocated to accommodate the Burns outbreak programme.
Trust wide	Ventilation grills and radiators require cleaning.	On regular cleaning programme. Request by IPACT for Estates and Hotel Services to increase the frequency but currently no extra resources available. Installation of easily removable radiator covers in Burns co-ordinated in the outbreak programme. Estates to assess these with the possibility of using the same type Trust wide.
PAC	Examination room 11 has a leak	Estates have attempted repairs. Awaiting bad weather to confirm if the repairs have been successful.
Public Toilets	All require refurbishment	Female toilet outside of RDU to have full refurbishment. Trust wide review of all public toilets and repair as required. Estimated start date to be arranged.
Burns	Possibility of installing permanent hand wash basins in the corridors	Request added to the Burns outbreak programme. Funding required, to be discussed at the next Estates and Facilities Group Meeting.
Burns	Following Peter Hoffman (PHE report) requirement to check if the side rooms are delivering positive or negative pressure ventilation	Request added to the Burns outbreak programme. To be completed as part of the ventilation revalidations checks.
Burns	Heating not functioning	Partially completed, aiming to finish at the end of September.
Burns Theatre	Doors damaged	Partial repair. Costings for new doors requested.
Burns	Dishwasher broken	Repaired and back in use.
Theatre Corridor	Flooring damaged	Willmott Dixon contacted by Estates Dept to organise a date for repair. All corridor flooring to be painted annually.
Prosthetics & Pharmacy	Require allocated hand washing facilities.	Estates to look into installation of sinks or refurbishment of current sink. To be discussed at the Estates and Facilities Group meeting.

General Information

Freedom of information act request sent to ascertain the number of cases of endocarditis secondary to viridans streptococci (confirmed by blood culture) since the introduction of NICE guidelines. Discussed with the Consultant Microbiologist and due to the Trust specialities we would not care for this patient group, therefore we were unable to submit any data.

During the PLACE inspection it was noted that the slit lamp used for eye examinations in MIU is currently being stored and used in the plaster room – IPACT have requested it is relocated to a clean clinical room.

Abbreviations

Abx	Antibiotics	ICC	Infection Control Committee
BBE	Bare below the elbows	ICNS	Infection Control Nurse Specialist
BSUH	Brighton & Sussex University Hospital	IPACT	Infection Prevention & Control Team
CAUTI	Catheter associated urinary tract infection	ITU	Intensive Therapy Unit
C.difficile/C.diff	Clostridium difficile	MDR	Multi drug resistant
CQC	Care Quality Commission	MSSA	Meticillin sensitive Staphylococcus aureus
C-Wing	Canadian Wing	MRSA	Meticillin resistant Staphylococcus aureus
DH	Department of Health	OPD	Out Patients Department
DIPC	Director of Infection Prevention & Control	PAC	Pre Assessment Clinic
E.Coli	Escherichia Coli	PHE	Public Health England
GRE / VRE	Glyptopeptide / Vancomycin resistant enterococci	PLACE	Patient led assessment of the care environment
HCAI	Healthcare associated infection	PPE	Personal protective equipment

HPA	Health Protection Agency	RCA	Root cause analysis
IC	Infection control	Strep A	Group A Streptococcus

EXECUTIVE SUMMARY

During the months of May to August 2014 there was an outbreak of a highly resistant strain of Meticillin Resistant Staphylococcus Aureus (MRSA), PFGE Pattern A, spa type t037)) on the Burns Unit that resulted in seven patients becoming infected with MRSA. The Burns Unit was formally closed to new admissions on the 25th July 2014.

Recommendations and Action Plan **(In addition to all actions listed in the review meeting minutes).**

The recommendations list has been collated throughout the outbreak and amendments will be made following review meetings held during the maintenance and deep cleaning of the Burns Unit. The changes will incorporate the future operations management of the Unit and take into consideration the broader issues learnt from multiple outbreaks over a period of the last twenty four months.

Arrangements for shared learning

- ICNs conducted the routine hand hygiene road show in May to all clinical and non-clinical departments.
- Ward Manager and ICNs provided advice on when to change scrubs and wash hands and on deep cleaning.
- ICNs checked the rooms after deep cleaning and highlighted issues as required.
- Daily visits to the Burns Unit by the ICNs.
- ICNs, Consultant Microbiologist and Matron available for telephone enquiries.
- Outbreak learning will be shared with the Infection Control Committee/ Clinical Cabinet/Trust Board/Link Group/Ward Managers.
- Training will continue to be delivered.
- Consultant Microbiologist to present the outbreak to the Joint Hospital Audit Meeting.
- Conversation held between Lead Clinician and the Burns Network group to update them on the situation and identify any further measures required, this will also be communicated at the September meeting by the Burns Consultant.
- ICNs regularly contacted Chelsea and Westminster Hospital to share learning eg resistancy patterns.
- Staff informed via the Trusts information letter `Connect` with the situation and what precautions they must follow when wanting to visit the Burns Unit.
- Information displayed on the doors for both staff and patients/relatives.

Recommendation	Owner	Timescale	Progress	Completed
Sink outside single rooms, installation to move up timeline agenda from 3 years to six months?	Estates Lead	Feb 2015		
Plug socket to be placed outside the rehabilitation flat eg for a portable sink	Estates Lead	Feb 2015		
Review the last three outbreaks for common themes	IPACT	Sept 2014	Booked for 18/9/14	**A**
EBAC patients not to be showered in the main ward.	Matron	Sept 2014	Can use showers in corridor, or flats if empty.	**G**
Human resources to review their system of how staff are sent letters to avoid mistakes	HR Lead/Deputy	Sept 14		
Footwear for staff changed to washable clogs. Protocol for cleaning to be written. ? shoe washer to be relocated.	Matron	Sept 14	Shoes being ordered. Shoe washer in theatres being used – spare machine to be relocated to ladies changing room (JT to assess)	**A**
Old theatre 7 to be used as a store room for Burns	Matron	Sept 14	Already in place.	**G**
Centralised lead for mattress ordering and checking	Medical Devices Lead		Completed - Ward Mgrs to inform Medical Device Officer when new mattress ordered.	**G**
Mattress spot checks to be undertaken by the ICNs every other month	IPACT	Next due Sept 14	On-going	**G**
All admissions from other burns units to be treated within same single room throughout their stay.	Matron	Sept 14	On-going – added to bed management policy	**G**
Operational Policy to be updated to reflect changes.	Matron	Sept 14	Completed	**G**
Burns Clinical Lead to remind staff of the importance of documenting results in the medical notes.	Burns Lead	August 14		
Ward Manager to remind staff of the importance of screening all patients for MRSA as per Trust policy	Ward Manager	August 14	25/7/14	**G**
Ward Manager to remind staff of the importance of completing documentation correctly such as MRSA checklists, signing for the MRSA decolonisation protocol and keeping the patient in the same bed space. Where this is not possible staff are required to document the rational for the move. Team meeting to be held on new operational guidance before reopening.	Ward Manager Ward Manager	August 14 Sept 14	Bed space - ? Signing for protocol – 12/8/14. Checklist - 25/7/14 To be discussed at ward meeting end Sept	**A**

Recommendation	Owner	Timescale	Progress	Completed
Discuss with staff the importance of pts remaining isolated following loose stools and the Trust policy	Ward Manager	August 14	Next ward meeting – end Sept.	A
External doors to SDC - use only as a fire exit. Remove swipe access	Matron	Feb 15	Currently signs on doors	A
Restrict access control to medical staff, burns staff and site team – list of staff to be provided to A Trinick. Communication to be put in Connect.	Matron	Sept 14	Sent out to all staff 5.9.14	A
Max fac ward round to be done in the quiet/MDT room and then only 1-2 staff to visit the patient daily. To be added to Operational Policy	Matron	Sept 14	On-going	G
Burns ward round to be done in the quiet/MDT room and then only 1-2 staff to visit the patient daily. To be added to Operational Policy	Matron	Sept 14	On-going	G
No routine transfer staff between wards.	Matron	August 14	On-going	G
Chlorclean - review alternative due to increased use that does not meet COSHH guidance.	Hotel Services Manager	Sept 14	Agreed to use soap and water daily to and Chlorclean on discharge.	G
Deep cleaning team proposal to be written	Hotel Services Manager	October 14	Completed	G
Male changing room in Burns too small - ? Relocate / make changes	Matron	October 14		
Gloves – longer to be sourced for cleaning	Hotel Services Manager	Sept 14		
Relatives to wear gowns on visiting	Matron/Ward Manager	Sept 14	On-going	G
Discuss infection control management with other burns units	Ward Manager	Oct 14	Questions devised, ZU to send out	
EBAC to adopt same process for changing of scrubs To be added to Operational Policy	Matron/Ward Manager	August 14		G
Thicker full length gowns to be sourced	Supplies		Completed	G
Office chairs - change to non-fabric	Ward Manager	Sept 14	On order	A
Blood gas machine additional to be sourced for Theatres to be discussed with theatre manager prior to action to identify location/management	Matron	Oct 2014	Looking into device rental; to be discussed at Medical Device Committee	A
Blood fridge - move to theatres when replacement occurs	Matron	2015	Proposed business case in progress in conjunction with BSUH. Longer term plan to move to theatre.	A

Recommendation	Owner	Timescale	Progress	Completed
Laser Doppler machine - 1 currently, ideally a second would be beneficial	Matron	2015	Looking at smaller machine details	A
Portable x-ray machine – confirm burns machine is not used outside of Burns Unit	Matron	October 14	Used outside of unit (x-ray back up machine) double chlor-cleaned prior to use.	G
Changing rooms – relocate scrubs outside department and inside in cupboards/trolleys	Matron	Sept 14	Interim cupboard outside changing rooms; new cupboards to be purchased	A
Psychotherapy team – review rooms and consider appointments for patients discharged from EBAC occur in main OPD	Matron	Sept 14	Team to remain on Burns at present	A
Update transfer / referral forms to include outbreak of resistant infections	Matron/Ward Manager	Sept 14	Drafted	A
Convert 4 bed bay into two single rooms with en suite	Estates Lead/ Ward Manager	2015/16	Added to E&F operational meeting for discussion	
Provide daylight tubes in Rooms 1 and 2 to increase patient comfort and reduce need to move patients	Estates Lead	Feb 15	Added to E&F operational meeting for discussion	
Room Signs – ensure they reflect precautions required	Ward Manager	Sept 14		G
Create a definitive High and Low categorising of patients aligned to Scrub Change Policy, add to Operational Policy	Ward Manager	Sept 14		G
Convert day room to single room with en suite	Estates/Ward Manager	2015/16	Added to E&F operational meeting for discussion	
Routinely use clinical tape to identify clean rooms and checking nurse to sign	Hotel Services/ Ward Manager	Sept 14		G
Review of staff dress code Uniform changing during shift	Ward Manager	Sept 14		G
Discuss adding further filtration units into the ITU rooms	Estates Lead/ IPACT	Feb 15	To be discussed at IPACT in September	
Purchase 3 portable sinks for corridors	Ward manager / IPACT	Nov 14		

APPENDIX D

COMPLAINTS, CLAIMS & PATIENT EXPERIENCE REPORT

Monthly Report September 2014

Executive Summary

Purpose:

To provide the board with assurance that;

- Patient experience, complaints and claims have been acknowledged and issues identified, assessed and acted on with any risk identified prioritised and managed.
- The report contains key information on;
    - complaints received and complaints closed
    - claims received
    - patient feedback

Key Points:

The key priority that the board need to be aware of for this month are ;

1. Four new complaints were received and eight complaints closed.
    - New complaints are under investigation with lead personnel identified.
    - Where identified immediate action was taken following a new complaint.
    - Investigations result in actions and a decision on whether the complaint is upheld

2. One new claim was received.
    - All claims are opened and investigated.
    - Claim information is summarised quarterly and provided to the Quality and Risk Committee.

3. Patient feedback is sought through a variety of methods.
    - Feedback is provided to individuals.
    - Information is passed on to relevant departments for action.
    - Comparison is made against like organisations
    - There is an action plan to address the implementation changes to the FFT patient experience measurement.
    - We are on target to achieve the CQUIN return rate.

Implications:

- Investment in an alternative data collection methodology or in staff resource to load FFT feedback will be required by April 2015. An options appraisal has commenced with a number of companies providing a demonstration on how are requirements can be met.

Recommendations:

The board is asked to note the actions currently being taken.

Monthly complaints, claims and patient experience report

1 August 2014 – 31 August 2014

This report provides an overview of all activity during this period. During this period there were 4 formal complaints received. This is a decrease of the previous month (11). The following is a summary of the complaints that were received during this period:

Monthly complaints, claims and patient experience report

1 August 2014 – 31 August 2014

Complaints

Open complaints: There were 4 complaints opened during this period. All Complaints received are acknowledged, investigated and responded to. Actions identified are monitored for completion by the monthly clinical governance group.

Plastics

1. **Medical** - Concerns were raised by the patient in relation to the extreme pain that they endured and the extreme difficulties had in the removal of a Suzuki frame from the patient's finger which took place in the outpatients setting. The patient has also queried why the area was not numbed which only occurred when the patient was in distress. When the patient enquired as to why the local anaesthetic had not been administered from outset, they were informed that it was not policy to do so in outpatients. **Investigating lead – Clinical lead**

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

2. **Medical/Nursing** - Infection control concerns were raised regarding evidence of a previous patient's splint being in an area where a patient's wound was to be reviewed. The patient believes that due to an unsterile area this may have resulted in them contracting an infection. The patient also felt that the clinician was not interested and dismissive when the patient asked questions. **Investigating lead – Clinical lead/ Infection control nurse specialist/Clinical nurse manager**

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

   Comment/Action – This complaint has been fully taken on board by the clinician concerned who accepts that their communication skills could have been more interactive with the patient and also should have called the nursing staff to clear down the area between patients. The IPACT issues will be discussed with the staff at their next departmental staff meeting. **Upheld.**

Sleep Disorder Centre

3. **Technical staff –** Issues raised about the noise level at night made by the staff whilst patients were trying to sleep. **Investigating lead – Sleep Physiology Team Leader**

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

   Comment/Action – Still undergoing investigation and awaiting comments.

Corneo Plastics

4. **Secretarial/administration –** Concerns raised about the inefficiency of the support services in the unit. Patient has experienced delays in being given a follow up appointment and has been advised by staff that there is a backlog in sending out appointments. **Investigating lead – Service manager**

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

   Comment/Action – As well as contacting the Trust the patient has contacted the CQC in relation to this matter. Still undergoing investigation and awaiting comments.

Closed complaints: There were 8 complaints closed during this period. The Trust triages all complaints in line with the Department of Health guidance to ensure that proportionate investigations take place. As part of the investigation the investigating managers are required to make a decision, after consideration of the evidence, whether or not a complaint should be upheld (supported), partially upheld (supported in part), or not upheld (unsupported). Actions are monitored for completion through the monthly clinical governance group.

Plastics

1. **See No. 2 above.**

Pre-assessment/Canadian Wing

2. **Nursing** – The patient was seen in clinic for melanoma and scheduled for surgery under local anaesthetic/sedation. On the day of surgery the operation was cancelled as the surgery had been listed only as local anaesthetic. It was then discovered that the patient hadn't been pre-assessed. When the patient was pre-assessed they omitted to perform an ECG which the patient had to have done by their GP. Following the surgery there were clear communication issues and a lack of information given to the patient in relation to follow their up care and when the patients stitches had to be removed. **Investigating lead – Ward manager/Matron**

   Outcome – Data inputting error and communication failure by ward staff. Apology and expression of regret conveyed to patient. **Action completed:** Members of staff have been spoken with and it has been reiterated that they must effectively communicate with patients at all times and that must ensure accurate data processing. **Upheld**

Theatres

3. **Nursing/reception –** Concerns raised by a patient in relation to a lack of communication and information. Patient sat in Main Theatre reception from 7:55am-14:00pm without a member of staff enquiring after them even when the patient commented about the length of time that they had been waiting.

Outcome - Apologies given and this particular member of staff has been spoken with. Departmental training to be undertaken re: Customer care training by Matron/Patient Experience Manager October 2014. **Upheld**

Plastics/Canadian Wing

4. **Medical/nursing** – Issues raised regarding the patients overall experience whilst on the unit in particular the lack of communication given to them by the staff about how to care for a graft postoperatively which the patient believes resulted in the graft failing. The patients consent prior to surgery was also taken in front of another patient.

   Outcome – Apologies given as the patient should not have been consented in front of another patient. Full information was given to the patient on how to manage their graft site and this has been clearly documented in the patient's notes. The clinician re-stitched the wound at the patient's bedside using an aseptic technique. **Partially upheld.**

Policy and commissioning

5. **NHS policy:** patient had implants fitted 10 years ago. The implant has ruptured and funding for replacement has been refused by the CCG. The patient informed by the implant company that they should have received a warranty form which was not given to her by the surgeon. The patient feels that this has resulted in her not having the benefits that the warranty provides and covers.

   Outcome – An appointment has been made for the patient to be reviewed by one of our breast surgeons to assess the clinical need for removal and possible replacement of the implant. Once she has been reviewed, should she need a new implant, we would consider covering the cost of the implant as by not giving the patient the warranty has led to her not being able to get a replacement via Nagor. We would then approach the CCG to let them know/ask them to fund/tell them what we are doing, if replacement is clinically indicated. **Partially upheld.**

Radiology

6. **Diagnostic staff** - Failure to diagnose fracture to wrist.

   Outcome – The bony injury was difficult to visualise and was missed at the time of the initial examination. However this was picked up by the orthopaedic surgeon when the patient was reviewed at the fracture clinic and the patient has come to no significant harm as a result of this delay. The x-ray examination has been fed into the Radiology quarterly discrepancy meeting for discussion and learning. This case was also reported as an incident. **Upheld.**

Support cancer services

7. **Administration** – Undiagnosed patient was in error sent a Macmillan cancer information pack and was extremely distressed upon receipt of this.

   Outcome – **Action completed:** All confirmed melanoma patients to be referred to skin cancer nurse specialists so that they can send appropriate written patient information. All confirmed

squamous cell carcinoma patients to be referred to the cancer information team who will dispatch the relevant information. Only confirmed diagnosed patients will be referred to Macmillan Information Centre and that the manager will countercheck any information that is sent out to patients. **Upheld**

Plastics/Joint complaint with SASH (SASH leading on complaint as main patient concern lies with SASH)

8. **Medical -** Patient raised concerns about what had been written within the SASH health records and also had concerns about their hand treatment at QVH. Due to the complexity of the patient's condition they were informed that it is not known why the patient is unable to move their thumb. Feels that referral to QVH was a waste of time.

   Outcome - Having undergone an MRI and a CT scan the clinician was unable to establish the reason why the patient is unable to move their thumb. The clinician wished to perform further tests and has spoken with fellow colleagues about this case. It was requested that the patient return for a further review, however the patient has since sought treatment privately. The outcome of this treatment is unknown. **Not upheld.**

Claims

There was 1 new claim opened during this period. Overall there are 45 claims. A quarterly report is provided to the Quality and Risk Committee on claims paid, lessons from claims are disseminated through the Joint Hospital Audit meeting each quarter.

1. **Medics**: Alleged Damage to lingual nerve during tooth extraction.

Patient comments & FFT

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

NHS Choices

There were 3 new comments posted onto the NHS Choices website.

5 days in Margaret Duncombe Ward

Having recently returned home after breast reconstruction, I have nothing but praise and thanks for all the staff that I came into contact with in the hospital. Nothing was too much trouble and one lovely Nurse even scratched my knees during the night following surgery.
The standard of care was superb and it is easier to recover when it feels like everyone is on the same side.
I would have no hesitation in recommending QVH to anyone and can hardly find the words to thank you all enough. Visited in August 2014

Excellent treatment by wonderful staff.

I had a facial lesion remove and then a skin graft. The surgical skill and comforting bedside manner provided by the Doctor and the Nurse and staff is second to none, My heartfelt thanks and gratitude to all those concerned.

Visited in August 2014. Posted on 28 August 2014

1st Class care and treatment

Recently visited the QVH for some treatment to a damaged hand. From the time I arrived to being discharged I was treated with respect by all the staff and made to feel at ease. The procedure of the operation was explained in full, and when the time came, all involved were fantastic. I would like to thank everyone at the hospital and to keep on doing fantastic work.

Visited in August 2014. Posted on 30 August 2014

Friends and Family Test

The role out of FFT is a national CQUIN by the end of 2014/15 we are required to achieve a return rate of 30% for inpatient returns and 20% for MIU.

The FFT scores for **August is +**83 with a 35.5% response rate with the % score for extremely likely/likely **100%.**

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

Area	Net promoter score	Percentage score	% Return rate
MD ward	+83	100%	40.2%
RT ward	+82	100%	32.1%
Peanut ward	0	0%	0.00%
Burns ward	+100	100%	100%
Sleep disorder centre	+78	95%	57.7%
MIU	+86	97%	43.6%
Trauma	+73	95%	28.1%
OPD	+80	98%	5.6%
DSU	+95	100%	15%

The following chart is a comparison of specialist hospitals and their FFT scores for July 2014 (please note that NHS England publish their statistics 1 month behind.

Trust	Total Responses	Total Eligible	Response Rate	Friends and Family Test Score
MOORFIELDS	74	95	77.89%	89

PAPWORTH	709	1138	62.30%	85
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	167	403	41.44%	93
ROYAL MARSDEN	249	579	43.01%	95
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL	279	508	54.92%	79
STOKE MANDEVILLE HOSPITAL	98	912	10.75%	77

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th Sept 2014
Reference number:	231-14
Report from:	Jane Morris, Interim Head of Operations
Author:	Jane Morris, Interim Head of Operations
Report date:	17th Sept 2014
Appendices:	A: Monitor Feedback Q1
	B: Operational Update Report
	C: Performance Report

Operational performance: targets, delivery and key performance indicators

Key issues

1. Trust income from patient activity was below plan in Month 5.

2. Demand in the form of referrals and the numbers of first outpatients seen has remained static. New to follow up ratios for outpatients have continued to fall but are still higher than the contracted level for 2014/15.

3. All three aggregate 18 week targets were not met in month.
    a. The Trust failed to achieve the admitted target in three specialities – Ophthalmology, Oral Surgery and Plastics.
    b. The Trust failed to achieve the non-admitted target in two specialities – Oral Surgery and Rheumatology.
    c. The Trust failed to achieve the open pathway target in three specialities – Oral Surgery, Plastics and Ophthalmology.

4. There was one patient with a closed pathway in August who waited over 52 weeks.

5. The Cancer data for July was not available at the time of writing this report. Therefore a verbal update will be provided at the Board, however the Trust is predicting to fail the 2 weeks waiting standard for July. This was due to lack of off-site outpatient capacity, which QVH was not informed of in advance.

6. There was one urgent operation cancelled for a second time in August which was a trauma patient due to other more urgent cases taking priority.

7. There were six operations cancelled on the day of admission but none of these resulted in a breach of the 28 day guarantee.

Implications of results reported

18 weeks

8. Focus on clearing backlog of long waiting patients and complete validation of open pathways as planned has resulted in failure of 18 week Trust aggregate targets for August.

9. For Q2 the Trust is expecting not to meet the aggregate admitted or non- admitted 18 week targets. The Trust does expect to meet the open pathway aggregate target during this quarter.

10. The Trust is introducing additional waiting list management systems alongside extra capacity to reduce the backlog and the Trust expects to achieve aggregate compliance with all 18 week targets from Q3. QVH continues working with commissioners and IST in monitoring trajectories to achieve Trust aggregate compliance by the end of September.

11. The trajectory for admitted speciality compliance for Ophthalmology is currently predicted to be achieved by Q4. However the speciality continues to reassess the situation as it uses the additional capacity it secured in September and October to expedite compliance.

12. Current issues facing both Orthodontics and Max Fac combined will highly likely result in Oral Surgery not being compliant with the non-admitted target until the end of Q3. Both departments continue to reassess the situation as they are in the process of securing more capacity to expedite compliance.

13. Monitor has recently confirmed in writing that, after review, the Trust's governance rating remains as 'Green' (see Appendix A) and will not at this stage take any further investigatory action. However they do request that the Trust returns to compliance as soon as possible and shares the IST findings, following their own review, as well as providing the information on 18 week performance that is shared with commissioners.

14. Department of Health continues to task all providers to have plans in place to return to Trust aggregate compliance for 18 weeks by the end of September as part of operational resilience.

15. Further detail is provided within the Operational update report (Appendix B)

Cancer

16. Monitor have recently confirmed in writing that, after review of Q1, our governance rating remains as 'Green' (see attached letter as Appendix) and will not at this stage take any further investigatory action. However they do request that the Trust ensures compliance with cancer waiting times standards as soon as possible.

Risks to achieving compliance and actions being taken

18 weeks

17. Main risks to returning to Trust compliance by the end of Q2 are as follows:

- Lack of administrative staff to validate, schedule and book patients – significant sickness currently within the teams.
- Theatre staffing shortages continue.
- Shortages of Registrars / Associate specialist due to vacancies, visa requirements and sickness.
- Cancelling elective lists to accommodate trauma including free flaps, lower leg, returns to theatre.
- Any further unpredictable problems within Oral Surgery related to capacity provided by doctors.

18. Actions being taken to mitigate the risks include

- Extra administrative staff being brought in to support existing teams, this includes some agency medical secretaries for typing to free up experienced staff to schedule.
- Additional hours for validation put in place along with dedicated analyst for 18 weeks.
- Agency nursing continues in Theatres until the end of October.
- Doctors' rotas are reviewed on weekly basis to ensure maximum capacity is provided whilst ensuring safe care is delivered. This has included the use of locums to fill gaps on the rotas where required.
- Pooling of lists amongst consultants continues.
- Extra evening clinics and additional staff being put into Orthodontics to increase capacity for treatments.
- Extra operating lists continue on Saturdays, alongside the additional theatre sessions for Ophthalmology which includes using Centre for Sight for complex corneal procedures that we are unable to currently provide at QVH.
- Access meeting held weekly with team to review individual patients and address immediate operational issues so that backlog continues to reduce as per trajectories.
- 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.
- Continue to progress work on the IST recommendations and associated action plan.

Cancer

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

- The Trust's cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at QVH, complex multi-organisational pathways and late secondary referrals.
- Reliance on other organisations administrative teams to notify us of problems when they book clinics on our behalf - QVH does not routinely see the referral first unless it comes to East Grinstead first.
- Administrative errors at QVH due to shortages of staff / incorrect listing as routine when added to waiting list
- Lack of availability of visiting consultants for immediate breast reconstructions.
- Significant sickness levels in cancer data team.

20. Actions being taken to mitigate the risks include

- Improving effective internal monitoring by automating PTL to be produced daily.
- Liaising with management teams of referring secondary organisations off-site to improve processes.
- Requesting copies of referrals to be sent to QVH as soon as possible from off-sites so that teams are aware of issues earlier.
- Training of administrative teams and reinforcing to junior doctors about the correct listing of patients.
- Contacting individual trusts when an 'immediate breast' breach has occurred due to unavailability of visiting consultant and asking them to review systems.
- Managing sickness within team and trying to cover hours where possible via the bank recognising that some roles are very specialised and difficult to fill.
- A bi-monthly performance report against cancer waiting time standards continues to run in addition to the cancer PTL.
- Issues highlighted by the cancer PTL, are regularly discussed at the weekly access meeting to ensure patients are escalated accordingly.
- Aim to increase number of skin cancer patients who are seen and treated on the same day as outpatient clinics following the opening of Theatre 11.

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

21. The income performance in month contributes to the financial sustainability objective, noting that there will be the application of penalties for the failure of some operational standards. The Trust is currently discussing with the CCGs if they would consider penalties being reduced / avoided for Q2 as backlog is cleared.

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

Recommendation

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

17 September 2014

Mr Richard Tyler
Chief Executive
Queen Victoria Hospital NHS Foundation Trust
Queen Victoria Hospital
Holtye Road
East Grinstead
West Sussex
RH19 3DZ

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.monitor.gov.uk

Dear Richard

Q1 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 4
- Governance risk rating - Green

These ratings will be published on Monitor's website later in September.

The Trust has been assigned a Green governance risk rating.

The Trust has failed to meet the Referral to treatment time (RTT), 18 weeks in aggregate, admitted patients target for the third consecutive quarter which has triggered consideration for further regulatory action. In addition, the Trust has failed to achieve both the RTT, 18 weeks in aggregate, non-admitted patients and incomplete pathways targets.

Monitor uses the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve the targets applicable to it could indicate that the Trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the 2012 Act, taking into account as appropriate its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

We expect the Trust to address the issues leading to the target failure and achieve sustainable compliance with these targets promptly.

Monitor has decided not to open an investigation to assess whether the Trust could be in breach of its licence at this stage. The Trust's governance risk rating has been reflected as

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

Green. Should any other relevant circumstances arise, Monitor will consider what, if any, further regulatory action may be appropriate.

In the meantime, we expect the Trust to:

- Share with Monitor the findings from the review undertaken by Department of Health's elective care Intensive Support Team;
- and Provide to Monitor its weekly RTT monitoring performance reports, including progress in clearing its backlog compared to trajectory, that it currently providers to its commissioners.

The Trust has also failed to meet the Cancer 31 day wait from diagnosis to first treatment target.

We expect the Trust to address the issues leading to this target failure and achieve sustainable compliance with the target promptly. Monitor does not intend to take any further action at this stage, however should these issues not be addressed promptly and effectively, or should any other relevant circumstances arise, it will consider what if any further regulatory action may be appropriate.

From our review of the Trust's Q1 submissions, we also note that there has been a spike of MRSA cases. We expect the Trust to share the outcomes of its root cause analysis undertaken with regard to these MRSA cases, including the outcome of any thematic review undertaken.

A report on the FT sector aggregate performance from Q1 2014/15 will shortly be available on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will shortly be issuing a press release setting out a summary of the key findings across the FT sector from the Q1 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 02037470192 or by email (Justin.Collings@Monitor.gov.uk).

Yours sincerely

Justin Collings
Senior Regional Manager

cc: Mr Peter Griffiths, Chair
Mr Stuart Butt, Interim Finance Director

Queen Victoria Hospital NHS
NHS Foundation Trust

Operational Update for Trust Board
25th Sept 2014

1. Operational Performance Update

i. 18 weeks

In August the Trust failed all 3 aggregate 18 week targets as shown in the table below

Treatment Function	Total Patients	Patient over 18 weeks	18 week % compliance
Ophthalmology	216	63	70.83%
Oral Surgery	151	19	87.42%
Plastic Surgery	519	78	84.97%
Other	100	8	92.00%
Admitted Total	986	168	82.96%
Ophthalmology	120	6	95.00%
Oral Surgery	598	64	89.30%
Plastic Surgery	459	22	95.20%
Cardiology	35	1	97.14%
Rheumatology	7	1	85.71%
Other	102	4	96.08%
Non Admitted Total	1321	98	92.50%
Ophthalmology	988	79	92.00%
Oral Surgery	2292	251	89.05%
Plastic Surgery	2205	239	89.16%
Cardiology	48	5	89.58%
Rheumatology	20	0	100.00%
Other	588	8	98.64%
Open Pathway Total	6141	582	90.52%

QVH continues to predict to fail both the Trust aggregate for admitted and non-admitted for the rest of Q2. However it is expected that Trust aggregate for open pathways will be compliant during Q2, reflecting the continued reduction in waiting list backlog and one-off validation that has now been completed.

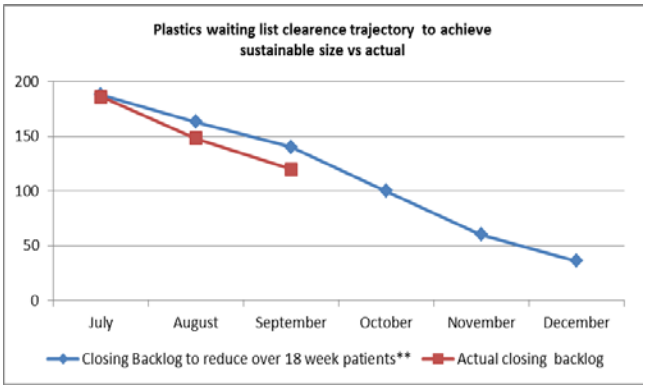
Theatre 11 as a dedicated LA DC facility has opened from the 8th Sept. However due to continued problems in recruiting registrars, particularly in Plastics, the number of sessions offered within this facility will be phased in during the month rather than opening all extra lists together. It is hoped that by the beginning of October all nine sessions, planned per week in this facility, should be fully operational.

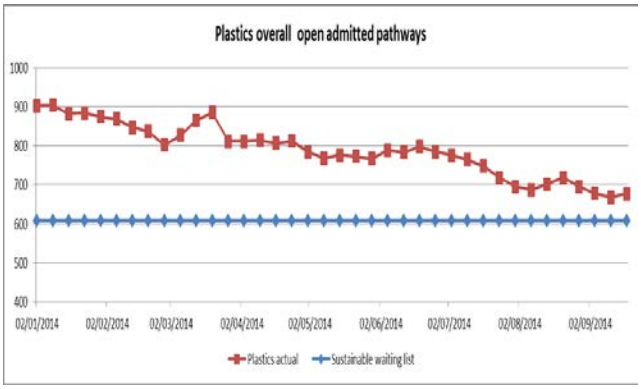
The continued delays in opening Theatre 11 will mean the Trust is likely to be behind the original activity plan by the end of Q2. However plans are in place to minimise the effect of this by continuing Saturdays twice a month and also by undertaking extra operating lists to reduce waiting times in

Ophthalmology. The operational team is monitoring closely the impact of delays in Theatre 11 and reported activity against plan during Q2.

a) Plastics 18 weeks performance

Despite the delays in opening Theatre 11, Plastics have continued to make significant reduction in their admitted waiting list and are currently making good progress against the predicted recovery trajectory for admitted as shown in the graphs below.

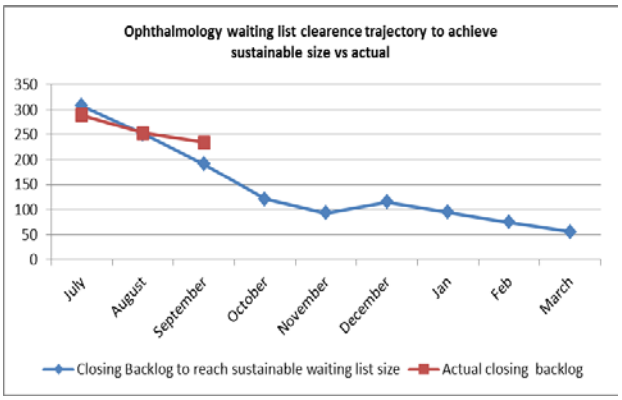


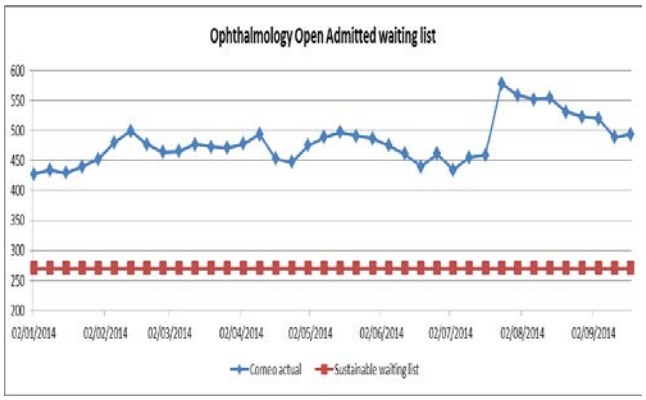


Plastics achieved non-admitted performance for August and this is now predicted to continue. Returning to compliance for open pathways for plastics is predominately linked with continuing to reduce patients waiting over 18 weeks for surgery based on the above trajectory.

b) Ophthalmology 18 weeks performance

Ophthalmology has also started to see a reduction in their admitted waiting list as extra all day lists have recently commenced. These will continue during Sept and October providing a total of 18 lists treating up to 204 patients. However due to the required reduction to the speciality's overall waiting list to reach a sustainable size, it is predicted that Ophthalmology will not be compliant with the admitted target until the end of Q3.





Please note - all graphs shown above are correct as of 17/9/14

Ophthalmology has consistently achieved non-admitted performance and this is not predicted to change. Returning to compliance for open pathways for Ophthalmology is again, predominately linked with continuing to reduce patients waiting over 18 weeks for surgery based on the above trajectory

c) Oral Surgery 18 week performance

Up until June 2014 Max Fac had been regularly meeting the RTT 18 week admitted target. However, since April the department has seen a significant shortage of middle grades due to long term sickness and vacancies. This has now resulted in patients waiting longer to be seen in outpatients or receiving their diagnostic test results at off-site clinics before being added to the waiting list. This has resulted in a steady climb in the number of patients waiting over 18 weeks within the speciality. Despite this Max Fac surgical waiting list remains below the calculated sustainable size. Therefore the main reason for this speciality continuing to fail is predominately related to a number of scheduling issues, including the need to accommodate cancer cases at short notice and delays in processing referrals to QVH from off-sites.

Orthodontics has seen a significant increase in the number of patients waiting for treatment following an administrative error which was identified earlier this year. This, coupled with vacancies, has meant there was not enough capacity to meet demand and so has resulted in a steady increase in the number of patients over 18 weeks. Additional sessions have been organised and more staff are due to start in October, however recently one of the consultants has needed to take compassionate leave which is again placing pressure on the service.

It should be noted that the current issues facing both Orthodontics and Max Fac combined will highly likely mean that Oral Surgery will not be compliant with the non-admitted target until the end of Q3.

d) Risks to Trust aggregate compliance and mitigating actions being put in place

Main risks to the returning to Trust compliance by the end of Q2 are as follows

- Lack of administrative staff to validate, schedule and book patients – significant sickness currently within the teams.
- Theatre staffing shortages continue.
- Shortages of Registrars / Associate specialist due to vacancies, visa requirements and sickness.
- Cancelling elective lists to accommodate trauma including free flaps, lower leg, returns to theatre.
- Any further unpredictable problems within Oral Surgery related to capacity provided by Doctors.

Actions being taken to mitigate the risks include

- Extra administrative staff being brought in to support existing teams this includes some agency medical secretaries for typing to free up experienced staff to schedule.
- Additional hours for validation put in place along with dedicated analyst for 18 weeks.
- Agency nursing continues in Theatres until the end of October.
- Doctors' rotas are reviewed on weekly basis to ensure maximum capacity is provided whilst ensuring safe care is delivered. This has included the use of locums to fill gaps on the rotas where required.
- Pooling of lists amongst consultants continues.

- Extra evening clinics and additional staff being put into Orthodontics to increase capacity for treatments.
- Extra operating lists continue on Saturdays, alongside the additional theatre sessions for Ophthalmology, which includes using Centre for Sight for complex corneal procedures we are unable to currently provide at QVH.
- Access meeting held weekly with team to review individual patients and address immediate operational issues so that backlog continues to reduce as per trajectories.
- Ensure clinics are coded as patient attended more promptly and accurately, particularly with regard to off-sites.
- Reinforce with off-site secretaries need to send information about additions to waiting list for surgery at QVH within 24 hours.
- Continue training of staff on 18 weeks and validation.

ii. 52 week breaches

From April to July the Trust has now had a total of 6 breaches that have been reported as waiting over 52 weeks as shown in the table below.

	April	May	June	July	Aug	Sept
Plastics		1		1	1[1]	
Orthodontics			3	1		1

There is a confirmed 52 week breach which will be reported for September due to a consultant needing to take compassionate leave. All patients over 35 weeks are being monitored daily, especially in Orthodontics, to ensure actions are taken to avoid any patients breaching 52 weeks.

iii. Cancer

As reported last month the cancer waiting times for April to June is shown in the table below.

	Apr	May	June		Q1
Cancer 2 wk rule (93%)	96.6%	96.9%	99.3%		97.5%
Cancer 31 FDT (96%)	97.9%	95.6%	94.5%		94.8%
Cancer 31 Subs (94%)	97.6%	95.2%	98.0%		97.2%
Cancer 62 day (85%)	92.3%	87.5%	84.6%		89.9%

[1] *Please note the case highlighted* is the same Plastic patient who had waited longer than 52 weeks in July but their treatment was in August.*

QVH failed the 31 day FDT performance target for Q1 and the reasons for breaching this standard were

- 1 x patient breached due to visiting surgeon's unavailability for immediate breast reconstruction
- 1 x patient breached due to lack of theatre capacity after patient declined one date for surgery
- 1 x patient breached due to lack of theatre capacity at QVH
- 2 x patients breached due to incorrectly being scheduled as routine rather than urgent cases by team
- 2 x patients breached off site due to theatre overrun
- 1 x patient breached due to delays in being scheduled due to administrative staffing shortages

The data for July was not available at the time of writing this report. Therefore a verbal update will be provided at the Board, however the Trust is predicting to fail the 2 week waiting time standard for July. This was due to lack of off-site outpatient capacity which QVH was not informed of in advance.

It does need to be stressed that throughout the year an element of risk remains with compliance with Cancer targets for the reasons given below. However the Trust is committed to reduce the likelihood of multiple breaches within any given period through a number of listed actions.

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

- The Trust's cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at QVH, complex multi-organisational pathways and late secondary referrals.
- Reliance on other organisations' administrative teams to notify us of problems when they book clinics on our behalf - QVH does not routinely see the referral unless it comes to East Grinstead first.
- Administrative errors at QVH due to shortages of staff / incorrect listing as routine when added to waiting list.
- Lack of availability of visiting consultants for immediate breast reconstructions.
- Significant sickness levels in cancer data team.

Actions being taken to mitigate the risks include

- Improving effective internal monitoring by automating PTL to be produced daily.
- Liaising with management teams of referring secondary organisations off site to improve processes.
- Requesting copies of referrals to be sent to QVH as soon as possible from off-sites so that teams are aware of issues earlier.
- Training of administrative teams and reinforcing to junior doctors about the correct listing of patients.
- Contacting individual trusts when an immediate breast breach has occurred due to unavailability of visiting consultant and asking them to review systems.
- Managing sickness within team and trying to cover hours where possible via the bank recognising that some roles are very specialised and difficult to fill.
- A bi-monthly performance report against cancer waiting time standards continues to run in addition to the cancer PTL.

- Issues highlighted by the Cancer PTL, are regularly discussed at weekly access meeting to ensure patients are escalated accordingly.
- Aim to increase number of skin cancer patients who are seen and treated on the same day as outpatient clinics following the opening of Theatre 11.

iv. Cancelled Operations

In total for August there were 6 elective operations cancelled on or after the day of admission for non- clinical reasons as listed below

- 1 x patient list overrun
- 1 x equipment not available
- 3 x patients more urgent case took priority
- 1 x patient no ITU bed due to shortages of staff caused by the Burns unit closure due to infection outbreak

All patients were treated within 28 days guarantee.

Also in August a single urgent cancellation cancelled for the second time was reported. This was a trauma patient who was cancelled due to more urgent cases taking priority.

Actions being taken

- Site practitioners have been reminded to alert Matron, General Manager /on-call manager and consultant when either an elective or a trauma patient may need to be cancelled in order to review all options to prevent a cancellation wherever possible.
- A new procedure guide has been produced to clarify how cancellations are recorded for both elective and trauma cases to tighten the process even further.
- The Trust has recently reviewed an options appraisal which plans to facilitate a gradual increase in trauma theatre capacity to two lists every day in addition to hand trauma sessions. This has been presented to Clinical Cabinet for consideration in September (see later section).

v. Financial Implications

Financial penalty applied by CCGs for 18 week non-compliance, urgent cancelled operation, 52 week breach is estimated to be circa £66,000. The Trust is currently in discussions with CCG to see if penalties can be reduced / avoided completely for Q2 as backlog is reduced.

vi. Impact to Monitor compliance

Monitor have reviewed our governance rating, following the failure to meet the 18 week Trust aggregate for three consecutive quarters and for failing the 31day FDT target for Q1. They have confirmed in writing that our governance rating remains as ‘Green’ and will not at this stage take any further investigatory action. However they have requested that the Trust returns to compliance as soon as possible and shares both the IST findings, following their own review, as well as the information that is shared with commissioners on 18 week performance.

2. Intensive Support Team (IST) Recommendations

The IST continues to review our performance and progress against their list of recommendations made earlier this year. A significant number are now completed and the IST is planning to sign off the Trust from their support in October after one more visit. A summary of progress against their key findings is outlined below and a detailed action plan is available on request.

	Summary of Key action	Timescale
1	Review of access policy IST has recommended a number of changes which are being incorporated to tighten up process	Completed and ratified by CPC this month. Newest version will be circulated.
2	Central referral point has been recommended	Completed and In place.
3	Increase engagement with commissioners to gain support with other providers who cause delays in patient pathways before referring to QVH	Discussions have continued with commissioners over the summer. Internal audit of referrals received late will be undertaken to identify further actions based on trends. J Morris continues to speak to other provider Director of Ops as required including immediate breast reconstructions following earlier communication with CEOs.
4	Further refine and improve patient tracking especially within OPD and diagnostics to proactively reduce waiting times	Daily tracking tool has been refined with the help of the IST and is now ready for launch in September.
5	Review demand and capacity using IST developed tools with their support	All specialties have now been completed for inpatients. Further analysis and compliance modeling to be undertaken for outpatients once dedicated 18 week analyst in place and aim to have this completed in October.
6	Implement process for booking pre-assessment and surgery date at same time (with 3 weeks apart)	Steps being put in place to implement booked pre-assessment being finalized and will be introduced within one specialty at a time from November.
7	Trust to ensure PAS is primary source for scheduling and should to discontinue medical secretaries using spreadsheets	Upgrade to Patient Centre is now provisionally planned from 14th October.
8	Review overall booking processes to ensure consistency and correct application of rules by all secretaries involved in scheduling	New system for offering dates for new OPD patients is being finalised. Appointment letters have already been revised and implemented. Weekly access meeting now embedded to ensure patients are booked according to clinical priority and to reduce waiting times as well as escalate issues.
9	Trust to introduce partial booking for follow up appointments – will need to purchase software to make this possible	Tender specification being devised ready for procurement to be commenced – part funded by Safer Hospital, Safe Wards Technology funding. Also exploring options for purchasing additional modules to add onto current PAS which would also give functionality to comply with this recommendation.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	232-14
Report from:	Stuart Butt, Director of Finance and Commerce
Author:	Stuart Butt, Director of Finance and Commerce
Report date:	17 September 2014
Appendices:	Finance Report

Finance Report M5 August 2014

Key issues

1. The financial performance report details the trust's financial performance for August 2014.

	Plan YTD (£k)	Actual YTD (£k)	Variance to Plan
Turnover	24,094	25,317	1,223
EBITDA	1,866	2,361	495
Surplus	386	953	567
Continuity of service risk rating (CoSRR)	4	4	-

NB table subject to rounding differences.

2. The trust is ahead of the surplus plan for the year with increased income partly offset by increased costs.
3. The Trust is maintaining a Continuity of Service Risk Rating of 4.

Implications of results reported

4. Achieving the improved surplus of £953k for the first 5 months provides assurance that the planned surplus of £2,203k for the year is achievable despite a small deficit in August.

Action required

5. Future plans rely on increased capacity and activity from theatre 11 and work continues to mobilise the resources required. Delivery of the action plans to meet performance targets is critical but costs need to be controlled when looking to reduce patient waiting times.

Link to Key Strategic Objectives

- Operational excellence
- Financial sustainability

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

Implications for BAF or Corporate Risk Register

7. Nothing new to add.

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
August 2014
Month 5
17 September 2014

Executive Director: Stuart Butt

Contents

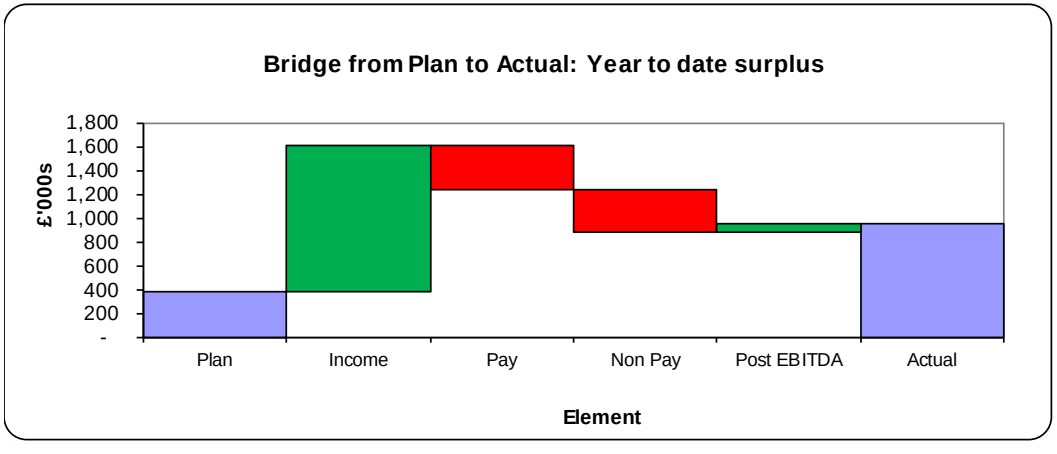
Queen Victoria Hospital NHS
NHS Foundation Trust

Summary Actual Position – YTD M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure	CM 13-14	Current Month-August			YTD 13-14	Year to Date		
	Actual £k	Actual £k	Budget £k	Variance £k	Actual £k	Actual £k	Budget £k	Variance £k
Income	*4,730*	5,135	4,929	206	*24,063*	25,317	24,094	1,223
Pay	*(3,212)*	(3,381)	(3,199)	(183)	*(15,528)*	(16,283)	(15,920)	(363)
Non Pay	*(1,306)*	(1,599)	(1,271)	(329)	*(6,262)*	(6,673)	(6,308)	(365)
EBITDA	*212*	154	459	(305)	*2,274*	2,361	1,866	495
EBITDA %	*4.5*	*3.0*	*9.3*	*-6.3*	*9.4*	***9.3***	*7.7*	*1.6*
Post EBITDA	*(179)*	(294)	(296)	2	*(1,253)*	(1,408)	(1,481)	73
Donated assets		-	-	-		-	-	-
Surplus (Deficit)	***32***	**(140)**	**163**	**(303)**	***1,021***	**953**	**386**	**567**

Continuity of Service Risk Rating	Metric	Level 4 threshold	Score	Weighted score	
Liquidity days	46	0	4	50%	2
Debt Service Cover	3.0	2.5x	4	50%	2
Combined Score			1 2 3		**4**



Summary

- The trust remains ahead of the surplus plan for the year, with additional income partly offset by additional costs.
- In month performance has deteriorated with a £140k deficit in the actual position, this in part relates to some one off costs which include £108k of potential pay claims for junior medical staffing.

Issues

- The surplus of £953k (3.8% surplus) is consistent with the annual plan of £2,203k (3.7% surplus) .
- Income is above plan and above that achieved last year.
- Income includes the recognition of 100% of CQUIN for the first quarter and 75% for July & August.
- Income reflects estimated performance penalties of £234k year to date. These are subject to confirmation.
- Pay includes £108k potential back pay claims that have recently come to light and are under negotiation.
- Non-pay variances reflect activity, including £85k for Corneo work subcontracted to Centre for Sight and £96k for Sleep Devices, (which are both offset by corresponding income), and £15k for Theatres, £35k for Burns' skin.
- The Continuity of service risk rating is 4, as planned.

Risks.

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

Actions

- Action plans to deliver additional activity and to meet performance targets (to reduce penalties and achieve incentives).
- Budgetary control through revised accountability and reporting arrangements.

Summary Actual Position – YTD M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

£k	Annual Budget	Current Month Actual	Current Month Budget	Current Month Variance	YTD Actual	YTD Budget	YTD Variance
Patient Activity Income	55,788	4,809	4,615	194	23,528	22,526	1,002
Other Income	3,763	326	314	12	1,754	1,568	186
Pay	(38,401)	(3,273)	(3,199)	(75)	(16,104)	(15,920)	(184)
Non Pay	(15,394)	(1,588)	(1,271)	(317)	(6,789)	(6,308)	(481)
Prior Year Items	-	(120)	-	(120)	(28)	-	(28)
Financing	(3,553)	(294)	(296)	2	(1,408)	(1,481)	73
Grand Total	**2,203**	**(140)**	**163**	**(303)**	**953**	**386**	**567**

Note: Financing costs consist mainly of depreciation, dividends and theatre loan interest.

Summary

- The impact of prior year items is shown separately in the above analysis. In month the negative impact is £120k and year to date it is a negative £28k.
- The patient activity income variance for the month includes matched income i.e. recharged at 100% of cost, this month includes additional expenditure of £128k (Corneo 85k, Sleep devices 43k). There is an in month benefit of £56k arising from the estimated CQUIN income increasing from 50% to 75% .
- Patient income is consistently above plan in most areas, with only elective inpatients showing an increasingly adverse variance.

Issues

- The prior year items are costs that match to prior year activity and income from prior year activity, that were not recognised at the time. These arise from the revision of estimates and the recognition of new liabilities.
- In this month new liabilities were recognised of £108k for retrospective pay claims (not agreed & under discussion) and £12k for King's House repair costs.
- These items have been split out to focus the remaining analysis on in year performance

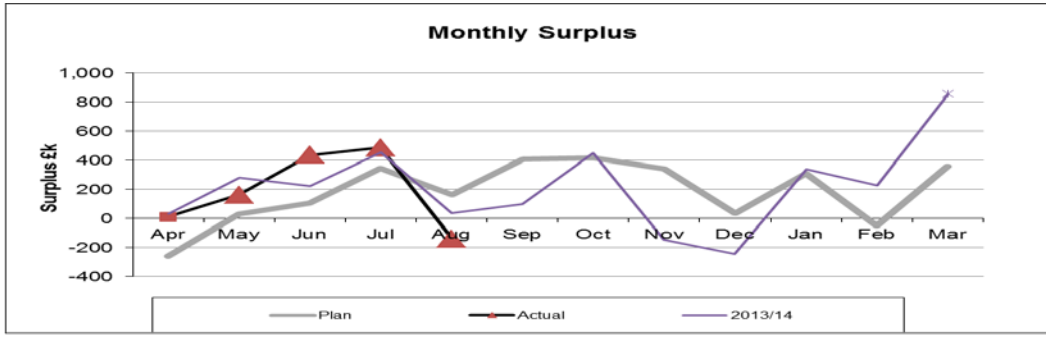
Risks.

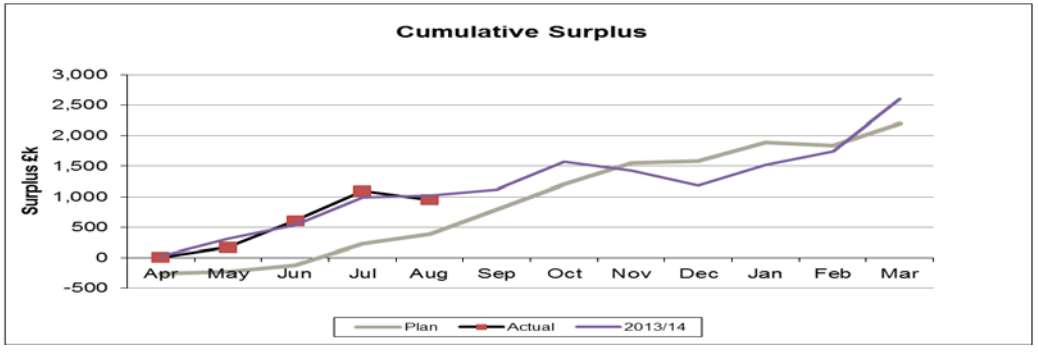
- The impact of the prior year is expected to return to a positive position as final agreement is reached with commissioners over 2013/14 income and as debts reduce. The potential upside from the prior year bad debt provision is between £200k and £400k but is not included in the current position.

Summary Trend Position – M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Position at Month 5	Reported		Prior Year Items		Income Matching Items		Non Recurrent		Underlying Position	
	CMA	YTD A	CMA	YTD A	CMA	YTD A	CMA	YTD A	CMA	YTD A
Income	5,135	25,317	-	34	208	736	27	-	4,901	24,546
Pay	(3,381)	(16,283)	(108)	(178)	(39)	(105)	(30)		(3,205)	(15,999)
Non Pay	(1,599)	(6,673)	(12)	116	(284)	(644)			(1,303)	(6,145)
Financing	(294)	(1,408)							(294)	(1,408)
Surplus (Deficit)	**(140)**	**953**	**(120)**	**(28)**	**(115)**	**(12)**	**(4)**	**-**	**98**	**993**





Summary

- August shows a deficit for the month but the underlying position is a surplus of c£98k against a plan of £163k after adjusting for prior year items (e.g. back pay claims), matching rechargeable costs to income, and non recurrent items such as costs or income that refer to previous periods.
- The cumulative surplus remains ahead of plan.

Issues

- The plans from July onward include additional activity associated with the opening of theatre 11.
- The plans for the remainder of the year reflect the phasing of additional activity rather than any service changes.
- 18 Week RTT compliance is expected to increase both activity and costs as the Trust reduces waiting times to a sustainable position.

Risks

- The trust surplus is sensitive to the achievement of income targets as costs are predominantly of a fixed nature.
- Cost control remains critical and additional activity needs to be delivered at marginal cost rates.

Actions

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

Forecast – M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Forecast at M5 2014-15	Plan £k	Downside	Downside £k	Upside	Upside £k	Midpoint £k
Income	59,581	Growth at actual levels	60,270	Increased activity to plan plus growth continues	62,516	61,393
Pay	38,431	Actual levels plus overspends	39,035	Increased activity and cost control.	39,122	39,079
Non-Pay	15,414	Historic overspending continues.	16,144	Increased activity and cost control.	16,294	16,219
ITDA	3,533		3,533		3,425	3,479
Surplus	2,203		1,558		3,675	2,617

Summary

- The downside forecast is for a surplus of £1,558k with an upside forecast of £3,675k, giving a midpoint of £2,617k. The surplus budget of £2,203k is at the lower end of this range and is the current forecast position for the Monitor returns.

Issues

- The downside forecast assumes that activity continues at current levels but that there is no further growth above this level. The cost assumptions are increased pay costs from additional activity, and increased non-pay costs, reflecting additional activity and historically seen overspends.
- The upside forecast is that the current overachievement on income continues and that the planned income growth is also achieved. The planned income growth is from additional capacity. The cost assumptions are increases in pay and non-pay to reflect additional activity.
- The phasing of income this year is unusual, with additional growth from extra capacity from quarter 2. In previous years activity and therefore surplus have been planned evenly across the quarters. Therefore achieving a surplus of £953k to date is consistent with achieving the planned surplus of £2,203k.

Risks

- The trust surplus is sensitive to the achievement of activity.
- The operational pressures around staffing means that cost control remains critical.
- Penalties are assumed at year to date levels so the financial position would worsen if penalties increased or continued at month 4 levels.

Actions

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

Income – M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

POD. Month 5 Year to date :	Actual £k	Plan £k	Variance £k
Day Case	4,596	4,308	288
Elective	3,891	4,296	-405
Non Elective	4,692	4,414	278
Exclusions	1,446	1,269	177
Outpatient First Attendance	2,184	2,098	86
Outpatient Follow Up	4,123	3,821	302
Outpatient Procedure	1,726	1,657	69
Minor Injuries	369	346	23
Radiology	555	446	109
Critical Care	363	316	47
Sub total	**23,945**	**22,970**	**975**
CQUIN reduction	-57		-57
Penalties	-234		-234
ERT deduction	-126	-444	318
Total Income	**23,528**	**22,526**	**1,002**

Summary

- Patient income by point of delivery (POD) is consistently above plan in most areas, with only elective care showing adverse variance due to reduced activity.
- The assumptions around CQUIN, penalties and Emergency Rate Threshold (ERT) are considered to be prudent at this stage and will be firmed up as each quarter is agreed with commissioners.

Issues

- Income is above plan, before the additional capacity from theatre 11 is in place.
- Income by POD is at the full rate, i.e. it assumes 100% CQUIN, no penalties and no reduction for ERT. These are accounted for separately.
- CQUIN has been planned at 100% achievement. Q1 CQUIN is now reflected at 100% based on internal calculations and M4&5 at 75% (from 50%), the net benefit of the change is £57k. 100% CQUIN was achieved last year.
- There is no budget for penalties and the £234k cost relates to penalties for 18 week breaches and other contractual penalties. These penalties are under review for Q2.
- ERT was prudently assumed to be suffered at 100% in the budget but agreements were reached to mitigate this. The actual cost reflects internal calculations rather than commissioner agreed values. Liable for change until agreed freeze.

Risks

- Elective is significantly below plan and follow-up growth is out of proportion with first attendance.
- Future income relies on additional capacity being utilised effectively.

Actions

- To better understand the reasons for elective under performance.
- To aim for full achievement of CQUIN and reduce costs associated with penalties.

Penalties: Issues / Risks

- Within income there is an accrual of £234k for penalties and challenges. (Month 5 is an estimate based on M4 data, activity data still to be finalised and any penalties to be further agreed with commissioners).

Penalties Accrual 2014/15	M1 £k	M2 £k	M3 £k	M4 £k	M5 £k	Total £k
RTT18 Admitted	2	3	11	28	28	**72**
RTT18 Non-Admitted	1	0	2	2	2	**7**
RTT18 Open pathways	7	5	8	25	25	**70**
Sub total RTT18	**10**	**8**	**21**	**55**	**55**	**149**
52 week waiters	0	5	15	10	10	**40**
Urgent operation cancelled for second time	0	10	10	10	10	**40**
Never Events (estimate)	0	1	2	0	0	**3**
Data Challenges (estimate)	1	1	0	0	**0**	**2**
Grand Total	**11**	**25**	**48**	**75**	**75**	**234**

- 18 week penalties constitute the majority of the accrual. The 18 week penalties for Q2 remain subject to discussion with CCGs as providers do not expect to be penalised for reducing backlogs.
- The forecasts assume the continuation of penalties at this average level for the remainder of the year.
- Last year total penalties and challenges were £307k.

Actions

- The actions to meet targets should reduce the level of penalties.

Directorate Performance – YTD M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Financial Performance	2014-15	August 2014			Year to Date 2014-15		
by Directorate	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	24,976	1,993	2,058	(65)	10,357	9,800	557
Clinical Support	(2,657)	(127)	(223)	96	(1,029)	(1,070)	41
Nursing	(8,837)	(917)	(740)	(178)	(3,698)	(3,675)	(22)
Estates and Hotel Services	(3,648)	(328)	(295)	(33)	(1,565)	(1,490)	(75)
Human Resources	(746)	(66)	(63)	(3)	(273)	(307)	33
Finance	(5,382)	(464)	(449)	(15)	(1,978)	(2,246)	268
Corporate	(1,504)	(230)	(125)	(105)	(862)	(627)	(235)
Grand Total	**2,203**	**(140)**	**163**	**(303)**	**953**	**386**	**567**

Summary

- Directorate performance reflects trust performance overall, increased income only partially offset by pay and non pay adverse variances.

Issues / Actions

- Page 10 gives greater detail of the performance by Directorate.
- Maintaining income levels, controlling costs and meeting performance targets are key financial challenges for the remainder of the year.

Actions

- Delivering additional capacity through theatre 11 opening which is now due in September 2014.
- Maintain control over costs through tighter budgetary control.
- Delivery of the action plans to meet performance targets.

Directorate Performance – YTD M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance by type		2014-15	August 2014			Year to Date 2014-15		
Directorate	Type	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	SLAM Income	49,958	4,319	4,140	179	20,985	20,101	883
	Other Income	1,390	131	116	15	633	579	54
	Pay	(18,766)	(1,585)	(1,567)	(18)	(7,880)	(7,768)	(113)
	Non Pay	(7,606)	(871)	(631)	(241)	(3,380)	(3,113)	(267)
Anaesthetics and Surgery Total		**24,976**	**1,993**	**2,058**	**(65)**	**10,357**	**9,800**	**557**
Clinical Support	SLAM Income	3,721	341	303	37	1,608	1,549	58
	Other Income	567	56	47	9	258	236	21
	Pay	(4,937)	(401)	(406)	5	(1,998)	(2,032)	34
	Non Pay	(2,008)	(123)	(167)	44	(897)	(824)	(73)
Clinical Support Total		**(2,657)**	**(127)**	**(223)**	**96**	**(1,029)**	**(1,070)**	**41**
Nursing	SLAM Income	1,873	151	153	(2)	794	780	14
	Other Income	1,046	71	87	(16)	528	436	92
	Pay	(9,452)	(851)	(788)	(63)	(3,970)	(3,938)	(32)
	Non Pay	(2,305)	(288)	(192)	(96)	(1,049)	(953)	(96)
Nursing Total		**(8,837)**	**(917)**	**(740)**	**(178)**	**(3,698)**	**(3,675)**	**(22)**
Estates and Hotel Services	Other Income	294	18	25	(7)	109	123	(13)
	Pay	(1,657)	(145)	(138)	(7)	(727)	(690)	(36)
	Non Pay	(2,286)	(201)	(182)	(19)	(947)	(922)	(25)
Estates and Hotel Services Total		**(3,648)**	**(328)**	**(295)**	**(33)**	**(1,565)**	**(1,490)**	**(75)**
Human Resources	Other Income	170	17	14	3	100	71	29
	Pay	(714)	(61)	(60)	(1)	(283)	(293)	10
	Non Pay	(202)	(22)	(17)	(5)	(90)	(84)	(6)
	ITDA	-	-	-	-	-	-	-
Human Resources Total		**(746)**	**(66)**	**(63)**	**(3)**	**(273)**	**(307)**	**33**
Finance	SLAM Income	236	(1)	20	(20)	142	95	47
	Other Income	345	16	29	(12)	126	144	(18)
	Pay	(1,605)	(128)	(134)	6	(641)	(669)	28
	Non Pay	(805)	(57)	(67)	10	(333)	(335)	3
	ITDA	(3,553)	(294)	(296)	2	(1,408)	(1,481)	73
	Other - Cross Year	-	-	-	-	136	-	136
Finance Total		**(5,382)**	**(464)**	**(449)**	**(15)**	**(1,978)**	**(2,246)**	**268**
Corporate	SLAM Income	-	-	-	-	-	-	-
	Other Income	(50)	17	(4)	21	-	(21)	21
	Pay	(1,270)	(102)	(106)	4	(606)	(529)	(76)
	Non Pay	(184)	(26)	(15)	(10)	(92)	(76)	(16)
	Other - Cross Year	-	(120)	-	(120)	(164)	-	(164)
Corporate Total		**(1,504)**	**(230)**	**(125)**	**(105)**	**(862)**	**(627)**	**(235)**
Grand Total		**2,203**	**(140)**	**163**	**(303)**	**953**	**386**	**567**

Summary

- The in month £303k negative surplus variance reflects £120K of new prior year costs being recognised, nursing agency backlog being invoiced and overspending in various pay and non pay lines.

Issues

- Anaesthetics and Surgery – M5 income positive variance relates to Corneo and Sleep which have corresponding non pay costs attached. YTD positive variance remains high for Plastics, Sleep, Ophthalmology . As above Non Pay variance largely relates to RTT18 outsourced work and Sleep equipment , and theatre items.
- Clinical Support's positive income position is mainly Radiography income. The non pay swing on the month is an internal movement of drug costs to outpatients.
- Nursing – M5 pay reflects bank and agency pay across a number of areas and agency backlog costs received. Non Pay on the month is the outpatients drug adjustment ,as above, and Burns-Skin costs.
- Estates and Hotel Services M5 pay is cover for absence.
- Finance includes a number of the technical adjustments and income not directly attributable to a service line e.g. RTAs. Pay and non pay includes compensation payments and an element of upside from the prior year.
- The Corporate pay overspending will reverse as reserves unwind to match agreed costs incurred in Q1.

Actions

- Maintain control over costs through budgetary control.
- Delivery of the action plans to meet performance targets.

Pay Analysis – M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Directorate Positions	2014-15	August 2014			Year to Date 2014-15		
Pay Costs	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	(18,766)	(1,585)	(1,567)	(18)	(7,880)	(7,768)	(113)
Clinical Support	(4,937)	(401)	(406)	5	(1,998)	(2,032)	34
Nursing	(9,452)	(851)	(788)	(63)	(3,970)	(3,938)	(32)
Estates and Hotel Services	(1,657)	(145)	(138)	(7)	(727)	(690)	(36)
Human Resources	(714)	(61)	(60)	(1)	(283)	(293)	10
Finance	(1,605)	(128)	(134)	6	(641)	(669)	28
Corporate	(1,270)	(102)	(106)	4	(606)	(529)	(76)
Grand Total	**(38,401)**	**(3,273)**	**(3,199)**	**(75)**	**(16,104)**	**(15,920)**	**(184)**

Summary

- Pay costs are above plan in month and year to date reflecting the operational challenges faced by the trust.

Issues

- Anaesthetics and Surgery adverse variance is payment for additional sessions and agency cover in theatre due to sickness and vacancies.
- Nursing adverse variance is due to agency covering vacancies and workload, with £30k being prior periods costs.
- Estates costs reflect agency cover.
- Finance saving is for vacancies that will be filled.
- Corporate variance in month reflects funding of costs from the pay reserve. The adverse variance will become a neutral variance by year end as the reserve is released.
- Not included in this table is £108k of pay claims relating to prior years that are subject to negotiation.

Risks

- Pay costs reflect the operational challenges facing the trust – scheduling of activity, sickness, recruitment, retention and the need to safely maintain capacity to meet performance targets and objectives.

Actions

- Improve budget holder accountability through change in reporting structure, accountability agreements and lower level controls.

Pay Costs – YTD M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Pay Variances by Directorate and Staff Group	Anaesthetics and Surgery		Clinical Support		Nursing		Estates and Hotel Services		Human Resources		Finance		Corporate		Total	Total
August 2014	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV
CONSULTANTS	(22)	(40)	(23)	(23)	(4)	(20)	-	-	-	-	-	-	2	8	(48)	(75)
JUNIOR MEDICAL	2	(56)	-	-	(0)	(2)	-	-	-	-	-	-	-	-	2	(58)
AGENCY JUNIOR MEDICAL	(12)	(26)	(4)	(9)	-	(4)	-	-	-	-	-	-	-	-	(15)	(39)
NURSING, MIDWIFERY & HEALTH VISITORS	39	140	1	(1)	53	192	-	-	(1)	(1)	-	(0)	-	-	91	331
AGENCY NURSING, MIDWIFERY & HEALTH VISITORS	4	(22)	-	-	(91)	(193)	-	-	-	-	-	-	-	-	(87)	(215)
SCIENTIFIC, THERAPEUTIC & TECHNICAL	(25)	(102)	38	113	(4)	(27)	-	-	-	-	-	-	-	-	10	(17)
AGENCY SCIENTIFIC, THERAPEUTIC & TECHNICAL	-	-	(7)	(41)	-	-	-	-	-	-	-	-	-	-	(7)	(41)
OTHER CLINICAL STAFF	2	14	(0)	(2)	11	44	-	-	-	-	-	-	-	-	12	57
AGENCY OTHER CLINICAL STAFF	-	-	-	-	-	(0)	-	-	-	-	-	-	-	-	-	(0)
NON CLINICAL STAFF	(7)	(22)	1	(1)	(4)	(2)	1	(26)	(0)	11	5	33	26	0	22	(6)
AGENCY NON CLINICAL STAFF	-	-	(0)	(1)	(23)	(20)	(8)	(11)	-	-	1	(5)	(24)	(84)	(54)	(121)
Grand Total	**(18)**	**(113)**	**5**	**34**	**(63)**	**(32)**	**(7)**	**(36)**	**(1)**	**10**	**6**	**28**	**4**	**(76)**	**(75)**	**(184)**

Key: CMV-Current month variance; YTDV- Year to date variances to budget; in £k's; (red) is adverse.

Summary

- Pay costs reflect the operational challenges facing the trust with overspends in month and year to date.
- The challenges include scheduling, sickness, recruitment, retention and the need to safely maintain capacity to meet performance targets and objectives.

Issues / Risks

- The key variances are explained on page 13.
- The Corporate overspend will reduce to zero as reserves are released to cover costs incurred early.
- The other overspends are a continuing risk given the operational challenges.

Actions

- Enhanced budgetary control would contribute to the maintenance of pay costs within budget.

Pay Costs – YTD M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Key Variances

- Anaesthetics and Surgery
  - Consultant and agency junior medical costs are high in month with payments for additional sessions and cover.
  - Scientific and therapeutic staffing costs are theatre staff covering sickness and absence.
  - Non clinical staff is additional support in Max Facs, theatres and health records.
- Clinical Support
  - Consultant cost are high in Radiology with additional cover.
  - Scientific and therapeutic underspend relates to vacancies that will be filled, particularly in the Prosthetics Lab.
- Nursing
  - Agency cover is driving the in month overspend and is covering vacancies / workload. There is a retrospective agency cost of £30k in this month. Year to date nursing is balanced but continued agency and bank use is offset by other nurse management vacancies.
  - £23k Non clinical agency is RMN agency which is offset with corresponding income.
- Estates and Hotel Services
  - The overspend is agency cover within Building & Engineering
- Corporate
  - The overspend relates to costs that are covered by reserves and the overspend will reduce to zero as reserves are released during the year.

Non Pay Analysis – M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Directorate Positions	2014-15	August 2014			Year to Date 2014-15		
Non Pay Costs	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Anaesthetics and Surgery	(7,606)	(871)	(631)	(241)	(3,380)	(3,113)	(267)
Clinical Support	(2,008)	(123)	(167)	44	(897)	(824)	(73)
Nursing	(2,305)	(288)	(192)	(96)	(1,049)	(953)	(96)
Estates and Hotel Services	(2,286)	(201)	(182)	(19)	(947)	(922)	(25)
Human Resources	(202)	(22)	(17)	(5)	(90)	(84)	(6)
Finance	(805)	(57)	(67)	10	(333)	(335)	3
Corporate	(184)	(26)	(15)	(10)	(92)	(76)	(16)
Grand Total	**(15,394)**	**(1,588)**	**(1,271)**	**(317)**	**(6,789)**	**(6,308)**	**(481)**

Summary

- Non pay costs are significantly over in month.

Issues

- Anaesthetics and surgery includes in month costs for Corneo outsourcing , Sleep machines and theatre supplies.
- Clinical Support positive variance is an internal recharge of drugs to nursing outpatients.
- Nursing variance in month relates to the drug recharge above, skin for the Burns unit and medical equipment maintenance.

Risks

- Overspends not linked to activity and shortfalls on cost improvement plans are risks.

Actions

- Improved budget holder accountability through change in reporting structure, accountability agreements and lower level controls.

Non Pay Costs – YTD M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Non Pay Variances by Directorate and Group	Anaesthetics and Surgery		Clinical Support		Nursing		Estates and Hotel Services		Human Resources		Finance		Corporate		Total	Total
August 2014	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV
CLINICAL SUPPLIES & SERVICES EXPENSES	(136)	(84)	(4)	(22)	(59)	(97)	0	1	-	(0)	(15)	(17)	-	-	(213)	(218)
DRUG EXPENSES	(3)	(6)	40	(23)	(44)	4	-	-	(0)	(0)	-	(4)	-	-	(7)	(30)
ESTABLISHMENT EXPENDITURE	(10)	(51)	10	(3)	14	15	3	(4)	(3)	3	3	9	(7)	7	10	(24)
GENERAL SUPPLIES & SERVICES	(3)	(8)	(2)	(5)	(3)	(16)	(7)	(1)	(0)	(0)	(0)	(0)	-	-	(16)	(30)
OTHER NON PAY EXPENSES	(88)	(122)	(1)	(4)	(0)	(3)	(0)	(0)	0	0	17	16	(2)	(20)	(74)	(134)
PREMISES AND FIXED PLANT	(0)	3	0	(16)	(3)	(4)	(15)	(21)	(1)	(8)	5	(1)	(2)	(2)	(16)	(50)
RESEARCH AND DEVELOPMENT	-	-	-	-	(0)	5	-	-	-	-	-	-	-	-	(0)	5
Grand Total	**(241)**	**(267)**	**44**	**(73)**	**(96)**	**(96)**	**(19)**	**(25)**	**(5)**	**(6)**	**10**	**3**	**(10)**	**(16)**	**(317)**	**(481)**

Key: CMV-Current month variance; YTDV- Year to date variances to budget; in £k's; (red) is adverse.

Summary

- Non-pay costs are £317k above budget in month and £481k over year to date, but this includes non-recurrent and activity related costs.

Issues / Risks

- Non Pay costs may come under pressure as the trust seeks to meet performance targets.
- Anaesthetics and Surgery - Costs are over budget in August mainly due to Corneo outsourcing, Sleep machines and theatre supplies.
- Nursing: Clinical supplies overspend is on Skin for Burns and equipment maintenance.

Actions

- Improved budget holder accountability through change in reporting structure, accountability agreements and lower level controls.

Cost Improvement Analysis – M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes built into budgets 2014-2015	Annual Plan £000's	M05 Plan	Achieved £000's	Achieved %	Shortfall
Pay	337	140	112	80%	28
Clinical Supplies	233	97	68	70%	29
Non Clinical Supplies	142	59	7	12%	52
Other non operating expenses	170	71	60	85%	10
Total Cost Improvement Programmes	**882**	**367**	**247**	**67%**	**120**

Summary

- At M5 the trust is achieving 67% of the cost improvement plan however this is expected to improve.

Issues

- Pay - the key adverse variance is in the Programme Office where costs have been brought forward. The adverse variance will reverse and the £100k planned saving will be achieved.
- Clinical supplies - sleep devices are the key adverse variance and the procurement process is underway and the expected saving will be delivered.
- Non clinical supplies includes the cost of leasing Operating Theatre 6. The decision to dispose is subject to a business case.
- Other non operating expenses variance is due to an increase in the PDC dividend.
- Additional procurement savings are in development to help to achieve the full plan.

Risks

- A 33% shortfall on plan is a risk for the full year of £288k. The forecast, before additional procurement savings and the disposal of the lease, is to achieve £734k of savings leaving a gap of £148k or 17% to be addressed by additional actions.

Actions

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

Balance Sheet – YTD M5 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet	2013/14 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,211	36,704	36,703
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	36,704	36,703
Current Assets			
Inventories	415	418	418
Trade and Other Receivables	8,939	6,995	6,658
Cash and Cash Equivalents	3,655	6,547	7,065
Current Liabilities	(6,574)	(6,426)	(6,464)
Sub Total Net Current Assets	6,436	7,535	7,676
Total Assets less Current Liabilities	43,647	44,239	44,379
Non-Current Liabilities			
Provisions for Liabilities and Charges	(554)	(582)	(582)
Non-Current Liabilities >1 Year	(8,933)	(8,545)	(8,545)
Total Assets Employed	**34,159**	**35,113**	**35,253**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	16,703	16,843
Revaluation Reserve	6,173	6,173	6,173
Total Tax Payers Equity	**34,159**	**35,113**	**35,253**

NB Analysis is subject to rounding differences

Summary

- Net assets improve with the generation of the surplus.

Issues

- Fixed assets are stable as depreciation matches additions, although this is not expected to continue as capital plans are re-phased and actioned.
- Debtor balances have improved significantly since the year end as commissioners reduce outstanding balances. This improvement brings debtor levels closer to those seen historically, although further improvement is being sought.
- Non-current liabilities have reduced with the loan repayment made in June. A further repayment will be made in December.

Risks

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

Actions

- Re-forecasting of the capital expenditure plan with a commitment to achieve the phased plan.
- Continued focus on reducing debtor balances.

Capital – M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Capital Programme	2014/15 Plan £000s	YTD Spend £000s	Committed £000s	Forecast £000s	2014/15 Total Spend £000s
Estates projects					
13/14 Projects:					
Jubilee/Burns heating	450	223	77	10	310
Other projects	92	12	20	34	65
14/15 Projects:					
Corneoplastic electrical upgrade	100	-	-	200	200
Fire compartmentalisation	160	-	-	15	15
A Wing repairs	100	-	-	-	-
Meeting rooms	50	-	-	-	-
Carbon reduction	50	-	-	-	-
Other projects	398	40	1	171	211
Medical Equipment	550	96	133	321	550
IT Equipment	1,400	78	99	1,013	1,190
Grand Total	**3,350**	**449**	**329**	**1,764**	**2,542**

Summary

- Capital expenditure is significantly below the phased plan and the latest forecast reflects potential slippage. New projects maybe approved that are funded from this slippage e.g. anaesthetic machines.

Issues

- The key project within IT is a replacement network to support more advanced clinical systems and a strategic outline case is due to come to Trust Board in October.
- Estates costs do not include the £372k lease purchase that is subject to approval and linked to the development of an Education Centre.

Risks

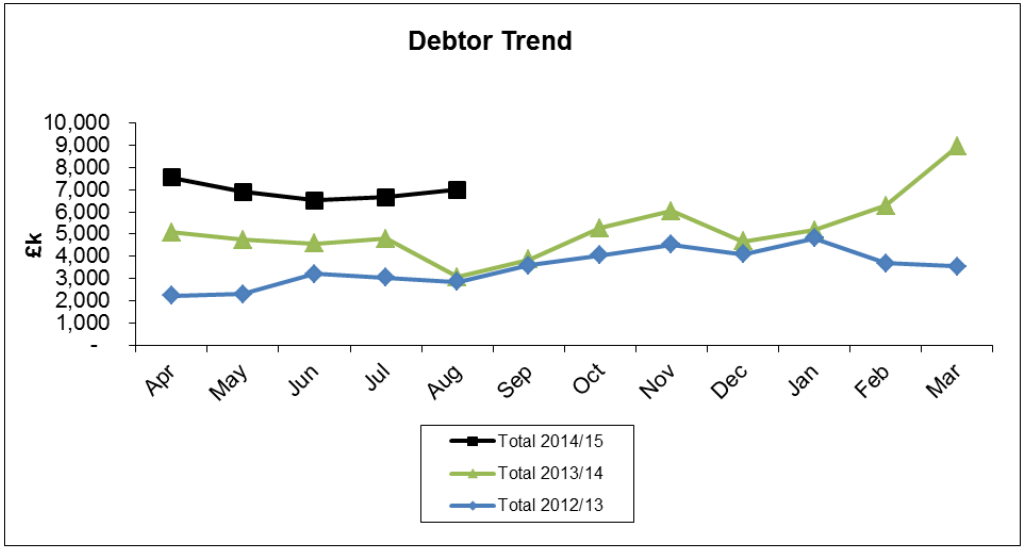
- Sufficient project management is key to the delivery of capital projects so this is being built into delivery plans.

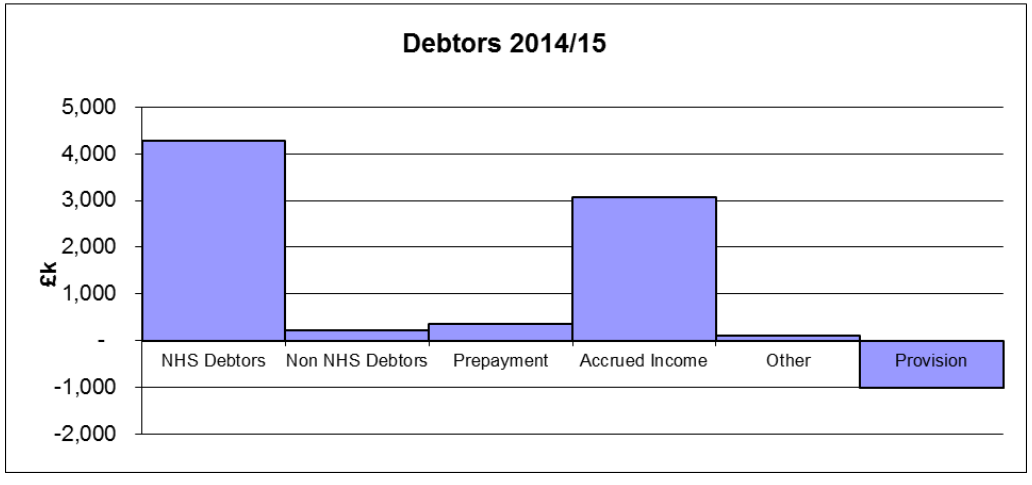
Actions

- Deliver planned projects.

Debtors – M5 2014/15

Queen Victoria Hospital NHS Foundation Trust





Summary

- Debtor balances initially reduced this year with commissioners reducing outstanding older balances.

Issues

- Debtor balances are at historically high levels because of delayed payments. Work continues with commissioners to reduce outstanding balances.
- Accrued income includes income over performance that is to be agreed and then invoiced.
- The bad debt provision is subject to monthly review. Given the current value of debt, its age, and the pattern of cash receipts the provision may reduce by between £200k and £400k by year end.

Risks

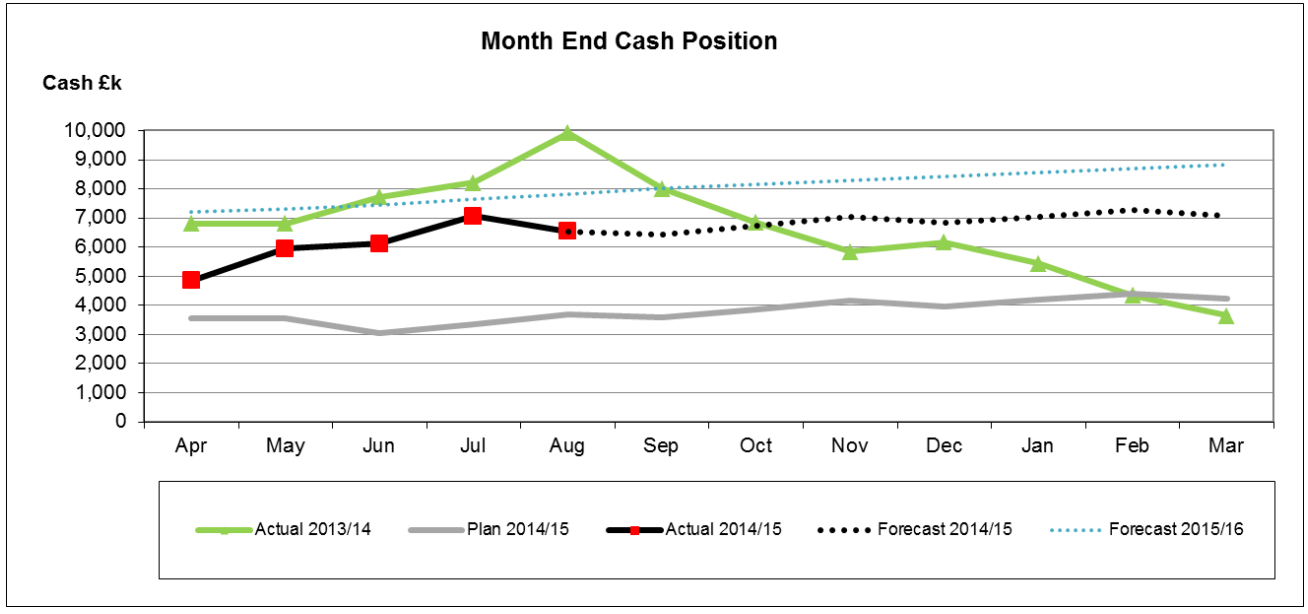
- Debt arising from over performance against income plans is slower to be paid.

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M5 2014/15

Queen Victoria Hospital NHS Foundation Trust



Summary

- Cash balances are significantly above plan because of reduced debtor balances and delays to capital expenditure.

Issues

- Cash balances peaked in 2013/14 and declined with delivery of the £4m internally funded theatres project. Increased debtor balances toward year end also contributed to the reduction in cash .
- Cash balances are projected to increase through to the end of 2015/16 reflecting surpluses, continued reduction in debtor balances and an increase in capital spend to get back on plan.

Risks

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

Actions

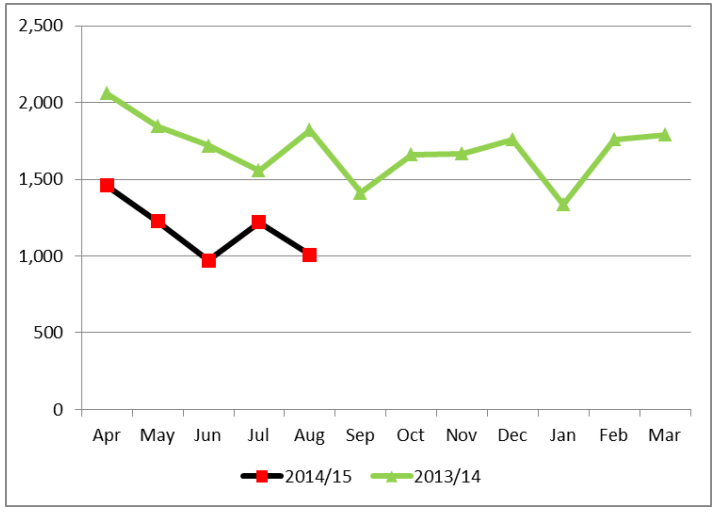
- Continued liaison with commissioners to ensure prompt payment.
- Management of capital schemes.

Creditors – M5 2014/15

Queen Victoria Hospital NHS Foundation Trust

Trade Creditors

£k



Better Payment Practice Code August 2014	2013/14 Outturn # Inv's	2013/14 Outturn £k	Current Month # Inv's	Current Month £k	YTD # Inv's	YTD £k
Total Non-NHS trade invoices paid	15,071	21,255	1,468	1,567	6,287	6,708
Total Non NHS trade invoices paid within target	9,386	15,087	937	1,047	4,044	4,340
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**64%**	**67%**	**64%**	**65%**
Total NHS trade invoices paid	1,082	4,544	59	466	409	2,100
Total NHS trade invoices paid within target	624	2,858	29	279	189	1,117
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**49%**	**60%**	**46%**	**53%**

Summary

- Current liabilities have shown a decrease this year.

Issues

- The trade creditors element of creditors has fallen through prompter payment and the reduction in capital spend.
- Payment performance against the 30 day target is below target, but not because of serious delays to payments.

Risks

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

Actions

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25th September 2014
Reference number:	233-14
Report from:	Graeme Armitage, Head of HR & Operational Development
Author:	Graeme Armitage, Head of HR & Operational Development
Report date:	17th September 2014
Appendices:	A: Workforce Performance Report

Workforce update – September 2014

Key issues

1. There has been a slight improvement in turnover in August but overall this remains above the Trust target of 11%. In addition there has been an increase in the number of vacancies being recruited to which is driving an increase in bank and agency use. However, pay levels remain at the levels expected and are within the budgeted establishment. Medical staffing is being reviewed closely with a joint meeting taking place on the 30th September to baseline the medical establishment and review initiatives in place to address the current overspend in this area.

2. Sickness has returned back to the levels normally seen at this time of year. Additional work by the HR ER Team in terms of direct help and training for managers will support the reduction in sickness absence which normally increases steadily through the autumn and winter months. Further promotion to encourage an increase take up of the flu jab will also support this approach.

3. Bank and agency levels remain low i.e. 2.7% and 2.2% of pay respectively. Changes to recruitment will have a further positive impact on this.

4. Statutory and Mandatory training performance continues to stabilise and despite a couple of areas currently being under reported i.e. Child Protection Level 3 and Equality and Diversity overall performance is now good. The focus of attention will be on the 3 areas where compliance is below 70% i.e. Child Protection Level 2, Conflict Resolution and Manual Handling (Clinical).

5. An external report on recruitment initiatives was commissioned in August and has now been received. The recommendations from this report will be taken forward to improve recruitment performance in support of the operational services.

6. Following the last Quality and Risk Committee it was highlighted that a number of HR Policies requiring an update have been outstanding for some time. This is being addressed by the Head of HR/OD and a workshop session has been planned for October. The workshop will review all outstanding policies, update where necessary for approval by the appropriate committee e.g. JCNC, Q&R Committee and Clinical Cabinet.

Implications of results reported

7. The workforce metrics within this report have an impact on the quality of patient care and so robust management of those remain a priority.

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

Action required

11. Although there are no obvious trends in the high levels of turnover this needs to be monitored closely and reduced towards the Trust target of 11%. Therefore a continued focus by the Workforce Information Team on vacancy levels, reasons for leaving and improvements in exit interview process are in train.

12. Continue with the controls for agency and bank usage which require senior management approval for non-clinical and over-establishment cover.
13. Continue to manage sickness absence proactively through collaboration between line managers, Human Resources and Occupational Health.

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

Link to Key Strategic Objectives

- Outstanding patient experience
- Financial sustainability
- Organisational excellence

15. Vacancies, sickness absence and bank and agency usage have an impact on the quality of patient care, cost more to the organisation and affect the wellbeing of staff who are at work. Therefore although the core stability of the Trust's workforce is very good i.e. over 92% turnover issues are being actively addressed and improvements to recruitment being implemented.

Implications for BAF or Corporate Risk Register

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

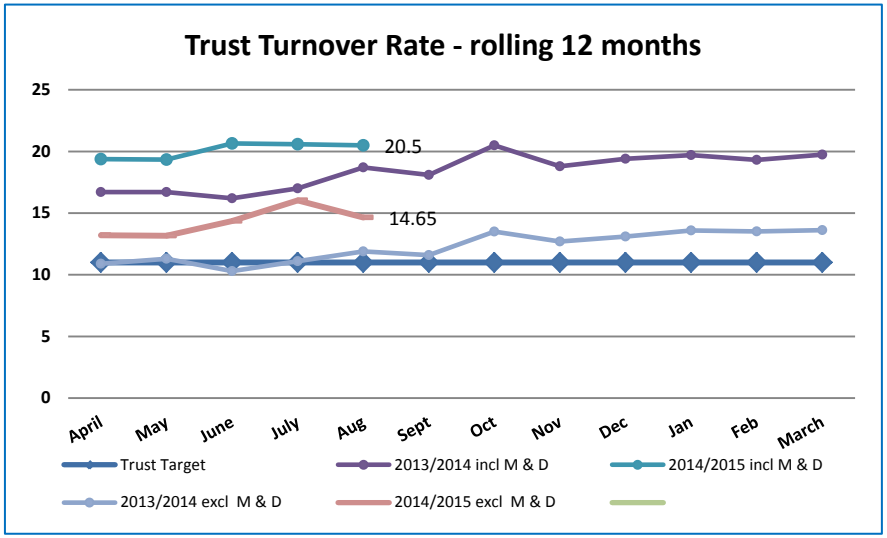
Regulatory impacts

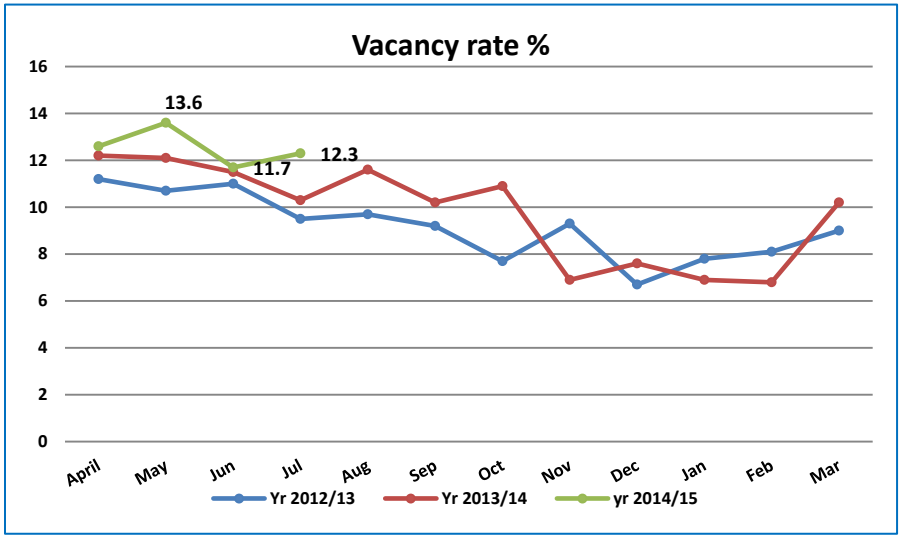
17. Although there is always a potential for high turnover and staff sickness to compromise quality of care and have a detrimental impact on the experience of other staff, it is not felt that the level of turnover and staff sickness prevailing currently is a genuine threat to regulatory compliance. Safety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

Recommendation

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

HEADLINE HR KPIs September 2014





	Staff Movements												
	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14
Headcount	930	938	942	960	959	967	971	971	966	966	967	965	957
WTE in Post	788.42	789	807	819	820	825	823.78	823.78	816.86	816.07	816.78	816.79	816.79
WTE Funded Establishment	867.99	867.99	867.99	867.99	867.99	867.99	867.99	867.99	897.51	897.51	897.51	897.51	897.51
New Hires	37	21	33	12	6	16	29	7	10	7	19	10	26
Leavers	43	12	24	6	14	11	22	15	9	9	21	12	43
Maternity Leave	15	18	18	19	21	16	17	19	19	20	17	16	19
Vacancy Rate	11.6%	10.2%	10.9%	6.9%	7.6%	6.9%	6.8%	10.2%	12.6%	13.6%	11.7%	12.3%	N/A
Turnover Rate	4.62%	1.27%	2.51%	0.73%	1.46%	1.14%	2.05%	1.65%	0.93%	0.93%	2.07%	1.24%	4.49%

	Rolling 12 Monthly Turnover Figures												
	Aug 13	Sep 13	Oct13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14
12 Month Turnover (including Medical & Dental)	18.89%	18.1%	20.5%	18.8%	19.4%	19.70%	19.32%	19.74%	19.38%	19.34%	20.65%	20.59%	20.50%
12 Month Turnover (Excluding Medical & Dental)	12.07%	11.6%	13.5%	12.7%	13.1%	13.59%	13.51%	13.62%	13.21%	13.17%	14.36%	16.03%	14.65%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 31st August 2014 remained at 20.5%, this has seen the Trust turnover remaining at the 20.5% mark for the last 3 months (including medical and dental) although turnover (excluding medical and dental) decreased by 1.38% to 14.65% this still remains high and has been for the last 3 months.

August saw 43 leavers (39.65 FTE), which is line with leavers for August 2013, 26 leavers were due to doctors rotation, 5 were due to retirement and 12 were voluntary resignations, which included 2 dismissals due to health.
The monthly turnover rate for August is 4.49% which is line with the same period in 2013. Staffing stability has fallen to 92.77%.

Vacancies Rates (figures 2 month in arrears)

Vacancy rate for July was 12.3 % of which 28.9 WTE were actively being recruited to. Bank and agency were being used to the total of 79.45 WTE. The reason for this is the need to cover establishment vacancies, maternity leave (currently 19 employees on maternity leave) and long-term sickness (20 employees with sick leave of 4 weeks or more)

Vacancies

Activity levels for August currently have 30.6 WTE of active vacancies currently being worked on, of which 10.2 WTE are Nursing posts and 7.0 WTE Medical and Dental. Recruitment to nursing remains a priority and new innovative approaches are being sought to encourage interest in posts. Areas experiencing difficulties in recruiting nurses are Corneo, Theatres, ITU and Canadian Wing.

Average recruitment timescales remain 5/6 weeks, from advert to conditional offer letter, with the exception of 1 Domestic Assistant post that has been 2.5 months with the DBS.

Exceptions

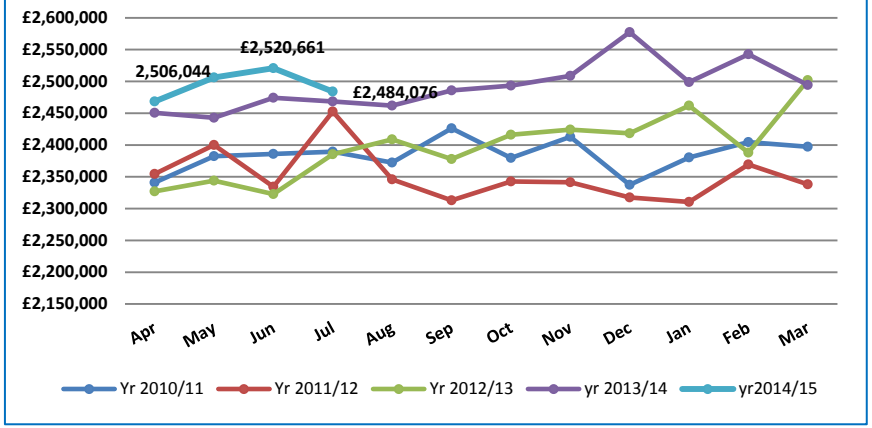
Recruitment times may slip during September due to sickness within the department.
Domestic post with DBS for 2.5 months causing higher bank usage within Hotel Services.
The Trust continues to experience the highest level of vacancies within the Nursing Workforce, where a centrally co-ordinated recruitment campaign is in progress to address both current vacancies & future workforce developments concerning the Trust.

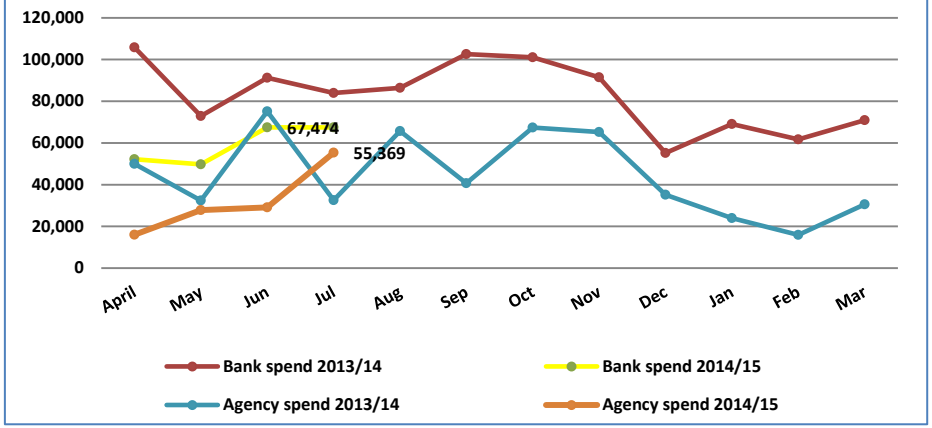
Actions

- Maintain relationships with universities to continue to employ nurses and build stronger links.
- Reviewing the recruitment team and planning changes to the current structure. To be implemented from October 2014
- External report on recruitment received and recommendations being taken forward. See cover sheet for details

RAG Rating

HEADLINE HR KPIs





Pay – A breakdown of the split between total staff paid WTE and bank/agency and overtime is reported in arrears and for July 14, shows WTE staff in post was 815.75, total WTE paid 897.28 (inclusive of 40.65 WTE Bank, 38.80 WTE Agency and 2.08 WTE over-time). There has been an increase in the use of Bank and agency usage due to establishment vacancies and sickness, 6.22 WTE in Canadian wing, 7.40 WTE in Burns and 2.2 WTE in Peanut.

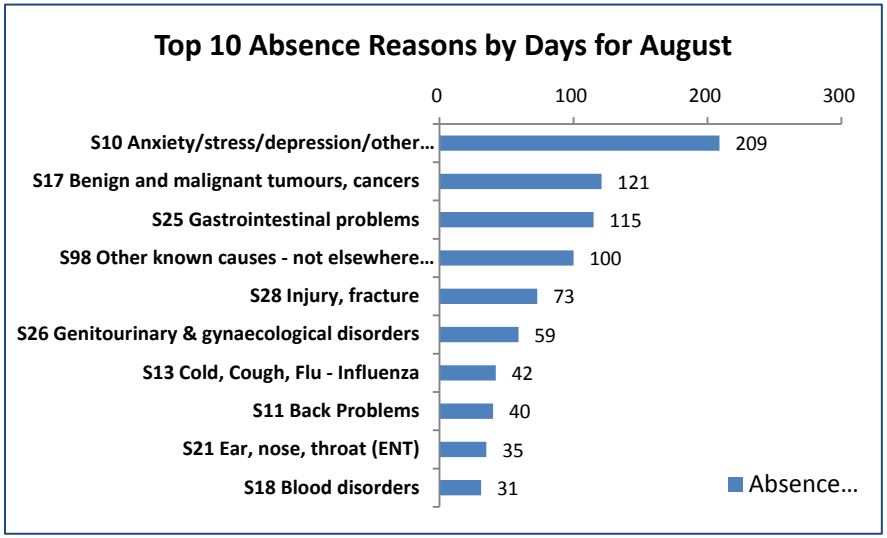
Bank and Agency usage – (figures are 2 month in arrears)
Bank expenditure for July increased very slightly to £67,474 from last month, while agency expenditure rose significantly to £55,369 an increase of 47% over last month, this was due to additional workload, establishment vacancies and high patient activity.

The Bank/agency combined fill rate for July was 82.2%, in total 6250 hours (59.18%)were filled by bank and 2435 hours (23.05%)were filled by agency. Canadian Wing were the highest users of bank and agency at 1110.15 hours (split 735.15 bank and 375.0 agency) due to establishment vacancies. Burns Ward used 973.45 hours (split 400.45 bank and 573.0 agency), this was due to establishment vacancies.

Actions - he total budgeted and paid establishment remains in balance with only 2.7% being attributable to Bank and 2.2% Agency. The increase in vacancies is the main driver of the increase in agency costs and this is being addressed through changes to the Trusts approach to recruitment. In the short to medium term this is not impacted adversely on patient quality however recruitment to vacancies needs to improve to ensure there are no long term implications. The HR Recruitment Team are working closely with managers to take forward initiatives to address the current situation and the Director of Nursing has been reviewing staffing levels within Theatres.

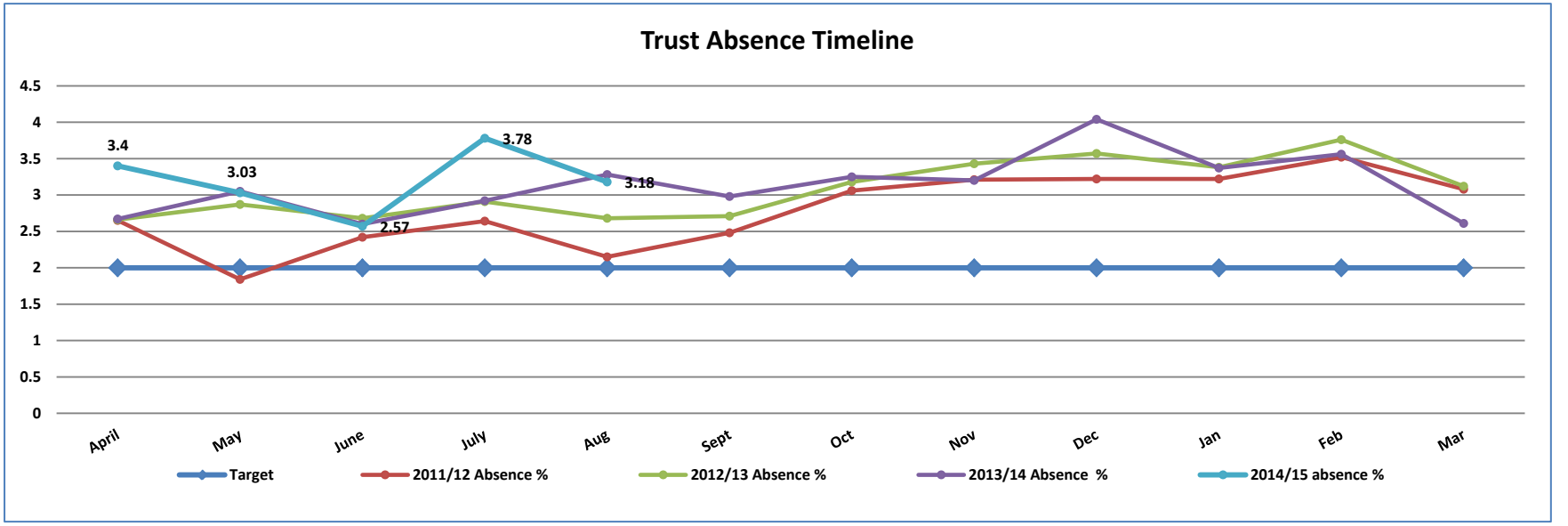
RAG Rating

HEADLINE HR KPIs



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

Staff Group	Estimated Cost	FTE Days Lost
Add Prof Scientific and Technic	£21,113	199.88
Additional Clinical Services	£10,183	243.29
Administrative and Clerical	£10,063	168.13
Allied Health Professionals	£2,780	21.80
Estates and Ancillary	£3,044	46.90
Healthcare Scientists	0	0
Medical and Dental	£1,742	10.55
Nursing and Midwifery Registered	£11,470	112.63
Grand Total	£60,395	803.17



HEADLINE HR KPIs

Sickness/Absence
August 2014 saw an encouraging fall in the sickness rate to 3.18% a fall of .60% from last month. There were 125 episodes of sickness absence through August, 79% were attributed to short term sickness.

There were 803 FTE days lost due to sickness, the most significant reason was still anxiety/stress/depression, which totalled 174 FTE days (21.8%). As reported at the August Board, the vast majority of stress related cases are not related to work matters however for those where external causes of stress and anxiety are apparent the HR team ensure that these staff are given access to Occupational Health, external counselling and phased returns to work to support them back into work as soon as possible. Cases associated with stress and anxiety which are work related are being managed effectively. Each individual is asked to complete a stress questionnaire which helps the HR team and managers determine how best to address the particular issues affecting a person.

NB: The highest number of episodes which can be mapped back to short term sickness remains consistent with gastrointestinal problems.

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

Efforts to maintain smarter control of absence is being coordinated between HR and OH, with monthly meetings with managers and case reviews in place. It has also been agreed to trial Mindfulness in the Trust to support those experiencing anxiety.

Exceptions
The main affected areas are Psychotherapy at 21.51%, a small department with a number of short term sickness cases, SLR Breast at 14.18% with 2 long-term sickness cases with stress and anxiety. SLR Burns at 11.72 % 1 long-term sickness case, Corporate Affairs at 16.36% a small department with 1 long-term sickness case (due to return shortly), Theatres (including Day Surgery and Recovery) 9.42% 7 long-term cases (2 due to return shortly) and 31 short term cases. Site Practitioners 9.18% 1 long-term sickness case. Paediatrics at 8.43% 1 long-term sickness and 3 short term cases. Max Facs Nursing at 7.05%, Pre-assessment at 5.68% and Corneo nursing at 5.09%.

Actions - Overall the Trust is now back to the levels seen in previous years and with the additional support being given to managers directly and through HR Best Practice sessions the usual trend of sickness increasing steadily through the autumn and winter months should be better controlled. In addition all staff will be encouraged to take up the flu vaccination this year to help reduce incidence of flu as a cause of sickness absence. 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

Payroll

All staff were paid on time, there were 5 overpayments with an increase in amount from £818.25 to £6095.45. The overpayments were due to 3 x late notification of change of hours, 1 x late notification of termination and 1 x late notification of absence by managers.

•Interim payments made in July due to managers error when finalising shifts on HealthRoster, decreased in volume from 9 to 5. Payroll errors decreased from 3 to 2.

Employee Relations

August saw 2 new cases, 1 investigation as the result of behaviour/conduct and 1 capability case who was suspended pending investigation. Long-term sickness cases being actively managed has reduced from 20 to 11, 10 employees have triggered under the sickness absence policy and 3 are at First Formal Review.

Main case types continue to be capability on health grounds and poor performance

Case Type	Number of cases
•Disciplinary	0
•Bullying & Harassment	0
•Conduct	1
•Capability	4 (this includes sickness capability cases)
•Long-term sickness	11
•Change Management	0
•Grievance	0
•Whistleblowing	0
•Probationary	1
•Appeals	0
•Suspension	1
	Total 18

•Actions

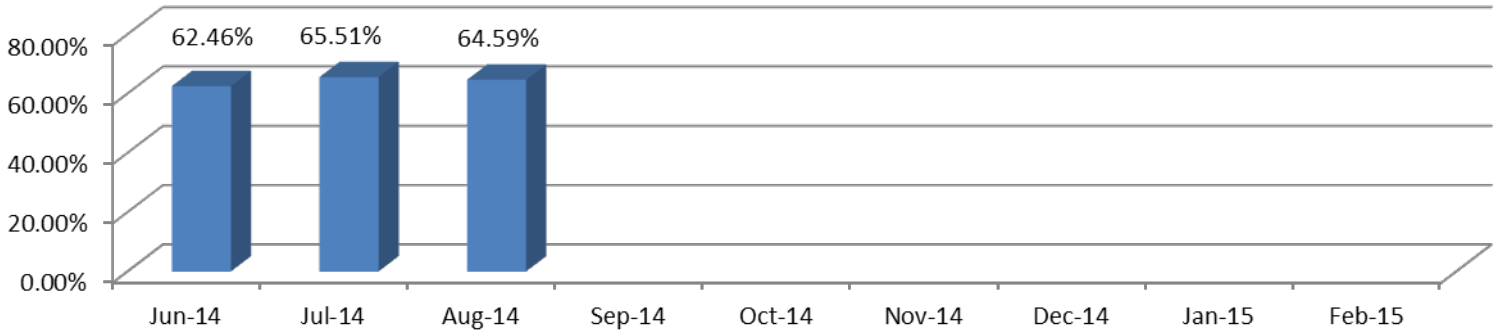
•Continue to focus on areas above 2% absence rates. Meetings being held regularly with ward managers/matrons/line managers to discuss cases and develop action plans.

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

RAG Rating

PDR's by Directorate as at 3.9.14

PDRs against 100% Target (Permanent Staff)



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

Directorate	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15		
Anaesthetics & Surgery Dir)	41.60%	34.43%								122
Clinical Support Services (Dir)	72.97%	78.50%								107
Corporate (Dir)	47.62%	52.17%								23
Estates & Hotel Services (Dir)	60.29%	46.27%								67
Finance (Dir)	42.11%	47.22%								36
Human Resources(Dir)	80.77%	87.50%								24
Nursing (Dir)	73.87%	74.25%								400

ALL Medical & Dental - PDR Achieved against 100%

Directorate	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15		
Anaesthetics & Surgery (Dir)	68.12%	63.64%								66
Clinical Support Services (Dir)	40.00%	60.00%								5

HR KPIs as at 3.9.14

PDRs

Appraisal rates for the Trust overall have dropped slightly for the month of August from 65.51% to 64.59%

The currently reported compliance rate is lower than the actual rate due to the transition to the new appraisal time table. The figures reported are approximately 10% less than the actual performance.

Exceptions

Please be aware that the Medical & Dental PDR percentage figures shown are for **ALL** Permanent Medical and Dental Staff at QVH.

This figure is different to those requested by NHS England; whereby quarterly returns are submitted (in accordance with NHS England deadlines) monitoring those doctors whom are required to revalidate and have a prescribed connection with QVH. The most recent return submitted was for the period 1.4.14 to 30.6.14 which shows a compliance rate of 97.5%.

Actions

Appraisal completion continues to remain a high priority and all the directorates have plans in place to ensure their teams will be compliant with regards PDR completion. Since last month we have had some areas being made aware to send their completed PDR paperwork to HR rather than L&D so this has helped with the completion rates.

In addition the L&D team are continuing to review the reporting arrangements and internal process to improve accuracy.

RAG Rating

Statutory and Mandatory Training

Competence Name	Non Compliance	Expired but Booked	Compliant	Grand Total	Trust Overall (Expired + Meets Req)
Adult & Paediatric BLS - annual	10.87%	6.38%	82.74%	100.00%	89.13%
Child Protection Level 1 - 3 yearly	19.43%	1.37%	79.20%	100.00%	80.57%
Child Protection: Level 2 - 3 yearly	33.94%	1.63%	64.43%	100.00%	66.06%
Child Protection: Level 3 - 3 yearly	70.59%	0.00%	29.41%	100.00%	29.41%
Conflict Resolution - 3 yearly	30.02%	9.77%	60.21%	100.00%	69.98%
Emergency Planning: annual	17.49%	3.89%	78.63%	100.00%	82.51%
Equality, Diversity & Human Rights - 3 yearly	89.60%	4.57%	5.83%	100.00%	10.40%
Infection Control: annual	18.29%	4.57%	77.14%	100.00%	81.71%
Manual Handling - Clinical - annual	31.46%	5.40%	63.15%	100.00%	68.54%
Manual Handling - Non-clinical - 3 yearly	17.71%	1.14%	81.14%	100.00%	82.29%
NHS CSTF Information Governance - 1 Year	21.71%	0.34%	77.94%	100.00%	78.29%
Risk: annual	16.80%	3.89%	79.31%	100.00%	83.20%
Safeguarding Adults - 3 yearly	18.63%	2.40%	78.97%	100.00%	81.37%
Grand Total	28.33%	3.57%	68.10%	100.00%	71.67%

Statutory & Mandatory Training

Statutory and mandatory training Trust overall figure has dropped again from 72.43% to 71.67% (from 68.54% to 68.10% excluding those who are expired but booked) but course completions are remaining steady and individually the majority of competencies have improved from last month. The L&D team have started the Statutory & Mandatory training aligning with the National passport and the intention is to complete 2-3 competencies per month until completed.

NB: The information is taken directly from the monthly reports provided to managers however the 2 areas marked red as mentioned above are not currently accurately reflected and therefore this is being addressed. The compliance rate for Child Protection is actually 89% and with the E&D figure being over 76% overall compliance is now very good. The Learning and Development Team will continue to focus on the areas which are now below 70% i.e. Child Protection Level 2, Conflict Resolution and Manual Handling (Clinical).

Exceptions

Child Protection Level 3 As the reports were being published we have been given the updated list of who requires CP L3, we now have some data cleansing to ensure that only those that require the training are reported against. This will be amended for next months figures which should show a more favourable percentage.

Actions

L&D are continuing to cleanse data whilst aligning competencies to the National Passport. This also allows us to target those individuals who do not have the relevant competencies and be more specific with course enrolment targeting.

RAG Rating

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	234-14
Report from:	Amanda Parker, Director of Nursing & Quality
Author:	Amanda Parker, Director of Nursing & Quality
Report date:	16 September 2014
Appendices:	KSO1

Quarterly update on delivery of Key Strategic Objective 1

Outstanding patient experience

Key issues

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

2. Along with the shorter term actions that were identified for achievement during 2014/15 a timetable for longer term aims for achievement is provided.

3. The summary demonstrates progress is being achieved against priorities identified for this year.

4. The attached document will be shared with the Clinical Cabinet and is shared at each patient experience group meeting as this groups action plan supports achievement of goals associated with delivering an outstanding patient experience.

Implication of results reported

5. Progress has been made against a number of the objectives many of these associated with the review of governance structures and the commencement of monthly clinical governance meetings that now report into a quality and risk committee that meets every two months with papers presented that reflect assurance of activity undertaken.

6. Quarter 2 progress against Quarter 1 shows; 15 action Green (8 previously), 22 amber (24 previously) and 1 red (6 previously).

7. The main areas of challenge remain;
    - Delivery of the safer care module the order has been placed and we are waiting for completion of the purchase so that implementation can commence.
    - Canadian wing refurbishment is being managed through maintenance monies but is reliant on reduced occupancy to allow vacant rooms/bays to be redecorated.
    - Introduction of an IT system for identification of deteriorating patients; this is a recommendation from recent national reports and will improve outcomes for

patients. Currently we are awaiting feedback from a bid to the Nursing Technology Fund.

8. Actions in progress that involve the senior team including Non-Executive directors are anticipated to improve staff familiarity with the senior team and feel able to raise concerns directly to them. The activities also provide opportunities for the senior team and Non-Executive directors to observe care, staff attitudes and behaviours and to meet with patients and hear their views. This is an on-going objective and attendance itself will not achieve the goal, for success engagement is required.

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

10. Achievement of actions will support improved safety and outcomes for patients and an improved experience. All of these aspects are a key focus for our commissioners, Monitor and the Care Quality Commission.

Link to Key Strategic Objectives

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

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

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

13. No new risk have been identified

Regulatory impacts

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

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

Recommendation

The Board is recommended to note the contents of the report

Outstanding Patient Experience - Key Projects Priorities 2014-2020

1.Superior care and outcomes 2.Exceptional environment 3.Outstanding personal service	14/15	15/16	16/17	17/18	18/19	19/20
Governance structure review	x	x	x	x	x	x
Electronic monitoring & alert system			x			
Safer care module	x					
Staff education	x	x	x	x	x	x
Measure nurse competence though observed practice (ROOPS)	x					
No well patients return for follow up		x				
Leaflets available electronically in Easy Read format			x			
Leaflets available for visually impaired			x			
New doors at car park entrance area CWing		x				
Car park & pathways level with no trip hazards				x		
Clear signage to all departments		x				
Full time presence 0700 – 1800 main entrance desk		x				
New ward area ~70% single rooms						x
All beds have TV available						x
Wi fi available for patients	x					
All corridors enclosed and warm						x
Food is consistently of good quality and variety		x				
Drinks available for ward visitors	x					
Consultation room within wards for family meetings						x
Wait area for family / friends with vending food	x					
Outpatients have water / drinks machines		x				
Outpatients have access to type talk TV		x				
Relative / patient overnight accommodation						x
Meet the matron sessions for patients	x					
Introduce privacy and dignity forum for staff	x					
Roll out FFT to all areas as per national guidance	x					
Governors and NEDS to join CIP assessments	x					
Develop practical toolkit for leaders in line with leadership development	x					

QVH 2020: Outstanding care delivered by outstanding people

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

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

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

	'Compliance in Practice'. (C6.1)		**AS**		R Tyler – Oct 14 G Armitage J Morris – Oct 14 S Butt		
3	The Trust Board to re-emphasise to all senior management having responsibility for, or interaction with, nursing staff or patients that, under no circumstances, should they, or staff reporting to them, be deflected from a focus on these core responsibilities as a result of involvement in other projects or as a result of a shortage of resources. Any concerns by individuals related to this must be raised by them, and discussed and resolved with the Chief Executive. (C6.2)	CEO	An AOB item on clinical cabinet agenda Observation area on CIP tool **LHR AS AP**	April 2014 May 2014	Added to CIP tool and to clinical cabinet agenda Awaiting feedback from CIP tool use and May clinical cabinet **Actions taken – monitoring required**	A / G	
4	Ensure that all Directors, Governors and Clinicians undertaking visits within the clinical areas are encouraged to feed back any comments or concerns relating to staff attitudes/morale or the quality of patient care directly to the Chief Executive. (C6.4)	CEO	Discussion at clinical cabinet - feedback minutes **LHR** Summary of those undertaking CIP directors / governors **AS**	June 14 May 14 March 15	Board to reflect on all visits at end of board agenda – to be introduced as standing item that is recorded Q1 Governors x 12 Directors x 1 Q2 Governors x Directors x Q3 Governors x Directors x Q4 Governors x Directors x	A	

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

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

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

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

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

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

	desk ideally covering 0800-1800 July **2014**				staff they can sit at desk and signpost patients with access to emails available. As a part of DN visibility 7.30-8.30 at volunteer desk x ½ per week. Currently 2 volunteers available for 0700 starts		
29	Support provision of a discharge lounge / transport waiting area **June 2014.**	Programme Director	Waiting area available for patients	June 14	Area identified within 'old admission lounge'. Included within proposal for MoHs and LOPA's move. Following discussion at site capacity meeting 30th April the option to relocate vending machines and create a space for patients will be developed as a high level proposal that will also be discussed with the League of Friends as they may help to fund – funding agreed. Project document in place with planned work for Q3/4	A	
30	Ward re fresh – painting, removal of arjo baths and replacement with showers etc. **2014/15 capital programme**	Programme Director	Ward redecorated Showers in place	?	Single rooms in Ross Tilley have been commenced Nurses' station RT completed. Project plan re conversion of bathrooms to wet rooms commencing (Sept 14)	A	Not noted to be included in capital programme
31	Refurbishment Physio/OT reception area. **2014/15 capital programme**	Programme Director	Physio / OT reception refurbished	Q3	On track	A	
32	Work with hotel service team to review food charter mark guidance and develop actions to work towards gaining a charter mark **March 2015** (CQUIN)	Programme Director	Quarterly reports provided that demonstrate progress against agreed CQUIN actions	March 15	Q1 – action plan seen Q2 Q3 Q4	A	

Outstanding personal service - ***All interactions with patients and their family/carers are caring and compassionate putting the patient at the heart of care.***							
33	Provide programme of engagement to patient experience group **May 2014**	DN	Minutes of PEG	May 14	Programme provided and staff and governors joining CIP etc	G	
34	Act on negative feedback and monitor actions to improve experience. **On-going**	Patient experience manager	Monthly complaints report – C Cabinet Information within Board report Patient stories at Board	May 14 May 14 June14	Reporting process in place	G	
35	Make available drinks for family within ward area **July 2014**	Matron Elective services	Drinks available on ward	June 14	Peanut and Burns in place. C Wing in progress – needs monitoring to ensure available consistently.Placed in day room for easy accesss	G	
36	Provide wider availability of information on how to access personal items / newspapers etc. **July 2014**	IHCA	Updated bedside guide	May 14	New guide distributed and includes information	G	
37	Take a zero tolerance to avoidable late start clinics initially identifying the causes August 2014 developing actions to address identified issues **March 2015**	HoOps	Information on clinic start times available Late clinics – evidence of action taken	June 14	Meeting held 10 June to discuss actions identified: a) for New system administrator to devise a dashboard that can show weekly reports regarding clinic start times from Enlighten b) Escalation flowchart in place for nurses to follow in Plastics, Max fac and Corneo when Dr's are late c) Kathy to discuss with OPD Sisters mechanism to record why clinics are running late (as this cannot be collected on Enlighten at the moment) d) Any clinics over 30mins late Datex to be raised	A	

					e) When new service manager in post they will be responsible for investigating these Datex's further and highlighting trends – this might be template changes / job plan amendments f) Trust policy to be devised to escalate persistent offenders (if not addressed by actions under e)) firstly to Clinical Directors, then to Medical Director as required moving onto displinary process if needed. This I suspect will need to be discussed at Clinical cabinet / LNC. Progress has been slow ober July and August and further focussed activity due to occur in September		
38	Wifi access for patients. **2014/15 capital programme**	HoIT	Wi Fi available to patients		Wi fi available to staff but not patients Wi fi covers some but not all of trust. Completion of this is anticptaed within the next few weeks	A	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	The Board of Directors, Queen Victoria Hospital
Meeting date:	25th September 2014
Reference number:	235-14
Report from:	Dr Steve Fenlon, Medical Director
Author:	Dr Steve Fenlon, Medical Director
Report date:	17th September 2014
Appendices:	Report

Queen Victoria Hospital 2020 Strategy.

KSO2 Background:

Provide world class clinical excellence: Develop and demonstrate the highest standards of safe, effective, efficient care, training and innovation.

KSO2(1) Clinical strategy (leads include Elin Richardson, Juliette Stern, Steve Fenlon, Ian Francis and others)

Like every health economy across the world, the NHS faces challenges. Contrary to its original aim, to build a healthy and less dependant population, the NHS has been highly successful in bringing longevity; paradoxically at the cost of greater dependency. The need to deliver more to an ever expectant client base and an increasingly elderly population with multiple co-morbidities has lead to inexhaustible demand. Change is not easy, especially when imposed from outside the organisation. Healthcare has seen huge advances but mostly in quality, very few in efficiency. The NHS has seen a rise in cost every year since its inception. Delivery of more for less is a huge challenge and possibly only local initiatives will succeed on any level. My part of the 2020 Strategy links to others to enable QVH to be

responsive and manage the necessary changes imposed upon us by patients and national demand, whilst pursuing an agenda allowing the organisation to succeed and continue to improve the service we offer.

Transformative and translational change

●Transforming our current services to develop safety, efficiency and the ability to adapt. Delivery of clinical services is dependant on recruiting staff with the correct skills and attitudes, providing the resources to develop and the environment in which to work effectively. Developing a medical workforce requires scrutiny of the job plans and provision of resources to enable improved clinical and leadership skills to emerge:

(i) Job planning review

(ii) CEA negotiation

(iii) Seven day services elective and non-elective

(iv) Ward Cover by junior medical staff, see KSO2(4)

(v) Recruiting staff with the abilities to be not just excellent clinicians but excellent leaders

(vi) Pursiing incremental growth of existing work by increase in surgery for LA cases requiring less resource

●Translating our services by exploring and expanding the range and capacity of patient services provided by the QVH.

A Long list of strategic aims was developed following an engagement process with the consultant body and can be grouped into five main headlines:

(i) Growth-existing markets

(ii) Growth-new markets

(iii) Community

(iv) Private practice

(v) Diversification

Within these 5 themes were 63 potential areas for development, some considered worth pursuing, a number placed on hold. The list has been updated since inception taking in to account the views of clinicians, Board of Directors and senior management team.

Service lines are encouraged and supported to continue to develop initiatives against all the above aims. The board has seen sight of some examples of these in clinical cabinet and board meetings such as the plans to develop on-site radiology services and further presentations to board members are planned.

Risks to delivery of KSO2(1) clinical strategy:

There are a number of risks that cut across all the aims of KSO2(1) and a non-exhaustive list is detailed here:

(i) Inability to manage complex co-morbidity on QVH site and meeting requirements for ITU/HDU and co-location (not just for burns)
(ii) Meeting the requirements of seven day consultant cover on the QVH site according to NHS Services, Seven Days a Week Forum to provide a required standard of consultant on-site presence outside normal working hours and to open to a seven day per week as normal service.
(iii) We function in a competitive health care market and other providers will look to exploit the same opportunities both within our standard catchment area and areas being explored further afield
(iv) Unknown commissioning intentions
(v) Existing and future specialised commissioning service criteria cannot be met at all or within reasonable cost
(vi) That we lack the capacity to manage more cases on the QVH without significant change to the current estate/working model/staffing. We may therefore experience both income and reputational loss through for example increased waiting times for surgery
(vii) That most clinically led initiatives aim to increase quality of care, few if any efficiency.
(viii) Increasing the day time elective activity necessarily increases the amount of non-elective activity by an unavoidable number of returns to theatre.
(ix) That existing workforce does not possess the skills or resource to deliver greater efficiency and growth.
(x) That the medical workforce remains disengaged from the trusts strategic aims and lacks adequate leadership to deliver on the strategy
(xi) Increased service delivery by trainees leads to disaffection and loss of popularity and rating of QVH as a place to learn, leading to difficulties in recruiting
(xii) We lack management resource to deliver our projects
(xiii) Communication is inadequate to realise full potential

<u>KSO2(2) Publish Consultant Level Clinical Outcomes (Lead Steve Fenlon, project manager Jacqueline Packer)</u>

● Agree with service leads representative measures to demonstrate safe effective care

● Deliver six outcome measures from services across the trust for publication on the trust website in 2014-15

● Picture and deliver the future shape of outcome measures for the QVH and engage with external stakeholders to ensure the boards aims for outcome measures are met, such as promotion of the trust's services to the wider healthcare community.

● Collate current consultant level outcomes and safety metrics and present as a single spreadsheet to provide board level assurance of the consultants safety.

Risks (and controls) to delivery of KSO2(2): outcomes

(i) Risk of adverse publicity.
(ii) Lack of information management resource (as distinct from information technology)
(iii) Publication of inaccurate or misleading information about an individual consultant may result in legal challenge for QVH
(iv) Failure to realise potential by lack of communication
(v) Lack of consultant engagement in the process and refusal to contribute data
(vi) Over dependence on consultants to harvest present and maintain clinical data, may present potential for bias
(vii) Failure to engage all stakeholders/clear vision of what this can or will deliver
(viii) Potential for high cost to deliver total package on a recurring basis

KSO2(3) Clinical research and development (Leads Steve Fenlon, Julian Giles, Brian Jones)

● Oversee the appointment of a secondee from University of Brighton as Research Director

●Close trials not actively recruiting at QVH

● Focus on clinical trials initiated by QVH clinicians and engage more clinicians in research

● Work collaboratively with the University of Brighton, Blond McIndoe Research Fund and QVH clinicians to contribute to the work of the local tissue regenerative medicine network

● Increase the number of patients recruited to portfolio studies at QVH by 25% compared to last year

● Foster a culture of developing research across other healthcare professionals at QVH by secondment to MRES courses.

● Begin planning for a tissue bank on the QVH site to enable greater access by researchers to discarded human tissues.

Risks (and controls) to delivery of KSO2(3)

(i) Research has risk of failing to attract funding and failure to develop through to publication and change in practice
(ii) Failure to engage consultants in QVH research
(iii) Failure to attract charitable funding and retain secondment
(iv) Failure of secondment to deliver expected benefits

KSO2(4) Education and Training (Leads Steve Fenlon, Julitte Stern, TBC)

● Seek funding for multi-professional education centre on QVH site

● Establish a simulation suite as part of the above with funding for equipment provided by HEKSS

● Establish the gaps at QVH from Deanery curricula and visits in all major specialities and provide an action plan to address.

● Trainee shortfall is currently addressed by recruitment of trust grade doctors, redraft the contracts and job descriptions for all such posts and change recruitment to provide clear induction and expectation for these roles

● Explore alternative models to deliver medical care at the most basic level. Project to explore potential for other professionals to develop into traditional medical roles such as surgical practitioner, physician's associate (PA) and expansion of the hand therapist roles.

● Options appraisal for the future medical workforce (Board presentation late 2014)

• QVH to fund time for the Director of Medical Education to ensure non-deanery, non-consultant staff are included in and developed by the educational strategy

Risks (and controls) to delivery of KSO2(4)

(i) Lack of trust ability to provide estate
(ii) Lack of charitable funding to develop education centre
(iii) Lack of consultant engagement and support
(iv) No dedicated resource to maintain the facility
(v) Unable to address gaps from Deanery intent
(vi) Lack of resource to fund DME to cover NCCG doctors
(vii) Junior workforce increasingly disengaged and risk of poor general care to patients
(viii) QVH has a high cost medical workforce due to its specialist nature and high volume of consultant delivered services including off-site. Negotiations to reduce benefits risk disengagement of medical staff

Recommendation: This report accompanies and provides background information to the regular update. The board is asked to note the contents of the report.

Headlines: KSO 2 World class clinical services

Sub heading		Projects	Time	Co-dependencies	Main Risks
KSO2(1)	Clinical Strategy	Growth- existing Growth-new Community Private Diversify Effective use of WF-CIP	2014-2020	KSO3	Site capacity Staff capacity Commissioning criteria Commissioning intent National negotiation Local negotiation
KSO2(2)	Outcomes	Publish six in QA Consult stakeholders External Advice	2014-2015 2014-2016 2014-2020	KSO3	IM resource Accuracy challenges Adverse publicity Unreceptive stakeholder Poor communication
KSO(3)	Research	Link UOB, BMRF, QVH Portfolio targets MRES courses Funding	2014-2015 2014-2020 2014-2016 2014-2020	KSO4	No funding attracted Lack of study approval Cross party agreement
KSO(4)	Education	Address deanery gaps Medical ward cover Develop existing WF Education Centre	2014-2015 2014-2017 2014-2020 2014-2018	KSO4	HEKSS requirements Lack of staff Financial challenge

KS02 (1) CLINICAL STRATEGY					
Project A) Growth of existing markets					
1.	**Increase breast reconstruction**	**Lead** ER/MJ/SF	**Due** 14/15	**Risks** Insufficient staff capacity and facilities	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
1.1.	Recruit additional medical staff			July 14	
1.2.	Expand operating time			Extra sessions from locum to permanent	
1.3.	Expand capacity of LA theatre			Awaiting recruitment Sept14	
2.	**Increase lower limb reconstruction**	**Lead**	**Due** 14/16	**Risks** Meeting deadlines for reconstruction	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
2.1	Appoint lower limb orthoplasts	SF/MAP		Jan 14	
2.2	Trauma pathway review to increase capacity	JM/JWB		Options to CC Sept14	
2.3	Introduce seven day working	SF/JS		Options to SMT Sept 14	
3.	**Develop head and neck oncology including ENT**	**Lead** ER/JM/ JT/SF	**Due** 14/15	**Risks** Commissioning criteria Cancer network view ITU capacity Theatre capacity	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
3.1	MD/CEO discussion	SF/RT		SASH meeting Aug14	
3.2	Joint apt Medway	JT/JM		Appointed Aug 14	
3.3	Poss joint apt SASH			Intention of SASH vs capacity at QVH	
3.4	Team developing pathway	BB		Report due to CC Oct 14	

3.5	Capacity release from burns			Uncertain	
4.	**Burns**	**Lead**	**Due** 14/15	**Risks** Commissioner intent on hold for review Partner arrangement is resource intensive for QVH	**Overlap**
Ref	Action	Who	Due	Update	Status
4.1	TBC once commissioner intentions clear	RT/BSD			
5.	**Imaging-one stop and growth of existing services inc MRI and cone beam CT and fluoroscopy**	**Lead** IF/PG/SF	**Due** 2016	**Risks** High capital cost Radiology staffing	**Overlap** KSO1
Ref	Action	Who	Due	Update	Status
5.1	OBC from IF for purchase of MRI scanner and dept development	IF		Due at SMT Oct 14	
6.	**Hand surgery for efficiency= therapy led clinics and protocol driven pathway GP based hand clinics**	**Lead** JWB / ER	**Due** 2014	**Risks** MSK tender still evolving	**Overlap** KSO1
Ref	Action	Who	Due	Update	Status
6.1	Introduce therapy –led clinics	PG/JWB		Work in progress Therapy led clinics have started	
7.	**Gamma probe for Sentinel node**	**Lead** SM/ER	**Due** 2014	**Risk** Cost of probe and covers	**Overlap**
Ref	Action	Who	Due	Update	Status
7.1	Business case	SM/SF		Cost approved, clinical case agreed	
7.2	Procurement			Awaiting approval from Med physics	
8.	**Minor ENT cases on site including paediatrics**	**Lead** ER/JM	**Due** 14/16	**Risk** Requires adequate on-call cover	**Overlap**
Ref	Action	Who	Due	Update	Status
8.1	To be confirmed as part of overall ENT service	SF/ER		Capacity review/ENT intent	
9.	**Tender for external histopathology**	**Lead** RL/SF	**Due** 14/16	**Risk** Current estate not FFP	**Overlap**
Ref	Action	Who	Due	Update	Status
9.1	Capacity assessment	RL/ER		Board presentation? Nov 14	
9.2	Estates review			Wider on going review	
10.	**MSK Tender**	**Lead** ER/JWB	**Due** 14/15	**Risk** Commissioning depends on prime provider	**Overlap**

Ref	Action	Who	Due	Update	Status
10.1	Working with consortium to maintain hand surgery	ER/JWB		In negotiation	
11.	**Laser refractive surgery**	**Lead** ER/DL/SF	**Due** 14/16	**Risk** High Capital Cost	**Overlap**
Ref	Action	Who	Due	Update	Status
11.1	Under consideration				
12.	**Expand trauma operating**	**Lead** JM/JWB/ SF/ER/JM	**Due** 14/15	**Risk** Cost of infrastructure and staff if underused MRET	**Overlap** KSO1 KSO3
Ref	Action	Who	Due	Update	Status
12.1	MRET negotiations for 14-15			Complete	
12.2	Project to determine need			CC presentation to establish capacity	
12.3	Links to lower limb			3 Options to take forward	
12.4	Links to seven day services			See later in KSO 2	
12.5	Links to one stop services				
13.	**Sussex dermatology service housed in OPD at EG**	**Lead** ER/JM	**Due** 2014	**Risk** Negotiating with a private company intent unclear	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
13.1					ON HOLD
14.	**ECT for skin oncology**	**Lead** ER/BSB	**Due** 14/15	**Risk** Capital cost Use of chemotherapy in theatres	**Overlap**
Ref	Action	Who	Due	Update	Status
14.1	Draft new policy	BSB		Policy drafted and approved clinically June14	
15.	**Lymphadenopathy surgery**	**Lead** ERTCT	**Due** 14/20	**Risk** Commissioning intent unclear Resource intensive long surgery Not approved as CIP	**Overlap**
Ref	Action	Who	Due	Update	Status
15.1					ON

					HOLD
16.	**Remove low tech cases from main theatre to allow expansion**	**Lead** JM/NR	**Due** 2014	**Risk** Cannot recruit theatre staff	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
16.1	Recruitment of staff			Completed – due to start Sept 2014 Update Sept 14 staff recruitment unsuccessful	
Project B) Growth of new markets					
17.	**Lower limb pathway project**	**Lead** ER/TC/NN	**Due** 14/16	**Risk** Commissioning intent uncertain Resource intensive on and off site	**Overlap**
Ref	Action	Who	Due	Update	Status
17.1	Produce plan linking lower limb projects	ER/TC/NN			
18.	**Private GP services**	**Lead** AK/PG	**Due** 14/16	**Risk** Relationship with local GP practices may deteriorate	**Overlap**
Ref	Action	Who	Due	Update	Status
18.1				Recruited private GP to cover MIU medical gap from Sept 14. Not GP services	ON HOLD
19.	**Eyes pathway project Linking of single visit surgery, training up optometrists to follow up, shared community pathway eg glaucoma**	**Lead** JM/RM	**Due** 14/16	**Risk** CCG intent uncertain Other organisations need to buy in	**Overlap**
Ref	Action	Who	Due	Update	Status
19.1	Review JM with RM	JM			
20.	**Franchise QVH services to other hospitals eg KIMS**	**Lead** ER	**Due** 14/20	**Risk** Uncertain demand Set up costs high	**Overlap**
Ref	Action	Who	Due	Update	Status
20.1					ON HOLD
21.	**Lymphatic surgery**	**Lead** ER/TCT	**Due** 14/20	**Risk** Commissioning intent unclear	**Overlap**

				Resource intensive long surgery Not approved as trust policy	
Ref	Action	Who	Due	Update	Status
21.1					ON HOLD
22.	**Hand surgery East Surrey clinics and day case, Wrist surgery, brachial plexus branding of hand unit**	**Lead** JWB/ER	**Due** 2014	**Risk** Departure from traditional referral May require cost to equip and staff	**Overlap**
Ref	Action	Who	Due	Update	Status
22.1				**15.09.14:** In discussion. Branding a wider topic	
23.	**Expansion of ENT work (some new to QVH)**	**Lead** BB/ER/JM	**Due** 2014	**Risk** Depends on intent of SaSH as to how much of Major ENT and minor to QVH	**Overlap**
Ref	Action	Who	Due	Update	Status
23.1				Part of wider discussion with SASH	
24.	**Therapies** **Wt loss** **Functional restoration**	**Lead** PG	**Due** 14/20	**Risk** Some falls within other strategy eg HCE	**Overlap**
Ref	Action	Who	Due	Update	Status
24.1					ON HOLD
Project C) Community					
25.	**Expand community HCE services**	**Lead** AK/PG/SF	**Due** 14/16	**Risk** Dependence on SLA National shortage of HCE physicians Desire to keep one BSUH physician	**Overlap** KSO1
Ref	Action	Who	Due	Update	Status
25.1	Commence negotiations with SASH	SF/PG/AK	Aug 14	MD has met with MD/CEO and CD and put plans out, capacity assessment by SASH awaited	
26.	**Community Imaging - offer same day service to local GPs and wider**	**Lead** ER/IF/PG	**Due** 14/15	**Risk**	**Overlap**
Ref	Action	Who	Due	Update	Status

26.1	OBC above for imaging infrastructure to cover this need too	IF/ER			
27.	**Primary Care Centre collocated on QVH site**	**Lead** ER/RT/ CCG (MP)	**Due** 14/20	**Risk** Commissioner and local GP intent remains unclear	**Overlap**
Ref	Action	Who	Due	Update	Status
28.1	Access to space to be maintained as part of estates strategy			Primary care debate at SMT August 14 Optionsot follow	
Project D) Private Healthcare					
28.	**Provide Private Healthcare on QVH site**	**Lead** SB/RT/ER	**Due** 14/20	**Risk** Legal Agreement between MSC and QVH may impair	**Overlap**
Ref	Action	Who	Due	Update	Status
28.1	Under investigation by finance and corporate team	SB/LH			
29.	**Expand private surgery for children**	**Lead** EP/SF	**Due** 14/20	**Risk** Legal Agreement between MSC and QVH may impair Age restriction in PP, but current capacity restraints in eye service	**Overlap**
Ref	Action	Who	Due	Update	Status
29.1	Limited opportunities maybe for under 3 year age group – to be investigated				
29.2	Corneoplastics market to be investigated				
29.3	Peadiatric eye surgery to be investigated	RM/SH/ ER	2014	Capacity limited on QVH site	ON HOLD
Project E) Effective use of clinical workforce					
30.	**Review of consultant job plans**	**Lead** SF/JS	**Due** 2014/ annual	**Risk** Appeals Failing to maximise consultant time Loss of off-site activity vs cost of delivering	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
30.1	Get job planning policy agreed by LNC			Policy agreed by LNC	Complete
30.2	Appoint Medical Workforce Manager			MWM in post	Complete

31.	**Seven day services for non-elective**	**Lead** SF/JS	**Due** 14/16	**Risk** Change in working patterns Potential cost of increasing on site consultant cover	**Overlap** KSO1 KSO3
Ref	Action	Who	Due	Update	Status
31.1	Gap analysis to be completed and sent to CCG			Appendix 1_7 Day working Key Compliar	Complete
31.2	Action plan to be developed			Completed with support of QVH 2020 team	Complete
31.3	Trauma actions for 7/7			Within trauma options	
32.	**Seven day services for elective**	**Lead** SF/JS	**Due** 14/20	**Risk** Change in working patterns National negotiations stalling Lack of support services 7/7 Cost of out of hours cover	**Overlap**
Ref	Action	Who	Due	Update	Status
32.1	Action plan to be completed with options for delivering elective alongside non-elective			Negotiation document sent by SF to CD for anaesthetics	
33.	**Review of local clinical excellence awards**	**Lead** SF/JS/RT	**Due** 14/15	**Risk** Informal negotiations as BMA fully opposed Options may not accepted by consultant body Legal challenge	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
33.1	Options appraisal to be completed			Options appraisal done	
33.2	Informal negotiation with consultant reps			Meeting (non LNC) agreed proposals Needs policy for next award round, no plans to address existing holders	
34.	**Adopt RO regulations**	**Lead** SF/JS/KA	**Due** 14/20	**Risk** Failure to fully embed RO requirements	**Overlap** KSO3
Ref	Action	Who	Due	Update	Status
34.1	Board report to be submitted July 14 and approved to NHSE			July 14 Accepted by NHSE	

34.2	Actions to carry forward to 2015 to be developed	KA/SF		Action plan in place	
35.	**Review of professional leave policy**	**Lead** SF/RT	**Due** 2014	**Risk** Disengagement of consultants Complaints from external organisations	**Overlap**
Ref	Action	Who	Due	Update	Status
35.1	Conduct review	SF/RT		Option paper by SF to CC Sept 14	
35.2	Establish process by which further individual appeal(s) to be heard at subcommittee of clinical cabinet	SF		Proposal to apply policy accepted and SF to communicate	
36.	**Recruitment and retention of Non-consultant career grade staff**	**Lead** SF/CH/JS	**Due** 2014	**Risk** Failure to recruit to posts More resource needed at time of recruitment	**Overlap** KSO4
Ref	Action	Who	Due	Update	Status
36.1	Policy to be agreed at LNC,			Policy agreed	
36.2	Terms, conditions and new contracts to be agreed			Terms, conditions and new contracts agreed	
37.	**Recruitment of the clinicians with the ability to be medical leaders**	**Lead** SF/JS	**Due** 14/20	**Risk** Cost of expanded recruitment process	**Overlap** KSO4
Ref	Action	Who	Due	Update	Status
37.1	Action plan required to frame recruitment policy including psychometric testing			On hold due to other issues	
38.	**Improve medical engagement with organisational priorities**	**Lead** SF/GA/RT	**Due** 14/16	**Risk** Training not taken up Medical management roles are typically unpopular	**Overlap**
Ref	Action	Who	Due	Update	Status
38.1	To begin leadership training				
38.2	Offer courses currently				
38.3	Restructure of CD/Cl roles	SF		SF to supply draft to RT Sept 14 may require investment in medical education lead and CCIO roles	
38.4	Link to CEA as above			CEA agreed contractually unable to link	
39.	**Alternative to ward cover by junior surgical staff**	**Lead**	**Due**	**Risk**	**Overlap**

		SF/JS/ Clin tutor	14/16	Inability to recruit to this grade in any speciality Maintaining a workforce in high cost area	
Ref	Action	Who	Due	Update	Status
39.1	SF/JS meeting with representatives of physicians associates to look at shared care model	SF/JS		SF/JS attending PA course run by HEKSS Sept 14 and report back to programme team	
39.2	Create Project plan with QVH 2020 team				
	40. KSO2(2) Outcomes				
Project F) Delivery of outcomes measures					
41.	**Orthognathic, Breast ,Anaesthetic, H&N Oncolgy, Orthodontic, Burns Outcomes for QA 14-15**	**Lead** SF/JP/JC	**Due** 14/15	**Risk** Adverse publicity following publication Inability to communicate to all stakeholders	**Overlap**
Ref	Action	Who	Due	Update	Status
41.1	Appointment of PM for outcomes			PM in post	
42.	**Consultant Governance Spreadsheet updated quarterly**	**Lead**	**Due** 14/15	**Risk** Incorrect information from multiple sources Adverse publicity and consultant disengagement with publication	**Overlap**
Ref	Action	Who	Due	Update	Status
42.1	Spreadsheet to be produced in draft			Remains difficult to collate data JP working on this	
43.	**The future face of QVH outcomes**	**Lead**	**Due** 14/20	**Risk** Uncertain who is reading the data and what they are really looking for Multiple views of value of outcome data direction not yet clear	**Overlap**
Ref	Action	Who	Due	Update	Status
43.1	Seek external advice			Marc farr from Beautiful information to interview key staff members and provide outline plan	
44.	**Linking the trusts strategy for data and information**	**Lead**	**Due**	**Risk**	**Overlap**

	management to the outcomes strategy		14/20	Multiple needs so must ensure outcome data is part of the remit	
Ref	Action	Who	Due	Update	Status
44.1	Project Manager to engage with JM on EPR				In hand
	45. KSO2(3) Research				
Project G) Research and Innovation					
46.	**Appoint a director of research from OUB to link clinical and cellular research links**	**Lead**	**Due**	**Risk** Funding provided by QVHCF renewed on basis of annual performance	**Overlap**
Ref	Action	Who	Due	Update	Status
46.1	Make appointment			Appointee in post Jan 14 reviewed QVHCF Nov 14	
47.	**Increase recruitment to portfolio studies by 25% on last year**	**Lead** JG/BJ/SF	**Due** 14/15	**Risk** Resource to ensure recruitment on target	**Overlap**
Ref	Action	Who	Due	Update	Status
47.1				**15.09.14:** Carried by well-performing studies	
48.	**Link research to clinical information management and consider housing alongside library and education centre**	**Lead** SF	**Due** 17/20	**Risk** Cost Resource to manage widespread departments	**Overlap** KSO 5
Ref	Action	Who	Due	Update	Status
48.1	Redraft plans to consider best option for collocation of all education facilities	KS/SF/AC ED comm		PKL building may represent poor value and lack of ambition in plans Need to keep LOF involved	ON HOLD
49.	**Attract industry and NHS funding to allow the director post to become self-funding**	**Lead**	**Due** 14/20	**Risk** Uncertainty of research funding bids and NHS intention QVH research is not easily aligned to AHSN aims reflecting wider NHS objectives	**Overlap**
Ref	Action	Who	Due	Update	Status

49.1				**15.09.14:** Outcome awaited over 2014-16	
KSO2(4) Education and Training					
Project H) Delivery of excellence in medical education					
50.	**Develop an Education Centre for multidisciplinary learning to include simulation**	**Lead** SF/AC	**Due** 14/18	**Risk** Cost Lack of clarity over estates strategy HEKSS withdraw further funding if not adequately used	**Overlap**
Ref	Action	Who	Due	Update	Status
50.1	Establish Education Centre in temporary premises	KS/AC/SF		Education Centre being set up in old theatre recovery unit	
50.2	Source further charitable funding once permanent base is agreed				ON HOLD
51.	**Develop a staged approach to provision ultimately aiming to incorporate library, clinical informatics, research and education on same site**	**Lead** SF	**Due** 2020	**Risk** Cost Resource to scope project Not achieving and loss of training status and poor feedback	**Overlap**
Ref	Action	Who	Due	Update	Status
51.1	Find resources for and recruit Project Manger				
52.	**Appoint new DME with 4 hours (1 PA) of Trust time to ensure oversight of NCCG doctors is taken up**	**Lead** SF	**Due** 14/15	**Risk** Cost of 1 PA per year + £7.5k Requires agreement, freeing time from clinical commitment for post holder Post may be unattractive	**Overlap**
Ref	Action	Who	Due	Update	Status
52.1	Create business case for 1 PA to be funded directly buy QVH to increase oversight of non-deanery doctors as well	SAF			
53.	**Explore alternative models of delivery of medical care, for example by Physicians' Associates or ENPs**	**Lead** SF/JS	**Due** 14/18	**Risk** Long term trust issue never addressed as difficult to recruit to and no clear line of responsibility for medical care at QVH	**Overlap**

				May not be adequate numbers and current restrictions on what can non-medics can do	
Ref	Action	Who	Due	Update	Status
53.1	Investigate possibility of replacing CT2 plastics trainees with another model	New DME			ON HOLD
54.	**Address trainee shortfalls due to difficulties in recruiting and deanery direction**	**Lead** SF/CH/JC/ AL/MP	**Due** 2014	**Risk** Disproportionate disciplinary issues in this group Not achieving consistency in appointments process Not following through on commitments to improve training, induction and monitoring Excess service demands leading to above and disengagement	**Overlap**
Ref	Action	Who	Due	Update	Status
54.1	Re-draft the JD and Person Specs	Clin Leads		Re-draft complete – now two separate posts. Agreed by LNC	
54.2	Re-draft the contracts	Clin Leads		Re-draft complete – aligned to national T&C. Agreed by LNC Not fully implemented due to resource and complexity of medics contracts and historical arrangements	
55.	**Options appraisal for future medical workforce**	**Lead** SF/JS	**Due** 2014	**Risk** Deanery intention can influence beyond QVH control Availability of medical workforce with adequate skills	**Overlap**
Ref	Action	Who	Due	Update	Status
55.1	Presentation to Board	SF	Oct 14		

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	236-14
Report from:	Interim Head of Corporate Affairs
Author:	Interim Head of Corporate Affairs
Report date:	12 September 2014
Appendices:	Stakeholder engagement plan

Stakeholder engagement

Background

1. Board members will recall that during the self-assessment against the Monitor / Trust Development Authority Board Governance Assurance Framework (BGAF) it was noted that the trust no longer has an up to date stakeholder engagement plan. As a result, the board scored poorly against this element of the assessment. To remedy this position, the BGAF action plan includes a requirement for a plan to be produced and submitted to the board for approval.

2. The interim Head of Corporate Affairs has developed the engagement plan set out at appendix 1, which describes the trust's main stakeholders, the key methods by which the trust engages with those bodies and individuals, the lead for such activities and an indication of usual frequency. The board is recommended to adopt the plan and schedule an annual review to ensure that the trust continues to acknowledge and engage effectively with those bodies and individuals who have an influence over, an interest in, or are affected by, the trust's performance and continued existence.

Development process

3. The engagement plan was developed in consultation with key members of trust staff, including the Medical Director, Director of Nursing, Head of Commerce and Head of Human Resources.

Key issues

4. The conduct of the review of engagement with stakeholders showed that although the majority of bodies and individuals with which the trust should engage are well covered, a gap was identified in respect of the Allied Health Professionals Council (AHPC), the regulatory body for the range of clinicians who are not registered doctors or nurses. Such clinicians include physio- and speech-therapists, Operating Department Practitioners, Social Workers and many others.

5. Unlike in the case of the Nursing & Midwifery Council (NMC) and General Medical Council (GMC), in respect of which there is a designated individual within the trust with responsibility for reporting concerns about the practice of a member, there is no trust officer with a specific responsibility to make similar reports to the AHPC. In practice, the Human Resources (HR) department may recommend that the most senior trust AHPC member within the same discipline makes a referral to the AHPC at the conclusion of a disciplinary or capability process, but there is nothing explicit in the Disciplinary or Capability policies about this.

6. The Board may wish to recommend that the relevant policies are amended to require the HR team to include a recommendation where appropriate and to oversee the process to ensure that a referral is made.

7. The engagement plan as drafted reflects the trust's current strategic, contractual, statutory and other partnerships and its aspirations under QVH 2020. As time passes and the trust's position changes it will be necessary to revise the plan periodically to ensure that the trust is directing its efforts and resources into those who are most closely associated with the trust at the time and most influential in the furtherance of the trust's objectives.

8. It is proposed that the Head of Corporate Affairs retains overall responsibility for ensuring that the plan is kept up to date and reviewed by the board annually.

9. Regular review of the plan to ensure its currency should ensure, amongst other things, that the trust engages in a fair and non-discriminatory way with all of its relevant stakeholders and maintains productive relationships with its commissioners, competitors and regulators.

Link to Key Strategic Objectives

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

10. Effective identification of, and engagement with, stakeholders will support the achievement of all of the trust's strategic objectives.

Implications for BAF or Corporate Risk Register

11. Nothing identified in the course of developing the plan represents a risk that should be fed through to either the corporate risk register or board assurance framework. Implementation and regular review of the plan should help to identify and manage risks associated with failure to engage effectively with important stakeholders (eg, reduction in clinical engagement, breakdown of relationships with regulators, damage to reputation and associated loss of business etc).

Regulatory impacts

12. As indicated above, implementation and regular review of the plan should help to identify and manage risks to compliance with the trust's significant regulatory obligations, ie, its Care Quality Commission authorisation and its Monitor licence.

Recommendation

10. The Board is recommended to approve the plan set out in appendix 1.

11. The Board is recommended to seek amendment of the Disciplinary and Capability policies to ensure that in relevant cases the HR department recommends that the most senior trust AHPC member within the appropriate discipline makes a referral to the AHPC at the conclusion of a disciplinary or capability process, and oversees the process to ensure that a referral is made.

Regulators / quasi regulators				
Stakeholder	**Activity**	**Objective**	**Lead**	**Frequency**
Monitor	**Regular:** Forward plans, quarterly returns and annual report and counts submitted per Financial Reporting Manual (FReM) / terms of Monitor licence	Licence compliance	DoF	Per FReM
	Reactive: DoN notifies Monitor directly if there is a serious incident or never event.	Relationship management	DoN	Ad hoc
	Reactive: CEO contacts Monitor in advance of changes to board membership or serious potential threats to risk ratings or reputation	Relationship management	CEO	Ad hoc
Care Quality Commission	**Regular:** weekly contact report submitted	Authorisation compliance	DoN	Weekly
	Reactive: DoN notifies CQC directly if there is a serious incident or never event, or serious potential threat to compliance with standards or reputation	Relationship management	DoN	Ad hoc
General Medical Council	**Regular:** MD makes recommendations for revalidation; meets biannually with a linkman	Regulatory compliance	MD	Biannual
	Reactive: MD liaises with GMC over performance issues with doctors	Regulatory compliance	MD	Ad hoc
General Dental Council	**Reactive:** MD liaises with GDC over performance issues with dentists	Regulatory compliance	MD	Ad hoc
Nursing & Midwifery Council	**Reactive:** DoN liaises with NMC over performance issues with nurses	Regulatory compliance	DoN	Ad hoc
Allied Health Professionals Council	**Reactive:** Referrals are made to the AHPC in connection with performance concerns regarding members	Regulatory compliance	Various	Ad hoc
Royal Colleges	**Reactive**: Royal Colleges invited to send a representative to participate in consultant interviews	Relationship management	MD	Ad hoc
NHS England (Responsible Officer functions)	**Regular**: NHS England oversees MD's role as responsible officer and allocates appraiser to ensure the processes followed are compliant	Regulatory compliance	MD	Annual / ad hoc

Healthwatch, via Local Healthwatch	**Regular**: Nominated link person for QVH attends Trust patient experience group	Relationship management	DoN	
	Regular: Local Healthwatch invited to comment on Trust quality account	Licence compliance	DoN	Annual
	Reactive: Trust responds to requests for information; notification of visits etc	Authorisation compliance	DoN	Ad hoc
Any relevant Health Scrutiny Committee	**Reactive:** Trust responds to requests for information	Statutory compliance	CEO	Ad hoc
Ombudsman	No significant engagement beyond notifying patients of the Ombudsman's existence and cooperating with any reviews undertaken by the Ombudsman	Statutory compliance	DoN	Ad hoc
Commissioners				
NHS England	**Regular:** DoN meets with Chief Nurse at regular Surrey & Sussex DoN meetings	Relationship management	DoN	Quarterly
	Regular: NHS England Specialist Commissioning Team invited to monthly Contract Management meeting chaired by Lead CCG, to discuss performance over previous month.	Contract / Relationship management	Head of Commerce	Monthly
	Regular: NHS England Specialist Commissioning Team invited to bi-monthly Programme Board meeting chaired by Lead CCG to develop strategy, plans etc	Relationship management	Head of Commerce	Bi-monthly
	Regular: QVH team attends NHS England regional Provider Forum	Relationship management	Head of Commerce	Quarterly
	Reactive: DoN notifies NHS England directly if there is a serious incident or never event, or serious threat to reputation, and cooperates with other NHS England requirements (eg Savile investigation)	Relationship management	DoN	Ad hoc
	Reactive: ad hoc meetings to discuss quality / commissioning / performance issues as required	Relationship management	Various	Ad hoc
Lead CCG	**Regular:** Programme board and single performance conversation meetings	Contractual compliance	Head of Commerce	Quarterly
	Reactive: DoN notifies CCG directly if there is a serious incident or never event, or serious threat to reputation; Head of Operations notifies CCG directly if there is a serious threat to delivery against contractual obligations	Relationship management	DoN / Head of Ops	Ad hoc

Other NHS				
Contractual 'partners'	Reactive: CEO to CEO meetings to discuss issues / developments as they arise / are required	Relationship management	CEO	As required
Strategic partners	**Reactive:** CEO to CEO meetings to discuss issues / developments as they arise / are required	Relationship management	CEO	As required
GPs	**Regular:** GP newsletter published quarterly, GP referral guide published annually	Relationship management	Comms team	Quarterly / annually
	Reactive: Meetings with specific practices as issues arise	Relationship management	Various	Ad hoc
Referring organisations / pathway colleagues	**Regular:** Clinicians attend Multi-Disciplinary Team meetings (MTDs) to discuss patients and pathways	Operational	Clinical teams	As required
	Reactive: CEO to CEO meetings to discuss issues / developments as they arise / are required	Relationship management	CEO	As required
Health Education England (KSS)	**Regular:** DoN or HHR attend quarterly meetings. Trust submits required workforce and education information	Regulatory compliance	DoN / HHR	Quarterly
	Reactive: DoN contacts HEE KSS if a trainee Dr is involved in a never event or SI	Regulatory compliance	DoN	Ad hoc
	Regular: Trust facilitates HEE KSS survey of trainees	Regulatory compliance		Annual
	Regular: Trust produces and implements action plan to address significant issues raised by trainee survey; HEE KSS monitors delivery and impact	Regulatory compliance	MD	Ad hoc
NHS Litigation Authority	**Reactive:** Trust responds to requests for statements, investigation reports, other evidence etc in litigation cases	Conduct of litigation	DoN	Ad hoc
National Clinical Assessment Service	**Reactive:** Trust responds to requests for statements, investigation reports, other evidence etc in litigation cases	Regulatory compliance	DoN / MD	Ad hoc
Public Sector				
Any relevant Health & Wellbeing Board	**Reactive:** Trust responds to requests for attendance, information etc made by any relevant Health & Wellbeing Board	Statutory compliance	CEO	Ad hoc

Internal				
Governors	**Regular:** Council of Governors' and CoG sub-committee meetings	Statutory compliance	HoCA/Chair	Quarterly
	Regular: Governor Steering Group meetings	Relationship management	HoCA/Chair	Six weekly
	Regular: Governor Update meetings	Relationship management	HoCA/Chair	Monthly
	Regular: Governor briefing circulated by email	Relationship management	HoCA	Monthly
	Reactive: Governor Forum meetings to discuss issues, development etc, as required	Relationship management	HoCA	Ad hoc
	Reactive: Governors invited to participate in Compliance in Practice visits	Relationship management	DoN	Ad hoc
Members	**Regular:** Members invited to stand for election as Governors and participate in elections	Statutory compliance	HoCA	Every three years
	Regular: QVH News	Relationship management	HoCA	Six monthly
	Regular: Annual Members' meeting held in public	Statutory compliance	HoCA	Annual
	Reactive: Emailed news updates sent out periodically (eg, new Chair's appointment)	Relationship management	HoCA	Ad hoc
Staff (collectively)	**Regular:** Connect (staff emailed newsletter)	Relationship management	Comms Team	Fortnightly
	Regular: Staff briefing (face to face update from CEO to staff)	Relationship management	CEO	Monthly
	Regular: Departmental visits – each SMT member to complete at least half a day front line each month	Relationship management	SMT members	Ad hoc
	Regular: Annual staff awards	Relationship management	Head of HR	Annual
	Reactive: All staff emails as and when required	Relationship management	Various	Ad hoc
Joint Consultation and Negotiation Committee (JCNC) / Unions	**Regular:** Quarterly meetings between HR, Senior Management and representatives of all non-medical staff, including local Union Representatives	Relationship management	Head of HR	Quarterly

Local Negotiating Committee	**Regular:** Quarterly meetings between HR, Senior Management and representatives of all medical staff, including local and regional British Medical Association Representatives	Relationship management	Head of HR	Quarterly
Volunteers	**Regular:** Annual social event	Relationship management	Volunteer Manager	Annual
	Regular: Supervision and inclusion in other "Staff" engagement events in placement	Relationship management	Relevant manger	Various
External				
Patients generally	**Regular:** Friends and Family test, national inpatient and outpatient surveys	Regulatory compliance	DoN	Every visit / annual
	Regular: Patient Experience Group meetings (includes patient members)	Relationship management	DoN	Quarterly
	Regular: contact with patients during Compliance in Practice visits and other ward / departmental visits	Regulatory compliance	DoN	Various
	Reactive: Responses to complaints and Patient Advice and Liaison Service contacts	Statutory compliance	DoN	Ad hoc
	Reactive: engagement through social media (Facebook, Twitter, web-site, NHS Choices etc)	Relationship management	Comms team	Ad hoc
	Reactive: responses to requests for visits, information etc, eg, Show and Tell	Relationship management	Various	Ad hoc
Head start – head and neck cancer support group	**Regular:** McMillan Head and Neck Cancer Nurse attends meetings and otherwise acts as liaison	Relationship management	Specialist nurse	Quarterly
Carers	**Reactive:** Trust responds to requests for visits / information etc, eg Dementia Friendly Group in East Grinstead	Relationship management	Various	Ad hoc
	Regular: Trust uses Butterfly Scheme to ensure effective engagement with dementia sufferers and their carers	Relationship management	DoN	N/A
Public	**Reactive:** Trust responds to requests for visits / information etc, eg, Governor presentations to community groups	Relationship management	Various	Ad hoc
Media	**Reactive:** press / media releases prepared in response to news and events as they arise	Relationship management	Comms Team	Ad hoc
Fundraisers	**Reactive:** fundraisers supported in advance of events and thanked by personal letter after donations made	Relationship management	Charitable Fund Team	Ad hoc

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	237-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	16 September 2014
Appendices:	Corporate Risk Register

Corporate Risk Register

Key issues

1. The trusts top five risks are identified as;
   - Ability to meet RTT18 targets (risk raised to 16)
   - Risk of breaching cancer targets (risk raised to 16)
   - Failure to deliver safe health care due to difficulties in recruiting (risk raised to 16)
   - Infection risk to patients due to poor systems and practice (currently 16)
   - The potential for loss of work if the clean room failed (currently 16)
2. Four new risks rated above 12 have been identified and mitigating actions have been taken and further actions that will further reduce the risk have been identified. Two of these are anticipated to close during September once the burns unit reopens. One includes the potential for reputational damage to the trust as a result of the occurrence of Never Events (new risk rated 12)
3. Changed risk scores (2 identified) reflect action taken to increase current controls to reduce risk and identification of an increasing risk and the implementation of additional actions and controls to mitigate the risk.
4. The corporate risk register was reviewed at the monthly clinical governance group and Clinical Cabinet in September.

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives

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

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

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

Recommendation

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

Clinical Cabinet and Trust Board
Summary of Risk Register Overview (Risks scoring 12 and above) - August 2014
(includes September change information on the Trust top four risks)

August 2014 data (01/08/2014 – 31/08/2014)

For the period of 01/08/2014 – 19/08/2014 there were 26 risks. A summary of any new risks added, closures and rescores is given in this report.

The Trusts top five risks are given below:

- Infection Control – Risk ID 27 – Infection risk to patients due to poor systems and practice of control (Score=16)
- RTT18 – Risk ID 159 - Ability to operationally meet 18 week target for all Directorates (Score=16) **(Risk score amended 10/09/2014)**
- Cancer – Risk ID 474 – Cancer target breaches (Score=16) **(Risk score amended 10/09/2014)**
- Failure to deliver safe healthcare due to difficulties in recruitment - Risk 388 – (**Risk score amended August 2014**)
- Failure of the clean room resulting in potential for loss of work - Risk 681 – (Score=16).

New Risks scoring 12 and above
Three new risks were added meeting this threshold between 01/08/2014 and 31/08/2014 (CxL scoring) and one during early September:

Risk Register	Date added	Risk Score	Risk ID	Description
Corp	12/08/2014	3x4=12	733	Restricted access to blood fridge/cross infection from staff movement
Dept	11/08/2014	3x4=12	732	Use of Long Term Model Box Store for Maxfacs (Identification of long term storage)
Corp	12/08/2014	4x3=12	734	Impact of staff redeployment to Theatres Recovery to manage major H&N cases due to Burns Unit closure
Corp	**09/09/2014**	**4x3=12**	**743**	**Reputational damage to the Trust as a result of the occurrence of Never Events (Risk added in September 2014)**

Closed risks scoring 12 and above
One risk scoring 12 or over was closed between 01/07/2014 – 31/08/2014

Risk Register	Risk ID	Risk Description	Rationale for closure	Risk Score	Date of closure
Dept	720	Use of Long Term Model Box Store for Maxfacs (vermin related)	Existing risk ID covers this area – focus of risk has moved	3x4=12	11/08/2014

Changes to Risk Scores – Two changes to risk scores between 01/08/2014 and 31/08/2014

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
Corp	388	Failure to deliver safe healthcare and breach of targets due to poor governance and staff training/recruitment	4x2=8	↑ 4x4=16	Difficulties in recruitment of suitable trained staff
Corp	540	Risk of Diagnostic tests involving Pathology	3x2=6	↑ 3x4=12	Histopathology reporting does not marry up against results.

Two further changes to risk scores have occurred to key risks during early September 2014 as below:

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore
Corp	159	Ability to operationally meet 18 week target for all Directorates	3x5=15	↑ 4x4=16	**Rescored 09/09/2014** – Trust prediction of failure to meet 18 week target based upon previous quarter 1 and impending quarter 2 non-compliance.
Corp	474	Cancer target breaches	3x4=12	↑ 4x4=16	**Rescored 09/09/2014** – Trust prediction of failure to meet cancer target based upon previous quarter 1 and impending quarter 2 non-compliance.

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
159	29/11/2006	Ability to operationally meet 18 week target for all directorates	1. RTT18 PTL established and now circulated daily. 2. Weekly escalation process now established via clinical specialties managers, OPG meeting twice a week to ensure all capacity is fully utilised. 3. 18 week steering group, each specialty highlighting capacity issues in issues log. 4. RTT 18 action plan being reviewed at steering group. 5. Additional theatre lists provided on Saturdays 5. RTT18 clinical outcome recorded on PAS 6. Additional data analyst post to provide cover for DH returns. 7. Clinical outcome forms revised for each specialty. 8. Develop reports to monitor specialty performance, planned w/l with expected TCI, backlog and open pathways monthly. 9. Validation of PTL lists weekly including admitted, non admitted and open pathways. 10. Amended policy incorporates new guidance re planned cases. 11. Training and guidance issued. 12. Monthly review of planned cases without date for attendance at QVH. 13. Develop early warning systems to track increased demand and mismatch with future capacity 14. Proactively discuss W/L each week at OPG for patients 10 weeks plus who do not have TCI date to avoid breach in each speciality 15. Review and validate all pending TCI's for Apr, May, June to ensure patients booked within 18 weeks 16. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably 17. Introduce new LA DC facility by July to increase capacity in main theatres for more complex work.	Stuart Butt	Jane Morris	16	8	Centralise all referrals through one access point - Completed Restructure of appointments and admissions teams to achieve consistent Trust wide approach to management of elective pathway bookings Training and guidance to be issued to all relevant staff - Completed Review to take place in January 2011. - Completed 3. Ensure all Planned cases have estimated TCI's when placed on list - Ongoing Implement daily ptl - completed Ensure all future TCI's are validated in relation to 18 weeks- completed 6. Introduce a new automated 6 month administrative WL validation - Completed Agree business case for increasing capacity in sleep studies - completed Explore locum for Ocular plastics - completed 1. Expediate Medway hub 2. Develop matrix of planned cases seen at QVH - Completed Policy being redrafted, to launch May, with associated training package. - completed Clinic outcome forms being revised within specialities - Completed 5. Clinical pathways for top 3 procedures within specialities with clock stops being devised with CD's - agreed, being put into trust format Appointment of Access and Performance Manager - Completed 9. Ensure 95% patients are pre-assessed at least 7 days prior to surgery (inc off site). Restructure of appointments and admissions teams to achieve consistent Trust-wide approprach to management of elective pathway bookings - Completed 7. Develop capacity model short, medium and long term - Completed	29/07/2014	KSO3	Corporate Risk (for mainTrust Risk Register)

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
474	10/03/2011	Cancer target breaches	1 - Cancer Data Co-coordinator issues reviewed monthly by Directorate Manager□ 2 - Patient tracking list for the specialties in place and produced twice a week.□ 3 - Cancer Data Co-coordinator communicates with staff on potential breaches.□ 4 - Secretaries respond to requests to bring patients forward wherever possible.□ 5 - Off site team leader in place to contribute and reconcile breaches.□ 6 - Appointments team allocate 2 week wait referrals to avoid delay.□ 7 - All breaches reviewed weekly by Directorate Manager.□ 8 - Project team established to integrate the cancer pathway.□ 9 - Action plan for skin cancer performance devised and implemented including process mapping sessions□ 10 - Cancer Outcomes Dataset report reviewed on a monthly basis by cancer team	Stuart Butt	Jane Morris	16	8	Introduce and use cancer network databases within QVH for all MDT's.- Completed Streamline current referral pathwaysfor all types of cancer Establish Cancer Group and Cancer Data Management/MDT team for QVH. Proposals in development - Completed Setting up of 2 week skin cancer clinic - Completed Setting up of central referral management - No longer required Implementation of infoflex and Somerset cancer databases on site - completed Introduce same day see and do LOPA slots - Completed Expand use of infoflex system across Trust Establish business continuity cover in the absence of the data co-ordinator - completed - restructure being agreed and implemented from 22nd April - Completed Create local access policy for the Trust- completed Establish project team to integrate the cancer pathway- Completed Process mapping of skin cancer pathway and cancer data - Completed Action plan specifically focused on skin cancer performance to be devised and implemented including process mapping sessions. - Completed Set up QVH cancer improvement steering group - completed Review COSD data completeness and agree action plan to improve % - Completed Employment of data entry clerk to support Thames Cancer	29/07/2014	KSO3	Corporate Risk (for mainTrust Risk Register)
388	08/10/2009	Failure to deliver safe healthcare and breach of targets due to poor governance and staff training/recruitment	1. Pre employment checks to ensure that suitably qualified staff are employed.□ 2. Registration checking process in place□ 3. Skill mix review completed and monitored.□ 4. Corporate and local induction and refresher training □ 5. Annual appraisals for all staff.□ 6. Regular review of complaints and incidents□	Amanda Parker	Amanda Parker	16	1	7. revised Q&RC and CPC to be devised 6. Governance review underway relating to structural governance reporting 2. Specific department plans to be actioned. 5. Complete documentation action plan 2. Refine regular review process for each outcome.Completed 3. DoN to receive monthly reports on individuals 3 months over	11/08/2014	KSO1	Corporate Risk (for mainTrust Risk Register)
27	07/01/2005	Infection risk to patients due to poor systems and practice of control	1. Mandatory training of all staff and awareness raising sessions.□ 2. Implementation of trust policies - isolation, screening, treatment including root cause analysis for all C Diff / MSSA/Ecoli bacteraemia cases and PIR review for all MRSA bacteraemia.□ 3. Routine audit of practice, and monthly PLACE inspections.□ 4. Cleaning strategy implemented including deep clean arrangements□	Amanda Parker	Amanda Parker	16	6	Awaiting ICNet computer system access 7. Complete actions from the MRSA RCA report 5. Provide infection control nurses with direct IT access to BSUH Microbiology system 3. Follow up actions from current infections - Completed 4. Review of anti-biotic policy to ensure best practice use and	11/08/2014	KSO1	Corporate Risk (for mainTrust Risk Register)
681	13/02/2014	Failure of cleanroom air handling unit due to wear and tear and age of unit. Latest failure in July 2014 - ongoing issues	Ad hoc repairs. □ Unit on quarterly maintenance contract (as recommended) □ Company last attended site on 13/02/2014 to fix the bearings□ Reporting of breakdowns on Datix (on 13/02/2014 ID 11705, On 28/03/2014 ID11878, and on 03/06/2014 ID12119).	Steve Fenlon	Nigel Jordan	16	8	Business Case/options appraisal being drafted by General Manager for 3 Options Case to the Estates & Facilitaties Steering Group on 08/09/2014 with quotes for decision.	19/08/2014	KSO2	Corporate Risk (for mainTrust Risk Register)

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
670	17/12/2013	Failure to maintain estates service due to continued staff shortages.	•Recruitment to temporary staff authorised by CEO□ •Staff volunteering for additional on call duties.□ •□Use of external contractors and agency staff to cover staff shortfalls e.g. lighting, storm damage and electrical failure□ Use of external contractors for March 2014 to provide additional cover.	PRODIR	John Trinick	15	6	June 2014-Company commissioned to undertake a review of the Estates Service - Report due in September 2014	19/08/2014	KSO4	Corporate Risk (for mainTrust Risk Register)
629	19/07/2013	Inadequate health records storage and processing and lack of budgetary allocation for ongoing storage costs from mid June 2014	1. Health records policy includes process for managing records off site□ 2. Bags used for transporting notes changed to fit within boxes therefore reducing handling□ 3. Regular destruction of notes in place.□ 4. Increased racking in place in Commonwealth house□ 5. Missing notes procedure in place□ Paper to Clinical Cabinet with costs of more packaging and moving records to free additional space□ 6. Regular transport runs between Kings House and QVH□ 7. Tracking system for notes in place□ 8. Outsourcing scanning of 10000 sets of notes to increase capacity	Jane Morris	Sally Joselyn	15	3	new group in place to monitor the progress of finding suitable a location and renewal of contract Paper to April Clinical Cabinet summarising the costs associated with packaging,moving and storage of medical records as space limited to mid June 2014 Transport tender renewal to include transport and storage of medical records (est costs of transport 2.5-3k) Continue collaborative procurement for EDN Review in 3 months whether further permanent notes need to be scanned to release more space Review on site storage and archive to ensure space utlilised	19/08/2014	KSO4	Corporate Risk (for mainTrust Risk Register)
710	22/05/2014	Increasing bed occupancy on MD ward restricting the trusts ability to deliver care	Staffing monitored in accordance with patient acuity□ Safer Staffing levels in place, reviewed actively twice daily□ Staff encouraged to report concerns regarding patient care, quality of care provided, etc□ Staff to ensure "red" tabard is worn when administering medications to avoid interruption□ Staff encouraged to report incidents via Matron/ Manager and by using DATIX system□ Matron to attend weekly OPG meeting to monitor occupancy levels□ Monthly reprots on occupancy and utilisation and length of stay provided	Amanda Parker	Kathy Brasier	15	8	Recruitment of Band 5 staff to meet vacancies Reduction in the use of agency and bank staff Recruitment drives to colleges and schools	23/07/2014	KSO3	Corporate Risk (for mainTrust Risk Register)
711	30/05/2014	Reliability of Theatre Doors	Risk Assessment completed and Risk added to the Theatre Risk Register on staff musculoskeletal injury.□ Two year "Willmott Dixon" agreement for repair of new build includes Theatre Doors□ Regular meetings to monitor situation takingplace□ Doors currently being reset by Estates and Theatre staff when faults occur □	Steve Fenlon	John Trinick	12	6	Affected staff to use alternative access to Theatres one Theatre door to be replaced to "test" if issue could be resolved by replacing the door Ongoing updates at Theatre User Group Meeting regardign this risk Increased follow-up with Estates & Willmott Dixon	11/08/2014		Departmental Risk(s) (low/very low and managed by local department)
715	11/06/2014	Patient notes not filed correctly	Staff vigilant about handling notes and information ensuring filed properly, which is time consuming for nursing staff.□ Ward clerk filing notes appropriately□ Filing instructions sent to relevant departments from CPU□ Datix all mislaid information or incorrectly filed	Mr Raman Malhotra	Sally Joselyn	12	6	Ongoing emails and reminders to staff - Also included in discussions at team meetings	19/08/2014		

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
725	09/07/2014	Reduced Radiologist cover over weekend for undertaking ultrasound procedures	1. Scheduling of cases managed in such a way that there is minimal requirements from radiology 2. Hours are covered by Radiologist until 31/08/2014 3. Arrangements in place until 31/08/2014	Steve Fenlon	Kirsty Humphry	12	8	referral pathway to be developed with Partnew Trust U/S - First morning slot available for any overnight cases Develop cover arrangements with BSUH/PRH	11/08/2014	KSO2	Corporate Risk (for mainTrust Risk Register)
728	29/07/2014	Risk of compliance with best practice and regulatory requirements at spoke sites	Annual H&S assessments programme (monitored by quarterly H&SC) Annual infection control/decontamination reviews CQC/HSE notifications of queries relating to service provision 	Amanda Parker	Alison Vizulis	12	8	Annual CiP assessments to continue at spoke sites revised programme of infection control and decontamination annual assessments	11/08/2014		Corporate Risk (for mainTrust Risk Register)
732	11/08/2014	Use of Long Term Model Box Store for Maxfacs	Existing model storage can be accessed by authorised staff using appropriate PPE Risk assessment in place for use of existing location	Stephanie Joice	Alison Vizulis	12	6	HoR to meet with new Records Manager (SJ) and Matron for Elective Services to agree action plan for documentation belonging to Department that is retained there to be reviewed as per retention guidelines	11/08/2014		
733	12/08/2014	restricted access to blood fridge/cross infection from staff movement	controlled access by burns staff who retrieve blood units and process blood gas cost and introduce a seperate blood fridge and blood gas anaylsis machine for theatres	Dr Ken Sim	Jo Davis	12	2	Review of blood fridge arrangements to be undertaken to include exploration of the purchase of an additional fridge	12/08/2014		Corporate Risk (for mainTrust Risk Register)
734	12/08/2014	Impact of staff redeployment to Theatres Recovery to manage major H&N cases due to Burns Unit closure	MRSA action plan in place Agency/bank staff utilised Staff rostered to meet requirements of both areas	Kathy Brasier	Alison Vizulis	12	8	Ongoing staff redeployment	12/08/2014		Departmental Risk(s) (low/very low and managed by local department)
639	10/10/2013	Support and access from supplier to ORSOS will cease 03/16 leaving Trust without electronic theatre record	Discussed at ICAG monthly and theatre user group.	Jane Morris	Mr Mark Savage	12	4	Agree on the preferred solution before sourcing the new supplier Source the new supplier Specification being drawn up to procure new/replacement system ICAG reviewing progress of replacement each month; also Theatre User Group	11/08/2014	KSO4	Corporate Risk (for mainTrust Risk Register)
689	25/04/2014	Potential to adversely affect statutory and mandatory training due to increasing number of vacancies (3mths and over)	1. Statutory and mandatory training reviewed monthly and reported to Board. 2. Departmental feedback from above. 3. Utilisation of bank and agency staff to release others to attend training.	Richard Tyler	Graeme Armitage	12	6	Training frequency under review to ensure match with NHS education passport Continue with utilisation of agency/bank staff to release others for training Review being completed of training matrix and adjustment of profiles as part of KSF skills passport Implementation of more elearning options Overseas recruitment initiative being taken forward Erostering review being undertaken to utilise staff efficiency/availability	08/07/2014	KSO5	Corporate Risk (for mainTrust Risk Register)

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
513	04/01/2012	Potential failure to act on infection concerns due to unavailability of Microbiologist	1.Daily lab sheet of positive specimen results however, not all positive specimen are listed on this sheet. 2. Presence of microbiologist during week on site has reduced, remainder of cover provided via telephone (24/7) 3. Trust policies and procedures. 4. Staff mandatory training 5. Access to ICE system winpath for ICNs to review organism resistances 6. Daily visits to wards by ICNs. 7. New consultant and Locum Microbiologist employed from Sept 2014	Amanda Parker	Emma Kerr	12	6	QVH to review BSUH contract to ensure appropriate microbiolgy service and consultant cover is available on site - BSUH issued with performance notice regarding the microbiology service provided to the QVH. Identify BSUH ability to deliver increased on site attendance Waiting feedback from BSUH	11/08/2014	KSO1	Corporate Risk (for mainTrust Risk Register)
540	26/04/2012	Risk of Diagnostic tests involving Pathology	1. Diagnostic Policy details procedure for each step of process. 2. Contract with BSUH for services. 3. Contract lead from BSUH provides training and support. 4. On site microbiologist 5. Infection prevention and control team in place. 6. Blood transfusion lead for the Trust and committee in place. 7. Monitoring of procedures within diagnostic policy. 8. New Interim Pathology Clinical Director in post 9. Successful accreditation achieved in Pathology - 2014 10. Quarterly Blood Transfusion Committee in place (incidents and risks reviewed)	Steve Fenlon	Rachael Liebmann	12	6	Actions to be fully implemented from the June 2014 Histopathology SI Performance notice issued, awaiting a response	02/07/2014	KSO1	Corporate Risk (for mainTrust Risk Register)
584	23/11/2012	Potential harm from medical devices due to inadequate training	1. Training and competencies for high risk devices 2. Meetings with medical device co-ordinators to develop action plans for above. 3. Training compliance monitored by medical device officer quarterly. 4. Junior doctors familiarisation session incorporated into induction. 5. Speciality training assessment forms available for ad hoc junior doctor starters. 6. Incident reports used to identify and monitor trends that would highlight training as an issue	Steve Fenlon	Alison Vizulis	12	6	Elearning options being utilised e.g. dermatomes Medical Devices Officer to review all medical device related incidents from 01/09/2014 High risk and moderate risk competencies to be completed by Medical devices Officer Risk rescoring amended to reflect L&D Strategy Group output	11/08/2014	KSO1	Corporate Risk (for mainTrust Risk Register)
602	10/02/2013	Business continuity risk to the organisation due to failure of IT network infrastructure	1: Available support from an external company to repair if failure occurs. 2: Limited support available on-site 3. A full network review has been carried out and awaiting budget approval. Funding approved for new infrastructure - Budget approved	Stuart Butt	Nasir Rafiq	12	8	IT Capital bids programme for 2014/15 monitored at Information Management and Governance Committee IT annual plan for 2014/15 in place to monitor progress on IT renewal Looking to procure new network (by 31/03/2016) Purchase and install 2nd core switch which is connected to all edges and other core switch New equipment to be rolled out within 12 months covered by life time warranties	30/07/2014	KSO4	Corporate Risk (for mainTrust Risk Register)

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
604	26/03/2013	Breach of information security due to use of unsecure email accounts to transfer person identifiable data (patient and staff)	1: Mandatory information governance training available for all staff and compliance rates increased. 2: Datix incident reporting and investigation procedure in place. 3: Trust information governance manager to oversee and advise regarding information governance standards. 4: The following solutions are in place for accessing and transferring information securely. 4.1 NHS mail 4.2 Good e-mail app 4.3 Remote access 4.5 encrypted memory sticks 5 IT & IG lead to review new security restrictions (soft ware applications) 6. Compatibility review in preparation for Windows 7	Stuart Butt	Nasir Rafiq	12	6	Implement data leakage prevention software Monitoring of compliance with IG Toolkit Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	30/07/2014	KSO4	Corporate Risk (for mainTrust Risk Register)
620	17/07/2013	Potential loss of referrals due to commissioners moving work to centralised centres	1. Quality of work and reputation of QVH provides a strong position. 2. Identified areas of opportunity - Head and Neck services and breast surgery from other trusts 3. Development of core reconstructive services 4. Contract monitoring meetings, 5. Programme Board overview 6. Review of Service Line reporting 7. Weekly Business meetings reviews of operational issues and referrals 8. Continued dialogue with Health Service Priorities Unit. 9. Business model adapted to cover lost procedures. 10. Engagement with GP's 11. Compliance with low priority procedure policy 12. Education and engagement with CCG leads 13. Engagement with the any qualified provider scheme. 14. 2013/14 reflects potential loss of income	Stuart Butt	Bill Stronach	12	6	Risk being reviewed and transferred to 2014/15 BAF Divest Gynaecology service - Completed Develop relocation of head and neck surgery from Brighton to QVH Develop provision of breast reconstruction surgery to Worthing and Brighton areas - Completed Develop hand surgery services for Surrey residents Develop new maxillo-facial clinics in Horsham - Completed Extend plastic-surgery service into East Kent Review non core services to ensure sustainability Develop referral base through business development plan - Completed annually Develop business intelligence capability	10/07/2014	KSO3	Corporate Risk (for mainTrust Risk Register)
623	19/07/2013	Failure to meet CQUIN requirements for 2014/15 therefore incurring a loss of CQUIN funds £1.4M	1. VTE risk assessments within each patient drug chart - VTE policy in place 2.Dementia - process in place to identify trauma patients >75 years of age.Clinical lead identified. 3. Dementia training in place 4. Patient experience group in place reviewing and ensuring actions implemented and linked to OPD experience. Family and friends test score. 4.NHS safety thermometer completion is linked within deputy director of nursing job role and harm score reported to the Board. 5. Organisational performance against CQUIN measures are monitored and reported to Trust board on a monthly basis. 6. High impact intervention CQUINS reports produced each quarter and reviewed by Q&R Committee.	Amanda Parker	Amanda Parker	12	3	Risk to be updated for 2014/15 CQUINS and 2014/15 BAF Ongoing audit reports to demonstrate CQUIN compliance e.g. WHO checklist and MaPSaF Provide Q3 update to quality and Risk Committee and Board	11/08/2014	KSO1	Corporate Risk (for mainTrust Risk Register)

12 and Above Risks (as at 19/08/2014) - By score (high to low)

ID	Opened	Title	Controls in place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed	Principal objectives	Corporate/ Department Risk
624	17/07/2013	Failure to invest in IT, estates and medical equipment due to insuficient funds or poor allocation	1. IT strategy and site development strategy 2. Estates capital programme for 2013/14 3. Medical device committee and procurement process 4. Procurement software and process to ensure good procurement practice. 5. Allocation for capital funding between medical devices, estates and Information Technology to be prioritised on a needs basis rather than the previous process of set amount for each area.	Stuart Butt	Stuart Butt	12	4	Continued monitoring at the Information Management and Governance Committee Complete capital bid / review process - Completed Develop wireless and mobile technology Extend self check in and patient calling system - Completed Implement digital dictation and voice recognition - Completed Progress joint procurement of electronic document management and clinical portal	30/07/2014	KSO4	Corporate Risk (for mainTrust Risk Register)
627	19/07/2013	Failure to embed safer surgery checklist process due to lack of engagement	1. 1st stage consent by experienced surgeon in out patients. 2. 2nd stage consent on admission (check with patient) 3. Surgical safety checklist-sign in and time out stages. 4. Patient marking policy changed, presentations to all medical staff and directorates by MD. 5. Consent working group set up to improve consent before day of operation. 6. Pre list brief in place and effective prior to full list starting 7. Safer surgery checklist in place - (WHO Checklist) 8. Information and awareness sent to all theatre staff and clinicians 9. Audit of checklist quality in place 10. operating surgeon is now responsible for timeout 11. training in place for all staff 12. patient safety forum in place to review practice. 13. Addition of WHO checklist compliance as a 2014/15 CQUIN 14. WHO checklist audit developed for 2014/15 CQUIN and reporting commenced 15. WHO checklist audits x 2 reviewed at monthly Theatre User Group and Patient Safety Forum. 16. Audit tool amended following pilot to improve robustness 17. Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting - Completed and ongoing 18. Ongoing monitoring at Patients Safety Forum and reporting as an indicator on the Quality Metrics dashboard	Steve Fenlon	Jo Davis	12	4	Ongoing monitoring of audit Reminders to clinicians during meetings on compliance with WHO checklist especially sign out	11/08/2014	KSO1	Corporate Risk (for mainTrust Risk Register)

Queen Victoria Hospital NHS
NHS Foundation Trust

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Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	238-14
Report from:	Amanda Parker, Director of Nursing & Quality
Author:	Ali Strowman, Deputy Director of Nursing
Report date:	16 September 2014
Appendices:	1) Statement of Readiness Letter 2) EPRR self-assessment

Emergency Preparedness, Resilience and Response Core Standards Self-Assessment

Key issues

1. There is an annual requirement for Category 1 and 2 responders (Civil Contingencies Act 2004) to complete a self-assessment and to submit a statement of readiness to the NHS England - Surrey and Sussex Area Team stating compliance against the National requirements of Emergency Preparedness, Resilience and Response (EPRR) Core Standards.
2. The attached assessment is against the 51 standards within which there are 57 assessment statements requiring assessment. Initial assessment shows QVH to be compliant (green) with 46 (80.7%), non-complaint with actions in place to become compliant (amber) for 8 (14%). No areas are declared red however 3 (5.3%) are declared as not applicable to QVH.
3. The areas for action are the need to update the communication section of the emergency plan and to confirm some aspects of our CBRN (Chemical, biological, radiological and nuclear) equipment, training and capacity. These are being addressed at present with an anticipated completion date of 1st October 2014.
4. The attached letter provides a statement of readiness.
5. During October 2014 there will then be an assurance meeting with NHS England – Surrey and Sussex Area Team to challenge and confirm the declared readiness.
6. The board previously received the EPRR annual report (June 2014) that additionally supports the statement of readiness.

Implications of results reported

7. The assessment demonstrates that the trust is aware of key risks that affect EPRR for the organisation and that these have been addressed.
8. No specific group/individual with a protected characteristic are affected.
9. Failure to address issues within the assessment or the ability to declare a state of readiness would be a key concern to our commissioners, NHS England, the Care Quality Commission and Monitor.

Action required

10. Completion of action to meet the communication requirements, this will be completed by October 1st.
11. Submission of a statement of readiness.

Emergency Preparedness Resilience and Response: Statement of Readiness

Queen Victoria Hospital NHS FT has undertaken a self-assessment undertaken by against the national core standards for EPRR and Hazmat CBRN.

The assessment of the 51 standards within which there are 57 statements requiring assessment (RAG) shows QVH to be compliant (green) with 46 (80.7%), non-complaint with actions in place to become compliant (amber) for 8 (14%). No areas are declared red however 3 (5.3%) are declared as not applicable to QVH.

As the executive lead for emergency planning I would identify that we are able to state our readiness as required against the core standards of the EPRR with the following exceptions; that the communication section of our emergency plan requires updating and confirmation of aspects of our CBRN capability is required. These actions will be completed by October 1st.

Link to Key Strategic Objectives

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

12. The attached assessment can be seen to impact on all the trusts KSO's.

Implications for BAF or Corporate Risk Register

13. Emergency preparedness is already reflected within the board assurance framework (KSO1) and within the corporate risk register.

Regulatory impacts

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

15. The attached assessment and statement of readiness does not impact on our Monitor governance risk rating or our continuity of service risk rating.

Recommendation

The Board is recommended to note the content of the self-assessment and approve the statement of readiness.

NHS England Core Standards for Emergency preparedness, resilience and response
v2.0

The attached EPRR Core Standards spreadsheet has 3 tabs:

EPRR Core Standards tab - with core standards nos 1 - 37.

HAZMAT/ CBRN core standards tab: with core standards 38- 51. Please note this is designed as a stand alone tab.

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43.

	Core standard	Clarifying information	Specialist providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.				
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y					
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology. • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y					
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y					
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages; • surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed				
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.		Y					
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y					
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.				
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y					
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y					
		Severe Weather (heatwave, flooding, snow and cold weather)	Y					
		Pandemic Influenza	Y					
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y		Don't have one but not applicable to size, scale or function of trust			
		Mass Casualties	Y		Don't have one but not applicable to size, scale or function of trust			
		Fuel Disruption	Y					
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y					
		Infectious Disease Outbreak	Y					
		Evacuation	Y					
		Lockdown	Y					
		Utilities, IT and Telecommunications Failure	Y					
		Excess Deaths/ Mass Fatalities	Y		Don't have one but not applicable due to size, scale or function of trust			
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme)						
		firearms incidents in line with National Joint Operating Procedures;						
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).				
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.				
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y					
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y			Comms section of the Emergency Plan sent to Corporate Affairs for updating.	**LH**	01/10/2014
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specifiy who has been consulted on the relevant documents/ plans etc.				
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y					

	Core standard	Clarifying information	Specialist providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Command and Control (C2)								
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.				
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.				
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.				
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y					
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y					
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials						
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident						
Duty to communicate with the public								
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.		Comms section of the Emergency Plan sent to Corporate Affairs for updating.	**LH**	01/10/2014
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.				
Information Sharing – mandatory requirements								
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.				
Co-operation								
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues • Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area				
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y					
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y					
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.							
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.							
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y					
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared							
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y					
Training And Exercising								
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years				
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y					
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y					
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y					

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Specialist providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
	Preparedness							
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control				
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	• Site inspection • IT system screen dump				
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)				
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.			• Resource provision / % staff trained and available • Rota / rostering arrangements				
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	• Provision documented in plan / procedures • Staff awareness				
	Decontamination Equipment							
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))				
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017				Assessment being undertaken		
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place				**Confirmatioin awaited**		
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment					Confirmation awaited		
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)				Asseement required	**AS**	Oct 1st
	Training							
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training					Confirmation required	**AS**	Oct 1st
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme				
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.					confirmation required	**AS**	Oct 1st

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Specialist providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y					

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Equipment Assessement Kits (ChEAKs) (via PHE) (replaced Toxboxes in 2010)		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 26 September 2014
Reference number: 239-14
Report from: Interim Company Secretary & Head of Corporate Affairs
Author: Lois Howell
Report date: 12 September 2014
Appendices: Updated action plan

C Wing action plan update

Key issues

1. Completion of the action plan is going well, with 45 of the 54 required actions now complete, several ahead of schedule. Appendix 1 sets out the latest version of the action plan, with dated updates. The updates are set out in italics for ease of identification.

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

Ref	Action	Due	Reason for delay
8.3b	Implementation of Safer Care module of e-rostering system to be assessed and planned	31.05.14	The module has been ordered form the supplier; a date for implementation is awaited. Additional resource to support effective implementation has been procured.
8.3c	Training for managers on use of Safer Care module of e-rostering to be developed and delivery commenced	31.05.14	Dependent on implementation of system, as above
14.2/3a	Flash reporting on safe staffing to be introduced	30.06.14	Requires implantation of Safer Care module of e-rostering system – see above
14.4a	Quarterly reports on implementation of Safer Care module of e-rostering system to commence	26.06.14	The module has been ordered form the supplier; a date for implementation is awaited. Additional resource to support effective implementation has been procured.
8.4e	Review policy on use of accrued annual leave during notice period	10.06.14	Negotiations in hand with staff side
12.3a	CEO to review structures to ensure adequate focus on performance and productivity targets	30.09.14	Action re-dated to 31.03.15. Initial discussions re: re-structure to begin at Nominations and Remuneration Committee 25.09.14
10.1a	Metrics for monitoring of performance management to be introduced	~~31.06.14~~ 31.10.14	To be re-dated to 31.03.15 – closely linked to re-structure

Implications of results reported

3. The delays to the Safer Care module of the e-rostering system do not place patients or staff at any greater risk than that to which they are currently exposed. The introduction and

publication of Safe Staffing reporting ensures that staff, patients, visitors and the trust have a clear picture of staffing levels on the wards, reasons for departure from plans and mitigations put in place. The Director of Nursing and Quality monitors these levels regularly and carefully.

4. The delay to the completion of the management restructure is unlikely to have a significant impact on quality and safety at the Trust – the principle focus of the restructure is performance and operational delivery. Separate reports to the board elsewhere on the agenda identify the mechanisms in place to monitor and manage performance in the interim until the re-structure is complete.

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

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

Action required

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

Link to Key Strategic Objectives (delete those not applicable)

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

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

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

Recommendation

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

Trust action plan in response to Canadian Wing Investigation March 2014

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

Trust action plan in response to Canadian Wing Investigation March 2014

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

Ref	Action	Who	When	Update	Status
6.2a	CEO to refresh Trust Vision and Values, and promote appropriately	CEO	31.05.14	**17.04.14:** This will form part of the QVH 2020 communications strategy; CEO in discussion with Laura Donaldson w/b 21st April regarding communications strategy **09.05.14:** QVH2020 Comms plan agreed, for launch late May **12.05.14:** Article re: Vision and Values to appear in next edition of Connect **31.05.14:** Connect article published; subject to be raised again periodically as opportunities arise	**COMPLETE**
6.2b	Recruitment, Appraisal and performance management policies and processes to reflect expected behaviours	HHR	10.06.14	**25.06.14:** Values-based recruitment criteria have been introduced. Revised appraisal system introduced for 2014/15 includes enhanced focus on performance, including performance against trust values. All appraisals conducted during 2014/15 will use the new documentation.	**COMPLETE**

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

Ref	Action	Who	When	Update	Status
6.3a	CEO and DN to consider revision to role and responsibilities as part of wider structural review.	CEO	31.05.14	**17.04.14:** Initial decision to move Matrons to DN agreed with effect from 1st June. Further discussion with DN scheduled for annual appraisal, late May 2014	**COMPLETE**

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

				14.04.14: Discussion between DN and iHCA; Patient Stories to be proposed for Board meetings – will include feedback about staff. Specific patient feedback about staff to be included in Patient Experience report to Quality & Risk Committee; template for feedback from Q & R Committee to Board will include a specific prompt re: patient feedback. **31.05.14:** New standing item added to board agenda from June meeting onwards – all board members to feedback re: internal and external stakeholder engagement events / incidents, to include reference to staffing issues identified	
RECOMMENDATION 6.7: As part of a wider review of Trust governance systems, the interim Head of Corporate Affairs to consider how best we can incorporate behavioural and cultural concerns within our governance systems.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
6.7a	Interim Head of Corporate Affairs to develop proposals for inclusion into corporate and clinical governance systems	iHCA	31.08.14	**17.03.14:** As action 6.6a. Review of board agenda and reporting processes generally underway; proposals to be presented at workshop / meeting of the board on morning of April Board meeting for implementation at May meeting **09.05.14:** Revised template for Board reporting includes prompt to explain whether report contents disclose a benefit or threat to Key Strategic Objectives, including "Outstanding Patient Experience" and "Organisational Excellence". Template for feedback from Quality & Risk Committee to Board includes prompt to emphasise any behaviours / staff morale etc issues revealed by Q&R Committee discussions and reports	**COMPLETE**

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 6.8: Head of HR to review whether sufficient emphasis in management training and development is given to identifying and dealing with inappropriate behaviour by supervisory staff towards their team members which does not reflect the core values of the Trust.

Ref	Action	Who	When	Update	Status
6.8a	Supervision Policy to be reviewed and amended as required to include minimum standards for the conduct, recording and monitoring of supervision (1:1)	HHR	10.06.14	**12.05.14:** Completed, awaiting DN sign off **25.06.14:** Amended policy signed off by Learning & Development Strategy Group; awaiting sign off by Quality & Risk Committee at next meeting (August) ***04.09.14:*** *Policy signed off at Committee*	**COMPLETE**
6.8b	Management Development Programme and HR Best Practice sessions to be reviewed and strengthened in respect of supervision / 1:1 practice	HHR	31.07.14	**17.04.14**: Programme and programme content review commenced **25.06.14:** Amendments made. New Leadership Framework, which will include supervision issues, drafted and awaiting approval. Management Best Practice sessions will include the new Supervision Policy once signed off (see action 6.8a). ***04.09.14:*** *Supervision Policy now signed off and incorporated into Management Best Practice Sessions*	**COMPLETE**

NURSING STANDARDS

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

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

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 8.2: The DN to work with the matrons and other senior nursing staff to develop a clear set of QVH nursing standards and behaviours that can be incorporated into recruitment, appraisal and performance management.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
8.2a	Review existing Nursing Strategy to strengthen link to Trust Values and recruitment, appraisal and performance management processes	DN	17.04.14	**14.04.14:** DN and Dep DN have met to commence review. Existing Nursing Strategy circulated to Matrons for comment on specific enhancements which could be made to each key role. Competing priorities (particularly Quality Account, Annual Report) have delayed full completion of this task. **31.05.14:** Reviewed Nursing Strategy launched by Chief Nursing Officer for England during visit to trust on 7 May.	**COMPLETE**
8.2b	Review existing role / responsibility descriptors to strengthen link to Trust Values and recruitment, appraisal and performance management processes	DN	17.04.14	**14.04.14:** See update at 8.2a above **31.05.14:** Revised strategy now included in recruitment packs for relevant staff and on intranet.	**COMPLETE**
RECOMMENDATION 8.3: Monthly publication of staffing data. Making use of e-rostering and other workforce data to provide assurance to the Board, staff and patients as to the provision of safe and competent levels of staffing throughout the Trust.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
8.3a	E-rostering reporting system to be reviewed to ensure the data is clear, understandable and relevant to users and managers (consultation with managers required)	HHR	30.04.14	**17.04.14:** Review completed. Safe Staffing report coming to board in April 2014. Quality of data to remain under review	**COMPLETE**
8.3b	Implementation of Safer Care module of e-rostering system to be assessed and planned	HHR	31.05.14	**17.04.14:** Implementation currently under review, discussion with developers in hand. **25.06.14:** HHR awaiting sign-off of budget ***27.08.14:*** *Module has been ordered, awaiting implementation date from provider. Additional support for roll-out of e-rostering generally, including safer care, has been arranged.*	Overdue

8.3c	Training for managers on use of Safer Care module of e-rostering to be developed and delivery commenced	HHR	30.09.14	As 8.3b above	Delayed
8.3d	Safer Care data outputs to be incorporated into routine reporting	HHR	Per 8.3b time-table	As 8.3b above	On track
8.3e	Nursing establishment to be reviewed in line with NICE staffing recommendations	DN	30.09.14	**03.03.14:** Publication of recommendations not expected until July 2014. DN is part of NICE team developing the guidance. **14.04.14:** DN has produced report on Safe Staffing for April Board, introducing new metric required by DH re: monitoring and publication of staffing levels ***04.09.14:*** *NICE guidance published in July; self-assessment completed and RAG rated result presented to Quality & Risk Committee with action plan to deliver full compliance*	COMPLETE
8.3f	Next available nursing establishment / acuity report to board to reflect outcome of NICE staffing recommendations review	DN	31.01.15	***29.08.14:*** *Nursing Establishment / acuity report to be presented to January 2015 Board*	On track
RECOMMENDATION 8.4: Develop an action plan to reduce the use of agency staff – exact level to be recommended by the DN taking into account benchmarked data from similar organisations.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
8.4a	Review existing weekly process of prospective challenge with Matrons of all planned non-RMN agency staff to ensure effectiveness	DN	31.03.14	**03.03.14:** This process happens routinely at Site Practitioner Meetings **20.03.14:** Review completed – DN satisfied that challenge is robust and effective	COMPLETE
8.4b	Review existing process of retrospective weekly review / challenge with Matrons of all non-RMN agency staff used in previous week to ensure effectiveness	DN	31.03.14	**03.03.14:** This process happens routinely at Site Practitioner Meetings **20.03.14:** Review completed – DN satisfied that challenge is robust and effective	COMPLETE

8.4c	Review existing process of weekly update on non-RMN agency usage to Finance Director, matrons and CEO to ensure effective	DN	31.03.14	**03.03.14:** This report is emailed out weekly **20.03.14:** Review completed – DN satisfied that challenge is robust and effective	COMPLETE
8.4d	Recruit and induct 3 WTE RNs above establishment to allow for recruitment time-lag	DN	31.05.14	**03.03.14:** These posts are currently out to advert **14.04.14:** Recruitment into established post continuing as well as recruitment to supernumerary posts. Interviews conducted 11.04.14; two RNs recruited **31.05.14:** Specific action completed, but recruitment activity to be maintained to ensure small pool of supernumerary staff available to backfill etc and prevent the problems previously associated with staff taking leave during notice period and other staff shortages	COMPLETE
8.4e	Review policy and practice in respect of use of annual leave during notice periods	HHR	10.06.14	**25.06.14:** Progress unlikely before end of July ***28.08.14:*** *Negotiations on policy amendments continuing with staff side*	Overdue

PERFORMANCE MANAGEMENT

RECOMMENDATION 10.1: Review of existing systems of individual performance management; ensure that all managers are competent to performance manage staff and that action is taken promptly to manage underperformance.

Ref	Action	Who	When	Update	Status
10.1a	Metrics for monitoring Performance Management performance of managers to be developed	HHR	~~30.06.14~~ ~~31.10.14~~ 31.03.15	**17.04.14:** in progress **25.06.14:** performance management metrics being reviewed in line with new Operations etc structure. New metrics need to dovetail with new budget and operational control governance measures being implemented by interim DoF. SMT workshop to be held 10.07.14 will develop further.	On track for new date

				28.08.14 *Metric development dependent on new structure and linked to work on accountability agreements currently under development by DoF*	
10.1b	HR Best Practice sessions to be reviewed to ensure more robust focus on PM issues	HHR	30.04.14	**17.04.14:** Programme reviewed and emphasis on PM included	COMPLETE
10.1c	New appraisal system to be reviewed six months post-implementation to ensure PM elements effective	HHR	31.07.14	***28.08.14:*** *Review completed – system seems to work well despite teething troubles during transition form old to new systems.*	COMPLETE
RECOMMENDATION 10.2: Introduce 360 degree feed-back for all managers.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.2a	NHS Leadership Academy 360 degree appraisal model to be adapted for use by QVH	HHR	30.06.14	**17.04.14:** Review completed; model is appropriate as drafted	COMPLETE
10.2b	360 degree appraisal process to be implemented	HHR	31.10.14	**20.03.14:** contingent on results of pending management re-structure, anticipated complete by 31.07.14 **25.06.14:** to be included in new Leadership Framework currently under development. ***28.08.14:*** *New framework to be launched in October, already includes 360 degree appraisal processes.*	On track
RECOMMENDATION 10.3: Ensure all leavers are strongly encouraged to take up the opportunity of an exit interview.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.3a	System for ensuring that exit interview results are fed back to department managers and relevant senior manager effectively to be developed and implemented	HHR	31.05.14	**12.05.14:** system in place. Plan to review in 6 months	COMPLETE

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 10.4: Review existing systems of staff feedback, including more frequent use of staff survey. Review possible link to the national work on cultural surveys that is occurring.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.4a	~~Wellbeing & Culture Group to conduct review~~ Staff Family and Friends test to be implemented in June and reported to Board quarterly	HHR	30.06.14	~~**17.04.14:** Next W&C Group meeting end of May – review will be on agenda~~ **12.05.14:** Staff Family and Friends test to be reported to Board from June **25.06.14:** included in June Board papers	**COMPLETE**
10.4b	~~Results of W&C Group review to be developed into proposals~~ Use of local staff surveys to be increased	HHR	15.08.14	**12.05.14:** Plans for local surveys in train – to involve survey monkey and paper copies ***27.08.14**: Staff Family & Friends Test in regular circulation; national staff survey due to be circulated in Q2 so no further staff surveys planned.*	**COMPLETE**
RECOMMENDATION 10.5: Introduce a system of 'talent management' designed to identify existing and potential high performers as well as those with significant development needs.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.5a	Consider results of six month review of new appraisal system to assess effectiveness in talent management	HHR	31.07.14	***27.08.14:** Review completed. Talent management process incorporated into Leadership Framework to be launched by end of October*	**COMPLETE**
10.5b	Develop any further actions required post-review	HHR	15.09.14	See above	**COMPLETE**
RECOMMENDATION 10.6: Ensure that the Board is involved in the annual review of talent management for the top tier of trust leadership					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
10.6a	Annual Board seminar to review the Trust's senior level structure and to provide input/scrutiny into succession planning for the Board and Senior Management Team.	HHR	30.11.14	**17.04.14:** On board work plan **12.05.14:** Deputy Head of HR designated as Talent Management Lead	On track

				25.06.14: Series of SMT workshops on structures etc to take place over coming months. Outcomes will inform definitions and structures upon which talent management plans to be based ***29.08.14:*** *Structure decisions awaited*	
MANAGEMENT STRUCTURES					
RECOMMENDATION 12.1: Chief Executive, in discussion with the Director of Nursing, to review the line management of matrons, site practitioners and clinical nurse specialists.					
RECOMMENDATION 12.2: In light of recommendation 12.1, review the respective roles and responsibilities of both the Director and Deputy Director of Nursing.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
12.1/2a	Following on from discussions which have taken place proposals for a new structure to be developed and agreed	DN	31.03.14	**03.03.14:** CEO and DN have discussed Trust needs; draft proposals produced and awaiting further discussion with CEO **17.04.14:** Initial decision to move Matrons to DN agreed with effect from 1st June. Interim operational structure to be implemented with effect from 1st June.	**COMPLETE**
12.1/2b	Implementation plan for new structure to be produced, agreed and actioned	DN	31.07.14	**17.04.14:** Further discussion with DN scheduled for annual appraisal, May 2014. **31.05.14:** New nursing structure to commence 02.06.14	**COMPLETE**
RECOMMENDATION 12.3: Chief Executive to review operational management structures to ensure sufficient focus and resource provided to delivery of key performance and productivity targets					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
12.3a	Review to be undertaken and completed	CEO	30.04.14	**12.05.14:** Interim structure to take effect from 01 June 2014	**COMPLETE**

	~~Interim structure to be reviewed~~ Permanent re-structure to be delivered	CEO	~~30.09.14~~ 31.03.15	***12.09.14:*** *Initial proposals for the re-structure will be discussed by the Nominations and Remuneration Committee 25.09.14*	On track
EARLY WARNING SYSTEM					
RECOMMENDATION 14.1: Build on the work already started by the Head of Human Resources to establish an integrated scorecard (monthly) for C wing and other clinical areas that makes use of both the existing indicators and the outputs from e-rostering highlighted above. Integrating these reports will provide a much fuller picture of both the day to day management and the longer term trends which would provide an improved system of early warning.					
RECOMMENDATION 14.2: Develop a weekly 'flash report' to provide early warning of challenges to staffing levels relative to patient numbers and acuity and inappropriate use of temporary staffing.					
RECOMMENDATION 14.3: Chief Executive to charge the Head of Human Resources with taking responsibility for developing and monitoring relevant and timely early warning data.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
14.1/3a	Scorecard based on data and information arising from workforce planning and e-rostering to be developed and introduced	HHR	30.06.14	**17.04.14**: Report to Board in April on Safe Staffing and efficient use of resources. Link to Performance Team's early warning metrics under development; report to Board planned for May. **31.05.14:** Safe Staffing updates included on all board agendas from May onwards	**COMPLETE**
14.2/3a	Flash reporting based on scorecard described at 12.4a to be introduced	HHR	30.06.14	**25.06.14:** Safe staffing reports now appear regularly on trust web-site but need to include Safer staffing element of e-Rostering once implemented. Implementation delayed awaiting finance sign off. ***29.08.14****: As indicated at 8.3b, Safer Staffing module of e-rostering has been ordered; implementation date awaited from supplier*	Overdue

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 14.4: Head of Human Resources to provide a quarterly update to the Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system.

Ref	Action	Who	When	Update	Status
14.4a	First quarterly report to be presented	HHR	26.06.14	**17.04.14:** On Board work plan ***29.08.14:*** *As indicated at 8.3b, Safer Staffing module of e-rostering has been ordered; implementation date awaited from supplier. Additional support for the e-rostering team has been commissioned to address outstanding performance issues and to ensure effective implementation of the Safer Care module.*	Overdue

GOVERNANCE

RECOMMENDATION 16.1: Whilst we are confident about the effectiveness of both the Quality & Risk and Audit Committees it would seem appropriate, both in the light of the Francis, Keogh and Berwick reports, and in Monitor's growing focus on formal governance processes, to review our Board level governance structures. We understand that the interim Director of Corporate Affairs has been tasked with reviewing the Board systems of both corporate and clinical governance.

Ref	Action	Who	When	Update	Status
16.1a	Self-assessment based on Trust Development Authority's Board Governance Assurance Framework (BGAF) to be completed	iHCA	31.03.14	**20.03.14:** assessment 70% complete **17.04.14:** assessment complete	COMPLETE
16.1b	Action plan based on outcome of BGAF assessment to be developed	iHCA	18.04.14	**14.04.14:** Draft action plan in development; for discussion at Board seminar 24.04.14 **09.04.14:** Action plan complete – to be presented to Board for adoption 19.05.14	COMPLETE
16.1c	Board workshop on proposed changes to Board governance and reporting arrangements to be delivered	iHCA	24.04.14	**20.03.14:** Discussed with Chairman; board time scheduled **24.04.14:** Workshop delivered	COMPLETE

Trust action plan in response to Canadian Wing Investigation March 2014

RECOMMENDATION 16.2: Establish a monthly executive level Quality & Safety Committee to be chaired by the CE, and review and amend the remit of the existing directorate quality & risk committees and other committees dealing with quality, risk and safety issues to align governance structures and reporting across the Trust.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.2a	Review terms of reference of all relevant Committees	CEO	31.03.14	**17.04.14:** Meeting scheduled CE, MS and DN with interim Head of Corporate Affairs to agree terms of reference, 28.04.14 **12.05.14:** Report on Executive assurance structures on May Board agenda	**COMPLETE**
16.2b	Revise Committee terms of reference as required	CEO	02.05.14	As above 16.2a	**COMPLETE**
16.2c	Produce work programme for operational Quality & Safety Committee	iHCA	02.05.14	**14.04.14:** Initial discussions between DN, iHCA and HoR held 14.04.14. Meeting to discuss further booked for CEO, MD, DoN, iHCA on 28.04.14 **31.05.14:** Work programme completed; meetings to start from July	**COMPLETE**
16.2d	Implement new Committee and reporting arrangements; commence workplan	iHCA	30.05.14	As above 16.2 a **31.05.14:** New Committee to begin meeting from July onwards ***29.08.14:*** *New Committee now meeting monthly*	**COMPLETE**
16.2e	Review effectiveness of new Committee arrangements	CEO	30.11.14	***12.09.14:*** *new committee has met three times; procedures settling in. Review on track for November.*	On track
RECOMMENDATION 16.3: Trend analysis to be included in monthly reporting to the Executive Quality & Safety Committee.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.3a	Report template to be produced	HoR	30.04.14	**25.06.14:** Report requirements not notified top HoR until June. Template creation underway. ***29.08.14:*** *Reports now submitted to Committee on monthly basis*	**COMPLETE**

16.3b	Trend reporting to begin	HoR	30.05.14	**25.06.14:** Committee to begin meeting July ***29.08.14:*** *New Committee now meeting monthly*	**COMPLETE**
RECOMMENDATION 16.4: Executive Quality & Safety Committee to define trend reporting requirements to be provided by the Risk Team.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.4a	Trend reporting requirements to be identified and notified to Head of Risk	CEO	11.04.14	**17.04.14:** to form part of discussion CEO, DN, MD, iHCA 28.04.14 **12.05.14:** DN producing workplan for end of May **31.05.14:** Work programme completed; meetings to start from July	**COMPLETE**
RECOMMENDATION 16.5: Quality & Safety Committee to review the Trust risk registers to ensure it is a 'live document' with risks appropriately identified, graded and escalated. To agree a unified approach for the different registers.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.5a	Risk management process to be reviewed by iHCA, DN, HoR	DN	15.04.14	**14.04.14:** iHCA, DN and HoR met 14.04.14 for discussion re: process. iHCA and HoR to meet again to review format. Revisions to process to be discussed as part of Board workshop on Board reporting, agenda etc 24.04.17	**COMPLETE**
RECOMMENDATION 16.6: Monitoring of incidents, including follow up on action plans to be included in monthly agendas for Quality & Safety Committee.					
Ref	**Action**	**Who**	**When**	**Update**	**Status**
16.6a	Allocation of responsibility for incident and action plan monitoring to be reviewed and if required changed	iHCA	30.04.14	**14.04.14:** Discussed by HoR, DN and iHCA – agreement reached. Action Plan owner formally to be designated as key collater of information and responsible for escalating delay to monitoring individual / committee. Incident reports and action plans to be reviewed bi-monthly by Quality & Risk Committee.	**COMPLETE**

Trust action plan in response to Canadian Wing Investigation March 2014

WHISTLEBLOWING

RECOMMENDATION 18.1: It is proposed that the whistle blowing policy is reviewed with the intention of giving greater clarity to staff as to when it is justified to be invoked and therefore when they can expect to receive the protection of anonymity; and also to cover the process to be followed after the whistleblowing occurs.

RECOMMENDATION 18.2: Whenever a response to a whistleblowing incident is required, the response team should be chaired by someone who is independent of the incident concerned. Exactly who this is will depend on the scale and scope of the incident concerned but it could include the Chief Executive, Executive Director or a Non-Executive Director.

RECOMMENDATION 18.3: The initial terms of reference should be signed off by the Chair of the response team with the remit to amend the terms of reference in the light of emerging evidence.

RECOMMENDATION 18.4: Any response should have three parts;
1. Immediate action to be taken to protect staff and patients as appropriate.
2. An initial report to determine the facts and recommend any follow up action directly connected to these events.
3. An examination of any broader lessons to be learned and recommendations on addressing these. The timescale for parts two and three should be determined by the Chair of the response team.

RECOMMENDATION 18.5: Depending on the likely scale of the enquiry, communication should be managed by the Chief Executive, Director of Nursing and Medical Director to ensure that both internal and external stakeholders are managed effectively.

Ref	Action	Who	When	Update	Status
18.1-5a	Whistleblowing Policy to be reviewed and recommendations 18.1 – 18.5 incorporated	HHR	31.07.14	**17.04.14:** Initial discussions with Staff Side held at JCNC early April **12.05.14:** Dep HHR in discussions with Counter Fraud re: their role. Policy to go to next JCNC meeting. ***27.08.14**: Policy agreed and approved with recommended changes. NB – Audit Committee to consider Whistleblowing arrangements during Q3*	**COMPLETE**

Trust action plan in response to Canadian Wing Investigation March 2014

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

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	Thursday 25th September 2014
Reference number:	240-14
Report from:	Stuart Butt, Interim Director of Finance and Commerce
Author:	Stuart Butt, Interim Director of Finance and Commerce
Report date:	Wednesday 17th September
Appendices:	Standing Financial Instructions, Standing Orders and Scheme of Delegation

Approval of Standing Financial Instructions, Standing Orders and Scheme of Delegation

Key issues

1. In accordance with the review of our policies the Standing Financial Instructions, Standing Orders and Scheme of Delegation have been reviewed.
2. The key amendments reflect the changes required to ensure the Scheme of Delegation reflects responsibilities, approval limits and roles following some changes to the structure earlier in the year.
3. The narrative has been subject to minimal changes other than to ensure consistency with the delegated approval limits.
4. The documents were reviewed by the Audit Committee on 17th September and recommended for approval to the Board subject to the changes identified below.

Proposed Changes

5. Page 38 Regulation and Control - to clarify the potential for a conflict of interest and ensure consistency with existing declaration of interest processes
6. Page 23 s8.13 - to consider including controls on the management and handling of 'donations' within charitable funds section.
7. Appendix D s27 - to amend the retention of patient materials to ensure reference is linked to NHS Retention Policy.
8. SOs Page 6 Council of Governors 1.13 - to provide additional clarity around the term 'significant transaction' i.e. what constitutes a significant transaction.
9. Page 26 – 9.7.1.i - To ensure that accountability reflects where CEO may be the post being replaced/recruited to.
10. To review and amend contents page and page numbering for consistency.

Action required

11. To review and discuss with a view to formal adoption of the policies.

Link to Key Strategic Objectives (delete those not applicable)

- Financial sustainability
- Operational Excellence

Implications for BAF or Corporate Risk Register

12. None.

Recommendation

13. The Board is recommended **to approve** the Standing Financial Instructions, Standing Orders and Scheme of Delegation subject to the proposed amendments.

Queen Victoria Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

FOR

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

Approved by Trust Board

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1. INTRODUCTION

1.1 Purpose

1.1.1 These Standing Financial Instructions (SFI's) are issued for the regulation of the conduct of the Trust, its Directors, officers and agents in relation to all financial matters. They shall have effect as if incorporated into the Trust's Standing Orders.

1.1.2 They explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy, the Department of Health guidelines and policies laid down by the Independent Regulator (Monitor) of foundation trusts and best practice. This is in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources.

1.1.3 They identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with any detailed department or financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFI's then the advice of Director of Finance must be sought before acting. The user of these SFI's should also be familiar with and comply with the provisions of the Trust's Standing Orders. Non-compliance with the SFI's is a disciplinary offence.

1.2 Interpretation and Definitions

1.2.1 Interpretation and definitions are as those within Standing Orders section B.

1.2.2 Wherever the title Chief Executive, Director or other nominated officer is used in these Instructions, this will include other officers who have been duly authorised to represent them.

1.2.3 References in these Instructions to 'officer' shall be deemed to include all employees of the Trust including any contractors/consultants.

2 RESPONSIBILITIES AND DELEGATION

2.1 Principles

2.1.1 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Schemes of Delegation. It has also resolved that the Board may only exercise certain powers and decisions in formal session. These are set out in the Reservations of Powers to the Board document.

2.1.2 Those aside, all powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant officers. The Chief Executive

and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.1.3 The Schemes of Delegation are a collection of schedules setting out various powers of authority by post holder. Separate schedules are to be retained by Directors setting out powers they have themselves delegated to identified post holders within their own organisational control. A full record of each scheme of delegation must be retained, with evidence of proper authorisation, and must be kept current. Copies shall be passed to the Director of Finance to enable a record to be kept of all schemes of delegation.

2.2 Chief Executive

2.2.1 Within the SFI's it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accounting Officer of the Trust and as such is accountable to Parliament through the Regulator, for all actions undertaken by the Trust

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2.3 Director of Finance

2.3.1 The Director of Finance is responsible for all financial matters. They are required to:

(a) implement the Trust's financial policies
(b) ensure that detailed financial procedures and systems are established
(c) ensure that sufficient records are maintained to show and explain the Trust's transactions in order to disclose the financial position of the Trust at any time.

2.3.2 The Director of Finance shall:

(a) prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these Instructions.
(b) Require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges their duties shall be to the satisfaction of the Director of Finance.
(c) develop, maintain and monitor detailed policies, procedures and instructions covering all aspects of the security of money, assets and other Trust resources.

2.4 Corporate Responsibilities of all Trust Officers

2.4.1 All Trust officers are severally and collectively responsible for:

(a) the security of the property of the Trust
(b) avoiding loss

(c) exercising economy and efficiency in the use of resources
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures, Scheme of Delegation and the Reservations of Powers to the Board document as well as all hospital policies and procedures.

2.5 **Schemes of Delegation**

2.5.1 The principles of the Schemes of Delegation are as follows:

i. No financial or approval powers can be delegated to an officer in excess of the powers invested in the delegating officer
ii. Powers may only be delegated to officers within the organisational control of the delegating officer
iii. All delegated powers must remain within the financial and approval limits set out in the Schemes of Delegation
iv. All powers of delegation must be provided in writing, duly authorised by the delegating officer. Any variations to such delegated powers must also be in writing.
v. All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating officer, prior to the period for which approval is sought
vi. Any officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate written powers, before any financial commitments are made in respect of the transaction
vii. A power is delegated on condition that it cannot be further delegated. Where this is not the case, the extent of the authority to delegate onwards must be stated in writing by the initial delegator, and details also provided in writing to the Director of Finance.

2.5.2 Failure to comply with these principles will be recognised as a disciplinary offence. Where such a breach results in clear financial loss, the officer may be personally liable to compensate the Trust.

2.5.3 The Reservation of Powers to the Board and the main scheme of delegation are attached to the Standing Financial Instructions (Appendix A). The lower level Schemes must be maintained by each Directorate and copies provided to the Director of Finance.

3. AUDIT

3.1 **References**

The Board of Directors shall establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors. The Regulator's publications *Audit Code for NHS Foundation Trusts* and the *Guide for Governors: Audit Code for NHS Foundation Trusts* give further guidance. (Code of Governance F3)

3.2 **Audit Committee**

In accordance with Standing Orders and the Regulator's Code of Governance, the Board of Directors shall formally establish an Audit

Committee with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

i) overseeing internal and external audit services (including agreeing both audit plans and monitoring progress against them)
ii) receiving reports from the internal and external auditors (including the External Auditor's Management Letter) and considering the management response.
iii) monitoring compliance with Standing Orders and Standing Financial Instructions.

3.2.2 The terms of reference for the Audit Committee shall be considered as forming part of these Standing Financial Instructions.

3.2.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors.

3.3 Internal Audit

3.3.1 Internal Audit will review, appraise and report on:

i) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
ii) the adequacy and application of financial and other related management controls
iii) the suitability of financial and other related management data
iv) the extent to which the Trust's assets and interests are accounted for and safeguarded for loss of any kind, arising from:

a. fraud and other offences
b. waste, extravagance, inefficient administration
c. poor value for money or other causes

3.3.2 The Director of Finance is responsible for:

i) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function
ii) ensuring that the internal audit is adequate and meets the mandatory audit standards
iii) deciding at what stage to involve the police in cases of misappropriation and other irregularities
iv) ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors covering:

a. progress against plan over the previous year
b. major internal financial control weaknesses discovered
c. progress on the implementation of internal audit recommendations
d. strategic audit plan covering the next three years
e. a detailed plan for the coming year

3.3.3 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

i) access to all records, documents and correspondence relating to any financial or other relevant transaction, including documents of a confidential nature. This includes work diaries
ii) access at all reasonable times to any land, premises or officer of the Trust
iii) the production of any cash, stores or other property of the Trust under an officer's control
iv) explanations concerning any matter under investigation

3.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

3.3.5 An Internal Audit representative will attend Audit Committee meetings and have a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

3.3.6 The Head of Internal Audit will be accountable to the Director of Finance.

3.4 External Audit

3.4.1 The Trust is to have an External Auditor appointed (or removed) by the Board of Governors.

3.4.2 The Auditor shall be provided every facility and all information which they may reasonably require for the purposes of their functions under Part 1 of the Health and Social Care (Community Health and Standards) Act 2003, consolidated into the NHS Act 2006, and to comply with the FT Audit Code.

3.4.3 The Auditor is to carry out his duties in accordance with any directions given by the Regulator (Monitor) on standards, procedures and techniques to be adopted.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and the Director of Finance shall monitor and ensure compliance with guidance and directions on Fraud and Corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist, as specified by the NHS Fraud and Corruption Manual and Guidance, who shall report to the Director of Finance.

3.6 Staff Expenses

3.6.1 The Director of Finance shall be responsible for establishing procedures for the management of expense claims submitted by Trust officers on forms approved by the Director of Finance. The Director of Finance shall arrange for duly approved expense claims to be processed locally or via the Trust

Payroll provider. Expense claims shall be authorised in accordance with the Schemes of Delegation.

3.6.2 Expenses should be claimed monthly. Any claims older than three months will not be paid unless approval is obtained from the Director of Finance.

3.7 Acceptance of Gifts, Hospitality and Sponsorship by Staff

3.7.1 The Director of Finance shall ensure that all staff are made aware of the Trust's policy on the acceptance of Gifts, Hospitality and Sponsorship, which should follow the Standards of Business Conduct and Code of Behaviour Policy, and any additional rules that the Trust may hold or adopt in respect of preventing corruption and complying with the Bribery Act 2010.

3.7.2 All staff will be responsible for notifying the Head of Corporate Affairs who will record in writing, any gift, hospitality or sponsorship accepted (or refused) by staff on behalf of the Trust.

3.7.3 Any offers for gifts, hospitality or sponsorship that do not comply with the policy, should be courteously but firmly refused and the firm or individual notified of the Trust's procedures and standards.

3.8 Overriding Standing Financial Instructions

3.8.1 If, for any reason, these SFIs are not complied with, full details of the non-compliance, any justification for non compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for action or ratification.

3.8.2 All members of the Board and officers have a duty to disclose any non-compliance with the SFIs to the Director of Finance as soon as possible

4. ANNUAL PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

4.1 Annual Business Planning

4.1.1 The Chief Executive, with the assistance of the Director of Finance, shall compile and submit to the Board of Directors and the Regulator, strategic and operational plans in accordance with the guidance issued about timing and the Trust's financial duties within the Regulator's Compliance Framework. The operational plan shall be reconcilable to regular updates of the financial proformas, which the Director of Finance will prepare and submit to the Board of Directors and the Regulator.

4.1.2 The Director of Finance will report to the Board of Directors any significant in-year variance from the Annual Plan and to advise the Board of Directors on the action to be taken.

4.1.3 The Director of Finance will also be required to compile and submit to the Board of Directors such financial estimates and forecasts, both revenue and capital, as may be required from time to time.

4.1.4 Officers shall provide the Director of Finance with all financial, statistical and other relevant information as necessary for the compilation of such business planning, estimates and forecasts.

4.2 **Budgets, Budgetary Control and Monitoring**

4.2.1 The Director of Finance shall, in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for its approval.

4.2.2 Budgets will be in accordance with the aims and objectives set out in the Trust's Annual Plan.

4.2.3 The Director of Finance will devise and maintain systems of budgetary control incorporating the reporting of, and investigation into, financial, activity or workforce variances from budget. All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems.

4.2.4 The Director of Finance shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.5 The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Schemes of Delegation shall include a clear definition of individual and group responsibilities for control of expenditure. In carrying out those duties, the Chief Executive shall not exceed the budgetary limits set by the Board of Directors, and officers shall not exceed the budgetary limits set them by the Chief Executive.

4.2.6 Any funds not required for their designated purpose shall revert to the immediate control of the Chief Executive

4.2.7 Expenditure for which no provision has been made in an approved budget and which is not subject to funding under the delegated powers of virement, shall only be incurred after authorisation by the Chief Executive or the Board of Directors as appropriate.

4.2.8 The Director of Finance shall keep the Chief Executive and Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

5. ANNUAL ACCOUNTS AND REPORTS

5.1 The Director of Finance will prepare financial returns in accordance with the guidance given by the Regulator, the Financial Reporting Manual (FReM) and the Treasury, the Trust's accounting policies and generally accepted accounting principles.

5.2 The Director of Finance will prepare annual accounts which must be certified by the Chief Executive or the Director of Finance. The Director of

Finance will submit them, and any report of auditor on them, to the Regulator and arrange for them to be laid before Parliament.

5.3 The Trust's annual accounts must be audited by an auditor appointed by the Board of Governors in accordance with the appointment process set out in the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Regulator.

5.4 The Trust will publish an Annual Report, in accordance with guidelines on local accountability and present it at a public meeting of the Board of Governors. The document will include the Audited Annual Accounts of the Trust.

5.5 The Annual Report will be laid before Parliament, with the annual accounts.

6. BANK ACCOUNTS

6.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the Regulator. The Board of Directors shall approve the banking arrangements.

6.2 The Director of Finance is responsible for all bank accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

6.3 The Director of Finance is responsible for ensuring payments from commercial banks or Government Banking Service accounts do not exceed the amount credited to the account except where arrangements have been made. Further they must report to the Board of Directors all arrangements with the Trust's bankers for accounts to be overdrawn.

6.4 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include the conditions under which each bank account is to be operated, the limit to be applied to any overdraft and those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.5 The Director of Finance must advise the Trust's bankers in writing of the condition under which each account will be operated.

6.6 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7. INCOME, FEES, SECURITY OF CASH, CHEQUES AND CREDIT CARDS

7.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including income from other NHS bodies. The Director of Finance is also responsible for the prompt banking of all monies received.

7.1.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.1.3 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance must be provided with a copy of all contracts, leases, tenancy agreements or any other type of financial contract.

7.1.4 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with losses procedures.

7.1.5 The Director of Finance is responsible for approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

7.1.6 The Director of Finance is responsible for the provision of adequate facilities and systems for officers whose duties including collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

7.1.7 The Director of Finance is responsible for prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.1.8 Official money shall not under any circumstances be used for the encashment of private cheques or I.O.U's.

7.1.9 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.1.10 The holders of safe keys shall not accept unofficial funds for depositing in their safe unless such deposits are in sealed envelopes (signed and dated across the seal) or lockable containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.2 **Money Laundering**

7.2.1 Under no circumstances will the Trust accept cash payments in excess of £1,000 or the equivalent in any other currency, in respect of any single transaction. Any attempts by an individual to effect payment above this amount should be notified immediately to the Director of Finance.

8. CONTRACTS, TENDERS AND HEALTHCARE SERVICE AGREEMENTS

8.1 Principles

8.1.1 The instructions in this section concern purchasing decisions for goods and services required where the Trust needs to enter formal tendering and contractual arrangements

8.1.2 The Director of Finance shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with EU rules on procurement.

8.1.3 The Director of Finance shall be responsible for establishing procedures to ensure that competitive quotations and tenders are invited for the supply of goods and services under contractual arrangements.

8.1.4 The Director of Finance shall ensure that a register is established and maintained by the Head of Corporate Affairs of all formal tenders.

8.1.5 EU directives governing procurement shall have effect as if incorporated into these SFIs.

8.1.6 The Trust should have policies and procedures in place for the control of all tendering activity.

8.2 Formal Competitive Tendering

8.2.1 The Director of Finance shall be responsible for establishing procedures to carry out financial appraisals, and shall instruct the appropriate requisitioning office to provide evidence of technical competence.

8.2.2 The Trust shall ensure that competitive tenders are invited for:

i) the supply of goods, materials and manufactured articles
ii) the rendering of services including all forms of management consultancy services
iii) for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens)
iv) for disposals

8.2.3 Formal tendering procedures need not be applied where:

i) the estimated expenditure or income does not, or is not reasonably expected to exceed £25,000
ii) nationally agreed NHS contract exists
iii) contracts negotiated by the NHS Commercial Solutions and/or the Government Procurement Service (GPS) exist
iv) disposals as set out in SFI numbers 8.11 and 14 are concerned.

8.2.4 Formal tendering procedures **may be waived** in the following circumstances, although approval is not to be regarded as automatic and each case shall be treated on its own merit. It is allowable for waivers to be agreed electronically in line with authorisation limits:

i) in very exceptional circumstances and subject to legal requirements where the Chief Executive and Director of Finance decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record

ii) where the requirement is covered by an existing contract

iii) where NHS Commercial Solutions or GPS agreements are in place.

iv) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of consortium members

v) where the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not regarded as a justification for a single tender

vi) where specialist expertise is required and is available from only one source

viii) there is a clear demonstrable benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering

ix) for the provision of legal advice in relation to the obtaining of Counsel's opinion.

8.2.5 The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work;

8.2.6 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

8.2.7 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented in an appropriate Trust record and reported to the Audit Committee at each meeting.

8.2.8 Competitive Tendering cannot be waived for building and engineering construction works and maintenance

8.2.9 Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record. If these items exceed the EU thresholds and the value is materially in excess of these limits (i.e. 10%)

then the items would need to be re-tendered through OJEU and such action formally recorded in the Tender Register.

8.3 **Health Care Services**

8.3.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Contracts with other Foundation Trusts', being Public Benefit Corporations, are legally binding and are enforceable in law.

8.3.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors.

8.3.3 Where the Trust elects to invite tenders for the supply of healthcare services these SFI's shall apply as far as they are applicable to the tendering procedure.

8.4 **Contracting/Tendering Procedure**

8.4.1 **Invitation to Tender**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) it is submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "Tender" followed by the subject to which it relates) and the latest date and time for the receipt such tender addressed to the Chief Executive or nominated officer.

(b) tenders submitted by e-mail must have the subject to which it relates in the e-mail title and be sent to the Chief Executive or nominated officer. The tender document must not be opened but the date and time of receipt should be notated. An e-mail receipt should be sent and a copy printed for the record showing the date and time received.

(d) the tender envelopes/packages shall are free from any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or any receipt so required by the deliverer.

(iii) Every tender for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of Environment (GC/Wks), or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the

Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors.

8.4.2 **Receipt and safe custody of tenders**

8.4.2.1 The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

8.4.2.2 The date and time of receipt of each tender shall be endorsed on the tender envelope/ package (or noted in the e-mail receipt; a copy of which shall be printed and retained see 8.4.1 ii) b) above).

8.4.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior managers designated by the Chief Executive (e-mail tenders shall be opened and printed).

(ii) A member of the Board of Directors will be required to be one of the two approved persons present for the opening of tenders. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Schemes of Delegation.

(iii) The 'originating' department will be taken to mean the department sponsoring or commissioning the tender.

(iv) The involvement of the finance department staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved senior manager from the finance department from serving as one of the two senior managers to open tenders.

(v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Head of Corporate Affairs (acting as Secretary to the Trust) will count as a director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening (including e-mail tenders).

(vii) Opening of E-tenders
Access to the Delta system is restricted to appropriate Trust approved officers with password controlled access.

Tender documents are uploaded into the secure, auditable system, and a time and date for submitting documents is set which enables tenders to be submitted electronically at the specified time. .

Supplier communications can be made using the e-mail facility located within the E-tendering system to allow full transparency of correspondence.

It is not possible to access tender details prior to the system set specified date and time of opening. This preserves the security of unopened tenders.

Once the tender submission closing date and time has elapsed access to the tender box is closed to suppliers. Suppliers cannot upload documents after the closing time.

Access to tender information at opening is restricted to authorised officers.

The tender opening record should be completed as per the conventional method,

A complete view of the activity of the tender process is available electronically.

A copy of all the original downloaded files is held by Delta and is available on secure CD if required for audit purposes.

In the event that both electronic and conventional tenders are returned at the designated time of opening then the procedures set out above must be adhered to dependent on the return format. Tenders will be annotated on the opening record to identify the tender return method.

The opening record shall be retained with the tender documents as per the conventional method.

Tenderers will be notified of the successful tender as per best practice and a Contract Award Notice (EU tenders only) will be submitted using the e-tendering system.

(viii) A register shall be maintained by the Chief Executive or a person authorised by him/her, to show for each set of competitive tender invitations despatched:

a. the name of all firms/individuals invited;
b. the names of firms/individuals from which tenders have been received;
c. the date the tenders were opened;
d. the price shown on each tender; a note where price alterations have been made on the tender.
e. fitness for purpose (quality)
f. delivery and availability (against price)
g. whole life costs or the cost of ownership (maintenance/running costs)
h. on cost (storage and transport)
i. the cost of procurement itself (the time spent on the purchase, invoicing etc)

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders should be dealt with in the same way as late tenders.

8.4.4 **Admissibility**

8.4.4.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive

8.4.4.2 Where only one tender is sought and/or received the Chief Executive and Director of Finance shall, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

8.4.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, will not be accepted. However, they may be considered if the Chief Executive or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

8.4.6 **Acceptance of formal tenders**

(i) Any discussion with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender.

(ii) The most economically advantageous tender, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in the contract file, or other appropriate record.

It is accepted that the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a. experience
b. understanding of client's needs
c. feasibility and credibility of proposed approach
d. ability to complete the project on time
e. quality

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reasons(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the written authorisation of the Chief Executive with quarterly report to the Audit Committee.

(iv) The use of these procedures must demonstrate that the award of the contract was:

a. not in excess of the going market rate/price current at the time the contract was awarded
b. that best value for money was achieved

8.5 **Tender reports to the Board of Directors**

8.5.1 Reports to the Board of Directors will be made on an exceptional circumstances basis only.

8.6 **Statutory Compliance**

(ii) Any firm engaged to provide goods or services to the Trust shall ensure that when engaging, training, promoting or dismissing officers or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay and Equality Act 2010, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944, Disability Discrimination Act 1995 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide the appropriate manager with a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

8.7 **Financial Standing and Technical Competence of Contractors**

8.7.1 The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

8.9 **Quotations: Competitive and non-competitive**

8.9.1 **General position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceeding £25,000.

8.9.2 **Competitive Quotations**

(i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing or e-mail

(iii) All quotations should be treated as confidential and should be retained for inspection and attached to the order for the goods or services.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money and the reasons why should be recorded in a Record of Quotations.

(v) The Procurement and Supplies department should maintain a record of quotations.

8.9.3 **Non-Competitive Quotations for less than £10K**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) The supply of proprietary or other goods of a special character and in the rendering of services of a special character, for which it is not, in the opinion of the Procurement & Supplies department, possible or desirable to obtain competitive quotations.

(ii) The supply of goods or manufactured articles of any kind which are required as a matter of urgency and are not obtainable under existing contracts.

(iii) Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI ((i) & (ii) above) apply.

8.9.4 **Authorisation of Tenders and Competitive Quotations**

Providing all the conditions and circumstances set out in these SFI's have been fully complied with, formal authorisation and awarding of a contract may to be decided by the following officers:

Board of Directors
Chief Executive
Director of Finance
Designated budget holders

The levels of authorisation are in the Schemes of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in the minutes.

8.9.5 **Instances where formal competitive tendering or competitive quotation are not required**

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) The Trust shall use the NHS Supply Chain, NHS Commercial Solutions or GPS agreed contracts for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate or better value for money can be obtained elsewhere. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain, NHS Commercial Solutions or GPS contracts where tenders or quotations are not required, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

8.9.6 **Private Finance Initiative (PFI) funding**

When the Board of Directors wish to use PFI the following should apply:

(a) The Chief Executive shall demonstrate that the use of PFI represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors.

(c) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

8.9.7 **Compliance requirements for all contracts**

The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions.

(b) EU directives and other Statutory provisions.

(c) Contracts with NHS Foundation trusts must be in a form compliant with appropriate NHS guidance.

(d) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(e) In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in

place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.10 **Personnel and Agency or Temporary Staff Contracts**

8.10.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

8.11 **Disposals (see overlap with SFI 8.3.4)**

Competitive tendering or quotations procedures shall not apply to the disposal of:

- any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined, or pre-determined in a reserve, by the Chief Executive or their nominated officer;
- obsolete or condemned articles, which may be disposed of in accordance with the supplies policy of the Trust;
- items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;
- items arising from works of construction, demolition or site clearance, which should be deal with in accordance with the relevant contract.

8.12 **In-house Services**

8.12.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in- house services should be market tested by competitive tendering.

8.12.2 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- Specification group, comprising the Chief Executive or nominated officer/s and specialist.
- In-house tender group, comprising a nominee of the Chief Executive and technical support.
- Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative.

8.12.3 All groups should work independently of each other and individual officers may be members of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

8.12.4 The evaluation team shall make recommendations to the Board of Directors.

8.12.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.13 **Applicability of SFIs on tendering and Contracting for funds held on trust including Charitable Funds**

8.13.1 These Instructions shall not only apply to expenditure of revenue funds but also to works, services and goods purchased from the Charitable Funds or any funds held on trust.

9. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

9.1 Nomination and Remuneration Committee

9.1.1 In accordance with Standing Orders and the Code of Governance, the Board of Directors shall establish a Nomination and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

9.1.2 The Terms of Reference shall be considered as forming part of these Standing Financial Instructions.

9.2 Funded Establishment

9.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive in consultation with the Director of Finance.

9.3 Contracts of Employment

9.3.1 The Board of Directors shall delegate responsibility to an officer for:

a) ensuring that all officers are issued with a Contract for Employment in a form approved by the Board of Directors and which complies with employment legislation

b) dealing with variations to, or termination of, contracts of employment

9.4 Payroll

9.4.1 The Director of Finance shall make arrangements for the provision of payroll services to the Trust to ensure the accurate determination of any entitlement and to enable prompt and accurate payment to officers.

9.4.2 The Director of Finance in conjunction with the Head of Human Resources shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submissions of payroll data to support the determination of pay including where appropriate, timetables and specifications for submission of properly authorised notification of new officers, leavers and amendments to standing pay data and terminations.

9.4.3 The Director of Finance is responsible for ensuring that instructions for the following exist, whether the payroll is provided in-house or externally:

i) specifying timetables for submission of properly authorised time records and other notifications
ii) the final determination of pay and allowances
iii) making payment on agreed dates
iv) agreeing method of payment

9.4.4 The Director of Finance will issue instructions regarding:

i) verification and documentation of data
ii) the timetable for payment of officers and allowances
iii) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay
iv) security and confidentiality of payroll information
v) checks to be applied to the completed payroll before and after payment
vi) authority to release payroll data under the provisions of the Data Protection Act
vii) procedures for payment by bank credit or cheque to officers. It is expected that all staff will be paid by bank credit
viii) procedures for the recall of cheques and bank credits
ix) pay advances and their recovery
x) maintenance of regular and independent reconciliation of payroll control accounts
xi) separation of duties for preparing records and handling cash
xii) a system to ensure the recovery of sums of money and property from those leaving the employment of the Trust

9.4.5 Appropriately nominated managers must have delegated responsibility for:

i) submitting correctly completed and authorised time records and other notifications in accordance with agreed timetables
ii) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance
iii) submitting termination forms in the prescribed form immediately upon knowing the effective date of an officer's resignation, termination or retirement. Where an officer fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance or nominated officer must be informed immediately.

9.4.6 Regardless of the arrangements for providing the payroll service the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 **Advances of Pay**

9.5.1 Advances of pay will only be made in exceptional circumstances subject to the approval of one of the following: Director of Finance, Deputy Director of Finance, Financial Services Manager, Head of HR, Deputy Head of HR.

9.6 **Loans**

9.6.1 The Trust will only extend loans towards the cost of approved training, education and season tickets.

9.6.2 The Director of Finance in conjunction with the Head of Human Resources will prepare detailed procedural instructions.

9.6.3 The Director of Finance will issue detailed procedures covering payments to staff.

9.7 Staff Appointments

9.7.1 No member of the Board of Directors or officer may engage, re-engage or re-grade officers, either on a permanent or temporary nature or hire agency staff, or agree to changes in any aspect of remuneration:

i) unless authorised to do so by the Chief Executive
ii) within the limit of their approved budget and funded establishment
iii) grading and re-grading of posts shall be in line with current Agenda for Change procedures.

9.7.2 The Board of Directors will approve procedures presented by the Chief Executive or nominated officer for the determination of commencing pay rates, conditions of service etc for officers.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services
b) the financial limits for requisitions and the system for authorisation above that level

10.1.3 The advice of the Procurement and Supplies department shall be sought before seeking alternative professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied or the service to be performed, shall always obtain best value for money for the Trust. In so doing, the advice of the Trust's Procurement & Supplies Department shall be sought. If the requisition is for a medical device then approval must be obtained from the Medical Devices Committee before an order can be placed.

Payment of contract invoices shall be in accordance with contract terms. The Director of Finance must be provided with a copy of all contracts and Service Level Agreements.

10.2.2 The Director of Finance will:

i) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds should be reviewed annually.

ii) prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services

iii) be responsible for the prompt payment of all properly authorised accounts and claims

iv) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

a) certification that:

- goods/services have been duly received, examined and are in accordance with specification and the prices are correct
- work done or services rendered have been satisfactorily carried out in accordance with the order and, where applicable, the materials used are of the requisite standard and the charges are correct
- in the case of contracts based on the measurement of time, materials or expense, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, price and the charges for the use of vehicles, plant and machinery have been examined
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
- the account is arithmetically correct
- the account is in order for payment

b) a system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

c) a list of officers, including specimens of their signatures, authorised to certify any type of payment. It is the responsibility of budget holders to inform the Director of Finance of changes to authorised officers

d) instructions to officers regarding the handling and payment of accounts within the finance department

e) the delegation of responsibility for ensuring that payment for goods and services is only made once the goods/services are received, except where 10.2.4 below applies

f) all invoices must be addressed to the financial services department and not to individual officers, wards or departments. Under no circumstances will invoices be paid on behalf of third parties.

10.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

i) the financial advantages must outweigh the disadvantages i.e. cash flows must be discounted to Net Present Value (NPV)
ii) the appropriate director must provide in the form of a written report, a case setting out all the relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement, unable to meet their commitments
iii) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed
iv) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the Director of Finance if problems are encountered

10.2.5 Official orders must:

i) be consecutively numbered
ii) be in a form approved by the Director of Finance
iii) state the Trust's terms and conditions of trade
iv) only be issued to, and used by, those duly authorised by the Chief Executive

10.2.6 officers must comply fully with the procedures and limits specified by the Director of Finance, ensuring that:

i) all contracts, leases, tenancy agreements and any other commitments which may result in a liability are notified and a copy sent to the Director of Finance in advance of any commitment being made
ii) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement
iii) where consultancy advice is being obtained, the procurement of such advice must be in accordance with best practice, for example as set out in *The Procurement and Management of Consultants within the NHS*
iv) no order shall be issued for any item or items to any firm that has made an offer of gifts, reward or benefit to Directors or officers, other than:

a) isolated gifts of a trivial nature or inexpensive seasonal gifts, such as calendars
b) conventional hospitality, such as lunches in the course of working visits

v) no requisition/order (including the use of purchasing cards) is placed for any item/service for which there is no budget provision unless authorised by the Director of Finance

vi) the Director of Finance shall determine that no goods, services or works, including works and services executed in accordance with a contract and those items listed below, shall be ordered except on an official order, raised following receipt by the purchasing and supplies office of a properly authorised requisition, either paper or electronic and contractors/suppliers shall be notified that they should not accept orders unless on an official order form.

a. Agency staffing services
b. Contract taxi services
c. Courses, conferences and lecture fees if approved via the Staff Development Centre
d. Rent of property or rooms
e. Services provided by high street opticians
f. Utility services – including all communication services
g. Travel claims

vii) they adhere to the procedures regarding verbal orders developed by the Director of Finance. These shall be issued only in cases of emergency by the procurement and supplies office following receipt of a properly completed requisition. The procurement and suppliers office will place the verbal order and then issue an official order marked 'confirmation order' no later than the next working day. The procurement and supplies office shall maintain a register of emergency orders issued. Persistent use of this method of purchasing goods or services to circumvent the ordering procedures will result in their withdrawal from use and if the circumstances warrant, the instigation of disciplinary procedures

viii) orders are not split or otherwise placed in a manner devised so as to circumvent the financial thresholds

10.2.7 Goods and services for which Trust or national contracts are in place should be purchased within those contracts. Any purchasing request made outside such contracts must be referred, in the first instance, to the Procurement and Supplies Manager for approval.

10.2.8 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within ESTATECODE. The technical audit of these contracts shall be the responsibility of the Director responsible for the Estates function.

11. INVESTMENTS, EXTERNAL BORROWING AND PUBLIC DIVIDEND CAPITAL

11.1 Investments

11.1.1 The Director of Finance will produce an investment policy in accordance with any guidance received from the Regulator, for approval by the Board of Directors. Investment may include investment made by forming or

participating in forming, bodies corporate and/or otherwise acquiring membership of bodies corporate.

11.1.2 The policy will set out the Director of Finance's responsibilities for advising the Board of Directors concerning the performance of investments held.

11.1.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.2 External Borrowing and Public Dividend Capital

11.2.1 The Director of Finance will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay the Public Dividend Capital (PDC) and any proposed commercial borrowing, within the limits set by the Foundation Trust's authorisation, which is reviewed annually by the Regulator (the Prudential Borrowing Code). The Director of Finance is also responsible for reporting periodically to the Board of Directors concerning the Public Dividend Capital and all loans and overdrafts.

11.2.2 Any application for a loan or overdraft will only be made by the Director of Finance or by an officer acting on their behalf and in accordance with the Scheme of Delegation, as appropriate.

11.2.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.2.4 All short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement must be authorised by the Director of Finance.

11.2.5 All long term borrowing must be consistent with the plans outlined in the current Annual Plan.

12. CAPITAL EXPENDITURE, INVESTMENT, ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Expenditure and Investment

12.1.1 The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will issue Schemes of Delegation for approval of capital commitments and will arrange for the development of detailed policies and procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

12.1.2 The Chief Executive shall provide executive delegation to the Project Director to manage programmes for capital works expenditure, including assets under construction, within the restrictions of Schemes of Delegation which will include:

a) Specific authority to commit expenditure
b) authority to proceed to tender
c) authority to accept a successful tender

12.1.3 The Chief Executive therefore shall:

i) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans
ii) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost
iii) ensure that the investment is not undertaken without confirmation, where appropriate, of purchaser's support and the availability of resources to finance all revenue consequences, including capital charges
ix) ensure a business case is produced setting out:

a) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs and
b) appropriate project management and control arrangements and
c) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case

12.1.4 Any commitment in excess of limits currently specified shall be referred to the Chief Executive and Board of Directors for approval before such commitment is made.

12.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

12.1.6 The Director of Finance shall be responsible for preparing detailed procedural guides for the financial management and control of expenditure on capital assets.

12.1.7 At all times, the Board of Directors and officers of the trust will work in accordance with the Trust's Standing Orders and be mindful of the recommendations within the NHS ESTATECODE.

12.2 **The Regulator and Board of Governors**

12.2.1 The Board of Directors must notify the Regulator and the Board of Governors without delay, and should consider whether it is in the public interest to bring to the public attention, any major new developments in the Trust's sphere of activity which are not public knowledge and which may lead, by virtue of their effect on its assets and liabilities or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the Trust. (Code of Governance F1.3)

12.3 **Asset Registers**

12.3.1 The Trust shall maintain an asset register recording fixed assets.

The Director of Finance shall:

a) be responsible for the maintenance of the asset register, approving the form of the register and the method of updating and arranging a physical check of assets against the register once a year.
b) implement procedures to comply with guidance on valuation in accordance with current national and international accounting standards as applicable to NHS Foundation Trusts
c) establish procedures covering the identification and recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified and validated by reference to appropriate supporting documentation.
d) develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence of disposal and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

12.3.2 Additions to the Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

i) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties
ii) stores, requisitions and wage records for own materials and labour including appropriate
iii) lease agreements in respect of assets held under lease and capitalised

12.4 **Security of Assets**

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. These procedures shall make provision for:

i) recording managerial responsibility for each asset
ii) identification of additions and disposals
iii) recording of all repairs and maintenance expenses
iv) physical security of assets
v) periodic verification of existence of, condition of, and title to, assets
vi) reporting, recording and safekeeping of cash cheques and negotiable instruments

12.4.3 All discrepancies from the fixed assets register revealed by verification of physical assets must be notified to the Director of Finance.

12.4.4 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported to the Director of Finance by all officers in accordance with the procedure for reporting losses.

12.4.5 Where practical, assets should be marked as Trust property.

13. STORES AND RECEIPTS OF GOODS

13.1 Control of Stores

13.1.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers, subject to such delegation being within the Scheme of Delegation.

13.1.2 Stores should be:

i) kept to a minimum
ii) subject to an annual stocktake
iii) valued at the lower of cost and net realisable value

13.1.2 The control of any pharmaceutical stocks shall be the responsibility of the designated pharmaceutical officer.

13.1.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager or pharmaceutical officer. Wherever practical, stocks should be marked Trust property.

13.1.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues and returns to stores, and losses.

13.1.5 Stocktaking arrangements shall be agreed with the Director of Finance.

13.1.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.2 Goods Supplied by NHS Supply Chain (NHSCC)

13.2.1 For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from NHSCC. The authorised person shall check receipt against the delivery note before forwarding this to the Supplies Department. The Finance Department shall satisfy themselves that the goods have been received before accepting the recharge.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS (see also 12.3 and 8.14)

14.1 Procedures

14.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking into account professional advice where appropriate. See also the Disposal Policy.

14.1.3 All unserviceable articles shall be:

i) condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance
ii) recorded by the condemning officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take appropriate action.

14.2 **Losses and Special Payments**

14.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

14.2.2 Any officer discovering or suspecting a loss of any kind must immediately inform their manager, who must immediately inform the Chief Executive and Director of Finance.

14.2.3 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

14.2.4 In cases of fraud or corruption, the Director of Finance must inform the Trust's Local counter Fraud Specialist (LCFS) and NHS Protect.

14.2.5 The Director of Finance must notify the Audit Committee, LCFS and the external auditors of all frauds.

14.2.6 For losses apparently caused by theft, arson, or neglect of duty, except if trivial, or gross carelessness, the Director of Finance must immediately notify:

i) the Board of Directors
ii) the External Auditor
iii) and the Audit Committee at the earliest opportunity

14.2.7 The Director of Finance shall approve the writing off of losses according to the limits set in the Schemes of Delegation.

14.2.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interest in bankruptcies and company liquidations.

14.2.9 For any loss, the Director of Finance should consider whether any insurance claim can be made.

14.2.10 No special payments exceeding delegated limits shall be made without prior approval of the Director of Finance and Chief Executive.

14.2.11 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Director of Finance

shall report losses and special payments to the Audit Committee on a regular basis.

15 INFORMATION TECHNOLOGY

15.1 Director of Finance Responsibilities

15.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

i) devise and implement any necessary procedures to ensure adequate and reasonable protection of the Trust's data, programmes and computer hardware for which the Director is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act and the Freedom of Information Act

ii) ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system

iii) ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment

iv) ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as the Director of Finance may consider necessary, are being carried out.

15.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

15.1.3 The Director of Finance shall publish and maintain a Freedom of Information (FOI) Publication Scheme, which is a complete guide to the information routinely published and describes the classes or types of information about the Trust which are publicly available.

15.2 Contracts for Computer Services with Other Health Bodies or # Outside Agencies

15.2.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency, shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.2.2 The Director of Finance shall periodically seek assurances that adequate controls are in operation.

15.3 Risk Assessments

15.3.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk.

15.3.2 This shall include the preparation of and testing of, appropriate disaster recovery plans.

15.4 **Requirements for Computer Systems which have an impact on Corporate Financial Systems**

15.4.1 Where computer systems have an impact on corporate financial systems, the Director of Finance shall need to be satisfied that:

i) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy
ii) data produced for use with financial systems is adequate, accurate, complete and timely and that an audit trail exists
iii) finance staff have access to such data and
iv) such computer audit reviews as are necessary, are carried out.

16. PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients,

16.2 in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.3 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

i) notices and information booklets
ii) hospital admission documentation and property records
iii) the oral advice of administrative and nursing staff responsible for admissions

that the Trust will not accept responsibility or liability for patients' property brought into the Trust's premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.4 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.5 In all cases where property of a deceased patient is of total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Staff should be informed on appointment by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. RETENTION OF RECORDS

17.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in The Records Management NHS Code of Practice 2006.

17.1.1 The documents held in archives shall be capable of retrieval by authorised persons.

17.2 Documents held under the HSC 1999/53 shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

18. RISK MANAGEMENT AND INSURANCE

18.1 The Chief Executive shall ensure that the Trust has a programme of risk management which shall be approved and monitored by the Board of Directors.

18.2The programme of risk management shall include:

i) a process for identifying and quantifying risks and potential liabilities
ii) engendering amongst all levels of staff a positive attitude towards the control and management of risk
iii) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk
iv) contingency plans to offset the impact of adverse events
v) audit arrangements including: internal audit; clinical audit; health and safety review
vi) arrangements to review the risk management programme

18.3 The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the Annual Report and Accounts.

18.4 The Director of Finance shall ensure that insurance arrangements exist in accordance with the risk management programme.

APPENDIX A

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND SCHEME OF DELEGATION

INTRODUCTION

The Code of Accountability for NHS Boards requires the Board of Directors to draw up a schedule of decisions reserved to it and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document therefore sets out the powers reserved to the Board of Directors and the Scheme of Delegation, together with tables of financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures and Schemes of Delegation within the Trust.

1 Reservation of Powers to the Board of Directors

1.1 General Enabling Provision

The Board of Directors (BoD) may determine any matter it wishes in full session within its statutory powers.

Powers are reserved to the Board of Directors to:

1.2 Regulation and Control

1.2.1 Approve Standing Orders (SOs), a schedule of matters reserved to the BoD and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business and other arrangements relating to standards of business conduct, suspend, vary or amend SOs.

1.2.2 Approve a Scheme of Delegation of powers from the BoD to committees or officers.

1.2.3 Require and receive the declarations of Board members' interests which may conflict with those of the Foundation Trust and determine the extent to which a Board member may remain involved with the matter under discussion.

1.2.6 Approve arrangements for dealing with complaints.

1.2.7 Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and agree modifications thereto.

1.2.8 Ratify any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 4.3.

1.2.9 Approve arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.

1.2.10 Approve proposals of the Nomination and Remuneration Committee regarding Board members and senior officers and those of the Chief Executive for staff not covered by the Nomination and Remuneration Committee.

1.3 Committees

1.3.1 Appoint and dismiss committees.

1.3.2 Establish terms of reference and reporting arrangements for committees.

1.3.3 Appoint members of all committees.

1.3.4 Receive reports from all committees and take appropriate action on these.

1.3.5 Confirm the recommendations of committees where the committees do have executive powers.

1.4 Strategy, Business Plans and Budgets

1.4.1 Define the strategic aims and objectives of the Foundation Trust.

1.4.2 Approve annually revenue and capital budgets.

1.4.3 Approve and monitor the Foundation Trust's policies and procedures for the management of risk.

1.4.4 Ratify proposals for the acquisition, disposal or change of use of land and/or buildings (subject to the Independent Regulator's approval in the case of property designated as 'protected' in the Foundation Trust authorisation).

1.4.5 Approve proposals for ensuring quality and developing clinical governance in service provided by the Foundation Trust.

1.4.6 Approve proposals for ensuring equality and diversity in both employment and the delivery of services.

1.4.7 Approve the Foundation Trust's investment policy and authorise institutions with which cash surpluses may be held.

1.4.8 Approve the Foundation Trust's borrowing policy, which will include other long term financing arrangements such as leases.

1.4.9 Authorise any necessary variations to total budget spends of capital schemes of more than 10% or £25,000, whichever is the greater. Authorise any increase in the total capital programme.

1.5 Financial and Performance Reporting Arrangements

1.5.1 Continuously appraise the affairs of the Foundation Trust by means of the receipt of reports as it sees fit from Board members, committees, and officers of the Foundation Trust. All monitoring returns required by the Independent Regulator and the Charity Commission shall be reported, at least in summary, to the Foundation Trust.

1.5.2 Approve the opening and closing of all bank and investment accounts.

1.5.3 Consider and approve the Foundation Trust's Annual Report and Accounts, prior to submission to the Board of Governors.

1.5.4 Receive and approve the Annual Report and Accounts for funds held on trust.

1.5.5 Receive reports from the Director of Finance on financial performance against budget and the annual business plan.

1.6 Audit Arrangements

1.6.1 Receive reports of Audit Committee meetings and take appropriate action.

1.6.2 Receive the annual management letter from the external auditor and agree action on the recommendation where appropriate of the Audit Committee.

Res = responsible officer Del = delegated officer	Director of Finance	Deputy Director of Finance	Financial Services Manager	Reporting & Planning Manager	Head of Procurement	Trust Board	CEO & Director of Finance	CEO & Chairman	Director of Quality & Nursing	Head of HR	Head of Corporate Affairs	Budget Holders
Payroll	Res	Del	Del	-	-	full	-	N/A	-	Del	-	-
Payroll advance - exceptional circumstances	Res	max 1mth salary	max 1mth salary	max 1mth salary	-	full	N/A	-	-	max 1mth salary	-	-
Payroll - Approval of new staff appointments	Res	-	-	-	-	full	-	-		-	-	-
Bank accounts (establishment & operation)	Res	Del	Del	Del	-	full	-	-	-	-	-	-
Bank accounts - Cheque - Cash single signature	£500	£500	£500	£500	-	-	-	-	-	-	-	-
Bank accounts - Cheque - Cash any two signatures	>£500	>£500	>£500	>£500	-	-	-	-	-	-	-	-
Bank accounts - Cheque - Revenue single signature	10k	10k	10k	10k	-	-	-	-	-	-	-	-
Bank accounts - Cheque - Revenue any two signatures	>10k	>10k	>10k	>10k	-	-	-	-	-	-	-	-
Treasury Management	Res	Del	Del	-	-	full	-	-	-	-	-	-
Accounts Payable - creditor payments	Res	Del	Del	-	-	full	-	-	-	-	-	-
Accounts Payable - Purchase Card	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income - Review & approval of fees & charges	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income - Debt recovery	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income receipting	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income - Credit notes	<20k	<5k	<5k	<5k	-	full	>20k	-	-	-	-	-
Income - Write Off(2)	<20k	<500	<500	<500	-	full	>20k	-	-	-	-	-
Income - Losses & special payments(2)	Res	Del	Del	Del	-	full	-	-	-	-	-	-
Procurement - Requisitioning goods & services	-	-	-	-	-	full	-	-	-	-	-	£5k
Procurement - Raising Orders	Res	Del	-	-	Del	full	-	-	-	-	-	-
Procurement - Signing supplies orders(3)	<25k	<25k	<10k	<10k	<25k	full	>£25k		-	-	-	
Procurement - Signing Estates orders(3)	-	-	-	-	<25k	full	>£25k		-	-	-	£5k
Procurement - Single Tender Action Estates(3)	-	-	-	-	-	full	>25k		-	-	-	-
Procurement - Single Tender Action (4)	Res	-	-	-	-	full	Res	-	-	-	-	-
Procurement - Awarding of contracts(5)	Res	-	-	-	-	full	Res	-	-	-	-	-
Procurement - Awarding of Estates contracts(5)	-	-	-	-	-	full	>25k	>25k	-	-	-	£5k
Annual Capital Programme & Expenditure Proposals (7)	Res	-	-	-	-	full	-	-	-	-	-	-
Assets - Land & Buildings	-	-	-	-	-	full	-	-	-	-	-	-
Assets - Land & Buildings	-	-	-	-	-	full	-	-	-	-	-	-
Assets - register & capital charges	-	-	-	Del	-	full	-	-	-	-	-	-
Assets - Security	-	-	-	-	-	full	-	-	-	-	-	-
Budgetary Control	Res	Del	Del	-	-	full	-	-	-	-	-	Del
Annual Business Plan	Res	-	-	-	-	full	-	-	-	-	-	-
Insurance Arrangements	-	-	-	Del	-	full	-	-	Res	-	-	-
Risk Management	-	-	-	-	-	full	-	-	Res	-	-	-
Fraud & Corruption	Res	Del	Del	-	-	full	-	-	-	-	-	-
Information & Tech. (Finance systems)	Res	Del	-	Del	-	full	-	-	-	-	-	-
Retention of Records	Res(finance)	-	Res(finance)	-	-	full	-	-	-	-	-	-
Corporate Affairs - Opening of Tenders & Maintaining Register	-	-	-	-	-	full	-	-	-	-	Res	-
Corporate Affairs - Sealing & Signing of Documents	-	-	-	-	-	full	-	-	-	-	Res	-
Corporate Affairs - Business Conduct,gifts,hospitality & sponsorshi	-	-	-	-	-	full	-	-	-	-	Res	-
Patients Property & Affairs (6)	>10k	10k	5k	-	-	full	-	-	Res	-	-	-
Patients Cash (6)	£100	-	£100	-	-	full	-	-	-	-	-	-
Patients Cheque (6)	>£100	-	>£100	-	-	full	-	-	-	-	-	-

(1) Budget Holder, who will determine the extent of further delegation

(2) Bad debt write off for these purposes does not include adjustments relating to invoices raised in error

(3) Order >10k - 25k 3 written quotes or a waiver. >£25 Minimum of 4 tenders. Supplies orders and Estates orders above OJEU limits must be tendered, waivers not permitted.

(4) Single Tender action - to be reported to the Board

(5) Awarding of contracts >25k to be reported to Audit Committee

(6) Disposal of deceased patients property only released to relatives who sign the form of indemnity. Cash or property in excess of these limits require production of probate or letter of administration

(7) A business case is to be prepared in support of every capital expenditure proposal

APPENDIX B

HIERACHY OF DELEGATED BUDGETARY AUTHORITY

Budgets	(£) Limit	Authorised Officer
Virement between non-pay budget lines within same core	£all	Budget holder together with authorisation from Head of Management Accounts
Virement between non-pay lines across cores	£all	Mutual agreement between budget holders with authorisation from Director of Finance/Deputy Director of Finance.
Any virement involving pay lines	£all	Budget holder with authorisation from Head of Management Accounts, any establishment change to authorised by Director of Finance or Deputy Director of Finance
Pay Expenditure Delegated Limits		
Commitment to incur costs as a result and contract of employment (including temporary contracts, existing post)	£all	Head of Human Resources (with reference to authorised establishment)
Commitment to incur costs as a result of a contract of employment (including temporary contacts), new post	£all	Chief Executive or Deputy Director of Finance (by authorising change to establishment)

Commitment to incur costs via consultancy or other means, for any continuous period fulfilling same duties, even if undertaken by different individuals	Up to £5,000 single or multiple employment £5,001 and over	Budget holder Director of Finance

APPENDIX D

Summary of Minimum retention period for records
(for full details see Annex 2 of the NHS Records Management Code of Practice)

No.	Class of Document	Retention Period
	FINANCIAL	
1	Salaries Records	10 years after the period to which they relate.
2	Pay sheets and records of unpaid salaries	6 years after the end of the financial year to which they relate.
3	Principal ledger records including cashbook, ledgers and journals	6 years after the end of the financial year to which they relate.
4	Bill, Receipts and Cleared Cheques	6 years after the end of the financial year to which they relate.
5	Debtors Records	2 years after the end of the financial year in which they are paid or written off, but at least 6 years in respect of any unpaid account which has not yet been written off.
6	Creditor Payment Records	3 years after the end of the financial year to which they relate.
7	Requisitions	1.5 years after the end of the financial year to which they relate
8	Minor accounting records; bank statements, deposit slips, cheques, petty cash expenditure accounts, travel & subsistence records etc.	2 years after the end of the financial year to which they relate.
9	Cost accounts	3 years after the end of the financial year to which they relate.
10	Tax Forms	6 years after the end of the financial year to which they relate.
11	VAT Records	6 years after the end of the financial year to which they relate
12	Budgets	2 years from the completion of the audit.
13	Major establishment records including personal files, letter of appointments, contract references and related correspondence and records of leave.	6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, which ever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destro9yed after the officer leaves the hospital's service.
14	Minor establishment records eg leave	2 years from the completion of the audit.
15	Stores Records, requisitions, issue notes, goods received	1.5 years after the end of the financial year to which they relate.

	books, delivery notes etc.	
16	Audit Reports	2 years after the formal clearance by the appointed auditor.
17	Accounts – Annual (Final one set only)	Permanent
18	Accounts – Working Papers	3 years after the end of the financial year to which they relate.
19	Document other than thos of permanent relevance in relaltion to trust funds and the terms of any trusts administered	6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted.

	NON-FINANCIAL	
20	Property Acquisitions/Disposal Records	Permanent
21	Buildings and engineering works, inclusive of projects abandoned or deferred – key records (eg final accounts, surveys, site plans, bills of quantities)	Permanent
22	Contracts – non sealed on termination	6 years after the end of the financial year to which they relate
23	Contracts – sealed and associated records	15 years after the end of the financial year to which they relate.
24	Tenders – Unsuccessful	6 years after the end of the financial year to which they relate
25	Inventories (not in current use) of items having a life of less than 5 years	1.5 years after the end of the financial year to which they relate.
26	Patient activity data	3 years after the end of the financial year to which they relate.
27	Patient Materials (part of their health record) e.g. orthodontic models	As advised by Clinical Requirements/Need

Res = responsible officer Del = delegated officer	Director of Finance	Deputy Director of Finance	Financial Services Manager	Reporting & Planning Manager	Head of Procurement	Trust Board	CEO & Director of Finance	CEO & Chairman	Director of Quality & Nursing	Head of HR	Head of Corporate Affairs	Budget Holders
Payroll	Res	Del	Del	-	-	full	-	N/A	-	Del	-	-
Payroll advance - exceptional circumstances	Res	max 1mth salary	max 1mth salary	max 1mth salary	-	full	N/A	-	-	max 1mth salary	-	-
Payroll - Approval of new staff appointments	Res	-	-	-	-	full	-	-		-	-	-
Bank accounts (establishment & operation)	Res	Del	Del	Del	-	full	-	-	-	-	-	-
Bank accounts - Cheque - Cash single signature	£500	£500	£500	£500	-	-	-	-	-	-	-	-
Bank accounts - Cheque - Cash any two signatures	>£500	>£500	>£500	>£500	-	-	-	-	-	-	-	-
Bank accounts - Cheque - Revenue single signature	10k	10k	10k	10k	-	-	-	-	-	-	-	-
Bank accounts - Cheque - Revenue any two signatures	>10k	>10k	>10k	>10k	-	-	-	-	-	-	-	-
Treasury Management	Res	Del	Del	-	-	full	-	-	-	-	-	-
Accounts Payable - creditor payments	Res	Del	Del	-	-	full	-	-	-	-	-	-
Accounts Payable - Purchase Card	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income - Review & approval of fees & charges	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income - Debt recovery	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income receipting	Res	Del	Del	-	-	full	-	-	-	-	-	-
Income - Credit notes	<20k	<5k	<5k	<5k	-	full	>20k	-	-	-	-	-
Income - Write Off(2)	<20k	<500	<500	<500	-	full	>20k	-	-	-	-	-
Income - Losses & special payments(2)	Res	Del	Del	Del	-	full	-	-	-	-	-	-
Procurement - Requisitioning goods & services	-	-	-	-	-	full	-	-	-	-	-	£5k
Procurement - Raising Orders	Res	Del	-	-	Del	full	-	-	-	-	-	-
Procurement - Signing supplies orders(3)	<25k	<25k	<10k	<10k	<25k	full	>£25k		-	-	-	
Procurement - Signing Estates orders(3)	-	-	-	-	<25k	full	>£25k		-	-	-	£5k
Procurement - Single Tender Action Estates(3)	-	-	-	-	-	full	>25k		-	-	-	-
Procurement - Single Tender Action (4)	Res	-	-	-	-	full	Res	-	-	-	-	-
Procurement - Awarding of contracts(5)	Res	-	-	-	-	full	Res	-	-	-	-	-
Procurement - Awarding of Estates contracts(5)	-	-	-	-	-	full	>25k	>25k	-	-	-	£5k
Annual Capital Programme & Expenditure Proposals (7)	Res	-	-	-	-	full	-	-	-	-	-	-
Assets - Land & Buildings	-	-	-	-	-	full	-	-	-	-	-	-
Assets - Land & Buildings	-	-	-	-	-	full	-	-	-	-	-	-
Assets - register & capital charges	-	-	-	Del	-	full	-	-	-	-	-	-
Assets - Security	-	-	-	-	-	full	-	-	-	-	-	-
Budgetary Control	Res	Del	Del	-	-	full	-	-	-	-	-	Del
Annual Business Plan	Res	-	-	-	-	full	-	-	-	-	-	-
Insurance Arrangements	-	-	-	Del	-	full	-	-	Res	-	-	-
Risk Management	-	-	-	-	-	full	-	-	Res	-	-	-
Fraud & Corruption	Res	Del	Del	-	-	full	-	-	-	-	-	-
Information & Tech. (Finance systems)	Res	Del	-	Del	-	full	-	-	-	-	-	-
Retention of Records	Res(finance)	-	Res(finance)	-	-	full	-	-	-	-	-	-
Corporate Affairs - Opening of Tenders & Maintaining Register	-	-	-	-	-	full	-	-	-	-	Res	-
Corporate Affairs - Sealing & Signing of Documents	-	-	-	-	-	full	-	-	-	-	Res	-
Corporate Affairs - Business Conduct,gifts,hospitality & sponsorshi	-	-	-	-	-	full	-	-	-	-	Res	-
Patients Property & Affairs (6)	>10k	10k	5k	-	-	full	-	-	Res	-	-	-
Patients Cash (6)	£100	-	£100	-	-	full	-	-	-	-	-	-
Patients Cheque (6)	>£100	-	>£100	-	-	full	-	-	-	-	-	-

(1) Budget Holder, who will determine the extent of further delegation

(2) Bad debt write off for these purposes does not include adjustments relating to invoices raised in error

(3) Order >10k - 25k 3 written quotes or a waiver. >£25 Minimum of 4 tenders. Supplies orders and Estates orders above OJEU limits must be tendered, waivers not permitted.

(4) Single Tender action - to be reported to the Board

(5) Awarding of contracts >25k to be reported to Audit Committee

(6) Disposal of deceased patients property only released to relatives who sign the form of indemnity. Cash or property in excess of these limits require production of probate or letter of administration

(7) A business case is to be prepared in support of every capital expenditure proposal

Queen Victoria Hospital NHS
NHS Foundation Trust

STANDING ORDERS

FOR

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

INCLUDING

BOARD OF DIRECTORS

AND

COUNCIL OF GOVERNORS

For approval by Board of Directors September 2014

CONTENTS

A INTRODUCTION

Statutory Framework

i) The Queen Victoria Hospital NHS Foundation Trust (the Trust) is a public benefit corporation which came into existence on 1 July 2004 under the Health and Social Care (Community Health and Standards) Act 2003.

ii) The principal place of business of the Trust is Holtye Road, East Grinstead, West Sussex, RH19 3DZ

iii) The functions of the Trust are conferred by this legislation

iv) The Trust has established Standing Orders for the Trust which encompasses the Board of Directors and Council of Governors.

B INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

Any expression to which a meaning is given in the Health and Social Care (Community Health and Standards) Act 2010, National Health Service Acts 1977 and 2006 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"Accounting Officer" means the officer responsible and accountable for funds entrusted to the Foundation Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Board of Directors" means the Chairman, Executive and Non-Executive Directors of the Trust collectively as a body.

"Council of Governors" means the Chairman and elected and appointed Governors of the Foundation Trust collectively as a body

"Board Member" means Executive or Non-Executive member of the Board of Directors or Governors as the context permits.

"Budget" means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust.

"Budget holder" means the director of employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chairman of the Board of Directors (or Foundation Trust)" is the person appointed by the Council of Governors to lead the Council of Governors and Board of Directors and to ensure that it successfully discharges its overall responsibility for the Foundation Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief executive of the Foundation Trust.

"Committee" means a committee or sub-committee created and appointed by the Foundation Trust.

"Committee members" means persons formally appointed by either Board of Directors or Council of Governors to sit on or to chair specific committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Deputy Chairman" means the Non-Executive member appointed to take on the Chairman's duties if the Chairman is absent for any reason.

"Director of Finance" means the Chief Financial Executive of the Trust.

"Executive" means employee of the Trust or any other person holding a paid appointment or office with the Foundation Trust.

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.51 of the NHS Act 2006.

"Nominated Executive" means an executive charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Secretary" means the person appointed to act independently of the Board of Directors or Council of Governors, to provide advice on corporate governance issues to the Board and the Chairman and monitor the Foundation Trust's compliance with the law, Standing Orders and all regulatory requirements.

"SFIs" means Standing Financial Instructions.

"Senior Independent Director" (SID) means the Non-Executive member who will be available to members and Governors if they have concerns which contact through the normal channels of Chairman, Chief Executive or Finance Director has failed to resolve or for which such contact would be inappropriate. They are also responsible for leading an evaluation of the Chairman's performance at least annually, as part of a process, which should be agreed with the Board of Governors

"SOs" mean Standing Orders.

C STANDING ORDERS

1 THE FOUNDATION TRUST BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

1.1 All business shall be conducted in the name of the Foundation Trust.

1.2 All funds received in trust shall be held in the name of the Foundation Trust as corporate Trustee

The Trust board of directors

1.3 The relevant powers of the Foundation Trust established under statute shall be exercised by the board of Directors meeting in public and / or private session.

1.4 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the schedule of powers reserved to the Board of Directors included in Appendix A to the Standing Financial Instructions which has effect as if incorporated into the Standing Orders.

1.5 **Composition of the Board of Directors:** In accordance with the constitution the composition of the Board of Directors shall be:

- The Chairman of the Foundation Trust;
- At least four Non-Executive Directors, excluding the Chairman;
- The following Executive Directors:
  - The Chief Executive (who shall be the Accounting Officer)
  - The Director of Finance and Performance
  - The Medical Director
  - The Director of Nursing and Quality

1.6 **Appointment of the Chairman and Board of Directors and Council of Governors:** The Chairman is appointed by the Council of Governors. The appointment and tenure of office of the Chairman and Members of the Board and Council are set out in the Constitution.

1.7 **Terms of Office of the Chairman and Board Members:** The regulations setting out the period of tenure of office of the Chairman and Board Members and for the termination or suspension of office of the Chairman and Board Members are contained in the Constitution

1.8 **Appointment and Powers of the Deputy Chairman:** Subject to SO 1.13 (below), the Chairman and Members of the Council of Governors and Board of Directors of the Foundation Trust may appoint one of their number, who is not also an Executive Director, to be Deputy Chairman, for such period, not exceeding the

remainder of his term as a Board Member of the Foundation Trust, as they may specify on appointing him.

1.9 Any Member of the Board so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Chairman and Board Members may thereupon appoint another Board Member as Deputy Chairman in accordance with the provisions of Standing Order 1.11.

1.10 Where the Chairman of the Foundation Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his/her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include references to the Deputy Chairman.

1.11 **Joint Board Members:** Where more than one person is appointed jointly to a post those persons shall count for the purpose of Standing Order 1.7 and 1.8 as one person.

The Council of Governors

1.12 The relevant powers of the Foundation Trust established under statute shall be exercised by the Council of Governors meeting in public session except as otherwise provided for in Standing Order 3.

1.13 By virtue of the National Health Service Act 2006, as amended by the Health & Social Care Act 2012, the Council of Governors has the following powers and duties:

a) the appointment and, if appropriate, the removal of the chair of the trust;

b) the appointment and, if appropriate, the removal of the other non-executive directors;

c) setting the remuneration, allowances and other terms and conditions of office of the chair and the other non-executive directors;

d) approving (or not) any new appointment of a chief executive;

e) the appointment and, if appropriate, the removal of the trust's auditor;

f) receiving the trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the council of governors

g) holding the non-executive directors, individually and collectively, to account for the performance of the board of directors;

h) representing the interests of the members of the trust as a whole and the interests of the public;

i) approving significant transactions;

j) approving an application by the trust to enter into a merger, acquisition, separation or dissolution;

k) deciding whether the trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the

health service in England, or performing its other functions; and

l) approving amendments to the trust's constitution.

The Council of Governors may only exercise these functions at a meeting of the full Council; the Council has no power to delegate its functions to any individual or committee.

1.14 Composition of the Council of Governors: In accordance with the Constitution the composition of the Council of Governors shall be:

- Twenty Public Governors
- Three Staff Governors
- One Appointed (Local Authority) Governor
- Two Partnership Governors

2 MEETINGS OF THE BOARD OF DIRECTORS

2.1 **Role of Members:** The Board of Directors will function as a corporate decision-making body. Executive and Non-Executive members will be full and equal members. Their role as Members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

Executive Members: Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

a) **Chief Executive** The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives.

b) **Director of Finance & Performance:** The Director of Finance & Performance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

c) **Medical Director:** The Medical Director shall be responsible for maintaining effective professional leadership for all medical staff, whilst providing advice to the Board and Chief Executive on key service and medical staffing issues.

d) **Director of Nursing & Quality:** The Director of Nursing & Quality shall be responsible for the professional quality standards for nursing professionals, ensuring their development and performance to deliver the highest standards of health care.

e) **Non-Executive Directors:** The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members, or when chairing a committee, of the Trust which has delegated

powers.

f) **Chairman:** The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.2 **Calling Meetings** Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

2.3 The Chairman of the Foundation Trust may call a meeting of the Foundation Trust (Board of Directors) at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Board Members, has been presented to him, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at the Foundation Trust's Headquarters, such one third or more Board Members may forthwith call a meeting.

2.4 **Notice of Meetings** Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an executive authorised by the Chairman to sign on his behalf shall be delivered to every Board Member, or sent by post to the usual place of residence of such Board Member, so as to be available to him at least three clear days before the meeting.

2.5 Want of service of the notice on any Board Member shall not affect the validity of a meeting.

2.6 In the case of a meeting called by Board Members in default of the Chairman, the notice shall be signed by those Board Members and no business shall be transacted at the meeting other than that specified in the notice

2.7 Agendas will be sent to Board Members 6 days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency. Failure to serve such a notice on more than three Board Members will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

2.8 **Setting the Agenda** - The Board of Directors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders.)

2.9 A Board Member desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information.

Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

2.10 **Petitions** Where a petition has been received by the Foundation Trust the Chairman of the Board of Directors shall include the petition as an item for the agenda of the next Board of Directors meeting.

2.11 **Chairman of Meeting** At any meeting of the Board of Directors, the Chairman of the Board of Directors, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he/she is present, shall preside. If the Deputy Chairman is also absent, such Non-Executive Director as the Board Members present shall choose shall preside.

2.12 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are absent, or are disqualified from participating, such Non-Executive Director as the Board Members present shall choose shall preside.

2.13 **Notices of Motion:** A Board Member of the Board of Directors desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

2.14 **Withdrawal of Motion or Amendments:** A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

2.15 **Motion to Rescind a Resolution:** A Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Board Member who gives it and also the signature of 4 other Board of Directors Board Members. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Board Member other than the Chairman to propose a motion to the same effect within 6 months; however the Chairman may do so if he considers it appropriate.

2.16 **Motions:** The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

2.17 When a motion is under discussion or immediately prior to discussion it shall be open to a Board Member to move:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;*
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put*
- A motion resolving to exclude the public (including the press).

*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Board Member who has not previously taken part in the debate and who is eligible to vote.

No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

2.18 **Chairman's Ruling:** Statements of Board Members made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

2.19 **Voting:** Every question at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and Board Members present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chairman of the meeting shall have a second or casting vote.

2.20 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Board Members present so request.

2.21 If at least one-third of the Board Members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Board Member present voted or abstained.

2.22 If a Board Member so requests, his vote shall be recorded by name upon any vote (other than by paper ballot).

2.23 In no circumstances may an absent Board Member vote by proxy. Absence is defined as being absent at the time of the vote.

2.24 An executive who has been appointed formally by the Board of Directors to act up for an executive Board Member during a period of incapacity or temporarily to fill an executive Board Member vacancy, shall be entitled to exercise the voting rights of the executive Board Member. An executive attending the Board of Directors to represent an executive Board Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Board Member. An executive's status when attending a meeting shall be recorded in the minutes.

2.25 **Minutes:** The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

2.26 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

2.27 Minutes shall be circulated in accordance with Board Members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness.

2.28 **Joint Board Members:** Where the office of a Board Member of the Board of Directors is shared jointly by more than one person:

a) Either or both of those persons may attend or take part in meetings of the Board of Directors:

b) If both are present at a meeting they should cast one vote if they agree;

c) In the case of disagreements no vote should be cast;

d) The presence of either or both of those persons should count as the presence of one person for the purposes of SO 2.36 and 2.37 (Quorum).

2.29 **Suspension of Standing Orders:** Except where this would contravene any statutory provision or any direction made by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two- thirds of the Board of Directors or Council of Governors are present, including one Executive and one Non-Executive Board Member, and that a majority of those present vote in favour of suspension.

2.30 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

2.31 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Board Members of the Board of Directors.

2.32 No formal business may be transacted while Standing Orders are suspended.

2.33 **Variation and Amendment of Standing Orders:** These Standing Orders shall be amended only if:

- Both the Board of Directors and Council of Governors agree;
- No fewer than half the total of the Foundation Trust's Non-Executive Directors vote in favour of amendment; and no fewer than half the total of the Trust's public Governors vote in favour of amendment;
- at least two-thirds of the Board of Directors and the Council of Governors are present; and
- the variation proposed does not contravene a statutory provision or direction made by the Independent Regulator.

2.34 **Record of Attendance:** The names of the Chairman and Board Members present at the meeting shall be recorded in the minutes.

2.35 **Quorum: Board of Directors** No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Board Members appointed, (including at least one Non-Executive and one Executive Board Member) are present.

2.36 **Quorum: Board of Governors** No business shall be transacted at a meeting unless at least one appointed Governor and one elected Governor are present and one third of the whole number of the Governors are present. Public Governors must be in the majority.

2.37 An executive in attendance for an executive Board Member but without formal acting up status may not count towards the quorum.

2.38 If the Chairman or Board Member has been disqualified from participating in the

discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 5 or 6) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3 MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 **Admission of the Public and the Press:** The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

3.2 The Chairman (or Deputy Chairman) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting be adjourned for (the period to be specified) to enable the Board to complete business without the presence of the public"

3.3 Nothing in these Standing Orders shall require the Trust to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.4 The Standing Orders for the Board of Directors Meetings (see SO 2) as far as they are applicable, shall apply with appropriate alteration to meetings of the Council of Governors.

4 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to such directions as may be given by the Independent Regulator, the Board of Directors may make arrangements for the exercise, on behalf of their Board, of any of the functions:

- by a committee, sub-committee, or;
- appointed by virtue of Standing Order 5 below or by an Executive of the Foundation Trust, or;
- by another body as defined in Standing Order 4.2 below

in each case, subject to such restrictions and conditions as the Foundation Trust

thinks fit.

4.2 Where a function is delegated to another body, the Foundation Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or executives, the Foundation Trust retains full responsibility.

4.3 **Emergency Powers – Board of Directors:** The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Board Members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board of Directors in public session for ratification.

4.4 **Emergency Powers – Council of Governors:** The powers which the Council of Governors has retained to itself within these Standing Orders may in emergency be exercised by the Chairman after having consulted at least four Public Governors. The exercise of such powers by the Chairman shall be reported to the next formal meeting of the Council of Governors in public session for ratification.

4.5 **Delegation to Committees:** The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Independent Regulator. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors in respect of its sub-committees.

4.6 When the Council of Governors is not meeting as the Foundation Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Foundation Trust in public session.

4.7 **Delegation to Executives** - Those functions of the Foundation Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Foundation Trust by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate executives to undertake the remaining functions for which he will still retain an accountability to the Foundation Trust.

4.8 **Scheme of Delegation -** The Chief Executive shall prepare a scheme of delegation identifying his proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the scheme of delegation that shall be considered and approved by the Board of Directors as indicated above.

4.9 Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Board of Directors or the Director of Finance to provide information and advise the Board of Directors in accordance with statutory or requirements of the Independent Regulator. Outside these statutory requirements the operational matters.

4.10 The arrangements made by the Board of Directors and Council of Governors, as

set out in the reservation of powers to the Board of Directors and Council of Governors shall have effect as if incorporated in these Standing Orders.

4.11 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors or Council of Governors (as appropriate) for action or ratification. All Members of either the Board of Directors or Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

5.1 Subject to such directions and guidance issued by the Independent Regulator, the Foundation Trust may and, if directed by him, shall appoint committees of the Foundation Trust, or together with one or more Authorities or other Foundation Trusts, appoint joint committees, consisting wholly or partly of the Chairman and Board Members of the Foundation Trust or other health service bodies or wholly of persons who are not Board Members of the Foundation Trust or other health service bodies in question.

5.2 A committee or joint committee appointed under this regulation may, subject to such directions as may be given by the Independent Regulator or the Foundation Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of Board Members of the committee or joint committee (whether or not they are Board Members of the Foundation Trust or other health service bodies in question); or wholly of persons who are not Board Members of the Foundation Trust or other health service bodies or the committee of the Foundation Trust or other health service bodies in question.

5.3 The Standing Orders of the Foundation Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Foundation Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of the committee as the context permits, and the term “Board Member” is to be read as a reference to a Board Member of the committee also as the context permits. (There is no requirement to hold meetings of committees, established by the Foundation Trust in public.)

5.4 **Terms of Reference:** Each such committee shall have such Terms of Reference and powers and be subject to such conditions (as to reporting back to the Board of Directors or Council of Governors), as the Board or Council shall decide and shall be in accordance with any legislation and regulation or direction issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the appropriate Board or Council.

5.6 The Board or Council shall approve the appointments to each of the committees which it has formally constituted. Where either the Board of Directors or Council of

Governors determines, and regulations permit, that persons, who are neither Board Members nor executives, shall be appointed to a committee the terms of such appointment shall be within the powers of the Boards as defined by the constitution. The Boards shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Where the Board or Council are required to appoint persons to a committee and/or to undertake statutory functions as required by the constitution, and where such appointments are to operate independently of either the Boards or Council such appointment shall be made in accordance with the regulations and directions made by the constitution.

5.8 **Board of Directors' Committees:** The committees, sub-committees, and joint- committees established by the Board of Directors shall include :

- **Audit Committee** (Comprising Non-Executive Directors only)
- **Nomination & Remuneration Committee** (Comprising Non-Executive Directors and the Chief Executive)
- **Quality and Risk Committee** (Chaired by a Non-Executive Director and including Executive Directors)
- **Charitable Funds Advisory Committee** (Chaired by a Non-Executive Director and including and Executive Directors)

5.9 **Charitable Funds Committee:** In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish a Charitable Funds Advisory Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission, the Independent Regulator or Secretary of State for Health.

5.10 **Council of Governors' Committees:** The committees, sub-committees and joint-committees established by the Board of Governors shall include:

- Appointments Committee
- Governors' Steering Group

5.11 The Deputy Company Secretary will attend all meetings of the Council of Governors' Committees, sub-committees and joint-committees in support of them.

5.12 The Chairman will be a member of the Council of Governors' Appointments Committee.

6 STANDARDS OF BUSINESS CONDUCT POLICY AND DECLARATIONS OF INTERESTS

6.1 Board Members and Staff should comply with the Trust's Code of Conduct, Code of Values and the Standards of Business Conduct Policy together with national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff'. This section of Standing Orders should be read in conjunction with

these documents which shall be appended to, and form part of, these Standing Orders.

6.2 **Interest of Executives in Contracts:** If it comes to the knowledge of an executive of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is himself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

6.3 An executive should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

6.4 **Canvassing of, and Recommendations by, Members in Relation to Appointments:** Canvassing of members of the Trust or of any Committee of the Foundation Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

6.5 A member of the Board or Council shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Foundation Trust.

6.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

6.7 **Relatives of Members or Executives:** Candidates for any staff appointment under the Foundation Trust shall, when making application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

6.8 The Chairman and every member and executive of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that member or executive is aware. It shall be the duty of the Chief Executive to report to the Board or Council any such disclosure made.

6.9 On appointment, members (and prior to acceptance of an appointment in the case of executive members) should disclose to the Board or Council whether they are related to any other member or holder of any office in the Trust.

6.10 Where the relationship to a member of the Trust is disclosed, the Standing Order headed `Disability of Chairman and members in proceedings on account of pecuniary interest' shall apply.

6.11 **Declarations of Interests:** Board and Council Members should declare interests

which are relevant and material to the Board of Directors or Council of Governors, of which they are a Board Member. All existing Board Members should declare such interests. Any Board Members appointed subsequently should do so on appointment.

6.12 Interests which should be regarded as "relevant and material" are:

a) Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of trust in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services

f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

g) Any other commercial interest in the decision before the meeting

h) Research funding/grants that may be received by an individual or their department;

6.13 At the time Board Members' interests are declared; they should be recorded in the Board of Directors' or Council of Governors' minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

6.14 Board Members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.15 During the course of a Board of Directors or Council of Governors meeting, if a conflict of interest is established, the Board Member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.16 There is no requirement for the interests of Board of Directors' or Council of Governors' spouses or partners to be declared. However Standing Order 6.3 requires that the interest of Board Members' spouses, if living together, in contracts should be declared. Therefore the interests of Board Members' spouses and cohabiting partners should also be regarded as relevant.

6.17 If Board of Directors or Council of Governors Members have any doubt about the relevance of an interest, this should be discussed with the Chairman or Head of Corporate Affairs. Financial Reporting Standard No 8 (issued by the Accounting Standards Board of Directors) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners

should also be considered.

6.18 **Register of Interests** - The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of all Board Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Board Members.

6.19 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.20 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.21 **Disability Of Chairman And Board Members In Proceedings On Account Of Pecuniary Interest -** Subject to the following provisions of this Standing Order, if the Chairman or a Board Member has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Foundation Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.22 The Independent Regulator may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him in the interests of the public that the disability shall be removed

6.23 The Board of Directors or Council of Governors may exclude the Chairman or a Board Member from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.24 Any remuneration, compensation or allowances payable to the Chairman or a Board Member shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.25 For the purpose of this Standing Order the Chairman or a Board Member shall be treated, subject to SO 6.12 and SO 6.16, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) he/she, or a nominee of his/her, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration, or

b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

and in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

6.26 The Chairman or a Board Member shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

a) of his Board Membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

b) of an interest in any company, body or person with which he is connected as mentioned in SO 6.25 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Board Member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

6.27 Where the Chairman or a Board Member has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

6.28 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Foundation Trust and applies to a Board Member of any such committee or sub-committee (whether or not he is also a Board Member of the Foundation Trust) as it applies to a Board Member of the Foundation Trust.

7. TENDERING AND CONTRACT PROCEDURE

7.1 **Duty to Comply with Standing Orders**

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders.

7.2 **EU Directives Governing Public Procurement**

European Union Directives on public sector purchasing, promulgated by the Department of Health prescribing procedures, for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders.

7.3 The Trust shall comply as far as is practicable with the requirements of best practice, for example as set out in the Department of Health "Capital Investment Manual", Delegated limits for capital investment Dec 2010 “Estate code” and "The Procurement and Management of Consultants within the NHS".

7.4 **Formal Competitive Tendering**

The Director of Finance shall be responsible for establishing procedures to carry out financial appraisals, and shall instruct the appropriate requisitioning office to provide evidence of technical competence.

The Trust shall ensure that competitive tenders are invited for:

i. the supply of goods, materials and manufactured articles

ii. the rendering of services including all forms of management consultancy services

iii. for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens)

iv. for disposals

7.5 Formal tendering procedures need not be applied where:

i. the estimated expenditure or income does not, or

ii. is not reasonably expected to exceed £25,000

iii. nationally agreed NHS contract exists

iv. contracts negotiated by the NHS Commercial Solutions and/or the Crown Commercial Service exist

v. disposals as set out in SFI numbers 8.11 and 14 are concerned.

7.6 Formal tendering procedures **may be waived** in the following circumstances, although approval is not to be regarded as automatic and each case shall be treated on its own merit. It is allowable for waivers to be agreed electronically in line with authorisation limits:

i. in very exceptional circumstances and subject to legal requirements where the Chief Executive and Director of Finance decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

ii. where the requirement is covered by an existing contract;

iii. where NHS Commercial Solutions or Crown Commercial Service agreements or other Procurement Hub agreements are in place;

iv. where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of consortium members;

v. where the timescale genuinely precludes competitive tendering; Failure to plan the work properly is not regarded as a justification for a single tender;

vi. where specialist expertise is required and is available from only one source;

vii. there is a clear demonstrable benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering, and

viii. for the provision of legal advice in relation to the obtaining of Counsel's opinion.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work;

7.7 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented in an appropriate Trust record and reported to the Audit Committee at each meeting.

Competitive Tendering cannot be waived for building and engineering construction works and maintenance

Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record. If these items exceed the EU thresholds and the value is materially in excess of these limits (i.e. 10%) then the items would need to be re-tendered through OJEU and such action formally recorded in the Tender Register.

7.8 Tendering procedures are set out in Financial Procedures.

7.9 **Quotations: General position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceeding £25,000.

7.10 **Competitive Quotations**

i. Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

ii. Quotations should be in writing or e-mail

iii. All quotations should be treated as confidential and should be retained for inspection and attached to the order for the goods or services.

iv. The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money and the reasons why should be recorded in a Record of Quotations.

v. The Procurement and Supplies department should maintain a record of quotations.

7.11 **Non-Competitive Quotations for less than £10K**

Non-competitive quotations in writing may be obtained in the following circumstances:

i. The supply of proprietary or other goods of a special character and in the rendering of services of a special character, for which it is not, in the opinion of the Procurement & Supplies department, possible or desirable to obtain competitive quotations.

ii. The supply of goods or manufactured articles of any kind which are required as a matter of urgency and are not obtainable under existing contracts

iii. Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI ((i) & (ii) above) apply.

7.12 **Authorisation of Tenders and Competitive Quotations**

Providing all the conditions and circumstances set out in the SFI's have been fully complied with, formal authorisation and awarding of a contract may to be decided by the following officers:

- Board of Directors
- Chief Executive
- Director of Finance
- Designated budget holders

The levels of authorisation are in the Schemes of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in the minutes.

7.13 **Instances where formal competitive tendering or competitive quotation are not required**

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a) The Trust shall use the NHS Supply Chain, NHS Commercial Solutions or Crown Commercial agreed contracts for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate or better value for money can be obtained elsewhere. The decision to use alternative sources must be documented.

b) If the Trust does not use the NHS Supply Chain, NHS Commercial Solutions or Crown Commercial contracts where tenders or quotations are not required, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

7.14 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15 **Private Finance:** When the Board of Directors proposes, or is required, to use finance provided by the private sector the following should apply:

a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

b) Where the sum exceeds stated limits, a business case must be referred to the Independent Regulator, the Department of Health or the Treasury, according to the relevant rules;

c) The proposal must be specifically agreed by the Board;

d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotation.

7.16 **Compliance requirements for all contracts**

The Board of Directors may only enter into contracts on behalf of the Trust within

the statutory powers delegated to it and shall comply with:

a) The Trust's Standing Orders and Standing Financial Instructions.

b) EU directives and other statutory provisions.

c) Contracts with NHS Foundation trusts must be in a form compliant with appropriate NHS guidance.

d) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

In all contracts made by the Trust, the Board of Directors shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.17 **Personnel and Agency or Temporary Staff Contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.18 **Health Care Services**

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Contracts with other Foundation Trusts', being Public Benefit Corporations, are legally binding and are enforceable in law. The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors.

Where the Trust elects to invite tenders for the supply of healthcare services these SFI's shall apply as far as they are applicable to the tendering procedure.

7.19 **Cancellation of Contracts**

Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use by the Trust, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and1916 and other appropriate legislation.

7.20 **Contracts involving Funds Held on Trust**

Shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

7.22 **Disposals** (see overlap with SFI 8.3.4)

Competitive tendering or quotations procedures shall not apply to the disposal of:

- any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined, or pre-determined in a reserve, by the Chief Executive or their nominated officer;
- obsolete or condemned articles, which may be disposed of in accordance with the supplies policy of the Trust;
- items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;
- items arising from works of construction, demolition or site clearance, which should be deal with in accordance with the relevant contract.

7.23 **In-house Services**

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- Specification group, comprising the Chief Executive or nominated officer/s and specialist.
- In-house tender group, comprising a nominee of the Chief Executive and technical support.
- Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative.

All groups should work independently of each other and individual officers may be members of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.24 The evaluation team shall make recommendations to the Board of Directors.

7.25 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8 CUSTODY OF SEAL AND SEALING DOCUMENTS

8.1 **Custody of Seal:** The Common Seal of the Trust shall be kept by the Chief Executive or Head of Corporate Affairs in a secure place.

8.2 **Sealing of Documents:** The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a

committee, thereof or where the Board has delegated its powers.

8.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an executive nominated by him/her) and authorised and countersigned by the Chief Executive (or an executive nominated by him/her who shall not be within the originating directorate).

8.4 **Register of Sealing:** An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least yearly. (The report shall contain details of the seal number, the description of the document and date of sealing).

9 SIGNATURE OF DOCUMENTS

9.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

9.2 The Chief Executive or nominated executives shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

10 MISCELLANEOUS

10.1 **Standing Orders to be given to Council of Governors, Board of Directors and Executives:** It is the duty of the Chief Executive to ensure that existing Board Members and Executives and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated executives shall be informed in writing and shall receive copies where appropriate in Standing Orders.

10.2 **Documents having the standing of Standing Order:** Financial Procedures and decisions relating to the reservation of powers to the Board and delegation of powers shall have effect as if incorporated into Standing Orders.

10.3 **Policy statements: general principles –** The Board of Directors will from time to time agree and approve policy statements and procedures which apply to all or specific groups of staff employed by the Foundation Trust. The decisions to approve such policies and procedure will be recorded in an appropriate Trust Board minute and will be deemed to be an integral part of the Trust's Standing Orders. Authority by the Board of Directors may be delegated to any of its Committees to approve policies and procedures.

10.4 **Review of Standing Orders:** Standing Orders shall be reviewed annually by each Board. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

10.5 **Standing Financial Instructions:** Standing Financial Instructions adopted by the Board of Directors in accordance with the Financial Regulations shall have effect as if incorporated within Standing Orders.

10.6 **Specific Guidance:** Notwithstanding the application of 10.3 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000
- Bribery Act 2010
- NHS Constitution

10.7 **Joint Finance Arrangements** - The Board of Directors may confirm contracts to purchase from a voluntary organisation or a local authority. The Board may confirm contracts to transfer money to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, and shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

10.8 Grants to Voluntary Bodies – The Board of Directors may provide financial assistance to such voluntary bodies in support of health related functions in accordance with Section 64 of the Health Services and Public Health Act 1968.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	241-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	16 September 2014
Appendices:	Annual Report

Child Protection and Safeguarding Annual Report

Key issues

1. The attached child protection and safeguarding annual report is presented to provide the board with assurance that QVH is fulfilling its statutory responsibility to safeguard children and young people as set out in Section 11 of the Children Act 2004.

Implications of results reported

2. Training at level 2 requires further commitment to ensure a minimum target of 80% is achieved.
3. Good relationships with the Local Safeguarding Children Board (LSCB) and consistent attendance by QVH at their meetings
4. Completion of the self-assessment against section 11 of the Children Act has raised no concerns with the LSCB.
5. During August 2014 the Lead Nurse and Named Nurse met formally with the Designated Nurse for Sussex to discuss arrangement for safeguarding at QVH to provide assurance that QVH arrangements for safeguarding did meet the standards required by the LSCB.
6. The attached annual report has been reviewed by the Paediatric Group and Quality and Risk Committee.

Action required

7. Completion of actions to meet level 2 training target of 80%.

Link to Key Strategic Objectives

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

8. The attached assessment can be seen to impact on four of the trust KSO's.

Implications for BAF or Corporate Risk Register

9. Delivery of safe care is reflected within both the BAF and corporate risk register.

Regulatory impacts

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

11. The attached assessment and statement of readiness does not impact on our Monitor governance risk rating or our continuity of service risk rating.

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Child Protection and Safeguarding
Annual Report
2013-2014

Child Protection and Safeguarding Team:

Amanda Parker: Board Lead for Child Protection

Dr. Mohammed Rahman: Named Doctor for Child Protection

Michael Brown: Named Nurse for Child Protection

Debra Yeoh: Specialist Paediatric Safeguarding Nurse

May 2014

INTRODUCTION

Child Protection and safeguarding work, continues to have an extremely high profile, on both local and national agendas. Over the past year, key documents have been released that have underlined its importance and also outlined new ways of working within the NHS. In 2013, the Departments of Health and Education published *'Safeguarding Vulnerable People in the Reformed NHS'*. This 'Accountability and Assurance Framework' sets out the roles and responsibilities of the NHS Commissioning Board, Clinical Commissioning Groups, NHS and Independent Sector providers, the CQC and Monitor.

It aims to promote-

- Partnership working at strategic and operational levels
- Clarify NHS roles and responsibilities; including education and training
- Provide a shared understanding of how the new system and how it will be held to account.
- Ensure that professional leadership and skills are retained within safeguarding, including designated and named professionals.
- Outlines a series of principles and ways of working, recognising that safeguarding is everyone's responsibility.

As a result of this framework, a revised *Working Together to Safeguard Children (2013)* has been released. This replaces the previous 2010 document and Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 1989.

The new *Working Together to Safeguard Children* (2013) streamlines previous guidance documents to clarify the responsibilities of professionals towards safeguarding children and strengthen the focus away from processes and onto the needs of the child. This in itself is a response from the report in 2012 from Professor Munro into the Child Protection system within the United Kingdom, which ultimately called for major changes to the existing approach and for the child to be at the centre of any system.

Although revisions have been made in the 2013 document, the overarching aim of *Working Together to Safeguard Children,* is to clarify the core legal requirements of both individuals and organisations to keep children and young people safe. Essentially, it is underpinned by two key principles:

- A child – centred approach is to always be implemented
- Safeguarding is *everyone's* responsibility.

The *Working Together* guidance therefore continues to form the focus of the safeguarding strategy within QVH and it is regularly highlighted within training sessions. It is also the framework for the Local Safeguarding Children Board (LSCB) to monitor effectiveness of local services (including the safeguarding at QVH).

A major issue on the current safeguarding agenda, is the *Child Protection Information Sharing Project* (DOH). This aims to enhance the national IT systems in Emergency Departments to include information on Child Protection. It is planned that this will allow nurses and doctors working in these areas to be alerted by a red flag once a child is booked onto their system, if they are subject to a Child Protection Plan or being looked after by the Local Authority. It is due to be introduced in 2015.

SAFEGUARDING/ CHILD PROTECTION TRAINING AND EDUCATION

Queen Victoria Hospital has made a clear statement within its Safeguarding policies, that all Trust employees (regardless of their position and including those who work primarily with adults) have a responsibility for safeguarding children and must make themselves aware of both Trust and Local Authority Policies. This is a responsibility that has been underlined within all job descriptions for staff throughout the Trust since 2012/13. As such, the Mandatory Training schedule within the Trust is reflective of this and has a focus on ensuring that all staff receive Child Protection training updates that are relevant for their role within the Trust and their level of responsibility.

The current QVH training strategy, was developed in response to 2010 guidance from the Royal College of Paediatrics and Child Health: '*Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate Document'*. This document gave clarity for healthcare Trusts about the relevant training required by different staff groups. It also emphasised the importance of being able to maximize flexible learning opportunities so that health care staff acquire knowledge and skills from research, case studies and serious case reviews (SCRs). Five main levels of competence have been identified within the 'Intercollegiate Document', which essentially recognises that different staff groups require a different level of training.

In March 2014, the '*Intercollegiate Document'*, was reviewed and updated. This has resulted in even clearer guidance being provided to Trusts in regards to the level of training that is needed for different staff groups, and also provided model job descriptions for certain Child Protection roles, which is hoped will provide a level of uniformity across Trusts. As a result of this review of training guidelines, QVH have been able to review their current requirements for staff training. This process is currently ongoing,

but it is hoped that by June 2014, our training strategy will be completely in line with the relevant National guidance in terms of which staff receive which training. Ultimately though, the following approach is likely to be necessary within the Trust-

- Level 1- all non-clinical staff.
- Level 2- clinical staff who have regular patient contact

  (*Within Trust this includes all clinical staff – HCA and above, regardless of Practice setting*)
- Level 3-Clinical Staff with regular contact with Paediatric patients.

  (*At QVH this equates to Paediatric Nurses on Peanut Ward and Minor Injuries Unit (MIU), Emergency Nurse (and care) Practitioners in MIU, Specialist Physiotherapists (of which there are 3 in Trust) Burns Surgeons.)*

At present, both Level 1 and Level 2 Child Protection are delivered in-house at QVH by the Named Nurse and Specialist Nurse. It is also possible to access these via e-learning, for those who do not wish to attend a face-to-face session. Level 3 training is provided by West Sussex LSCB, and can be booked via their website. This provides essential inter-agency training for all staff who require this level of knowledge and is free for all Trust staff. Currently, plans are underway to offer some Level 3 sessions within the Trust during 2014/15 and these will be evaluated in due course.

Current training competence across the organisation is as follows:

Level 1: 85.03% Level 2: 60.5% Level 3: 89.18%.

It is apparent that the level of training amongst staff who require Level 2 training needs to improve. A plan has now been put in place by the Named Nurse for Child Protection, to increase the level of offered Level 2 sessions to at least 1 per week until December 2014. All staff who require this training have been emailed and asked to book onto a session and this will be closely monitored by the Named Nurse to ensure attendance. The aim of this plan is to have at least 80% compliance by December 2014.

CLINICAL AND SAFEGUARDING SUPERVISION.

Queen Victoria Hospital understands the necessity of both clinical and safeguarding supervision and the need for this to be embedded within all Child Protection work. This was identified by Munro (2012) as being an essential component towards ensuring services are able to appropriately meet the needs

of children and ensure their safety. The Trust Lead for safeguarding has closely reviewed the current processes within QVH to ensure the supervision of staff is suitable

All staff are able to access supervision as and when required from the Named Nurses. The Named Nurses receive monthly supervision from the Trust Lead for safeguarding- this provides them with the opportunity to discuss any issues affecting their role or individual cases of concern if required. The Trust Lead then receives regular safeguarding supervision externally- from the Designated Nurse for Safeguarding Children for Sussex. This process provides a clear structure of safeguarding supervision throughout the Trust.

In addition to both clinical and safeguarding supervision, it is also important to acknowledge the need for staff to ensure they feel able to access appropriate services for debriefing following potential stressful safeguarding situations. Therefore, all staff employees are able to access supervision from the Trust's Psychological Therapies department. This is available to both individuals and groups of staff who require debriefing following child-related safeguarding incidents.

POLICY AND PROCEDURES.

Queen Victoria Hospital's *Child Protection Policies and Procedures* are available on the intranet and in all areas where children are seen or treated. Reference to the policy is regularly made reference to during staff training, to ensure all staff are aware of the appropriate procedures to follow and that they also understand their responsibilities. The policy continues to be updated regularly to ensure it keeps in line with the Sussex Child Protection and Safeguarding Procedures.

SAFEGUARDING CONCERNS AND ACTIVITY.

Total concerns 2013-14:- 145.

Referrals made to Children's services by QVH :- 24

Referrals made by referring hospital to other services (ie. Generally to social services and/or their own safeguarding team): 43.

Total number of contacts for 2013/14: 32, 848 (2709 inpatients, 26565 outpatients, 3574 MIU attenders)

Over the period of April 2013- March 2014, the Trust has continued to closely monitor the overall safeguarding activity and the type of concerns that have been raised. These are outlined below:

INJURIES with safeguarding / child protection issues by speciality:-

Age	Burn Injuries	Plastic surgery	Maxillo facial	Corneo
0-2 years	45	5	12	0
3-5 years	22	6	0	0
6-18 years	23	22	3	0

As can be seen above, of the 145 concerns raised within QVH, 24 were referred to Social Care via our own staff and 43 were referred by other hospitals (although QVH were required to then assist with the safeguarding process once the child was referred to the Trust). However, these numbers only depict a small fraction of the work carried out by the safeguarding team and ward staff. Information sharing with other agencies also plays a huge part in the safeguarding workload. The team have also attended and provided written reports for Child Protection Case Conferences during the past year. It must be recognised that all of the 145 concerns were closely followed up by the Child Protection team, but not all required Social Services engagement and instead required intense liaison with other external agencies.

As is our requirement under Section 11 of the Children Act (1989), the Trust maintains a secure database to collate information regarding Paediatric cases that have raised a safeguarding concern. It allows us to ensure patients are effectively safeguarded and assists in the process of highlighting repeated admissions to the Trust etc. once Child Protection issues are identified.

MEETINGS AND EXTERNAL LIAISON

The Child Protection Steering Group meetings are held quarterly within the Trust. The group traditionally comprises:

- Named Doctor for Child Protection
- Named Nurse for Child Protection
- Lead Nurse for Safeguarding
- Link Nurses/ Practitioners from individual departments throughout the Trust.

This provides an opportunity to attempt to ensure that Child Protection services within the Hospital are co-ordinated and developed, adhering to relevant guidance and changes. In addition, it provides a useful forum for reflective practice, allowing any current concerns or issues in practice to be discussed, to promote shared learning from incidents and to consider feedback from the LSCB and any relevant recommendations from serious case reviews.

As a Trust, Queen Victoria Hospital also continues to actively engage with the Local Safeguarding Children's Board (LSCB) and its relevant partners. The Director of Nursing attends quarterly LSCB meetings where changes in practice are raised and discussed and these are then shared with the safeguarding team. Close liaison between the Director of Nursing (Board Lead for safeguarding Children) and the Lead Nurse for Safeguarding Children has proved extremely effective at ensuring required changes in practice are implemented early and also any potential issues are quickly raised back to Board level.

In addition to the above meetings, the Lead Nurse and Named Nurses regularly attend other relevant LSCB meetings, thus sharing good practice and learning from relevant incidents. Over the past 12 months, the Trust have continued to contribute to LSCB audits as requested and will continue to fulfill this requirement in future. At least 4 audits have been completed for the LSCB in the last 6 months.

During the year a self-assessment was undertaken against Section 11 of the Children Act and presented to the LSCB who required no follow up action from QVH.

SUMMARY

Child Protection continues to have an extremely high profile within the national agenda. In the past 12 months major changes have been made, including the introduction of the *Accountability and Assurance*

Framework, the revision of *Working Together to Safeguard Children* and the vast overhaul of the *Intercollegiate Document* (which advices on training standards).

During her 2012/13 review of National approaches to Child Protection work, Professor Eileen Munro, concluded that the child protection system as a whole had become too concerned with procedures and had lost its focus on the needs and experiences of the child. In agreeing with this analysis, the Government is attempting to ensure that professionals are able to spend more time focusing directly on the needs of the children and families in their care. As a Trust, the Queen Victoria Hospital is in a good position to ensure they are able to adapt to changes requested from national guidance. We continue to participate with the LSCB on a regular basis and have strong input from the Executive Lead for safeguarding, which ensures its profile remains high amongst staff.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Trust Board
Meeting date:	25th September 2014
Reference number:	242-14
Report from:	Clinical Cabinet
Author:	Richard Tyler
Report date:	September 2014
Appendices:	None

Report from meetings of the Clinical Cabinet held on 1st & 15th September

Key issues and Actions

1. Performance: 18 weeks: Updated on progress of recovery plan and delivery of Intensive Support Team (IST) recommendations.
2. Theatre Productivity: Updated on work of Theatre User Group. Agreement to review current approach to staggered admissions times and introduction of 'zero tolerance to late starts' with effect from October.
3. Review of Trauma Service: Received report back from Trauma Review Group. Agreed group should undertake detailed option appraisal on the extension of trauma capacity with report back at the beginning of November.
4. Professional Leave policy: Endorsed existing policy.
5. Quality & Risk: Endorsed September Quality & Risk report.
6. Quality & Risk: Approved Emergency Preparedness, Resilience & Response (EPRR) self-assessment and agreed to recommend to the Trust Board for sign off.
7. Key Strategic Objectives: Cabinet were updated on progress against KSOs 2 & 5.

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

8. None

Regulatory impacts

9. Issues reported do not have an immediate impact on either CQC or Monitor risk ratings. However it should be noted that the Trust continues to fail the aggregate in-patient waiting list target for three consecutive quarters. This was the subject of discussion with Monitor at the Q1 review on 18th August. Monitor remains assured that the Trust is on track to deliver on its recovery plan.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	243-14
Report from:	Ginny Colwell, Chair of Q & RC
Committee meeting date:	4 September 2014
Appendices:	None

Report of the Chair of Quality and Risk Committee

Key issues discussed

There was discussion around the newest 'never event' and concerns the Programme Board has raised. The committee were assured that appropriate actions were being taken.

It was agreed that the Trust would engage with the new national patient safety campaign which aims to make the NHS the safest healthcare system in the world. This will link into other quality initiatives and enable the Trust to access support from other institutions.

Following discussion at a previous meeting a new report was submitted that triangulated patient incidents, complaints and claims. The findings of these activities will be disseminated via a new patient safety and risk newsletter, the resurrected Junior Drs forum and Morbidity and Mortality (MM) meeting

Concern was raised at how achievable CQUIN is around the WHO check list as the target is now 100%.

The Programme Board has also raised concern around our incidence of staff reporting stress and anxiety. (Graeme Armitage is aware)

Additional information or assurance sought

The NHSLA (Litigation Authority) is changing its methodology. The committee supported increased training and use of Root Cause Analysis, (RCA) but requested more detailed understanding of the financial implications of the changes

The annual child protection and safeguarding report was received; further understanding of trends, possible benchmarking and triangulation was requested for subsequent reports

The risk register was discussed and it was agreed that the Executive Governance committee needed to further assure itself that the risk ratings reflected their understanding of our risk priorities. This will take place at the next Clinical governance meeting

Implications for BAF or Corporate Risk Register

Never Events should be fed through to the Corporate Risk Register or Board Assurance Framework

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	25 September 2014
Reference number:	244-14
Report from:	Governor Representative on the Board
Council meeting date:	11 September 2014
Appendices:	

Report of the Governor representative on the Board on the Council of Governors meeting

Key issues discussed

1. In its private session, the Council considered and approved a proposal to appoint Lester Porter as Non-Executive Director for a further three year term of office.
2. In the public part of the meeting, the Council heard formally for the first time from the Chair-designate, Beryl Hobson.
3. The Council received the usual quarterly updates from the Non-Executive Directors on matters of relevance to the Trust. The Council sought and received clarification and/or assurance on the following matters:
    - Failure to meet national performance targets and the impact of associated financial penalties
    - 'Never Event' definitions, reporting and benchmarking
    - Monitoring of the reasons for the cancellation by the Trust of outpatient appointments
    - The adequacy of seating provision in waiting areas
    - Patient transport (in connection with a reported incident of excessive delay)
    - The future of the post of Charitable Fund-raiser
    - Car parking on site
    - Membership levels and engagement plans
4. The Council also heard from the interim Head of Corporate Affairs about plans for a review of the effectiveness of the Council of Governors. Council members were encouraged to complete an on-line survey to inform the review.
5. Allocations to committee memberships and Lead Governor roles were proposed and agreed, following a vote for the position of Vice Chair of the Council.

Implications for BAF or Corporate Risk Register

6. Nothing raised at the Council of Governors requires to be added to the Corporate Risk Register or Board Assurance Framework; a number of the items mentioned above already appear on these documents.

Recommendation

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