Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 18 December 2014

Session in public at 13.00
Session in private at 16.00

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

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 18th December 2014

Members (voting):

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

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 18 December 2014 at 13:00
The Council Chamber, East Court, College Lane, East Grinstead RH19 3LT

PUBLIC AGENDA		
No.	**Item**	**Page no**
WELCOME		
325-14	**Welcome, apologies and declarations of interest** Beryl Hobson, NED and Chair Designate	-
PATIENT SAFETY		
326-14	**Patient Experience** Amanda Parker, Director of Nursing and Quality	-
STANDING ITEMS		
327-14	**Draft minutes of the meeting session held in public on 27 November 2014 (for approval)** Beryl Hobson, NED and Chair Designate	1
328-14	**Matters arising and actions pending** Beryl Hobson, NED and Chair Designate	9
329-14	**Update from the Chief Executive** Richard Tyler, Chief Executive	11
RESULTS AND ACTIONS		
330-14	**Patients: safe staffing and quality of care** Amanda Parker, Director of Nursing and Quality	14
331-14	**Operational performance: targets, delivery and key performance indicators** Jane Morris, Interim Head of Operations	34
332-14	**Financial performance: monthly update** Dominic Tkaczyk, Interim Director of Finance and Performance	41
333-14	**Workforce** Graeme Armitage, Head of Human Resources and Organisational Development	57
STRATEGIC PRIORITIES		

334-14	**Quarterly update on delivery of Key Strategic Objective One: Outstanding Patient Experience** Amanda Parker, Director of Nursing and Quality	67
335-14	**Quarterly update on delivery of Key Strategic Objective Two: World Class Clinical Excellence** Richard Tyler, Chief Executive (on behalf of Steve Fenlon, Medical Director)	82
GOVERNANCE		
336-14	**Corporate Risk Register** Amanda Parker, Director of Nursing and Quality	86
337-14	**Board Assurance Framework** Amanda Parker, Director of Nursing and Quality	97
338-14	**C-Wing Action Plan update** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	145
339-14	**Fit and Proper Persons Test** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	165
340-14	**Duty of Candour** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	169
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD (AND COUNCIL OF GOVERNORS)		
341-14	**Clinical Cabinet** Richard Tyler, Chief Executive	173
342-14	**Charitable Fund Corporate Trustee** Beryl Hobson, NED and Chair Designate	-
STAKEHOLDER AND STAFF ENGAGEMENT		
343-14	**Feedback from events and other engagement with staff and stakeholders** All board members	-
GOVERNOR REPRESENTATIVE AND NON-EXECUTIVE DIRECTORS		
344-14	**Observations from the Chairman, Non-Executive Directors & Governor Representative** Beryl Hobson, NED and Chair Designate	-
MEMBERS OF THE PUBLIC		
345-14	**Observations from members of the public** Beryl Hobson, NED and Chair Designate	-

346-14	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. Beryl Hobson, NED and Chair Designate	-
PRIVATE AGENDA		
COMMERCIAL-IN-CONFIDENCE		
347-14	**Draft minutes of the meeting session held in private on 27 November 2014 for approval** Beryl Hobson, NED and Chair Designate	174
348-14	**Charitable Fund Trustees: Approval of Auditor's letter** Beryl Hobson, NED and Chair Designate	-
349-14	**Theatre Review** Richard Tyler, Chief Executive	179
350-14	**Contract Update** Dominic Tkaczyk, Interim Director of Finance and Performance	214
NEXT MONTH'S AGENDA		
351-14	**Draft agenda for next month's meeting** Lois Howell, Interim Company Secretary and Head of Corporate Affairs	220
ANY OTHER BUSINESS (BY APPLICATION TO THE CHAIR)		
352-14	Beryl Hobson, NED and Chair Designate	-

DATES OF THE NEXT MEETINGS

Board of Directors:	**Sub-Committees**	**Council of Governors**
Public: 29 January at 13:00	**N & R**: 29 January 2015 at 09:00 **Q & R:** 03 March 2015 at 09:00 **Audit**: 18 March 2015 at 14:00 **CFAC:** 26 March 2015 at 09:00	**Public**: 09 April 2015 at 15.00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 27th November 2014, 13.00 – 16.00, The Council Chamber, East Court, College Lane, East Grinstead RH19 3LT**	
Present:	Beryl Hobson, (BH)	Non-Executive Director and Chair Designate (Chair)
	Lester Porter (LP)	Non-Executive Director
	John Thornton (JT)	Non-Executive Director
	Ginny Colwell (GC)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
	Stuart Butt (SB)	Interim Director of Finance
	Amanda Parker (AP)	Director of Nursing & Quality
	Steve Fenlon (SF)	Medical Director
In attendance:	Graeme Armitage (GA)	Head of Human Resources & Organisational Development
	Lois Howell (LH)	Interim Head of Corporate Affairs & Co Sec
	Brian Goode (BG)	Governor Representative
	Jane Morris (JM)	Interim Head of Operations
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Peter Griffiths (PAG)	Trust Chairman

WELCOME

297-14 **Welcome, apologies and declarations of interest**

As apologies had been received from the Peter Griffiths (QVH Trust Chair), today's meeting would be chaired by BH (Non-executive Director and Chair Designate) in his absence. BH opened the meeting and welcomed those present.

GA advised the board that he was undertaking work for CSH Surrey but that this work did not conflict with the interests of the QVH at present. Other than this, there were no new declarations of interest.

PATIENT STORY

298-14 **Patient Safety**

AP shared details of a letter received from a patient who was the main carer for his wife, who had both dementia and learning disabilities. Thanks to the care and support of consultant Asit Khandwala, the patient was able to undergo treatment whilst still able to provide support and assurance to his wife. The patient had expressed gratitude for the compassion shown and asked that thanks be conveyed to Mr Khandwala.

The Chair thanked AP for her update which was duly **NOTED** and also asked that the board's formal thanks be passed on to Mr Khandwala.

STANDING ITEMS

299-14 **Draft minutes of the meeting session held in public on 30 October 2014 for approval**

It was noted that under item 263-14, the figures should be amended to read £300k - £400k of provision.

Subject to this revision, the minutes of the meeting were **APPROVED** as a correct record.

300-14 **Matters Arising & Actions Pending**

The board reviewed the current record of matters arising and actions pending and the document

	was updated as appropriate. The update was received and **APPROVED**.
301-14	**Update on behalf of the Chief Executive** The CEO opened by reminding the board that AP would be leaving the trust in February to take up the post of Director of Nursing at Western Hospitals, and confirmed the trust had advertised a six-month secondment opportunity to provide cover during the recruitment period. Whilst recognising this new role as a great opportunity, the board also expressed regret that AP would be leaving QVH. RT highlighted significant changes to the way in which specialised services would be commissioned from 2015, with plans for NHS England to co-commission the majority of specialist services in partnership with CCGs; whilst noting it was not clear at this stage how these changes would work in practice, the trust would need to focus carefully on how it might affect future income streams. RT also asked the board to note that the 5-year forward plan indicated consolidation of services into a smaller number of specialist centres, which could pose a risk for QVH. In the meantime, RT was pleased to report that the trust's five-year plan had been rated as green; moreover, at the recent quarterly meeting held with Monitor there had been no indication of any change to the trust's risk rating. The Chair thanked RT and the board **NOTED** the contents of his update.
RESULTS AND ACTIONS	
302-14	**Patients: safe staffing and quality of care** AP presented the monthly update on Patient care, highlighting the following issues: Whilst safe staffing levels were met in October, this was only achieved through use of bank and agency staff. A number of medication errors had been attributed to agency staff. Whilst HR teams are developing a plan to address vacancy rates, recruitment concerns have been reflected within the risk register. There were also concerns that insufficient levels of substantive Intensive Treatment Unit (ITU) nursing staff had led to recent issues in the Unit. Whilst this was an ongoing concern, AP assured the board that any issues which emerge are handled by herself and the Medical Director to ensure the trust was maintaining safe levels at all times. On a more positive note, AP reported that she had recently signed an agreement with the Military for a 5-year collaborative contract, which would bring specialist trained nurses to QVH on a rotation basis from January. Two serious incidents had been reported to the Clinical Commissioning Group (CCG) in October; the first related to a patient who had contracted Legionella, and the trust was awaiting a formal response from Public Health England. The second incident related to a patient who, as a result of post-operative complications, had lost his sight. A root cause analysis was underway, the results of which would be reported to the board next month **[Action: AP]** There had been a significant increase in the number of incidents causing harm to staff, (with one being reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) although no trend had been identified. AP asked the board to note that an incident of C.Diff, would be reported in next month's figures.

	Despite this being acquired by the patient within the community rather than the hospital, the data capture system did not allow for true reporting. AP had highlighted this inaccuracy to both the Commissioning Support Unit (CSU) and the Clinical Commissioning Group (CCG) but there appeared to be no recourse at present. AP assured the board that the trust had disseminated information to staff regarding the risks associated with the potential spread of the Ebola virus, and also participated in a local multi-disciplinary exercise during October to confirm the local health economy's preparedness. The board also noted that the Deputy Director of Nursing had accepted a secondment to the Department of Health to support its programme of preparedness. It was recognised that whilst patients with suspected Ebola symptoms arriving at Gatwick Airport would normally be referred directly to East Surrey, there was still a risk that infected patients could present at the Trust's Minor Injuries Unit (MIU) with an unrelated complaint. Eight complaints were recorded in October, with staff attitude remaining a continuing theme. GC asked GA what was being done to address this and was advised that this issue was highlighted during the recruitment process, and within leadership training and management development programmes; RT reiterated this was also emphasised at induction, and recognised that a multifaceted approach was required in order to address this fully. AP had recommended that a provider be appointed to manage Friends and Family Test data as current manual systems were becoming unsustainable; an automated system was necessary in order to capture response rates. JM warned of survey overload, although AP provided assurance that an automated system would enable rules to be established to prevent patients being surveyed too frequently. SF asked for clarification regarding targets for keeping the number of patients who would be unlikely to recommend QVH to friends and family low; AP agreed to investigate and report back **[Action: AP]** An annual report setting out progress against key actions and achievements to date in response to the Francis enquiry had been circulated to the board. The plan also identified and included actions relating to the Cavendish and Keogh reports. AP confirmed that the Quality and Risk Committee routinely reviewed progress against the plan. AP asked the board to note there were financial implications associated with the provision of the observation recording system and that a nursing technology fund bid was being developed in time for the December deadline. In response to JT's concerns, AP observed that despite some recommendations being labour-intensive, on the whole processes introduced had enabled greater transparency. The Chair thanked AP for her update, the contents of which were **NOTED** by the board.
303-14	**Operational performance: targets, delivery and key performance indicators** JM presented the monthly operational update report, noting that since July considerable progress had been made in reducing the waiting list backlog; the trust was forecasting compliance with the open pathway target in November, one month ahead of schedule. In order to continue progress in achieving a sustainable waiting list whilst reducing the number of patients waiting over 18 weeks, the trust would be forecasting non-compliance for both admitted and non-admitted targets for November, but anticipated compliance by the beginning of December. SB reported that there were only around 5-6% of patients still waiting over 18 weeks, and only 20 patients still without a date (due predominant patient choice). He also noted a significant

	improvement on the quality of information now received on a daily basis, with improvements set to continue into the future. The board discussed how best to express its thanks to staff who had come in at weekends throughout November in order to assist in reducing the backlog; the importance of thanking staff in person, as well as via Connect or the staff briefing, was emphasised. JT sought clarification as to the level of penalties which would be levied by the CCG; SB confirmed these would not be applicable in October or November, but it was hoped that around £120k of penalties could be recovered. He also agreed to prepare a report on the financial implications of the additional work for the December board meeting **[Action: SB].** JM reported that the trust had breached the 62-day cancer target for Q2 due to performance in July and August; these were predominately at off-site clinics where other trusts were experiencing difficulty in managing patient pathways. As there did not appear to be a particular trend, there was no action plan in place at this stage, although JM assured the board this was not related to breast reconstruction surgery, which had previously been a problem. JM confirmed that the trust should achieve the 62-week target for October, although the 31-week target was still awaiting validation. The Chair thanked JM for her report, the contents of which were **NOTED** by the board.
304-14	**Financial performance: monthly update** SB presented the Finance report for October highlighting the following: The trust achieved a £431k surplus in October; the forecast surplus figure of £2.4m reflected the original £2.2m target plus donated income from the League of Friends (for anaesthetic machines). The downside forecast is for a surplus of £2.4m (with an upside of £3.4m), giving a midpoint of £2.9m. Cumulative surplus remains ahead of plan with October surplus on plan and consistent with the same period in 2013-14. Whilst the November position was more aligned to last year, the planned surplus of £350k was unachievable due to income profile; whilst staff are paid in equal 12th (twelfths) throughout the year, the way that weekends and week days fall during any given mean month means that potential income varies, and this had not been taken into account when the target for November had been set. However, future planning would be phased in a different way; SB noted it would not be unusual to see a similar downturn in December because of the Bank Holidays on that month. The trust is achieving 69% of the cost improvement plan, with work progressing to ensure further improvement. SB asked the board to note that the original plan was predicated on acquiring the OT6 building, however, the building is yet to be disposed of and in the meantime the trust is still paying rental charges. Cash balances are significantly above plan (c £7.5m), due in part to delays to capital expenditure; the capital plan and associated schemes continue to be managed robustly. Good progress has been made in respect of debtors, with balances below the prior year-end balance. SB asked the board to note a change to reporting, which now set out the headline financial position for each individual directorate (including a summary of variances). He hoped that future reporting will be further refined to provide narrative outlining key risks, issues and opportunities. JT sought clarification with regard to agency and bank expenditure and was advised that whilst some was included in the plan, there was also provision made for emergency cover.

	BG asked for information on how the additional work would be paid for and how this would be presented within the finance reporting; SB advised that this activity would be clearly identified in order to provide assurance to the board whilst also assisting with planning for next year. The board was also reminded by RT of the importance of remaining alert to referral criteria and of ensuring that funding would be available to pay for activity, taking into account the constrictions of the wider health economy. The Chair thanked SB for his comprehensive update, the contents of which were **NOTED** by the board.
305-14	**Workforce** GA presented the Workforce update for October, reminding the board that recruitment and retention remained high on the agenda, with challenges in both turnover and vacancy rates. A number of new initiatives were being implemented to help address the issue, including establishment of a recruitment taskforce. GA tabled a recruitment 'dashboard' and noted the first meeting of the Recruitment Taskforce had been well attended. A recruitment day for nursing staff was scheduled for 27th January, with a similar event for medical staff planned for March. In the meantime, the level of staff vacancies remained high on the risk register. BH advised that NEDs had been asked to provide feedback on the current state of recruitment at the next Council of Governors meeting in December. GA agreed to circulate the latest update to NEDs for information **[Action: GA]** Sickness levels had fallen and there was also a reduction in the number of episodes relating to stress and anxiety. The HR team continues to support managers in addressing cases affecting their departments. GC commended the workforce report but requested additional information around absence and vacancies, for example separating out different staff groups; JM cautioned that administrative and clerical did not relate only to medical secretaries and that maybe a breakdown into more specific groups would be more helpful; GA agreed to review and simplify the current report. **[Action GA]** AP noted that the taskforce considered retention as well as recruitment and reminded the board that as a small trust it couldn't offer the same opportunities for development as a larger trust. SF noted that overseas recruitment had proved problematic within other trusts, but was assured the trust would never resort to taking on staff just to fill a gap; AP concurred, and confirmed the trust was currently investigating a range of alternative strategies. Whilst not a formal element of the Workforce report, GA asked the board to note that a new Leadership management development framework was being piloted and should be implemented next month. ERostering was under review at present (in an attempt to iron out issues which managers and the HR team had been experiencing since implementation). With these changes in place, it was hoped data could be used more effectively as part of an early warning system. The Chairman thanked GA for his update, and the board **NOTED** its contents.

STRATEGIC PRIORITIES	
306-14	**Quarterly update on delivery of Key Strategic Objective (KSO) 5: Organisational Excellence** GA presented a quarterly update on delivery of the KSO on which he was leading and reported that whilst overall progress was good, the launch of the Leadership and Development framework had been delayed whilst further refining took place; a revised launch date was set for the end of December; GA agreed to circulate the revised draft to members of the board for information **[Action: GA]** Following on from the monthly workforce update, GA reiterated changes which had been made to improve accuracy of eRostering information, and highlighted the importance of implementing the SafeCare system module. This was due to be completed by January/February 2015 and would provide up to date information about levels of staffing against the acuity of patients being cared for; until this was effective, the HR team would be instigating a temporary early warning solution. GA noted that strategic objectives were incorporated in the Workforce Strategy and where appropriate extended to reflect more detailed actions, for example long term workforce planning now dovetailed with the business planning process for Year 1, and extended further to enable the organisation to plan workforce requirements more effectively for the future. SB suggested that the strategy should also take account of the Directorate/Divisional perspective to achieve a more balanced picture. The Chair was assured by the amount of work being undertaken at present and thanked GA for his update, the contents of which were duly **NOTED** by the board.
GOVERNANCE	
307-14	**Corporate Risk Register (CRR)** AP presented the Corporate Risk Register (CRR) and asked the board to note the top four risks and in-month changes set out in the report. The board was pleased the report demonstrated clear engagement throughout the organisation. During discussions the following points were noted: • ID 629: there had been an improvement in the risk score (the arrow should be changed to a downward direction); • RT suggested that whilst the Clean Room failure had been scored above 12, this should be recalibrated to reflect the lower level of impact; • JT noted that the fields for IDs and 648 and 749 were inaccurate and should be reviewed AP noted his comments and agreed to action as appropriate; • LP requested a status update in respect of ID711 and was advised by SB that Willmott Dixon had verbally agreed to replace all door mechanisms at no cost to the trust, (to include new warranties); written confirmation of this offer was awaited. RT suggested that proposed changes to elective activity and tariff for 2015-16 should be captured within the risk register; SB agreed this could be done once details had been confirmed. The Chair thanked AP for her update the contents of which were **NOTED** by the board.
308-14	**Working Capital Facility** SB presented a report to the board regarding the Working Capital Facility (WCF) which provided

	the trust with a facility to draw down up to £4.1m to meet short term cash flow requirements. The figure of £4.1m represents approximately 27 days of operating expenses and whilst the trust has no plans to utilise this facility, it currently acts as a safeguard (at a cost of £20.5k with interest of Base Rate plus 2% on any funds drawn down). SB explained that whilst WCF was no longer a requirement under Monitor's Continuity of Service Risk Rating, it still remained best practice to have this facility in place. After due consideration, the board duly **NOTED** the contents of the report and **APPROVED** continuation of the existing Working Capital Facility arrangement.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
309-14	**Clinical Cabinet** The Chief Executive confirmed that he would provide a written report to the board at its meeting next month.
310-14	**Nomination & Remuneration Committee** As Chair of the Nomination and Remuneration Committee, LP had provided a written update on last month's meeting. He concluded there was very little to add to his report, the contents of which were duly **NOTED** by the board.
311-14	**Quality & Risk Committee** GC noted that the recent meeting had not been well attended due to a date change. Although GC had little to add to the written report, the Q & R committee was focusing on CQC inspection evidence in preparation for the trust's anticipated inspection next year. The board **NOTED** the contents of the update.
STAKEHOLDER AND STAFF ENGAGEMENT	
312-14	**Feedback from events and other engagement with staff and stakeholders** LH reported that she had undertaken a Compliance in Practice (CiP) session in the Minor Injuries Department; it was noted that despite the limited space, privacy and dignity was handled very well and patients appeared grateful to be seen at the local MIU, rather than at a larger Accident and Emergency Department. However, if a 'returners' clinic was underway in MIU, LH suggested this should be clearly communicated to all patients in order to alleviate concerns that some patients were 'queue jumping'. AP agreed to feed this back. **[Action: AP]** BH had met recently with the Chair of Brighton and Sussex University Hospitals Trust (BSUHT) who was keen to hold a 'board to board' event at QVH in the new financial year. GC had attended a Royal College of Nursing study day and reported that nursing revalidation would be introduced next year; it was noted that as with the medical revalidation programme this initiative would have associated costs but no additional funding.
GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
313-14	**Observations from the Chairman, Non-Executive Directors and Governor Representatives** LH, RT and BH had all attended this month's Foundation Trust Network (FTN) conference which this year had focused on integrated care, innovation and efficiency and accountability. LH agreed to circulate her notes of the event to all board members.

	AP had recently attended the Chief Nursing Officers conference and advised that the Learning Disabilities report was due to be published. AP noted that QVH had performed well during a recent peer review and results would be reported to the board in due course. With regard to current non-executive director (NED) recruitment plans, BH reported that she had undertaken a skills analysis of the current NEDs and would feedback the results to the Chair of the Appointments Committee; this in turn would inform the candidate brief currently being developed by Odgers. The current timetable indicated that a new appointment should be in place for the start of the new financial year. BH reminded the board that the governance review had been progressing since October, with a further meeting scheduled for December; an interim report would be provided at the January board meeting.
MEMBERS OF THE PUBLIC	
314-14	**Observations from members of the public** One member of the public present at today's meeting advised she had particular interest in the 5 Communities Plan and raised concerns that local residents were having to travel further from home in order to receive treatment. RT confirmed he was working with local GPs to help provide more services locally; BH advised that the Chief Executive would be making a presentation on Community Services at Council of Governors meeting on 11th December and suggested any members of the public with a particular interest in this issue should attend.
315-14	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

Chairman…… Date…….....

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
November 2014 meeting						
1	**317-14**	Board to receive a presentation in the New Year as to how the new Electronic Patient Record system will affect the organisation as a whole.	**JM**	February	Now scheduled for the board seminar in February 2015	On track
2	**312-14**	AP to notify MIU that patients should be advised if a clinic is running within the department in order to alleviate perceptions that some patients are 'queue jumping'	**AP**	December	This has now been requested	**Complete**
3	**306-14**	Revised draft Leadership and Development framework to be circulated to the board for information.	**GA**	?	**?**	**?**
4	**305-14**	Current workforce report to be refined to provide additional information around absence and vacancies, including a breakdown of individual staff groups.	**GA**	?	**?**	**?**
5	**305-14**	Latest update on staff recruitment to be circulated to NEDs for information.	**GA**	?	**?**	**?**
6	**303-14**	Report to be prepared on financial implications of the additional work undertaken in respect of RTT18 targets	**SB**	Dec	Information relating to the RTT costs and income included within finance and contract reports for M8	**Complete**
7	**302-14**	Clarification to be provided in respect of target for those patients unlikely to recommend QVH to friends and family.	**AP**	Dec	• Internally proposal is to use ▪ <5% green, ▪ 6-10 amber ▪ >10 red. • Externally no target identified as yet	**Pending**
8	**302-14**	Root cause analysis to be presented to board in respect of patient who lost their sight as a result of post-operative complications.	**AP**	Jan	Final report not due for completion until January	**Pending**
October 2014 meeting						
9	**294-14**	To acknowledge staff efforts for RTT18 work and keep apprised of results.	**RT**	Dec	Staff appreciation published in Connect w/c 8 December	**Complete**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
September 2014 meeting						
10	**235-14**	Clarity on project delivery dates to be provided as part of future KSO2 quarterly reporting.	**SF**	Dec	**21.10.14:** Next update due December	**Pending**
11	**239-14**	Following completion of action plan, changes to culture and practice within C-Wing to be identified and reported to the board.	**RT**	Dec	On December board agenda	**On track**
July 2014 meeting						
12	**181-14**	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**	~~Oct~~ Dec	This will form part of the wider organisational review which will start in October 2014 **21.10.14:** Review has commenced, not expected to conclude until December	**On-track**
May 2014 meeting						
13	**117-14**	Deputy Director of Nursing to attend future board seminar to provide update on Leadership Development.	**LH**	~~June~~ ~~Nov~~ TBC	**26.06.14:** Dep DoN to attend Board seminar session in November to provide update	**TBC**
14	**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~~ Mar	**08.07.14:** Presentation to be made to October Nomination & Remuneration Committee **15.09.14:** Well Led Review template to be used as framework for Board self-assessment commencing at December away day. **21.10.14:** Current Governance Review led by Chair Designate to be based on Well –Led Framework	**Pending**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18th December 2014
Agenda item reference no:	329-14
Author:	Richard Tyler, Chief Executive
Date of report:	11th December 2014

CHIEF EXECUTIVE'S REPORT DECEMBER 2014

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

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

Chief Executive's Report
December 2014

Note: this report is briefer than normal due to the earlier meeting date

TRUST ISSUES

Performance – 18-week recovery plan

1. As reported to the November Board I am pleased to confirm that we made significant progress is reducing the backlog of patients waiting over 18 weeks and that we are on track to achieve the RTT18 target in December. This is a reflection of hard work across the Trust and I have written to all staff on behalf of the Board to thank them for their hard work and support.

Monitor: Q2 Feedback

2. We have received formal notification of our Q2 ratings and I am pleased to report that we have maintained a continuity of service rating of 4 and a green governance rating. Monitor reiterates the need for us to achieve RTT18 week compliance from Q4 in line with national targets for compliance.

Organisational restructuring

3. We launched our organisational restructuring proposals on 1st December. The engagement period will run until 19th December. As part of the restructuring we have creating an 'Ask Richard' portal on the intranet for staff to post comments and questions, organised a series of meetings with various staff groups and offered individual staff the opportunity to meet with the Chief Executive or other member of the senior management team. At the time of writing (5th December) 27 comments have been received and 10 meetings arranged. All comments are responded to personally by the Chief Executive.

NATIONAL & REGIONAL ISSUES

The Dalton Review

4. Sir David Dalton's review of provider models 'Examining new options and opportunities for providers of NHS care' was published on 5th December. The full report can be found at www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care. The report makes two main recommendations;
    a. As part of 2015/16 business planning, trust boards should consider their response to the Five Year Forward Plan and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations;
    b. Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

CQC Intelligent Monitoring Reports

5. The latest CQC Intelligent Monitoring Report was published on 3rd December. The detailed report for the Trust can be found on the CQC website. The reports rank trusts into six priority bands for inspection. The bands are based on the likelihood that people may not be receiving safe, effective, high quality care with band 1 being the highest priority for inspection and band

6 the lowest. I am pleased to report that the Trust remains in band 6, the lowest priority for inspection.

Letter from the Secretary of State for Health.

6. All Chief Executives received a letter on 5th December outlining details of the additional funding announced in the Autumn Statement. An extract from the letter is included below:

The financial package involves the following elements:

- **£1.5 billion of additional revenue funding** for the NHS in 15/16. NHS England will allocate the majority of this funding to CCGs for local services, and will commission primary care and specialised services. NHS England's Board will confirm the details of these allocations at its meeting on 17 December.
- **£200 million** for a new Transformation Fund in 15/16 to kick start the work needed to deliver the new integrated models of care we need. This will be based around the four models in the *Forward View* all designed to deliver better care nearer home for vulnerable older people in particular.
- **£1 billion fund for advanced care in GP practices and other out of hospital care settings** - £250 million will be available each year for four years from 15/16 to pay for the modern premises and technology that will give patients access to advanced care, such as chemotherapy and dialysis, in their local communities. NHS England will announce the process for applying for this funding before the end of the year.
- **£30 million new funding** in 15/16, £150 million over 5 years, for the NHS to develop the best approaches to caring for young people with eating disorders in both inpatient and community settings, which will help develop a treatment standard for these conditions.

The NHS England Planning Guidance, to be published in the coming weeks, will provide further detail on how this money will be distributed.

Richard Tyler
December 2014

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date: 18 December 2014	18th December 2014
Reference number:	330-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	9th December 2014
Appendices:	1:Safe Staffing
	2:Patient experience, complaints & 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 1).
    - Quality and risk management with information provided on quality and safety metrics and incident management.
    - Infection prevention and control issues and actions.
    - Information on new and closed complaints, claims and patient experience feedback. (Appendix 2).

Safe Staffing

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

Quality and Risk Management

4. No serious incidents were reported to the Clinical Commissioning Group in November.
5. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.
6. Complaints have reduced during November however communication and staff attitude remain a theme.
7. An increase in medication administration errors is noted, though no harm was identified.
8. Flu vaccination has achieved a good start.

Infection Control

9. Infection control concerns being addressed are;

- Action was taken following a case of Legionella currently Public Health England require no further information from QBH and the SI declared has been downgraded.
  The risk of Ebola, the trust has disseminated information for staff and participated in a local multi-disciplinary exercise during October to confirm the local health economies preparedness. Further testing will occur during November.

Complaints, Claims and Patient Experience

10. There were seven complaints acknowledged during November 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.
11. 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.
12. Patient feedback is good, changes made to the scoring methodology of the FFT continue to be reflected within the dashboard.

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives (delete those not applicable)

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

15. 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

16. The corporate risk associated with the recruitment of staff remains at a rating of 16.
17. The corporate risks associated with infection control have been reduced to 12.

Regulatory impacts

18. 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

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

Patients: Safe Staffing and Quality of Care

Introduction

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

Safe Staffing

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

2. Recruitment and agency and bank usage was unavailable at the time of writing however vacancy rates have not changed significantly within the ward areas and the use of agency and bank staff remains significant. Recruitment is reflected within the risk register and the Head of HR is aware of the DN's concerns that recruitment to nursing vacancies appears to currently be challenging.

3. A number of medication errors are noted, no patients were harmed and these are noted in the main to be related to failure to sign for medication given or to communicate drugs given. Where individuals have made errors these are communicated and drug assessments are required to be repeated.

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	
SAFE STAFFING - Percentage of staff actually on duty against those planned	Margaret Duncombe Registered staff Day shift			112%	103%	111%	103%	102%	100%	100%	108%					
	Margaret Duncombe Support staff Day shift			115%	100%	94%	95%	97%	102%	98%	102%					
	Margaret Duncombe Registered staff Night shift			101%	96%	100%	102%	98%	99%	98%	102%					
	Margaret Duncombe Support staff Night shift			106%	97%	97%	100%	100%	100%	103%	94%					
	Ross Tilley Registered staff Day shift			73%	97%	96%	103%	98%	101%	100%	96%					
	Ross Tilley Support staff Day shift			69%	87%	90%	100%	101%	100%	98%	94%					
	Ross Tilley Registered staff Night shift			79%	96%	94%	95%	98%	100%	99%	92%					
	Ross Tilley Support staff Night shift			71%	97%	93%	93%	83%	100%	93%	89%					
	Peanut Registered staff Day shift			100%	94%	101%	95%	93%	99%	100%	105%					
	Peanut Support staff Day shift			106%	97%	100%	100%	103%	100%	100%	106%					
	Peanut Registered staff Night shift			100%	98%	98%	98%	95%	98%	93%	97%					
	Peanut Support staff Night shift			100%	100%	100%	100%	100%	100%	100%	100%					
	Burns Registered staff Day shift			86%	93%	94%	99%	96%	100%	99%	100%					
	Burns Support staff Day shift			113%	103%	108%	106%	91%	100%	94%	109%					
	Burns Registered staff Night shift			97%	98%	103%	100%	92%	100%	98%	103%					
	Burns Support staff Night shift			88%	93%	93%	106%	150%	100%	100%	100%					
	ITU Registered staff Day shift			99%	93%	95%	98%	93%	98%	100%	100%					
	ITU Support staff Day shift			128%	95%	94%	112%	100%	110%	100%	58%					
	ITU Registered staff Night shift			90%	96%	87%	95%	99%	98%	92%	102%					
	ITU Support staff Night shift			110%	100%	100%	100%	93%	100%	100%	100%					

Commissioning for Quality and Innovation (CQUIN)

4. One metric did not achieve the expected target for November. Within dementia only 5 out of 7 patients were asked the indicative question or formally assessed. This has been raised with the ward staff.

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

Patient Experience

5. Complaints received during November totalled 7 the full report is attached at Appendix 2.

6. Seven complaints were closed during November.

7. One new claim was received during November and these will be followed up and reported on to the Quality and Risk committee.

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 Experience	Complaints per 1000 spells	4.7		3.4	2.9	6.9	6.6	2.5	6.7	4.9	3.9					1
	Claims per 1000 spells	1		1.4	0.0	2.7	1.2	0.6	1.3	1.2	0.6					
	FFT Score acute in-patients: likely and very likely to recommend QVH	86%	>90%	99%	100%	99%	97%	100%	97%	98%	97%					0
	FFT score acute in-patients: unlikely and very unlikely to recommend QVH			started October						1%	0%					
	FFT score MIU: likely and very likely to recommend QVH	85%	>90%	99%	97%	96%	96%	97%	92%	86%	94%					
	FFT score MIU: unlikely and very unlikely to recommend QVH			started October						5%	2%					
	FFT score OPD: likely and very likely to recommend QVH	82%	>90%	98%	98%	98%	98%	98%	97%	97	95%					0
	FFT score OPD: unlikely and very unlikely to recommend QVH			started October						1%	3%					
	FFT score DSU: likely and very likely to recommend QVH	93%	>90%	0	98%	99%	99%	100%	99%	99	99%					
	FFT score DSU: unlikely and very unlikely to recommend QVH			started October						0	0%					49
	FFT score Sleep disorder centre: likely and very likely to recommend QVH	76%	>90%	99%	97%	98%	98.0%	95%	98%	97	100%					0%
	FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH			started October						0%	0%					#REF!
	Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0					
	Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	—	>90%	92%	97%	99%	98%	98%	97%	98%	96%					

Patient Safety

8. Two falls occurred, no harm was suffered these occurred within two different clinical areas.

9. The falls risk assessment completion rate which was noted previously to be due to a data collection anomaly has been corrected though the percentage achieved is slightly below the desired target. This has been raised to staff at their team meetings.

10. No Serious incidents were reported during November.

11. Two serious incidents were reported during October; 1) due to a previous patient contacting legionella - this has been downgraded and all actions required by Public Health England undertaken. The patient is fully recovered and currently no further actions are required.

12. Following confirmation that loss of sight previously noted as an incident during August could have been prevented, this incident currently has a full investigation underway, and has now been reported as a serious incident to the CCG, CQC and Monitor. Immediate actions were taken in August to prevent reoccurrence and the final report is due for completion in January. The patient is being kept informed of progress.

13. Medication administration errors are noted to have increased during November – no patients were harmed as a result of these incidents and actions are I place to address issues with individual staff and to raises awareness. All incidents are investigated and will be reported back to the Medicines Management Committee.

14. Trust wide, consent taking prior to surgery is noted to be just below the 75% target, with improvement within the maxilla facial team noted though all specialities achieved below the target for 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	
Patient Safety	Number of Pressure ulcer development Grade 2 or over acquired at QVH	8		0	0	0	0	1	3	0	0					
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	NEW	>95%		100%	97%	100%	100%	100%	100%	100%					
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	NEW	>95%		80%	83%	100%	100%	100%	100%	66%					
	Patient Falls resulting in no or low harm	16	—	4	1	3	6	4	5	3	2					
	Patient Falls resulting in moderate or severe harm or death	NEW	—	0	0	0	0	0	1	0	0					0.9
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	NEW	>95%	100%	73%	82%	85%	88%	80%	86%	92%					
	Avoidable patient falls identified on the Safety Thermometer	—		0	0	0	0	0	0	0	0					
	Serious Incidents	5		0	0	1	1	0	1	2	0					
	Never Events	NEW		0	1	0	0	1	0	0	0					
	Total number of incidents involving drug / prescribing errors	NEW		13	10	19	16	17	20	19	31					
	No & Low harm incidents involving drug / prescribing errors	NEW		13	10	18	16	17	20	19	31					0.1
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	NEW		0	0	1	0	0	0	0	0					
	Medication administration errors per 1000 spells	1.3		0.7	3.6	2.7	1.2	0	2	2.4	5.6					
	To take consent for elective surgery prior to the day of surgery (Total)	72.2%	75%	84.7%	69.6%	76.8%	77.1%	68.7%	74.5%	74.8%	74.3%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
	To take consent for elective surgery prior to the day of surgery (Max Fax)	60%		68.2%	69.7%	71.4%	77.8%	57.1%	51.6%	65.2%	72.7%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
	To take consent for elective surgery prior to the day of surgery (Plastics)	46%		84.3%	65.1%	72.9%	72.4%	69.4%	79.6%	72.2%	70.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	To take consent for elective surgery prior to the day of surgery (Corneo)	81%		95.0%	88.5%	93.9%	87.8%	75.7%	75.3%	87.2%	87.5%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
	Number of outstanding CAS alerts	NEW		0	0	0	0	0	0	0	1					13%
	Number of reported incidents relating to fraud, bribery and corruption	NEW		0	0	1	0	0	0	0	0					

Staff Safety

15. Five incidents of harm to staff are noted, none of these are noted as having caused significant harm.

16. The mandatory training figures is low following a data cleansing exercise and not all competencies have been re-registered on the system.

17. Flu vaccination clinics have commenced and national reporting will figures will be collated and submitted. The trust continues to have an internal target of 60% of all staff take up the offer of vaccination. Nationally in 2013/14 54.8% vaccination rates were achieved against a national aspiration target of 75%.

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
Staff Safety	Staff incidents causing harm	58		9	8	6	10	9	8	13	5					
	RIDDOR (Patients & Staff)	4		1	0	0	0	0	0	1	0					0
	Mandatory training attendance	71%	80%	82%	78%	82%	89%	79%	77%	74%	43%*					0
	Flu vaccine uptake	55%	60%	Not due till October						38.1%	49.70%					0

* low figure due to data cleanse; some competencies not yet registered on system

Infection Control

18. The limit for MRSA and Clostridium difficile 2014/15 remains as zero unavoidable cases. We have reported one clostridium difficile case that on review did not meet the 72 hour admission time required for trust declaration. However due to the way the data capture system works this is in days rather than hours.

19. Screening of elective patients for MRSA fell below the target of 95% during November, this has been discussed with the ward manager of the relevant area and identified that staff needed to be clearer about the screening of patients who are readmitted or have planned frequent visits.

20. Availability of microbiology support on site has been limited due to recruitment processes however full telephone support is available 24 hours a day. It was anticipated that from mid-November we would return to having on site presence twice a week however this has not been the case due to induction and annual leave. This has been raised as an issue at the latest contract meeting

21. The Burns unit continues to remains open and no further infection control issues have arisen and the risk associated with infection control remains reduced to 12.

22. Training, provision of information and testing on the management of patients suspected of having Ebola has continued to meet DH requirements.

Source	Description (Activity per 1000 spells is based on HES Data which is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0					13%
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0	0	1	0					0%
	E-coli bacteraemia	0	0	0	0	0	0	0	0	0	0					0%
	MSSA bacteraemia	0	0	0	0	0	0	0	0	0	0					
	MRSA screening - elective	96%	>95%	97%	97%	97%	95%	94%	96%	96%	94%					
	MRSA screening - trauma	98%	>95%	95%	97%	97%	97%	93%	99%	96%	98%					
	Trust hand hygiene compliance	95%	>95%	99%	100%	96%	99%	97%	99%	99%	97%					

Care Quality Commission (CQC)

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

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

Safe staffing Information – November

APPENDIX 1

CANADIAN WING													
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies wte/hrs Est = 62.88	7.76 WTE 1288.7hrs	9.21 WTE 1480hrs	6.22 WTE 1033hrs	3.83WTE 636hrs	6.38WTE 1025.3hr	6.38WTE 1059.53		<5%	10.1%				Action required under established adverts out to recruit
Temporary staffing Exc RMN Bank / Agency hours	530.10 431.30	553.15 360.30	735.15 375.0	836.50 452.30	418.15 499.30	579.00 795.15		<10% 235.8 + vacancy	+ 78.82				No action required
Sickness	2.4%	1.2%	1.0%	1.8%	1.5%	3.56%		<2%	+1.56%				High short term sickness
Shifts meeting Est Day RN Support	97.0%	98.0%	100.0%	99.0%	100% 101%	100% 98%	108% 102%	>95%					On track no action required
Shifts meeting Est RN day/night Support day/night					99% 100%	98.5% 98%	102% 94%	>95%					On track no action required
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	70.2%	70.3%	63.2%	61.6%	48.0%	64.80%	68.00%	>85%	-20.2%				Action required below target
Appraisals	67.7%	70.5%	73.7%	68.9%	66.7%	61.29%	70.00%	>85%	-23.71%				Action required below target
Drug Assessments	96%	98%	100%	100%	100%	100%		>95%	5%				On track no action required
Friends and Family Test Score **MD / RT**	89 85	94 94	87 91	83 82	73 75	97% 100%	98% 95%	>95%	+3 +2				Scoring methodology changes to percentage rating
Staff Friends and Family Test Score		79 17											
Budget (K)	15	6	12.6	-24	-37	-22		>0	-24				Over spend on nursing budget due to reliance on bank and agency to cover established posts

MARGARET DUNCOMBE	MAY	JUNE	July	Aug	Sept	Oct	Nov	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	1	0	0	0	0	0				On track no action required
Falls	0	1	2	1	4	1	0	0	1				For discussion at ward meeting no harm to patient
Medication errors	5	2	1	0	2	2	2	0	0				Failure to sign for meduication and wrong chart used. Staff spoken to individually
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	88%	95%	0%				Staff reminded of the need to check reassessment occurs
Nutrition assessment MUST/7 day review	100% 30%	94% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 50%	>95%	5%				Staff reminded of the need to check reassessment occurs
Activity	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy (10am)		73%	67%	82%	67%	Data unavail	Data unavail	<90%	-23%				On track no action required
Bed utilisation	93%							<100%					On track no action required
Patient numbers	158	141	148	132	133	143	98						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	SEPT	OCT	NOV	DN Rating					
Safe Care	No/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0	0	0	0				On track no action required
Falls	1	0	1	0	0	0	1	0	1				No harm sustained - patient reassessed
Medication errors	0	15	0	0	1	4	6	0	0				One ommission of medication , others were errors in signing, communicating and storing of medication
MRSA/Cdiff	0\0	0/0	0/0	0/0	0/0	0/1	0/0	0	0				One C Diff declared though unavoidable as within 72 hours of admission
VTE reassessment	91%	100%	100%	100%	100%	100%	78%	95%	5%				Staff reminded of the need to check reassessment occurs
Nutrition assessment MUST / 7 day	100% 100%	100% 92%	100% 100%	100% 100%	100% 100%	100% 100%	100% 0%	>95%	5%				On track no action required
Activity	No/%	No/%	No/%	No/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy		67%	64%	67%	59%	Data unavail		<90%	23%				On track no action required
Bed utilisation	107%							<100%					On track no action required
Patient numbers	199	186	207	190	178	212	179						On track no action required
Average length of stay	34.9Hrs												
Average patient acuity numbers/day		0 = 14.3 1a = 0.86 1b = 1.5											Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE

BURNS UNIT													
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 30.63	1.6 wte 266hrs	6.40 wte 1028hrs	7.40 wte 1229hrs	6.40 wte 1062.85	6.50wte 1044.6	6.53WTE 1084.44		<5%	21.31%				Vacancy on establishment
Temporary staffing Exc RMN Bank / Agency	398.15 114	466.30 128.55	400.45 573.0	335.0 216.0	124.45 78.0	301.25 137.45		<10% 114.8hrs + vacancy	-790.54				No action required
Sickness	4.1%	4.79%	2.42%	1.98%	0.75%	0.66%		<2%	-1.44				no action required
Shifts meeting Est Day RN Support							100 103%						
Shifts meeting Est Night RN Support	96%	99%	98%	92%	100%	98%	109 100%	>95%					Staffing identified as safe due to acuity of patients
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	80.25%	83.60%	77.10%	75.91%	58.79%	74.17%	78.00%	>85%	-10.83%				Below target
Appraisals	58.82%	66.67%	86.21%	80.00%	79.31%	80.00%	80.00%	>85%	-5.00%				Below target
Drug Assessments	95%	97%	97%	94%	90%	90%		>95%	-1%				Action required
Friends and Family Test Score	100	94	100	100	100	100%	100%	>95%	20				Scoring methodology changes to percentage rating
Staff Friends and Family Test Score		79 17											
Budget	3	15	-14.6	-90	-95	-99		>0	-90				Overspend is split between income and non pay

BURNS WARD	MAY	JUNE	July	Aug	Sept	Oct	Nov	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No%**	**No%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	1	0	0	0	0				On track no action required
Falls	0	2	3	0	0	0	1	0	0				Fall was due to patient trying mobilise independently and no harm was sustained
Medication errors	0	0	0	0	0	0	3	0	0				All incidents related to delayed or omitted medication
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	83%	95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	78%	68%	77%	29%	39%	Data unavail	Data unavail	<95%	18%				Closed during August
Bed utilisation													
Patient numbers	28	25	38	3	15	31	19						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	Sept	Oct	Nov	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No%**	**No%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0	0	0	0				On track no action required
Falls	0	0	0	0	0	0	0	0	0				On track no action required
Medication errors	0	0	0	0	1	2	2	0	0				Incorrect fluid provided to patients - staff have been spoken to on an indiviudal basis and drug assessments to be retaken
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	100%	>95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy													
Bed utilisation													
Patient numbers													
Average patient acuity numbers/day burns & ITU		1a = 0.23 1b = 3 2 = 0.29 3 = 0.1											Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE, 2 = 1.97WTE, 3 = 5.96WTE
ITU													
Staff utilisation	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Vacancies Est = 16.16	2.40 WTE 386 hrs	0 WTE 0.0	.44wte 73.0	1.76 wte 292.28	2.76wte 443.5	2.76WTE 458.35		<5%	17.07%				action required
Temporary staffing Exc RMN Bank / Agency	151.30 280.20	238.40 112.30	124.4 426.0	249.30 414.00	64.00 184.00	119.30 444.00		<10% 60.6hrs + vacancy	-143.05				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%	2.15%	2.09%		<2%	+0.09%				Sickness improved over last month,
Shifts meeting Est Day RN Support	95%	91%	97%	96%	99%	96%	100 58%	>95%	2%				
Shifts meeting Est Night RN Support							102 100						
Training / Appraisal	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**		**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Stat and Mand compliance	79.17%	83.60%	76.00%	80.27%	56.42%	78.57%	78.00%	>85%	-6.43%				Fallen slightly below target, action required
Appraisals	50.0%	46.67%	33.33%	37.71%	38.46%	53.85%	53.00%	>85%	-31.15%				Raised directly with manager
Drug Assessments	95%	97%	97%	94%				>95	-1%				Action required
Budget	-7	-25	-48	-62	-63	-47		>0	-62				Split is 1/3 pay and 2/3 income

Peanut	MAY	JUNE	July	Aug	Sept	Oct	Nov	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	No/%	No%	No%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Pressure Ulcers	0	0	0	0	0	0	0	0	0				On track no action required
Falls	0	0	0	0	0	0	0	0	0				On track no action required
Medication errors	0	0	0	1	0	0	0	0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0	0				On track no action required
Activity	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Bed occupancy Taken at 10.00 daily excluding weekends	64%	67%	68%	67%	59%	Data unavail	Data unavail	<95%	27%				
Bed utilisation													
Patient numbers													
Average length of stay	5.5Hrs												
Average acuity													
Peanut													
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Vacancies Est = 25.00	1.72wte 286hrs	2.2wte 365hrs	2.2wte 365hrs	.63wte 104.62	.63wte	1.0WTE 166.07		<5%	4.0%				No action required
Temporary staffing Exc RMN Bank / Agency	160.15 23.45	289.20 0	328.05 7.30	331.0 35.0	196.45 20.00	212.45		<10% 93.75 + vacancy	-47.37				
Sickness	3.8%	4.36%	10.03%	8.43%	6.05%	6.42%		<2%	+4.42				Carrying 1 long-term sickness case from 16.06.14 and 9 9 Short-term occurrences for October
Shifts meeting Est Day RN Support	96%	100%	97%	94%	99%	98%	105 97%	>95%					No action required
Shifts meeting Est Night RN Support							106 100						
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%		Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Stat and Mand compliance	81.3%	85.00%	67.20%	77.69%	58.54%	73.28%	69.00%	>85%	-11.72%				Action required
Appraisals	87.1%	96.77	84.38%	87.10%	87.88%	84.38%	78.00%	>85%	-0.62%				On track no action
Drug Assessments	100.0%	95.5%	88.0%	100.0%	100.0%	100.0%		>95%	-8%				On track no action
Friends and Family Test Score	100	100	66	-100	100	88%	100%	>95%	-14				Scoring methodolgy changes to percentage rating
Staff Friends and Family Test Score		79 17											
Budget	-6	-5	-6.6	-12	-17	-15		>0	-12				This is asplit between pay, non pay and income

Monthly complaints, claims and patient experience report

1 November 2014 – 30 November 2014

This report provides an overview of all activity during this period. During this period there were 7 formal complaints received. This is a slight decrease of the previous month (8). The following is a summary of the complaints that were received during this period:

Monthly complaints, claims and patient experience report

1 November 2014 – 30 November 2014

Complaints

Open complaints: There were 7 complaints opened during this period. All Complaints received are acknowledged, investigated and responded to. Actions identified are monitored for completion by the monthly clinical governance group.

Plastic Surgery

1. **Medical (MOHS)/communication/attitude** - Felt that clinician was disrespectful and rude to patient and her daughter. After consultation patient was asked to provide an MRSA swab from nose and groin which patient was not prepared for and quite shocked to be asked for. Have suggested that there should be notices in the waiting room to warn patients of this. **Investigating lead – Clinical Lead**

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

   Comment/Action – Still undergoing investigation and awaiting comments.
   .

2. **Medical – clinical care** – During procedure liquid nitrogen went into patients right eye which resulted in patient seeking treatment from the eye clinic. **Investigating lead – Clinical Lead**

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

   Comment/Action – Still undergoing investigation and awaiting comments.

3. **Medical/Nursing – Communication** Lack of communication by medical and nursing staff. Due to language barrier the results were not explained clearly to patient. Felt that Dr was disinterested. Has asked that at next appt she is seen by consultant. **Investigating lead – Clinical Lead**

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

   Comment/Action – Still undergoing investigation and awaiting comments.

Corneo Plastics

4. **Medical - Clinical care** – Delay in dealing with post-operative complication which has resulted in permanent loss of sight in one eye. **Investigating lead – Clinical Lead**

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

   Comment/Action – Case being investigated as a SUI.

Canadian Wing

5. **Nursing – Nursing care and security** - Allegation of poor care concerns treatment in the 'Day Room' wherein a male nurse who redressed the patient's head wound was careless resulting in the wound later 'exploding in a fountain of blood'. His theft allegation relates to some items of clothing going missing during his stay at QVH and then not being found despite repeated inquiries.

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

   Comment/Action – Still undergoing investigation and awaiting comments

Maxillofacial Unit

6. **Medical/consent/surgical treatment -** Following surgery for removal of supraclavicular lipoma patient says that they are suffering from loss of movement in arm and shoulder. Patient was not made aware of the risks associated with this type of surgery. I**nvestigating lead – Clinical Lead**

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

   Comment/Action – Patient has been advised to contact BSUH directly. At the time of this patients surgery QVH were offering bed capacity for some BSUH patients. The actual surgery was performed by a BSUH surgeon and his team.

Off-site clinic (Medway)

7. **Medical/attitude - Medical -** Found the manner of the clinician 'condescending and patronising'. I**nvestigating lead – Clinical Lead**

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

   Comment/Action – Still undergoing investigation and awaiting comments.

Closed complaints: There were 7 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.

Claims

Open claims: There were 1 new claims opened during this period, a summary of which is below. Overall there are 46 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.

Maxillofacial

1. **Histopathology** - Limited information other than that there was a 2 year delay in diagnosing a benign facial tumour.

Closed claims: 1 claim was closed during this period.

Plastics

1. **Medical** – Alleged surgery for trigger finger was performed negligently resulting in injury to the ulnar digital nerve.

   Outcome – Settled out of court. £5,000.

Patient comments, surveys & Friends and Family Test

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

NHS Choices

There was 1 new comments posted onto the NHS Choices website.

1. **Peanut** -My 5 year old was sent to QVH (Peanut Ward) from Eastbourne DGH for surgery on an open fracture to a finger. Staff there, particularly the nursing team, were very friendly and helpful and explained everything to me and then my daughter in a very appropriate way. The facilities for children are great - we had a private room and the playroom and parent room were good. We have stayed at both the DGH and Conquest children's wards and this was by far the most child friendly and welcoming by design. We were given a follow up appointment which was made around our availability and given great aftercare advice and a number to contact with any problems. Can't fault the care my daughter received.

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.

As of October 2014 the FFT scoring has changed and we are now using the percentage of in-patients respondents that would recommend/wouldn't recommend the service in place of the Net Promoter Score. The Trust wide FFT scores for in-patients in November **is 97% of patients would recommend and 0% of patients would not recommend us.** Please note that for this month due to technical problems the data for Total Eligible and Response Rate has been omitted.

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

Area	Total Responses	Percentage recommended	Percentage Not recommended
MD ward	99	98%	0%
RT ward	40	95%	0%
Peanut ward	4	100%	0%
Burns ward	14	100%	0%
Sleep centre	70	100%	0%
MIU	247	94%	2%
Trauma	120	93%	4%
OPD	770	95%	3%
DSU	83	99%	0%

The following chart is a comparison of specialist hospitals and their FFT net promoter scores for October 2014 (please note that NHS England publishes their statistics 1 month behind and the new FFT scoring is now in place.

Trust	Total Responses	Total Eligible	Response Rate	Percentage recommended	Percentage Not recommended
Moorfields Eye Hospital NHS Foundation Trust	61	87	70.11%	100%	0%

Papworth Hospital NHS Foundation Trust	634	1042	60.84%	98%	1%
Queen Victoria Hospital NHS Foundation Trust	115	402	28.61%	98%	1%
The Royal Marsden NHS Foundation Trust	72	306	23.52%	94%	0%
Royal National Orthopaedic Hospital NHS Trust	269	522	51.53%	96%	1%
Stoke Mandeville Hospital	273	919	29.71%	96%	1%

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18th December 2014
Reference number:	331-14
Report from:	Jane Morris, Interim Head of Operations
Author:	Jane Morris, Interim Head of Operations
Report date:	10th December 2014
Appendices:	Appendix A) - NHS IMST Elective Sign off letter

Operational performance: targets, delivery and key performance indicators

Key Performance Indicators

1. Trust income from patient activity was slightly under plan in Month 8.

2. The Trust is forecasting non-compliance at an aggregate level for both the admitted and non-admitted 18 weeks in November.

3. The Trust is forecasting compliance with the Open Pathways target in Nov.

4. Speciality level information for November is still subject to validation and will be confirmed at the Board following submission of the data to the Department of Health on the 17th Dec.

5. Following the extra activity in November the Trust is continuing to forecast compliance with all three targets for December as planned.

6. There are no breaches of 52 weeks forecast for November.

7. The Trust achieved all cancer waiting times in October except for 31 day subsequent treatment. This was due to a single patient breach that had originally been booked for minor surgery but needed treatment in a main theatre so had to be rebooked accordingly.

8. There were no urgent operations cancelled for a second time in November.

9. There was one operation cancelled on the day of admission in November due to a lack of critical beds for a major Head and Neck patient. This resulted in a breach of the 28 day guarantee as It was not possible to reschedule the surgery earlier due to coordinating consultant surgeons commitments to undertake this complex case.

Implications of results reported

18 weeks

10. Focus on clearing backlog of long waiting patients will result in failure of 18 week Trust aggregate targets for admitted and Non admitted in November.

11. The trust continues to maintain additional waiting list management systems introduced since October alongside extra capacity to reduce the backlog. and the trust expects to achieve aggregate compliance with all 18 week targets by the 1st December.

12. QVH continues working with commissioners in monitoring trajectories to achieve Trust aggregate compliance by the 1st Dec.

13. The Intensive support team has now formally signed off the Trust from requiring further national input, due to progress made. A copy of their letter is included as Appendix A.

Actions being taken to achieve compliance

18 weeks

14. Key actions in place

- Operational Control centre is now fully embedded and meets daily. This group focuses on providing targeted lists of patients to be booked by secretaries, waiting list progress as well as addressing immediate operational issues so that backlog continues to reduce as per trajectories
- Alongside the daily meetings the Information team are continuing to refine the information provided to the operational team to support the control centre
- A total of 55 extra operating sessions have taken place during November to ensure the Trust continues to reduce the waiting list backlog.
- Extra evening and Saturday clinics have been run in Orthodontics to increase capacity for treatments as well as another 50 patients have been treated before the end of November with an external provider.
- In addition other extra evening theatre lists have taken place in November for Plastics as well as minor oral surgery sessions, alongside outpatient clinics in Max Fac and Corneo.
- The Trust is still also securing extra capacity at Centre for Sight until February, for the more complex corneal patients who cannot currently be treated at QVH as well as continuing with Saturday operating twice a month until the end of March.

Cancer

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

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

16. Actions being taken to mitigate the risks include

    - Liaising with management teams off site to improve processes
    - Training of admin teams and reinforcing to junior doctors about the correct listing of patients
    - Contacting individual Trusts when an immediate breast breach has occurred due to unavailability of visiting consultant and asking them to review systems
    - An interim manager has completed a review and new data collection process surrounding cancer waiting times and COSD is being introduced in Jan with a new tracking system..

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

17. The income performance in Month contributes to the financial sustainability objective. The Trust has agreed with the CCG's that no penalties will be applied from July if compliance is achieved by 1st December as backlog is cleared.

18. 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

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

Regulatory impacts

20. 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

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

Interim Management and Support
Elective Care Intensive Support Team
David.boothey@nhs.net

Mobile number: 07920 450 165

1st December 2014

Management in Confidence
Richard Tyler
Chief Executive Officer
Queen Victoria Hospital NHS Foundation Trust
By email to: richard.tyler@qvh.nhs.uk

Dear Richard

RE: Sign Off Report Elective Care
Further to the ongoing IST support provided to the Trust for elective care, I am writing to formally confirm sign off the Elective Intensive Support Team's work with Queen Victoria Hospital NHS Foundation Trust.

Reason for engagement

The Intensive Support Team (IST) was initially engaged at the request of the Trust to support them in reviewing the provision of elective care services at the Trust, with the specific support and review objectives as outlined below:

- General waiting list management;
- Current RTT18 Trust Access Policy;
- The Trusts' current model whereby predominately medical secretaries undertake scheduling rather than a centralised waiting list office;
- Support the Trust in undertaking demand and capacity review for Plastics and Corneo.

Support Provided

The IST has provided support to the Trust in relation to a number of specific recommendations relating to the above reviews including:

1. Support the Trust to undertake a full demand and capacity planning exercise at the level necessary for operational delivery, through providing training and advice in the use of the IST demand and capacity models;
2. IST to review methodology used for backlog clearance trajectories with Trust staff as part of a future visit.
3. IST to provide advice on the content of recovery plans for the relevant services, to support the recovery trajectories developed; and
4. IST to meet with a member of the central information team to review PTL and other reports supporting operational delivery.

The IST would like to thank staff for their openness and commitment during the period of support. In particular, Jane Morris, Interim Head of Operations, who has been key in providing leadership and driving forward implementation of the action plan, and providing challenge at a Trust level, and also working closely with specialties. Additionally, we would like to thank the information team, for their support in the development of the operational PTL, and Pauline Sharp, Patient Access and Performance Manager, for the timeliness of work to update the Trust Access Policy and training materials, and her availability in meeting so frequently during the review period. We would also like to thank the operational management teams, in particular Avis Warburton-Pullen, for her support in undertaking the demand and capacity work with the information team, and to commend her on her level of knowledge and understanding of specialty specific issues and challenges. Lastly, we would like to thank Brenda Mitchell for coordinating arrangements with colleagues for our visits to the Trust.

Trust progress towards sustainable achievement of sustainable elective care standards

As part of the support provided to the Trust, the IST worked with team members to take forward actions from the IST report. The Trust has made considerable progress since the review, including the following:

a) Implementation of actions in response to the recommendations provided by IST as an outcome of our review:

The Trust has made good progress in addressing the backlog of patients, and expects to have cleared the backlog of patients, and achieve compliance at Trust and specialty level by 1st December 2014;

b) Demand and Capacity planning:

The IST undertook several meetings with specialty level teams as part of developing and reviewing the demand and capacity modelling. As part of this work, the IST provided challenge with regard to the key assumptions within the models, including the capacity arrangements and parameters used.

Specialty teams have a good understand of clinical pathways, including potential issues, opportunities, and topics for inclusion within the specialty level recovery plans.

The IST is confident Trust colleagues have a good understanding of the principles of demand and capacity management, and use of the IST demand and capacity tools.

c) Recovery Plan Development

The IST discussed recovery plan development with the Interim Head of Operations and key management staff, and the IST recommended development of the monitoring tools for backlog clearance going forward, including sustainable waiting list size, and trajectory for backlog clearance (both in terms of reduction to achieve a sustainable waiting list size, and clearance of patients waiting over 18 weeks).

The Trust has developed monitoring tools which enable this visibility, and are reviewing and tracking performance on a weekly basis. The IST reviewed recovery trajectories with the Trust at regular intervals, and the Trust have refined and reviewed the plans in response to staff changes during the period.

d) Development of an Operational PTL

The IST worked with the Trust to develop an operational PTL to assist in the chronological management of patients. This enabled the consolidation of existing patient level and summary information, with the new operational PTL providing a tool to support chronological booking, and readily identify long waiting patients, as well as differentiating urgent and routine patient waiting times.

Use of the PTL for the management of bookings is becoming embedded within the Trust, and the Trust has made good progress in improving chronology of booking and scheduling of urgent patients within the defined timeframes.

e) Trust Access Policy Review

The IST worked with the Trust Patient Access and Performance Manager to review the Trust Access Policy, and also met with the Interim Head of Operations to discuss specific points for clarification. As a result of the changes to the Trust Access Policy, the Trust has since refreshed RTT training for staff to address the issues identified within our review.

The Trust validation team has been strengthened enabling more timely validation of the waiting list, and implementation of new processes to improve the efficiency of patient scheduling, through providing timely feedback to teams and individuals regarding themes identified in validation, to improve operational team capability.

f) Commissioning Arrangements

The IST noted, due to the nature of commissioning arrangements for the Trust, engagement with commissioners on a number of key recommendations will be challenging, due to the number of commissioners, and the nature of being a specialist regional treatment centre.

Subsequently recommendations relating to commissioner engagement, for example development of integrated care pathways may be challenging to develop, particularly in the short term, and the Trust will need to ensure timely identification of patients who may be delayed in referral to the Trust, so treatment can be expedited.

The new operational PTL will support identification and management of these patients. The Trust has also agreed a new procedure for managing inter provider transfers without a minimum data set.

g) Booking Scheduling Service Level Agreement (SLA)

The booking and scheduling SLA is still under development, however the IST would be happy to review the draft when available and provide comment. The document will be important in clarifying roles and responsibilities of the central appointments team and the clinical service areas, and associated timeframes and service standards.

The IST is reassured that there is sufficient internal capacity to drive the change programme without further support of our team.

Conclusion

IST are happy to provide telephone advice at any time, and should you require us to, re-engage with the Trust in the future, we would be happy to consider this, as appropriate.

As a part of our sign off process we ask that you take a little time to provide us with feedback on the support that the IST has provided. . I would therefore be grateful if you could complete and return the attached feedback request to both peter.kennedy4@nhs.net and jordan.scott@nhs.net.

If you would like to discuss any details either from this letter or any area where support from IST would be helpful please do not hesitate to contact me.

Yours sincerely,

David Boothey
Intensive Support Manager
Elective Care Intensive Support Team

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18th December 2014
Reference number:	332-14
Report from:	Dominic Tkaczyk, Director of Finance and Commerce
Author:	Dominic Tkaczyk, Director of Finance and Commerce
Report date:	10th December 2014
Appendices:	Finance Report

Finance Report M8 November 2014

Key issues

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

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	5,240	5,165	76	41,014	39,702	1,312
EBITDA	343	638	(295)	3,884	3,918	(34)
Surplus	57	342	(285)	1,623	1,549	74
Continuity of Service risk rating (CoSRR)	4	4	-	4	4	-

NB table subject to rounding differences.

2. The Trust is £74k ahead of the surplus plan for the year with increased income largely offset by increased costs. In month the Trust made a surplus of £57k being £285k behind plan.
3. The Trust is maintaining a Continuity of Service Risk Rating of 4.

Implications of results reported

4. Achieving the surplus of £1,623k to Month 8 provides some assurance that the planned surplus of £2,205k for the year is achievable. This performance underpins the forecast to Monitor which is a year-end surplus of £2,445k being plan plus £240k expected additional income for donated assets.

Action required

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

Link to Key Strategic Objectives

- Operational excellence

- Financial sustainability

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

Implications for BAF or Corporate Risk Register

7. Nothing new to add.

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
November 2014
Month 8
10 December 2014

Executive Director: Dominic Tkaczyk

Contents

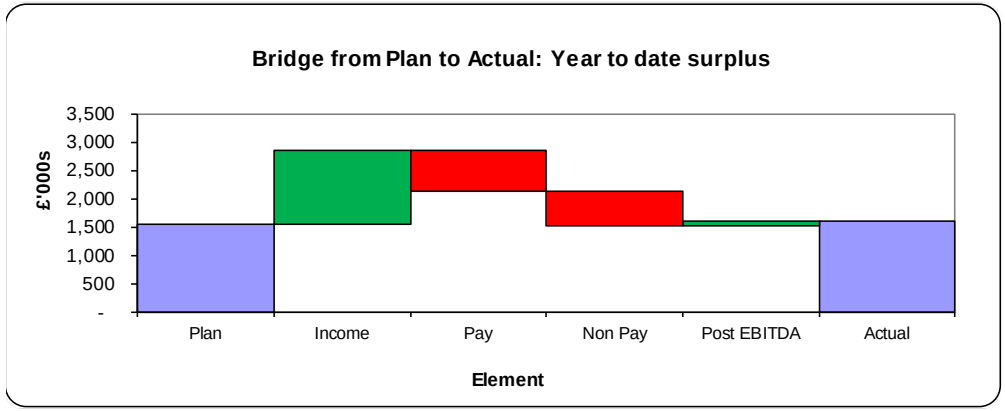
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M8 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure	M8 13-14 CM Actual £k	Current Month-November Actual £k	Budget £k	Variance £k	M8 13-14 YTD Actual £k	Year to Date 14/15 Actual £k	Budget £k	Variance £k
Income	*4,877*	5,240	5,165	76	*38,985*	41,014	39,702	1,312
Pay	*(3,230)*	(3,525)	(3,215)	(310)	*(25,126)*	(26,253)	(25,542)	(711)
Non Pay	*(1,498)*	(1,373)	(1,312)	(60)	*(10,342)*	(10,877)	(10,242)	(635)
EBITDA	*149*	343	638	(295)	*3,518*	3,884	3,918	(34)
EBITDA %	*3.1*	*6.5*	*12.3*	*-5.8*	*9.0*	***9.5***	*9.9*	*-0.4*
Post EBITDA	*(297)*	(286)	(296)	11	*(2,096)*	(2,261)	(2,369)	108
Donated assets					*113*			
Surplus (Deficit)	*(148)*	**57**	**342**	**(285)**	*1,535*	**1,623**	**1,549**	**74**
Surplus (Deficit) %	-3.0%	1.1%	6.6%	-5.5%	3.9%	4.0%	3.9%	0.1%

Continuity of Service Risk Rating	Metric	Level 4 threshold	Score	Weighted score
Liquidity days	51	0	4	50% 2
Debt Service Cover	3.0	2.5x	4	50% 2
Combined Score (1 to 4)				**4**



Summary

- The Trust remains ahead of the surplus plan for the year, with additional income mostly offset by additional costs.
- The activity income for November, which includes additional income of £412k from the 18Week sessions, was slightly below plan.

Issues

- The year to date surplus of £1,623k (4.0% surplus) is consistent with the annual plan of £2,203k (3.7% surplus) .
- Income includes the recognition of 100% of CQUIN for the first quarter and 75% for the rest of the year.
- Income reflects estimated performance penalties of £401k year to date including a new estimate for Outpatient follow up penalties of £86k for the year to date. These are subject to confirmation.
- Pay cost s in November includes £227k for additional 18Week sessions
- The Continuity of service risk rating is 4, as planned.
- The Trust continues to forecast achievement of the planned surplus .

Risks.

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

Actions

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

Forecast – M8 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Full Year Forecast at Month 8 2014/15	Plan £k	Downside	Downside £k	Upside	Upside £k	Midpoint £k
Income	59,551	Current levels less quality and activity risks	61,049	Current performance to plan plus growth continues with increased quality	61,809	61,429
Pay	(38,401)	Actual levels plus overspends	(39,233)	Increased activity and cost control.	(39,173)	(39,203)
Non-Pay	(15,394)	Historic overspending continues	(16,149)	Increased activity and cost control.	(16,089)	(16,119)
ITDA	(3,553)		(3,445)		(3,445)	(3,445)
Surplus	2,203		2,222		3,102	2,662

Summary

- Achievement of planned surpluses for the remainder of the year provide for an outturn forecast of £2.2m, however actual performance to date is consistent with previous years and indicates the potential for marginally lower than planned income levels in the coming months.
- The downside forecast is for a surplus of £2,222k with an upside forecast of £3,102k, giving a midpoint of £2,662k.
- The Monitor forecast remains at £2,445k.

Issues

- The downside forecast assumes that activity income levels continue at plan levels with additional risks of quality penalties and increased costs.
- The upside forecast assumes that the year to date trend of overachievement on income continues, the 18 week initiative is successful in reducing penalties and achievement of 100% of the CQUIN in 2014-15.
- The potential to release £500k of debt and creditor provisions by year end has been agreed by the Board and will be offset by additional non-recurrent costs to support organisation transformational projects. (The forecast position assumes the release of provisions is matched with additional non-recurrent costs).

Risks

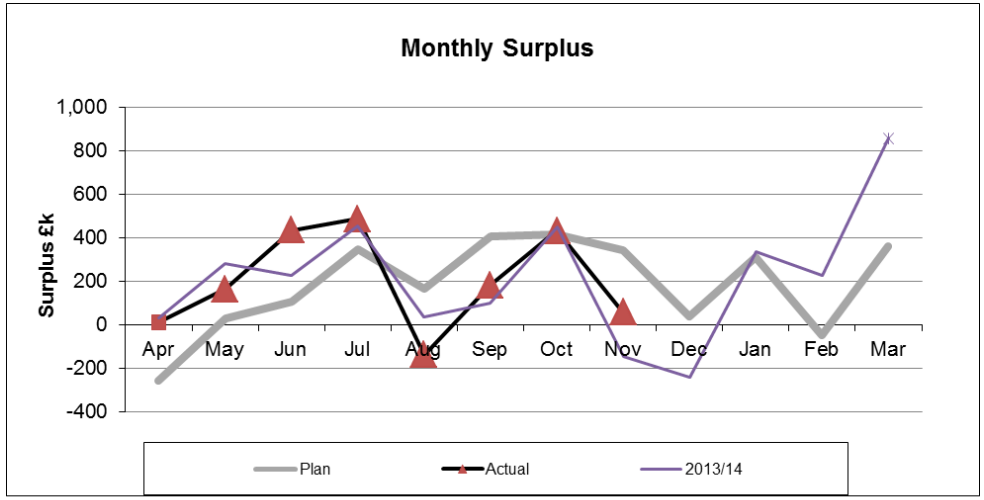
- The Trust surplus is sensitive to the achievement of the agreed activity/income plans .
- The operational pressures around staffing means that cost control remains critical.
- Penalties are assumed at year to date levels so the financial position would worsen if penalties increased.

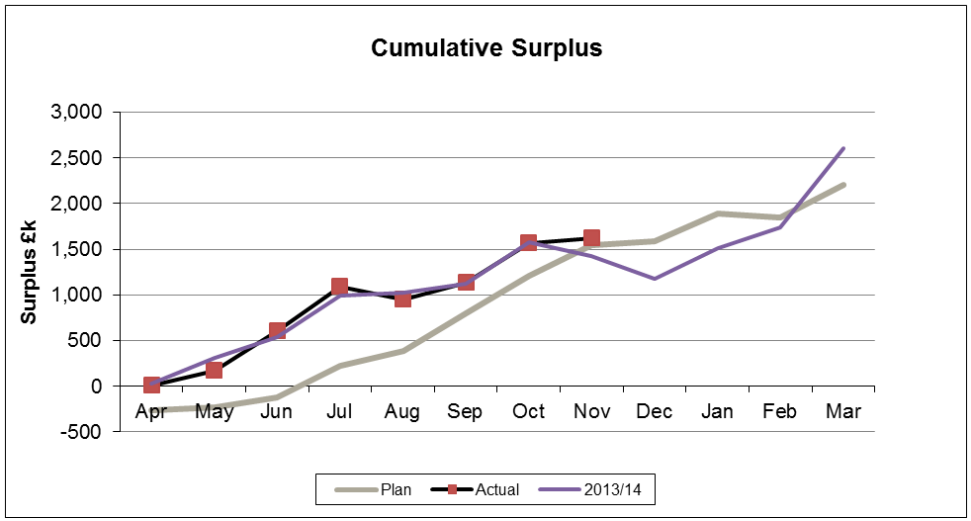
Actions

- 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 looks at pay and non-pay costs associated with the delivery of all activity.

Summary Trend Position – M8 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust





Summary

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

Risks & Issues

- The trust surplus is sensitive to the achievement of income targets as costs are predominantly of a fixed base nature. December and February have low activity plans so it is essential that these are met or exceeded to avoid a loss in those months.
- 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.

Summary Actual Position – YTD M8 2014/15

Queen Victoria Hospital NHS Foundation Trust

Financial Performance	2014-15	November 14-15			Year to Date 2014-15		
Summary by Type	Annual Budget £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable / (Adverse))
Patient Activity Income	54,664	4,686	4,756	(70)	36,968	36,436	532
Other Income	3,763	427	314	114	3,010	2,509	501
Pay	(38,196)	(3,516)	(3,198)	(318)	(26,005)	(25,405)	(600)
Non Pay	(14,451)	(1,268)	(1,232)	(36)	(10,089)	(9,608)	(481)
Financing	(3,553)	(286)	(296)	11	(2,261)	(2,369)	108
Underlying Position	**2,227**	**43**	**343**	**(300)**	**1,623**	**1,563**	**60**
Offset Items	(25)	15	(1)	17	(30)	(14)	(16)
Prior Year Items	-	(2)	-	(2)	30	-	30
Surplus / (Deficit)	**2,203**	**57**	**342**	**(285)**	**1,623**	**1,549**	**74**
Note: Financing costs consist mainly of depreciation, dividends and theatre loan interest.							

Summary

- The headline total income variance for month 8 is +£76k which consists of: matched income +£32k , patient activity -£70k and other +£114k.
- Pay includes £227k of additional 18week session costs in November.

Issues

- The impact of prior year items is shown separately in the above analysis.
- The impact of the prior year is expected to be positive the benefit of any write back of provisions will be subject to further review at the end of Q3. At this stage the Trust has assumed £500k of provisions will be utilised to support non-recurrent cost pressures.
- Offset items show a negative variance due to timing differences and is expected to reverse.

Income – M8 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

POD Month 8:	Current Month Actual	Current Month Plan	Current Month Variance £k	Year to Date Actual £k	Year to Date Plan £k	Year to Date Variance £k
Day Case	1,180	998	183	7,842	7,298	544
Elective	767	933	(166)	6,174	7,101	(927)
Non Elective	841	953	(112)	7,485	7,290	195
Exclusions	272	258	13	2,280	2,052	228
Outpatient First Attendance	427	438	(11)	3,450	3,422	28
Outpatient Follow Up	804	791	13	6,608	6,211	397
Outpatient Procedure	392	339	52	2,869	2,681	188
Minor Injuries	56	71	(14)	556	559	(3)
Radiology	105	101	4	880	800	79
Critical Care	72	65	7	576	511	65
Sub total	**4,916**	**4,947**	**(31)**	**38,719**	**37,927**	**793**
CQUIN reduction	(29)	-	(29)	(144)	-	(144)
Penalties	(20)	-	(20)	(315)	-	(315)
ERT deduction	33	(96)	128	(182)	(733)	551
Add back offset items	(128)	(96)	(32)	(1,023)	(757)	(266)
OPFUP penalties	(86)	-	(86)	(86)	-	(86)
Patient Activity Income	**4,686**	**4,756**	**(70)**	**36,968**	**36,436**	**532**

Summary

- Patient income by point of delivery (POD) was £31k behind plan in M8 (before adjustments) with elective inpatients showing a significant adverse variance.
- The assumptions around CQUIN, penalties and Emergency Rate Threshold (ERT) are considered to be prudent at this stage and may be subject to revision.

Issues

- Income by POD is at the full rate, i.e. it assumes 100% CQUIN, no penalties and no reduction for ERT. These are accounted for separately.
- CQUIN has been planned at 100% achievement. Q1 CQUIN is reflected at 100% based on internal calculations and Q2 onwards at 75% . 100% CQUIN was achieved last year.
- The penalties relate to 18 week breaches and other contractual penalties; these remain subject to commissioner agreement.
- ERT was prudently assumed to be suffered at 100% in the budget but contracts reflected an improved position. The financial provision assumes ERT is incurred at a provider not CCG level.
- Out patient follow up penalties have been recognised for the first time this month.

Risks

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

Actions

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

Penalties: Issues / Risks

- Within income there is an accrual of £401k for penalties and challenges. (activity data is still to be finalised and any penalties to be further agreed with commissioners).

Penalties Accrual 2014/15	M1	M2	M3	M4	M5	M6	M7	M8	Total
	£	£	£	£	£	£	£	£	£
RTT18 Admitted	2,400	2,400	10,800	23,600	29,200	30,800	0	0	**99,200**
RTT18 Non-Admitted	600	0	2,000	2,400	3,600	4,900	0	0	**13,500**
RTT18 Open pathways	7,200	5,200	8,200	9,000	13,300	14,800	0	0	**57,700**
Sub total RTT18	**10,200**	**7,600**	**21,000**	**35,000**	**46,100**	**50,500**	**0**	**0**	**170,400**
52 week waiters (estimate)	0	5,000	15,000	10,000	*10,000*	*10,000*	*10,000*	*10,000*	**70,000**
Urgent operation cancelled for 2nd time	0	10,000	10,000	10,000	*10,000*	*10,000*	*10,000*	*10,000*	**70,000**
Never Events (estimate)	0	1,000	2,000	0	0	0	0	0	**3,000**
Data Challenges (estimate)	1,000	1,000	0	0	**0**	**0**	**0**	**0**	**2,000**
Outpatient Follow Up Ratios								85,603	**85,603**
Grand Total	**11,200**	**24,600**	**48,000**	**55,000**	**66,100**	**70,500**	**20,000**	**105,603**	**401,003**

- 18 week penalties constitute the majority of the accrual. The 18 week penalties for Q2 onward remain subject to discussion with CCGs as providers do not expect to be penalised for reducing backlogs.
- Out patient follow up penalties have been recognised for the first time this month, estimated at £85.6k for the year to date based on analysis to month 6.
- No additional penalties for 18 weeks have been accrued for October or November because these will not be applied by commissioners. The achievement of full 18 week compliance from December is expected to eliminate the Q2 18 week penalties and improve the financial position as presented.
- Last year total penalties and challenges were £307k.

Actions

- Robust management of 18 week performance standards continue and the latest forecasts suggest full compliance from December onwards.

Cost Improvement Analysis – M8 2014/15

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes built into budgets 2014-2015	Annual Plan £000's	Month 8 Plan	Achieved £000's	Achieved %	Shortfall
Pay	337	224	189	84%	36
Clinical Supplies	233	155	112	72%	43
Non Clinical Supplies	142	95	9	9%	86
Other non operating expenses	170	113	96	85%	17
Total Cost Improvement Programmes	**882**	**588**	**406**	**69%**	**182**

Summary

- At M8 the trust is achieving 69% of the cost improvement plan , work is progressing to ensure further improvement.

Issues

- Pay - the key adverse variance is in the Programme Office where costs have been brought forward. The adverse variance will reverse and the planned savings 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 and is unlikely to realise the full benefit of the savings plan in year. Additional procurement savings are in development to help to achieve the full plan
- Other non operating expenses variance is due to an increase in the PDC dividend.

Risks

- A 31% shortfall on plan is a risk for the full year of £273k. 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 M8 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet for: Month 8 2014/15	2013/14 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,211	36,509	36,665
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	36,509	36,665
Current Assets			
Inventories	415	425	412
Trade and Other Receivables	8,939	6,342	6,735
Cash and Cash Equivalents	3,655	7,680	7,427
Current Liabilities	(6,574)	(6,046)	(6,386)
Sub Total Net Current Assets	6,436	8,401	8,188
Total Assets less Current Liabilities	43,647	44,910	44,852
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**	**35,784**	**35,726**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	17,374	17,316
Revaluation Reserve	6,173	6,173	6,173
Total Tax Payers Equity	**34,159**	**35,784**	**35,726**

NB Analysis is subject to rounding differences

Summary

- Net assets improve with the generation of the surplus.

Issues

- Fixed assets are down slightly as depreciation exceeds new 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.
- Non-current liabilities have reduced in year due to the theatre 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 – M8 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	294	5	-	299
Other projects	92	11	15	31	56
14/15 Projects:					
Corneoplastic electrical upgrade	100	-	-	144	144
Fire compartmentalisation	160	-	-	15	15
A Wing repairs	100	-	-	-	-
Meeting rooms	50	-	-	20	20
Carbon reduction	50	-	-	-	-
Other projects	398	42	29	227	297
Medical Equipment	550	263	64	833	1,160
IT Equipment	1,400	240	80	265	585
Grand Total	**3,350**	**849**	**193**	**1,535**	**2,576**

Summary

- Capital expenditure is significantly below the phased plan.

Issues

- Following review the forecast for IT spend in this financial year has been reduced to £585k. The key project within IT is a replacement network to support more advanced clinical systems.
- Medical equipment spend forecast has also been reduced subject to business case.

Risks

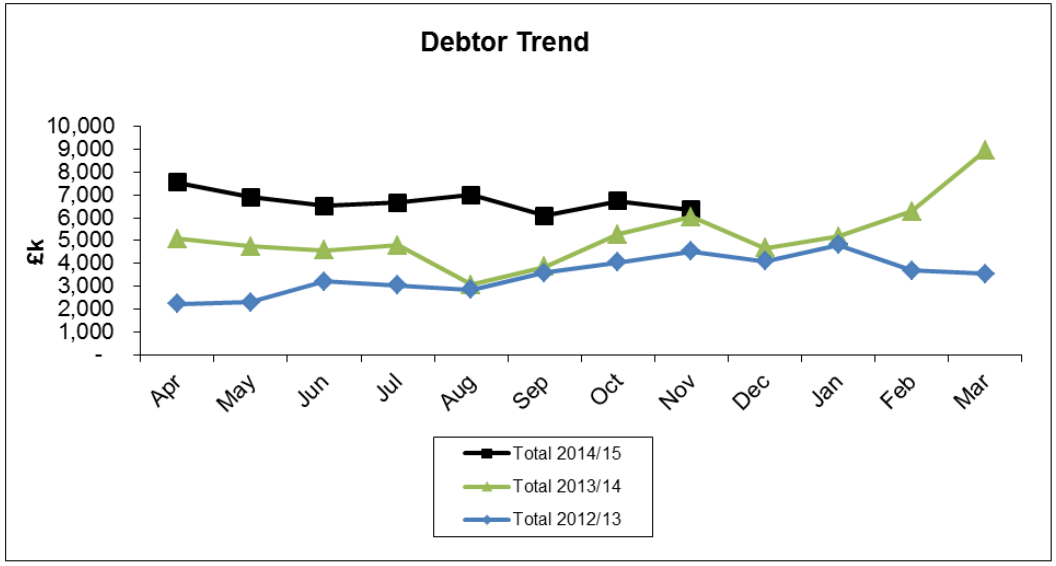
- Sufficient project management is key to the delivery of capital projects so this is being built into delivery plans.

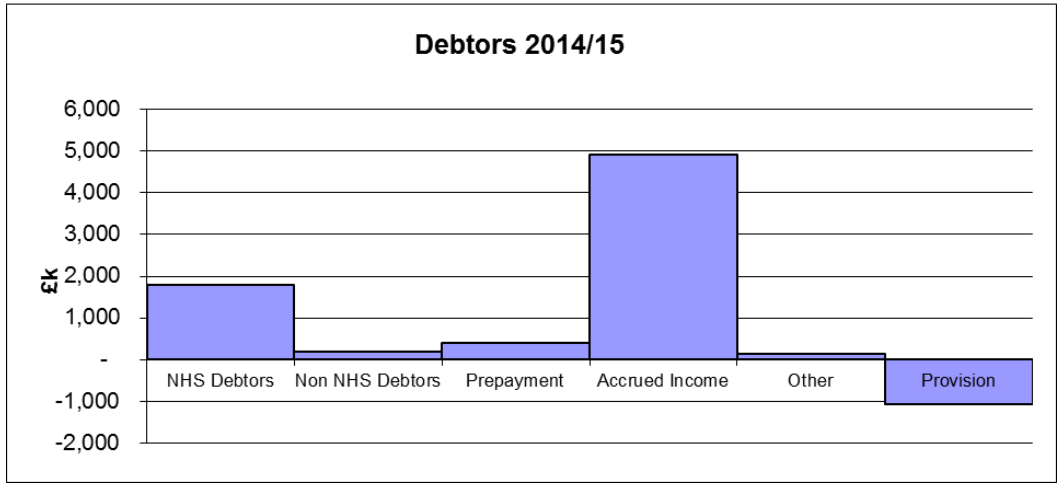
Actions

- Deliver planned projects.

Debtors – M8 2014/15

Queen Victoria Hospital NHS Foundation Trust





Summary

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

Issues

- Debtor balances are at 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 is expected to reduce by c£200k by year end.

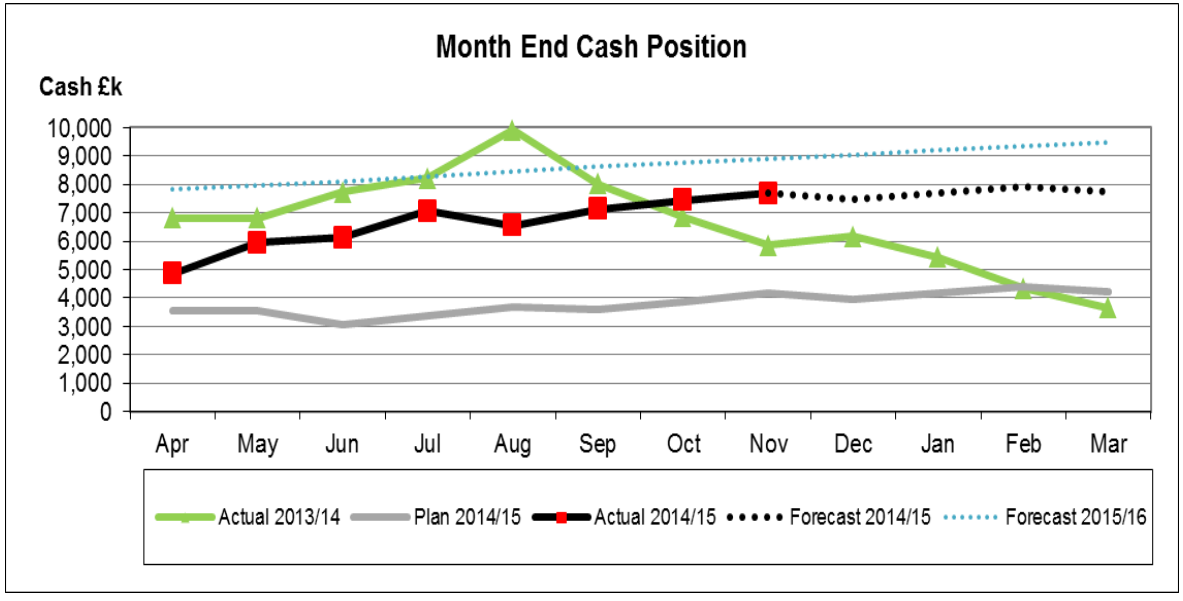
Risks

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

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M8 2014/15



Summary

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

Issues

- 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.

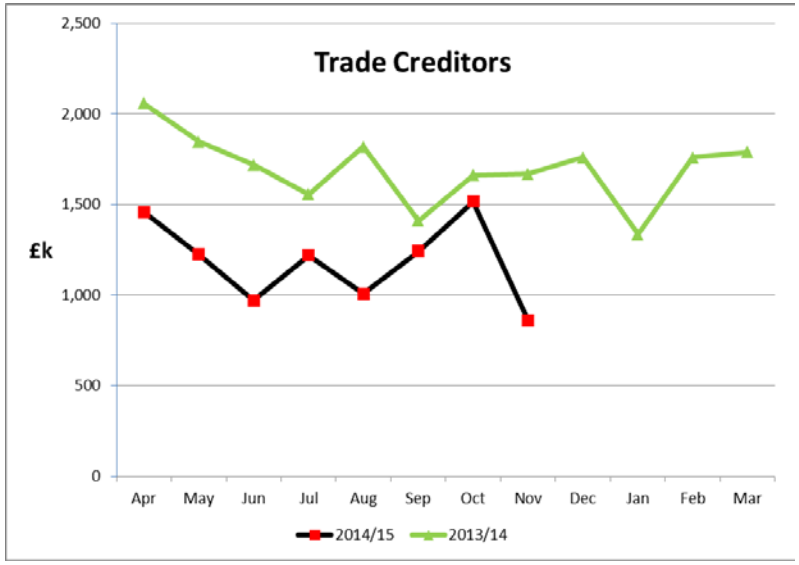
Risks

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

Actions

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

Creditors – M8 2014/15



Better Payment Practice Code November 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	1,364	1,436	10,582	10,865
Total **Non NHS** trade invoices paid within target	9,386	15,087	977	955	6,756	6,930
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**72%**	**66%**	**64%**	**64%**
Total **NHS** trade invoices paid	1,082	4,544	116	643	665	3,690
Total **NHS** trade invoices paid within target	624	2,858	42	145	312	2,023
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**36%**	**23%**	**47%**	**55%**

Summary

- Trade creditors have decreased following action to improve payment terms. Non NHS performance has improved and NHS performance shows a reported decrease because of increased clearance of older previously held invoices.

Issues

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

Risks

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

Actions

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18th December 2014
Reference number:	333-14
Report from:	Graeme Armitage, Head of HR & Operational Development
Author:	Graeme Armitage, Head of HR & Operational Development
Report date:	10th December 2014
Appendices:	A: Workforce Performance Report

Workforce update – December 2014

Key issues

1. Recruitment and retention continues to be the main priority and a number of initiatives to help address this have now been put in place. The second meeting of the R & R Task and Finish Group developed further the initiatives to support the organisation and the action plan updated accordingly. The current level of turnover remains around the same level as the previous month which proves a more stable position for the last 3 months and is a result of some of the focus this is now having.

2. It has not been possible to give a full picture for some of the workforce metrics this month due to the data not being available.

3. Sickness is likely to show a further fall in November however the data was not fully available at the time of producing this report. A verbal update will be provided by the Head of HR/OD at the meeting on the 18th December 2014. The HR Team continue to focus on those areas where sickness is high and continue to work with managers to support them to address cases affecting their departments. Weekly reviews of all sickness cases takes place within the HR ER team and actions agreed. All staff are being encouraged to take up the flu jab to help minimise absence due to flu and close monitoring of all sickness will be maintained to reduce absence levels towards the outturn target of 2%.

4. Phase 3 of the Statutory and Mandatory Training improvements are taking place and are on track with the plan. The January 2015 report will be the first opportunity for the revised reporting to be provided to the Board. This will give a more accurate position for training with all posts aligned to training profiles associated with the Skills Passport.

5. E-Rostering has been subject to a formal review over the last 2 months to iron out some of the system problems which managers and the HR team have been experiencing. A number of changes have been made to improve the accuracy of the information available from the system and we are now implementing the SafeCare module. This will provide up to date information about the levels of staffing against the acuity of the patients being cared for. In the meantime we are also looking at the information currently available to be able to provide managers with an early warning of potential staffing shortages at the beginning of each week. This will be trialled in December 2014.

Implications of results reported

6. The workforce metrics within this report have an impact on the quality of patient care and so robust management of those remain a priority.
7. 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.
8. Workforce data is shared with NHS England and may be used by commissioners.
9. 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

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

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

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

13. 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

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

Implications for BAF or Corporate Risk Register

15. The issues raised at paragraphs 1 – 5 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.

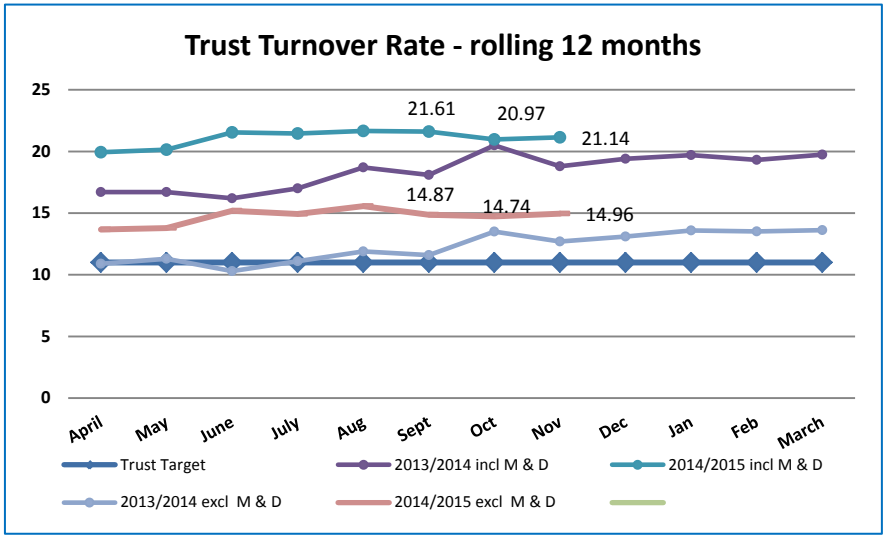
Regulatory impacts

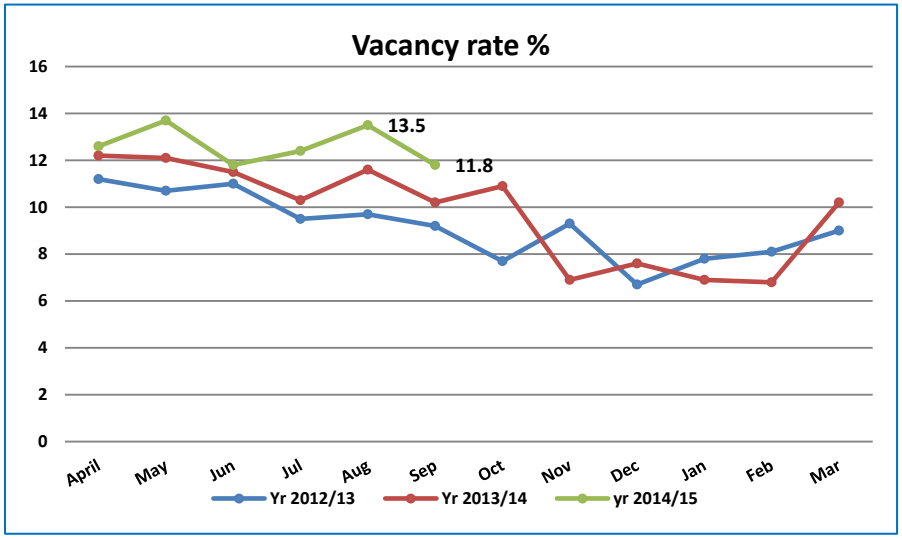
16. Although there is always a potential for high turnover and staff sickness to compromise quality of care and have a detrimental impact on the experience of other staff, it is not felt that the level of turnover and staff sickness prevailing currently is a genuine threat to regulatory compliance. Safety 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

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

HEADLINE HR KPIs December 2014





Staff Movements

	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14
Headcount	960	959	967	971	971	966	966	967	965	957	961	965	966
WTE in Post	819	820	825	823.78	823.78	816.86	816.07	816.78	816.79	816.79	812.47	816.49	818.86
WTE Funded Establishment	867.99	867.99	867.99	867.99	867.99	897.51	897.51	897.51	897.51	897.51	897.51	897.18	897.14
New Hires	12	6	16	29	7	10	7	19	10	23	24	23	12
Leavers	6	14	11	22	15	9	9	21	12	44	17	17	12
Maternity Leave	19	21	16	17	19	19	20	17	16	19	20	18	16
Vacancy Rate	6.9%	7.6%	6.9%	6.8%	10.2%	12.6%	13.7%	11.8%	12.4%	13.5%	11.8%	N/A	N/A
Turnover Rate Headcount	0.73%	1.46%	1.14%	2.37%	1.55%	1.04%	1.04%	2.18%	1.35%	4.62%	1.77%	1.76%	1.24%
Turnover Rate	0.73%	1.46%	1.14%	2.05%	1.65%	0.93%	0.93%	2.07%	1.24%	4.49%	1.69%	1.66%	1.14%

Rolling 12 Monthly Turnover Figures

	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov14
12 Month Turnover (including Medical & Dental)	18.8%	19.4%	19.70%	19.32%	19.74%	19.94%	20.15%	21.55%	21.45%	21.66%	21.61%	20.97%	21.47%
12 Month Turnover (Excluding Medical & Dental)	12.7%	13.1%	13.59%	13.51%	13.62%	13.67%	13.79%	15.19%	14.93%	15.57%	14.87%	14.74%	14.96%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 30th November 2014 is 14.96%, the last quarter has remained steady although higher than the same period last year. Turnover for the year 2014 has been consistently higher than the previous year. Recruitment and retention initiatives are being taken forward by the R and R Task and Finish Group to address this. Recruitment open days planned for January and March with additional analysis and review taking place to find out the reasons for staff leaving and what they like about working for QVH. "014 staff survey results will be available in Jan/Feb and these will be closely analysed to identify issues affecting retention.

November saw 12 leavers (9.35 FTE), which is higher compared to the same period last year where we had 6 leavers. Of the 12 leavers, 5 were voluntary resignations – other/not known , 3 voluntary resignation – promotion, 2- relocation, 1 – end of fixed term contract and 1 – voluntary early retirement.

Vacancies Rates (figures 2 month in arrears)

Trust Vacancy figures for October are not available due to the December Board Report being produced early this month. Updated figures will be produced for January Board Report.

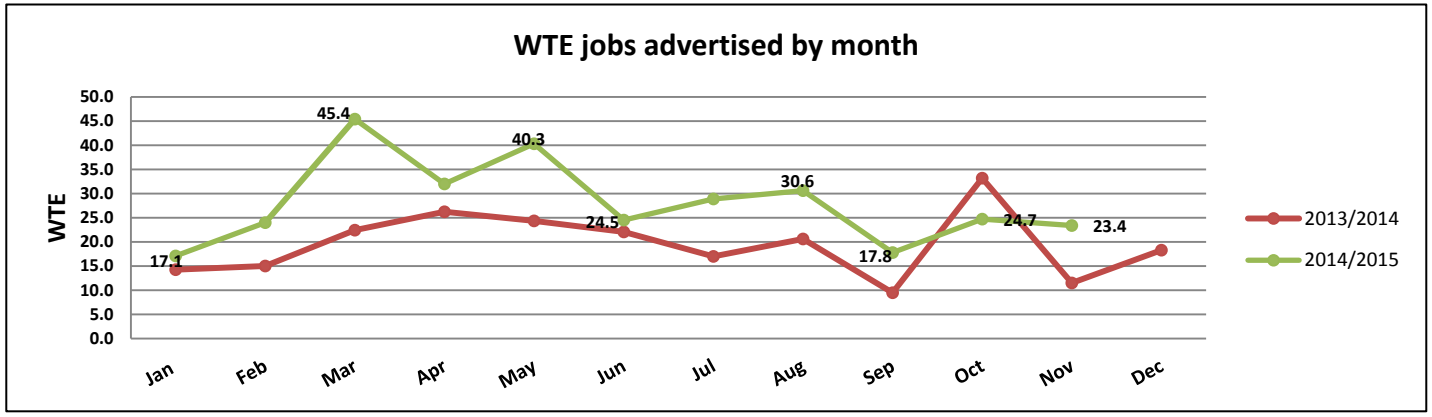
Vacancies/Recruitment

There were 23.4 WTE vacancies advertised in November which included 8.6 WTE nursing posts, 6.3 WTE admin and clerical posts, 4 WTE medical and dental posts and 2 WTE allied Health professional posts.

The Trust continues to experience high levels of unfilled vacancies in ITU, Burns, Corneo, Theatres and Canadian Wing. Research done by NHS Employers has shown that other Trusts are facing recruitment shortages within the registered nurse staff group and that a high number of NHS organisations have already or are considering the use of international recruitment primarily in Portugal and Spain to fill the gaps.

RAG Rating

HEADLINE HR KPIs



A total of 256.3 jobs have been advertised over the 2014 period, as mentioned earlier in Novembers report, this has been a mixture of both new and re-advertised roles not being recruited into at the first opportunity; there has been an increase in both the turnover rate and the vacancy rate for 2014.

Exceptions

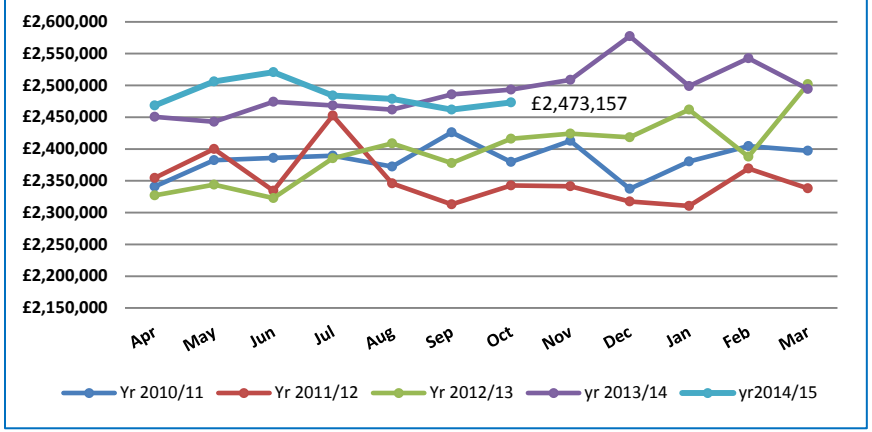
The average time taken to recruit timescale remains circa 5-6 weeks; from advert stage to the conditional offer letter.; The 2 identified staff posts from last month awaiting DBS clearances have now been processed. There are no staff currently awaiting DBS clearance.

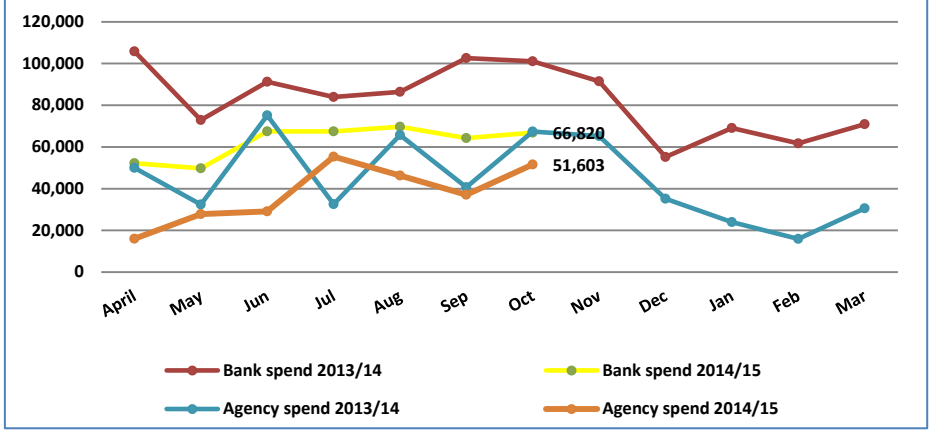
Actions

There have been a number key action developments arising from Thursday 4th December 2014' QVH Recruitment 'Task & Finish' Steering Group;

- More scoping work to provide guidance criteria around potential relocation allowance packages (on a case by case basis) aiming at the Band 5 staff nurse initially).
- Scoping / guidance criteria around the development of a QVH 'Refer a Friend' recruitment reward strategy
- Planning work /discussions to formulate development of a 2015 xmas lunch entitlement for staff
- Review of staff accommodation to improve current range of provision and raise the standard
- Weekly jobs bulletin board in staff public areas depicting weekly internal job vacancies in QVH
- Retention and dissemination of a candidate 'talent pool' via discussions with managers in key areas

HEADLINE HR KPIs





Pay Bill – (2 months in arrears) reported pay does not include on costs.
Pay for October remained stable at £2,473,157 due to tighter monitoring of budgets and robust controls in place for the use of bank and agency workers.

A breakdown of the split between total staff paid WTE and bank/agency and overtime is not available due to the December Board Report being produced early this month. Updated figures will be produced for January Board Report.

Bank and Agency usage – (figures are 2 month in arrears)
Bank expenditure for September was £66,820 an increase of £2,572 from last month, agency (excluding RMN) expenditure was £51,603 an increase of £14,531. The top three highest users of bank and agency expenditure were Canadian Wing at a combined amount of £32,114 an increase from last month. The increase in expenditure was due to establishment vacancies and increased workload. Corneo had a combined expenditure of £13,885 an increase from last month due to establishment vacancies and increased workload and Theatres with a combined expenditure of £12422.72.

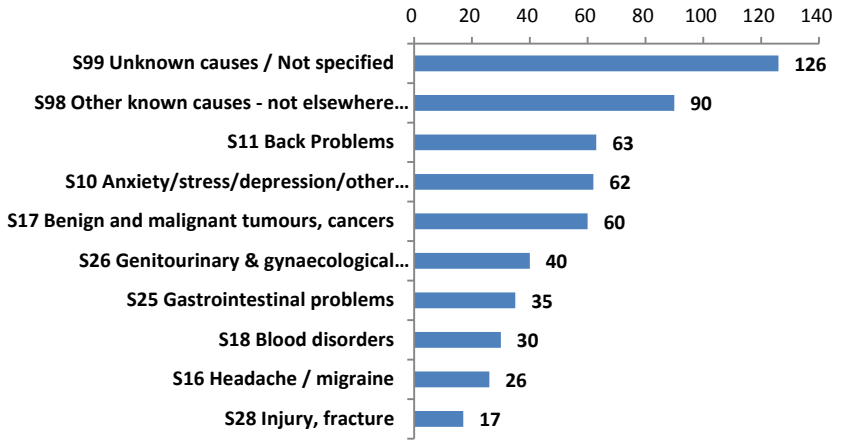
Actions

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

RAG Rating

HEADLINE HR KPIs

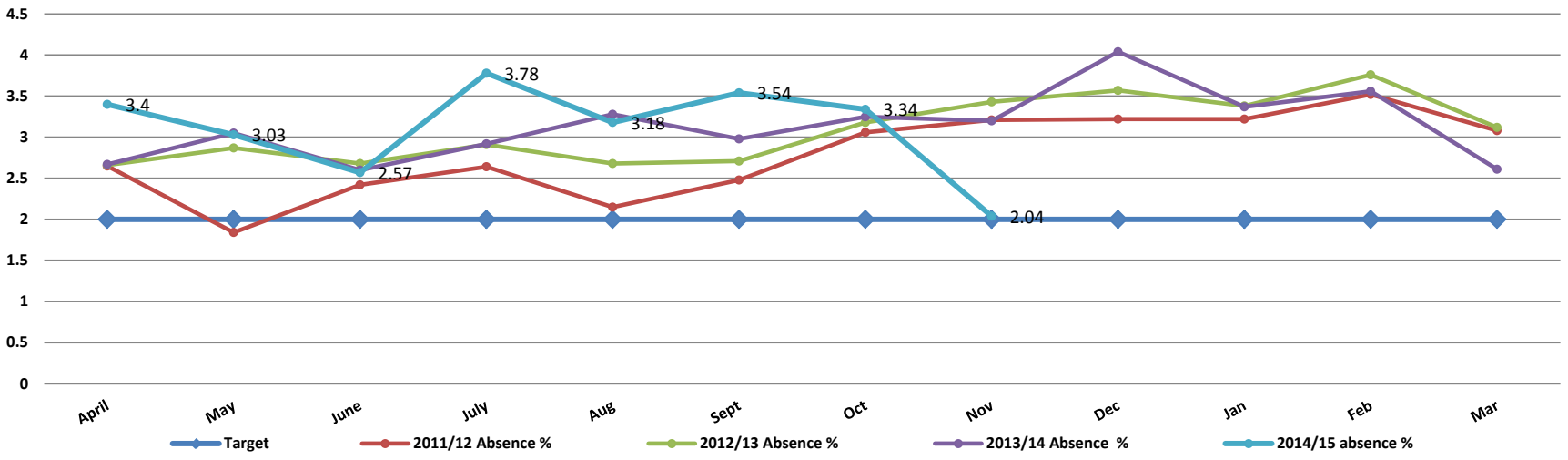
Top 10 Absence Reasons by Absence Days



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

Staff Group	Estimated Cost	FTE Days Lost
Add Prof Scientific and Technical	£9,287	96.92
Additional Clinical Services	£4,923	128.56
Administrative and Clerical	£6,502	82.81
Allied Health Professionals	£2,500	18.00
Estates and Ancillary	£4,703	83.07
Healthcare Scientists	£0	0
Medical and Dental	£5,974	38.00
Nursing and Midwifery Registered	£4,025	56.40
Grand Total	£37,914	503.76

Trust Absence Timeline



HEADLINE HR KPIs

Sickness/Absence

Trust sickness figures for November do not reflect an accurate picture of sickness for this period due to absence data not being uploaded to payroll until the beginning of December and the Board Report being produced early this month. A true reflection of sickness absence will be produced for January Board Report.

The top 3 reasons for sickness were 1)Anxiety/Stress/depression equating to 102 FTE days lost, 2) Musculoskeletal problems at 93 FTE days lost and 3) Unknown causes at 90 FTE days lost.

Long term sickness cases which are over 28 days have increased from 14 to 16 for November, the top three main causes reported are 1) Unknown causes/not specified 2) Other known causes – not elsewhere classified 3) Anxiety/stress/depression.

There were 568 absence days lost (503.76 FTE days) due to sickness, the most significant reason being 'Unknown causes – not specified' - which totalled 126 days.

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

Exceptions

The main affected areas are; Days Surgery at 12.94% with 1 – long-term and 7 – short-term sickness cases, Peanut at 10.87% with 2 – long-term and 6 – short-term sickness cases, Site Practitioners at 9.41% with 1 – long-term and 2 – short-term cases, Admissions and Appointments at 9.10% with 4 short-term sickness cases, Radiography at 6.37% with 1 - long-term and 1 – short-term sickness case. Out-Patients at 5.40% with 1 – long-term and 3 short-term sickness cases, Canadian Wing at 5.29% with 25 short-term cases, Theatres at 4.68% 1 – long-term and 21 short-term sickness cases, Therapies at 4.23% with 1 long-term and 8- short-term cases.

Actions

- Mindfulness will be trailed in the Trust as part of our Wellbeing strategy and to address absence due to anxiety.
- 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. The overpayments were due to 1 x incorrect payroll action and 3 x ESR input errors and 1 x late termination of employment by a manager. All over payments have recovery plans in place with the exception of 1.

Interim payments made in November decreased in volume from 5 to 3, due to managers error when finalising shifts on HealthRoster and late notification of doctors starting in the Trust.

Employee Relations

There have been a number of long term cases return to work both in clinical and non-clinical areas, some of these cases are on phased return for this period. On Monday 1st December the OH physician was unwell and this resulted in 3 long term sickness cases being postponed. This may affect future return to work dates.

The Whistle Blowing case has now concluded, there were a number of staff involved and this was a very time consuming process for us in HR. 2 conduct case investigations have been reported and we are awaiting a final decision for the next steps from the commissioning managers.

We have made several redeployments this month on the grounds of health and these are currently being trialled with OH support. All capability and probation cases are being managed by the line managers with HR support and these cases are being managed proactively.

Case Type	Number of cases	
•Disciplinary	0	
•Bullying & Harassment	0	
•Conduct	3	
•Capability	4	(this includes sickness capability cases)
•Long-term sickness	7	
•Change Management	0	
•Grievance	1	
•Whistleblowing	1	
•Probationary	3	
•Appeals	0	
•Suspension	0	
•Flexible Working	1	
•Dismissals	0	
	Total 20	

RAG Rating

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18 December 2014
Reference number:	334-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	9th December 2014
Appendices:	QVH2020 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 continues to be made against the objectives many of these associated with the review of governance structures and the commencement of monthly clinical governance meetings that now report into a quality and risk committee that meets every two months with papers presented that reflect assurance of activity undertaken.
6. Quarter 3 progress against Quarter 1 shows; 17 action Green (15 previously), 21 amber (22 previously) and 0 red (1 previously).
7. The main areas of challenge remain;
    - Delivery of the safer care module has been purchased and the project work has commenced.
    - Wi-Fi has been made available to patients.
    - Changes have been made to the patients menu which are hoped will improve patients perception of food.
8. Actions in progress that involve the senior team including Non-Executive directors are anticipated to improve staff familiarity with the senior team and feel able to raise concerns directly to them. The activities also provide opportunities for the senior team and Non-Executive directors to observe care, staff attitudes and behaviours and to meet with

patients and hear their views. This is an on-going objective and attendance itself will not achieve the goal, for success engagement is required.

9. 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 (delete those not applicable)

- 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

16. 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 - B Hobson – Dec 14		
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 14 Directors x 4 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 – No progress this quarter		
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 - recruitment occurring – almost to full establishment	A	Mixed team crucial for care – staffing a challenge in UK currently

	Safe Care, Safe Staffing						
11	Monthly publication of staffing data. Making use of e-rostering and other workforce data to provide assurance to the Board, staff and patients as to the provision of safe and competent levels of staffing throughout the Trust. (C8.3)	DN	Monthly board report Information on trust website Information on NHS Choices **HS**	June 14	Proposal to board April 14 Proposal agreed – first paper to May board	G	
12	Meet with Allocate to introduce the Safer Care module to the e-roster 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 First meeting have occurred and project plan in place	A	Availability provider / HR team / IT
13	Introduction of Patient monitoring system – IT system for identification of deteriorating patient (QA). **Dependent on successful bid to Nursing Technology Fund**	DDOF	Electronic observations available for alerting	March 15	Bid submitted to nursing technology fund – awaiting feedback which is due in January	A	Dependent on NT Funding
14	Develop an action plan to reduce the use of agency staff – exact level to be recommended by the DN taking into account benchmarked data from similar organisations. (C8.4)	DN	No non RMN agency used Ward / board reports indicate agency / bank / substantive staff	June 14	Usage currently provided each week Recruitment programme underway. Recruitment day booked for January	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 Further work will be linked to the introduction of	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)				the Safe Care module		
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 amended 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 linked to activity above and due date deferred to November. Discussion has shown that this is most effective when linked to safe care module	A	
18	Head of Human Resources to provide a quarterly update to the Board on the progress of implementing, embedding and fully utilizing the capability of the e-rostering system (C14.4)	HHR&OD	Quarterly report to board **GA**	June 14	Q1 Referred to within HR September report Q2 Updated within individual KSO Q3 Q4	A	
19	Monthly reporting of safety thermometer 'harm-free care' (CQUIN)	DDN	Board dashboard	May 14	Process in place – covered in board dashboard	G	

20	Monthly collection of compliance with WHO checklist (CQUIN)	Matron Periop	Board dashboard	May 14	Process in place – Audited each month – information provided within CQUIN update	A	
	Governance						
21	Whilst we are confident about the effectiveness of both the Quality & Risk and Audit Committees it would seem appropriate, both in the light of the *Frances*, *Keogh* and *Berwick* reports, and in *Monitor's* growing focus on formal governance processes, to review our Board level governance structures. 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. Now established	G	
26	Quality & Safety Committee to review the Trust risk registers to ensure it is a 'live document' with risks appropriately identified, graded and escalated. To agree a unified approach for the different registers. (C16.5)	HoR	Trust risk register to Q&R with updated risks BAF to audit committee quarterly Teams review risks at dept / directorate meetings	June 14 June 14 June 14	Risks being updated – Q&R to receive all corporate risks and to do an in depth review of one risk at each meeting BAF under review – 14/15 in progress Re formatted BAF reviewed at Audit committee September 14 and November 14	A	
27	Monitoring of incidents, including follow up on action plans to be included in monthly agendas for Quality & 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 – changes made during November 14. Updates provided within CQUIN report 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. Meeting held December and work is progressing		
38	Wifi access for patients. **2014/15 capital programme**	HoIT	Wi Fi available to patients		Wi fi available to both staff and patients	G	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18th December 2014
Reference number:	335-14
Report from:	Dr Steve Fenlon, Medical Director
Author:	Dr Steve Fenlon, Medical Director
Report date:	10th December 2014
Appendices:	None

KSO2 World Class Clinical Excellence

KSO2 (i) Clinical strategy:
(To be updated within CEO report)

Seven day service is a project for medium long term. Non elective care requires changes to working practices and engagement with the anaesthetic department now. Trainees and the site practitioner team are also helping to examine the medical care of patients at QVH. Medium term aims are to increase out of hours (OOH) cover, so far as possible within the Keogh objectives, not increasing the cost. Further operational work will focus on OOH provision of elective activity across all areas.

KSO2 (ii) Publish Consultant Level Clinical Outcomes
(Lead: Steve Fenlon, Project Manager: Jacqueline Packer)

- Delivery of six outcome measures from services across the trust, for publication to the trust website in 2014-15. As expected, this has proved to be an extremely challenging target to meet. The reasons for this are:

  i. Lack of data or lack of data validity
  ii. Manual data collection and inaccuracy
  iii. Clinical challenge on accuracy
  iv. Existing information management not created with clinical outcomes in mind
  v. Slow progress with national outcome comparators
  vi. Failure of external IT company to engage in developing kiosk based PROMS

  QVH submits data to a national outcomes database for head and neck cancer; it takes 0.5WTE of a Band 7 six months to collate and cross check data at QVH for only around 50 patients, (using data that is considered state of the art). We then pay HSCIC £5k per annum for the publication of this data showing just three variables for each patient. The publication of head and neck oncology data has been removed from the national outcome requirements for next year; subsequent measures and the reason for this are unknown. Publishing data about what we do is right and worthwhile. Consultant level outcomes for individual procedures represent the ideal end point of this process and we have learned a great deal in this worthwhile attempt to get there. So far only one measure is published and much effort is going in to publishing the remaining 5 in the last four months of the year.

- Picture and deliver the future shape of outcome measures for the QVH. Jaqueline Packer has achieved a great deal in the eight months in post as project manager. Whilst the wider NHS is talking animatedly about outcome measures, their implication and publication remains very limited. PROMs form an important part of the national outcomes framework and for us are essential. We are in consultation with a number of companies including the well-known https://www.iwantgreatcare.org (and the less well-known) to make PROMs easy to collect and publish. Early optimism that Jayex would use us as a model to deliver PROMs has not been realised, hence the search for alternatives. Jaqueline continues to push the limits and linkage of our current data systems to deliver outcomes in those service lines we targeted for year one.

- We have undertaken engagement 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. EKBI were selected to come in to the trust and scope the project, the report from EKBI a company with experience in this field has been delivered. Following this report, a discussion at executive and board level to determine the future strategy for outcomes is planned. EKBI agreed that this is an excellent project and should be pursued in the interests of openness and quality improvement, the intention is good. However QVH lacks the information management software, hardware and skill sets to deliver this programme at the current time. To achieve this and provide cutting edge information, both for outcomes and other performance measures within the trust, requires an overhaul of all of these, and may only be achievable by merger with another service or larger, better resourced department.

- Collate current consultant level safety metrics, and present as a single spreadsheet to provide board level assurance of the consultant's safety. This is now complete and can be shared at individual level with consultants to agree data validity and address concerns. The spreadsheet is available for review by trust senior management but is of particular use to the medical director for the purposes of revalidation.

KSO2 (iii) Clinical Research and Development
(Leads: Steve Fenlon, Medical Director; Julian Giles, Clinical Lead for Research; Brian Jones, Director of Research Development)

Report kindly prepared by Julian Giles. In addition to this report, the next quarterly update will include a strategy for the next year for research, (now that the CFAC has approved a further two years of funding to the post of director of research development).

- Grant Applications:
  The QVH has been a join applicant on fifteen grants this year. The total value of the applications submitted are in excess of £11 million this year. The details of these are appended;

- Extension of Research Director Secondment:
  The Charitable Trustees have agreed to extend the secondment of Dr Jones as the Director of Research Development for a further 2 years.

- Trust Research Day
  This occurred on the 23rd June 2014. The keynote speaker was Dr Brain Jones. Twelve speakers outlined their projects. This is a record for the research day.

- Nursing Research Afternoon
  On the 10th November we had a joint meeting with the University of Brighton to discuss and highlight research opportunities. Professor Julie Scholes gave the keynote address. A similar event for therapists is planned in January 2015.

- IRP Students
  Four new IRP students from BSMS began their projects in September.

- Research Methodoligist
  Dr Claire Rosten a research methodologist from the Uob and the NIHR Research Design service has been on a work shadowing placement at the QVH and proved invaluable in setting up projects.

- Set up a one year MSc in plastic surgery
  A curriculum is being drawn up.

- NIHR Portfolio Recruitment Targets
  We have already exceeded our 2014/15 by 60% recruitment targets thus ensuring on going NIHR infrastructure funding.

- Biobank
  Ongoing discussions about the feasibility and mechanics of setting up a biobank to archive tissues for research. Oversight Committee established.

- A Research Statistics Support Link
  This has been set up with Dr Diewi Zhou at the University of Brighton. Access through Dr Giles and Dr Jones.

- Melanoma Special Interest Research Group
  This has been set up with academics and clinicians from the BSMS, QVH, UoB and BSMS. The inaugural meeting was on 25 July 2014

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

- Board approval to proceed to FBC for a multi-professional education centre on the QVH site with 2 preferred options.

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

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

- Trainee shortfall is currently addressed by recruitment of trust grade doctors, A recruitment plan has been put together (seen by Board at November meeting)

- Re-engaging with junior medical staff has begun with a trainees forum to discuss their and trust issues. A temporary rest room has been established and trainees will be invited to trust meetings to better voice their opinions and gather their input to some of the trust issues
- Director of Medical Education recently appointed with additional 4 hours per week trust funded time to ensure the increasing number of directly employed trainees do not suffer from lack of training input and are treated similarly to deanery trainees

- Explore alternative models to deliver medical care at the most basic level. Scope the potential for other professionals to develop into traditional medical roles such as surgical practitioner and expansion of the hand therapist roles. On-going meetings with colleagues at SASH to explore the viability of PA role.

- Options appraisal for the future medical workforce presentation delivered to the November Board and feedback received.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18 December 2014
Reference number:	336-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	9th December 2014
Appendices:	Corporate Risk Register

Corporate Risk Register

Key issues

1. The trusts top three risks are, risk of;
   - ability to meet RTT18 targets (risk escalated to 20).
   - breaching cancer targets.
   - failing to deliver safe health care due to difficulties in recruiting.
2. No new risks rated above 12 have been identified.
3. No risks were closed.
4. Changed risk score (1 identified) to 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.
5. The corporate risk register was reviewed at the monthly clinical governance group and Clinical Cabinet in December.

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives (delete those not applicable)

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

- Organisational excellence

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

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

Recommendation

9. Options include
   - 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) - November 2014
(includes December change information on the Trust top three risks)

November 2014 data (01/11/2014 – 30/11/2014)

For the period of 01/11/2014 – 31/11/2014 there were 30 open risks scoring 12 and above. A summary of any new risks added, closures and rescores is given in this report. On this occasion ne changes were identified for risks during November 2014. However there is one change to note for a risk in December (see below).

The Trusts top three risks are given below (*all were reviewed in November 2014*):

- RTT18 – Risk ID 159 - Ability to operationally meet 18 week target for all Directorates (Score=20) **(Risk score increased on 13/10/2014)**
- Cancer – Risk ID 474 – Cancer target breaches (Score=20) **(Risk score increased on 13/10/2014)**
- Recruitment of appropriate nursing, non-clinical and medical staff/skill mix (includes staffing numbers) - Risk 749 **(Risk added 10/10/2014 Replaces ID 388)**

New 12+ Risks added between 01/11/2014 and 30/11/2014 - None

Risk register	Risk Score	Risk ID	Risk Description	Rationale and/or Where identified/discussed

12+ Risks Closed between 01/11/2014 and 30/11/2014 - None

Risk register	Risk ID	Risk Description	Risk Score	Rationale for closure	Committee where closure agreed/proposed

Changes to Risk Scores for November 2014 – None (1 x change in early December 2014)

However one risk score was changed on 05/12/2014 – Risk ID 681 Failure of the clean room resulting in potential for loss of work (Score = 4x4=16). Risk rescored (4x3=12) following discussion with the Medical Director and clarification of impact upon workload when failure occurs. Revised score agreed at 08/12/2014 CGG.

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed

Committee Key:

- TB – Trust Board
- TUG – Theatre User Group
- Q&RC – Quality and Risk Committee
- COG – Clinical Outcomes Group
- RPC – Radiation Protection Committee
- PDC - Patient Documentation Committee
- MDC – Medical devices Committee
- HNE – Head, Neck & Eye Clinical Directorate
- EMM – Estates Monthly Meeting

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
474	10/03/2011	Cancer target breaches	Breach in any quarter for an Oncology treatment targets for 31 and 62 day pathways resulting in delay to patient care and reduction in Monitor rating. This could also result in financial loss to Trust.	1.Administration Staff for plastics and maxfacs failing to follow alerts on potential breaches identified by cancer data coordinator. 2.Lack of theatre capacity. 3. Lack of outpatient capacity. 4. Delays in recieving referals from other trusts. 5. Patient choice to wait longer for surgery however the clock continues to run. Small numbers at QVH cause this to be an issue.	1 - Cancer Data Co-coordinator issues reviewed monthly by Directorate Manager 2 - Patient tracking list for the specialties in place and produced twice a week. 3 - Cancer Data Co-coordinator communicates with staff on potential breaches. 4 - Secretaries respond to requests to bring patients forward wherever possible. 5 - Off site team leader in place to contribute and reconcile breaches. 6 - Appointments team allocate 2 week wait referrals to avoid delay. 7 - All breaches reviewed weekly by Directorate Manager. 8 - Project team established to integrate the cancer pathway. 9 - Action plan for skin cancer performance devised and implemented including process mapping sessions 10 - Cancer Outcomes Dataset report reviewed on a monthly basis by cancer team 11. Risk reviewed as part of BAF risk update	Stuart Butt	Jane Morris	20	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 registery, DAHNO, and ensure 100% data completeness - Substantive post out to advert, post currently being filled by Bank staff. Completed Ensure off site 2 week H&N cancer appointments are booked efficiently	21/11/2014
159	29/11/2006	Ability to operationally meet 18 week target for all directorates	Failure to meet referral to treatment time of 18 weeks (RTT18)for a second month could result in reduced Monitor rating and a financial loss of 1.2 million. This could be for the trust aggregate failing to meet target which could be more than two specialties failing in one month.	1. Failure to update booking system on changes during pathway - administration errors 2. Failure to update system on patients declining treatment dates 3. Increased number of patients requiring treatment 4. Inadequate number of surgeons or Consultant absence 5. Lack of theatre space (capacity) 6. Poor validation of data.	1. RTT18 PTL established and now circulated daily. 2. Weekly escalation process now established via clinical specialties managers, OPG meeting twice a week to ensure all capacity is fully utilised. 3. 18 week steering group, each specialty highlighting capacity issues in issues log. 4. RTT 18 action plan being reviewed at steering group. 5. Additional theatre lists provided on Saturdays 5. RTT18 clinical outcome recorded on PAS 6. Additional data analyst post to provide cover for DH returns. 7. Clinical outcome forms revised for each specialty. 8. Develop reports to monitor specialty performance, planned w/l with expected TCI, backlog and open pathways monthly. 9. Validation of PTL lists weekly including admitted, non admitted and open pathways. 10. Amended policy incorporates new guidance re planned cases. 11. Training and guidance issued. 12. Monthly review of planned cases without date for attendance at QVH. 13. Develop early warning systems to track increased demand and mismatch with future capacity 14. Proactively discuss W/L each week at OPG for patients 10 weeks plus who do not have TCI date to avoid breach in each speciality 15. Review and validate all pending TCI's for Apr, May, June to ensure patients booked within 18 weeks 16. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably 17. Introduce new LA DC facility by July to increase capacity in main theatres for more complex work.	Stuart Butt	Jane Morris	20	8	Centralise all referrals through one access point - Completed Plans and agreements in place until the end of November 2014 to enable compliance from December 2014 Restructure of appointments and admissions teams to achieve consistent Trust wide approach to management of elective pathway bookings Training and guidance to be issued to all relevant staff - Completed Review to take place in January 2011. - Completed 3. Ensure all Planned cases have estimated TCI's when placed on list - Ongoing Implement daily ptl - completed Ensure all future TCI's are validated in relation to 18 weeks- completed 6. Introduce a new automated 6 month administrative WL validation - Completed Agree business case for increasing capacity in sleep studies - completed Explore locum for Ocular plastics - completed 1. Expediate Medway hub 2. Develop matrix of planned cases seen at QVH - Completed Policy being redrafted, to launch May, with associated training package. - completed Clinic outcome forms being revised within specialities - Completed 5. Clinical pathways for top 3 procedures within specialities with clock stops being devised with CD's - agreed, being put into trust format Appointment of Access and Performance 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 RTT18 action plan to be monitored monthly - Completed 4. Review tracking resources, ie, information or operational function - completed Develop early warning systems to track increased demand and mismatch with future capacity Introduce new LA DC facility by July to increase capacity in main theatres for more complex work. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably Develop referral management and booking process in all specialties to ensure 18 week target achieved Improve pre-assessment service through web based technology Mainain detailed demand and capacity work to ensure resources meet demand and reduce overall waiting times and extend methodology for out patients	14/11/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
749	10/10/2014	**BAF Risk** Recruitment and retention of appropriate nursing, medical and non-clinical staff (includes skill mix and safe staffing requirements	Recruitment and retention of appropriate nursing, medical and non-clinical staff (includes skill mix and safe staffing requirements		1. Continual review of recruitment processes 2. HR team review difficult to fill vacancies with operational managers 3. Medical staffing team enhanced to improve recruitment to medical vacancies 4. HR attending weekly operational review meeting	Graeme Armitage	Alison Vizulis	16	6		25/11/2014
710	22/05/2014	Increasing bed occupancy on MD ward restricting the trusts ability to deliver care	Patient care compromised, suboptimal quality and safe care not provided Staff exposure to increased stress and anxiety Safe and effective patient discharge Increase in bank and agency use Increase in major cases requiring higher level care - SDU Increase in complaints Increase in drug adminstraion errors CQUIN targets compromised Adequate cover from surgical/ medical team Trust inability to admit referred trauma patients/ elective	Increased occupancy places strain upon the service/ nursing care provided to patients/ carers/ relatives Staff resources are stretched due to the increased demands upon them Patients readmission/ return to theatre may increase Potential catastrophic patient outcome due to drug prescription/ administration errors Increase in litigation Loss of License to operate Loss of reputation	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	08/09/2014
670	17/12/2013	Failure to maintain estates service due to continued staff shortages.	Failure to maintain estates service due to continued staff shortages. Continued staff shortages due to un planned absences and long term vacancies which we have been unable to find suitable candidates and annual leave entitlement, has put pressure on the service.	• Unable to maintain a full on call cover 24/7 • Increased stress in the work place leading to potential sickness absences. • Insufficient staff to cover annual leave. • Potential breeches in compliance work being carried out. • Loss of reputation. • Loss of business.	• Recruitment to temporary staff authorised by CEO • Staff volunteering for additional on call duties. • Use of external contractors and agency staff to cover staff shortfalls e.g. lighting, storm damage and electrical failure Use of external contractors for March 2014 to provide additional cover.	PRODIR	John Trinick	15	6	June 2014-Company commissioned to undertake a review of the Estates Service - Draft Report due end of September 2014	18/11/2014
756	02/12/2014	potential impact on core service delivery	Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilsation unit. Possible delays/cancelations to patient care Damage to QVH reputation Financial impact	Trustwide disruption to the processing of sterile equipment during the relocation of the sterile service facility	Contingency plans in service contract to provide an on going service	Amanda Parker	Jo Davis	15	6		02/12/2014
732	11/08/2014	Use of Long Term Model Box Store for Maxfacs	Identification of alternative storage for Maxillofacial models on a long term basis		Existing model storage can be accessed by authorised staff using appropriate PPE Risk assessment in place for use of existing location Email sent to owners of materials found in area asking for clearance to enable resiting of model boxes	Stephanie Joice	Alison Vizulis	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. Met and discussed - Informally agreed and material owners identified and notified to remove items.	08/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
620	17/07/2013	Potential loss of referrals due to commissioners moving work to centralised centres	1. Loss of income affecting financial viability of the organisation 2. Loss of activity	1. Commissioners set up central services such as muscular skeletal services reducing hand services at QVH. 2. Increased number of community based providers established 3. Reduction in national tarrif makes routine work non viable financially	1. Quality of work and reputation of QVH provides a strong position. 2. Identified areas of opportunity - Head and Neck services and breast surgery from other trusts 3. Development of core reconstructive services 4. Contract monitoring meetings, 5. Programme Board overview 6. Review of Service Line reporting 7. Weekly Business meetings reviews of operational issues and referrals 8. Continued dialogue with Health Service Priorities Unit. 9. Business model adapted to cover lost procedures. 10. Engagement with GP's 11. Compliance with low priority procedure policy 12. Education and engagement with CCG leads 13. Engagement with the any qualified provider scheme. 14. 2013/14 reflects potential loss of income	Stuart Butt	Bill Stronach	12	6	Risk being reviewed and transferred to 2014/15 BAF - BAF Risk 1B 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	08/09/2014
623	19/07/2013	Failure to meet CQUIN requirements for 2014/15 therefore incurring a loss of CQUIN funds £1.4M	1. Financial penalty and loss of CQUIN funds	1. Failure to meet CQUIN requirements set for 2013/14	1. VTE risk assessments within each patient drug chart - VTE policy in place 2.Dementia - process in place to identify trauma patients >75 years of age.Clinical lead identified. 3. Dementia training in place 4. Patient experience group in place reviewing and ensuring actions implemented and linked to OPD experience. Family and friends test score. 4.NHS safety thermometer completion is linked within deputy director of nursing job role and harm score reported to the Board. 5. Organisational performance against CQUIN measures are monitored and reported to Trust board on a monthly basis. 6. High impact intervention CQUINS reports produced each quarter and reviewed by Q&R Committee.	Amanda Parker	Amanda Parker	12	3	Risk to be updated for 2014/15 CQUINS and 2014/15 BAF - Completed Ongoing audit reports to demonstrate CQUIN compliance e.g. WHO checklist and MaPSaF - Completed Provide Q3 update to quality and Risk Committee and Board	08/12/2014
689	25/04/2014	Potential to adversely affect statutory and mandatory training due to increasing number of vacancies (3mths and over)	Risk to patient safety if staff are not up to date with their statutory and mandatory training.	Staff would be unaware of latest updates relating to key clinical and non-clinical areas including infection control, M&H, risk management and governance arrangements.	1. Statutory and mandatory training reviewed monthly and reported to Board. 2. Departmental feedback from above. 3. Utilisation of bank and agency staff to release others to attend training. 4. Risk monitored as part of BAF risks 5A & 5B	Richard Tyler	Graeme Armitage	12	6	Training frequency under review to ensure match with NHS education passport Continue with utilisation of agency/bank staff to release others for training Review being completed of training matrix and adjustment of profiles as part of KSF skills passport Implementation of more elearning options Overseas recruitment initiative being taken forward Erostering review being undertaken to utilise staff efficiency/availability	08/12/2014
743	09/09/2014	Reputational damage to the Trust as a result of the occurrence of Never Events	Reputation damage to the Trust as a result of the occurrence of Never Events		Risk Management and Incident Reporting Policy Completion of RCAs Never Event reporting and notification process that includes internal and external notifications Internal incident reviews and analysis undertaken via meetings/committees etc Monitoring via dashboards External publishing of Never Event occurrence via NHS England	Amanda Parker	Alison Vizulis	12	8	Governance reporting review underway. Revisions scheduled for CQC regulations in 2015	08/12/2014
742	12/09/2014	Limited ability to disseminate information on criminal sanctions	Non-Compliance to NHS Protect Security Standards due to ilimited ability to disseminate information on successful convictions due to infrequent occurrences	No criminal sanctions brought to date to demnstrate compliance	Head of Risk added reference to disseminating information on successful convictions to the Draft Comms Strategy in Sept 2014. Use of newletters e.g. Connect, and new Risk newsletter. Induction, mandatory training and other traingin sessions Dissemination of LSMS leaflets and information	Amanda Parker	Alison Vizulis	12	12	NHS Protect approached for advice on utilising a historic case to demonstrate compliance with processes - Completed Discussed with LSMS - completed Identification of a relevant case/incident - Completed	08/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
711	30/05/2014	Reliability of Theatre Doors	Defective doors to theatre areas are affecting entry for both staff and patients - Please note this affects ALL automatic doors	Musculoskeletal injury to staff Restricts high levels of privacy and dignity for patients Inconsistency across a range of Theatre doors could lead to staff applying inappropraite pressure when opening doors	Risk Assessment completed and Risk added to the Theatre Risk Register on staff musculoskeletal injury. Two year "Willmott Dixon" agreement for repair of new build includes Theatre Doors Regular meetings to monitor situation takingplace Doors currently being reset by Estates and Theatre staff when faults occur Willmott Dixon visit on 5th and 6th July to fully service all doors	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 Trial of replacement door-motors on doors on Theatre 1 and Theatre 4 - Completed Increased follow-up with Estates & Willmott Dixon Notices to be put up in Theatres to alert staff of defective doors - Completed Staff utilised to retain privacy and dignity - in affecetd areas - Completed Raise staff awareness at team meetings - completed Willmott Dixon agreed to replace doors - Date to be agreed.	30/09/2014
602	10/02/2013	Business continuity risk to the organisation due to failure of IT network infrastructure	1: Inability for the organisation to function and provide services 2: Delay/inability to provide patient care 3: Financial loss and reputational damage	1: Failure of organisational IT network infrastructure 2: Lack of access to data/patient information i.e PACs, Clinical and business systems. 3: Lack of immediate replacement/back-up hardware/system	1: Available support from an external company to repair if failure occurs. 2: Limited support available on-site 3. A full network review has been carried out and awaiting budget approval. Funding approved for new infrastructure - Budget approved	Stuart Butt	Nasir Rafiq	12	8	Looking to procure new network (by 31/03/2016) IT Capital bids programme for 2014/15 monitored at Information Management and Governance Committee IT annual plan for 2014/15 in place to monitor progress on IT renewal Purchase and install 2nd core switch which is connected to all edges and other core switch New equipment to be rolled out within 12 months covered by life time warranties	07/10/2014
604	26/03/2013	Breach of information security due to use of unsecure email accounts to transfer person identifiable data (patient and staff)	1: Breach of data protection act 2: Loss/accidental disclosure of patient identifiable data 3: Reputational damage to the organisation 4: Information Commissioner's Office (ICO) investigation and fines 5: Complaints and litigation	1: Failure to follow Trust policy, legislation and confidentiality 2: Lack of responsibility from staff to adhere to IG standards 3: Potential for private email accounts to be subject to hacking 4. Emails containing patient identifiable data sent to non secure address	1: Mandatory information governance training available for all staff and compliance rates increased. 2: Datix incident reporting and investigation procedure in place. 3: Trust information governance manager to oversee and advise regarding information governance standards. 4: The following solutions are in place for accessing and transferring information securely. 4.1 NHS mail 4.2 Good e-mail app 4.3 Remote access 4.5 encrypted memory sticks 5 IT & IG lead to review new security restrictions (soft ware applications) 6. Compatibility review in preparation for Windows 7	Stuart Butt	Nasir Rafiq	12	6	Monitoring of compliance with IG Toolkit Implement data leakage prevention software Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	07/10/2014
639	10/10/2013	Support and access from supplier to ORSOS will cease 03/16 leaving Trust without electronic theatre record	Unable to record data for operations. - impact on scheduling - effect on live theatre management - ORSOS reporting including management reports.	Source company withdrawn support.	Discussed at ICAG monthly and theatre user group. Paper back up	Jane Morris	Mr Mark Savage	12	4	Agree on the preferred solution before sourcing the new supplier Source the new supplier Demo of ORSOS completed in Sept 2014 Specification being drawn up to procure new/replacement system ICAG reviewing progress of replacement each month; also Theatre User Group	08/12/2014
727	21/07/2014	Limited on site Physician cover and non compliance with NCEPOD standards	Limited on site Physician cover and non compliance with NCEPOD standards		Cover arrangements managed by Consultant Plastic Surgeon Onsite cover available on Tuesdays and Thursdays (in ward referrals taken by Sleep Studies Locum Physician on Thursdays) Telephone cover provided as part of SLA with Brighton Geriatrics Clinic covered by Locum Geriatrician from Brighton Patient would be transferred to Brighton (Haywards Heath) if specialised care required BSUH will be providing consultant cover for elderly medicine every Wednesday from 03/12/2014	Mr Asit Khandwala	Paul Gable	12	6	Explore GPSI option and cover from London Trusts SLA being agreed with East Surrey Hospital Arrangements agreed in principal with ESH Meeting between QVH Medical Director and Head of Geriatrics at ESH	03/11/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
748	03/10/2014	Field safety notice FSN83000189 patient data may not be updated when exporting to 3rd party devices using the auto export featur	Patient identifiable information on x-rays may not be updated in the VNA (vendor neutral archive. Studies pulled back from the VNA or pushed into a new PACS will potentially contain incorrect patient demographics.	Philips Healthcare released an FSN regarding their implementation of a PACS/Ris solution dated 27/07/2014 stating that when a study requires patient informaion be updated the updated informaion is not always passed to the VNA. There is no fix for for our current version of PACS but there is a solution in the next release of software (Kona). However the release of Kona has been delayed due to desktop intergration issues.	We await the following from Philips: -An explanation as to what workflow causes this miss match in patient data between PACS and VNA. -A description of a workflow to reduce/remove the risk of miss-matched patient data between the PACS and VNA -Implement Kona across Surrey and Sussex to correct this error -Identify studies that have miss-matched data -Produce and implement a fix for the identified miss-matached data	Paul Gable	Paul Gable	12	6		04/11/2014
728	29/07/2014	Risk of non-compliance with best practice and regulatory requirements at spoke sites	Risk of compliance with regulatory and best practice requirements e.g. CQC, HSE, CiP assessments and audit etc at spoke sites offering QVH services		Annual H&S assessments programme (monitored by quarterly H&SC) Annual infection control/decontamination reviews CQC/HSE notifications of queries relating to service provision	Amanda Parker	Alison Vizulis	12	8	Annual CiP assessments to continue at spoke sites revised programme of infection control and decontamination annual assessments	08/12/2014
733	12/08/2014	restricted access to blood fridge/cross infection from staff movement	due to the recent restrictive access status of the burns unit there is a potential for delay for both obtaining units of blood and blood gas analysis	delays to treatment for patient burns staff diverted from patient care to manage theatre requests cross infection between burns and theatres	controlled access by burns staff who retrieve blood units and process blood gas cost and introduce a seperate blood fridge and blood gas anaylsis machine for theatres	Dr Ken Sim	Jo Davis	12	2	Idneitifation of funding for additional blood fridge in Theatres Review of Blood Fridge arrangements to be undertaken-to include exploration of the purchase of an additional fridge	10/11/2014
744	09/09/2014	Risk of non compliance with HSE/IRMER due to vacant RPS post in Radiology	Recent vacancy of Head of Radiology and RPS have led to there being a vacant RPS post within Radiology.		Nominated RPC in place Extended SLA with MTW physics for on-site presence and support on half day a month RPS role is written into the job description of the new band 6 role. Until this person is in post the service manager, operational lead and exisitng band 6 will share this role. Physics to provide a course for these staff members.	Amanda Parker	Kirsty Humphry	12	8	Interim RPS cover arrangements to be agreed - Completed - responsibilities shared amongst existing staff Recruit to permanent RPS post	10/11/2014
745	09/09/2014	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/ resources	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources		Provision of an additional day included in the BSUH Radiology SLA. Radiation Protection Committee reporting and governance structures and reporting Positive outcome of 2014 IRMER iinspection	Steve Fenlon	Kirsty Humphry	12	8		10/11/2014
540	26/04/2012	Risk of Diagnostic tests involving Pathology	Risk to patients condition and treatment being misdiagnosed or delayed due to ineffective communication for diagnostic tests involving pathology. These include Histopathology (including Biopsy), Clinical Chemistry, Microbiology and Haematology.	1. Ineffective communication for diagnostic tests. 2. Lack of request forms. 3. Incorrect information on forms. 4. Specimens lost in transit / department. 5. Results not reported back to clinician. 6. Misdiagnosis of test.	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 implemented from the June 2014 Histopathology SI Performance notice issued, awaiting a response	10/11/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
584	23/11/2012	Potential harm from medical devices due to inadequate training	1: Harm to patient from incorrect use of medical devices 2: Financial loss due to litigation 3: Reputational damage from complaints	1: Staff operating devices without training	1. Training and competencies for high risk devices 2. Meetings with medical device co-ordinators to develop action plans for above. 3. Training compliance monitored by medical device officer quarterly. 4. Junior doctors familiarisation session incorporated into induction. 5. Speciality training assessment forms available for ad hoc junior doctor starters. 6. Incident reports used to identify and monitor trends that would highlight training as an issue 7. Monitoring at quarterly Medical Device Committee (with actions) 8. High risk and moderate risk competencies to be completed by Medical Devices Officer 9. Risk rescoring amended to reflect L&D Strategy Group output 10. Dermatome related incident review and business case completed due to number of incidents reported and purchase of devices 11. Elearning completed for dermatomes	Steve Fenlon	Alison Vizulis	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	10/11/2014
627	19/07/2013	Failure to embed safer surgery checklist process due to lack of engagement	1. Patient harm due to incorrect procedure 2. Lititigation 3. damage to reputation	1. Key safety checks not undertaken for each individual patient such as correct patient, operation site and side and procedure. 2, Not all staff engaged in process so vital members could be missing	1. 1st stage consent by experienced surgeon in out patients. 2. 2nd stage consent on admission (check with patient) 3. Surgical safety checklist-sign in and time out stages. 4. Patient marking policy changed, presentations to all medical staff and directorates by MD. 5. Consent working group set up to improve consent before day of operation. 6. Pre list brief in place and effective prior to full list starting 7. Safer surgery checklist in place - (WHO Checklist) 8. Information and awareness sent to all theatre staff and clinicians 9. Audit of checklist quality in place 10. operating surgeon is now responsible for timeout 11. training in place for all staff 12. patient safety forum in place to review practice. 13. Addition of WHO checklist compliance as a 2014/15 CQUIN - Q1 & Q" audit reports submitted. 14. WHO checklist audit developed for 2014/15 CQUIN and reporting commenced 15. WHO checklist audits x 2 reviewed at monthly Theatre User Group and Patient Safety Forum.	Steve Fenlon	Jo Davis	12	4	Ongoing monitoring at Patients Safety Forum and reporting as an indicator on the Quality Metrics dashboard - Completed Audit tool amended following pilot to improve robustness - Completed WHO CQUIN audit reports fro Q3 & Q4 to be submitted Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting - Completed and ongoing	08/12/2014
629	19/07/2013	Inadequate health records storage	1. Staff injury from increased moving and handling for staff 2. Staff injury from slip,trip / fall over notes/boxes 3. Lack of storage space for paper records for Trust 4. Delay to obtain health record 5. Lack on budgetary allocation for ongoing storage costs from mid June 2014	1. Kings House near capacity 2. Delay in procurement of electronic patient record system 3. Failure for departments to follow archiving and storage proccess 4. Destruction of records less than 10% of new records created 5. Departments following different storage methods 6. Existihg tender for transport and storage requires renewal	1. Health records policy includes process for managing records off site 2. Bags used for transporting notes changed to fit within boxes therefore reducing handling 3. Regular destruction of notes in place. 4. Increased racking in place in Commonwealth house 5. Missing notes procedure in place Paper to Clinical Cabinet with costs of more packaging and moving records to free additional space 6. Regular transport runs between Kings House and QVH 7. Tracking system for notes in place 8. Outsourcing scanning of 10000 sets of notes to increase capacity completed 9. Tender renewal process underway. 10.Regular meetings between Head of Procurement, Head of RM, HR Manager and Matron (commenced 09/04/2014)to monitor progress 11. Action plan developed and monitored at above meetings	Jane Morris	Nicola Reeves	12	3	new group in place to monitor the progress of finding suitable a location and renewal of contract Paper to April Clinical Cabinet summarising the costs associated with packaging,moving and storage of medical records as space limited to mid June 2014 Transport tender renewal to include transport and storage of medical records (est costs of transport 2.5-3k) Continue collaborative procurement for EDN Review in 3 months whether further permanent notes need to be scanned to release more space Review on site storage and archive to ensure space utlilised appropriately Develop report showing audits and monitoring of compliance to discuss at Patient Documentation Committee Implement 5 S's lean approach to keeping Health records tidy and that trip hazards are kept to a minimum Provide training sessions for staff to raise awareness of correct filing system - Completed Review staffing on a regular basis to ensure all processing kept up to date including destruction as per policy	10/11/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
513	04/01/2012	Potential failure to act on infection concerns due to unavailability of Microbiologist	1. Delay in updating policies 2. Reduced patient care due to review not conducted by microbiologist on site 3. Delay in reporting on specimens 4. Reduced attendance on site by Microbiologist	1. Problems recruiting consultants at BSUH 2. No regular microbiology consultant cover on-site 3. Failure for BSUH to fulfil contract requirements	1.Daily lab sheet of positive specimen results however, not all positive specimen are listed on this sheet. 2. Presence of microbiologist during week 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	20/11/2014
648	06/11/2013	Cross infection resulting in an outbreak and closure of services	1. Infection to patients causing harm and delay in recovery. 2. Closure of department resulting in loss of activity 3. Potential for this bacteria to spread to other patients	1.Spread of Multi Resistant Infections to burns patients 2.Unable to contain bacteria/outbreak	- Hand hygiene (failure to achieve 90% compliance in any staff group leads to matron audit) - Robust implementation of gowning procedure - Strict universal precautions - Review of patients requiring admission on individual basis with consultant microbiologist and clinician - Regular outbreak review meetings to discuss other actions required. - Monitoring via Datix reporting - Internal inspections undertaken e.g. PLACE inspections and Hotel Services cleaning audits - Reporting of outbreaks as required e.g. Health Protection Agency, CCG, PHE. - Mandatory training of all staff and awareness raising sessions. - Implementation of trust policies.	Amanda Parker	Emma Kerr	12	4	Dept training as required Abx review by microbiologist Complete RCA / PIR / outbreak report / SUI Specific interventions depend on risk identified. Prepare Rycroft Ward as possible decant area - complete	20/11/2014
27	07/01/2005	Infection risk to individual patients due to poor systems and practice of control	Increased risk of patient(s) contracting a HCAI such as MRSA, C.diff, MRAB or Norovirus.	1. Unknown infection to patients admitted to hospital. 2. Infected patients not isolated on admission. 3. Poor hand hygiene / environmental cleaning.	1. Mandatory training of all staff and awareness raising sessions. 2. Implementation of trust policies - isolation, screening, treatment including root cause analysis for all C Diff / MSSA/Ecoli bacteraemia cases and PIR review for all MRSA bacteraemia. 3. Routine audit of practice, and monthly PLACE inspections. 4. Cleaning strategy implemented including deep clean arrangements 5. Monitoring of trajectory targets for MRSA bacteraemia, MSSA, E Coli and C.diff. 6. Monthly monitoring and Board reports from DIPC to inform organisation of acquisition of infection 7. Failure to achieve 90% or more in any staff group for hand hygiene leads to matron auditing. 8. Decant arrangements include wider involvement of matrons regarding single room use, with advice from IPACT. 9. Specific interventions depends on risk identified i.e. staff undertake an MRSA protocol treatment 10: Training completed for IPAC Team re: access to BSUH IT System. Awaiting ICNet. 11. Review of investigation processes completed 12. Follow up actions from current infections completed 13. Infection control nurses have direct IT access to BSUH Microbiology system 14. Antibiotic policy reviewed to ensure best practice use and reduce risk of C.diff 15. Departmental training provided as and when required	Amanda Parker	Amanda Parker	12	6	Awaiting ICNet computer system access 7. Complete actions from RCA/PIR investigations 5. Provide direct IT access to BSUH Microbiology system - complete 3. Follow up actions from current infections - Completed 4. Review of anti-biotic policy to ensure best practice use and reduce risk of C.diff -completed 2. Review of investigation process - Completed Complete actions from MRAB SI report 6. Monitor microbiologist attendance on site to ensure antibiotic prescribing reviewed	20/11/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
681	13/02/2014	Failure of cleanroom air handling unit due to wear and tear and age of unit - ongoing issues	Repeated failure of the cleanroom air handling unit is occuring due to the age of the plant equipment leading to cancelled internal and external grafts, loss of income and harm to reputation (unit was installed in 2004 and it has a life expectancy of 10 years)	cancelled internal and external grafts, loss of income and harm to reputation	Ad hoc repairs. Unit on quarterly maintenance contract (as recommended) Company last attended site on 13/02/2014 to fix the bearings Reporting of breakdowns on Datix (on 13/02/2014 ID 11705, On 28/03/2014 ID11878, and on 03/06/2014 ID12119).	Steve Fenlon	Nigel Jordan	12	8	28/10/2014: Head of Estates to recommend to Finance Director that a 'reduced scheme' be agreed to the value of £30K as per Clinical Scientists submission. Case to the Estates & Facilitaties Steering Group on 08/09/2014 with quotes for decision Business Case/options appraisal being drafted by General Manager for 3 Options	05/12/2014

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18th December 2014
Reference number:	337-14
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	9th December 2014
Appendices:	Board Assurance Framework

Board Assurance Framework (BAF)

Key issues

1. The BAF has been devised using a robust process ensuring the risks associated with the key strategic objectives of the trust and the QVH2020 strategy have all been captured.
2. Provided is a summary of all KSO board assurance risks, further detail around each KSO and the associated trust risks.
3. The process for development was reviewed by the Audit Committee and there was agreement that an overarching statement/risk would also be devised for monitoring.
4. This is a revised process still under development for 2014/15.

Implications of results reported

5. The BAF demonstrates that the Trust has been able to identify its key risks to achieving the strategic objectives for 2014/15.
6. No specific group/individual with a protected characteristic are affected issues identified within the risk register.
7. Failure to address the risks within the BAF or to recognise the action required to mitigate them would be key concerns to our commissioners, the Care Quality Commission (CQC) and Monitor. The CQC would consider risk management within the category of was the organisation well led.
8. The attached documents were reviewed at the Audit committee on 4 December 2014.

Action required

9. Regular review and monitoring of the BAF will take place through the Audit Committee and at Board where executive leads will give an update on actions taken as identified in the KSO's.

Link to Key Strategic Objectives (delete those not applicable)

- Outstanding patient experience

- World class clinical services
- Operational excellence
- Financial sustainability
- Organisational excellence

Regulatory impacts

10. The attached BAF would inform the CQC and has a direct impact on our ability to comply with our CQC authorisation and would indicate that the Trust is:

- Safe
- Effective
- Caring
- Well led
- Responsive

11. The attached BAF does not impact on our Monitor governance risk rating or our continuity of service risk rating, however it does inform our quarterly Monitor declaration.

Recommendation

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

Board Assurance Framework (BAF) November 2014 update

These Trusts strategic objectives inform the Trust's business objectives and vision for the future. The Board Assurance Framework identifies where there are risks to the delivery of these objectives and provides assurance on risk mitigation and their delivery.

Trust Objectives and BAF Risks	Score			
Principal Risk – Risk to the Trust of not meeting its Key Strategic Objectives (KSOs) **Executive Lead –** Chief Executive (RT) **Reviewed by scrutinising committee** – Trust Board – Date: **Link to Corporate Risk Register:** All BAF Risks	**Initial Risk Rating C X L: 4 x 3 = 8** **Current Risk Rating C X L: 4 x 3 = 12 (Amber)** **Residual Risk rating C X L: 4 x 3 = 12**			
	Q1	**Q2**	**Q3**	**Q4**
KSO 1 – Outstanding Patient Experience – SAFETY/STANDARDS - AP				
Principal Risk 1A – Failure to deliver a safe service and learn from incidents, and complaints **Executive lead** – Director of Nursing and Patient Experience (AP) **Reviewed by scrutinising committee** – Quality and Risk Committee – Date: **Link to Corporate Risk Register:** Risk IDs 27,749, 648, 513, 627, 744, 629, 540, 728, 745, 584, 727, 733, 675, 649, 535, 713, 715, 167, 60, 628, 594, 650, 666, 712, 718, 719, 721, 725, 539, 547, 609, 738, 684, 458, 615, 687, 622, 115, 484, 524, 632, 646, 577, 585, 671, 612, 686, 566, 512, 478, 422, 453, 631, 683, 731, 737, 668, 645, 611, 457 & 545	**Initial Risk Rating C X L: 4 x 2 = 8** **Current Risk Rating C X L: 4 x 2 = 8 (Yellow)** **Residual Risk rating C X L: 4 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**
Principal Risk 1B – Failure to meet regulatory standards **Executive lead** – Director of Nursing (AP) **Reviewed by scrutinising committee** – Quality and Risk Committee – Date: **Link to Corporate Risk Register:** Risk IDs 159, 474, 27, 749, 648, 710, 513, 627, 744, 623, 604, 745, 728, 499, 234, 673, 594, 517, 741, 738, 678, 548, 534, 686, 644, 587, 708 & 588	**Initial Risk Rating C X L: 4 x 2 =8** **Current Risk Rating C X L: 4 x 2 = 8 (Yellow)** **Residual Risk rating C X L: 4 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**
Principal Risk 1C – Inadequate resilience or preparedness for a major incident/critical incident **Executive lead** – Head of Operations (JC) **Reviewed by scrutinising committee** – Audit Committee – Date: **Link to Corporate Risk Register: IDs** 602, 60, 481, 72, 644, 643 & 501	**Initial Risk Rating C X L: 4 x 2 = 8** **Current Risk Rating C X L: 4 x 2 = 8 (Yellow)** **Residual Risk Rating C X L: 4 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**

Principal Risk 1D - Risk of adverse publicity and damage to reputation – Includes engagement with stakeholders and the community **Executive lead** – Head of Operations (JM) **Reviewed by scrutinising committee** – Audit Committee – Date: **Link to Corporate Risk Register:** IDs 474, 159, 513, 627, 623, 745, 743, 728, 620, 499, 672, 488, 60, 517, 741, 725, 738, 678 & 457	**Initial Risk Rating C X L: 4 x 2 = 8** **Current Risk Rating C X L: 4 x 2 = 8 (Yellow)** **Residual Risk Rating C X L:4 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**

Trust Objectives and BAF Risks	**Score**			
KSO 2 – World Class Clinical Services – STANDARDS – SF				
Principal Risk 2B – Potential for improved Trust-wide governance structures and reporting including review of clinical indicators, clinical audit and morbidity and mortality data **Executive lead** – Medical Director (SF) **Reviewed by scrutinising committee** – Quality and Risk Committee – Date: **Link to Corporate Risk Register:** Risk IDs 58, 749	**Initial Risk Rating C X L: 4 x 4 = 16** **Current Risk Rating C X L: 4 x 4 = 16 (Red)** **Residual Risk rating C X L: 4 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**
Principal Risk 2C – Risks emergent of the Trusts Research and Development arrangements **Executive lead** – Medical Director (SF) **Reviewed by scrutinising committee** – Quality and Risk Committee – date: **Link to Corporate Risk Register:** Risk IDs 361, 295	**Initial Risk Rating C X L: 4 x 4 = 16** **Current Risk Rating C X L: 4 x 4 = 8 (Yellow)** **Residual Risk rating C X L: 4 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**
Principal Risk – 2D – Compliance with Responsible Officer requirements (includes revalidation arrangements) **Executive lead** – Medical Director (SF) **Reviewed by scrutinising committee** – Quality and Risk Committee **Link to Corporate Risk Register:** Risk IDs 431	**Initial Risk Rating C X L: 4 X 2 = 8** **Current Risk Rating C X L: 4 X 2 = 8 (Yellow)** **Residual Risk rating C X L: 4 x 1 = 4**			
	Q1	**Q2**	**Q3**	**Q4**

Trust Objectives and BAF Risks	Score			
KS03 – Operational Excellence – Sustainability - (JM)				
Principal Risk – 3B Inability to deliver annual operational plan **Executive lead** – Head of Operations (JM) **Reviewed by scrutinising committee** – Audit Committee – Date: **Link to Corporate Risk Register:** ID159	**Initial Risk Rating C X L: 3 x 4 = 12** **Current Risk Rating C X L: 4 x 4 = 16 (Red)** **Residual Risk rating : C X L: 3 x 3 = 9**			
	Q1	**Q2**	**Q3**	**Q4**
Principal Risk – 3C Inability to deliver increased productivity to meet demand **Executive lead** – Head of Operations (JM) **Reviewed by scrutinising committee** – Audit Committee – date: **Link to Corporate Risk Register**: ID613	**Initial Risk Rating C X L: 3 x 4 = 12** **Current Risk Rating C X L: 3 x 4 = 12 (Amber)** **Residual Risk rating C X L: 3 x 3 = 9**			
	Q1	**Q2**	**Q3**	**Q4**

Trust Objectives and BAF Risks	Score			
KS04 – Financial Stability and Standards -				
Principle Risk 4A – Overall Financial Sustainability **Executive lead** – Finance Director (SB) **Reviewed by scrutinising committee** – Date: **Link to Corporate Risk Register:** ID499	**Initial Risk Rating C X L: 4x2=8** **Current Risk Rating C X L: 4x2=8 (Yellow)** **Residual Risk rating C X L: 4x2=8**			
	Q1	**Q2**	**Q3**	**Q4**
Principle Risk 4B – Scope and Provision of Clinical Services **Executive lead** – Finance Director (SB) **Reviewed by scrutinising committee** – **Link to Corporate Risk Register:** ID499	**Initial Risk Rating C X L: 4x3=12** **Current Risk Rating C X L:4x3=12 (Amber)** **Residual Risk rating C X L: 4x2=8**			
	Q1	**Q2**	**Q3**	**Q4**

Principle Risk 4C – Financial Control **Executive lead** – Finance Director (SB) **Reviewed by scrutinising committee** – Date: **Link to Corporate Risk Register:** ID499	**Initial Risk Rating C X L: 4x3=12** **Current Risk Rating C X L:4x3=12 (Amber)** **Residual Risk rating C X L: 4x2=8**			
	Q1	**Q2**	**Q3**	**Q4**
Principle Risk 4D – Infrastructure and Investment **Executive lead** – Finance Director (SB) **Reviewed by scrutinising committee** – Date: **Link to Corporate Risk Register:** ID499	**Initial Risk Rating C X L: 4x3=12** **Current Risk Rating C X L:4x3=12 (Amber)** **Residual Risk rating C X L: 4x2=8**			
	Q1	**Q2**	**Q3**	**Q4**
Principle Risk 4E – Performance and Standards **Executive lead** – Finance Director (SB) **Reviewed by scrutinising committee** – Date: **Link to Corporate Risk Register:** ID 499, 494 & 587	**Initial Risk Rating C X L: 4x5=20** **Current Risk Rating C X L:4x5=20 (Red)** **Residual Risk rating C X L:4x3=12**			
	Q1	**Q2**	**Q3**	**Q4**

Trust Objectives and BAF Risks	**Score**			
KS05 – Organisational Excellence – Staffing - (GA)				
Principal Risk – 5A Risk of poor quality care resulting from low mandatory training and appraisal rates. **Executive lead** – Head of Human Resources **Reviewed by scrutinising committee** – Human Resources Committee (to be introduced in August 2014) **Link to Corporate Risk Register:** ID749, 689, 584, 721	**Initial Risk Rating C X L: 3 x 4 = 12** **Current Risk Rating C X L: 3 x 4 = 12 (Amber)** **Residual Risk rating C X L: 3 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**
Principal Risk – 5B Recruitment of appropriate nursing and non-clinical skill mix (includes staffing numbers) **Executive lead** – Head of Human Resources **Reviewed by scrutinising committee** – Human Resources Committee (to be introduced in August 2014) **Link to Corporate Risk Register:** ID749	**Initial Risk Rating C X L: 3 x 4 = 12** **Current Risk Rating C X L: 3 x 4 = 12 (Amber)** **Residual Risk rating C X L: 3 x 2 = 8**			
	Q1	**Q2**	**Q3**	**Q4**

<table>
<tr><th>Trust Objectives and BAF Risks</th><th colspan="4">Score</th></tr>
<tr><td rowspan="2">Principal Risk – 5C Risk of staff not complying and promoting the Trust core values

Executive lead – Head of Human Resources
Reviewed by scrutinising committee – Human Resources Committee (to be introduced in August 2014)
Link to Corporate Risk Register: 1B</td><td colspan="4">Initial Risk Rating C X L: 3 x 4 = 12
Current Risk Rating C X L: 3 x 4 = 12 (Amber)
Residual Risk rating C X L: 3 x 2 = 8</td></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td rowspan="2">Principal Risk – 5D Inability to support staff educational requirements due to financial costs and pressures (477)

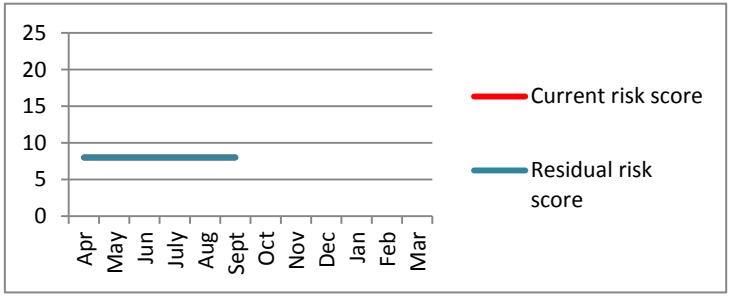
Executive lead – Head of Human Resources
Reviewed by scrutinising committee – Learning and Development Strategy Group
Link to Corporate Risk Register: ID477</td><td colspan="4">Initial Risk Rating C X L: 3 x 4 = 12
Current Risk Rating C X L: 3 x 4 = 12 (Amber)
Residual Risk rating C X L: 3 x 2 = 8</td></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
</table>

2014/15 BOARD ASSURANCE FRAMEWORK

KSO 1 – Outstanding Patient Experience – AP
SAFETY/STANDARDS

Principal Risk 1A – Failure to deliver a safe service and to learn from incidents and complaints

Executive lead – Director of Nursing and Patient Experience (AP)
Scrutinising committee – Quality and Risk Committee
Date last reviewed by Committee: Oct 2014 Trust Board
Review by responsible committee – Q&RC – June
Link to Corporate Risk Register: Risk IDs 27,749, 648, 513, 627, 744, 629, 540, 728, 745, 584, 727, 733, 675, 649, 535, 713, 715, 167, 60, 628, 594, 650, 666, 712, 718, 719, 721, 725, 539, 547, 609, 738, 684, 458, 615, 687, 622, 115, 484, 524, 632, 646, 577, 585, 671, 612, 686, 566, 512, 478, 422, 453, 631, 683, 731, 737, 668, 645, 611, 457 & 545
Links to Corporate and Priority Objectives: KSO 1
Last Reviewed: 16/10/2014



Initial Risk Rating C X L: 4 x 2 = 8
Current Risk Rating C X L: 4 x 2 = 8
Residual Risk rating C X L: 4 x 2 = 8

	Q1	Q2	Q3	Q4

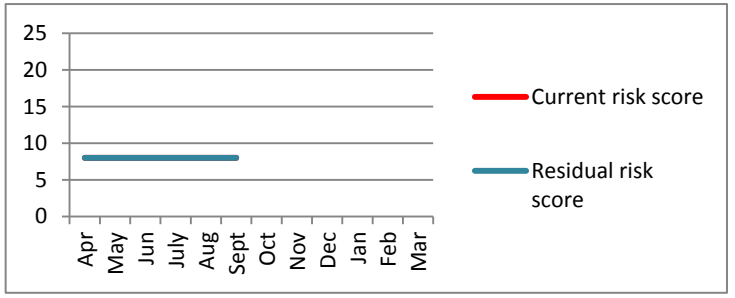
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(E)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1. Compliance in Practice (CiP) assessments undertaken	1. Compliance in Practice (CiP) assessment summary presented to the Quality and Risk Committee **(I)** 2. CQC report of last inspection and intelligent monitoring **(E)**	• Revised CiP assessment process from May 2014	• Revised CiP assessment process from May 2014	**May 2014 Completed**
2. Quality Metrics Dashboard completed monthly	1. Included in the Trust Board and senior committee reporting e.g. Clinical Cabinet, and Trust Board **(I)** 2. Minutes from the Programme Board and Single Performance meetings where the CCG issues can be raised **(E)**	• Updated Quality metrics dashboard still requires clarity for two indicators	• Updated Quality metrics dashboard still requires clarity for two indicators	**Discussed with CCG quality lead Completed**

3. Patient Safety Dashboard completed monthly	1. Included in the Trust Board and senior committee reporting e.g. Clinical Cabinet, and Trust Board **(I)** 2. CCG review and as at 2 above **(E)**	• None		
4. Family and friends questionnaire in place	1. Family and Friends data included in the monthly dashboard reporting to Quality and Risk Committee, and Trust Board **(I)** 2. Family and friends test data reporting into national data **(E)**	• Reporting of national staff Family and friends data	• To be included within Board HR reports • To be disseminated to QVH staff at staff briefing	**Oct 2014** **Oct 2014**
5. Clinical Audit and Outcomes Group established to determine outcome data	1. Minutes of Clinical and Outcomes Group available and onward reporting to the Quality and Risk Committee **(I)** 2. Clinical indicators on the dashboard so reviewed as a part of the CCG quality and as above (2&3) All data submitted through Quality Account **(E)**	• Outcome data not available for all specialties	• Ability to deliver under review by clinical outcomes group	**Update Oct 2014**
6. Included in the outcome measure for the 2014/15 Quality Account	1. Committee reporting e.g. Clinical Cabinet, Trust Board, Quality and Risk Committee and Clinical Governance Group **(I)** 2. Internal and External Audit Annual Reports and Internal Audit Programme of 2014/15 **(E)**.	• Revised Quality Account measures in place for 2014/15	• Revised Quality Account measures in place for 2014/15	**May 2015 Priorities identified and published May 2014**
7. Incident data and trends reviewed at various committees including Clinical Cabinet, Trust Board, Quality and Risk Committee and Clinical Governance Group	1. Committee reporting e.g. Clinical Cabinet, Trust Board, Quality and Risk Committee and Clinical Governance Group and Patient Safety reporting to the NRLS **(I)** 2. Six monthly NRLS benchmarking reports **(E)**	• Trust identified as a low incident reporter	• Active engagement with staff to increase reporting and identify target • Identify as an action within the sign up to safety campaign • Ongoing MaPSaf workshops to encourage staff feedback on incident reporting processes • New staff risk/patient safety newsletter under development	**Dec 2014** **Oct 2014** **Dec 2014** **Nov 2014**

8. Serious Incidents, and "red" and "amber" incident actions transferred to a learning log (also complaints) that is reviewed at the Clinical Governance Group to action closure	1. Committee reporting e.g. Clinical Cabinet, Trust Board, Quality and Risk Committee and Clinical Governance Group **(I)** 2. CCG and LAT scrutiny and agreement before final closure by them **(E)**	• None	• Following further IC outbreak in BU undertake a review of learning from last 3 outbreaks	**Sept 2014**
9. Presentations included in the monthly Joint Clinical Audit meetings (and notes published on intranet)	1. Joint Clinical Audit meetings notes (also published on the intranet) report in to the Quality and Risk Committee (includes clinical indicators e.g. via the dashboard) **(I)** 2. CCG and external auditors receive copies of QVH annual reports **(E)**	• Limited opportunities to disseminate learning in some specialties and levels	• Identify opportunities to disseminate learning to identified specialties and levels that do not receive feedback/learning • Junior Drs Forum commenced Oct 2014 • Head of Risk and Medication Safety Officer to attend M&M meetings to improve dissemination of learning	**Update Oct 2014** **Nov 2014** **Dec 2014**
10. Staff Risk Management training, which includes being open and lessons learnt	1. Included in the Trust Board and senior committee reporting e.g. Clinical Cabinet, and Trust Board **(I)** 2. CCG and external auditors receive copies of QVH annual reports **(E)** 3. All Risk Management training fully reviewed (induction, refresher, etc and aimed at various staffing levels e.g. junior doctors, Consultants etc.**(I)**	• Training currently under review (induction and clinical refresher completed).	• Training currently under review (induction and clinical refresher completed).	**All completed Oct 2014**
11.MaPSaF	1. Quarterly summary provided to CCG as part of CQUIN data **(E)**	• MaPSaF meetings with depts. now need to commence	• Programme of MaPSaF meetings with depts. to be developed and rolled out	**Plan in process of being rolled out complete March 2015**

Principal Risk 1B – Failure to meet regulatory standards

Executive lead – Director of Nursing (AP)
Scrutinising committee – Quality and Risk Committee
Date last reviewed by Committee: Oct 2014 Trust Board
Review by responsible committee – Q&RC – June
Link to Corporate Risk Register: Risk IDs 159, 474, 27, 749, 648, 710, 513, 627, 744, 623, 604, 745, 728, 499, 234, 673, 594, 517, 741, 738, 678, 548, 534, 686, 644, 587, 708 & 588
Links to Corporate and Priority Objectives: KSO 2
Last Reviewed: 16/10/2014



Initial Risk Rating C X L: 4 x 2 =8
Current Risk Rating C X L: 4 x 2 = 8 (Yellow)
Residual Risk rating C X L: 4 x 2 = 8

Q1	Q2	Q3	Q4

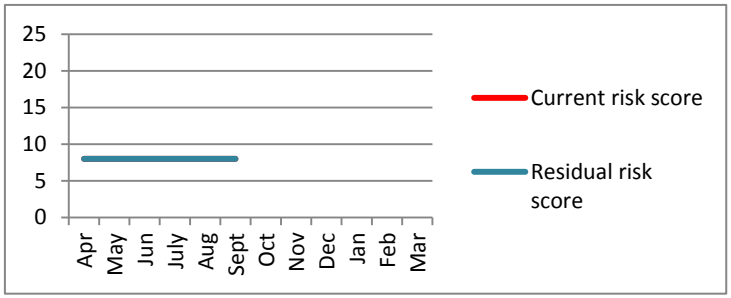
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(E)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1 Compliance in Practice (CiP) assessments in place.	1. CiP outcomes reported to the Quality and Risk Committee **(I)** 2. CQC inspection reports e.g. IRMER review) and intelligent monitoring **(E)**	• Revised assessments from May 2014	• Revised CiP assessments from May 2014	**July 2014**
2. Policies in place and published on Trust Intranet	1. Clinical policies approved by the Clinical Policy Group and non clinical policies approved at Information Governance Committee or other specific groups as per Policy on Policies **(I)** 2. Internal and External Audit Reports **(E)**	• Revised governance process commenced in May 2014 includes policy approval and policy on policies to be updated.	• Revised governance process commenced in May 2014 includes policy approval and policy on policies to be updated.	**Dec 2014**
3. Databases used for collation of evidence IG Toolkit, HSE, NHS Protect reviews and other assessments	1. Update reports on impending inspections to relevant committees/groups e.g. NHS Protect (Security) reported to H&SC **(I)**.	• None but work underway to develop a system to triangulate inspection and	• Work underway to develop a system to triangulate inspection and assessment outcomes to provide	**Dec 2014**

	2. Compliance with assessments, accreditations and regulatory requirements e.g. IG Toolkit, HSE, MHRA and NHS Protect Security and Fraud requirements **(E)** 3. Trusts quarterly and annual Monitor Governance return **(E)**	assessment outcomes to provide assurance.	assurance.	
4. Clinical Governance Group (CGG) responsible and in place for approval of clinical policies.	1. Clinical policies approved by the Clinical Policy Group and non clinical policies approved at Information Governance Committee or other specific groups as per Policy on Policies **(I)** 2. Internal and External Audit Reports **(E)**	• None		
5. Quality and Risk Committee responsible for triangulating and monitoring patient safety outcomes including incidents, complaints, audits, risks etc. Also received Compliance in Practice update reports	1. Quality and Risk Committee is a sub committee of the Trust Board and minutes and reporting are escalated **(I)**. 2. Trusts quarterly and annual Monitor Governance return **(E)**	• None		
6. Audit and monitoring programmes in place for reporting to Trust Board, Quality and Risk and Audit Committee, Clinical Cabinet, CCG and to relevant subcommittees on assessments and recommendations	1. Committee minutes and inclusion of data in the Trust Annual Report and Quality Account. Also specific reports e.g. quarterly Risk Management and Complaints Reports **(I)**. 2. Trusts quarterly and annual Monitor Governance return **(E)**	• None		
7. Mock PLACE assessments undertaken and annual PLACE inspection completed	1. Reporting of annual PLACE outcomes to Quality and Risk Committee and Trust Board and supporting PLACE outcomes reported to TBC **(I)** 2. Annual PLACE outcome report **(E)**	• None		

8. Education and training available for staff	1. Attendance rates monitored against an 80% target on the Quality Metrics dashboard **(I)** 2. Annual report (submitted to Q&RC) **(E)**	• Maintenance of compliance with mandatory training rates		
9. Risk Management systems in place e.g. risk assessments, risk registers, Root cause analysis for "red" and "amber " incidents and Serious Incidents and for any C.diff case and MRSA Bacteraemia (also reported) to ICC.	1. Reporting to Directorate meetings, Clinical Governance Group, Quality and Risk Committee and Trust Board including the BAF **(I)** 2. External reporting to CCG of SIs and Health and Safety Executive review of a RIDDOR reportable incident in March 2014 **(E)**	• None		
10. IPAC team in place to ensure processes followed and monitor cleanliness/hygiene.	1. Monitoring at the Infection Prevention and Control Committee (a sub committee of the Quality and Risk Committee) **(I)** 2. National reporting of infection control data **(E)**	• None		
11. Deep clean programme in place.	1. Reporting of annual PLACE outcomes to Quality and Risk Committee and Trust Board and supporting PLACE outcomes reported to TBC **(I)** 2. Monitoring at the Infection Prevention and Control Committee (a sub committee of the Quality and Risk Committee) **(I)** 3. Annual PLACE review report **(E)** 4. Annual PLACE outcome report **(E)**	• None		

Principal Risk 1C – Failure of emergency planning and business continuity arrangements

Executive lead – Head of Operations (JC)
Scrutinising committee – Audit Committee
Date last reviewed by Committee: Oct 2014 Trust Board
Review by responsible committee – Audit Committee
Link to Corporate Risk Register: IDs 602, 60, 481, 72, 644, 643 & 501
Links to Corporate and Priority Objectives: KSO 3
Last Reviewed: 16/10/2014



Initial Risk Rating C X L: 4 x 2 = 8
Current Risk Rating C X L: 4 x 2 = 8 (Yellow)
Residual Risk Rating C X L: 4 x 2 = 8

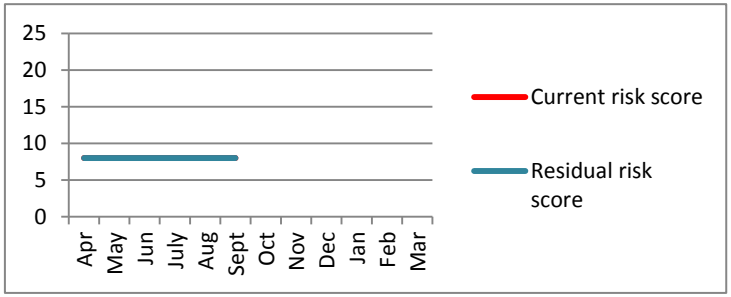
Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(E)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1. The Trust has two servers located in two separate rooms.	1. Dashboard of IT system and application performance and resilience in place **(I)** 2. External reporting to Emergency Planning network, Internal and External Audit review reports. Assurance meeting with LAT annually on completion of EPRR **(E)**	None	N/A	
2. Data is replicated daily to the second server.	1. Dashboard of IT system and application performance and resilience in place **(I)**	None	N/A	
3. Back of main server is carried out in second server room.	1. Dashboard of IT system and application performance and resilience in place **(I)**	None	N/A	

4. Back up tapes stored in fire-proof safe in second server room.	1. Dashboard of IT system and application performance and resilience in place **(I)**	None	N/A	
5. First server room has fire suppression.	1. Dashboard of IT system and application performance and resilience in place **(I)**	None	N/A	
6. Information Management and Governance Committee monitor capacity and capability of IT systems and plan future developments.	1. Dashboard of IT system and application performance and resilience in place **(I)**	None	N/A	
7. Dashboard of IT system and application performance and resilience in place.	1. Dashboard of IT system and application performance and resilience in place **(I)**	None	N/A	
8. Additional external support provided for server breakdown	1. Independent survey completed of whole site infrastructure **(I)**	None	N/A	
9. Independent survey completed of whole site infrastructure	1. Independent survey completed of whole site infrastructure **(I)**	None	N/A	
10. Trust Business Continuity arrangements in place	1. Business Continuity Plan in place **(I)**	None	N/A	
11. Old and new Theatres on different circuits, so rerouting is an available option.	1. Old and new Theatres on different circuits, so rerouting is an available option **(I)**.	None	N/A	
12. Backup generators in place.	1. Routine testing programme in place **(I)**	None	N/A	
13. Planned electrical shutdown managed successfully on 26/04/2014	1. Minutes and reports of preparation and also debrief report of Major Incident Datix ID 11638 **(I)** 2. External reporting to Emergency Planning network, Internal and External Audit review reports. Assurance meeting with LAT annually on completion of EPRR **(E)**	None	N/A	

Principal Risk – 1D Risk of adverse publicity, reputation and stakeholder relationships

Executive lead – Head of Operations (JM)
Scrutinising committee – Audit Committee
Date last reviewed by Committee: Oct 2014 Trust Board
Review by responsible committee – Audit Committee
Link to Corporate Risk Register: IDs 474, 159, 513, 627, 623, 745, 743, 728, 620, 499, 672, 488, 60, 517, 741, 725, 738, 678 & 457
Links to Corporate and Priority Objectives: KSO3
Last Reviewed: 16/10/2014



Initial Risk Rating C X L: 4 x 2 = 8
Current Risk Rating C X L: 4 x 2 = 8 (Yellow)
Residual Risk Rating C X L:4 x 2 = 8

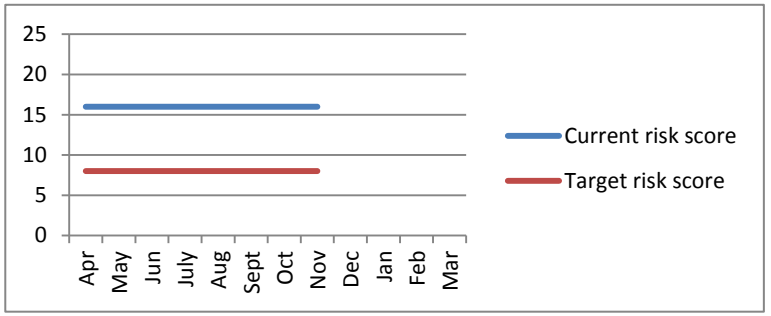
		Q1	Q2	Q3	Q4
ey controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(E)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**	
1. QVH Comms Department in place	1. Structure of direct reporting to the CEO **(I)**	None	N/A		
2. Incident and Risk Management Policy and Risk Management Strategy, and Comms Strategy in place	1. Internal reporting and minutes **(I)** 2. Internal and external audit reviews **(E)**	None	N/A		
3. Committee review of risks and incidents (as per the schedule of reporting) and at departmental level	1. Internal reporting and minutes **(I)** 2. Internal and external audit reviews **(E)**	None	N/A		
4 Serious incidents reported on STEIS and communicated to CCG, CQC and Monitor at time of discovery	1. Internal reporting and minutes **(I)** 2. Internal and external audit reviews **(E)** 3. CCG, Monitor and CQC reporting **(E)**	None	N/A		

5. Monthly Trust Board in place with public sessions	1. Internal reporting and minutes **(I)** 2. Internal and external audit reviews **(E)** 3. CCG, Monitor and CQC reporting **(E)**	None	N/A	
6. Quarterly CCG meetings	1. Internal reporting and minutes **(I)** 2. Internal and external audit reviews **(E)** 3. CCG, Monitor and CQC reporting **(E)**	None	N/A	
7. National level reporting e.g. NHS England, NRLS	1. Internal reporting and minutes **(I)** 2. Internal and external audit reviews **(E)** 3. CCG, Monitor and CQC reporting **(E)**	None	N/A	

2014/15 BOARD ASSURANCE FRAMEWORK

Principal Risk 2B – Failure to meet the Trusts Clinical Strategy and Clinical Outcomes

Executive lead – Medical Director (SF)
Scrutinising committee – Quality and Risk Committee
Date last reviewed by Committee: TBC
Review by responsible committee – Q&RC – June
Link to Corporate Risk Register: Risk IDs 58, 388
Links to Corporate and Priority Objectives: KSO 2
Last Reviewed: Medical Director (SF) 23/10/2014



Initial Risk Rating C X L: 4 x 4 = 16
Current Risk Rating C X L: 4 x 4 = 16 (Red)
Target Risk Rating C X L: 4 x 2 = 8

Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(E)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1. Committee reporting structure in place from Directorate levels to Trust Board and back and includes assurance committees e.g. Q&RC and Audit Committee clinical indicators, incidents and other data reviewed	• Minutes from committees and sub committees e.g. Q&RC, Audit Committee and H&SC, IPACTC and Clinical Outcomes Group **(I)** • Internal and external audit reviews and annual report, Quality Account review by overview and Scrutiny Group, CQC Intelligent Monitoring reporting, CCG reporting **(E)**	• Review of governance reporting structure currently in place	Amanda Parker	31/12/2014

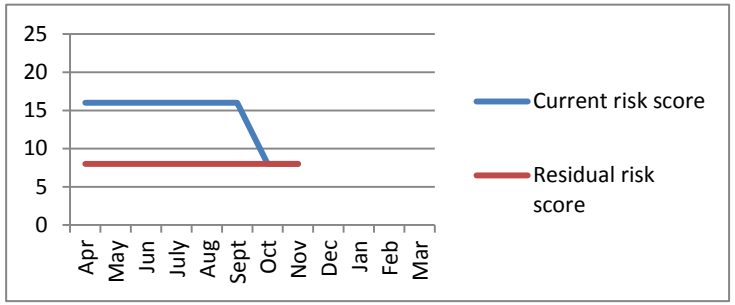
2.	Assurance Committees receive minutes from sub committees	• Minutes from committees and sub committees e.g. Q&RC, Audit Committee and H&SC, IPACTC and Clinical Outcomes Group **(I)** • Internal and external audit reviews and annual report, Quality Account review by overview and Scrutiny Group, CQC Intelligent Monitoring reporting, CCG reporting **(E)**	• None		
3.	Incident and Risk Management Policy in place	• Clinical Governance Group minutes available regarding policy ratifications **(I)** • Internal and external audit reviews and annual report, Quality Account review by overview and Scrutiny Group, CQC Intelligent Monitoring reporting, CCG reporting **(E)**	• Incident reporting and Risk Management Policy require update	Amanda Parker	31/12/2014
4.	Risk Management Strategy in place	• Clinical Governance Group minutes available regarding policy ratifications **(I)** • Internal and external audit reviews and annual report, Quality Account review by overview and Scrutiny Group, CQC Intelligent Monitoring reporting, CCG reporting(E)	3. Risk Management Strategy requires update	Amanda Parker	31/12/2014
5.	Clinical Outcomes Committee in place to review clinical audit, and M&M data	• Internal and external audit reviews and annual report, Quality Account review by overview and Scrutiny Group, CQC Intelligent Monitoring reporting, CCG reporting **(E)** • Clinical audit process and Department in place **(I)**	3. Standardised M&M data and reporting currently being improved	Steve Fenlon	31/12/2014
6.	Clinical audit process and Department in place	• Internal and external audit reviews and annual report, Quality Account review by overview and Scrutiny Group, CQC Intelligent	• None		

	Monitoring reporting, CCG reporting **(E)** • Notes of Joint Clinical Audit meeting published on the intranet **(I)**			
7. Directorate M&M meetings in place	Notes of Joint Clinical Audit meeting published on the intranet **(I)**	• None		
8. Regular review of incidents, complaints and claims to triangulate with audit data (Q&RC)	Notes of Joint Clinical Audit meeting published on the intranet **(I)**	• None		
9. Incidents, complaints and claims reviewed as part of the revalidation process	Q&RC minutes **(I)**	• None		
10. Compliance with CQC requirements (2009 assessment and update of 2013)	Revalidation related enquires and appraisal process **(I)**	• None		
11. Annual department risk assessment process to monitor HSE compliance	CQC Report **(E)** Local H&S report **(I)**	• None		
12. Policy monitoring system in place.	Annual department risk assessments and register presented to H&SC **(I)**	• None		
13. Incident reporting system in place	Minutes from the Clinical Governance Group (previously the CPC). **(I)**	• None		
14. Incident reporting to National Reporting & Learning System (NRLS).	Incident reports and trend analysis (to Directorates, Q&RC, Clinical Cabinet and Trust Board) **(I)**	• None		
15. Regular review of complaints by CEO and DON.	National 6monthly feedback reports from NRLS **(I)**	• None		
16. Monitoring by commissioning CCG's.	Meeting feedback at Q&RC and Trust Board. **(I)**	• None		
17. National and local guidance/policy discussed at Directorate meetings and Clinical Cabinet	Minutes from CCG quality meetings and SI reporting.**(I)**	• None		
18. Clinical Governance Group in place for review and monitoring of incidents, complaints,	H&S / IC assessments annually at off site clinics **(I)**	• None		

policies, learning, management of risks and key performance indicators, etc				

Principal Risk 2C – Risks emergent of the Trusts Research and Development arrangements

Executive lead – Medical Director (SF)
Scrutinising committee – Quality and Risk Committee
Date last reviewed by Committee: TBC
Review by responsible committee – Q&RC – June
Link to Corporate Risk Register: Risk IDs 361, 295
Links to Corporate and Priority Objectives: KSO 2
Last Reviewed: Medical Director (SF), 23/10/2014



Initial Risk Rating C X L: 4 x 4 = 16
Current Risk Rating C X L: 4 x 2 = 8 (Yellow)
Target Risk Rating C X L: 4 x 2 = 8

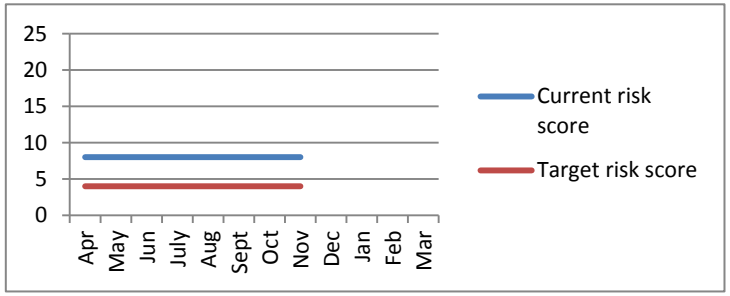
Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed **Internal Sources of Assurance (quality and level)**	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1. Research Committee and appropriate sub committees in place	Research Committee minutes (I)	None	None	
2. Research policy in place	Research policy approval and audits/trials (I)	None	None	

3. Research trials monitored	1. Reporting to committees (I) 2. Closure of defunct trials (target exceeded) (I) 3. Increased portfolio recruitment/studies by 25% (I) 4. Seconded assistant to help with 5. Research applications for one year	None	None	
4. Training in clinical research to all practitioners involved in research	Training logs (I) QVH Nurse enrolled on MRES course	None	None	
5. External oversight from funding organisations, ethics committees and the local research network	1. Reporting to committees (I) 2. External oversight from funding organisations, ethics committees and the local research network (E) 3. Links with the University of Brighton	None	Set up Tissue bank with BMRF/UOB	Dec 2014

Principal Risk – 2D – Failure to comply with Responsible Officer requirements (includes revalidation arrangements)

Executive lead – Medical Director (SF)
Scrutinising committee – Quality and Risk Committee
Date last reviewed by Committee: TBC
Review by responsible committee – Q&RC – June
Link to Corporate Risk Register: Risk IDs 431
Links to Corporate and Priority Objectives: KSO 2
Last Reviewed: Medical Director (SF), 23/10/2014



Initial Risk Rating C X L: 4 X 2 = 8
Current Risk Rating C X L: 4 X 2 = 8 (Yellow)
Target Risk Rating C X L: 4 x 1 = 4

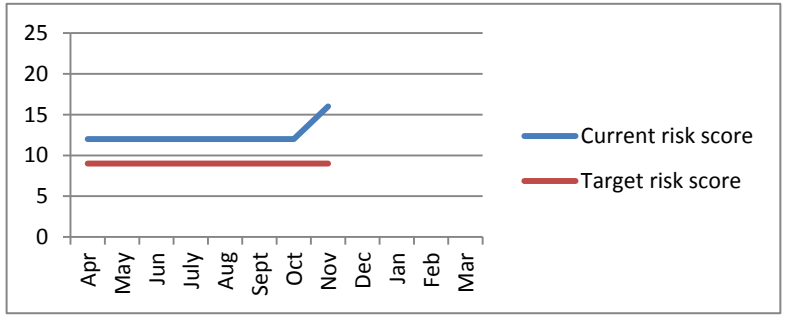
Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1. Annual Trust Board medical staffing report	Medical Directors Annual Report to Trust Board includes medical staffing information Committee minutes and reporting e.g. Clinical Cabinet and Quality and Risk Committee (I)	None	None	N/A
2. Appraisal rates	Monitored via Trust Board reporting (I)	None	1. Improvements to be made to appraisal quality 2. Improvements to be made to appraisal training	April 2015 April 2015

3. Appraiser training	Led by Medical Director and delivered as per national requirements (I)	None	None	N/A
4. Feedback from patients and staff on the quality of individual doctors care included in the appraisal process	Information incorporated within the Medical Directors Reporting (I)	None	None	N/A
5. Reporting and systematic measurement of the output of a doctors work	Ongoing reporting and collated to inform revalidation process (I)	None	None	N/A
6. Recruitment processes (above and beyond standard checks)	Led by Medical Director and delivered as per national requirements (I)	None	None	N/A
7. Monitoring of complaints, clinical indicators, behavioural and clinical incidents, audits and outcomes, reports from other organisations etc	Reports to NHS England (by Medical Director in July (E)	None	None	N/A
8. Monitoring of clinical indicators by consultant	Reporting to relevant committees and Trust Board (I)	None	None	N/A
9. Review of all policies and procedures within the organisation that relate to medical staff.	Policy review database and Clinical Governance Group reporting (I)	None	None	N/A
10. Incident, complaint and audit review at relevant committees e.g. Clinical Governance Group, Clinical Cabinet, Quality and Risk Committee etc	Ongoing reporting (I) External audit reporting and reviews (E)	None	None	N/A

BOARD ASSURANCE FRAMEWORK

KSO3 – Operational Excellence (JM) - SUSTAINABILITY

Principal Risk – 3B Inability to deliver annual plan and operational performance standards **Executive lead** – Head of Operations (JM) **Scrutinising committee** – Audit Committee **Date last reviewed by Committee: TBC** **Review by responsible committee – Clinical Cabinet and Trust Board** **Link to Corporate Risk Register:** ID159 **Links to Corporate and Priority Objectives: KSO3** **Last Reviewed:** 22/11/2014	 **Initial Risk Rating C X L: 4x 4 = 16** **Current Risk Rating C X L: 4 x 4 = 16 (Red)** **Target Risk Rating C X L: 3 x 3 = 9** Q1 | Q2 | Q3 | Q4

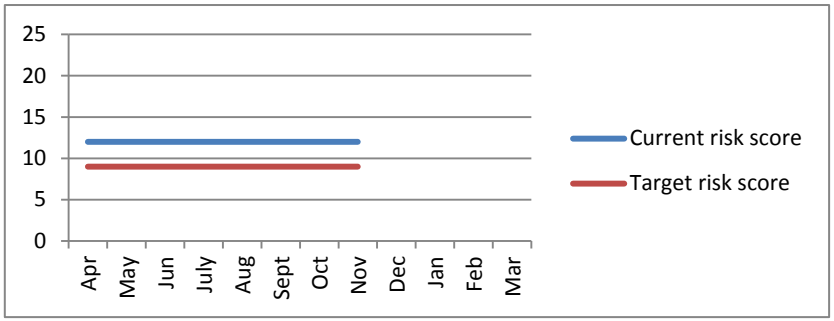
Key controls to manage risks Identify the key controls in place to manage the risks	Assurance on controls Identify internal (I) or external (E) sources of assurance and indicate if they need to be re-confirmed	Gaps Identify any gaps in controls or assurance or negative assurance	Action Plans Identify Action plans to address gaps and negative assurances with responsible Director identified	Date for completion of action
1. Trust Board and Audit Committee minutes for monitoring of the QVH Annual Plan 2. Programme Board meeting with CCG's to monitor performance and Quality account delivery 3. Monitor quarterly return Monthly Trust Board reporting of Operational and Financial performance	1 Annual Quality Account and sign off process (I) 2 Internal and external audit reviews (E) 3 Quarterly monitor returns & annual Monitor report (E) 4 Quarterly Quality Account sign off process with CCG's 5 Programme Board/Single performance conversation – CCG scrutiny (E)	• Failure to meet 18 weeks and cancer targets in Q1 –Q3 • Additional staff and capacity required to allow delivery of capacity to achieve sustainable waiting list Information used to report 18 week and cancer performance to be reviewed	• Monthly dashboard delivery to Clinical Cabinet and Trust Board to provide early alert • Exception reports provided to Clinical Cabinet Monthly • Weekly Updates provided to Trust Board • Progress against action plan for 18 weeks post IST visit in April 2014 reported at Clinical Cabinet and Trust Board	On going - Included in the Monthly reporting

4. Weekly Trust Board update regarding 18 week compliance and forecast position 5. Intensive support review 6. Monthly and Quarterly Directorate Performance meetings 7. Weekly Operational Review meeting 8. Daily Patient Access meeting 9. Mthly 18 week steering group meeting 10. Quarterly Cancer Steering Group 11. Monitor reporting e.g. 2 year plan and 2 year financial return 12. 5 year financial return to Monitor 13. Maintain and Increase capacity as required in year 14. Implementation of new services a. Increase ENT services at QVH in conjunction with Medway and SASH b. 5 day cover for lower leg trauma at BSUH c. Lower leg trauma x 1 week cover at Pembury d. Support new CCG MSK service e. Open Th11 for LA DC's	1 Intensive support review report(E) 2 Intensive support team demand and capacity tool analysis 3 Service Line activity and finance reports including referral data 4 Weekly operational performance 'Flash report' 5 Internal and external Auditor review reports (E) 6 Interim Operational structure in post 7 Minutes available from a. Monthly / Quarterly Directorate performance meetings b. Weekly Operational review meeting c. Daily access including action plan d. 18 week steering group e. Quarterly Cancer steering group	• Operational information from daily PTL insufficient and needs further refining and dedicated resources for admitted and non-admitted patients • Insufficient operational management team resources to manage day to day issues due to sickness and vacancies	• Implement Cancer waiting time action plan including o trend analysis of breaches to be completed o Complete review of data collection systems used within team to refine process and streamline information o Introduce a daily cancer PTL o COSD action plan to be progressed o Off-site issues to be escalated accordingly to prevent recurrence • Implement findings of internal auditors following late referrals / breaches off site audit • IST demand and capacity tools to be completed for Q2-Q4 for each Specialty and incorporated into business planning • Actions to be implemented to increase capacity include o Recruit to full establishment of Associate Specialists for Minor oral surgery o Recruit 5th Head and Neck Consultant	On going - Included in the Monthly reporting Dec 14 On going Nov 14 Jan 15
			o Recruit substantive part time Sleep Consultant o Recruit substantive Hand consultant (post retirement)	Nov 14 March 15

			○ Recruit locum Skin Consultant (direct replacement whilst substantive post reviewed) ○ Recruit substantive Breast /Burns consultant (post retirement) ○ Recruit two senior fellows to support opening of Th 11 ○ Recruit locum Orthodontic consultant ○ Open additional treatment room in Orthodontics ○ Run additional theatre and clinic sessions in order to maintain waiting time performance as required ○ Outsource Orthodontic activity as required until Locum and additional treatment room in place. • Actions surrounding new services to be implemented including ○ Appoint Plastic lower leg Consultant	Nov 14 – complete Aug 14 – complete July 14 – complete Oct 14 By March 15 By March 15 Aug 14– March 15 Nov &Dec 14 June 14 - complete
			○ Medway ENT service to commence ○ SASH ENT service to commence ○ Provide plastic input to Trauma service at Pembury ○ Take referrals from new MSK service ○ Open Th 11 – 9 sessions a week	Nov 14 – complete Tbc Jan 15 Sept 14 – complete

			• Interim service manager to be recruited to increase capacity within operational team • Substantive Operational structure to be announced and recruited to in Q4	By Sept 50% open Nov 14 – in place Q4

Principal Risk – 3C Inability to deliver the required transformation of services to deliver increased productivity to meet demand
Executive lead – Head of Operations (JM)
Scrutinising committee – Trust Board
Date last reviewed by Committee: October 2014
Review by responsible committee – Clinical cabinet and Senior Management team
Link to Corporate Risk Register: ID613
Links to Corporate and Priority Objectives: KSO3
Last Reviewed: 22/11/2014



Initial Risk Rating C X L: 3 x 4 = 12
Current Risk Rating C X L: 3 x 4 = 12 (Amber)
Residual Risk Rating C X L: 3 x 3 = 9

Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	Assurance on controls Identify internal (I) or external (E) sources of assurance and indicate if they need to be re-confirmed	Gaps Identify any gaps in controls or assurance or negative assurance	Action Plans Identify Action plans to address gaps and negative assurances with responsible Director identified	Date for completion of action
1. Annual business planning process. 2. Monthly and Quarterly Directorate reviews 3. QVH 2020 –Delivering	1. Reporting to Audit Committee and Trust Board (I) 2. Strategic plan submissions to Monitor (E) 3. Internal and external Auditor	• Review of Job planning process • Delays in delivering transformational change due to operational pressures	• QVH 2020 Operational excellence - Full action plan in place and presented to clinical cabinet and Trust Board including o Zero tolerance on late starts	Ongoing Dec 14

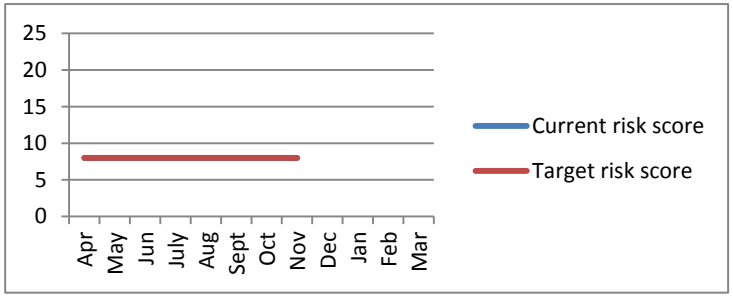
operational excellence - service improvement plans focused on Electronic patient record, Theatres, outpatients, trauma, pre-assessment and inpatient care 4. Clinical IT systems annual and strategic implementation plan	review reports (E) 4. Quality Account (including quarterly updates) (E) 5. Weekly and Monthly service line reporting reviewed by Directorates and reported to Clinical Cabinet 6. Reporting to Senior Management team 7. Reporting to ICAG and IM&G committee	• Lack of trained staff with service improvement skills	o Increased trauma theatre capacity and one stop service o Booked pre-assessment appointments o Introduction of smart scheduling o Introduction of QVH 2020 programme office	April 15 Dec 14 Q4 June 14 – complete
5. Annual Job Planning 6. Theatre 11 – progress on opening new facility and increase numbers of one stop LOPA clinics 7. Services delivered at off site	• Updates and minutes from Electronic Patient record, Theatre user group, patient documentation, Outpatient steering group, pre-assessment and trauma management group to Clinical Cabinet and Trust Board • Service review report (E)	• IT Network upgrade to ensure systems are robust for additional systems to be rolled out • Lack of resources to implement IT systems • Up to date review of spoke services required to evaluate current value to QVH to be completed	• Full action plan in place following internal audit of theatres being presented and progressed by Theatre user group. o Patient Centre V4.3 to be introduced Cancellation process policy to be agreed o Review of operating list processes to be completed • KPI Metrics being devised for Outpatients and Theatres in Q2 to focus productivity work • Pilot planned for 3 operating lists for Q4 to improve productivity • Recruit Theatre and surgical teams to open theatre 11 • Review of clinic templates and alternatives to FU's to release capacity – specific project in Corneo to be prioritised • Offsite spoke review (cross referenced with the clinical strategy) •	Ongoing Dec 14 Ongoing Q2- complete Q4 Sept 14 – complete Q4 Sept 14

			• Job planning review underway with aim to introduce new process in March / April 2015 • Business case for improved IT network being progressed	March / April 2015 Dec 14
			• Progress on IT systems being rolled out in year presented to ICAG and IM&G • Resources being reviewed to support roll out of transformation and electronic patient record as part of operational structure review • Implement Trust wide service Improvement training course	Ongoing Q4 Q4

Key Strategic Objective 4 – Financial Sustainability & Standards

Principal Risk 4A – Overall financial stability

Executive lead –Finance Director (SB)
Scrutinising committee – Audit Committee
Date last reviewed by Committee: TBC
Review by responsible committee – Audit Committee – TBC
Link to Corporate Risk Register: Risk IDs
Links to Corporate and Priority Objectives: KSO 4
Last Reviewed: Finance Director (SB), 21st November 2014

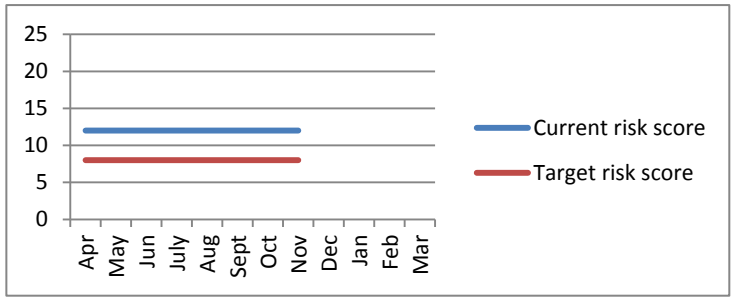


Initial Risk Rating C X L: 4 x 2 = 8
Current Risk Rating C X L: 4 x 2 = 8 (Yellow)
Target Risk Rating C X L: 4 x 2 = 2

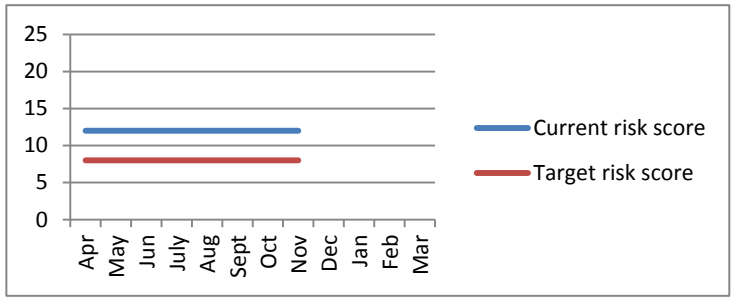
Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(e)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
5 Year planning	Trust Board approval (I) Submission to Monitor (E)	None	N/A	N/A
Annual budgets	Trust Board approval and monthly reporting at all levels (I) Internal audit reviews (E)	Clearly defined process and formal sign off by budget holders	Introduction of accountability agreements	By end of August 14
Cash management and forecasts	Monthly reporting to Trust Board (I) Monitor CoSRR and external audit assessment of on going financial stability (E)	None	N/A	N/A
Capital Planning	5 year plans with detailed annual plans approved by Trust Board (I)	Review of existing groups to ensure terms of reference	Formal review of the estates and IT groups	By end of August 14

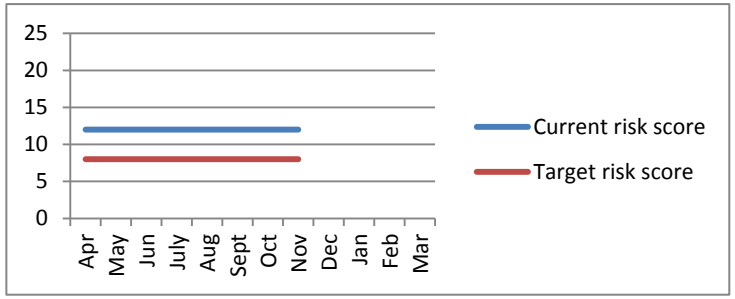
	Routine review of capital planning and approval processes (E)	make clear approval processes and delegated limits	Update to capital approval process and wider transparency of planning and priorities.	
Signed contracts and operational compliance	All material contracts with commissioners and other NHS providers agreed (I) Internal Audit – review of controls and documents (E)	None	N/A	N/A
CIP Programme (current and future years) and Monitoring	Reporting of future CIP schemes, forecasts and financial plans to Trust Board as part of 2 and 5 year planning cycle (I) Internal Audit – review of controls and documents (E)	Visibility of compliance and progress to date via Trust Board	Inclusion within routine monthly reporting to Trust Board	Public Report - July 14
Balance Sheet controls	Monthly reporting to Trust Board (I) Major aspects subject to internal/external audit as routine (E)	None	N/A	N/A
Financial Reporting – internal and external	Comprehensive reporting to all levels in the Trust (I) Internal Audit – review of controls and documents (E)	None	N/A	N/A
Profitability - SLR	Monthly reporting to Trust Board (I) Internal Audit – review of controls and documents (E)	Concerns relating to apportionment methodology and understanding of outputs	Broad review of SLR to address issues arising from 'reference cost' audit and need to seek wider internal engagement	By end of Q3
Competent staffing	Appraisals, performance reviews and training plans (I) Feedback from routine audits (E)	Ability of staff to meet increasing demands and requirement to adopt more of a business partnering role.	Review of staffing numbers and competencies	On going

Principal Risk 4B – Scope and provision of clinical services **Executive lead** –Finance Director (SB) **Scrutinising committee** – Audit Committee **Date last reviewed by Committee: TBC** **Review by responsible committee – Audit Committee – TBC** **Link to Corporate Risk Register:** Risk IDs **Links to Corporate and Priority Objectives: KSO 4** **Last Reviewed: Finance Director (SB), 21st November 2014**		 **Initial Risk Rating C X L:4 x 3 = 12** **Current Risk Rating C X L: 4 x 3 = 12 (Amber)** **Target Risk Rating C X L: 4 x 2 = 8**		
		Q1	Q2	Q3	Q4
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(e)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**	
Inability to provide information externally e.g. failure to submit to SUS / CCGs / national returns on UNIFY etc.	Agreed timetables and information processes documented (I) Senior management review and sign off of all submissions(I) Internal Audit – review of controls and documents (E)	Lack of formal sign off IT failure Absence of key personnel	Tbc		
Commissioner behaviour when under extreme financial	Ability to respond to challenges in accordance with contractual deadlines (I) Internal Audit –	Inability to manage increased data challenges	tbc		

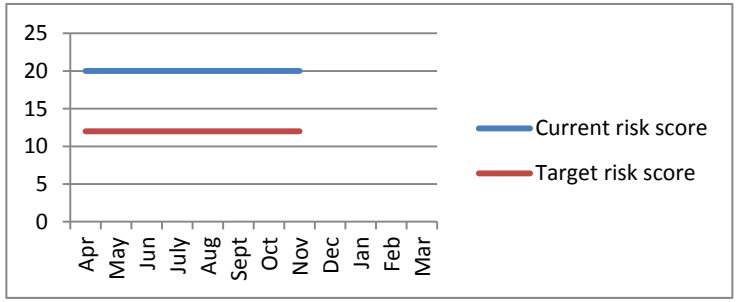
pressure / financial position of the CCGs	review of controls and documents (E)	Increasing use of policies of procedures deemed low clinical priority Failure of commissioners to recognise that under commissioned in the first place and then challenge "over performance"		
Increased use of standardised service specifications (i.e. not allowing for local variation) with significant focus on co-location of DGH-type services	Broad understanding of service requirements and ability to identify any gaps that may arise (I) Internal Audit – review of controls and documents(E)	Inability to provide services that meet proposed service specifications e.g. burns	Gap analyses to be completed for services with schedule of actions required to mitigate risks	
Commissioner led service redesign and tendering of existing QVH services.	Engagement with commissioners in developing services. Visibility of all proposed tenders and resources to be able to respond where required (I) Internal Audit – review of controls and documents(E)	Potential that QVH is either directly or indirectly impacted by service redesign. Commissioner expand their use of 'prime provider' strategies e.g. MSK and leave QVH at risk of services being transferred.		
Invoicing arrangements of NHSE	Ability to be able to charge for all NHSE activity in accordance with changing demands (I) Internal Audit – review of controls and documents (E)	Review of invoicing arrangements		
Non elective / ERT	Contract T&Cs Confirmation of performance to both commissioners and Board via routine monthly reporting (I) Internal Audit – review of controls and documents (E)	Engagement of commissioners and consistent reporting of financial impact.		
SLAs with other Providers (P2P)	Documented and signed agreements, shared with divisional leads (I) Internal Audit – review of controls and documents (E)	SLA with BSUH for provision of paediatric cover and pathology services		
Contract monitoring meetings	Regular attendance Routine reporting (I) Internal Audit – review of controls and documents (E)	None	N/A	N/A

Principal Risk 4C – Financial control **Executive lead** –Finance Director (SB) **Scrutinising committee** – Audit Committee **Date last reviewed by Committee: TBC** **Review by responsible committee – Audit Committee – TBC** **Link to Corporate Risk Register:** Risk IDs **Links to Corporate and Priority Objectives: KSO 4** **Last Reviewed: Finance Director (SB), 21st November 2014**		 **Initial Risk Rating C X L: 4 x 3 = 12** **Current Risk Rating C X L: 4 x 3 = 12 (Amber)** **Target Risk Rating C X L: 4 x 2 = 8**		
		Q1	Q2	Q3	Q4
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(e)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**	
Financial plans, budgets and activity targets communicated and understood	Signed accountability agreements (I)	Agreements not yet in place	Work underway	End of August 14	
Robust budgetary reporting	Evidence of budget reports being sent and routinely used to review performance (I) Monthly reporting, internal and external auditor reviews and reports (E)				
CIP plans – delivery of 14-15 savings	Embedded within regular financial reporting framework (I)	Visibility of CIP delivery within existing financial reporting	Financial reporting is subject to review and will be updated for Q1 to provide		

			greater clarity and transparency. Development of SMT Week 4 Revisit SLR in Autumn	
Monthly reviews of financial performance including CIP at weekly				
Monthly finance reports for each department showing income, pay and non-pay costs				
Monthly Senior Management Team meeting focusing on financial and operational performance				
Monthly Board report on financial position with supporting narrative				
Monthly production of SLR reports providing				

Principal Risk 4D – Infrastructure and investment **Executive lead** –Finance Director (SB) **Scrutinising committee** – Audit Committee **Date last reviewed by Committee: TBC** **Review by responsible committee – Audit Committee – TBC** **Link to Corporate Risk Register:** Risk IDs **Links to Corporate and Priority Objectives: KSO 4** **Last Reviewed: Finance Director (SB), 21st November 2014**	 **Initial Risk Rating C X L: 4 x 3 = 12** **Current Risk Rating C X L: 4 x 3 = 12 (Amber)** **Target Risk Rating C X L: 4 x 2 = 8**

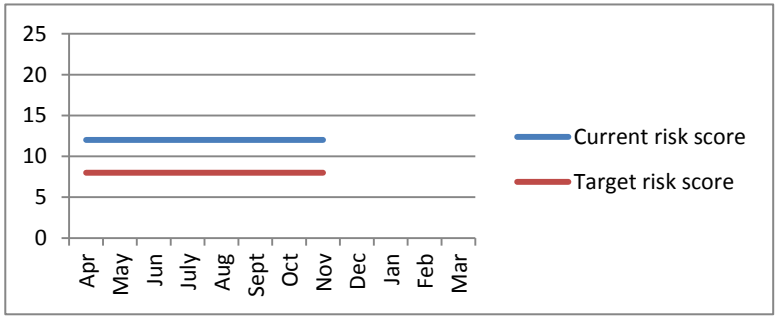
		Q1	Q2	Q3	Q4
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(e)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance		**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
Site strategy	Reviewed and approved by Trust Board (I)				
Capital Plans and Programmes	Consistent with broader strategies and quarterly updates to Board Routine review and monitoring via executive led groups (I)				
Project management	Sufficient and appropriately skilled resources in place to deliver schemes in accordance with SFIs etc. (I)				
Backlog maintenance programme	Detailed plans shared and approved by executive led groups (I)				
PLACE Reports	Evidence of progress with identified gaps or deficiencies through detailed work programmes (I)				
System downtime	Routine reporting to IM&G (I)				
Routine maintenance of clinical equipment	Regular updates to medical devices				
Medical device alerts	Register of compliance with all medical device alerts (I)				
Operational continuity	Routine review of estate and IT plans that support wider business continuity plans. (I)				
Helpdesk responsiveness and themes	Helpdesk reports to IM&G showing volume of calls, key themes and response times (I)				

Principal Risk 4E – Performance standards **Executive lead** –Finance Director (SB) **Scrutinising committee** – Audit Committee **Date last reviewed by Committee: TBC** **Review by responsible committee – Audit Committee – TBC** **Link to Corporate Risk Register:** Risk IDs **Links to Corporate and Priority Objectives: KSO 4** **Last Reviewed: Finance Director (SB), 21st November 2014**		 **Initial Risk Rating C X L: 4 x 5 = 20** **Current Risk Rating C X L: 4 x 5 = 20 (Red)** **Target Risk Rating C X L: 4 x 3 = 12**		
		Q1 Q2	Q3	Q4
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(e)** sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
External Reporting and Sign Off	Senior management and review of all external submissions (I)	Formal process for identifying and authorising all external submissions		
Information infrastructure and/or inability to produce information internally (for same reasons as above)	Provision of information to the wider organisation, including timetables for publication (I)	Lack of robust management information Internal Reporting – databases, consistency, triangulation with plans Access not as stable as other platforms Large data sets having to be broken up due to capacity of data constraints		
Data quality - validation				
Offsite data		Reliant on data for income and performance that is totally at the hands of another provider		
Performance against national standards		financial risk (penalties) reputational risk		

RTT		Robustness of action plans and delivery within agreed timeframes		
Cancer				
Skills gap in operational managers in planning				
Robust P2P management				
Contractual Penalties	Monthly reporting of compliance and financial impact to Trust Board (I)	Risk of genuine application of rules such as new to follow ups etc because organisation just can't respond - either data quality an issue or pathway an issue but lack of capacity and skills for someone to pick this up as a project		

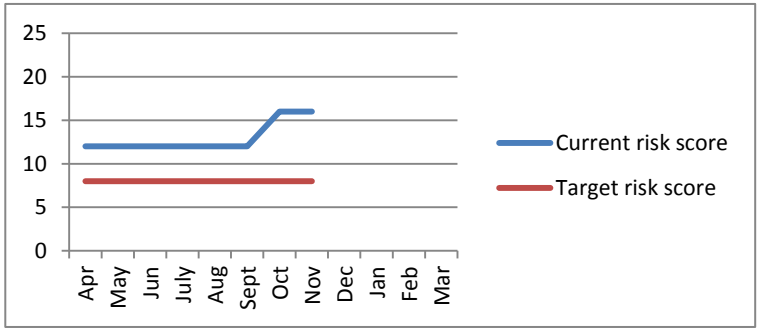
BOARD ASSURANCE FRAMEWORK

KS05 – Organisational Excellence (GA)
STAFFING

<table>
<tr><td colspan="2">Principal Risk – 5A Risk of poor quality care resulting from low mandatory training and appraisal rates.
Executive lead – Head of Human Resources
Scrutinising committee – Human Resources Committee (to be introduced in 2015 following Governance restructure)
Date last reviewed by Committee: TBC
Review by responsible committee – TBC
Link to Corporate Risk Register: ID749, 689, 584, 721
Links to Corporate and Priority Objectives: KSO5
Last Reviewed: 25/11/2014</td><td colspan="3"> 

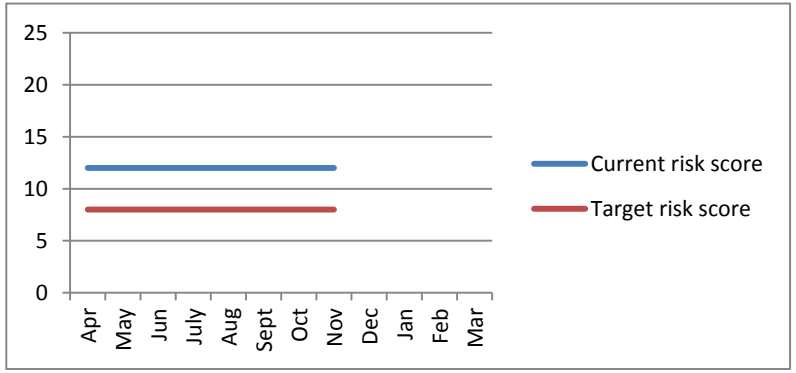
Initial Risk Rating C X L: 3 x 4 = 12
Current Risk Rating C X L: 3 x 4 = 12 (Amber)
Target Risk Rating C X L: 3 x 2 = 8
Q1 | Q2 | Q3 | Q4</td></tr>
<tr><td>Key controls to manage risks
Identify the key controls in place to manage the risks</td><td>Assurance on controls
Identify internal (I) or external (E) sources of assurance and indicate if they need to be re-confirmed</td><td>Gaps
Identify any gaps in controls or assurance or negative assurance</td><td>Action Plans
Identify Action plans to address gaps and negative assurances with responsible Director identified</td><td>Date for completion of action</td></tr>
<tr><td>1. Statutory and Mandatory training reviewed monthly.</td><td>• Trust Board reports and dashboards on Statutory and Mandatory training reviewed monthly and reported to Trust Board (I)
• Patient experience surveys (E)</td><td>Low performance in Equality & Diversity compliance has been identified</td><td>Statutory and mandatory training Target is 80%. Best performance = 79.8%. Currently undertaking Phase 3 of system improvements</td><td>31/01/2015</td></tr>
</table>

2. Departmental feedback from above.	Department reporting and follow up (I)	None	N/A	N/A
3. Utilisation of bank and agency staff to release others to attend training	Bank and agency logs (I)	None	Ongoing monthly report to Trust Board on Bank and Agency staff use	Ongoing
4. Ward staffing levels monitored locally and reported to Board monthly	• Staffing dashboards displayed in ward areas (I) • Patient experience surveys (E) • Incident reporting to committees and Trust Board (I)	None	N/A	N/A

Principal Risk – 5B Recruitment and retention of appropriate nursing, medical and non-clinical staff (includes skill mix and safe staffing requirements) **Executive lead** – Head of Human Resources **Scrutinising committee** – Human Resources Committee (to be introduced in 2015 following Governance restructure) **Date last reviewed by Committee: TBC** **Review by responsible committee – TBC** **Link to Corporate Risk Register:** ID749 **Links to Corporate and Priority Objectives: KSO5** **Last Reviewed:** 25/11/2014		 **Initial Risk Rating C X L: 3 x 4 = 12** **Current Risk Rating C X L: 4 x 4 = 16 (Red)** **Target Risk Rating C X L: 3 x 2 = 8**		
		Q1	**Q2**	**Q3**	**Q4**
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**	

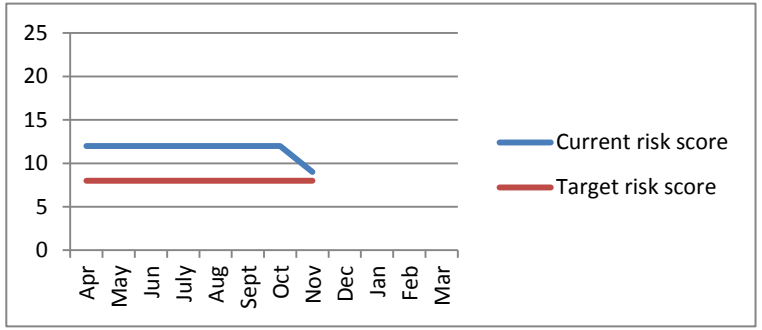
Continual review of recruitment processes	Monthly Workforce Board report highlighting vacancies, turnover, sickness and stability	None	• Established Recruitment and retention Task and Finish Group. • Recruitment and retention initiative identified as part of an action plan currently being implemented	From Feb 2015
HR Team review difficult to fill vacancies with operational managers	Actions to address highlighted areas are included in the report	None	Feed into Task & Finish Group Review of action plan	31/03/2015
Medical Staffing team enhanced to improve recruitment to medical vacancies	ECF process requires review of vacancies before being advertised	None	N/A	N/A
Integrated medical staffing and recruitment teams	Committee reporting (I)	None	N/A	N/A
Revised tracking system in use for medical vacancies	Committee reporting (I)	None	N/A	N/A
Medical Education and Medical Staffing Managers are working closely together to improve medical recruitment	Committee reporting (I)	None	N/A	N/A
Junior Doctors Forum commenced October 2014. Discussions have included how to improve recruitment to medical vacancies	Notes from Junior Drs Forum with actions (I)	None	Meetings to continue (next one scheduled for Jan 2015)	Ongoing

HR attending weekly operational review meeting	1. HR supporting managers to fill vacancies and also identify short term solutions e.g. bank/agency 2. External Audit of recruitment process (E)	None	N/A	N/A

Principal Risk – 5C Risk of staff not complying and promoting the Trust core values **Executive lead** – Head of Human Resources **Scrutinising committee** – Human Resources Committee (to be introduced in 2015 following Governance restructure) **Date last reviewed by Committee: TBC** **Review by responsible committee – TBC** **Link to Corporate Risk Register:** 1B **Links to Corporate and Priority Objectives: KSO5** **Last Reviewed:** 25/11/2014	 **Initial Risk Rating C X L: 3 x 4 = 12** **Current Risk Rating C X L: 3 x 4 = 12 (Amber)** **Target Risk rating C X L: 3 x 2 = 8**			
		Q1	**Q2**	**Q3**	**Q4**
Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified		**Date for completion of action**
1. Values Based interviews introduced	Weekly review of HR case work (I) Reduction in casework identified e.g. staff disciplinaries	None	Review of current system to be commenced		31/01/2015

2. Patient experience survey feedback – staff attitude	• 2013/14 Annual Training Needs Analysis (I) • Friends and Family Test scores (E)	None	2014/15 Annual Training Needs Analysis	N/A
3. Values included within revised Appraisal process review and feedback	Patient experience to be included as part of quarterly reviews (I)	None	N/A	N/A
4. Training for managers on addressing performance	Committee and Trust Board reporting (I)	None	N/A	N/A
5. Staff Friends and Family questionnaires	Feedback reports (E)	None	N/A	N/A
6. Monthly HR best practice sessions	Committee and Trust Board reporting (I)	None	N/A	N/A
7. MaPSaF outcomes	CQUIN reporting (E) Quality metrics dashboard and Trust Board reporting (I)	None	• Ongoing MaPSaF session to end of Q3 • Completion of annual audit report	31/03/2015

Principal Risk – 5D Inability to support staff educational requirements due to financial and other pressures
Executive lead – Head of Human Resources
Scrutinising committee – Human Resources Committee (to be introduced in 2015 following Governance restructure)
Date last reviewed by Committee: TBC
Review by responsible committee – Learning and Development Strategy Group
Link to Corporate Risk Register: ID477
Links to Corporate and Priority Objectives: KSO5
Last Reviewed: 25/11/2014



Initial Risk Rating C X L: 3 x 4 = 12
Current Risk Rating C X L: 3 x 3 = 9 (Amber)
Target Risk Rating C X L: 3 x 2 = 8

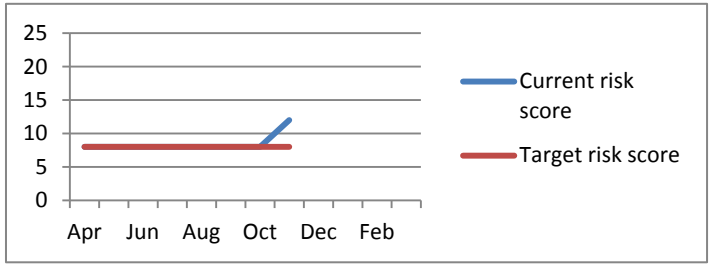
Q1	Q2	Q3	Q4

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal or external sources of assurance and indicate if they need to be re-confirmed	**Gaps** Identify any gaps in controls or assurance or negative assurance	**Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Date for completion of action**
1. Bi monthly funding panels ensure robust management	Minutes from panel meetings (I)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015
2. Study leave policy amended to include expectations from staff.	Study leave policy and approval notes (I)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015
3. At present essential education funded from SHA; all other applications considered by League of Friends (Rosemary Wooten Bursary).	Application process and notes of approval (I)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015

4. Funding allocation from Trust budget	Application process and notes of approval (I)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015
5. Funding confirmed for 13/14 from HEKSS - increase from 2012/13	Funding documentation from HEKSS (I) HEEKSS quality assurance framework(E)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015
6. 2014/15 remains at target as Brighton University costs are reduced due to a structure change	Brighton University notification (I)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015
7. A review of the 13/14 training provision showed low refusal rates for part-time courses.	Brighton University notification HEEKSS quality assurance framework(E)	N/A	• 2014 Training Needs analysis to inform progress and allocation of resources more effectively • MaPSaF feedback has indicated training needs and staff release to attend development and training	28/02/2014 31/03/2015

Principal Risk – Risk to the Trust of not meeting its Key Strategic Objectives (KSOs)

Executive Lead – Chief Executive (RT)
Reviewed by scrutinising committee – Trust Board – Date:
Date last reviewed by Committee:
Review by responsible committee –
Link to Corporate Risk Register: All BAF risks
Links to Corporate and Priority Objectives: KSO 1 -5
Last Reviewed: 25/11/2014



Initial Risk Rating C X L: 4 x 2 = 8
Current Risk Rating C X L: 4 x 3 = 12
Residual Risk rating C X L: 4 x 2 = 8

Key controls to manage risks Identify the key controls in place to manage the risks	**Assurance on controls** Identify internal **(I)** or external **(E)** sources of assurance and indicate if they need to be re-confirmed	**Q1** **Gaps** Identify any gaps in controls or assurance or negative assurance	**Q2** / **Q3** **Action Plans** Identify Action plans to address gaps and negative assurances with responsible Director identified	**Q4** **Date for completion of action**
Trust Board reporting	• Weekly flash report on Trust key performance indicators (I) • Board Assurance Framework (I) • Risk Registers (I)		Clinical Strategy in place	31/03/2015
KSOS aligned to QVH 20/20	• Trust Board and Committee reporting (I)		QVH 20/20 operational excellence work programme in place	31/03/2015
Governance structure and escalation framework in place within the Trust	• Trust Board (I) • External reporting e.g. Monitor, external audit (E) • Monitor Quality Governance review (I & E)		Governance review underway	31/03/2015
Reporting of a range of trigger data	Trust Board and committee reporting			31/03/2015

including incidents, complaints, claims, workforce, etc in place				
Executive Director/Senior Management personnel has responsibility for delivery for each one	• Board Assurance Framework (I) • ED appraisals			31/03/2015
Daily 18 week monitoring meeting			Clinical Strategy in place	31/03/2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 18 December 2014
Reference number: 338-14
Report from: Interim Company Secretary & Head of Corporate Affairs
Author: Lois Howell
Report date: 5 December 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 several actions are now overdue. The actions and the reasons for the delays are set out below. Board members will no doubt note that these items were those flagged up as overdue in the last update report, presented to the Board in September. Where there has been progress in these matters it is described below and in the action plan itself

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; implementation is expected by the end of February. 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	Dependent on implementation of system, as above
8.4e	Review policy on use of accrued annual leave during notice period	10.06.14	Verbal update to be provided at the meeting
10.2b	360 degree appraisal to be introduced	31.10.14	Verbal update to be provided at the meeting
10.6a	Annual Board seminar to look at Talent Management to be conducted	30.11.14	Dependant on outcome of restructure – see below
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. dependant on implementation of the re-structure. Restructure progressing – engagement activity underway.

			Decision planned for February March after results of consultation (to be held during January) known.
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

				09.12.14: *Implemtation of the module expected by the end of February 2015*	
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	DN	31.03.14	**03.03.14:** This process happens routinely at Site Practitioner Meetings **20.03.14:** Review completed – DN satisfied	COMPLETE

	effectiveness			that challenge is robust and effective	
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	On track for new date

				being implemented by interim DoF. SMT workshop to be held 10.07.14 will develop further. **28.08.14** Metric development dependent on new structure and linked to work on accountability agreements currently under development by DoF ***09.12.14:*** *update on new structure to be presented to the Board at December meeting (18.12.14)*	
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

Trust action plan in response to Canadian Wing Investigation March 2014

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**
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**

Trust action plan in response to Canadian Wing Investigation March 2014

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~~ 31.03.15	**17.04.14:** On board work plan **12.05.14:** Deputy Head of HR designated as Talent Management Lead **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 ***09.12.14:*** *Update on progress of restructure to be presented to the board at meeting 18.12.14*	On track
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.	**COMPLETE**

				31.05.14: New nursing structure to commence 02.06.14	
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 ***09.12.14:*** *Restructure progressing – engagement activity underway. Decision planned for February March after results of consultation (to be held during January) known.*	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	**COMPLETE**

				Board planned for May. **31.05.14:** Safe Staffing updates included on all board agendas from May onwards	
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 ***09.12.14:*** *Implementation expected by end of February 2015.*	Overdue
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. ***09.12.14:*** *Implementation expected by end of February*	Overdue

Trust action plan in response to Canadian Wing Investigation March 2014

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**
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,	**COMPLETE**

				iHCA on 28.04.14 **31.05.14:** Work programme completed; meetings to start from July	
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. ***09.12.14:*** *Review completed. New format working effectively, but may be subject to further review following outcome of current Governance Review*	**COMPLETE**
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	**COMPLETE**

				31.05.14: Work programme completed; meetings to start from July	
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**
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**

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:	18 December 2014
Reference number:	339-14
Report from:	Interim Company Secretary & Head of Corporate Affairs
Author:	Interim Company Secretary & Head of Corporate Affairs
Report date:	5 December 2014
Appendices:	N/A

Fit and Proper Persons test

Key issues

1. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Regulations) came into force on 27 November 2014. These regulations represent the formalisation of a key recommendation of the 2013 Francis Report into events at Mid-Staffordshire NHS Foundation Trust between 2005 and 2009.

2. This report sets out the key provisions of the new tests and provides assurances that enquiries have been made to ensure that all members of the trust's board of directors meet the new requirements.

Application of the test

3. Regulation 5 (2) provides that health service bodies registered by the Care Quality Commission (CQC) to carry out regulated activity may not

   > "…appoint or have in place an individual as a director….or performing the functions of, or functions equivalent or similar to the functions or, such a director"

   who does not satisfy the tests set out in paragraph 3 of Regulation 5.

4. Both Executive and Non-Executive Directors are covered by the Regulations, and as indicated above, they also apply to "an individual …performing the functions of, or functions equivalent or similar to the functions or, such a director." It is submitted that this means that the Trust should consider that the Regulations apply to persons who report directly to the Chief Executive and advise the Board on specific areas of operation, and to those who "act up" into such roles or Executive Director roles.

The paragraph 3 tests

<u>The good character test – Regulation 5 (3)</u>

5. All directors of a Foundation Trust must

   - be of "of good character"
   - have the qualifications, skills and experience necessary to hold the position on the board
   - be capable by reason of health, after reasonable adjustments are made, to carry out the tasks required of a person holding that board role
   - not have been responsible for, or privy to, or contributed to, or facilitated, any serious misconduct or mismanagement (whether unlawful or not) in the course of

carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider, and,

- not be "unfit" to hold the office by virtue of the grounds set out in Part 2 of Schedule 4 to the Regulations

6. The Regulations advise that in assessing "good character" a Trust must include consideration of whether or not a person has been convicted of a criminal offence and whether or not s/he has been erased, removed or struck off a register maintained by a regulator of health or social care professionals.

7. The CQC has issued guidance on the interpretation of "serious misconduct or mismanagement", but it is for each Trust to take a view on the facts of any given case. The guidance indicates that the CQC would generally view the following as examples of serious misconduct:
    - Assault
    - Fraud
    - Theft
    - Breaches of health & safety regulations
    - Intoxication while on duty
    - Any breach of confidentiality
    - Disobedience of lawful and reasonable instruction
    - Disrespect in the workplace

8. The guidance offers the following advice in connection with assessing whether or not an individual has been responsible for serious mismanagement:

    "Mismanagement would indicate, for example, that a director has dealt with responsibilities badly or carelessly, by mismanaging funds and/or not adhering to recognised practice, or following guidance, internal or external processes within which he or she is meant to work.

    …a director must not have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement in carrying on a regulated activity. Individuals should not have been associated with significant care failures."

<u>The "unfit" person test – Schedule 4</u>

9. A person is unfit for the purposes of Regulation 5 (3) if

    i. "The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

    ii. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

    iii. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

    iv. The person has made a composition or arrangement with, or granted a trust deed for, creditors and has not been discharged in respect of it.

    v. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in

any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

vi. The person is prohibited from holding the relevant office of position, or in the case of an individual from carrying on the regulated activity, by or under any enactment."

Implications for the Trust

10. The trust's directors have all been asked formally to confirm that none of the circumstances set out in Schedule 1 of the Regulations applies to them; all have confirmed that none of the "unfit" criteria applies to them.

11. The Trust's existing recruitment and appointment processes assess compliance with these criteria, by, amongst other things, conducting identity checks and seeking references, but it is recommended that applicants are required in future to make formal declarations as to the "Good character" and "Unfit person" tests as part of their application. The board will need to ensure that all future recruitment and appointment of board members incorporates the test, and the Recruitment Policy should be amended to include this.

12. Future contracts for the employment and appointment of directors will need to identify on-going compliance with the prevailing "Fit and Proper Person Test" as a requirement of continued employment / appointment, and require relevant employees and appointees to notify the trust in the event that circumstances change so as to render him or her unfit to hold his or her post / appointment. Contracts with existing directors will need to be amended to include these provisions.

13. The Trust will need to deal formally with any allegations made concerning a director's "fitness" to hold such post. There are existing policies for investigating and managing concerns about any individual's capability to do the job for which the trust employs him or her, and these can be used to ensure that any investigation into fitness is fair and effective.

Link to Key Strategic Objectives (KSOs)

14. Ensuring that all board directors are fit and proper persons to hold such roles in the organisation will support the delivery of all KSOs, and in particular KSO 5 – organisational excellence.

Implications for the Board Assurance Framework or Corporate Risk Register

15. Nothing in the recent review of the fitness of the trust's directors to hold such posts has disclosed any matter or concern which needs to be added to the corporate risk register or board assurance framework.

Regulatory impacts

16. Compliance with the new regulations is a requirement of the trust's Care Quality Commission licence as well as the legislation. Breach of the licence by virtue of breach of the regulations would attract enforcement action, but there is no reason to believe that this is likely. Ensuring that all board directors are fit persons to fulfil such role supports meeting the Care Quality Commission's requirement that the trust is:

- Safe
- Effective
- Caring
- Responsive, and, in particular,
- Well led.

17. Monitor requires all Foundation Trusts to demonstrate that they are well-led. Failure to comply with the regulations is likely to lead to a finding of breach of the trust's authorisation as a foundation trust and attract associated regulatory activity.

Recommendation

18. The Board is recommended to note the contents of the report and
    a. To require the amendment of the Recruitment Policy in line with paragraph 11 above
    b. To require the amendment of existing director contracts in line with paragraph 12 above
19. If approved, the Head of Human Resources will oversee the delivery of these actions.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	18 December 2014
Reference number:	340-14
Report from:	Interim Company Secretary & Head of Corporate Affairs
Author:	Interim Company Secretary & Head of Corporate Affairs
Report date:	4 December 2014
Appendices:	N/A

Duty of Candour

Key issues

1. The Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 came into force on 27 November 2014. These regulations represent the formalisation of a key recommendation of the 2013 Francis Report into events at Mid-Staffordshire NHS Foundation Trust between 2005 and 2009.

2. This report sets out the various legal obligations on the trust in connection with openness and transparency following untoward incidents and confirms to the board that arrangements are in place to ensure that the Trust complies with them all.

Existing contractual duty of candour

3. Since April 2013 all providers who deliver services under the NHS Standard Contract are already subject to a duty of candour provision in that contract (service condition 35).

4. In the event of a "Reportable Patient Safety Incident" (ie, an incident leading to moderate or more harm or death) the provider must (in summary):
    - Notify the service user (or next of kin), in person, preferably via the clinician responsible for the care
    - Provide all facts known about the incident at the time of the notification
    - Apologise
    - Provide a written copy of the notification
    - Make a written record of the discussion with the patient

    within 10 operational days of the incident.

5. The provider must also launch an investigation and notify relevant commissioners and regulators and engage with any other relevant reporting provisions (eg, Care Quality Commission, Health & Safety Executive).

6. During the investigation, the provider must offer the relevant service user (or next of kin) with a step-by-step explanation of what happened and why. This should be updated regularly during the investigation as it progresses.

7. At the conclusion of the investigation the service user (or next of kin) must be offered a copy of the report and a face to face meeting to discuss it.

8. Failure to comply with service condition 35 leads to the recovery from the provider of the costs of the care, or £10,000 if the value is unknown.

Regulatory duty of candour

9. Bodies registered with the CQC have a requirement imposed upon them in their registration to notify the CQC in the event of specific incidents, including over exposure to radiation, applications for authority to deprive someone of his/her liberty.

10. Failure to comply with the regulatory requirement is a breach of the licence conditions and likely to attract enforcement action. It is also a criminal offence, triable in the Magistrates' or Crown Court.

Existing statutory obligations

11. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, made under the Health & Safety at Work Act 1974, requires the reporting to the Health & Safety Executive of all accidents occurring at work (including in a hospital) involving fatality or any of the injuries listed in the regulations (including, for example, fractures, loss of sight in one or both eyes, loss of consciousness, serious burns, amputation).

12. Reporting is not required if the death occurs in the course of treatment, unless as a result of the accident. For example if a patient failed to regain consciousness after surgery and dies there is no need to report. If s/he dies as a result if a head injury sustained during manoeuvre from the trolley to the operating table, reporting is required.

13. Failure to report as required is a criminal offence.

Statutory duty of candour

14. The Health and Social Care Act 2008 (Duty of Candour) Regulations 2014 came into force on 1 October 2014 requiring any body or individual registered by the CQC as a provider of regulated services to:
    - Act in an open and honest way with relevant persons in relation to service users' care and treatment
    - As soon as possible after a "notifiable patient safety incident" (ie, a safety incident that appears to have resulted in the death of a service user, or moderate to severe harm or prolonged psychological harm to a service user) to:
        - Notify the service user / next of kin
        - Provide him / her / them with all information relating directly to the incident
        - Provide reasonable support to the service user / next of kin.

15. The definition of moderate harm also covers harm that requires a moderate increase in treatment, which includes an unplanned return to surgery, a prolonged episode of care, cancelling of treatment or unplanned readmission, although these results must have arisen from error rather than a consequence of appropriate but unsuccessful surgery.

16. The notification must
    - be conducted in person by a Trust employee

- be recorded in writing
- provide a truthful account of what happened, so far as it is known at that stage
- include advice and if possible agree what will happen next to investigate
- include an apology
- be followed up in writing, including the outcome of any investigation completed / underway at that time.

17. Failure to comply with the regulations is an offence in itself – prosecution would be in the Magistrates' Court and conviction would lead to a fine.

18. Failure to comply would also represent a breach of the CQC's licence conditions and attract CQC enforcement action.

Implications of results reported

19. The Trust already has in place mechanisms for reporting notifiable incidents to the relevant commissioners, the Care Quality Commission and the Health & Safety Executive through the Director of Nursing and her teams. It is not proposed that this process needs to change at all as a result of the implementation of the new regulations.

20. With regard to engagement with patients and their families / carers following untoward incidents, the Trust has in place its Being Open policy. This policy was a requirement of the NHS Litigation Authority as part of its risk management processes.

21. The Being Open policy is due for routine review in November 2014 and will be considered in the light of the new regulations. As drafted, however, the policy includes already all the requirements of the new regulations and will need little or no change. Given that the Being Open policy has been in place since 2011 and has operated effectively and without undue detrimental impact on practice or resources since that time, it seems unlikely that the new regulations will give rise to additional demands on staff time.

22. Staff knowledge of, and willingness to use, incident reporting systems is addressed and monitored through the existing Compliance in Practice scheme. Lack of knowledge or unwillingness to report is addressed along with any other issue of concern raised during such visits.

Action required

23. Non-observance of the policy is not known to be a problem in this trust, but clearly non-compliance with the regulations would be a serious matter with potential legal and regulatory consequences for the trust. When the Being Open policy is revised and approved it will be promoted to all relevant staff and the association with the new regulations made clear. As now, the Director of Nursing will be responsible, with her teams, for ensuring that patient safety incidents are appropriately recorded, reported and addressed, in line with the Being Open policy and thus the regulations.

Link to Key Strategic Objectives (KSOs)

24. Delivery of services in line with the Being Open policy and the new regulations supports the achievement of KSO 1 – outstanding patient experience.

Implications for BAF or Corporate Risk Register

25. Given that the trust's existing policy and practice aligns so closely with the provisions of the regulations, it is not believed that there are any significant risks arising from their implementation.

Regulatory impacts

26. Compliance with the new regulations is a requirement of the trust's Care Quality Commission licence as well as the legislation. Breach of the licence by virtue of breach of the regulations would attract enforcement action, but there is no reason to believe that this is likely. Delivery of care in line with the policy and regulations supports meeting the Care Quality Commission's requirement that the trust is:
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Trust Board of Directors
Meeting date:	18th December 2014
Reference number:	341-14
Report from:	Clinical Cabinet
Author:	Richard Tyler, Chief Executive
Report date:	10th December 2014
Appendices:	NA

Report from meetings of the Clinical Cabinet held on 3rd and 17th November 2014

Key issues and Actions

1. Performance: 18 weeks: Updated on progress of recovery plan and November waiting list initiatives.
2. Service Transformation & Productivity: Updated on development of 2015/16 cost improvement programme..
3. Review of Trauma Service: Received update from Trauma Review Group. Detailed options appraisal scheduled for December Cabinet.
4. Quality & Risk: Endorsed September Quality & Risk report.
5. Head & Neck Services: Presentation from Brian Bisase on vision for development of head & neck services. Agreed version of the presentation should be made to the Trust Board.
6. Key Strategic Objectives: Cabinet were updated on progress against KSOs 1 & 2

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

7. None

Regulatory impacts

8. 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.

Recommendation

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