Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 29th January 2015

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: 29th January 2015

Members (voting):

Chairman:	-	Peter Griffiths
Chair Designate & Non-Executive Director	-	Beryl Hobson
Non-Executive Directors:	-	Ginny Colwell
	-	Lester Porter
	-	John Thornton
Chief Executive:	-	Richard Tyler
Medical Director:	-	Stephen Fenlon
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
Company Secretary & Head of Corporate Affairs	-	Kathleen Dalby
Interim Company Secretary & Head of Corporate Affairs	-	Lois Howell
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode
Interim Director of Nursing & Quality	-	Joanne Thomas

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NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 29th January 2015 at 13:00
The Council Chamber, East Court, College Lane, East Grinstead RH19 3LT

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026-15	Further to paragraph 39.1 and annex 6 of the Trust's Constitution, it is proposed that members of the public and representatives of the press shall be excluded from the remainder of the meeting for the purposes of allowing the board to discuss issues of a commercially sensitive nature. *Peter Griffiths, Chair*	-
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DATES OF THE NEXT MEETINGS		
Board of Directors: **Public**: 26th February at 13:00	**Sub-Committees** **Q & R:** 05 March 2015 at 09:00 **Audit**: 18 March 2015 at 14:00 **CFAC:** 26 March 2015 at 09:00 **N & R:** 30 April 2015 at 09:00	**Council of Governors** **Public**: 09 April 2015 at 15.00

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 18th December 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
	Ginny Colwell (GC)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
	Dominic Tkaczyk (DT)	Interim Director of Finance
	Amanda Parker (AP)	Director of Nursing & Quality [Items 330, 334, 336, 337 & 343]
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
	John Thornton (JT)	Non-Executive Director
	Steve Fenlon (SF)	Medical Director

WELCOME

325-14 **Welcome, apologies and declarations of interest**

The Chair welcomed everyone to the meeting including one member of the public.

Apologies were noted as above. The Chair advised that Amanda Parker was unwell but had indicated she wished to attend the latter part of today's meeting in order to present her reports in person. For the purposes of accuracy therefore, it should be noted that items 330, 334, 336, 337 and 343 were not taken in agenda order. It was also noted that item 326-14 (patient experience) would not be presented this month.

There were no new declarations of interest.

STANDING ITEMS

327-14 **Draft minutes of the meeting session held in public on 27 November 2014 for approval**

The minutes of the meeting were **APPROVED** as a correct record.

328-14 **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**.

329-14 **Update from the Chief Executive**

RT presented his monthly report, highlighting the following:

1. The trust had made significant progress in reducing the backlog of patients waiting over 18 weeks between referral and treatment (RTT18 target) and that it was on track to achieve the RTT18 target in December. RT acknowledged the dedication of staff across the Trust and confirmed that he had written on behalf of the Board to thank them for their hard work and support.

2. Monitor: Quarter 2 (Q2) Feedback: The trust has recently received formal notification of its Q2 ratings; a continuity of service rating of 4 and a green governance rating have been

	maintained. However, Monitor has reiterated the need to achieve RTT18 week compliance from Q4 in line with national targets for compliance. 3. Restructure: the trust launched its organisational restructuring proposals on 1st December and, as reported during the earlier board seminar, engagement levels with staff appear high. 4. Dalton Review: RT apprised the board of the contents of the Review which had been published in early December; two recommendations of particular interest to QVH were that: i. 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; ii. Trust boards of successful and ambitious organisations should develop an enterprise strategy and consider developing a standard operating model that could be transferred to another organisation or wider system. 5. CQC Intelligent Monitoring Reports: The latest was published on 3rd December and ranks 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. RT was pleased to advise the board that QVH remains in band 6, (the lowest priority for inspection). 6. Additional funding: RT drew the board's attention to a letter from the Secretary of State for Health which outlined details of additional funding announced in the Autumn statement. DT agreed to provide supplementary information within his finance update. 7. Serious Incident: The trust had declared a Serious Incident (SI) having been advised that its sterilisation//decontamination provider had supplied unsterile equipment, some of which had been used on patients. The company concerned, (Synergy) has taken immediate action to prevent recurrence, as had the trust. In the meantime, the trust was contacting all patients by phone and by letter to apprise them of the situation. A full investigation was currently underway, including a Root Cause Analysis (RCA) and actions were being taken accordingly. GC stressed the importance of notifying all theatre staff and recommended a subsequent audit to provide assurance of a change in practice. **[Action: AP]** The Chair thanked RT and the board **NOTED** the contents of his update.
RESULTS AND ACTIONS	
330-14	**Patients: safe staffing and quality of care** AP presented the monthly update on Patient care, highlighting the following issues: Public Health England had now closed the recent Legionella investigation; internal tests indicated there was no ambiguity within the trust despite the case being classified as 'source unknown'. GC asked for an update in respect of the Food Charter-mark. As the standard of patient food was a recurrent theme amongst complaints and feedback, AP promised a more detailed update would be provided to the board in Q3; in the meantime, this item would be provided with a separate section under the CQUINS report. **[Action: AP]** BG asked for an update with regard to the Corneo Plastic issue, highlighted within the Patient

	Complaints report; AP advised that the final report was still being completed, but was hopeful that details of the Root Cause Analysis would be presented to the board in January. **[Action: AP]** The Chair thanked AP for her update, the contents of which were **NOTED** by the board.
331-14	**Operational performance: targets, delivery and key performance indicators** JM presented this month's operational performance report, highlighting the following: The Open Pathways 18 week target was reached in November, earlier than anticipated, although the trust was non-compliant at aggregate level in both admitted and non-admitted 18 week targets in the same month. Teams were continuing to work hard to maintain momentum. The trust had achieved all cancer waiting times in October with the exception of the 31-day subsequent treatment (due to a single patient breach who was originally booked for minor surgery but in the event required treatment in a main theatre and was therefore rebooked); however no urgent operations were cancelled for a second time in November. One operation had been 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 rescheduled the surgery earlier (due to logistics of coordinating commitments of the surgeons required to undertake such a complex case). The trust was non-compliant in respect of diagnostic waits in November with 11 patients breaching; this was as a result of the breakdown of the cone scanner. Whilst financial penalties would be attributed on this occasion, this should not recur in the future. BH asked if the weekly 18-week Referral To Treatment (RTT18) reporting (currently circulated to the board) would continue, and was assured by JM that it would. LP noted that some additional work had been undertaken at the nearby Centre for Sight (CfS) and asked how the trust could be assured that the site adhered to NHS standards; RT observed that as the CfS was registered by the Care Quality Commission this should provide sufficient assurance; in the meantime, however, he agreed to report back to the board on what criteria the trust used when planning additional off-site activity. **[Action: RT]** JM drew the board's attention to the letter sent from the Department of Health's Intensive Support Team (IST) to the Chief Executive which had been included in the board reports, and which was a positive reflection on the QVH team. JM noted that models provided by the IST would greatly improve the business planning process in the future, providing more accurate forecasting. RT asked the board to be aware that January would continue to be a challenge as a result of the November backlog; however, February was more promising and medical secretaries were clear of the need to escalate cases of patients likely to breach. BG asked how likely the trust would be to achieve its anticipated internal 15-week target; RT confirmed it remained a trust objective to achieve 90% compliance within 15-weeks but outlined the factors which could make this difficult; JM concurred it would remain an aspirational objective for the time being. The Chair thanked JM for her report, the contents of which were **NOTED** by the board.
332-14	**Financial performance: monthly update** DT presented the Finance report for November which included the following highlights:

	The trust remained ahead of the surplus plan for the year and, even assuming the downside position arose, should achieve plan at the end of the financial year. At best, the trust should break-even in respect of the work undertaken to achieve RTT18 targets, although it was noted that pay costs in November included £227k for these additional sessions. BG queried whether the trust would have been down on activity without this additional work; DT agreed that Service Line Planning revealed activity in certain areas would not have achieved plan, and whilst overall the trust was achieving activity targets, this was predominantly due to follow-up appointments which posed a risk in the longer term. Cash balances remained significantly above plan due to delays to capital expenditure. As previously reported to the board, there were risks in respect of the level of capital spend which Monitor might interpret as difficulties with planning and forecasting. At present there was a £1.5m gap. LP asked what was being done to bridge this and DT outlined the steps being taken to accelerate expenditure and replenish equipment. RT reminded the board that the trust had originally intended to invest in Information Technology (IT) infrastructure but this had been delayed due to changes in the business planning process; in the meantime a number of items had been earmarked to bridge the gap including replacement anaesthetic machines. DT reminded the board that cash balances were sensitive to payment for over performance by commissioners, however appropriate provision had been made for this. DT observed that the trust's Cost Improvement Programme (CiP) of £800k (1.5%) was not particularly difficult but noted this was still not being achieved. Expanding on the Chief Executive's earlier update [item: 000-14], DT warned that despite NHS England's recent announcement of additional funding, not all money was new money and a significant proportion of the £2m would be allocated to CCGs for local services and to commission primary care and specialised services. The board was reminded that there had always been plans to allocate specialist commissioning to CCGs, which would probably increase the number of commissioners with which the trust had to work. Whilst the 50% Emergency Rate Tariff (ERT) might be welcomed in the acute sector, this would not necessarily be the case for specialised services; up until now this had always been paid at standard tariff rate, however, in the future anything over and above plan would be paid at 50% only. DT noted that the baseline was still to be set and agreed to update the board of developments at next month's meeting **[Action: DT]** The Chair asked when the board would be apprised of the business planning process; DT agreed to provide an update on the schedule in January with a view to submission for formal approval in February **[Action: DT]** GC asked if the trust was collating evidence to determine that all follow-up appointments were undertaken for sound clinical reasons. JM confirmed that coding work was already underway within Corneo and agreed this should be done in other areas to provide assurance that this was clinically appropriate for patients. RT reminded the board that Stuart Butt had reported last month that whilst staff were paid in equal 12th (twelfths) throughout the year, the way that weekends and week days fall during any given month means potential income varies, this had not been taken into account when the target for November had been set, (although future planning would be phased in a different way); the board has also been asked to note that it would not be unusual to see a similar downturn in December due to the number of Bank Holidays in the month. RT stressed the importance of identifying the areas which were generating profit, whilst

	ascertaining the reasons for falling behind on elective work; JM provided examples of specific consultant related activity which had resulted in a recent drop in performance. However, she felt confident that improved dialogue within developing business units would improve future business planning and activity. The Chair thanked DT for his comprehensive update, the contents of which were **NOTED** by the board.
333-14	**Workforce** GA reported that recruitment and retention continued to be the main priority, with a number of initiatives now in place to help address this. A recruitment open day was scheduled for 19th January and a further event would be arranged for March. GA asked the board to note that it had not been possible to provide full workforce metrics today due to the board meeting being brought forward this month (to account for the Christmas break). Phase 3 of the Statutory and Mandatory Training improvement programme was being implemented; GA was hopeful next month's report would give a more accurate position for training, with all posts aligned to training profiles associated with the Skills Passport. In order to address problems within eRostering the system was currently under review. Reviews were being undertaken by a project steering and project implementation group. A revised system was on track to go live in March, and in the meantime HR teams were supporting managers in identifying early warning of potential staffing shortages. GA advised that on the whole retention and stability remained good, however, there remained a problem within Canadian Wing (with only a 72% stability rate); one option under review was to implement rotational appointments for Band 5 staff, thereby providing greater experience. The trust was also considering expansion of its current agreement with the military, which had proved effective on Canadian Wing. There was also a problem with recruitment of Band 7 staff within Prosthetics and GA outlined the reasons behind this; he was working with Mark Cutler and Paul Gable to see if any solutions could be identified. Whilst the board reiterated its resolve to avoid overseas recruitment at this stage, it was recognised that recruitment was a national problem which would not be addressed overnight. The Chair thanked GA for his update, and the board **NOTED** its contents.
STRATEGIC PRIORITIES	
334-14	**Quarterly update on delivery of Key Strategic Objective (KSO) 1: Outstanding Patient Experience** AP had circulated the latest update on delivery of the Outstanding Patient Experience Key Strategic Objective, the contents of which were **NOTED** by the board. As RT had confirmed previously, it was acknowledged that the KSOs would be reviewed in an effort to make them more streamlined and accessible to everyone within the trust.
335-14	**Quarterly update on delivery of Key Strategic Objective (KSO) 2: World Class Clinical Services** On behalf of the Medical Director, RT presented an update on World Class Clinical Services. The three key elements this quarter were: I. Clinical Research and Development

	A presentation had been made at the recent Charitable Fund Trustees meeting at which it was agreed to extend the secondment of Dr Jones as Director of Research and Development for a further two years. It was noted that the joint initiative with Brighton and Sussex University Hospitals Trust had helped to revitalise research and development activity. II. Education & Training Dr Ed Pickles was the newly appointed Director of Medical Education following the retirement of Dr Steve Squires. A key focus would be to re-engage with junior medical staff. III. Consultant Level Clinical Outcomes RT reminded the board of the amount of work undertaken to date; however, the trust currently lacked information management software, hardware and skill sets to develop further at this stage. The Clinical Outcomes project was overseen by the board outcomes group comprising RT, LP and SF, and the group intended to review its options in the New Year. GC sought clarification in respect of clinical strategy accountabilities; RT confirmed these remained within the Medical Director's remit, but acknowledged this would be clarified following the refresh of the current Key Strategic Objectives. The Chair thanked RT for his update, and the board **NOTED** its contents.
GOVERNANCE	
336-14	**Corporate Risk Register (CRR)** . The latest Corporate Risk Register had been circulated to the board, highlighting three top risks as: • The ability to meet RTT18 targets • Breaching cancer targets • Failing to deliver safe health care due to difficulties in recruiting Whilst the trust was on track for compliance for the RTT18 target in December, it was agreed these risks would remain on the register until compliance was confirmed. The Chair thanked AP for her update the contents of which were **NOTED** by the board.
337-14	**Board Assurance Framework (BAF)** AP confirmed that the current BAF had been presented to the Audit Committee at its meeting earlier this month. It was acknowledged that overall the framework was developing in the right direction, although there was still confusion amongst some members of the board as to its purpose. DT explained that the BAF was designed to communicate progress towards mitigating risks to strategic objectives, and conceded that there was considerable detail contained within the current version. He suggested it might be helpful if future versions highlighted main changes requiring the board's attention. After brief discussion, it was agreed that a board seminar should be dedicated to explaining how key high level risks are identified and communicated; AP urged the board to ensure the Head of Risk Management was invited to take part in discussions. It was agreed the most appropriate timescale would be April 2015 (once business planning had been confirmed)**. [Action: AP]** AP notified the board that once priorities had been agreed for 2015/16, external audit would be

	commissioned to undertake a review of the framework which would provide additional assurance. The Chair thanked AP for her update, the contents of which were **NOTED** by the board.
338-14	**C-Wing Action Plan update** LH reported that the action plan was predominantly complete; the following exceptions were highlighted: • 8.3c: As reported earlier under [item 333-14], implementation of the Safer Care module was well underway and reporting would be improved as a result. • 8.4e: GA advised it was contractually difficult to prevent staff using accrued annual leave during a notice period; if staff shortages were an issue, one option would be to offer payment in lieu, although this could not be imposed. The board agreed this item should be removed from the action plan. **[Action: LH]** • 10.2b: 360^0 appraisals were now incorporated into the new Leadership and Development Framework programme. It was agreed that following today's update there would be a hiatus in reporting; accordingly the board would receive its next update in June 2015 **[Action: LH]** LP queried whether the action plan was addressing appropriately the intentions of the original report; RT concurred there would always be difficulties but the trust should always strive to hold people to account for their behaviours and values. The Chair thanked LH for her update the contents of which were **NOTED** by the board.
339-14	**Fit and Proper persons test** LH presented a paper setting out the main provisions of the new 'Fit and Proper Persons' test, which had been designed to provide assurance that appropriate enquiries had been made to ensure all board members met key criteria. It was agreed the trust's Recruitment Policy be amended to ensure test criteria be incorporated into future appointment of board members. BH asked this to be prioritised in light of the current non-executive recruitment process. **[Action: GA]** Existing director contracts would also be amended to include the current provisions. **[Action: GA]** The Chair thanked LH for her report, the contents of which were **NOTED** by the board.
340-14	**Duty of Candour** LH presented a report setting out recently introduced legal obligations on the trust relating to openness and transparency following untoward incidents. BH asked if aspects of the new legislation were already incorporated into the 'Being Open' policy; AP agreed to check and report back. **[Action: AP]** JM queried whether junior medical staff fully understood the implications of the legislation; whilst the 'Being Open' policy had been in place for some time, LH reminded the board that the trust

	could now be prosecuted if it failed to comply. BH asked how implementation should be progressed; RT suggested it would be helpful if AP and LH could meet to discuss the most appropriate method of applying the new legislation this and report back to the board **[Action: LH]** The Chair thanked LH for her report, the contents of which were **NOTED** by the board.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
341-14	**Clinical Cabinet** RT provided a summary of the Clinical Cabinet meetings held on 3rd and 17th November, highlighting key issues. The Chair thanked RT and the board **NOTED** the contents of the monthly update.
342-14	**Charitable Fund Corporate Trustee** The Chair provided a brief summary of the recent Charitable Fund Corporate Trustee AGM which had taken place last month. Trustees had received a presentation on the Research and Development role which the fund was currently supporting. A short meeting would be convened later in the day to approve formally the annual report and accounts.
STAKEHOLDER AND STAFF ENGAGEMENT	
343-14	**Feedback from events and other engagement with staff and stakeholders** Board members and attendees were invited to report on events in which they had participated in the last month; these included the following: BH had attended the Trust induction programme and felt assured by the level of high quality staff being recruited into the organisation; she had also attended last week's Appointments' Committee at which the skills set of the new NED appointment had been agreed. In PAG's absence, BH had chaired her first Council of Governors' meeting; feedback in respect of the new format was on the whole positive, (although additional refinement would be required over time). BH had also joined recruitment panels for the Director of Finance and Histopathology appointments. Finally, BH reported she had undertaken one of the trust's Compliance in Practice (CiP) sessions which had provided an opportunity to interview patients in the Outpatients Department. As highlighted in his earlier report, RT had been attending a series of internal engagement meetings relating to the current organisational restructure. In line with findings of recent reviews he felt more needed to be done to address organisational culture and communications but on the whole felt morale was better than it had been this time last year. JM had also been involved in various internal engagement meetings; she had also attended meetings at Pembury Hospital (part of Maidstone & Tunbridge Wells NHS Trust) and would be meeting with representatives of Kings College Hospital shortly to discuss potential service developments. LP had attended a recent meeting held by the Association of NHS Charities and observed that despite recent changes in legislation there was no real benefit for a trust the size of QVH moving to have individual trustees rather than remaining as a corporate trustee. GA had been supporting staff at weekends during last month's drive to clear waiting lists; conversations with staff indicated a wealth of ideas for improvements which the trust should

	draw on, and which long-term would help tackle some of the current cultural issues. BH concurred and expressed thanks to all members of the Senior Team who had supported staff in this way. GA also reported he had seen early results of the recent Staff Survey which appeared encouraging; should timescales allow, he would aim make a formal report at next month's board. [**Action: GA]** AP had spent time in ITU and was assured by how well working arrangements were being implemented. LH had taken part in a recent CiP, and had also joined the stakeholder panel for the recent Director of Finance interviews. The Chair thanked the board for their updates, the contents of which were **NOTED**.
GOVERNOR REPRESENTATIVE & NON-EXECUTIVE DIRECTORS	
344-14	**Observations from the Chairman, Non-Executive Directors and Governor Representatives** There were none.
MEMBERS OF THE PUBLIC	
345-14	**Observations from members of the public** There were none.
346-14	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**
December 2014 meeting						
1	**329-14**	All theatre staff to be notified of details of recent SI, with a subsequent audit to be undertaken to provide assurance of a change in practice.	**AP**	January	**22.01.2015** AP has met with theatre management, theatre education and scrub staff and is assured changes have now been made. A Root Case Analysis (RCA) is underway. In addition, the Head of Risk has been asked to review all SIs after one year to ensure actions have remained embedded.	Complete
2	**330-14**	Detailed update on Food Charter mark to be provided to board in Q3	**AP**	January	CQUIN update will be included within the monthly report on staff safety and experience	On track
3	**331-14**	Board to be apprised of criteria used when approving locations for off-site activity	**RT**	TBA	TBA	TBA
4	**332-14**	Business planning update to be provided to the board	**DT**	January	Scheduled as part of January seminar programme	Pending
5	**337-14**	Explanation of how key high level risks are identified to be provided at a future board seminar.	**AP**	April 2015	Scheduled as part of April seminar programme	On track
6	**338-14**	Item 8.4e to be removed from C-Wing Action Plan	**LH**	January 2015	Now actioned	Complete
7	**338-14**	C-Wing Action plan to be returned to board for review in June 2015	**KD**	June 2015	Now incorporated into 2015/16 work programme	On track
8	**339-14**	Recruitment policy to be amended to ensure Fit and Proper Persons Test criteria is incorporated	**GA**	January 2015	Policy now updated	Complete
9	**339-14**	Existing director contracts to be amended to reflect Fit and Proper Persons Test criteria	**GA**	January 2015	Policy now updated	Complete
10	**340-14**	Board to be apprised of how legislation relating to new Duty of Candour will be implemented	**LH**	January 2015	Email sent to board on 19 January apprising them of process	Complete
11	**349-14**	Board to be apprised of current status of Theatre Review	**RT**	Jan 2015	**07.01.2015** On January board agenda (closed session)	On track

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
12	**352-14**	Whistleblowing policy to be updated, approved by Clinical Cabinet and presented to BoD for information	**RT**	Jan 2015	**07.01.2015** On January board agenda	On track
November 2014 meeting						
13	**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**
14	**306-14**	Revised draft Leadership and Development framework to be circulated to the board for information.	**GA**	December	**18.12.2014** GA confirmed this had been done	**Complete**
15	**305-14**	Current workforce report to be refined to provide additional information around absence and vacancies, including a breakdown of individual staff groups.	**GA**	January	**18.12 2014** To be presented to board in January 2015	**Pending**
16	**305-14**	Latest update on staff recruitment to be circulated to NEDs for information.	**GA**	December	**18.12.2014** GA advised this was now complete	**Complete**
17	**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	Summary of report included within monthly report to Board	**Pending**
September 2014 meeting						
18	**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	**Complete**
19	**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	**Complete**
July 2014 meeting						
20	**181-14**	Further consideration as to which directorate risk management should sit under, as part of wider review of Executive workload.	**RT**	~~Oct~~ ~~Dec~~ TBA	This will form part of the wider organisational review which will start in October 2014 **21.10.14:** Review has commenced, not expected to conclude until December **18.12.14** Review still underway	**Pending**
May 2014 meeting						
21	**136-14**	Monitor's "Well-Led" assessment framework to be implemented as part of the governance review.	**LH**	~~Aug~~ ~~Oct~~ ~~Dec~~	**08.07.14:** Presentation to be made to October Nomination & Remuneration Committee **15.09.14:** Well Led Review template to be	**Pending**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
		LH to liaise with RT regarding next steps, and board to be updated accordingly.		Mar	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	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29th January 2015
Agenda item reference no:	005-15
Author:	Richard Tyler, Chief Executive
Date of report:	22nd January 2015

CHIEF EXECUTIVE'S REPORT JANUARY 2015

Key Issues
Attached is the January report which covers key issues of operational performance and external issues of interest to the Trust

Implications of results reported
The Trust remains on track to deliver against key in-year performance measures and has clear plans in place to mitigate risks to delivery.

Action Required
At this stage the key action is continue monitoring delivery against in-year performance targets and action plans to provide assurance as to delivery.

Links to Strategic Objectives
The areas covered in the report link to all of the Trust's key strategic objectives.

Implications for BAF or Corporate Risk Register
Vacancy levels, risks to income and delivery of RTT 18 are all covered by the BAF. It is proposed to add a new risk relating to the organisational re-structure to the BAF.

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

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

CHIEF EXECUTIVE'S REPORT
DECEMBER 2015

TRUST ISSUES

Quality – staffing vacancies

In October I highlighted trust risk 749, *recruitment of appropriate nursing, non-clinical and medical staff/skill mix*. This risk remains one of the Trust's top six risks with a risk score of 16. Since October the overall vacancy rate has fallen slightly from 12.4% to 11.4%. However concerns remain regarding the rate within individual clinical areas with Canadian Wing approaching 19%. This is reflected in turn in high levels of agency usage, with overall agency expenditure approaching its highest level for 18 months.

As was reported last month, the Deputy Head of Human Resources & Organisational Development is leading a recruitment and retention task force and I am pleased to report that the Trust is holding a recruitment day on 27th January with the specific objective of increasing our rates of recruitment in key clinical areas. Further details are provided in the relevant report later on the agenda.

We continue to monitor the impact of rising vacancies on safe staffing level, the overall quality of patient care and the potentially adverse financial impact. I am able to assure the board that we are maintaining safe staffing levels, as evidenced by the report by the Director of Nursing. It should also be noted that our performance against the Friends & Family Test has improved with the overall percentage of patients recommending the trust in November reaching 97%.

We also aim to use a regular cohort of agency staff to minimise the impact of staff that are unfamiliar with the Trust. At its January meeting the Quality & Risk Committee considered a report on the incidence of hospital acquired pressure ulcers following earlier concerns regarding an increase during quarter 2 and possible links to an increase in agency usage. The report concluded that 'no specific trends were identified in relation to the use of agency staff' which suggests we are managing our use of agency effectively. Finally in relation to the financial implications, whilst agency staff are more expensive than bank staff we are not seeing a significant deterioration in our financial position.

Finance – income volatility

The Board will recall that I raised previously some concerns regarding lower than expected levels of in-patient activity and that I asked the Director of Finance to undertake a more detailed analysis of these changes.

The analysis has been completed and draws the following conclusions; the fall in activity relates to three specific consultants; two of the three have increased the complexity of their case-mix resulting in lower activity with the same or increased levels of utilisation; one had higher than expected levels of sickness absence; one unexpectedly resigned mid-year; and in one instance was there some evidence of a drop in referrals resulting from a new appointment elsewhere.

Whilst the analysis does provide some assurance that we are not seeing a wider shift in referral patterns I have tasked the Director of Finance and Head of Operations with making sure that we build all known changes of consultant workforce into 2015/16 business planning alongside any known changes in case-mix.

Performance – 18 week recovery plan

I am pleased to confirm that we have reported full compliance in December with the 18-week target at an aggregate level for admitted, non-admitted and open patient pathways. We have also achieved compliance at a speciality level across all patient pathways with the exception of oral surgery where we missed compliance on the non-admitted pathway by a single patient. As the Board will recall, the orthodontic component of oral surgery was a considerable challenge with an overall backlog in November in excess of 200 patients. This was reduced significantly but inevitably an element of the backlog rolled over into December resulting in the near miss.

Staffing – organisational restructuring

As the Board is aware we are in the middle of a significant restructuring programme. At board level we are recruiting to both the Director of Finance and the Director of Nursing posts and aim to complete the recruitment process during February. We have two highly experienced interims in post in each of these roles to provide assurance and continuity over the next three to four months. We are also recruiting substantively for the Associate Director – Operations post and again this should be completed in early February.

In December we undertook an extensive staff engagement exercise on the proposed organisational structure. The engagement process was successful with over 800 'hits' on the intranet site, over 50 individual questions/comments and a series of meetings with staff groups from across the trust. The revised structure will be considered at the Board nominations and remuneration committee on 29th January and we will then undertake a formal consultation for one month before implementing the changes.

Finally I would like to take this opportunity to say thank you and goodbye to Lois Howell who has been covering Kathleen Dalby's maternity leave. Lois has been instrumental in helping us review and refresh our governance structures as well as being a sound source of advice and guidance to both myself and the Board.

Staffing – industrial action

As the Board will be aware, a number of the healthcare unions have called one day of industrial action on Thursday 29th January between 9am and 9pm. At this stage we predict the impact on the trust to be minimal and an update will be provided at the board meeting.

Business Developments – trauma capacity

Developing our burns and trauma service is one of the five focus areas for our clinical strategy. Over the last 6 months a trauma working group, led by Jane Morris and James Blair, has been considering how best to increase our trauma capacity.

The need to increase capacity is driven by a number of considerations; it enables us to offer increased support to the major trauma centres, building on the recent appointment of the lower-limb trauma specialist; it offers improved patient safety through a reduction in 'out of hours' operating; and finally it offers improved patient experience through reduced cancellations.

The proposals have been discussed at regular intervals with the clinical cabinet and the final business case was signed off by the cabinet at its meeting on 19th January. The business case is included later on the agenda for board approval.

NATIONAL & REGIONAL ISSUES

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

The above document describes the approach for national and local organisations to make a start in 2015/16 towards fulfilling the vision set out in the NHS *Five Year Forward View*. Of particular interest to the board will be section 3, Co-creating new models of care. NHS England is looking to 'prototype' four different types of care models outlined in the Forward View:

1. Multispecialty community providers (MCPs) which may include a number of variants;
2. Integrated primary and acute care systems (PACS);
3. Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms advocated by the Dalton Review, such as specialist franchises and management chains; and
4. Models of enhanced health in care homes.

NHS England is looking to support a number of pilot sites across each of these four areas with initial expressions of interest invited by 2nd February. Further information is promised during January. For us at QVH models 2 & 3 have the potential to align with our *community facing* and *hub & spoke* strategic workstreams. We have had initial discussions on each of these areas both internally and with potential partners and I will update the trust board on progress at the board meeting.

Monitor consultation on pricing and tariffs for 2015/16

Board members will be aware of the controversy surrounding the proposed changes to tariff for 2015/16 and in particular the proposal to introduce a marginal rate tariff of 50% for specialist services commissioned directly by NHS England. The Trust, through the Federation of Specialist Hospitals, objected strongly to the proposal as did the majority of providers of specialist services. Under the terms of the Health & Social Care Act (2012) Monitor are required to re-consult or refer to the Competition and Markets Authority if the level of objections is greater than or equal to 51%. At the time of writing Monitor are considering whether the level of objections has reached this point. Until this is resolved we cannot provide a definitive view on our income assumptions for 2015/16. This will be discussed in more detail in the business planning session planned prior to the trust board.

Richard Tyler
22nd January 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29 January 2015
Reference number:	006-15
Report from:	Amanda Parker, Director of Nursing
Author:	Amanda Parker, Director of Nursing
Report date:	13 January 2015
Appendices:	0. Main Report 1. Safe Staffing 2. Food for Life 3. QA Priorities update 4. QA timetable 2015/16 5. Complaints, claims and patient experience 6. Root Cause Analysis 7. Learning Disability Peer Review

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).
- CQUIN updates for Q3 including the Food for Life action plan (Appendix 2).
- Quality and risk management with information provided on quality and safety metrics and incident management.
- Infection prevention and control issues and actions.
- Quality Account updates and process for agreeing priorities for 2015/15 (Appendices 3 and 4).
- Information on new and closed complaints, claims and patient experience feedback. (Appendix 5).
- Following confirmation that loss of sight previously noted as an incident during August could have been prevented, the incident had a full RCA undertaken and the final report was produced in December 2014 and presented to Clinical Cabinet on 19th January 2015. (Appendix 6).
- Learning Disability Peer Review Report (Appendix 7)

Safe Staffing

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

CQUIN

4. Dementia screening target continues to fall short of the desired target; this due to the readmission of an elective patient who is categorised as a trauma patient.
5. The Food for Life Action Plan continues to have outstanding actions and is being monitored in the Patient Experience Group and by Hotel Services.

Quality and Risk Management

6. One grade 2 QVH acquired pressure ulcer developed in December
7. One serious incident was reported to the Clinical Commissioning Group in December.
8. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.
9. An improvement in consent prior to the day of surgery has been noted across almost all specialties.
10. Flu vaccination continues although we are still a way from our 60% target.

Infection Control

11. The Serious Incident declared in December 2014 was related to a lapse in processes around decontamination by Synergy Health.
12. The Legionella incident from October has been closed by PHE.

Quality Account Priorities

13. Q3 update indicates not all priorities have been achieved and work continues to take place to ensure achievement by year end.
14. Process of agreement for 2014/15 priorities is described and has commenced.

Complaints, Claims and Patient Experience

15. There were five new complaints acknowledged during December and these are under investigation and progress is reviewed monthly by the Chief Executive and Director of Nursing. For all closed complaints letters sent are signed by either the Chief Executive or Director of Nursing.
16. Any action identified as the result of a complaint is monitored through the monthly clinical governance group and good progress on closure of actions is reported by the DN.
17. Patient feedback is good, changes made to the scoring methodology of the FFT continue to be reflected within the dashboard.

Learning Disability Peer Review

18. Action plan and report enclosed- minor reasonable adjustments have been highlighted by the review team and these actions are in progress.

Implications of results reported

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

Action required

20. 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

21. 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

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

Regulatory impacts

24. 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 December 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 review of ward establishments within all wards at QVH took place in November 2014 and can be seen at **Appendix 1.** Recommendations from this review are that recruitment into vacant posts continues so that staff can aim to work with the minimum number of bank and agency staff. During previous months incidents have been reported to the board that have been identified as occurring due to the increase in agency use in some instances. A recruitment day is planned for the end of January 2015 and it is hoped that this will attract new staff to QVH.

4. During December three incidents were reported related to lack of staffing. Investigation revealed that in two cases a lack of appropriate escalation was undertaken to resolve issues. In these instances the individual staff members have been reminded of the correct process and this has then been raised at team meetings to inform the wider team. The thirds incident occurred due to short notice staff sickness and staff on site were redeployed to ensure patient safety.

5. Within the safe staffing metrics the board is alerted to the vacancy rate within Canadian Wing and the sickness rate within the Burns ITU.

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%	99%				
	Margaret Duncombe Support staff Day shift			115%	100%	94%	95%	97%	102%	98%	102%	91%				
	Margaret Duncombe Registered staff Night shift			101%	96%	100%	102%	98%	99%	98%	102%	100%				
	Margaret Duncombe Support staff Night shift			106%	97%	97%	100%	100%	100%	103%	94%	92%				
	Ross Tilley Registered staff Day shift			73%	97%	96%	103%	98%	101%	100%	96%	97%				
	Ross Tilley Support staff Day shift			69%	87%	90%	100%	101%	100%	98%	94%	102%				
	Ross Tilley Registered staff Night shift			79%	96%	94%	95%	98%	100%	99%	92%	99%				
	Ross Tilley Support staff Night shift			71%	97%	93%	93%	83%	100%	93%	89%	83%				
	Peanut Registered staff Day shift			100%	94%	101%	95%	93%	99%	100%	105%	100%				
	Peanut Support staff Day shift			106%	97%	100%	100%	103%	100%	100%	106%	89%				
	Peanut Registered staff Night shift			100%	98%	98%	98%	95%	98%	93%	97%	100%				
	Peanut Support staff Night shift			100%	100%	100%	100%	100%	100%	100%	100%	100%				
	Burns Registered staff Day shift			86%	93%	94%	99%	96%	100%	99%	100%	100%				
	Burns Support staff Day shift			113%	103%	108%	106%	91%	100%	94%	109%	100%				
	Burns Registered staff Night shift			97%	98%	103%	100%	92%	100%	98%	103%	97%				
	Burns Support staff Night shift			88%	93%	93%	106%	150%	100%	100%	100%	100%				
	ITU Registered staff Day shift			99%	93%	95%	98%	93%	98%	100%	100%	93%				
	ITU Support staff Day shift			128%	95%	94%	112%	100%	110%	100%	58%	125%				
	ITU Registered staff Night shift			90%	96%	87%	95%	99%	98%	92%	102%	94%				
	ITU Support staff Night shift			110%	100%	100%	100%	93%	100%	100%	100%	100%				

Commissioning for Quality and Innovation (CQUIN)

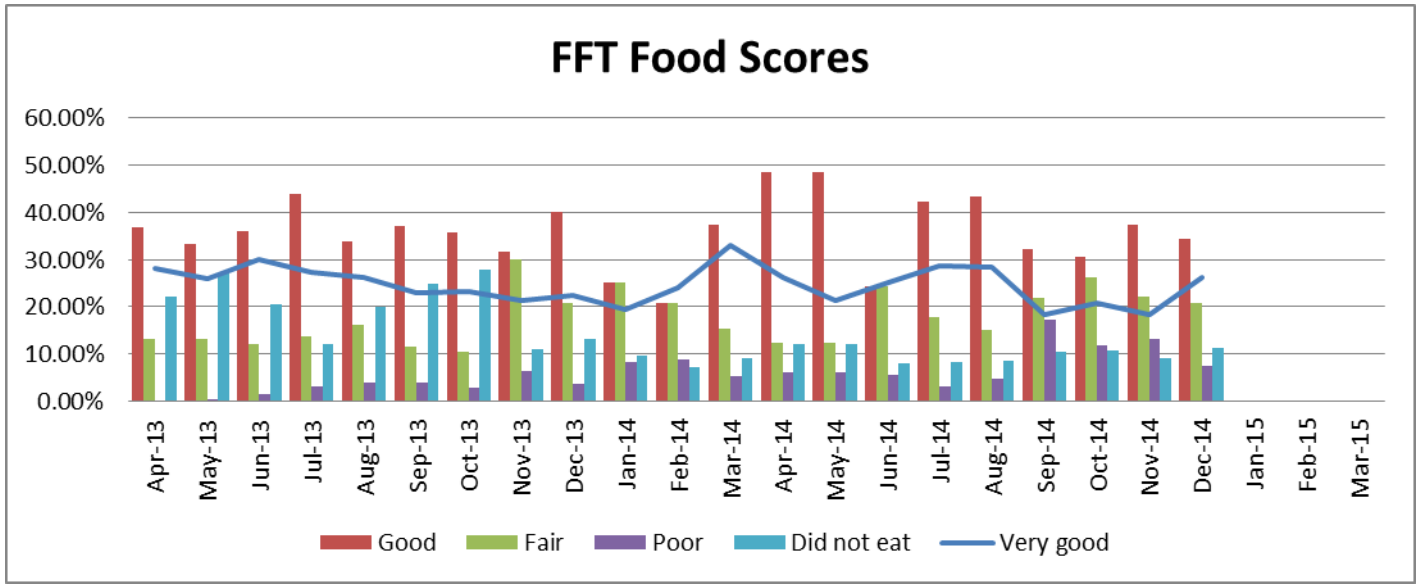
6. One metric did not achieve the expected target for December. Within dementia only 7 out of 8 patients were asked the indicative question or formally assessed. This was because an elective patient who was readmitted did not have the questions asked as was not a trauma patient.

Source	Description (Activity per 1000 spells is based on HES Data w hich is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total /	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
CQUIN	VTE prophylaxis	100%	>95%	100%	100%	100%	100%	100%	100%	100%	100%	97.4%	#DIV/0!	#DIV/0!	#DIV/0!
	VTE in hospital/RCA undertaken	100%	0/100	0	0	0	0	0	0	0	0	0			
	FFT Score acute in-patients extremely likely/likely	86%	>80	88	86	94	91	83	75	98%	97%	99%			
	FFT Score acute in-patients unlikely/extremely unlikely									1%	0%	0%			
	Number of responses	NEW	30%	72%	37%	47%	48%	35%	27%	28.6%	47%	60%			
	FFT Score MIU extremely likely/likely	85%	>80	76	77	77	75	86	62	86%	94%	94%		Feb	Mar
	FFT Score MIU unlikely/extremely unlikely							1		5%	2%	4%			
	Number of responses	NEW	20%	21%	8%	45%	19%	44%	34.50%	35.3	29%	31%			
	FFT Staff Survey Recommend trust to friends and family / as a place to work	NEW	>4	Recommend to Friends and			Recommend to Friends and								
	Dementia >75 trauma asked indicative question	93%	90%	Apr	May	Jun	100%	100%	100%	100%	71%	86%			
	Dementia >75 having diagnostic assessment	100%	90%	100%	100%	100%	100%	100%	100%	100%	71%	86%			
	Dementia > 75 referred for further diagnostic advice	89%	90%	100%	100%	0%	100%	100%	100%	100%	100%	100%	0%	0%	0%
	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 have been contacted with the			Q2 audit information collated								
	Safety thermometer data submission	100%	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	Harm free care rate	100%	>95%	100%	98%	100%	95%	92%	100%	100%	95%	95%			
	No new harm rate (aquired at QVH)	100%	>95%	100%	100%	100%	100%	96%	100%	100%	95%	97%			
	Reducing cancelled operations	—	TBC	Baseline identified & reported			2 data collected, submitted to CQ			Reported 1/4ly			Reported 1/4ly		
	WHO Checklist compliance - Qualitative (100% compliance is CCG target)	100%	90% by end Q2 & >95% by end Q4	47%	90.50%	89%	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly		
	WHO Checklist compliance - Quantative (100% compliance is CCG CQUIN)	96%	>95%	96%	91%	96%	96%	98%	99%	96%	95%	98%			
	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		

Food For Life Action Plan

7. In order to improve the quality and standard of patient and staff food, the Food For Life Action plan has been devised and followed throughout 2014. The action plan detailing progress can be seen at **Appendix 2.**

8. While completing discharge surveys food quality has been questioned and it was hoped that food scores would improve from November with the change in menu. As can be seen from the chart below this is not the case and further discussions will be held with the catering lead to consider other ways of gaining feedback to improve patients' experience of food at QVH.



Quality Account Priorities 2014/15 Quarter Three Update

9. Progress on priorities has not been achieved as expected by the end of quarter three. Work continues within all of them to enable achievement of the end of year goal identified. No significant barriers are foreseen for priorities one, three and four. Risk to achievement of priority two remains but it is hoped that new ways of working will enable this priority to achieve improved results over the next quarter. A full update report can be found at **Appendix 3.**

Quality Account Priorities for 2015/16

10. The process for agreement of Quality Account Priorities and suggested areas to focus on for 2015/16 has commenced and is outlined in **Appendix 4**.

11. At the Quality and Risk Committee there was agreement that the format should remain as last year due to the number of internal changes occurring at the trust.

Patient Experience

12. There were five new complaints opened in December 2014 and 7 complaints were closed. The full report can be seen at **Appendix 5**.
13. No new claims were opened in December 2014.

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 /	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Patient Experience	Complaints per 1000 spells	4.7		3.4	2.9	6.9	6.6	2.5	6.7	4.9	3.9	4.5			
	Claims per 1000 spells	1		1.4	0.0	2.7	1.2	0.6	1.3	1.2	0.6	0%			
	FFT Score acute in-patients: likely and very likely to recommend QVH	86%	>90%	99%	100%	99%	97%	100%	97%	98%	97%	99%			
	FFT score acute in-patients: unlikely and very unlikely to recommend QVH			started October						1%	0%	0%			
	FFT score MIU: likely and very likely to recommend QVH	85%	>90%	99%	97%	96%	96%	97%	92%	86%	94%	94%			
	FFT score MIU: unlikely and very unlikely to recommend QVH			started October						5%	2%	4%			
	FFT score OPD: likely and very likely to recommend QVH	82%	>90%	98%	98%	98%	98%	98%	97%	97	95%	97%			
	FFT score OPD: unlikely and very unlikely to recommend QVH			started October						1%	3%	1%			
	FFT score DSU: likely and very likely to recommend QVH	93%	>90%	0	98%	99%	99%	100%	99%	99	99%	95%			
	FFT score DSU: unlikely and very unlikely to recommend QVH			started October						0	0%	0%			
	FFT score Sleep disorder centre: likely and very likely to recommend QVH	76%	>90%	99%	97%	98%	98.0%	95%	98%	97	100%	95%			
	FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH			started October						0%	0%	0%			
	Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0	0			
	Patient experience - Did you have enough privacy when discussing your condition or	—	>90%	92%	97%	99%	98%	98%	97%	98%	96%	97%			

Patient Safety

14. One grade 2 pressure ulcer was acquired at QVH during December 2014 on Burns ITU. A Root Cause Analysis is being undertaken.

15. Three patient falls occurred in December 2014, no harm was suffered and these occurred within three different clinical areas.

16. One Serious Incident was declared during December 2014 involving Synergy Health following the receipt of re-processes instruments through a washer disinfector; the instruments did not go through the sterilisation (autoclave) process. A process to review notes of all patients likely to have been affected was undertaken. All affected patients were contacted and offered appointments and reassurance regarding the extremely low risk of any transmission. A full RCA is underway. The Director of Nursing has met with all professional staff identified as involved in the incident to discuss professional roles and responsibilities and to identify changes required to systems and processes or culture.

17. Following confirmation that loss of sight previously noted as an incident during August could have been prevented, the incident had a full RCA undertaken and the final report was produced in December 2014 and presented to Clinical Cabinet on 19th January 2015. Recommendations reached as a result of the full investigation include the development of a post orbital surgery protocol. An action plan to ensure implementation of the recommended actions has been devised and will be monitored through the Head of Risk. Shared learning will be disseminated through Joint Hospital Audit, Corneo and Plastics meetings. The Executive summary can be found at **Appendix 6**.

18. Trust wide, consent taking prior to surgery has shown a marked improvement and is noted to above the 75% target in all specialties apart from Plastics which achieved below the target.

Source	Description (Activity per 1000 spells is based on HES Data w hich is the number of inpatients discharged per month including ordinary, daycase and emergency - figure /HES x 1000)	2013/14 total /	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Patient Safety	Number of Pressure ulcer development Grade 2 or over acquired at QVH	8		0	0	0	0	1	3	0	0	1			
	% of completed nutritional screening assessments (MUST) within 24 hours of admission (Commences May 2014)	NEW	>95%		100%	97%	100%	100%	100%	100%	100%	97%			
	% of patients who have had a (MUST) reassessment after 7 days (Commences May 2014)	NEW	>95%		80%	83%	100%	100%	100%	100%	66%	100%			
	Patient Falls resulting in no or low harm	16	—	4	1	3	6	4	5	3	2	3			
	Patient Falls resulting in moderate or severe harm or death	NEW	—	0	0	0	0	0	1	0	0	0			
	Patient Falls assessment completed within 24 hrs of admission (Commences May 2014)	NEW	>95%	100%	73%	82%	85%	88%	80%	86%	92%	97%			
	Avoidable patient falls identified on the Safety Thermometer	—		0	0	0	0	0	0	0	0	0			
	Serious Incidents	5		0	0	1	1	0	1	2	0	1			
	Never Events	NEW		0	1	0	0	1	0	0	0	0			
	Total number of incidents involving drug / prescribing errors	NEW		13	10	19	16	17	20	19	31	20			
	No & Low harm incidents involving drug / prescribing errors	NEW		13	10	18	16	17	20	19	31	20			
	Moderate, Severe or Fatal incidents involving drug / prescribing errors	NEW		0	0	1	0	0	0	0	0	0.0			
	Medication administration errors per 1000 spells	1.3		0.7	3.6	2.7	1.2	0	2	2.4	5.6	2.7			
	To take consent for elective surgery prior to the day of surgery (Total)	72.2%	75%	84.7%	69.6%	76.8%	77.1%	68.7%	74.5%	74.8%	74.3%	75.2%	#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%	81.3%	#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%	69.4%	#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%	87.5%	#DIV/0!	#DIV/0!	#DIV/0!
	Number of outstanding CAS alerts	NEW		0	0	0	0	0	0	0	1	0			
	Number of reported incidents relating to fraud, bribery and corruption	NEW		0	0	1	0	0	0	0	0	0			

Staff Safety

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

20. The mandatory training figure is reported as 68.9% and the process of data cleansing continues.

21. 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	5				
	RIDDOR (Patients & Staff)	4		1	0	0	0	0	0	1	0	0				0
	Mandatory training attendance	71%	80%	82%	78%	82%	89%	79%	77%	74%	43%*	69%				0
	Flu vaccine uptake	55%	60%	Not due till October						38.1%	49.70%	51.50%				0

Infection Control

22. 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.

23. Training, provision of information and testing on the management of patients suspected of having Ebola has continued to meet NHS England 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 /	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Clostridium Difficile acquired at QVH post 72 hours after admission	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	E-coli bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MSSA bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MRSA screening - elective	96%	>95%	342%	97%	97%	95%	94%	96%	96%	94%	95%	0%		
	MRSA screening - trauma	98%	>95%	137%	97%	97%	97%	93%	99%	96%	98%	98%	0%		
	Trust hand hygiene compliance	95%	>95%	8800%	8600%	96%	99%	97%	99%	99%	97%	98%	0%	0%	0%

Care Quality Commission (CQC)

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

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

26. QVH has not been identified for in the CQC's next wave of inspections for April – June 2015.

Learning Disability Peer Review

27. In November 2014, QVH underwent a peer review inspection to assess how accessible QVH services are for patients with a learning disability. The review team consisted of staff from QVH, Learning Disability staff from other NHS Trusts in Sussex and a service user with a learning disability. The full inspection report is contained at **Appendix 7** and contains an action plan designed for service improvement.

Executive summary

The purpose of this report is to present to the board a review of ward establishments, as directed by the National Quality Board (NQB). A number of national reports have influenced the requirement for boards to be responsible for ensuring that there is sufficient staffing on wards meet the care requirements of patients.

The Francis report on Mid Staffordshire (2013) resulted in the publication of a number of documents focussing on the importance of safe nurse staffing levels.

- 'How to ensure the right people, with the right skills, are in the place at the right time. A guide to nursing, midwifery and care staffing capacity and capability' (National Quality Board 2013).
- 'Hard truths. The journey to putting patients first' (DH, 2013)

'Safe staffing for Nursing in adult inpatient wards in acute hospitals' (NICE consultation document 2014), this resulted in the introduction of 'red flags' which were a series of incidents that NICE identified should be reported by ward staff. These have been introduced with a list available to remind ward staff and the categories are now available via datix for recording.

In November 2014 Safer staffing: A guide to care contact time was released this recommends that a contact time assessment is undertaken that would provide a baseline for each ward on the amount of contact time staff have with patients or on other nursing activities versus time that is unproductive.

The NQB has stipulated that; 'Boards must take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability'. Within their recommendations they state that every six months the board of directors should receive and discuss at a public board meeting a report on staffing capacity and capability.

This report provides information on all inpatient wards at QVH; Canadian Wing, Burns Unit and Peanut.
Calculating staffing requirements is not straight forward and is dependent upon a number of factors. These include; the dependency (acuity) of patients on nursing care and factors such as skill mix of staff available and others including the culture and leadership of the team. Evidence would show that where a nurse cares for more than 8 patients there is an increase in harm to patients.

The methodology used included;

- ward level engagement, triangulation, comparison, standardisation.

Ward establishments were agreed at the beginning of the financial year and a staffing review is undertaken every three months and presented to the board twice a year, the last presented to the board in July 2014 (June 2014 data). The data collected for this review was November 17 – December 14 2014.

Overall planned establishment, actual establishment and patient required care can be seen to be sufficient within the shaded are of the table below.

Recommendations from this review are that recruitment into vacant posts so that staff can aim to work with the minimum of bank and agency staff. During previous months incidents have been reported to the board that have been identified as occurring due to the increase in agency use in some instances. A recruitment day is planned for the end of January 2015 and it is hoped that this will attract new staff to QVH.

Patient dependency (acuity)

Nationally the Safer Nursing Care Tool which is an evidenced based tool that enables nurses to assess patient acuity and dependency. It incorporates a staff multiplier that ensures that staffing establishments meet the needs of patients and their acuity and dependency.

The following whole time equivalents (WTE) per patient are used to calculate nursing staff required per patient, dependent upon their acuity scores which provides an indicator of dependency requirements for care. Within the WTE per patient an uplift of 22% has been included to allow for annual leave, sickness and training. While this provides a figure for staffing it does not provide a definitive guide for skill mix (grade/skill set of registered nurse required) or the ratio between registered and non-registered staff.

Patient acuity is rated as 0,1a, 1b or 2 and the whole time equivalents to calculate nurse staffing levels are;

Level 0 = 0.99 WTE / patient - Patient requires hospitalisation. Needs are met through normal ward care

Level 1a= 1.39 WTE / patient – Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate

Level 1b= 1.72 WTE / patient - Patients who are in a stable condition but are dependent on nursing care to meet most or all of the activities of daily living

Level 2 = 1.97 WTE (previously 2.44) / patient - May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit

Level 3 = 5.96 WTE / patient – Patients needing advanced respiratory support and/or therapeutic support of multiple organs

Royal College of Nursing guidance suggests a registered nurse to non-registered nurse ratio of 65:35. Evidence would show that where the registered nurse to patient ratio is greater than 1:8 patient safe care is compromised, this ration is generally considered for care during the day with recent suggestions that this could be 1:11 at night. Canada work on 1:8 nurse to patient, with Australia on 1:7 both with supernumerary managers. At QVH due to the specialist nature of work we consider 1:6 an appropriate benchmark for the surgical ward with a supernumerary nurse in charge. These are different for the Burns Unit and children's' ward.

The trust plans to introduce the safer care module to support the e-roster system this provides information on staffing versus the acuity of patients and can be used on a daily basis to provide assurance that staffing is sufficient to meet the changing care needs of patients. Currently the purchase order for this has been raised and we are awaiting an implementation date.

Summary of trust position against benchmark information in November 2014 – figures exclude manger and educator roles when calculating nurse per bed or patient

National benchmark		Burns Ward 6 beds + (2 rehab)	ITU 2.5 beds staffed (Capacity 5)	Margaret Duncombe 23 beds (inc step down)	Ross Tilley 24 beds	Peanut 9 beds + Outpatient area
		Burns Centre		Canadian Wing		
SUMMARY of staffing based on acuity	**Planned establishment** **Actual Establishment** **Patient required care**	**Ward** **2.6** **1.3** **1.2**	**ITU** **6.4** **4.9** **2.4**	**1.2** **1.1** **1.17**		**2.1** **1.9**
Budgeted nursing establishment		26.8 WTE RN – 20.29 WTE 1.4 WTE manager / educator Unregistered – 5.11 WTE	17.1 WTE RN RN – 16.6 WTE 0.5 WTE manager	58.72 WTE Registered – 40.3 WTE 2.5 WTE manager / educator Unregistered – 15.92 WTE		22.67 WTE Registered – 16.07 WTE 1.8 WTE manager/educator Unregistered – 3 WTE
Actual nursing establishment		22.7 WTE RN – 18.3 WTE 1.4 WTE manager / educator Unregistered – 3 WTE	12.94 WTE RN – 12.44 WTE 0.5 manager	52.94 WTE Registered – 36.54 WTE 2.5 WTE manager / educator Unregistered – 13.9 WTE		20.6 WTE Registered – 14.4 WTE 1.6 WTE manager / educator Unregistered – 3 WTE
Nursing vacancies		6.58 WTE 1057.5 (month)	3.72 WTE 598 hours (month)	6.62 WTE (11.7%) 1064 hours (month)		1.67 WTE (8%) =268 hours (month)
Nursing sickness during month	<3%	1.2 WTE 192 hours	0.82 WTE 132 hours (month)	2.72 WTE = 437 hours (month)		2.54 WTE =395 hours
Maternity leave Secondment during month		1.1 WTE 177 hours	1.4 WTE 225 hours	3 WTE = 482 hours (month)		0 WTE = 0 hours
Total vacant hours excluding sickness		**1234.5 hours**	**823 hours**	**1546 hours**		**268 hours**
Bank use / month		212	239.4 hours	648.45 hours		230.1 hours

Agency /month Excluding RMN's		42 **Total = 254**	600.5 hours **Total = 839.9**	982.4 hours **Total = 1330 hours**	25 hours **TOTAL 255.1**
Ward Occupancy		**6 ward beds = 71%** **2 rehab beds = 12.5%** **Total 8 beds = 57%**	**2.5 ITU beds** **54%**	**Margaret Duncombe 70%** **Ross Tilley 59%** **Total Canadian Wing occupancy 47 beds = 65%**	
Nurse (WTE) to bed ratio		Establishment – 2.6 **Actual – 1.3**	Establishment – 6.4 **Actual – 4.9**	Establishment – 1.2 **Actual – 1.1**	Establishment – 2.1 **Actual – 1.9**
Average monthly acuity and staffing WTE required per patient / month		0 = 82 1a = 6 1b = 39 **Average acuity = 1.2**	0 = 0 1a = 8 1b = 2 2 = 22 3 = 6 **Average acuity = 2.4** Overall staffing requirement **= 3.35 WTE**	MD RT 0 = 324 0 = 353 1a = 60 1a = 25 1b = 2 1b = 6 2 = 2 MD Average acuity = 1.07 RT average acuity = 1.02 **Average acuity = 1.17** **Total staffing identified as required = 31.5 WTE**	SCNT does not calculate for paediatric care
Ratio Registered :Non Registered	65:35	80:20 (budget) 86:14 (actual)	100:0	72:28 (budget) 72:28 (actual)	84:16 (budget) 83:17 (actual)
Paediatric Registered ratio per child	Under 2 yrs - 1:3 Over 2 yrs – 1:4	NA	NA	NA	Rostering of staff provides 1 nurse to 3 children
Registered Nurse to patient per shift Day Night Monthly data on shift by shift establishment provided each month	Canada 1:8 Australia 1:7 UK Adult general ward 1:8 day UK Adult general ward 1:11 night	1 – 2.6 day 1-4 night	1-1	Minimum taking step down into consideration 1-6 day 1-8 night	NA

It is anticipated that the data presented will from May be able to be extracted from the Safer Care Module being launched during January

Burns Unit:

The Burns Unit has 6 ward beds, 2 rehab beds and 2.5 staffed ITU (though availability for 5 ITU) beds, staffing also covers the burns emergency assessment clinic (EBAC).

In November the ward skill mix ratio was 86% registered staff to 14% unregistered staff, with 22.7 WTE staff in post in against an establishment of 26.8 WTE. There was a 4.47 WTE registered staff vacancy and 2.11 WTE unregistered staff vacancy. Ward occupancy is noted having been at 57%.

The nurse to bed ratio is 1:2.6, it should be noted that patients within the burns unit require significant time in regard to management of their dressings, and these figures include management of the outpatient dressing area. Daily staffing provides 3 trained nurse to eight patients on an early shift. The Emergency Burns Assessment Clinic (EBAC) is co-located with the ward and additional staff are allocated to this area.

Within ITU there is a vacancy of 3.72 WTE with staffing provided for 2.5 beds. Each ITU bed requires 5.96 staff allocated to deliver 24 hours of 1-1 care. Occupancy during November was 54%, but it is noted that this is a fluctuating patient group and the maximum on anyone day during the audit period was 3 patients.

Calculation of staffing required came to 5.6 WTE for the ward and 3.34 WTE for ITU however this does not take into account the need to staff the department for level 3 ventilated patients at all times.

During November the staff within post in the burns unit and ITU were sufficient to provide safe care for patients admitted, where additional staffing needs were identified this was addressed with bank and agency staff.

Recommnedation

Recruit to vacant posts – a recruitment day is ocurring in Jnauary 2015.

Canadian Wing

Following the introduction of e rostering staffing fugures are quoted for the combined unit. Patient acuity is provided and the staffing for the combined unit is presented. It is relevant that Maragret Duncombe ward and Ross Tilley ward have different acuity levels however ward staffing is treated as one team to enable flexile use of staff and their skills.

Margaret Duncombe ward has 23 beds of which 7 may be designated as Step down beds, for patients requiring additional care. Ross Tilley has 24 beds some of these are currently used for ophthalmic patients who may require frequent eye drops increasing the nursing care time they require.

In November the skill mix ratio was 72% trained to 28% untrained staff, with a total budgeted nursing establishment of 58.72 WTE. There was a vacancy factor of 4.61 WTE registered staff and 2.03 WTE unregistered staff. Ward managers and an educator account for 2.5WTE of this team and they work in a supernumerary capacity. In addition the ward has 3 WTE registered RAF nursing staff seconded to their establishment. These staff are in addition to the ward establishment and experienced nurses on pre-course training, their presence equates to less than full time staffing as these staff are required

to fulfil armed forces duties during their secondment. From January 1WTE will be committed to be provided by the RAF though this will require a number of their nurses to provide this commitment as they will still be required to remain ‘combat ready’.

The total staffing establishment excluding supervisory ward manager positions provides a staff to bed ratio of 1.1, with average acuity suggesting 1.17 is required. Daily staffing rotas provide 1 registered nurse to six patients on a day shift and 1 to eight patients at night, and of late the ward has been supported by additional staff whom are registered nurses undertaking post registration courses.

Using the acuity tool the calculation of staffing required came to 14.1 WTE for Ross Tilley and 17.4 WTE for Margaret Duncombe (17.9 WTE Ross Tilley and 26.2 for Margaret Duncombe in June), giving a combined requirement of 31.5 (44.1WTE in June). During November the bed occupancy rate for the unit was 65% with Margaret Duncombe at 70% and Ross Tilley at 59%, further analysis shows a higher occupancy rate during the week with a much lower occupancy rate at the weekend. It should be noted that occupancy does not takes into account the number of admissions and discharges per day.

While undertaking the acuity review of Canadian wing data was collected on 3 occasions during the day 10.00, 1500 and 2200, this was in preparation for adding information to the safer care module. Undertaking this exercise showed that acuity on Margaret Duncombe ward has its highest acuity and thus nursing dependency in the morning while for Ross Tilly ward their highest dependency need is identified as the afternoon. This was from a one day snapshot – the use of the safer care module will provide more information around acuity and dependency of patients.

To ensure delivery of safe care Canadian Wing shifts continue to be supplemented with bank and agency staff to cover maternity and vacanct posts.

Recommendations:
Recruitment to remaining vacant posts
Further review of budet to ensure supevisory role is available at weekends
Consideratation of band 4 roles and skills to support budget and bring skill mix in line with 70:30, this may not be feasible and may relate to the additional skill set required for level 1b care for step down patients whose numbers have increased lately.

Peanut ward

Peanut ward has 9 beds, however it receives a significant number of day attenders and has very few patients that stay overnight. Co-located is the paediatric outpatient / assessment clinic.

In November the staffing for this area was made up of an establishment of 14.4 WTE registered nurse establishment with a vacancy of 1.16 WTE and healthcare assistant / nursery nurse establishment of 3 WTE of which there was no vacancy. A ratio of 83:17 registered/unregistered staffing was in place for the month. On an early shift they will have 3 trained staff providing one nurse to three patients with RCN recommendations stating that for under 2 years old the ratio should be 1- 3 and for over 2’s 1- 4. In addition to the nursing workforce two full time play specialists support the ward and clinic environments. There is also 1.6WTE of ward manager and educator roles that are supervisory within the department.

Ward occupancy is variable over the days of the week with a weekend and night occupancy rates noted as very low – actual figures were unavailable at the time writing.

During November the staff within post in Peanut ward was sufficient to provide safe care for patients admitted. Staff at night are utilised across the trust to enhance numbers even further on Canadian Wing when there are no patients on Peanut. They may however be called back to undertake burns assessments.

Recommendations:

Consider a review of staffing at night and investigate alternative models that do reduce the quality or safety of care delivered.

SAFE STAFFING DATA - DECEMBER

CANADIAN WING															
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies wte/hrs Est = 62.88	7.76 WTE 1288.7hrs	9.21 WTE 1480hrs	6.22 WTE 1033hrs	3.83WTE 636hrs	6.38WTE 1025.3hr	6.38WTE 1059.53	11.25WTE 1808hrs	12.41 WTE 1994hrs		<5%	19.73%				Action required under established adverts out to recruit
Temporary staffing Exc RMN Bank / Agency hours	530.10 431.30	553.15 360.30	735.15 375.0	836.50 452.30	418.15 499.30	579.00 795.15	648.45 982.40	418.50 471.30		<10% 235.8 + vacancy	+ 1340.00				No action required
Sickness	2.4%	1.2%	1.0%	1.8%	1.5%	3.56%	5.29%	4.90%		<2%	+2.29%				High short term sickness
Shifts meeting Est Day RN Support	97.0%	98.0%	100.0%	99.0%	100% 101%	100% 98%	108% 102%	99% 91%		>95%					On track no action required
Shifts meeting Est RN day/night Support day/night					99% 100%	98.5% 98%	102% 94%	100% 92%		>95%					On track no action required
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	70.2%	70.3%	63.2%	61.6%	48.0%	64.80%	68.00%	65.00%		>85%	-20.2%				Action required below target
Appraisals	67.7%	70.5%	73.7%	68.9%	66.7%	61.29%	70.00%	76.00%		>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%	99% 100%		>95%	+3 +2				Scoring methodology changes to percentage rating
Staff Friends and Family Test Score		79 17													
Budget (K)	15	6	12.6	-24	-37	-22	-52	-80		>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	Dec	Jan	DN Rating					
Safe Care	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	1	0	0	0	0		0	0				On track no action required
Falls	0	1	2	1	4	1	0	0		0	0				On track no action required
Medication errors	5	2	1	0	2	2	2	1		0	1				Ommission of medication
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0		0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	88%	67%	100%	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%	100% 100%	100% 100%	>95%	0%				On track no action required
Activity	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy (10am)		73%	67%	82%	67%	Data unavail	Data unavail	Data unavail		<90%	-23%				On track no action required
Bed utilisation	93%									<100%					On track no action required
Patient numbers	158	141	148	132	133	143	122	94							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	DEC	JAN	DN Rating					
Safe Care	No/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0	0	0		0	0				On track no action required
Falls	1	0	1	0	0	0	1	1		0	1				No harm sustained - patient reassessed
Medication errors	0	15	0	0	1	4	6	1		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	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%	90%	100%	95%	5%				Staff reminded of the need to check reassessment occurs
Nutrition assessment MUST / 7 day	100% 100%	100% 92%	100% 100%	100% 100%	100% 100%	100% 100%	100% 0%	94.4% N/A	100% N/A	>95%	5%				On track no action required
Activity	No/%	No/%	No/%	No/%	NO/%	NO/%	NO/%	NO/%	NO/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Bed occupancy		67%	64%	67%	59%	Data unavail	Data unavail	Data unavail		<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	151							On track no action required
Average length of stay	34.9Hrs														
Average patient acuity numbers/day		0 = 14.3 1a = 0.86 1b = 1.5													Patient acuity provides and indication of the level of nursing required; acuity 0 = .99WTE, 1a = 1.39WTE, 1b 1.72 WTE

BURNS UNIT															
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 30.63	1.6 wte 266hrs	6.40 wte 1028hrs	7.40 wte 1229hrs	6.40 wte 1062.85	6.50wte 1044.6	6.53WTE 1084.44	6.53WTE 1044.64	6.50WTE 1044.64		<5%	21.22%				Vacancy on establishment
Temporary staffing Exc RMN Bank / Agency	398.15 114	466.30 128.55	400.45 573.0	335.0 216.0	124.45 78.0	301.25 137.45	212.30 42.00	226.00 144.00		<10% 114.8hrs + vacancy	+788.80				No action required
Sickness	4.1%	4.79%	2.42%	1.98%	0.75%	0.66%	2.05%	6.46%		<2%	+4.46%				no action required
Shifts meeting Est Day RN Support							100 103%	100% 100%							
Shifts meeting Est Night RN Support	96%	99%	98%	92%	100%	98%	109 100%	97% 100%		>95%					Staffing identified as safe due to acuity of patients
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	80.25%	83.60%	77.10%	75.91%	58.79%	74.17%	78.00%	70.00%		>85%	-10.83%				Below target
Appraisals	58.82%	66.67%	86.21%	80.00%	79.31%	80.00%	80.00%	77.00%		>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	-101	-124		>0	-90				Overspend is split between income and non pay

BURNS WARD	MAY	JUNE	July	Aug	Sept	Oct	Nov	Dec	Jan	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No%**	**No%**	**No%**	**No%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	1	0	0	0		0	0				On track no action required
Falls	0	2	3	0	0	0	1	1		0	0				Fall was due to patient trying mobilise independently and no harm was sustained
Medication errors	0	0	0	0	0	0	3	0		0	0				All incidents related to delayed or omitted medication
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0		0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	83%	100%	100%	95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 75%	>95%	5%				On track no action required
Activity	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Bed occupancy	78%	68%	77%	29%	39%	Data unavail	Data unavail			<95%	18%				Closed during August
Bed utilisation															
Patient numbers	28	25	38	3	15	31	19	26							On track no action required
Average length of stay	36.5Hrs														

ITU															
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	**Improvement Plan / Actions**
Vacancies Est = 16.16	2.40 WTE 386 hrs	0 WTE 0.0	.44wte 73.0	1.76 wte 292.28	2.76wte 443.5	2.76WTE 458.35	1.76WTE 282.85	1.76WTE 282.85		<5%	10.89%				action required
Temporary staffing Exc RMN Bank / Agency	151.30 280.20	238.40 112.30	124.4 426.0	249.30 414.00	64.00 184.00	119.30 444.00	239.45 600.50	95.20 100.20		<10% 60.6hrs + vacancy	+147.90				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%	1.67%	13.46%		<2%	+11.46%				Significant sickness
Shifts meeting Est Day RN Support	95%	91%	97%	96%	99%	96%	100 58%	93% 125%		>95%	2%				
Shifts meeting Est Night RN Support							102 100	94% 100%							
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target		RAG	Change	Trend	**Improvement Plan / Actions**
Stat and Mand compliance	79.17%	83.60%	76.00%	80.27%	56.42%	78.57%	78.00%	70.00%		>85%	-6.43%				Fallen slightly below target, action required
Appraisals	50.0%	46.67%	33.33%	37.71%	38.46%	53.85%	53.00%	62.00%		>85%	-31.15%				Raised directly with manager
Drug Assessments	95%	97%	97%	94%						>95	-1%				Action required
Budget	-7	-25	-48	-62	-63	-47	-3	-22		>0	-62				Pay oversepnd

ITU	MAY	JUNE	July	Aug	Sept	Oct	Nov	Dec	Jan	DN Rating					
Safe Care	**No/%**	**No/%**	**No/%**	**No/%**	**No/%**	**No%**	**No%**	**No%**	**No%**	**Target**	**Variance**	**RAG**	**Change**	**Trend**	**Improvement Plan / Actions**
Pressure Ulcers	0	0	0	0	0	0	0	1		0	0				On track no action required
Falls	0	0	0	0	0	0	0	0		0	0				On track no action required
Medication errors	0	0	0	0	1	2	2	0		0	0				On track no action required
MRSA/Cdiff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0		0	0				On track no action required
VTE reassessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	>95%	5%				On track no action required
Nutrition assessment MUST/7 day review	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 100%	100% 75%	>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

Peanut															
Staff utilisation	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Vacancies Est = 25.00	1.72wte 286hrs	2.2wte 365hrs	2.2wte 365hrs	.63wte 104.62	.63wte	1.0WTE 166.07	1.35WTE 216.96	1.99WTE 319.82%		<5%	7.96%				No action required
Temporary staffing Exc RMN Bank / Agency	160.15 23.45	289.20 0	328.05 7.30	331.0 35.0	196.45 20.00	212.45 0.00	230.10 25.00	166.00 35.30		<10% 93.75 + vacancy	+212.27				
Sickness	3.8%	4.36%	10.03%	8.43%	6.05%	6.42%	10.87%	4.93%		<2%	+2.93%				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%	100% 89%		>95%					No action required
Shifts meeting Est Night RN Support							106 100	100% 100%							
Training / Appraisal	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	No/%	Target	Variance	RAG	Change	Trend	Improvement Plan / Actions
Stat and Mand compliance	81.3%	85.00%	67.20%	77.69%	58.54%	73.28%	69.00%	63.00%		>85%	-11.72%				Action required
Appraisals	87.1%	96.77	84.38%	87.10%	87.88%	84.38%	78.00%	77.00%		>85%	-0.62%				On track no action
Drug Assessments	100.0%	95.5%	88.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>95%	-8%				On track no action
Friends and Family Test Score	100	100	66	-100	100	88%	100%	100%		>95%	-14				Scoring methodolgy changes to percentage rating
Staff Friends and Family Test Score		79 17													
Budget	-6	-5	-6.6	-12	-17	-15	-18	-25		>0	-12				This is asplit between pay, non pay and income

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

FOOD FOR LIFE CATERING STANDARDS MANUAL

Version 2.0 – 2013

If you purchase free range, Freedom Food or organic eggs you will be meeting and exceeding this standard	**You need to guarantee that all eggs are from cage-free hens by at least one of the following:** • Holding invoices, a declaration or evidence from the supplier that eggs are free range, Freedom Food or organic.	JW to find supplier Already used for eggs + gain declaration	**Quarter 1** **Completed**
Seasonal produce is fresh produce that can be produced outdoors in the UK at that time of year	**To meet this standard you need to:** • Use seasonal ingredients throughout the year • Highlight seasonal ingredients on menus	LS to change menus to comply as required	**Quarter 2** **Completed**
Catering staff are supported with skills training in fresh food preparation and the Catering Mark	**To meet this standard you must ensure:** • Catering staff have been briefed about the Catering Mark Completed, all staff has copy of report and discussed at team brief. • Front of house staff can respond to enquiries about food where it comes from and which animal welfare and environmental standards it meets; once meat supplier changes, Jan 2015 • The caterer proactively communicates about the Catering Mark to customers/patients through displays or other means. Newsletter once meat supplier changes, Jan 2015	AT to brief. LS to confirm at team meeting. All staff working in Outlets. Staff working in outlets to complete displays.	**Quarter 2**
Consider giving catering staff the opportunity to visit local farms and suppliers to see how the food they serve is produced	• Send Chefs to visit local butchers to support local suppliers follow 'Field to Fork'. • Sausages, burgers, meatballs (minimum meat content 62%)	Head Chef to meet with local butchers.	**Quarter 2** **Completed**
You will need to show that free drinking water is prominently available by demonstrating two of the following:	• Your policy to provide free drinking water Covered in Nutritional and Hydration Policy • The location of water dispensers and fountains is actively promoted • Jugs of tap water are available at point of sale or on tables	Add line to policy. JW To make poster. LS to speak to Hurricane staff.	**Quarter 1** **Completed**
You need to guarantee that no fish are served that are on the Marine Conservation Society 'fish to avoid' list by demonstrating you do at least one of the following:	• Specify in contracts that one of the fish supplied are on the Marine Conservation Society ' fish to avoid' list • Have a written procedure for purchasing to be added into catering policy end Jan 2015 • Fish to be breaded or battered on site (not brought in)	LS to check list. LS to write procedure. All chefs	**Quarter 3** **Fish battered on site completed**

You need to ensure products containing undesirable additives and trans fats are not purchased by demonstrating you do at least one of the following:	**Specify in contracts that products must not contain the undesirable additives or trans fats.** • Have declarations from suppliers on file. • Have a written procedure for purchasing • Check all labels • Only purchase organic produce **Information required at inspection:** • Invoices or delivery notes • Copies of the agreements or suppliers declarations or a copy of the purchase procedure.	LS to complete written procedure Labels to be checked by outlet staff. Still waiting on information from NHS suppliers, end of January 2015	**Quarter 3**
You will be complying with this requirement if 75% of the dishes on your menu (s) are freshly prepared from basic unprocessed ingredients:	• To calculate your percentage, add up each of the freshly prepared dishes on your menu rotation and calculate this is a percentage of the total number of dishes.	LS to calculate.	**Quarter 3 Completed**
All met is purchased from farms which satisfy UK welfare standards:	**All meat and meat within the products o the menu must be accredited by one of the following welfare schemes:** • Assured Food Standards (Red Tractor Assurance) • Farm Assured Welsh Livestock (FAWL) • Quality Meat Scotland (QMS) • Farm Quality Assurance Scheme (FQAS) Northern Ireland • EBLEX Quality Standard Mark (English Beef & Lamb Executive) • Organic • Freedom Food	AT to email. CA to gain accreditation. Supplies on Framework unable to give assurance	**Quarter 3 New butcher sourced, waiting for Supply's to set up ordering**
Demonstrate that all meat products on the menu are accredited to one of the welfare schemes by demonstrating you do at least two of the following:	• Specify farm assured meat in contracts or obtain declaration from your suppliers. • Ensure invoices/delivery notes can demonstrate that the products supply comply with this standard – either by product description of product code. • Hold the accreditation certificates on file for all farms which supply you. • Only use organic meat.	As above	**Quarter 3 As above**

Demonstrate that food provenance is conveyed by one of the following methods:	• Information on menus or blackboards • Table talkers or posters • Point of sale materials • Newsletters of flyers • Information on your website	LS to ensure outlet staff are following Newsletter to follow once new meat supplier is set-up	**Quarter 2 News letter**
Demonstrate that you have planned appropriate menus for everyone you cater for by;	• Showing us that you have asked parents/customers/patients for feedback on menus. Completed, surveys, 'tell Amanda' • Using results of customer surveys to plan your menus • Gathering information on the cultural make-up of your customers.	LS to complete using survey from each Chef. 1 x each week. Chefs to take-it-in-turns Surveys to be completed in catering outlets.	**Quarter 4 Completed**
Steps taken to minimise salt:	• All recipes are tested to ensure the minimum amount of salt is used without compromising on taste. Completed, food tested in Spitfire. • Vegetables, rice, potatoes and pulses are not routinely salted when cooking. Completed • Non-salted flavourings (e.g. home made stocks, lemon juice and vinegars, spices, curry powder/paste or mustard powder, frozen, dried and fresh herbs, onions, peppers and tomato paste) are used to enhance the taste of the food. • No extra salt is added to any foods (e.g. chips) prior to service Completed • Access to table salt is restricted .Completed • Only low-salt or unsalted savoury snack foods are available.	LS to check all recipes and remove all salt. Outlet staff to remove all from point of sale. AT to email Ward Managers and ask them to remove salt.	**Quarter ¼ Completed**
Actions to cut plate waste:	• Plate waste is regularly reviewed and the amounts of any frequency wasted items are changed. • Portion sizes are measured to ensure they are suitable for the target audience.	LS, PB, CB to monitor when carrying out patient surveys. Food served at ward level, patients receive the correct portion	**Quarter 3 Completed**

More than 50% of bread on offer is wholemeal:	• Specify in contracts that there must be at least 50% wholemeal bread for sandwiches rolls and wraps. Completed • Check when compiling menus that there will be at least 50% wholemeal bread on offer Completed • Have a written procedure for making or purchasing at least 50% wholemeal bread to accompany meals.	LS to check all menus LS to comply with written procedure	**Quarter 2 Completed**
Fruit is cheaper than desert:	• Fruit offered on the menu must be cheaper than non-fruit dessert options to encourage uptake of fruit and healthy eating. Completed • Please record your prices for fresh fruit and desserts, which we will check on inspection. Completed	Check prices in outlets, outlet staff. LS to send basket each day to wards	**Quarter 1 Completed**
Steps to serve meat in moderation:	• We have reduced the meat used in some dishes and replaced it with vegetables, potatoes or other starchy roots, pulses or wholegrain cereals. • We have reduced the total amount of meat and meat products we use each week. • We are actively promoting non-meat dishes.	LS to follow and produce evidence to show achieved.	**Quarter 3 Completed**
All items to be checked for the following:	• Remove items that contain any of the lists. • Check all brought items, including sacks of sponge mix, stock, flapjacks, sweets etc. •	LS to ensure items are listed and checked. Awaiting confirmation from some suppliers	**Quarter 3**
New menus to be started using the James Martin recipes:	• New menus to be added. Reduce use of meat and show. • Show Kcal amount.	LS to instigate new ingredients to be sourced.	**Quarter 1 Completed**

Appendix 3 Quality Account Priorities 2014/15 Quarter Three Update

The information below summarises progress against the four quality account priorities identified for 2014/15.

Priority 1 Provision of clinical outcome measures

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

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

Quarter One Progress

For quarter one a Project Manager with responsibility to help deliver the six measures for 2014-15 was appointed, but more importantly to shape the means by which outcome measures are collected and presented in the future. All service leads have been consulted and index procedures are agreed for most. The first consultant level outcome measure has been uploaded to the trust website, these were the orthognathic PROMs as planned for quarter one.
We are in the process of consulting external organisations to better understand the resource implications of the project in the future. It is primarily based on information management not information technology, it is in the former that QVH has no substantial resource now or planned for the future and for which we may need to engage those organisations.
The consultant governance database has been revised and will be made available to the medical director and shared with board members as required to provide reassurance on issues of governance.

Quarter Two Progress

We have not published any further consultant level outcome measures for quarter two, we had planned to be in a position to publish data on orthodontics, anaesthesia and breast surgery. Lack of support from the IT company (Jayex) this is holding up the collection of orthodontic PROMs. Though orthodontic outcome scores are available we have opted to wait until we could add in the individual consultant PROM measures.
The anaesthetic outcome data has been collected, this data was recorded manually and the time taken to transcribe this into an electronic format has taken longer than anticipated. This is now completed and the data is due to be submitted to the consultants to agree the validity of the data prior to publication.

The breast outcome database now contains extensive information, but the breast team are not yet in a position to agree validity of the data due to our lack of context to describe accurately differences in case mix and patient co-morbidity. It is hoped that these difficulties can be resolved by partial publication of the data.

All projects are continuing to make good progress but have suffered some delays that were only realised as the project progressed. I would anticipate that Priority one will still be delivered within the year as agreed.

Quarter Three Progress

In the third quarter Jacqueline has been successful in getting further close to publication, these are
Head and neck oncology
Orthodontics
Sleep

Possibilities for publication are Hands (tendon repair rupture rate), anaesthetics (personal patient feedback), breast (reconstruction numbers, flap success, length of stay all by team, note breast free flap reconstructions national outcome data to be run by BAPRAS and has eclipsed the attempts by QVH to publish from our bespoke but less comprehensive database. The BAPRAS data unlikely to report before April 2015, burns (healing time)

Therefore at quarter three we are confident of publishing 4 outcome measures by year end and may be able to reach the intended six measures.

Priority 2 Scheduling of elective surgery

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

We are excluding cancer patients and patients requiring donor tissue from this target as these cases are planned to meet patient's individual needs.

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

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

Quarter One progress

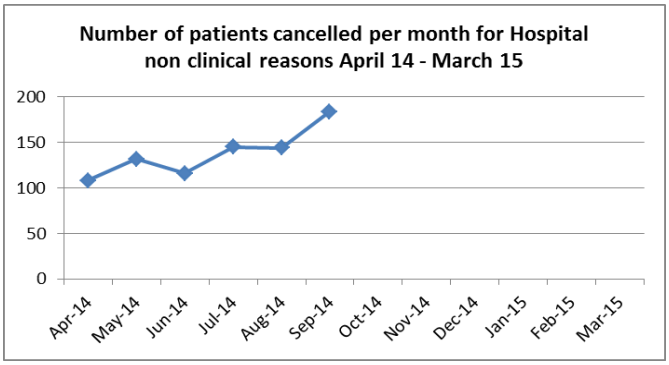
In Quarter 1 the benchmark has now been established for non-clinical reasons for cancellation before admission. An action plan to reduce these is being devised based on analysis of data from Q1. The introduction of the new version of Patient Centre has been delayed and this will now be introduced in Q3, which will allow further refinement of process. This has meant a delay in clarifying the benchmark of the patients booked with 3 weeks' notice. As a result instead of being able to report a percentage of total number of admissions (excluding cancer) per month being booked over 3 weeks, we have only been able to establish that patients are on average booked 34 days ahead of surgery.

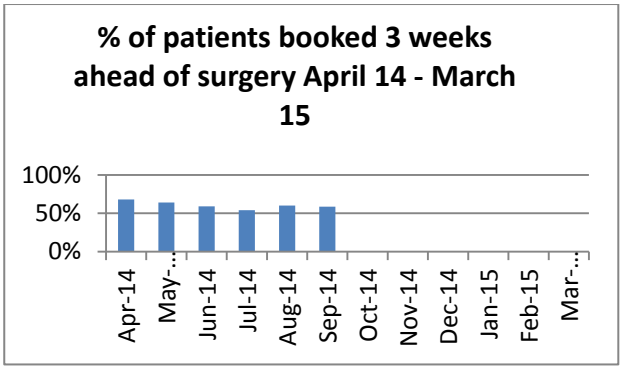
During quarter two we will further refine this data to ensure we can provide the benchmark as a percentage of all patients in advance of the upgrade to Patient Centre. This refined dataset should be in place by the end of July. Once available this information will be used for further analysis to identify trends and create an action plan to target specific areas where this is not being met.

Quarter Two progress

The baseline for hospital non clinical reasons for cancellation was established at the end of Q1 averaging around 118 per month. In Q2 this rose to an average of 144 per month with a peak in Sept of 184. The increase in cancellations in Q2 was predominately due to significant recruitment issues with junior doctors reducing theatre capacity available and higher number of urgent cases that take priority.

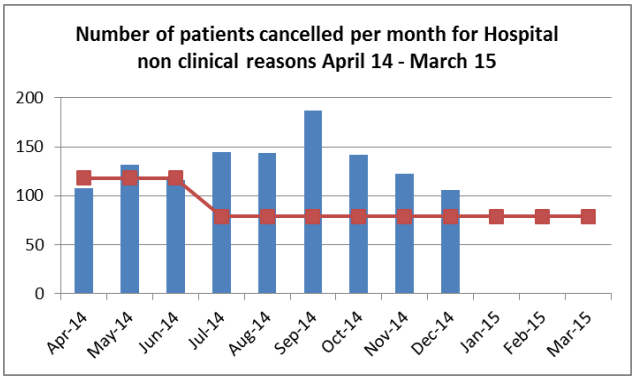
Booking patients 3 week ahead has been hampered across Q1 and Q2 due to significant vacancies and sickness within the secretarial workforce responsible for scheduling. The upgrade to Patient Centre has now been delayed until Dec as further testing is required following the roll out of Windows 7. Despite this there is an initiative is being introduced in November to increase the percentage of patients booked 3 weeks ahead of surgery which will be continued for the rest of the year.

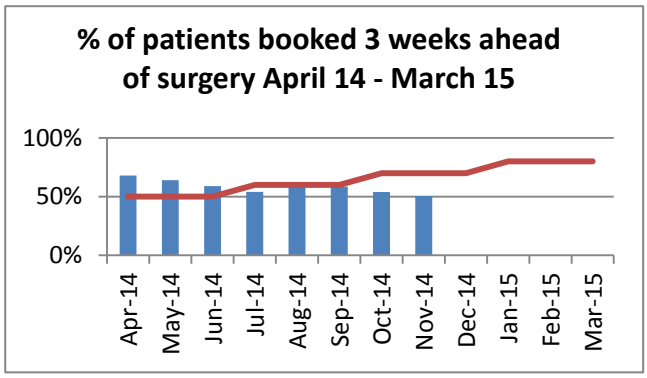




Quarter 3 Progress (Note - Dec data for patients booked 3 weeks ahead still to be confirmed)

During Q3 the number of cancellations cancelled due to non-clinical reasons has steadily reduced as junior doctor vacancies improved and theatre capacity increased in response to national drive to reduce waiting times. The teams are continuing to review processes and now that the new version of Patient Centre is in place the reasons for cancellation are being further refined.





The upgrade to Patient Centre has now been completed in December following the roll out of Windows 7. Despite this progress in booking patients 3 week ahead has declined since September as focus of the Trust has been to reduce overall backlog of patients in line with national drive to improve waiting times. We are continuing to work with our secretarial teams to increase the percentage of patients booked 3 weeks ahead of surgery now that the backlog of patients has been cleared. This will include specifically targeting teams with action plans for improvement for the rest of the year.

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

Our aim is to increase the number of elective patients seen and treated on the same day by at least 50%. The plan for quarter one was to establish a baseline.

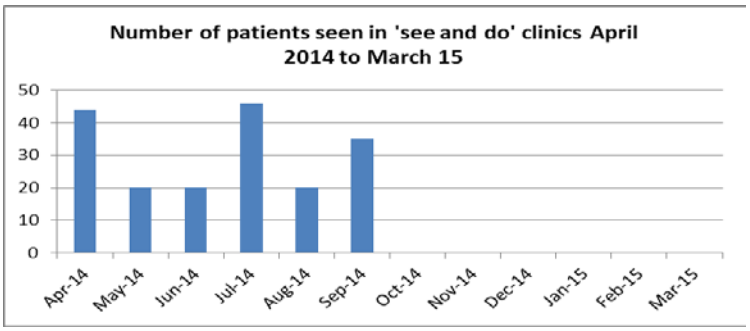
Quarter One Progress

In Quarter 1 a baseline position has been established. Specific clinics were identified for focus on to change to the 'See and Do' model. In May a paediatric minor hand clinic was successfully changed to see and do which has already led to an increase in cases performed on the same day.

Discussions are now underway to change minor local anaesthetic (LOPA) type cases to be treated on the same day as they are seen as OPD, once the Theatre 11 complex is opened. This change is planned to occur in September. We plan to start with identifying one clinic a month to be converted into the see and do model for a number of our plastic surgery consultants who see skin lesion patients.

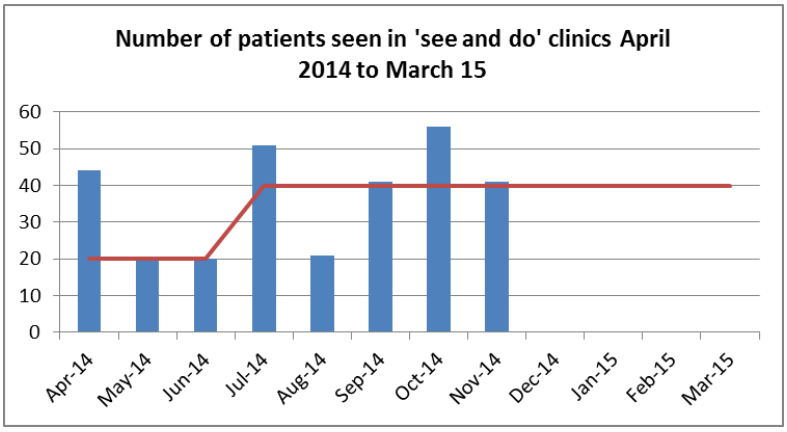
Quarter Two progress

Paediatric minor Hand clinic is now embedded and the Theatre 11 facility opened in Sept. Due to vacancies in recruitment of registrars, Theatre 11 is only 50% utilised, however we are planning from December that a further skin clinic will be developed to offer a see and do service.



Quarter Three progress

During Q3 the new services are now being embedded and we are now consistently ensuring that 50% more patients are being treated on the same day. From January another clinic is planned following the appointment of a locum Skin Consultant and we are planning to further increase the numbers seen during Q4.



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

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

Quarter One Progress

The safe care module has now been purchased and we are awaiting an installation date. In the meantime acuity data continues to be collected each quarter through manual data collection and a summary report has been provided to the board of directors (July 2014).

Quarter Two Progress

A launch meeting for the introduction of the Safer Care module is booked for November 3rd with key staff identified to attend. This will then allow us to commence data collection that allows for a wider understanding of whether staffing is sufficient for the acuity of the patients being cared for.

Quarter Three Progress

Good progress has been made during quarter three; a project team has been identified with a project lead. The team meet formally as the Safecare Project Steering Group for terms of reference are available. The next meeting is

booked for 15th January at which the project initiation document (PID) will be signed off and the risks and issues log reviewed. Training for key staff is booked for January 13th and overall steady progress is reported.

Conclusion

Progress on priorities has not been achieved as expected by the end of quarter three. Work continues within all of them to enable achievement of the end of year goal identified. No significant barriers are foreseen for priorities one, three and four. Risk to achievement of priority two remains but it is hoped that new ways of working will enable this priority to achieve improved results over the next quarter.

Appendix 4 QUALITY ACCOUNT 2014/15 TIMETABLE

The Quality Account for 14/15 is a formal document that requires completion by the end of May 2015. Updates will be provided on the 14/15 priorities and key quality indicators identified under the categories of safety, outcome and experience.

Previous years have seen the document produced as a basic document rather than as a 'publicity' document. The trust needs to agree on the format for the 14/15 quality account, this previously delivered by the DN with input from key staff. The current DN would note the following options for delivery of quality account for 2014/15;

- Retain a simple document and utilise the format of previous years – this would allow the incoming interim DN to manage the delivery
- Identify an external source to redesign and develop the quality account, with the DN, Head of Risk and Clinical Audit lead identified as key stakeholders to support delivery

Below summarises the key actions required to deliver the quality account for 2014/15 taking into consideration that final data cannot be available until after the 31 March 2015 and that stakeholders are required to comment on the document. There is also a requirement to work with the auditors on ensuring accuracy and review of the document as it is developed.

Action	**Where / By**	**When**
Commence identifying priorities for 15/16	DN	November 2014
Discussion regarding process	Q&R committee	January 8th 2015
Send out data request to key internal stakeholders	DN	January 2015
Create long list of priorities for discussion	DN	February 2015
Priorities 15/16 agreement	Clinical Cabinet	Feb 16th
Priorities 15/16 agreement	Q&R committee	March 2015
Priorities 15/16 agreement	Board	March 2015
Draft review	Board members	Email April 2015
Draft sent to external stakeholders for comment	DN	April 2015
Final sign off	Board	May 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Appendix 5

Monthly complaints, claims and patient experience report

1 December 2014 – 31 December 2014

This report provides an overview of all activity during this period. During this period there were 5 formal complaints received. This is a slight decrease of the previous month (7). The following is a summary of the complaints that were received during this period:

Monthly complaints, claims and patient experience report

1 December 2014 – 31 December 2014

Complaints

Open complaints: There were 5 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 – clinical care** – following hand surgery the patient claims they now suffer with problems which they did not have prior to the surgery. **Investigating lead – Clinical Lead**

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

   Comment/Action – Patient was made an appointment for 09.01.15 to be seen and reviewed by the clinical lead.

   .

2. **Medical – clinical care** – Patient raised concerns about the staff that were providing care to them during their surgery. It would appear that the anaesthetic block was administered too soon prior to surgery resulting in anaesthetic wearing off during surgery. This was as the anaesthetists changed the theatre list without informing the surgeon and also the assisting surgeon was 'falling asleep' during the surgery. **Investigating lead – Clinical Lead**

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

   Comment/Action – Still undergoing investigation and awaiting comments. Please note that the individual who was observed to be ‘falling asleep’ has been spoken to. It would appear that he was working extra shifts to cover colleague absences. He has been spoken to about professionalism and has assured that this will not happen again. He has also reassured his consultant that if he is, indeed, tired he will let his seniors know so that he does not have to be put in this situation again.

3. **Nursing/Hotel Services – Communication/food** the patient has raised concerns about the lack of food and choice available to patients who have undergone head and neck surgery. Also family were not expecting patient to be discharged when they were and therefore were unable to collect the patient until the early evening. Patient was therefore sitting in the day room since the morning and was very upset by this. **Investigating lead – Matron/Hotel Services Manager**

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

   Comment/Action – Still undergoing investigation and awaiting comments.

Theatre

4. **Theatre staff – Communication** – Patient was extremely upset by the way the he was contacted by the hospital in relation to the Synergy incident and that there was no offer with the letter that the hospital would be happy to test patients. **Investigating lead – Matron**

   Initial risk grading: **Minor.** Likelihood of recurrence as: **Very unlikely**

   Comment/Action – Case being investigated as a Serious Incident.

Off-site clinic (Darent Valley Hospital) Maxillofacial Unit

5. **Medical – cancelled appointments** – Patient has had their appointments cancelled on several occasions. This appears to be due to sickness or annual leave commitments.

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

   Comment/Action – Patient has been offered an appointment with consultant on 20.01.15

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.

Plastic Surgery

1. **Medical/Nursing – attitude and communication -** Daughter of patient felt that clinician was disrespectful and rude towards patient. After consultation patient was asked to provide an MRSA swab from nose and groin which patient was not prepared for. Both patient and daughter were quite shocked by this. They have suggested that there should be notices in the waiting room to warn patients of this that they may be asked to give a MRSA swab.

   Comment/Action - Apologies have been relayed to patient if clinician was rude in any way as this was not their intention and has fully taken the concerns raised onboard. **Change planned**: Patient has suggested that we place notices in the waiting areas in relation to MRSA tests and having this information within a letter would be beneficial to patients. The Trust is currently considering implementing these changes.

Plastic Surgery

2. **Secretarial Administration** - Failure to place non-insulin dependent diabetic first on the theatre list. This resulted in the patient feeling unwell whilst waiting for surgery and having to be reviewed by an anaesthetist. The theatre list was then rescheduled and patient was immediately taken through for surgery.

   Comment/Action - The information about the patients diabetic status was not relayed to the theatre list scheduler therefore patient was not placed first on the list. The administration staff have been reminded that they must ensure that all relevant clinical information is logged and recorded when booking patients surgery.

Maxillofacial Surgery

3. **Medical -** Following surgery for the removal of supraclavicular lipoma patient alleges that they are now suffering from a loss of movement in their arm and shoulder. Patient claims that they were not made aware of the risks associated with this type of surgery.

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 ENT surgeon and their team.

4. **Medical -** Patient alleges that she was not informed that a lipoma and a nerve were removed during surgery to remove a cyst. Patient now unable to move part of their forehead and referral has been made to the facial palsy clinic (FPC) (05.08.14). Wishes to also know why it has taken so long for them to be given an appt. (27.11/14).

   Comment/Action – The patient received the appropriate treatment throughout and was warned of the associated risks which are clearly documented within the health records and consent form. The patient was appropriately referred to the FPC. Due to annual leave commitments the patient was given the earliest available appointment in November. The patient was reviewed in the FPC and was discharged as no treatment required as muscle function in forehead had resumed.

Theatres/Plastic Surgery/Appointments

5. **Medical/Theatre staff/administration** – Following surgery the patient was booked for a booked follow up appointment (facial palsy clinic) and was placed onto the wrong clinic (general plastics clinic).

   Comment/Action – The consultant who manages the patients surgery writes on the operation list which clinic they want the patient to attend i.e. facial palsy/general clinic. This in turn directs the nurses – it has been suggested that the other surgeons within this team do this as well. **Change planned:** Consultant to discuss this matter with their team.

Sleep Disorder Centre

6. **Medical/administration –** The patient was initially seen in clinic in November 2013. Following a sleep study the patient was informed that a referral would be made to neurological department at PRH. Patient repeatedly chased for this and referral only made on 19 Sept 2014. There was no explanation given within letter to the patient as the reason for the delay.

   Comment/Action - We have been unable to ascertain whether there was an issue with the dictation machine, the letter was not dictated or if it was the secretarial staff omitted to type it up. Apologies conveyed to the patient.

Radiology

7. **Diagnostics -** Failure to diagnose a fractured arm. Patient feels that images should be reviewed by orthopaedic colleagues at Pembury within 24 hours.

   Comment/Action - It is agreed that where there are clinical concerns of an injury that are not obvious on imaging, a specialist orthopaedic opinion should be sought. Clinician has assured patient that this case has been used to emphasise the need for clinical correlation from the clinical imaging team. In addition it has been reiterated to the staff in our Minor Injuries Unit that if they suspect that a patient may have a fracture then they should discuss these concerns with the orthopaedic team at Tunbridge Wells Hospital at Pembury.

Claims

Open claims: There were 0 new claims opened during this period. Overall there are 47 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.

Closed claims: 0 claims were closed during this period.

Patient comments, surveys & Friends and Family Test

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

There were no new comments posted onto the NHS Choices/Patient Opinion websites.

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 December **is 99% of patients would recommend and 0% of patients would not recommend us.**

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

Area	Total Responses	Total Eligible	Response rate	Percentage recommended	Percentage Not recommended
MD ward	68	94	72.3%	99%	0%
RT ward	78	151	51.7%	100%	0%
Peanut ward	4	6	66.7%	100%	0%
Burns ward	18	26	69.2%	100%	0%
Sleep centre	82	111	73.9%	94%	0%
MIU	272	885	30.7%	94%	4%
Trauma	154	358	43.0%	95%	1%
OPD	488	9328	5.2%	97%	1%
DSU	19	460	4.1%	95%	0%

The following chart is a comparison of specialist hospitals and their FFT net promoter scores for November 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	54	78	69.23%	100%	0%
Papworth Hospital NHS Foundation Trust	567	989	57.33%	96%	2%
Queen Victoria Hospital NHS Foundation Trust	157	327	48.01%	97%	0%
The Royal Marsden NHS Foundation Trust	108	261	41.38%	100%	0%
Royal National Orthopaedic Hospital NHS Trust	239	477	50.10%	95%	1%

Stoke Mandeville Hospital	188	710	26.48%	98%	2%

Queen Victoria Hospital NHS
NHS Foundation Trust

Root Cause Analysis Investigation Report

EXECUTIVE SUMMARY

Incident Details

Incident date: 5th August 2014
Incident type: Other :Development of haematoma following surgical procedure
Effect on patient: Major - Loss of Sight in one eye
Severity level: Major

Background and Context

Patient was admitted to Ross Tilley ward on 5th August 2014 following Right Pericranial Flap and Orbital surgery procedure. Patient complained of a throbbing pain at 01:00 at which point a large haematoma was noticed and the patient was unable to open the right eye. The patient ultimately has lost sight in the right eye.

The Site Practitioner was notified and advised that the on call Oculoplastic doctor should be contacted, which was done. A pressure bandage and cold compresses were applied as per telephone advice of on call Oculoplastic doctor, and observations undertaken of the patient. The patient was seen by the Oculoplastic doctor during the night. Emergency Canthotomy was undertaken in the morning by the Oculoplastic Consultant, and the patient was sent for a CT scan.

Loss of sight is a recognised complication of the procedure.

Involvement and support of patient and relatives

An Oculoplastic Consultant discussed the incident with the patient. Following this, the incident was reported on Datix and categorised as an internal Amber incident whilst it was investigated. No log was made of the incident as a complaint by the patient at this time.

On 28 October 2014 the incident was identified as a serious Incident (SI). The incident still remained unrecorded as a complaint on QVH systems. Contact was made with the Oculoplastic Consultant secretary twice on 30 October 2014 and on 4 November 2014 to ask for an update on the investigation. The Site Practitioners were contacted on 5 November 2014 for an update and this was communicated to the Patient Experience Manager the same day and this information was then forwarded to the Head of Risk.

On 13 November 2014, the Head of Risk made contact and it was agreed that a letter of apology and update would be sent to the patient so that it was received by 20 November 2014. It was confirmed verbally that the incident was to be treated as a complaint.

On 14 November 2014 a letter was sent to the patient from the CEO. The letter included reference to inviting the patient (and her family if preferred) to attend the Trust to discuss the incident, the approximate length of time that the investigation would take, and also to confirm that a copy of the SI report would be shared with her. The incident was logged on Datix as a complaint.

On 21 November contact was made to check that the letter had been received (it had). It was confirmed that a response would be compiled over the next two weeks. The Head of Risk confirmed that patient could be met at another location other than the Trust e.g. at the patients home if this was

easier. The Head of Risk also confirmed that a telephone update would be given by 12 December 2014 (although the investigation may not be complete by then).

Involvement and support provided for staff involved

The Nurse Manager for Corneo Plastics who reported the incident spoke to the Head of Risk at the time of the incident and the relevant Matron. The Matron counselled all staff members concerned including offering support via the Trusts OH and counselling services. The Director of Nursing was also informed of the situation.

Detection of incident

The incident was identified by Nursing staff and the Site Practitioner on Ross Tilley Ward on 5th August 2014. The incident was discussed with the Nursing Manager who liaised with the Head of Risk prior to the incident being reported on Datix. The incident was not reported immediately due to the full details being clarified, as loss of sight is a recognised complication of the procedure that was undertaken. The incident was reported on Datix on 31st August 2014, when it was established that a full investigation was required.

Care and service delivery problems

1. The patients observations focussed on the management of the flap and did not include monitoring of the eye e.g. movement, vision, pupils and proptosis.
2. The use of mechanical/chemical thromboprophylaxis should have been agreed with the patient prior to its use/prescription due to the risks associated with loss of vision. A patient information leaflet should have been given to the patient and the risks and benefits of chemical thromboprophylaxis discussed with the patient.
3. Use of non-chemical thromboprophylaxis may have been a more suitable option for the patient, in the opinion of NICE guidelines and hospital policy. Local anaesthesia would not normally require chemical thromboprophylaxis due to the low level of risk of blood clots in an operation under ninety minutes and not involving lower limb surgery.
4. The Oculoplastic Doctor should have contacted the Oculoplastic Consultant for further advice when prompted to do so by the Nursing staff.

Contributory factors

- Lack of a post Orbital surgery care protocol being in place as this would have included correct areas to be checked e.g. eye movement, vision, pupil and proptosis checks.
- Lack of escalation to the On-call Oculoplastic Consultant who was able to provide additional advice and support to the Oculoplastic Doctor providing care to the patient.
- Oculoplastic Doctor who saw the patient should have examined the eye on the night of the emergency when responding to the call
- The thromboprophylaxis medicine will have increased the risk of a significant bleed
- The emergency Canthotomy unfortunately was not performed in good time

Root causes

1. The thromboprophylaxis assessment in the In-Patient prescription chart does not differentiate between local and general anaesthetic procedures and does not make it clear that the Trust protocol does not require chemical thromboprophylaxis medicine to be given in local anaesthetic cases. See action No. 4
2. No protocol in place for monitoring ocular function after orbital surgery. See action no. 2
3. Lack of attention to the care of the eye when the Oculoplastic Doctor was called to see the

patient. See actions 1 - 4

4. Lack of escalation & communication with the Oculoplastic Consultant at the time of the emergency. See actions 1 - 4

Recommendations and Action Plan

Development of a post Orbital surgery care protocol to include eye movement, vision, pupil and proptosis checks

Review the Thromboprophylaxis protocol
a) Design of the assessment section in the drug chart
b) Eye related exclusions to be more prominent
c) Addition of a section to record patient information given to the patient

Action Description (Specific)	Success Criteria (measurable)	Plan (Achievable and Realistic)	Timescale (Time-limited)	Lead (Specific)	Date Completed
1. Review of Junior Doctors training to include reminders of the escalation process	Training in place for rotational staff	Training in place for rotational staff	31/12/2014	RM	31/08/2014
2. Protocol to be developed for post Orbital surgery care to include eye movement, vision, pupil and proptosis checks	Protocol in place	Protocol in place	28/02/2015	RM	
3. Nursing escalation checklist to be developed (similar concept to SBARD/EWS)	Revised protocol in place	Revised protocol in place	28/02/2014	KB AV	
4. Review the Thromboprophylaxis protocol a) Design of the assessment section in the drug chart to include whether patient is having a LA or GA. b) Eye related exclusions to be more prominent c) Addition of a section to record patient information given to the patient	Revised protocol in place	Revised protocol in place	28/02/2015	SF SFi	

Appendix 7 Learning Disability Acute Peer Review Queen Victoria Hospital 2014

Purpose

Queen Victoria Hospital are aware that people with Learning Disabilities often have difficulties accessing their services. They have embraced the need to ensure that people with Learning Disabilities are able to use their hospitals and provide reasonable adjustments to help them do so. So the Peer review helps Queen Victoria Hospital to;

- To review and continually improve the healthcare experience of people with learning disabilities.
- To recognise and share good practice within Queen Victoria Hospital.
- To ensure equitable access to healthcare across the trust
- To make recommendations for local learning disability action plans.

The peer review domains link directly with the Joint Health and Social Care Self-Assessment Framework, NHS Outcomes Framework 2013- 2014 and the Care Quality Commission's National Standards.

Process

A day was spent at the hospital and one team visited both inpatient and outpatients services.
The team was made up of:

A person with Learning Disabilities
A member of staff from Queen Victoria Hospital
A member of staff that specialises in working for people with Learning Disabilities

The team visited different departments and used easy read checklists to look at the following areas.

1.1 Reasonable adjustments
We ask each department if they had an easy read information that you would give or use with people with Learning Disabilities to help them understand, whether they had pictorial menus to help people choose their meals, if they had a copy of the hospital communication book within the department, if they knew what a hospital passport was and whether they read them when someone brought one with them and if they were able to offer flexible appointments or visiting times.

1.2 Learning Disabilities liaison nurse function/ training
We asked each department if they knew who the acute liaison nurse was and how to contact them for support and also whether they had received any training on supporting a person with learning disabilities.

1.3 Referral to acute

We asked each department if they knew prior to the person arriving in the department whether they were told that the person had learning disabilities and if they had any special needs or reasonable adjustments that should be made to make their stay in hospital easier.

1.4 Environmental factors

We looked at whether there were the following facilities within the department

- Adult changing area with changing bed
- Quiet room for waiting
- Were the signs to the toilets clear?
- Was it easy to find the way to the department?

1.5 Carer involvement

We looked at whether the carers were involved in the patients care if they were able to visit and provide support outside of normal visiting hours was there any partnership working between the ward staff and the carers

2.1 Mental capacity Act

We ask the staff if they knew what the mental capacity act was, if they knew who they could contact for support if required and whether they had had training on the mental capacity act.

2.2 Admission, Transfer and Discharge planning

We looked at whether the person's learning disability was being noted on admission and whether their needs were discussed and their discharged planned for.

2.3 Policy Drivers

We asked people if the trust had a Learning Disabilities and a safeguarding policy and if so where was it and had they read it.

2.4 Complaints process

We asked staff how they would support someone with learning disabilities to make a complaint and did they have an easy read leaflet about the process.

2.5 Flagging and Tracking

We asked staff if a flag can be added to let people know the patient had a learning disability and does it include their special needs.

2.6 Assurance of governance arrangements for people with learning disabilities

We asked staff if the hospital had an action plan in order to try and improve the care for people with learning disabilities when they came to hospital.

3.1 Compassion, Dignity and respect

We asked staff whether people with learning disabilities and their carers where asked how the hospital could meet their needs, if they had the opportunity to feedback after their visit to hospital and how they involved carers.

3.2 Choice

We asked staff if people with learning disabilities are offered advocates or IMCA's to help them make decisions about their care requirements.

Appendix 7 Learning Disability Acute Peer Review Queen Victoria Hospital 2014

A variety of staff were questioned in each of the areas; nursing, medical and admin staff. After looking at the areas they were was rated;

Green – Good evidence

Amber – Partial Evidence

Red – Limited Evidence

Results

See appendix 2 for a table of the results for the individual departments assessed

1.1 Reasonable adjustments

Very little easy read information is available throughout the hospital. Not all departments knew where their hospital communication book was. Most people had seen or used the hospital passport – Pre-assessment will hand it out if necessary. Inpatient wards had made their own pictorial menus. All departments are able to offer flexible appointments.

1.2 Learning Disabilities Liaison function/ training

All departments knew about the Learning Disabilities Liaison nurse – Posters with details were on the wards. All staff said that training in Learning Disabilities was available. During the visit to Margaret Duncombe ward the reviewing team found the ward clerk to be very knowledgeable and she showed the team an excellent resource file which was well maintained.

1.3 Referral to acute

The hospital is usually made aware that someone has a Learning Disability in the referral letter. Flagging system available but use is not well established within all departments.

1.4 Environment and Facilities.

No department had a changing area for adults with changing beds although all departments said that they would use an empty cubicle or bed if they were able to, but there were no facilities for disabled visitors requiring a changing bed. All departments could provide a quiet waiting area if required .Nobody available at main reception desk all morning/afternoon. Self-check in system in Out patients department was very user friendly, reviewer with learning disability able to use it with ease. Signs are good with arrows although it is still difficult to navigate around the hospital. An Easy read map has been developed.

1.5 Carer Involvement (family and paid)

All departments said that they involved carers and that they offer flexible visiting times.

2.1 Mental capacity act

Training is available- many of the staff spoken to on the day did not have a clear understanding of how to assess someone's capacity and the best interest process.

2.2 Admission, transfer and discharge planning.

All the areas assessed had a good admission and discharge process.

2.3 Policy Drivers

Reviewing team were informed there was a policy on the intranet, however it was not seen.

2.4 Complaints Process

No leaflets available in any department. Everyone knew who the PALS officer was. No clear signposting to PALS. During visit to PALS department no easy read PALS leaflets available, informed there was one somewhere on the system but no offer to find it.

2.5 Flagging and Tracking

Most departments knew about the flagging system, one ward said that it would be coming into action soon.

2.6 Assurance of governance

Staff were not sure if there was an Action Plan in place, felt it would be somewhere on the intranet.

3.1 Compassion, Dignity and Respect

Feedback Forms are available on inpatient wards but this is not in easy read format.

3.2 Choices

All staff knew how to get an IMCA

Recommendations

1.1 Reasonable adjustments

All staff working in the hospital need to know what tools are available to help them support their patients with a learning disability, staff need to use easy read materials to help the person with learning disabilities understand.

1.3 Referral to acute

Each referral should include when a patient has a Learning Disability and what reasonable adjustments would be help so the hospital and plan to offer the support required.

1.4 Environment and facilities.

The provision of toilets with changing beds. Easy read map should be sent to all patients with their appointment letters. The manning of reception desk to be investigated as to how it can be manned throughout the day when a volunteer is not available as this is a key place for all patients to help navigate their way around the hospital.

2.1 Mental Capacity act

Further work is undertaken to ensure every nurse has a working knowledge of the MCA

2.3 Policy Drivers

For each department to have a policy of the month that their staff should read so they become more familiar with the policies.

2.4 Complaints process

Feedback forms to be devised in easy read format. Easy read leaflet about PALS/complaints to be available in all departments

2.5 Flagging and Tracking

Use of the flagging system to become established throughout the hospital.

Appendix 7 Learning Disability Acute Peer Review Queen Victoria Hospital 2014

For Action Plan- See appendix 1

Report completed by
Christine Mazek
Acute Liaison Nurse
Learning Disabilities Health facilitation Team
Sussex Community NHS Trust
Dec 2014

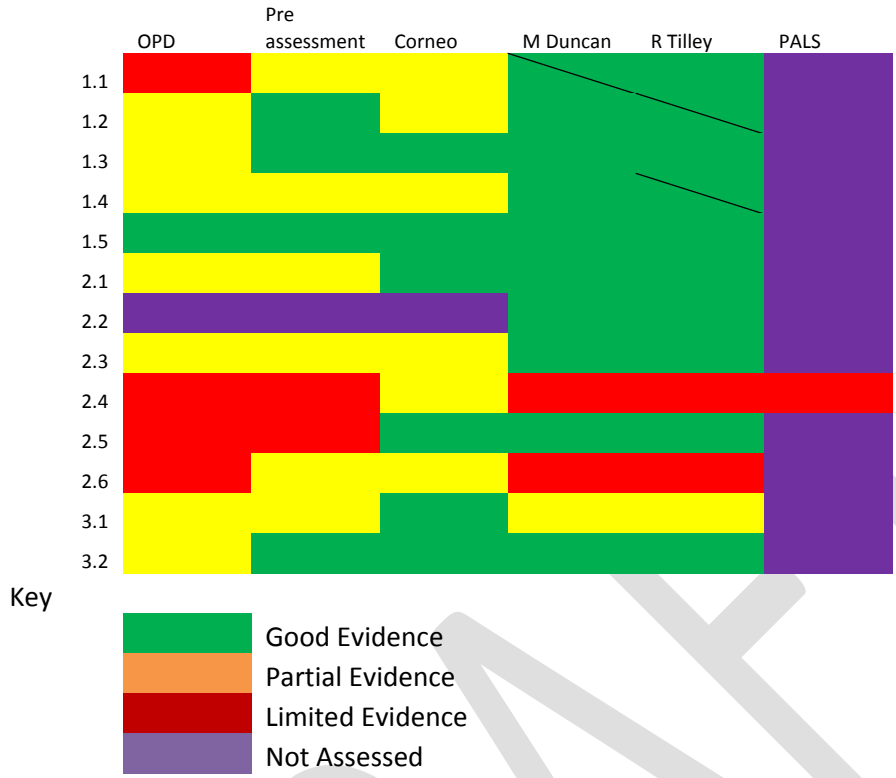
Appendix 1

Action Plan

Domain	Action	By who	By when	Progress made
1.1 Reasonable adjustments	Posters to be developed about tools that staff can use to support the care for people with Learning Disabilities and displayed in staff areas.	Acute Liaison Nurse	Jan 2015	
1.4 Environment and Facilities	To include in future hospital development plans adult disabled changing places	Estates	2020	
1.4 Environment and Facilities	To look at how the reception desk can be manned throughout the day	PALs	?	
2.4 Complaints Process	For PALS to produce and use easy read complaints leaflet	PALs	Feb 15	
2.4 Complaints process	To develop easy read feed back forms so people with learning disabilities can give their feedback about the care they receive.	Patient Experience lead Acute Liaison nurse to give the patient experience lead some examples		

Appendix 2

Queen Victoria Hospital – East Grinstead



Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29th January 2015
Reference number:	007-15
Report from:	Jane Morris, Interim Head of Operations
Author:	Jane Morris, Interim Head of Operations
Report date:	20th January 2015
Appendices:	Appendix A – Commerce KPI report

Operational performance: targets, delivery and key performance indicators

Key Performance Indicators

1. Trust income from patient activity was slightly under plan in Month 9.

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

3. The Trust was also compliant in December for all three 18 week performance targets at a speciality level except for Oral Surgery Non-admitted. Despite the significant reduction in backlog within Orthodontics in November the speciality still carried over 19 breaches. In addition the Maxillo-facial department also incurred a number of delays in patient pathways due to the Cone Beam CT Scanner breaking down in November, These combined caused Oral Surgery speciality to be non-compliant for December, i.e. reporting 94.4% against compliance target of 95%.

4. The Trust is forecasting compliance for all three 18 week targets in January. There is a risk that Oral Surgery may not be complaint at a speciality level for admitted.

5. There are no breaches of 52 weeks forecast for December.

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

7. There were no urgent operations cancelled in December.

8. There were no patients cancelled on the day of admission in December.

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

Implications of results reported

18 weeks

10. The Trust has achieved both the national and Monitor requirement to be compliant at an aggregate level for all three 18 week performance targets by December.

11. As the Trust has achieved backlog reduction and compliance by 1st December, no penalties are expected to be applied from July to November, as per the agreement reached with the CCG's earlier this year.

Actions being taken to achieve compliance

18 weeks

12. Key actions in place

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

Cancer

13. 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

14. 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

15. 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.

16. 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

17. Risks associated with this paper, will be reviewed following the submission of December's performance figures to the Department Health and Corporate Risk Register will be updated accordingly, before the Trust Board in January

Regulatory impacts

18. 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

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

KPIs Progression

Previous Months:

Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Operational Standards	Threshold
90.5%	90.8%	88.0%	85.0%	83.0%	84.7%	86.9%	86.7%	91.6%				Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral	90%
95.1%	96.6%	94.1%	94.0%	92.6%	92.2%	91.6%	84.9%	95.7%				Percentage of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	95%
93.3%	92.4%	91.5%	91.3%	90.5%	90.6%	91.8%	95.4%	95.9%				Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	92%
100.0%	100.0%	100.0%	100.0%	99.8%	98.1%	99.1%	96.8%	99.6%				Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	99%
99.5%	99.5%	99.3%	99.8%	99.3%	99.2%	98.4%	99.5%	TBC				Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%
96.6%	96.9%	99.3%	94.6%	99.0%	99.1%	96.8%	95.0%	TBC				Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93%
#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A				Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for OPFA	93%
97.9%	95.6%	94.5%	97.5%	96.9%	98.7%	96.1%	100.0%	TBC				Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96%
97.6%	95.2%	98.0%	98.0%	93.5%	100.0%	92.3%	100.0%	TBC				Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	94%
92.3%	87.5%	84.6%	75.0%	80.5%	88.2%	94.1%	96.9%	TBC				Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85%
66.7%	0.0%	0.0%	66.7%	100.0%	50.0%	66.7%	#N/A	#N/A	deminimis 5 cases in quarter - we'			Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	90%
100.0%	100.0%	#N/A	100.0%	#N/A	100.0%	#N/A	#N/A	#N/A				% of Service Users waiting no more than 62 days for 1st definitive treatment following a consultant's decision to upgrade the priority of the Service User (all canc	85%
1			0			TBC						Operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons not offered another binding date within 28 days	0
0	0	0	0	0	0	0	0	0				Zero tolerance MRSA	0
0	0	0	0	0	0	1	0	0				Minimise rates of Clostridium Difficile	0
0	1	3	2	0	1	1	0	TBC				Zero tolerance RTT waits over 52 weeks for incomplete pathways	0
99.2%	99.3%	99.5%	99.4%	99.4%	99.4%	99.4%	99.4%	TBC				Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (APC)	99%
99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	TBC				Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (OP)	99%
99.4%	99.0%	98.7%	98.4%	98.4%	98.3%	98.3%	98.3%	TBC				Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	95%
0	2	2	0	1	0	0	0	0				No urgent operation should be cancelled for a second time (Monthly SITREPs)	0
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%				VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95%
TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE				Publication of Formulary	TRUE
0	1	0	0	1	0	0	0	0				Never Events	0

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 29th January 2015
Reference number: 008-15
Report from: Jane Morris, Interim Head of Operations
Author: Jane Morris, Interim Head of Operations
Report date: 21st January 2015
Appendices: A: Increasing trauma Capacity Business Case

Increasing trauma Capacity

Background

1. The vision for trauma services at QVH includes creating capacity for growth to further improve trauma services by reducing waiting times by offering one stop services and provide increased support to lower leg trauma within the region.

2. In order to facilitate this vision increasing trauma capacity is a priority for the Trust and is one of the organisation's key clinical strategies within QVH 2020

3. This has resulted in a piece of work that has reviewed and refined 13 options before deciding on a single preferred model that provides two main lists for complex cases and a further one for hand trauma, as set out below

Description Future Capacity
Trauma Theatre 1 – 8.30-10pm 7 days a week (77hrs)
Trauma Theatre 2 – 830-5pm 5 days a week (40 hrs NEW capacity)
Hand Trauma – Weekdays 9am – 5pm (40hrs) and 9am – 1pm at weekends (8hrs NEW capacity

4. This proposed model increases the total trauma capacity from 117hrs per week to 165 hours which is an increase of 30%. However it should be noted that this will generally be 80% utilised.

5. In order to facilitate this model alterations are required to the physical space within Rowntree which includes converting a disused patient changing room at an estimated cost of 70K.This will then enable the creation of a Day treatment unit to move existing lists to create three theatres allocated to trauma in the main theatre block.

6. The attached document is the business case presented to clinical cabinet in January to increase trauma capacity during 2015/16 and covers
   - Staffing requirements and cost implications
   - Income and activity projections
   - Patient experience

7. As demand for trauma is difficult to predict the proposal shows both a 5% and 10% growth in activity (4 and 8 additional cases per week respectively)

8. Any planned increase to trauma activity must be included as part of business planning, in order to agree a baseline with commissioners as part of QVH discussions surrounding ERT so that the Trust is not adversely affected.

9. 5% increase in activity would mean this proposal just about breaks even however there is also a strong quality case as to why QVH needs to consider increasing theatre capacity for trauma.

10. Implications for not implementing this proposal are outlined including not being able to deliver the Trust's plans for Trauma as part of QVH 2020.

11. The full business case was approved by Clinical Cabinet on the 19th January.

Link to Key Strategic Objectives

7. This proposal relates to the following key strategic objective

- QVH 2020 Clinical Strategy
- Outstanding patient experience
- Operational excellence
- Financial sustainability

Implications for Board Assurance Framework or Corporate Risk Register

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

9. No new risks have been identified.

Regulatory impacts

10. Nothing within the paper attached indicates that the organisation is not fully compliant with the Care Quality Commission's requirement for the Trust to be
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

11. There is no impact on the Trust's Monitor governance risk rating or continuity of service risk rating as a result of this paper.

Recommendation

12. The Board is asked to endorse the decision of the Clinical Cabinet to progress with the implementation of this proposal to increase trauma capacity.

Queen Victoria Hospital NHS
NHS Foundation Trust

Appendix A - Increasing Trauma Operating Capacity
Business Case

1. Executive Summary

1.1 This paper outlines the business case for the final proposal to increase the Trauma theatre capacity in 2015 based on work carried out last year after considering a number of options.

1.2 The paper describes the model being put forward and covers the following in detail

- Estate requirements
- Patient experience
- Staffing requirements and cost implications
- Income and activity projections

1.3 The Clinical Cabinet is asked to approve the model being put forward for implementation from Q2 in 2015/16.

2. Background

2.1 Increasing trauma capacity is a priority for QVH and is one of the organisation's key clinical strategies. The work to date has included reviewing and refining a total of 13 separate options (which are available on request). This has now concluded and has resulted in the emergence of a preferred model which facilitates providing two lists for complex cases and increased hand trauma capacity, as outlined below

Description Current Capacity
Trauma Theatre 1 – 9.00-10pm 7 days a week (77hrs)
Hand Trauma – Weekdays 9am – 5pm (40hrs)

Description Future Capacity
Trauma Theatre 1 – 8.30-10pm 7 days a week (77hrs)
Trauma Theatre 2 – 830-5pm 5 days a week (40 hrs NEW capacity)
Hand Trauma – Weekdays 9am – 5pm (40hrs) and 9am – 1pm at weekends (8hrs NEW capacity)

2.2 This proposed model increases the total trauma capacity from 117hrs per week to 165 hrs which is an increase of 30%. However it should be noted that this will generally be 80% utilised. It is proposed that this capacity will be used as follows but it can be flexed between the specialities as required, without impacting on elective workload.

- Trauma Theatre 1 would be allocated to Plastics for all complex cases.
- Trauma Theatre 2 would be allocated to Max Fac, Corneo, Lower leg trauma and any returns to theatre.

- Hand Trauma – would continue to be allocated as it is now i.e. taking cases less than 3 hours under LA / Nerve Block.

2.3 By allocating the capacity in the proposed way, means that current resources allocated to Trauma would no longer need to compete for the same theatre. Therefore the model being put forward provides additional capacity but is less dependent on recruitment than some of the options previously examined. This is because it uses existing medical staff who are otherwise allocated at the same time to trauma from different specialities.

2.4 Initially it would be feasible to implement this mid-week during early part of 15/16, whilst the departments recruit additional staff to extend as planned for weekends. The exact staffing requirements and estate changes to facilitate this are set out in subsequent sections.

3. Estate requirements

3.1 Any option to increase trauma capacity at QVH was predicated on the relocation of the current OPLA (outpatient procedure under local anaesthetic) service. Three estate options were looked at in detail including costs, ease of implementation, advantages and disadvantages, summary of which is provided in Appendix 1

3.2 Initially the concept was that OPLA's moved to enable Hand trauma to be reallocated to the old Rowntree unit to make way for a second Trauma list for complex cases in main theatres, but in order to achieve this there was an estimated equipment cost in the region of £300k. In addition to this factor it was also felt clinically that trauma would be easier to manage if all three theatres were together within main theatre complex.

3.3 This in turn would provide more effective use of resources and staffing rather than having it spread to another area within the site. This also had the additional effect of providing a focal point for a key part of our trauma services. The estimated cost for equipment by keeping Hand Trauma within main theatres is also significantly cheaper at £57K.

3.4 Therefore the final option being put forward to create the physical space to increase our trauma capacity is as follows

i. converting a disused patient changing room in Rowntree for OPLA's at an estimated cost of 70K and

ii. then using the Old Theatre 8 and 9 either side to move existing lists in order that 3 theatres can be allocated to trauma in the main theatre block.

3.5 This proposal is heavily reliant on the agreement from all Consultants that a number of existing lists will need to move from main theatres to old Rowntree as specific Local anaesthetic day case sessions. Whilst this may not be appealing initially to clinicians, as it would give rise to a number of scheduling issues, it does provide the opportunity to create a dedicated consultant led Day Treatment Unit. This could be used by all specialities for minor procedures as well as enabling the organisation to increase see and do clinics in the same facility. This would also reduce the overall throughput of patients using both the admission and discharge area in main theatres.

3.6 It does however mean that the potential to relocate Trauma clinic to be based near Hand Trauma from MIU will need to be deferred until a decision about our wider estate for the 'front door' is clarified.

4. Patient Experience

4.1 Trauma activity has remained quite static over the last few years as the current service has reached a maximum level of capacity and is on average turning away up to 4 referrals a week. In addition, during 14/15, the service has seen an increased number of occasions where elective cases were cancelled, to accommodate trauma due to lack of theatre capacity resulting in some cases being operated on out of hours.

4.2 Therefore increasing trauma capacity at QVH is seen as crucial to ensuring QVH can provide an enhanced patient experience in the following ways

- Almost eradicate the need to operate on cases out of hours between 10pm – 1am
- Ensure that 90% of cases are treated within 24hours of admission is always achieved
- Reduce the risk in cancelling elective cases to zero
- Reduce the occasions that the Trust restricts admissions for trauma
- Reduce the incidents of Trauma cases who were starved being cancelled more than once
- Almost eradicate the need for trauma list order changes as cases would no longer need to compete for one theatre
- Reduce overall patient's waits for treatment and length of stay.
- Reduce patients having to travel long distances for multiple journeys for treatment as QVH will be able to increasingly offer assessment and surgery on the same day.

5. Staffing requirements and Cost implications

5.1 Staffing and the associated costs for introducing the preferred model for increasing trauma capacity have been calculated at £390,000 per year. The details are shown in Appendix 2.

5.2 Two registrar posts are needed in Plastics to ensure that the increase in trauma capacity can be covered, especially at weekends, as well as to ensure elective activity is maintained. However one of the registrar posts required for this proposal, could also have a job plan that fits in with another opportunity we are currently discussing with BSUH. This involves having two fellow posts (one funded by BSUH) to support lower leg trauma in Brighton that would rotate between QVH and the Royal Sussex site. Again this would further strengthen our partnerships with BSUH as the region's trauma centre as well as possibly attracting more junior doctors to work at QVH.

5.3 Longer term there may be opportunities, as more cases are done within hours, to reduce the junior on call commitments especially within Plastics after 10pm.

5.4 Any concerns about downtime in trauma theatres during quiet periods could be used to help elective lists as required and ensure patients are seen and treated quickly in trauma clinic or by providing additional staff to busy clinics so that all sessions don't overrun.

6. Income / activity projections

6.1 The unpredictability of trauma demand in the future has made it hard to predict the impact of the proposed option on activity and income. Theoretically the proposed model provides additional capacity that would ensure current trauma patients are treated a lot quicker. It would also potentially negate almost all operating after 10pm. Both of which improve the overall quality of the service provided.

6.2 Although the case for increasing trauma capacity based on improved quality is strong on its own, it is conceivable that any increase to QVH's trauma capacity will inevitably mean more patients are referred. For example, just reducing the number of patients turned away each week could result potentially in another 200 cases a year being treated at QVH.

6.3 In addition QVH has been approached by both BSUH and Kings to provide support to lower leg trauma but it is difficult to accommodate this work currently. However it would be more feasible if this model was implemented and so we would treat more patients. If we can provide more support to these MTC units it would further strengthen our partnerships with these organisations which in turn could be advantageous in the long term for our Burns service.

6.4 Commissioners have also recently indicated support in principle for QVH to invest ERT monies in increasing our trauma services especially when they might reduce NEL pressures on neighbouring organisations.

6.3 Whilst it is difficult to predict exactly the activity and income implementing this proposal would generate, it is especially crucial to ensure in contract discussions any potential increase is included in a baseline as the ERT threshold is changing next year to 50%. However it is not reasonable to forecast activity based on the level of capacity increase i.e. 30%, because we will not be utilising 100% of all trauma lists and there is an element that this proposal moves existing cases to be operated on in normal hours rather than just new activity.

6.4 Instead a more realistic suggestion is to look at how much activity we would need to operate on in order to cover all costs needed to put this proposal in place. Excluding capital this is currently estimated at £470,098 (5%) / £493,196 (10%). Therefore if we increased our activity by 5% i.e. 4 hand cases per week, based on activity to date, it is feasible that the increase in trauma capacity would be at almost breakeven (see figures overleaf).

£9,183,632	FOT income
4,134	FOT activity
2,221	average £ per spell
924,139	income from 8 additional hand cases per week
462,069.51	income from 4 additional hand cases per week
5	% increase in income from 4 additional hands

6.5 In addition there would also be cost savings by reducing the current pre-op LOS for NEL admissions and on call costs for theatre teams. Increasing activity by just 4 patients a week would also have minimal impact on beds if the cases are predominately hands however it is recognised that increased numbers of lower leg trauma longer term may change this. Therefore it would need to be kept under close review.

7. Options Appraisal

Option 1: *Do Nothing*
Advantages: ▪ No on-going commitment to employ further staff ▪ Status quo means there is no requirement to manage significant change project
Disadvantages: ▪ Continue to turn away referrals and go on 'restricted' which puts additional strain on other parts of the NHS who are already under significant pressure ▪ Unable to deliver QVH 2020 strategy for trauma ▪ Unable to offer capacity to develop lower leg trauma support for Kings or BSUH MTC's which in turn may place strain on our relationships with these organisations ▪ Cases would continue to be done out of hours regularly between 10pm – 1am ▪ Continue to struggle to treat 90% of cases within 24hours of admission ▪ Elective cases increasingly being at risk of being cancelled ▪ Potential to have increased incidents of Trauma cases who were starved being cancelled more than once ▪ Regular list order changes due to clinical priorities competing throughout the day ▪ Patients having to wait longer for treatment and increased length of stay ▪ Patients travel long distances for multiple journeys for treatment as QVH is not always able to offer assessment and surgery on the same day

Option 2: *Increase trauma capacity as proposed*
Advantages: ▪ Additional capacity would almost completely negate all of the disadvantages mentioned in Option 1. ▪ Ability to grow our service and respond to request for support from Kings and BSUH MTC's ▪ Additional staff employed would enable QVH to offer same day assessment and treatment ▪ More daytime operating will lead to greater senior supervision of cases improving quality of care provided ▪ Proposal potentially has the ability to reduce pressure on the regions A&E departments by assessing and treating more patients ▪ Proposal could be put forward to secure ERT 50% with commissioners as part of contract negotiations.
Disadvantages: ▪ Additional costs for 15/16 for estates, equipment and staffing to put in place which may mean other developments are deferred ▪ No guarantee investment will result in increased activity or demand as trauma is unpredictable ▪ May have problems in recruiting at a time when NHS is seeing national shortage of staff.

8. Financial Summary

8.1 The below table indicates the financial summary of putting this proposal in place. Overall the proposal will almost break even by an increase in 5% activity i.e. 4 cases per week assuming that the conversion of the changing room comes from 15/16 capital budget. Any additional activity above and beyond this would enable a positive contribution to the Trust's surplus.

	Cost	Income benefit (5%)	Income benefit (10%)
Total Staffing	£ 390,000 (inc on costs)		
Equipment	£57,000		
Non pay	£23,098 (5%) / £46,197 (10%)		
		£461,968	£923,936
Total	£470,098 (5%) / £493,196 (10%)		

9. Risks

9.1 If this proposal is not adopted all of the issues highlighted below would continue

- Cases done out of hours regularly between 10pm – 1am
- Increasingly struggle to treat 90% of cases within 24hours of admission
- Elective cases increasingly being at risk of being cancelled
- The Trust restricting admissions for trauma on a more regular basis
- Increased incidents of Trauma cases who were starved being cancelled more than once
- Regular list order changes due to clinical priorities competing throughout the day
- Patients having to wait longer for treatment and increased length of stay
- Patients travel long distances for multiple journeys for treatment as QVH is not always able to offer assessment and surgery on the same day.

9.2 Not going ahead would also mean that the Trust would not be in a position to deliver many of its key aims of the organisation's strategy for Trauma (see table below and Appendix 1 for details). The additional capacity is fundamental to enhance further the quality of QVH's current trauma service.

9.3 It should be recognised that there is potentially no guarantee that this investment will result in increased activity or income. However the strength to progress this proposal on just the grounds of improving the quality of QVH current trauma service is very strong and this needs to be taken into account when assessing the financial risk this model poses to QVH. Despite this, doing nothing means we will not be in a position to mitigate this as we won't be able to grow our capacity to offer services to the two MTC's who are keen for QVH support to treat lower leg trauma.

10. Recommendation

10.1 It is recommended that the model being put forward to increase trauma capacity by 30% is approved, along with the associated costs to put this into place during 15/16. The Clinical Cabinet are also asked to note that this proposal is also reliant on the creation of a Day Treatment Unit which will require commitment from all Consultants to agree that existing lists will need to move from main theatres to old Rowntree as specific LA DC sessions.

11. Next Steps

- Agree full business case for increasing trauma capacity at Clinical Cabinet in January
- Agree capital expenditure to be allocated in 15/16 to facilitate move of OPLA's
- Progress via Estates the work required to convert the patient changing area in old Rowntree unit to facilitate the move of burns including design, quotes, tender etc. Aim to be complete by the end of Q1.
- Discuss and finalise detail to move existing elective lists from MTR from all specialities on a rotating basis to create 2 theatres dedicated to LA DC only sessions in the Day Treatment Unit either side of the relocated OPLA's
- Finalise activity plan as part of business planning and contract negotiations with CCG's
- Continue discussions with BSUH to agree joint registrar posts to support this proposal
- Set up a dedicated task and finish group to oversee this project that feeds into the Trauma Management group and reports progress to Clinical Cabinet
- Recruit additional nursing staff and registrar post with aim to have these in place by Q2.

Appendix 1

Option	Advantages	Disadvantages	Ease of implementation	Costs
A. Using old theatre 7	None, other than facilitates the move of OPLA's	• Burns storage would need to be re-provided • Further work would be needed to also ensure infection control measures recently put into place for Burns are not impacted • Theatre would need to be completely refurbished as is not compliant with current standards • Old Theatre 7 is fed from the old theatre plant which would need to be reactivated	Difficult	Significant
B. Creating a treatment OPLA area in a disused changing room area within Rowntree.	• Facilitates the move of OPLA's • As area is currently not in use it would have minimal impact on the rest of the unit • The consulting rooms in Rowntree could be used to accommodate and increase number of see and do clinics • Facilitate the development of a dedicated Day Treatment Centre • Room would be close to other LA procedures and so cover is more robust if juniors run into difficulties	• Increasing use of Rowntree would only be limited to LA DC type of procedures as there is no longer piped gases or adequate air changes for accommodating complex procedures and so will need to rely on portables	Moderate – as will need to tie into planning to move existing lists from MTR	Estimated £70K
C. Using a room on the ground floor known as MOPD T/A/M. This would be free 10 sessions a week if audio booth was relocated.	▪ Facilitates the move of OPLA's	▪ Audio booth would need to be relocated and currently there is no space in OPD to facilitate this ▪ Room identified is remote and if junior doctor ran into difficulties it may cause issues to seek help especially if no Plastic surgeons are running clinics ▪ Building is rented and so would be difficult to put in overhead light and make any other alterations. ▪ No piped gases or suction in place so would need to rely on portables	Difficult	Unable to cost as building is rented

Appendix 2

Option			Growth	5%	Growth	10%
Activity / Revenue						
		Income / patient £k	**Patients**	**£k**	**Patients**	**£k**
		2,221	208	461,968	416	923,936
		Income		**461,968**		**923,936**
Pay						
	Grade	**Cost/WTE in £k**	**WTE**	**£k**	**WTE**	**£k**
Medical Staff (Service Line)	Registrar	70000	2.0	140,000	2.0	140,000
Anaesthetic Staff	Consultant	100000	0.0	0	0.0	0
Theatre Staff	Total					
Band 6 - 47.5hrs per week	M-F		1.26	50,000		50,000
Band 5 - 95hrs per week	M-F		2.53	83,000		83,000
Band 2 - 95hrs per week	M-F		2.53	51,000		51,000
Band 6 - 24hrs per week	WE		0.64	35,000		35,000
Band 5 - 18hrs per week	WE		0.48	22,000		22,000
Band 2 - 12hrs per week	WE		0.32	9,000		9,000
		Pay		**390,000**		**390,000**
Non Pay						
		% of income				
Theatres	Consumables etc.	5		23,098		46,197
		Non Pay		23,098		46,197
		Contribution		**48,870**		**487,739**
		Contribution %		***11***		***53***

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 29th January 2015
Reference number: 009-15
Report from: Dominic Tkaczyk, Director of Finance and Commerce
Author: Dominic Tkaczyk, Director of Finance and Commerce
Report date: 21st January 2015
Appendices:

Finance Report M9 December 2014

Key issues

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

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	4,700	4,820	(120)	45,714	44,522	1,192
EBITDA	431	332	99	4,314	4,250	65
Surplus	92	36	56	1,715	1,585	130
Continuity of Service risk rating (CoSRR)	4	4	-	4	4	-

NB table subject to rounding differences.

2. The Trust is £130k ahead of the surplus plan for the year with increased income largely offset by increased costs. In month the Trust made a surplus of £92k being £56k ahead of plan.
3. The Trust is maintaining a Continuity of Service Risk Rating of 4.

Implications of results reported

4. Achieving the surplus of £1,715k to Month 9 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
December 2014
Month 9
21 January 2015

Executive Director: Dominic Tkaczyk

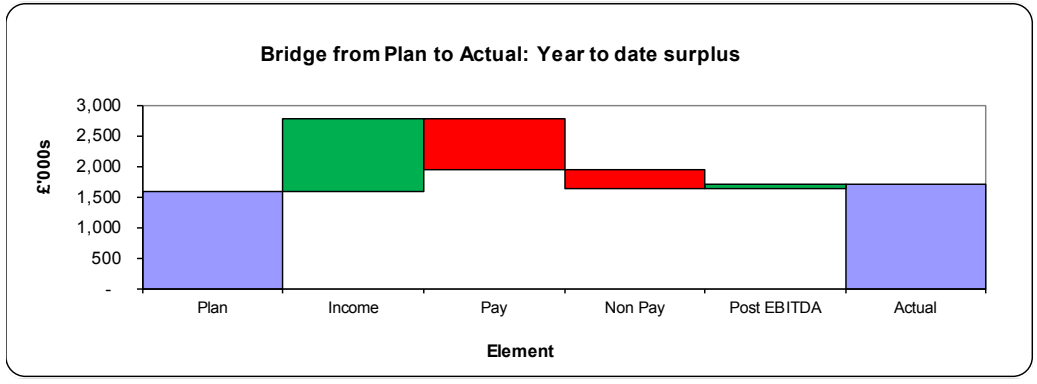
Contents

Summary Actual Position – YTD M9 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Income and Expenditure	Annual Plan £k	M9 13-14 CM Actual £k	Current Month-December Actual £k	Budget £k	Variance £k	M9 13-14 YTD Actual £k	Year to Date 14/15 Actual £k	Budget £k	Variance £k
Income	59,551	*4,781*	4,700	4,820	(120)	*43,766*	45,714	44,522	1,192
Pay	(38,401)	*(3,376)*	(3,321)	(3,215)	(106)	*(28,503)*	(29,574)	(28,757)	(817)
Non Pay	(15,394)	*(1,310)*	(948)	(1,273)	325	*(11,652)*	(11,825)	(11,515)	(310)
EBITDA	5,756	*94*	431	332	99	*3,612*	4,314	4,250	65
EBITDA %	*9.7*	*2.0*	*9.2*	*6.9*	*2.3*	*8.3*	***9.4***	*9.5*	*-0.1*
Post EBITDA	(3,553)	*(295)*	(339)	(296)	(43)	*(2,391)*	(2,600)	(2,665)	65
Donated/(Impaired) assets		*(602)*				*(488)*			
Surplus (Deficit)	**2,203**	*(803)*	**92**	**36**	**56**	*732*	**1,715**	**1,585**	**130**
Surplus (Deficit) %	3.7%	-16.8%	2.0%	0.7%	1.2%	1.7%	3.8%	3.6%	0.2%

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.
- Activity income for December was below plan.

Issues

- The year to date surplus of £1,715k (3.8% surplus) is consistent with the annual plan of £2,203k (3.7% surplus) .
- Income includes the recognition of 100% of CQUIN for the first two quarters and 75% for the rest of the year.
- Income reflects estimated performance penalties of £626k year to date. These are subject to confirmation.
- Pay costs include additional interim agency costs covering vacancies and initiatives.
- Non-pay costs include the release of £655k of provisions and the accrual of £300k to dispose of the leased operating theatre.
- 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 – M9 2014/15

Queen Victoria Hospital NHS Foundation Trust

Full Year Forecast at Month 9	Plan £k	Downside	Downside £k	Upside	Upside £k	Midpoint £k
Income	59,551	Current levels less quality and activity risks	61,095	Current performance to plan plus growth continues with increased quality	61,555	61,325
Pay	(38,401)	Actual levels plus overspends	(39,339)	Increased activity and cost control.	(39,279)	(39,309)
Non-Pay	(15,394)	Historic overspending continues	(15,824)	Increased activity and cost control.	(15,764)	(15,794)
ITDA	(3,553)		(3,488)		(3,488)	(3,488)
Surplus	2,203		2,445		3,024	2,734

Summary

- Achievement of planned surpluses for the remainder of the year would give an outturn of £2,573k, i.e. £1,715k achieved to M9 plus £618k plan for Q4 plus £240k additional income from donated assets.
- The downside forecast is for a surplus of £2,445k with an upside forecast of £3,024k, giving a midpoint of £2,734k.
- 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 ERT provision of £655k that reflected the estimated risk to income in 2013/14 has been released.

Risks

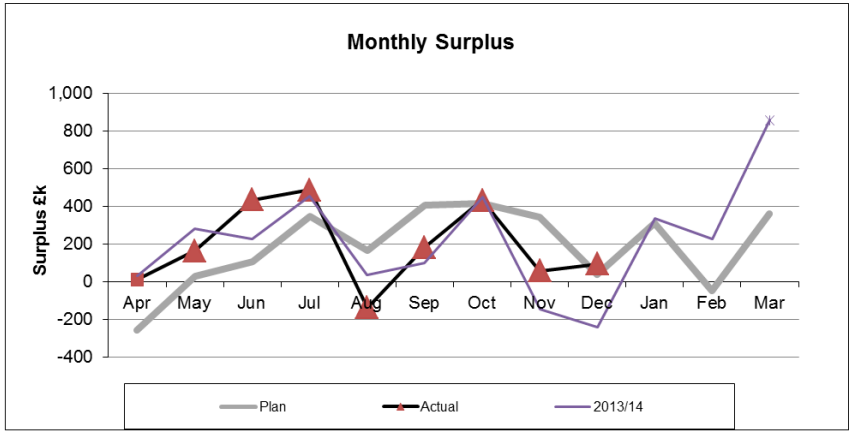
- The Trust surplus is sensitive to the achievement of the agreed activity/income plans .
- The operational pressures around staffing means that cost control remains critical.
- Penalties are assumed at year to date levels so the financial position would improve if the RTT18 penalties of £131.6k for Q2 were waived by the commissioners.

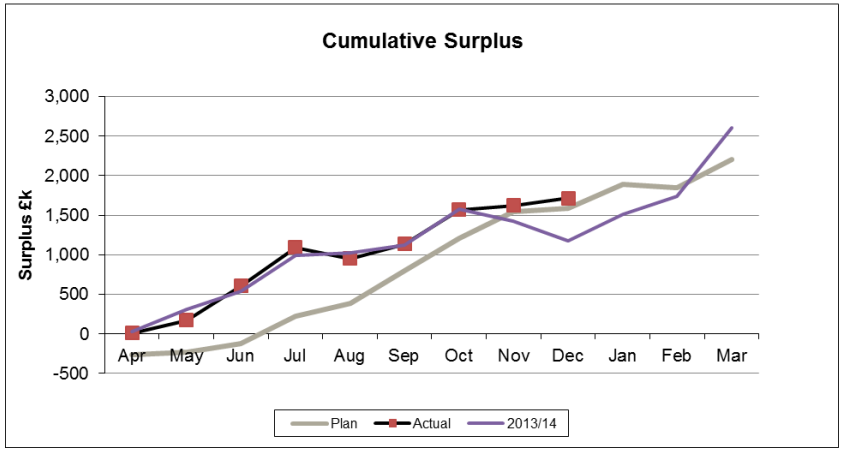
Actions

- 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 – M9 2014/15

Queen Victoria Hospital NHS Foundation Trust





Summary

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

Risks & Issues

- The trust surplus is sensitive to the achievement of income targets as costs are predominantly of a fixed base nature. February has a low activity plan so it is essential that this is met or exceeded to avoid a loss in that month.
- 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 M9 2014/15

Queen Victoria Hospital NHS Foundation Trust

Financial Performance	2014-15	December 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	55,788	4,438	4,506	(69)	42,428	41,699	729
Other Income	3,763	262	314	(51)	3,273	2,823	450
Pay	(38,401)	(3,321)	(3,215)	(106)	(29,473)	(28,757)	(716)
Non Pay	(15,394)	(1,604)	(1,273)	(330)	(12,599)	(11,515)	(1,084)
Financing	(3,553)	(339)	(296)	(43)	(2,600)	(2,665)	65
Underlying Position	**2,203**	**(564)**	**36**	**(600)**	**1,029**	**1,585**	**(556)**
Prior Year Items	-	655	-	655	686	-	686
Surplus / (Deficit)	**2,203**	**92**	**36**	**56**	**1,715**	**1,585**	**130**
Note: Financing costs consist mainly of depreciation, dividends and theatre loan interest.							

Summary

- The headline total income variance for month 9 is £120k adverse. Reserves for penalties have increased by £225k this month and this is considered to be prudent.
- Pay includes additional non-recurrent costs of interim cover and for transformation initiatives.
- Non Pay includes a £300k provision for the commitment to removal costs of the day case unit leased by the trust. This sum is subject to negotiation and final confirmation.
- The Prior Year Item is the adjustment to the ERT provision estimate that has resulted in the release of a provision of £655k.

Issues

- The impact of prior year items is shown separately in the above analysis.
- The impact of the revision of prior year estimates is positive.

Divisional Performance Summary – M9 2014/15

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Patient Income		Other Income		Pay		Non Pay		Financing		Prior Year			Total Current Month			Total Year To Date		
Direct Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Anaesthetics and Surgery																			
Plastics	(128)	(163)	(0)	29	(35)	(132)	44	122					24,156	1,844	1,963	(119)	17,814	17,959	(145)
Oral	16	(122)	(9)	35	(40)	(114)	(73)	(52)					6,987	434	540	(106)	4,996	5,249	(253)
Ophthalmology	33	489	1	9	(20)	(46)	(6)	(130)					2,583	206	197	8	2,273	1,952	321
Sleep	15	359	2	11	(16)	(75)	25	(237)					1,852	171	144	27	1,453	1,396	57
Theatres			1	(1)	(45)	(61)	48	12					(6,637)	(544)	(548)	4	(5,023)	(4,973)	(50)
Anaesthetics			(2)	(9)	(7)	38	(5)	(40)					(3,335)	(291)	(277)	(14)	(2,512)	(2,500)	(11)
Administration	0	63	(0)	(1)	(5)	(26)	5	3					(630)	(52)	(52)	0	(434)	(472)	38
Anaesthetics and Surgery Total	**(63)**	**625**	**(7)**	**72**	**(169)**	**(417)**	**39**	**(324)**					**24,976**	**1,768**	**1,968**	**(200)**	**18,567**	**18,610**	**(43)**
Clinical Support																			
Radiology	11	87	1	12	(5)	(83)	0	(29)					117	7	0	7	93	106	(14)
Pathology			-	-			0	(0)					(653)	(53)	(53)	0	(489)	(489)	(0)
Histopathology			(1)	(21)	4	43	4	(43)					(981)	(74)	(82)	8	(756)	(735)	(21)
Pharmacy	1	3	(0)	6	(2)	8	(7)	(22)					(64)	(15)	(7)	(8)	(53)	(47)	(6)
Surgical Appliances	0	6	-	-	0	0	(0)	(6)					8	0	1	(0)	6	6	0
Prosthetics	(1)	(74)	1	6	2	112	5	12					(315)	(21)	(29)	8	(180)	(235)	55
Medical Photography			0	(4)	(2)	(5)	2	4					(136)	(11)	(11)	0	(107)	(102)	(6)
Therapies	9	70	(8)	(0)	(12)	(2)	(9)	(1)					(543)	(70)	(50)	(21)	(338)	(404)	67
Psychotherapy	(2)	(1)	-	-	1	18	0	6					(125)	(12)	(11)	(1)	(71)	(93)	22
Clean room			(10)	30	1	10	28	(22)					(183)	5	(15)	20	(119)	(137)	18
General Specialities	(1)	(27)	-	-	(20)	(30)	9	28					218	4	16	(12)	135	164	(30)
Clinical Support Total	**17**	**64**	**(16)**	**28**	**(33)**	**70**	**33**	**(75)**					**(2,657)**	**(239)**	**(240)**	**1**	**(1,879)**	**(1,965)**	**87**
Nursing																			
MIU	18	85	-	-	(1)	(22)	(0)	(13)					539	57	40	17	457	408	50
Inpatient	(18)	(36)	-	0	(64)	(111)	6	(109)					(5,455)	(533)	(457)	(76)	(4,345)	(4,089)	(256)
Outpatient			1	4	(2)	5	(16)	(42)					(2,238)	(203)	(186)	(17)	(1,711)	(1,678)	(33)
Audit and Risk			(15)	167	6	79	3	(15)					(1,608)	(140)	(134)	(5)	(975)	(1,206)	231
Research			9	48	(5)	(44)	(0)	2					(74)	(2)	(6)	4	(49)	(55)	6
Nursing Total	**16**	**203**	**(5)**	**218**	**(66)**	**(92)**	**(7)**	**(177)**					**(8,837)**	**(821)**	**(743)**	**(78)**	**(6,624)**	**(6,621)**	**(2)**
Estates and Hotel Services																			
Estates			0	(12)	5	(15)	(325)	(350)					(1,989)	(495)	(174)	(321)	(1,849)	(1,472)	(377)
Hotel Services			(4)	(5)	(7)	(30)	1	(35)					(1,659)	(147)	(137)	(9)	(1,313)	(1,244)	(69)
Estates and Hotel Services Total			**(4)**	**(16)**	**(2)**	**(45)**	**(324)**	**(385)**					**(3,648)**	**(642)**	**(312)**	**(330)**	**(3,162)**	**(2,716)**	**(446)**
Human Resources			11	63	1	12	(5)	(14)	-	-			(746)	(56)	(63)	7	(496)	(557)	62
Human Resources Total			**11**	**63**	**1**	**12**	**(5)**	**(14)**	**-**	**-**			**(746)**	**(56)**	**(63)**	**7**	**(496)**	**(557)**	**62**
Finance																			
Finance Commerce IT			0	22	116	128	(8)	45	-	-			(2,328)	(85)	(194)	109	(1,550)	(1,746)	196
Finance Other	(22)	(9)	(35)	24	-	(0)	9	(81)	(43)	65	655	791	(3,054)	309	(255)	564	(1,501)	(2,291)	791
Finance Total	**(22)**	**(9)**	**(35)**	**46**	**116**	**128**	**1**	**(36)**	**(43)**	**65**	**655**	**791**	**(5,382)**	**224**	**(449)**	**673**	**(3,051)**	**(4,037)**	**986**
Corporate			4	38	46	(372)	(67)	(74)			-	(105)	(1,504)	(142)	(125)	(16)	(1,642)	(1,128)	(513)
Corporate Total			**4**	**38**	**46**	**(372)**	**(67)**	**(74)**			**-**	**(105)**	**(1,504)**	**(142)**	**(125)**	**(16)**	**(1,642)**	**(1,128)**	**(513)**
Grand Total	(69)	729	(51)	450	(106)	(716)	(330)	(1,084)	(43)	65	[illegible]	[illegible]	[illegible]	36	56	1,715	1,585	130	

Summary

- This analysis shows financial performance by division.

Issues

- The three operational divisions are largely on plan although there are variances in income/cost categories and within each division.
- Estates and Hotel Services have an adverse variance due to £300k for disposal of the theatre unit and increased costs from the continued rental of the unit.
- Human Resources are benefiting from higher than expected training income.
- Finance includes the £655k provision release and the other underspends partially offset the increased costs in Corporate that reflect interim pay costs.

Risks

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

Actions

- Continued action to meet targets.

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

Income by Point of Delivery – M9 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

POD Month 9	Current Month Actual £K	Current Month Plan £K	Current Month Variance £k	Year to Date Actual £k	Year to Date Plan £k	Year to Date Variance £k
Day Case	957	926	31	8,799	8,225	574
Elective	634	866	(232)	6,808	7,967	(1,159)
Non Elective	958	885	73	8,443	8,181	262
Exclusions	272	242	30	2,552	2,288	264
Outpatient First Attendance	396	407	(11)	3,846	3,829	17
Outpatient Follow Up	757	735	22	7,365	6,946	419
Outpatient Procedure	327	315	12	3,196	2,996	200
Minor Injuries	59	66	(7)	615	625	(10)
Radiology	105	94	11	985	894	91
Critical Care	82	60	22	658	571	87
Sub total	**4,547**	**4,595**	**(49)**	**43,266**	**42,522**	**744**
CQUIN reduction	59	-	59	(85)	-	(85)
Penalties	(224)	-	(224)	(626)	-	(626)
ERT deduction	56	(89)	145	(126)	(823)	697
Total Penalties Provision	**(109)**	**(89)**	**(20)**	**(837)**	**(823)**	**(14)**
Patient Activity Income	**4,438**	**4,506**	**(69)**	**42,428**	**41,699**	**729**

Summary

- Patient income by point of delivery (POD) was £49k behind plan in M9 (before performance adjustments) with elective inpatients showing a significant adverse variance.
- The in month improvement in CQUIN performance reflects the change in the assumption for Q2 from 75% to 100%, and the year to date variance reflects 25% risk for Q3.
- The increase in the penalties provision reflects a reconsideration of the year to date risk.
- 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 and Q2 CQUIN is reflected at 100% based on agreement with commissioners and Q3 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.

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.

Income Issues and Risks – YTD M9 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Penalties: Issues / Risks

- Within income there is an accrual of £837k for penalties and challenges (activity data is still to be finalised and any penalties are to be agreed with commissioners).

Provision for Income Performance Penalties 2014/15	M1 £	M2 £	M3 £	M4 £	M5 £	M6 £	M7 £	M8 £	M9 £	Year to Date
RTT18 Admitted	2,400	2,400	10,800	23,600	29,200	30,800	0	0	0	**99,200**
RTT18 Non-Admitted	600	0	2,000	2,400	3,600	4,900	0	0	100	**13,600**
RTT18 Open pathways	7,200	5,200	8,200	9,000	13,300	14,800	0	0	0	**57,700**
Sub total RTT18	**10,200**	**7,600**	**21,000**	**35,000**	**46,100**	**50,500**	**0**	**0**	**100**	**170,500**
52 week waiters (estimate)	0	5,000	15,000	10,000	0	5,000	5,000	0	0	**40,000**
Urgent operation cancelled for 2nd time	0	10,000	10,000	5,000	0	0	0	0	0	**25,000**
Never Events (estimate)	0	1,000	2,000	1,000	1,000	0	0	0	0	**5,000**
Data Challenges (estimate)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**9,000**
Outpatient Follow Up Ratios								85,600	11,100	**96,700**
Diagnostic Unbundling Risk Share									69,000	**69,000**
BPT Cataract Penalty									24,220	**24,220**
Additional Risks									186,143	**186,143**
Sub total non RTT penalties	**1,000**	**17,000**	**28,000**	**17,000**	**2,000**	**6,000**	**6,000**	**86,600**	**291,463**	**455,063**
Total Penalties	**11,200**	**24,600**	**49,000**	**52,000**	**48,100**	**56,500**	**6,000**	**86,600**	**291,563**	**625,563**
Emergency Rate Threshold reductions	22,506	1,853	34,973	6,609	61,482	82,293	5,365	-33,109	-56,000	**125,971**
CQUIN reduced achievement provision							29,452	29,039	26,975	**85,466**
Grand Total	**33,706**	**26,453**	**83,973**	**58,609**	**109,582**	**138,793**	**40,817**	**82,530**	**262,538**	**837,000**

- 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.
- The other penalties are subject to finalisation and additional penalties are reflected this month including £186k for penalties that may exceed current expectations. This change is part of the month 9 interim accounts review of penalties and is funded by the release of the ERT provision brought forward from 2013/14.
- Last year total penalties and challenges were £307k.

Actions

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

Cost Improvement Analysis – M9 2014/15

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes built into budgets 2014-2015	Annual Plan £000's	Month 9 Plan	Achieved £000's	Achieved %	Shortfall
Pay	337	252	215	85%	37
Clinical Supplies	233	175	141	80%	34
Non Clinical Supplies	142	107	9	8%	98
Other non operating expenses	170	128	108	85%	19
Total Cost Improvement Programmes	**882**	**661**	**473**	**71%**	**189**

Summary

- At M9 the trust is achieving 71% of the cost improvement plan , work is progressing to ensure further improvement.

Issues

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

Risks

- A 29% shortfall on plan is a risk for the full year of £251k.

Actions

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

Balance Sheet – YTD M9 2014/15

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet for: Month 9 2014/15	2013/14 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,211	36,429	36,509
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,211	36,429	36,509
Current Assets			
Inventories	415	423	425
Trade and Other Receivables	8,939	7,052	6,342
Cash and Cash Equivalents	3,655	7,126	7,680
Current Liabilities	(6,574)	(6,383)	(6,046)
Sub Total Net Current Assets	6,436	8,218	8,401
Total Assets less Current Liabilities	43,647	44,647	44,910
Non-Current Liabilities			
Provisions for Liabilities and Charges	(554)	(616)	(582)
Non-Current Liabilities >1 Year	(8,933)	(8,156)	(8,545)
Total Assets Employed	**34,159**	**35,875**	**35,784**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	15,749	17,465	17,374
Revaluation Reserve	6,173	6,173	6,173
Total Tax Payers Equity	**34,159**	**35,875**	**35,784**

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.
- Debtor balances have improved significantly since the year end as commissioners reduce outstanding balances. Debtors increased this month but payments were received directly after month end that brought debtor balances down to November levels.
- Non-current liabilities have reduced in year due to the theatre loan repayments made in June and December.

Risks

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

Actions

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

Capital – M9 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	296	5	-	301
Other projects	92	45	22	13	81
14/15 Projects:					
Corneoplastic electrical upgrade	100	-	19	125	144
Fire compartmentalisation	160	-	-	15	15
A Wing repairs	100	-	-	-	-
Meeting rooms	50	-	-	20	20
Carbon reduction	50	-	-	-	-
Wet rooms	24	-	-	72	72
Canadian Wing waiting area	-	-	4	56	60
Other projects	374	64	34	37	135
Medical Equipment	550	305	673	163	1,141
IT Equipment	1,400	217	72	196	485
Grand Total	**3,350**	**928**	**828**	**698**	**2,453**

Summary

- Capital expenditure is significantly below the phased plan because of the delayed start of the IT network replacement project and the reconsideration of the Estates programme.

Issues

- Following review the forecast for IT spend in this financial year has been reduced to £485k. The key project within IT is a replacement network to support more advanced clinical systems.

Risks

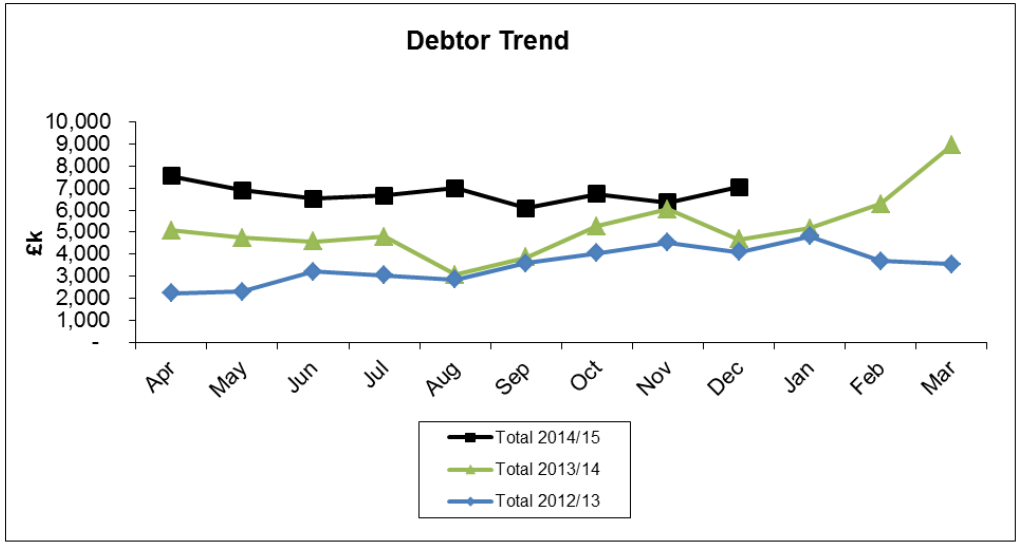
- Sufficient project management is key to the delivery of capital projects so this is being built into delivery plans.

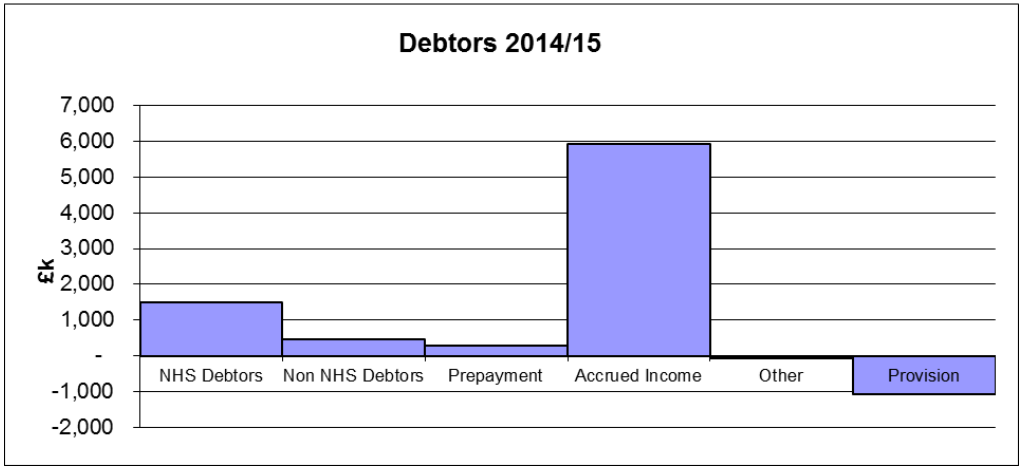
Actions

- Deliver planned projects.

Debtors – M9 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 may reduce by c£200k by year end.

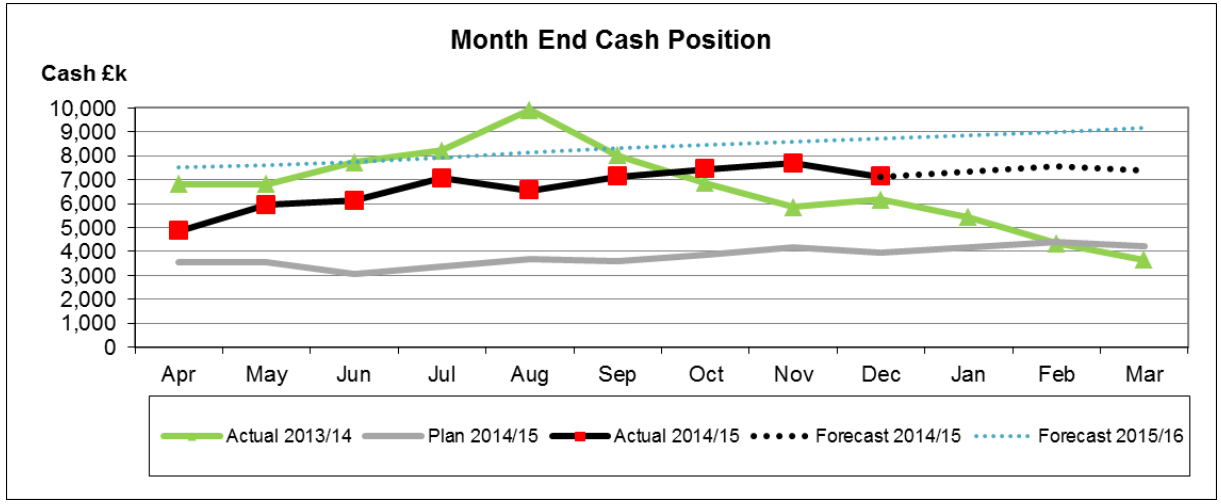
Risks

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

Actions

- Continued liaison with commissioners to ensure prompt payment.

Cash – M9 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.

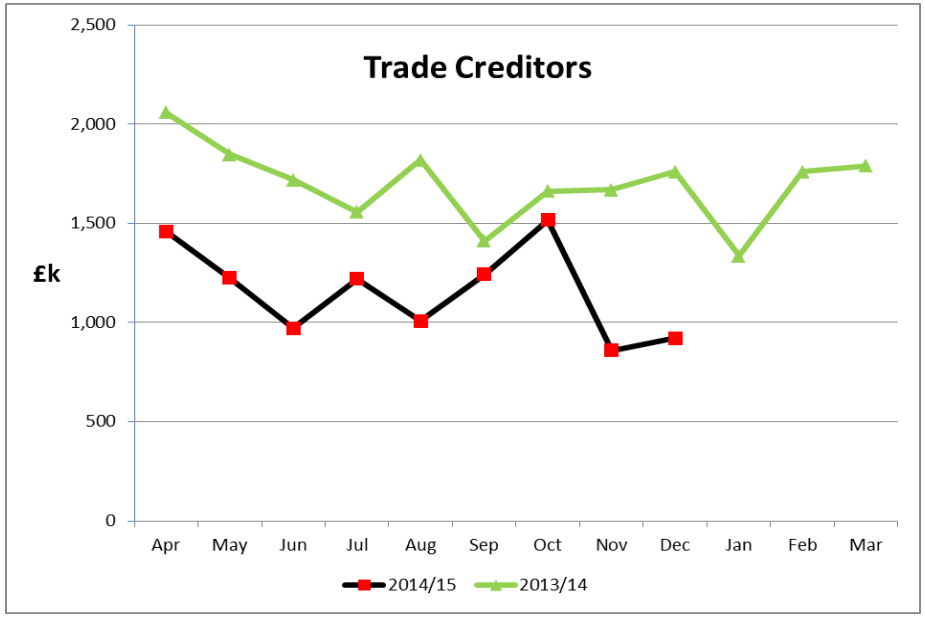
Risks

- 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 – M9 2014/15



Better Payment Practice Code December 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	1,177	1,249	11,759	12,113
Total **Non NHS** trade invoices paid within target	9,386	15,087	929	1,010	7,685	7,940
Percentage of Non-NHS trade invoices paid within target	**62%**	**71%**	**79%**	**81%**	**65%**	**66%**
Total **NHS** trade invoices paid	1,082	4,544	66	351	731	4,041
Total **NHS** trade invoices paid within target	624	2,858	51	284	363	2,307
Percentage of NHS trade invoices paid within target	**58%**	**63%**	**77%**	**81%**	**50%**	**57%**

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:	Thursday 29th January 2015
Reference number:	010-15
Report from:	Dominic Tkacyzk, Interim Director of Finance and Commerce
Author:	Elin Richardson, Head of Commerce
Report date:	Tuesday 20th January 2015
Appendices:	Contract Update (public)

2014/15 Contract Report

Key issues

1. This paper provides an update on activity and income performance against the signed contracts with the commissioners.
2. Trust actual income and activity is higher than the external commissioner plans at Month 9.
3. Over performance is predominantly in day cases and outpatient follow ups.
4. Performance penalties for 18 weeks remain the largest risk to reported income and the finance report which sets out the provisions made.
5. An update on ERT is provided.

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives

- Financial sustainability

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

2014/15 Contract Report

Prepared for Board of Directors

20th January 2015

Elin Richardson, Head of Commerce

1.0 Executive Summary

The Trust continues to over perform against external contracts with CCGs and NHS England.

Over performance is predominantly in day cases and outpatient follow ups. This is largely due to:

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

2.0 Overall Contract Performance

Table 1 below shows the year-to-date performance against all contract and non-contract activity before the removal of any penalties / adjustments. This shows that the Trust has over performed against these plans by £3.6m at Month 9 (up from £3.4m at Month 8). This is a slight slow down in the rate of over performance experienced in prior months.

The greatest over performance is in areas where signed contracts are in place i.e. General Acute (CCG contracts 9% over year to date), and dental and specialised (NHS England contracts 8% and 15% over year to date). These are broken down further in subsequent sections.

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

Contract Group	YTD M09 Plan £	YTD M09 Actual £	Variance £
General Acute	£23,837,677	£26,093,931	£2,256,254
Dental	£8,580,968	£9,291,973	£711,005
Specialised	£4,591,657	£5,287,990	£696,333
NCA	£1,181,884	£1,091,450	-£90,434
AQPNOUS	£0	£75,379	£75,379
non-England NCA	£57,531	£69,037	£11,507
Private Patients	£47,430	£24,533	-£22,896
Overseas	£28,023	£18,732	-£9,291
Offenders	£2,684	£6,868	£4,184
Military	£3,536	£3,697	£161
Grand Total	**£38,331,388**	**£41,963,590**	**£3,632,202**

3.0 CCG Contracts for Acute Care

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

Table 2: Performance against general acute care contracts

CCG	YTD M09 Plan	YTD M09 Actual	Variance
NHS HORSHAM AND MID SUSSEX CCG	£3,442,742	£4,193,102	£750,361
NHS WEST KENT CCG	£3,257,285	£3,639,349	£382,064
NHS HIGH WEALD LEWES HAVENS CCG	£2,302,360	£2,511,491	£209,131
NHS EAST SURREY CCG	£1,742,344	£1,991,027	£248,683
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG	£1,772,912	£1,828,722	£55,810
NHS MEDWAY CCG	£1,656,297	£1,774,494	£118,196
NHS COASTAL WEST SUSSEX CCG	£1,421,809	£1,516,886	£95,077
NHS HASTINGS AND ROTHER CCG	£1,227,107	£1,249,021	£21,915
NHS CRAWLEY CCG	£1,116,346	£1,192,490	£76,144
NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG	£551,042	£758,751	£207,709
NHS BRIGHTON AND HOVE CCG	£949,399	£757,460	-£191,940
NHS SWALE CCG	£730,177	£677,437	-£52,740
NHS SOUTH KENT COAST CCG	£533,087	£570,359	£37,272
NHS SURREY DOWNS CCG	£425,594	£531,980	£106,386
NHS CANTERBURY AND COASTAL CCG	£469,852	£528,283	£58,430
NHS BROMLEY CCG	£492,431	£438,092	-£54,338
NHS BEXLEY CCG	£460,497	£429,496	-£31,001
NHS ASHFORD CCG	£282,133	£407,282	£125,150
NHS THANET CCG	£396,193	£371,837	-£24,356
NHS GUILDFORD AND WAVERLEY CCG	£323,026	£353,587	£30,561
NHS CROYDON CCG	£285,044	£242,784	-£42,260
Accrual	£0	£130,000	£130,000
Grand Total	**£23,837,677**	**£26,093,931**	**£2,256,254**

At Month 9 the Trust had over performed by £2.256m against these contracts. Continuing the trend from previous months the greatest over performance (in value) is with our host commissioner Horsham and Mid Sussex CCG.

As noted previously Horsham and Mid Sussex, Crawley and Brighton and Hove CCGs removed a block amount of activity for the change in their musculo skeletal services (MSK) contract. This was not profiled over the year but taken out in straight 1/12ths. In addition the anticipated start of the new contract was October 2014 however QVH's provision was extended until the end of December 2014 therefore the plan is lower than would be expected at this point.

The Trust continues to under-perform against the Brighton and Hove CCG contract predominantly in skin procedures (part of plastics).

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

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

Point of Delivery (POD)	YTD M09 Plan £	YTD M09 Actual £	Variance £	YTD M09 Activity Plan	YTD M09 Actual Activity	Variance
Non elective	£5,309,889	£5,538,777	£228,888	2,449	2,420	-29
Day case	£5,118,813	£6,095,602	£976,789	4,397	5,546	1,149
Elective inpatient	£4,441,685	£4,236,771	-£204,914	2,061	1,987	-74
Outpatient First Attendance	£1,894,005	£1,988,859	£94,854	18,001	18,425	424
Outpatient Follow Up	£4,105,863	£4,666,124	£560,262	64,381	71,834	7,453
Exclusions	£858,369	£1,275,911	£417,542	0	0	0
Outpatient Procedures	£715,688	£731,309	£15,621	4,310	4,881	571
MIU attendances	£538,404	£575,120	£36,716	8,283	8,848	565
Radiology	£738,610	£856,973	£118,363	18,940	21,379	2,439
Other	£116,351	£128,485	£12,134	385	358	-27
Grand Total	**£23,837,677**	**£26,093,931**	**£2,256,254**	**123,208**	**135,678**	**12,470**

Day cases continue to over perform significantly. The over performance reflects

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

Outpatient follow ups remain an area of significant over performance. The service line team for ophthalmology continue to review the outpatient follow up process and data recording due to this area reporting a new to follow up ratio that is particularly high and an outlier with other specialist Trusts.

3.1 Developments in acute care contracting

MSK services – the Trust signed a sub contract with Sussex MSK Partnership to provide MSK services for the period 1st January to 31st March 2015.

Skin services – the Trust remain committed to supporting the community dermatology providers awarded the Any Qualified Provider (AQP) Community Dermatology contract for the CCGs in Horsham and Mid Sussex and Crawley. Kent CCGs have put their community dermatology services out to tender.

AQP Non Obstetric Ultrasound (NOUS) and Direct Access Magnetic Resonance Imaging (MRI) for West Kent CCG – the Trust has bid to provide services in this area. The decision of the CCGs is awaited.

High Weald Lewes Havens Community Services – the Trust is part of a bid (the lead accountable organisation being another provider) which has been successful at pre-qualification questionnaire(PQQ) stage. The response to the Invitation to Submit Outline Solution (ITSOS) has been completed with input from QVH and will be submitted by the deadline of 22nd January by the lead organisation.

4.0 NHS England Contract for Specialised Care and Dental Services

Table 4 below shows the year-to-date over performance for the NHS England contract covering specialised services and dental. This shows over performance of £1.4m at Month 9 up from £1.1m at Month 8. This is again before the application of any penalties.

Table 4: Performance against the NHS England contract

Contract Name	YTD M09 Plan £	YTD M09 Actual £	Variance £
NHS England Specialised	£4,591,657	£5,287,990	£696,333
NHS England Dental	£8,580,968	£9,291,973	£711,005
Grand Total	**£13,172,625**	**£14,579,963**	**£1,407,338**

The over performance on the specialised element of the contract remains elective inpatients (including day cases) in specialised ophthalmology and burns although every POD area is over performing with the exception of 'other'.

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

For the dental element of the contract, over performing areas again continue to be elective inpatients (including day cases). There is also over performance in outpatient new and outpatient procedures and much less so outpatient follow ups.

As noted previously, NHS England commissioned at approximately 8% below the 13/14 outturn without any demand management schemes in place. The Trust, in good faith, signed the agreement on the basis of an activity / volume mechanism for payment and yet NHS England challenge all over performance.

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

Point of Delivery (POD)	YTD M09 Plan £	YTD M09 Actual £	Variance £	YTD M09 Activity Plan	YTD M09 Actual Activity	Variance
Elective inpatients inc. day cases	£1,508,991	£1,749,411	£240,420	736	914	178
Non elective inpatients	£1,229,755	£1,343,037	£113,282	493	558	65
First outpatients	£220,362	£285,046	£64,684	855	1,105	250
Follow up outpatients	£996,759	£1,134,352	£137,593	3,880	4,410	530
Critical care bed days	£285,627	£476,748	£191,122	116	255	139
Other	£356,383	£309,961	-£46,422	351	147	-204
Grand Total	**£4,597,876**	**£5,298,555**	**£700,678**	**6,431**	**7,389**	**958**

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

Point of Delivery (POD)	YTD M09 Plan £	YTD M09 Actual £	Variance £	YTD M09 Activity Plan	YTD M09 Actual Activity	Variance
Elective inpatients inc. day cases	£2,391,183	£2,627,742	£236,558	2,085	2,330	245
Non elective inpatients	£916,194	£980,663	£64,469	525	501	-24
First outpatients	£1,262,124	£1,411,451	£149,327	8,891	10,041	1,150
Follow up outpatients	£1,050,122	£1,148,291	£98,169	11,999	13,106	1,107
Outpatient procedures	£1,977,848	£2,332,306	£354,458	12,719	14,702	1,983
Critical care bed days	£250,947	£108,945	-£142,002	226	100	-126
Other	£732,549	£682,575	-£49,974	98	150	52
Grand Total	**£8,580,968**	**£9,291,973**	**£711,005**	**36,543**	**40,930**	**4,387**

5.0 Risks against contract income

Performance challenges from 18 weeks remain the single biggest risk to the contract and the financial report includes the provisions made in this area.

6.0 Emergency Rate Threshold (ERT) update

This continues to be worked through as part of the Quarter 2 reconciliation process and the host CCG, Horsham and Mid Sussex have contacted the remaining 20 associate CCGs to agree the approach. Responses have been variable and actions to address this are being led through the QVH Programme Board – a joint commissioner and provider forum chaired by a local GP and Clinical Lead in this area.

End.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29th January 2015
Reference number:	011-15
Report from:	Graeme Armitage, Head of HR & Operational Development
Author:	Graeme Armitage, Head of HR & Operational Development
Report date:	21st January 2015
Appendices:	1: Workforce Performance Report 2: Recruitment & Retention Action Plan

Workforce update – January 2015

Key issues

1. The key areas to draw attention to this month are recruitment and retention of staff and sickness absence. A summary of current live vacancies has been included along with an update of the Recruitment and Retention Task Group action plan. The third meeting of this group took place earlier in January 2015 and further progress has been made in all areas. The impact of the work taking place within the group will start to have effect towards the end of Q4. Turnover has fallen slightly and this has been the trend since August 2014, we are now approaching a similar level of turnover compared to last year at the same time. This will continue to be closely monitored especially the relationship between turnover, vacancies and sickness absence.

2. Sickness has increased slightly over the previous month but is lower than the same period last year. We are still some way above the 2% outturn target but there are some encouraging signs relating to long term sickness with the majority of cases being resolved either by individuals returning to work or leaving due to ill-health retirement / contract termination. The current main cause is seasonal and relates to colds and flu. This was expected, although 50% of our staff have received the flu vaccination to help reduce the impact of flu on our sickness performance. Stress and anxiety cases have dropped considerably with only 59 days lost in December (stress and anxiety is now only 6th on the top 10 reasons for absence having been top earlier in the year). Whilst sickness levels remain high, the NHS as a whole is averaging at 4%, however the HR team are continuing to work with managers to achieve improvements with a special emphasis now on short term sickness. Bank and agency will remain high whilst sickness level continue at current levels however services are using the same agency and back staff wherever possible to ensure consistency I patient care. There has been no adverse effect on care to patients as a result of the use of bank and agency.

3. Phase 3 of the Statutory and Mandatory Training improvements are now complete. There are a few areas requiring further attention which has been highlighted following the data cleansing. The reports now available to managers monthly are a step forward and provide a more accurate position on performance; they have details for each member of staff by department based on their statutory and mandatory requirements and are also available in

summary form providing a quick view of current performance in each department. The January 2015 reports went live mid-month and to date the number of queries/corrections have been minimal.

4. Safecare implementation remains on track for go live by the end of March 2015. There has been very good engagement with the matrons and their teams in the project planning and training. Data collection exercises have taken place in January 2015 to work through the acuity and dependency criteria and to see the impact this has for rostering staff and maintaining safe levels of care.

5. There were 23.4wte vacancies advertised in November 2014 of which included, 6.6 wte were nursing, 6.3wte admin and clerical posts and 4.0wte Medical and Dental. It is worth noting that 11.4% vacancy rate is derived from the Funded Establishment figure minus the In Post figure with current live vacancies added to give a staffing gap between funded and in post of 101.68 wte. We are therefore, only seeing 23% of this gap in the form of live vacancies. This is being looked into further to understand in more detail how managers are using their vacancies and the impact for the efficient use of resources

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.

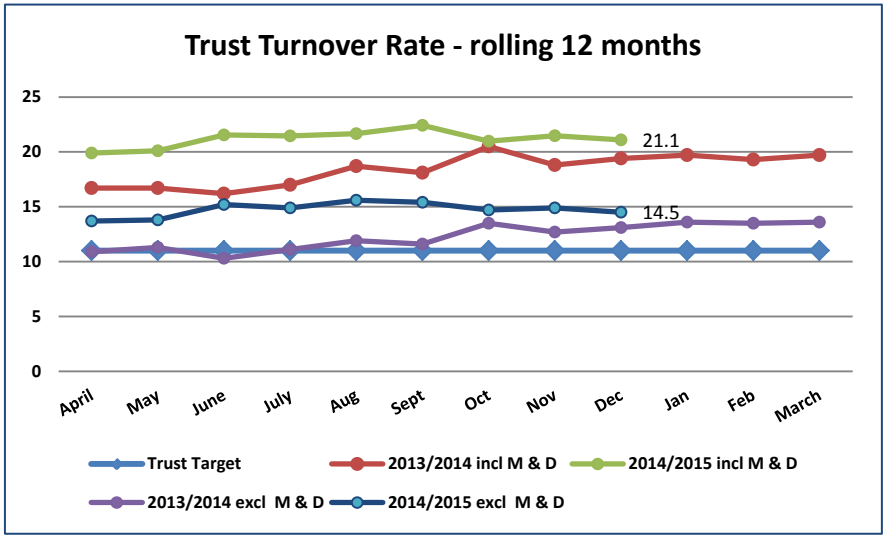
Regulatory impacts

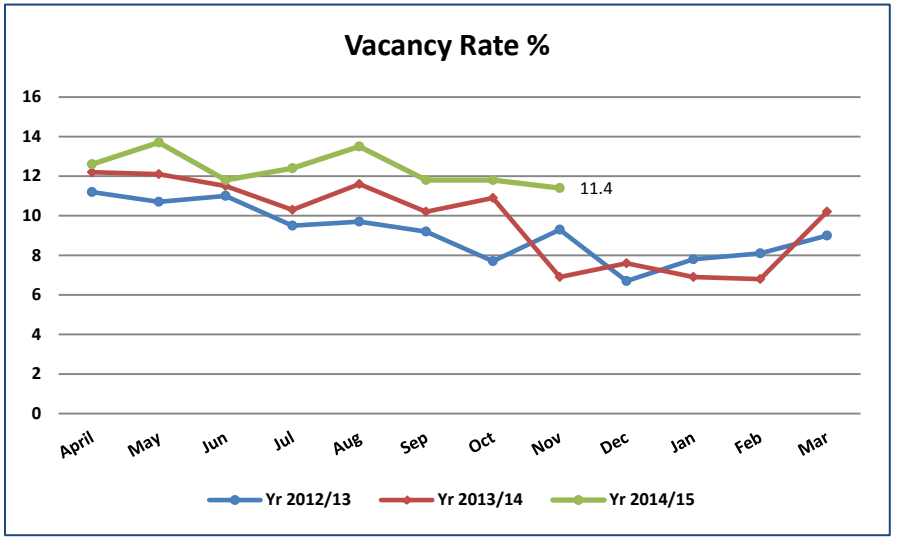
16. Although there is always a potential for high turnover and staff sickness to compromise quality of care and have a detrimental impact on the experience of other staff, it is not felt that the level of turnover and staff sickness prevailing currently is a genuine threat to regulatory compliance. Safety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

HEADLINE HR KPIs January 2015





Staff Movements

	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14
Headcount	959	967	971	971	966	966	967	965	957	961	965	966	965
WTE in Post	820	825	823.78	823.78	816.86	816.07	816.78	816.79	816.79	812.47	816.49	818.86	818.48
WTE Funded Establishment	867.99	867.99	867.99	867.99	897.51	897.51	897.51	897.51	897.51	897.51	897.18	897.14	897.14
New Hires	6	16	29	7	10	7	19	10	23	24	23	12	8
Leavers	14	11	22	15	9	9	21	12	44	17	17	12	12
Maternity Leave	21	16	17	19	19	20	17	16	19	20	18	16	16
Vacancy Rate	7.6%	6.9%	6.8%	10.2%	12.6%	13.7%	11.8%	12.4%	13.5%	11.8%	11.8%	11.4%	N/A
Turnover Rate Headcount	1.46%	1.14%	2.37%	1.55%	1.04%	1.04%	2.18%	1.35%	4.62%	1.77%	1.76%	1.24%	1.24%
Turnover Rate	1.46%	1.14%	2.05%	1.65%	0.93%	0.93%	2.07%	1.24%	4.49%	1.69%	1.66%	1.14%	1.15%

Rolling 12 Monthly Turnover Figures

	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov14	Dec14
12 Month Turnover (including Medical & Dental)	19.4%	19.70%	19.32%	19.74%	19.94%	20.15%	21.55%	21.45%	21.66%	21.61%	20.97%	21.47%	21.09%
12 Month Turnover (Excluding Medical & Dental)	13.1%	13.59%	13.51%	13.62%	13.67%	13.79%	15.19%	14.93%	15.57%	14.87%	14.74%	14.96%	14.50%

HEADLINE HR KPIs

Turnover (12 month rolling turnover)

Trust turnover for the 12 month rolling period ending 31st December 2014 is 14.50% which is still above Trust target, although a slight fall over the previous month, turnover still remains 1.4% higher than the same period last year.

December saw 11 leavers (9.38 WTE), of which 4 were due to retirement, one of which returned on reduced hours, 5 were voluntary resignations – other/not known, 1 – lack of opportunities, 1 – end of fixed term contract.

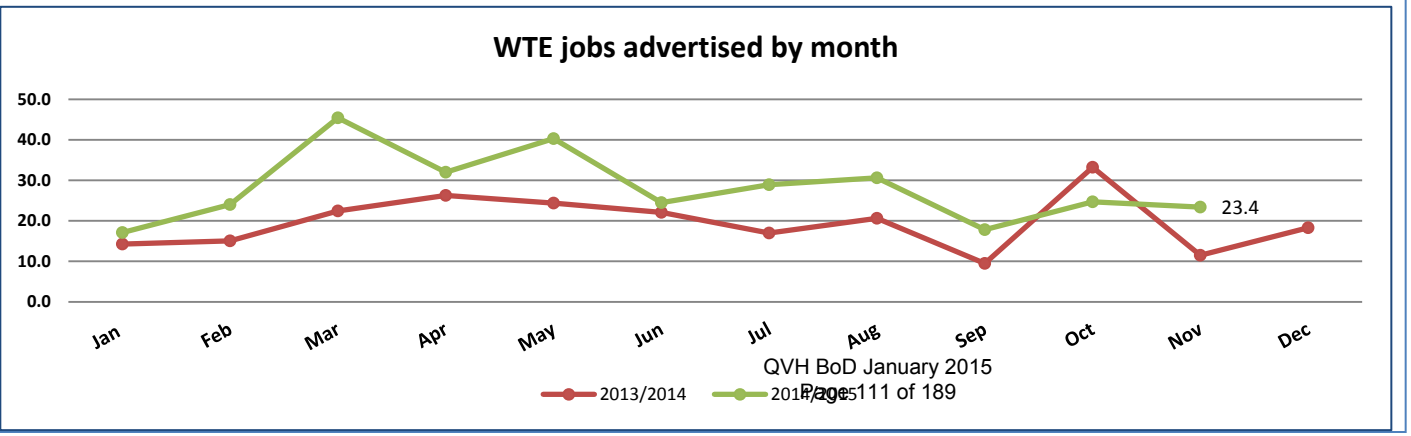
Vacancies Rates (figures 2 month in arrears)

Vacancy rate for November was 11.4 % of which 23.4 WTE were actively being recruited to. Bank and agency were being used to the total of 82.91 WTE. The reason for this is the need to cover establishment vacancies, maternity leave (currently 16 employees on maternity leave) and long-term sickness (18 employees with sick leave of 4 weeks or more). The vacancy rate has been slowly reducing over the past 7 months this is line with jobs being advertised.

Vacancies/Recruitment (figures 2 months in arrears)

There were 23.4 WTE vacancies advertised in November of which included, 6.6 WTE Nursing posts, 6.3 WTE Admin and Clerical posts and 4.0 WTE Medical and Dental posts.

NB: It is worth noting that 11.4% vacancy rate is derived from the Funded Establishment figure minus the In Post figure (in wte) i.e. 897.14 – 818.86 (November figures provided from Finance 2 months in arrears). Added back to this are the current live vacancies of 23.4 wte giving a total of 101.68 wte. Therefore at present we are only seeing 23% of this gap in the form of live vacancies. This is being looked into further to understand in more detail how managers are using their vacancies and the impact for the efficient use of resources.



RAG Rating

HEADLINE HR KPIs

There were 16 job offers of employment made in November, this includes bank staff. The recruitment team operate a 5 week target to complete pre-employment checks after the offer of employment has been made.

In November of the 16 applicants within the system, there were 4 cases (25%) that had breached the pre-employment check target of 5 weeks, there were multiple reasons but common themes include delays in occupational health clearance, reference delays due to candidates not providing correct information.

The recruitment team regularly chase those candidates who supply incorrect information.

A recruitment open day is planned for Tuesday 27th January 2015 in the aim to canvass prospective new staff who may be interested in working at QVH, either on a full-time or part-time basis.

Exceptions

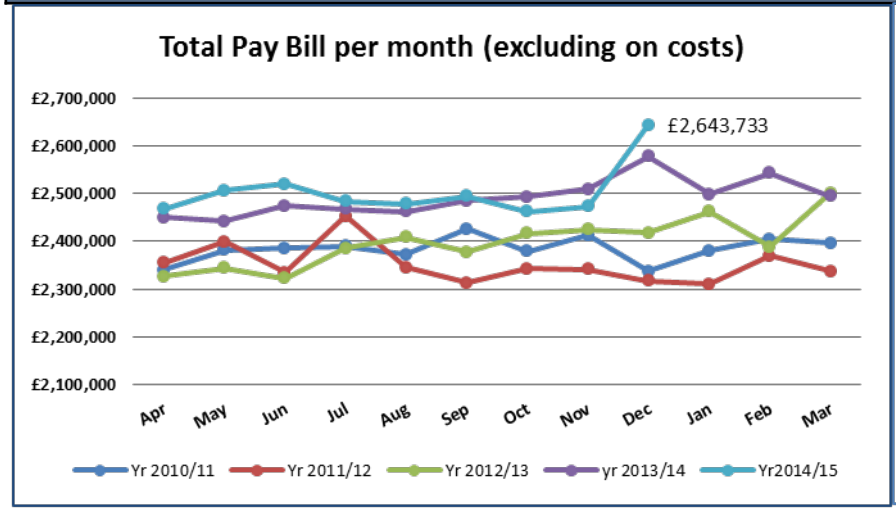
Canadian Wing currently has 50.41 WTE against a budget establishment of 62.88 WTE a gap of 12.41 WTE, approximately 19% of their staffing .

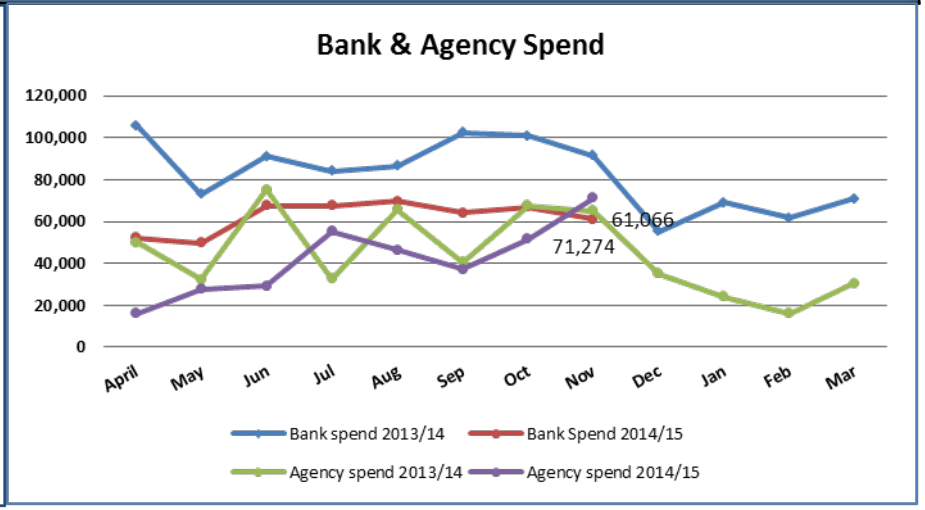
ITU currently has 14.4 WTE against a budget establishment of 16.16 WTE a gap of 1.76 WTE, however due to high acuity within the department 6.0WTE additional nursing vacancy are being advertised in December, this will reduce the spend on Bank and agency. The additional capacity will also be used to off set vacancies in Canadian Wing and is part of the initiatives being taken forward within the Recruitment and Retention Task Group.

Actions

- Heads of department & key managers notify recruitment ASAP after a resignation letter is received and begin filling the vacancy, commencing the ECF process.
- Rotate nursing staff to gain skills in other nursing areas, allowing cross cover in areas hard to fill
- Implement local Recruitment and Retention Premia in accordance with Agenda for Change
- Expand our talent pool so that the Trust can successfully recruit to our nursing posts.
- Look to recruit within Europe (Portugal & Spain) this is at present a last resort option not yet being actively pursued.
- Please refer to latest Recruitment and Retention Task Group action plan attached to this report for information

HEADLINE HR KPIs





Pay Bill – (1 months in arrears) reported pay does not include on costs. *Pay for December increased by £170,576, this was due to increased activity to clear the back log for the 'RTT18'.*

A breakdown of the split between total staff paid WTE and bank/agency and overtime is reported in arrears and for November 2014, shows WTE staff in post was 818.86 however total WTE paid was 901.77 this is inclusive of 41.86 WTE Bank, 37.20 WTE Agency (excluding RMNs) and 3.85 WTE over-time. The Budgeted establishment inclusive of temporary staffing is budgeted at 902.71, currently the WTE inclusive of temporary staffing is at 901.77, which indicates that the paid WTE is close to being over budget for November.

Bank and Agency usage – (figures are 2 month in arrears)
Bank expenditure for November was £61,066 a slight decrease of £5754 from last month. With the controls and monitoring put in place bank expenditure has reduced by £30,000 compared to the same period last year. Agency expenditure (excluding RMN) was £71,274 an increase of £19,671 from last month. Over the past 7 months agency figures have increased month on month and is now its highest for the last 18 months. The top three highest users of bank and agency expenditure were Canadian Wing at a combined amount of £40,114 an increase from last month. The increase in expenditure was due to establishment vacancies and increased workload. ITU has a combined expenditure of £25,718 due to high patient acuity and additional workload. Corneo nursing combined expenditure of £12,769 due to establishment vacancies and additional workload. NB: higher than average Bank and Agency usage was expected due to the additional work during November 2014. The higher levels will continue through Q4 whilst recruitment and retention initiatives begin to take effect.

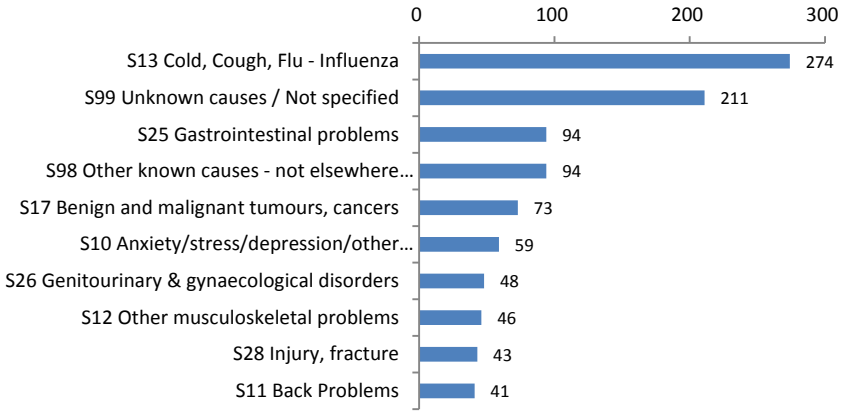
Actions

- Linking to the Recruitment and Retention Task Group and changes to the e-rostering system
- Senior managers to sign off before any bank or agency agreed to avoid unnecessary use of bank/agency workers.

RAG Rating

HEADLINE HR KPIs

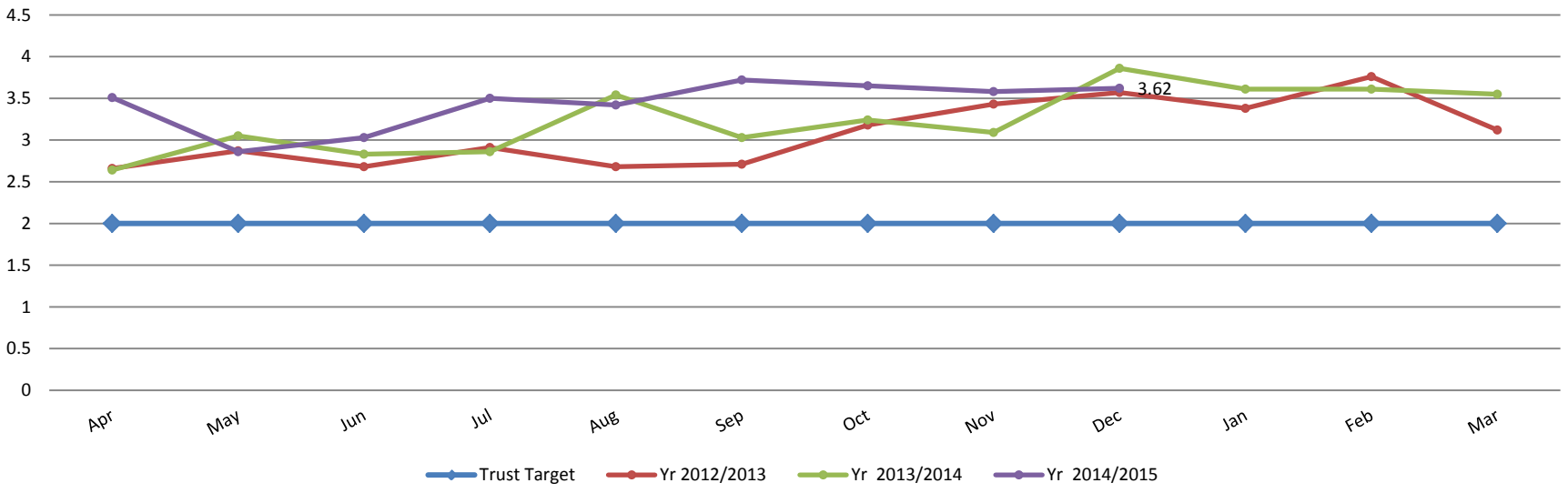
Top 10 Absence Reasons by Absence Days for December



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

Staff Group	Estimated Cost	Absence Occurrences
Add Prof Scientific and Technical	£7,907	32
Additional Clinical Services	£11,154	44
Administrative and Clerical	£15,705	70
Allied Health Professionals	£4,035	7
Estates and Ancillary	£5,761	18
Healthcare Scientists	£0	0
Medical and Dental	£13,286	21
Nursing and Midwifery Registered	£21,479	65
Grand Total	£79,327	257

Trust Absence Timeline



HEADLINE HR KPIs

Sickness/Absence

Trust sickness for December is at 3.62%, although sickness has increased slightly over last month, it is lower than the same period in 2013.

There were 239 episodes of short-term sickness throughout December, with the highest number of short-term sickness cases being Cough, Cold and Flu, equating to 25.6 % of all short-term sickness reported. Unknown Causes – Not Specified had the second highest level of short-term sickness, equating to 19.7% of all short-term sickness recorded.

Long term sickness cases which are over 28 days have increased from 14 to 18 for December (6 of which are being dealt with under the capability due to ill health. The top two main causes reported are 1) Unknown causes/not specified 2) Benign and malignant tumours/cancer. The early information relating to January indicates that all long term cases are now back in work or contracts have been terminated on ill-health grounds.

There were 1,072 absence days lost (926.50 FTE) due to sickness. The average days lost to sickness for December was 7.99 days with a cost to the Trust of £79,327. Monday was the highest first day absent for a continuing month, a recurring trend for the Trust – work is being undertaken to identify any individuals who take sickness absence on a Monday managers being supported to take action where, on an individual basis, this is a trend..

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

Admin and clerical staff had the most sickness absence in December with 70 occurrences of sickness (of which 3 are long-term cases), 50 % of short-term sickness was down to Cough, Cold and Flu, 11% Genitourinary and Gynaecological disorders and 10% Gastrointestinal problems. The top 3 admin and clerical staffing groups were;

- Medical Secretaries
- Health Records
- Human Resources

Nursing Registered had the second highest sickness absence in December with 65 occurrences of sickness and 38% of all short-term sickness was due to Cough, Cold and Flu. The top 3 nursing areas were;

- Canadian Wing
- ITU
- Out-Patients

RAG Rating

HEADLINE HR KPIs

Sickness Absence continued

Exceptions

The main affected areas are; Psychological Therapies at 24.75%, this should be noted that this is a small department carrying 1 x long-term sickness and 1 x short-term sickness.

ITU at 13.46% with 10 short-term sickness cases being Cough, Cold and Flu and Stress and Anxiety. The levels of sickness with in the department will be reflected in the higher usage of bank and agency for December.

Site Practitioners at 12.40%, a small department carrying 1 x long-term sickness since April 2014 and 5 short-term sickness cases for December. The employee on long-term sickness has put in a formal request for ill-health retirement as there is no chance this employee will be able to return to work. Recruitment is underway to replace the long-term sick employee which will hopefully lesson the stressors within the department.

Catering at 12.10% a small department carrying 1 x long-term sickness cases due to 'Injury/facture' and 2x short-term sickness cases.

Operational Management at 9.94% a small department carrying 1 x long-term sickness case due to 'Other Known Causes not else where specified' and 5 x short-term sicknesses resulting from Cough, Cold and Flu and Genitourinary and Gynaecological problems.

Radiography at 9.78% carrying 1 x long-term sickness case and 3 short-term sickness cases of various illness.

Histopathology at 9.75% a small department carrying 1 x Long-term sickness case since November 2014.

Actions

- A new HR session has been also been added entitled 'Managing Work Related Stress' which is designed to support managers more specifically in understanding and recognising the signs of stress in the workplace and how to make improvements e.g. ensuring staff have their breaks on time.
- The HR Employee Relations Team are now actively tackling short term sickness absence with managers having gained a high degree of success with regard to long term sickness cases.

RAG Rating

HEADLINE HR KPIs

Payroll

All staff were paid on time, overpayments decreased from 5 to 1 for December with a decrease in amount from £7640.90 to £246.09. The overpayment was due to incorrect data being supplied regarding a change to grade, recovery of overpayment has been arranged to be taken over 4 months.

Interim payments made in December increased in volume from 6 to 143, enhancements were due to be paid to employees at the same time as employees received their double time payment for the 'RTT18' work done in December. The majority of interim payments were made before the 22nd December by the finance department who put a stop to all their work to make sure these payments went out on time. Payroll errors decreased from 2 to 1.

Employee Relations

Human Resources have been working with line managers on Long-term sickness cases in trying to get the employees back into work with the support of Occupational Health. Of the 7 long-term cases outstanding, 2 will be returning to work in December and 4 have a return date of January 2015. There are 2 formal short-term sickness cases due in December and January.

The 2 conduct case investigations have been concluded and 1 employee was issued with a reprimand and the other employee was issued with an action plan.

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	0
•Capability	4 (this includes sickness capability cases)
•Long-term sickness	7
•Change Management	0
•Grievance	0
•Whistleblowing	0
•Probationary	1
•Appeals	0
•Suspension	0
•Flexible Working	1
•Dismissals	0
	Total 13

RAG Rating

Statutory and Mandatory Permanent Staff Training – 14.1.15

Competence Name	Does not meet requirement	Expired but Booked	Meets Requirement	Grand Total	Trust Overall (Expired + Meets Req)
CSTF Equality, Diversity and Human Rights - 3 Years|	45.97%	4.59%	49.44%	100.00%	54.03%
CSTF Health, Safety and Welfare - 3 Years|	43.51%	7.38%	49.11%	100.00%	56.49%
CSTF Infection Prevention and Control - Level 1 - 1 Year|	67.39%	0.00%	32.61%	100.00%	32.61%
CSTF Infection Prevention and Control - Level 1 - 3 Years|	18.65%	2.89%	78.46%	100.00%	81.35%
CSTF Infection Prevention and Control - Level 2 - 1 Year|	11.38%	8.71%	79.91%	100.00%	88.62%
CSTF Information Governance - 1 Year|	33.22%	1.23%	65.55%	100.00%	66.78%
CSTF Moving and Handling - Level 1 - 2 Years|	66.67%	0.00%	33.33%	100.00%	33.33%
CSTF Moving and Handling - Level 1 - 3 Years|	30.23%	3.88%	65.89%	100.00%	69.77%
CSTF Moving and Handling - Level 2 - 1 Year|	40.60%	11.40%	48.00%	100.00%	59.40%
CSTF NHS Conflict Resolution (England) - 3 Years|	30.44%	3.23%	66.33%	100.00%	69.56%
CSTF Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	39.76%	11.65%	48.59%	100.00%	60.24%
CSTF Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year|	41.16%	12.45%	46.39%	100.00%	58.84%
CSTF Safeguarding Adults - Level 1 - 3 Years|	24.05%	2.01%	73.94%	100.00%	75.95%
CSTF Safeguarding Children - Level 1 - 3 Years|	17.45%	2.91%	79.64%	100.00%	82.55%
CSTF Safeguarding Children - Level 2 - 3 Years|	28.68%	2.61%	68.72%	100.00%	71.32%
CSTF Safeguarding Children - Level 3 - 3 Years|	28.95%	0.00%	71.05%	100.00%	71.05%
LOCAL Emergency Planning - Non-Clinical - 3 Yearly|	17.43%	2.29%	80.29%	100.00%	82.57%
LOCAL Emergency Planning: annual|	13.42%	8.60%	77.99%	100.00%	86.58%
Grand Total	30.62%	5.31%	64.07%	100.00%	69.38%

Statutory & Mandatory Training

The overall Trust performance has increased from 59.90% to 64.07% (69.38% if those who are booked is included). 2 areas are particularly low which is affecting the overall performance, these are Infection Control and Manual handling Level 1. Both are related to the transition to the new skills passport and are being addressed to more accurately represent the Trust position. The underlying position therefore is 82.61% Infection Control Level 1 and 69.49 Manual Handling Level 1. The competency mapping exercise carried out by L&D over the last few months is complete and whilst there are still some outstanding anomalies to amend, the overall impact for managers is easier reporting of their staff's individual training records. The reports went live in January and so far the level of queries has been minimal.

Exceptions

Moving & Handling Like Infection Control this has 3 CSTF's – Level 1 – mainly Non Clinical Staff but some Clinical staff (eg Pharmacy and Histopathology) do the Level 1 training at an earlier 2 year frequency as they do not require the clinical detail as in the annual Level 2 aimed at the remaining Clinical Staff. Therefore 69.49% of staff have Level 1 and the overall Trust figure for meeting Moving & Handling competency is 63.82%.

Equality, Diversity & Human Rights. Despite remaining in red, the overall figures have increased again this month (7%) and individuals are booking onto future courses.

Emergency Planning The cleansing work from last month has corrected the figures and these are now very positive.

Health, Safety & Welfare : This is the nationally recognised title for Risk. All staff now need to repeat this every 3 years. Clinical staff who currently have the annual competency will not get their 3 year Risk competency until they have done the risk training in 2015. The clinical mandatory training sessions will be amended to reflect this in 2016.

Safeguarding Adults : This has now been mapped and a significant improvement from last month - from 15.78% to 73.94% meeting requirements

ACTIONS: Completion of the outstanding competency anomalies.

RAG Rating

Recruitment Data - Vacancies December 2014

Vacancy Reference	Staff Group	Department	Job Title	WTE Advertised	Dept Budegeted WTE	Actual WTE	Vacancy covered by agency/bank	Recruitment Notes	Anyother absence within department, sickness etc	5 week Target cleared or breached
276-1330	Administrative & Clerical	276 200002 SLR Breast	Medical Secretary	1	6.76WTE	8.77WTE	Bank	Appointed		
276-1345	Administrative & Clerical	276 200002 SLR Breast	Medical Secretary	0.27	6.76WTE	8.77WTE	Bank	Vacancy withdrawn due to restructure of hours with in department		N/A
276-1242E	Medical & Dental	276 200011 Plastic Surgery	Trust Registrar Plastic Surgery	1						
276-1343A	Medical & Dental	276 200011 Plastic Surgery	Specialty Registrar - CT2	1						
276-1348	Administrative & Clerical	276 200013 SLR Sleep Studies	Administration Support Assistant	0.53	8.04WTE	5.15WTE	Bank	appointed bank to permanent		
276-1339	Medical & Dental	276 210001 Anaesthetics	Consultant Anaesthetist	1				Pre-employment checks in progress - start date agreed		
276-1342	Nursing & Midwifery Registered	276 210002 Theatres	Peri-Operative Practitioner (NMC)	1	128.88WTE	115.26WTE		Not appointed applicants withdrawn		
276-1351	Nursing & Midwifery Registered	276 210005 Paediatrics	Senior Paediatric Staff Nurse	0.64	17.87 WTE	16.28 Wte		Apointed - waiting clearances		Now cleared start date 26.01.15 Breached by 2 days
276-1354	Nursing & Midwifery Registered	276 210005 Paediatrics	Staff Nurse	1	17.87 WTE	16.28 WTE		Appointed bank to permanent		
276-1328A	Allied Health Professionals	276 210006 Radiography	Senior I Radiographer	1	7.17 WTE	4.96 WTE		Appointed		
276-1349	Healthcare Scientists	276 210012 Prosthetics Laboratory	Principal (2) Maxillofacial Prosthetist	1	12.26WTE	10.16 WTE		Waiting DBS Clearances at 5.01.14		
276-1332A	Allied Health Professionals	276 210014 Therapies	Occupational Therapist	1	29.56WTE	27.90WTE		Internal promotion		Cleared
276-1320A	Additional Clinical Services	276 210027 Maxillofacial Nursing	Maxillo-Facial Dental Nurse	1	20.16WTE	19.05WTE	Unknown	2 WTE appointed 15th Dec - position to date 1. waiting references and DBS. 1. waiting occupational health clearance		Not cleared 2 cases now beaching 5 week target
276-1344	Nursing & Midwifery Registered	276 210027 Maxillofacial Nursing	Maxillofacial Unit RN Staff Nurse (Band 6)	1	2.80 WTE	2.19WTE	Unknown	Appointed - Internal promotion		
276-1275C	Nursing & Midwifery Registered	276 210031 Canadian Wing	Staff Nurses (C-wing)	2	40.30WTE	29.23WTE	Agency	Not appointed - extended live date on NHS Jobs		
276-1355	Nursing & Midwifery Registered	276 210033 SLR ITU	Practice Educator	1	16.16WTE	11.80WTE		Appointed internal promotion		
276-1353	Nursing & Midwifery Registered	276 230001 Trust Board	Director of Nursing & Quality	1	1.0WTe	1.0WTE	No	Successfully recruited Interim DON		
276-1285A	Administrative & Clerical	276 240001 Human Resources	Deputy Head of Human Resources	1	11.74WTE	15.24WTE	Interim	Successfully appointed		Cleared start date agreed 16.02.15
276-1338	Administrative & Clerical	276 240001 Human Resources	HR Assistant	1	11.74WTE	15.24WTE	No	Successfully appointed		Now cleared start date 02.02.15 Breached by 23 days
276-1327A	Additional Professional Scientific & Technical	276 250009 Risk Management	Medical Devices Officer	0.5	0.50WTW	0.0WTE		No suitable candidates shortlisted		
276-1347	Administrative & Clerical	276 260001 Finance Department	Accounts Payable Team Leader	1	17.72WTE	15.93WTE	Unknown	Did not appoint - readvertised		
276-1309	Administrative & Clerical	Maxillofacial (off-site at Darent Valley Hospital)	Typist	1			Unknown	Appointed and cleared to start		
276-1358	Medical & Dental	Maxillofacial Surgery	Locum Consultant: Oral and Maxillofacial Surgery-Head	1						

	Internal Promotion
	At interview stage
	Breached 5 week target

QVH Recruitment –Task & Finish Group – updated on 21st January 2015

Area	Activity	Details	Who	Timescale	Progress RAG	Progress update
	First Level / Tier					
Enhancing internal recruitment processes		Agreed at December forum to book 2 days per month for recruitment activity – (for all depts inclusive) –none specific but aimed primarily towards nurse recruitment from January **2015** onwards:- 06 Jan – Jubilee Rm 20 Jan – OT6 11 Feb – Jubilee Rm 17 Feb – Jubilee Rm 06 Mar – Jubilee Room 18 Mar – Jubilee Rm T&F successes report -1 side A4 End Jan 15	MDH Agreed as an action at December 2014 meeting	Dec 2014		December 2014
New schemes		Development of an Apprenticeship Training Scheme within QVH	MDH and Dominic I/DOF discussions Dec 2014 Develop for:- • Hotel Services • Medical Secretaries	?		
Employment Incentives and Support	Nurse post rotations Bands 5 & B6	• Implement rotational postings for QVH nursing workforce - commencing with B5 Posts ;- **approved** 15/12/14 –all B5 posts rotate at 6m intervals – Including ENT Nurses with exception of Theatres due to training issues –B6 post to follow	Matrons Matrons / Ward Mngrs / Recruitment Team Matrons /Ward Managers	Dec 14 - **actioned**		December 2014

Recruitment / Reward Initiatives	Post Registration Course Training	• Document Nurse rotational / 6 month post structuring in future recruitment advertisements discussions - (Burns / C Wing /O/Patients) (begin with Band 5 –**actioned** migrate to Band 6 over time • Band 5 Nurse JD discussed Jan 14 meeting –develop B6 JD next • Record rotational area work cycles into new /existing Nurse B5 Nurse JD – basic competencies • Contract in place with Brighton Univ to fund burns and plastic surgery modules for nursing degree top up modules or clinical enhancement pathways dependant • Michael Turner recruitment of 6 posts -2 posts mid Feb 50% nursing staffing **Action**: MT to liaise with MB ref this activity) • Offer of Nurse Post Registration course as part of PD at 18 month stage of service with QVH	Matrons / Ward Managers / Dep Head of HR - Recruitment DON / Matrons / L&D Team - **All agreed in principle** Michael Brown (CDP) Will raise paper for Feb 15T&F meeting MT to discuss at Feb meeting **Agreed at Jan meeting** – reflect this in future documentation and JD's	Dec 14 – **achieved** DON not present at Dec meeting but all in agreement – subject to financial approval MDH liaise with matrons and recruitment ref this action		
	Estates & Facilities (Hotel Services)	• Consideration towards development of a staff 'apprenticeship' scheme • 18+ apprenticeship • Katherine Bond knows about funds to develop scheme • 4 days PW at QVH	Raised by Dominic Tkaczyk (I/DOF) in early Jan 2015 for group consideration?	Raise via Board paper in next business quarter for Board support?		

		• 1 day at college • £1000 grant per student • Pathway to develop working alongside work experience scheme/				
	Relocation Allowance	• (Out of date) Relocation Expenses Policy Dated 10/03, stipulates :- 1) Current / new workplace location is at least 50ml apart in distance 2) Is relocation required /arrangements made reasonable? 3) Alleviation of hardship if not supported 4) Can be financially supported 5) 100% / part refundable on scale if post holder leaves within a 2yr timeframe 6) None householder – renting accommodation up to £2k maximum in expenses 7) House owner can claim up to £5K max in expenses. **<u>Relocation Allowance - criteria of eligibility :-</u>** Eligibility Assistance with relocation expenses may be given in the following circumstances: 1 Where, on taking up a new post with QVH the relocation of an employee's home is necessary and the post is one which has been designated as 'eligible' in advance, i.e. is at the advert stage, as attracting support with relocation.	(or agreed distance? 50 mile proposal currently? Time limit for claiming this within 6 months of moving? Agreed at Jan mtg Leads :- Head of HR / Deputy Head of HR / DON & Matrons	2015-16 financial year?		December 2014

		2. Posts that will be eligible for assistance with relocation expenses in accordance with this agreement , must: a. be clearly stated on the UK Home Office Border Agency, Shortage Occupation List?. Or: b. be proven, by unsuccessful advertisement on 2 occasions, to be a 'hard to fill' post. In this case the recruiting manager must demonstrate this and have agreement from the Dir of Nursing / Finance Dir & Head of Human Resources, clearly stating on subsequent adverts that relocation expenses will apply to this post. 3. The Head of HR retains the discretion to extend eligibility to other posts that may not meet criteria above, but are seen as key to service delivery in QVH. - It is anticipated that any such exceptions will be minimal. 4. Where suitable employment is offered and accepted as an alternative to redundancy and the new post involves a change of base, necessitating relocation, etc. 5. In circumstances where the Trust agrees with the employee that relocation is not appropriate or practical, including circumstances where the employee is not in a position to move home, assistance with excess travelling expenses may be given for a period of up to 3 years? 1. Any such payments will be made irrespective of their grade. Such reimbursements will be subject to income tax deductions under PAYE. 6.Mileage rate will be reimbursed at public transport rate, which be reviewed in light of any changes to nationally agreed mileage rates.	Item b - Dependent upon individual circumstances As and when to be agreed by the current I/DOF and HOD This scheme Excludes Medical Consultants in QVH who have a separate policy and structure for this As contractually different			

	Utilisation of 'good' candidates interviewed from other roles –not 100% for role they applied for but good fit for similar / other roles within QVH	Retention of good unsuccessful candidates at interviews for other roles deemed to be a good fit? Establish structure of notifying good 'second place' candidates to other recruiting managers. within a 7 day timeframe – spreadsheets /database/word of mouth!	Deputy Head of HR & / Matrons Database with limited shelf life and word of mouth from Matrons and ward managers ref good candidates –with :- • Skillsets • Put names and offer to bank rosters – if agreeable for admin /clerical take up? • Offer other vacancies to them as opportunities arise whilst on bank contracts			
	Xmas 2015 Issues	Internal Quick Wins Schemes for staff reward				
	Xmas Lunch – December 2015	• Develop a situation that works for everyone -transparency to process!	Agenda item next JNC/LNC meeting? – develop and canvass staff	Discuss again at Feb 2015 meeting		

	Xmas decorations around QVH (2015)	• Staff subsidy –charitable funds £10ph token to all staff • Agreed funding package • Set aside funds for this - £1000 initially to grow over the 12m? Same vein discussions as for staff xmas support package	for opinions so we can action before summer 2015? • Available to everyone • Token via payroll? • Release email c Sept 2015 with agreed package for staff IPAC censored Xmas decorations spend - £2000? Charitable league of friends?			
	Positive action to staff sickness	• Staff who have a nil record of sickness in year 2014 -15 are rewarded from • 1 x days (7.5 hrs.) extra leave - 2015/16 • Half days xmas shopping - or gift voucher to spend • Discretion to give it over a 3m period Nov-Jan e.g.	• Equality impact this? • Need to ensure sickness is unrelated to a known chronic condition /issue • Development of a buy back your leave scheme for those in key posts who cannot take all their leave over the set period			
	Second Level / Tier					
	Refer a friend scheme / Staff reward incentive	• (Strictly on a case by case basis; subject to management approval) • £250 per head / staff recruited member into a post after a 3m period • Further £250 payment at the 12m stage subject to /	OK in principle post meeting with Stuart Butt 04/12 – Scheme if approved is subject to strict caveats of not having close families working in same dept as	MDH saw Dominic (I/DOF on 15/1 – **scheme not supported so issue is now closed**		

	Exit Surveys	• All staff leaving QVH complete a staff exit questionnaire online / paper copy • Develop /analyse trends developing? • Patterns emerging • Tell us what you think?	Jan & Jan mtg group approach:- Open Envelope and hard copy survey approach –exciter places the survey into the envelope – seals it and HR picks it up approach? Sense check and owned by HR	MDH to raise email to managers raising awareness of exit interviews Karol G & team briefed on this 21/1		
Trust / NHS Jobs Website	Refresh QVH Web-based Media	To include: • NHS jobs hyperlink on intranet • Video clip of QVH key staff advertising QVH as a 'good place to work' – then hyperlinks to get more information? • Jobs available to staff application form – • Review recruitment packs • Patient stories of QVH as a centre of excellence to work in. • Meet with Michael Brown (PDC) to share /explore best practice he undertakes –/ conversion rate - who stays at QVH? • Information about East Grinstead and any local attractions?	Driven by recruitment Matrons/ Deputy Head of HR & Matrons Deputy Head of HR	Nov 14 - onwards		

	Weekly Jobs Bulletin	• Production of a weekly internal jobs bulletin on public noticeboards to identify posts being recruited to QVH to support promotion and joint working between departments. • QVH Intranet Posters adverting working here in public areas – • canteen notice board • /hospital notice board –main corridor • TV screen in waiting area listing current QVH vacancies? • Recruitment terms • HR metrics	MDH / Deputy Head of HR / Matrons Listing of Posts on HR Intranet	Immediate		
	NHS Jobs 2	• Use of video clips to accompany NHS jobs advertisements currently used? • Recruitment 'template' pool – to work with managers on	Deputy Head of HR / Matrons • Need to set up a scoping meeting with recruitment • Life for busy people? • MDH to canvass Southampton Hospital HRD for opt out discussions NHS jobs • Ideas base? • MDH spoke to	Immediate		

			Soton GH HRD **on 21/1** ref opting out of NHS Jobs 2 process – work still in progress			
QVH **Branding and Promotion**	Communications Dept promotion of QVH as a 'good' place to work		• Reflective wording on new /current documentation?	Deputy Head of HR liaise with Comms?		
	Use of 'Friends and Family' Test results		• Utilising the friends and family test results to promote QVH as a place to work- weave this into future staff attitude survey action plans / promotions etc.; • Add a strap line to all vacancies about current QVH average. • Top performing Cancer care NHS Trust -100%	Deputy Head of HR /All MDH sent out 2 emails to QVH staff ref F&F Q4 2014-15		
	Increasing Employee Advocates		• Identifying individuals in QVH who will act as 'advocates' for the Trust, through promoting their department and roles to prospective candidates.	All		
	Utilisation of Open days for registered nurse corporate recruitment – N.B. **Jan / Feb 2015?**		• Creating QVH wide open days for registered nurses to offer a one stop shop process.-interview guaranteed with a senior member of the team upon arrival. • Offer interviews and assessments on the day?. • Ensuring information and general literature is available for prospective staff. • Wide publication of	All MDH meeting with Laura Donaldson on		Agree the value of corporate/individual open days –. Broaden the existing plan to move to a corporate calendar of activity.

		events. • share names after the event with other QVH areas.	25/11 to discuss this		
	Utilisation of Recruitment Open days for staff – Jan 2015 – every year? HCA corporate recruitment on agenda	• Creating Trust wide open days for HCA recruitment to offer a one stop shop process for those who wish to understand and undertake the role. • Offer interviews and assessments on the day.	Matrons		
	Third Level				
Overseas Recruitment	Secure a strategic partner(s) for overseas recruitment	• Secure a strategic partner(s) for overseas recruitment campaign, via a procurement exercise. • Partners(s) must be able to focus on nursing supply, and other key areas (Medical, AHP). • Selection process to be conducted during August / September.	All (if required)		
	Employee Accommodation	• Accommodation for new nursing staff? • Draw up business plan in 2015? To explore issues and funding? • 2 x protected house in meridian way	DON		
	Ongoing overseas campaign to Spain/Portugal for registered nurses (incentive supported)	• Continue overseas campaign to Spain/Portugal to secure additional WTE's. • Review package			

		including a golden welcome to ensure QVH remains competitive with other overseas recruiters.			
	Set up alternative interview screening processes for direct hires	Establish a formal process for interviewing via internet media such as Skype. Set up a Skype interview hub.			
Recruitment of newly qualified registrants	Co-ordinate corporate recruitment events to maximise recruitment from new qualifiers (2x year) • Michael Brown - (Paper written and submitted to steering group – Dec 14) – to be disseminated & discussed at Jan 2015 meeting)	• Participate in all available recruitment open days run by local HEI's. • Run corporate trust wide interview process for newly qualified staff twice yearly. • Run corporate induction and oversee local induction process and preceptorship for recruits. • Aim to ensure promotion prior to London Hospitals.			
Utilisation of Candidates					
	Talent database?	Explore how a talent database could be created to hold details potential candidates (2nd place, or appointable in the future with experience).			

Next meeting in Feb 2015 (from Jan meeting):-

- Emphasis about recruitment as an agenda item
- Feedback ref recruitment open day –Tues 27th Jan 2015
- Later items on the agenda not discussed at Jan meeting-take up

Key:

Anticipate Impact	Definition	Progress RAG	Definition
High	Likely to yield more than 10 candidates	Green	Complete
Medium	Likely to yield more than 5 but less than 10	Amber	In progress
Low	Likely to yield less than 5 candidates	Red	Significant slippage against target and / or at significant risk

V1.0 November 2014

Review further use of local Recruitment and Retention payments (in line with Agenda for Change terms and conditions) for hard to recruit posts, and where there is a specific business need. Identify plan for the next 6 months.

Ensure sustained system to centrally monitor use of R&R. Note that R&R premia must be funded by the Divisions / Operational area.

Depts to review R&R Premia for B5 Nurses, working together to review cases and design appropriate premia. –consideration to appointing B6 nurses to fill vacancies existing but also provide a higher level of nursing to work within our specialist foundation trust.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29th January 2015
Reference number:	012-15
Report from:	Jane Morris, Interim Head of Operations
Author:	Jane Morris, Interim Head of Operations
Report date:	19th January 2015
Appendices:	A: QVH 2020 KS03

Quarterly update on delivery of Key Strategic Objective 3

Operational Excellence

Background

1. The attached document summarises the progress against actions in respect of delivery of key strategic objective (KSO) 3 – Operational Excellence.

2. This is a key strand of QVH 2020 and identifies the actions that support organisational delivery of streamlined services that ensure our patients are offered choice and are treated in timely manner. Operational excellence will be about everything we do.

3. This will involve embracing the use of technology, implementing lean systems, reducing duplication, striving to be paperless by 2018, standardising processes, reducing waste, co-locating departments to improve efficiency and reviewing structures to ensure fit for purpose.

Process

4. Operational Excellence QVH 2020 programme has been prioritised and incorporated into a 'roadmap' for implementation over the next 5 years.

5. The following groups are meeting regularly and are being used to ensure Operational Excellence is delivered over the next five years

    - Electronic Patient Record steering group
    - Out Patient Redesign group
    - Pre-assessment group
    - Theatre User group
    - Trauma Management group
    - In-patient redesign (due to be set up in Q4)

6. The actions that were identified for achievement during 2014/15 are shown in Appendix A and have been updated to reflect progress to date.

7. The attached document is shared with the Clinical Cabinet and is updated following discussions at the groups mentioned overleaf, using their action plans to support the achievement of delivering operational excellence as part of QVH 2020 programme.

Key issues

8. The main focus of the actions relate to the key areas of focus of KS03 in 2014/15: Pathway redesign, Capacity review and delivery of the annual operational plan.

9. Delivery of the objectives sits across the operational team, with the Interim Head of Operations coordinating progress through the key transformation groups that are supporting QVH 2020 as part of the wider Operational Excellence action plan.

10. Progress has already been made against a number of the objectives. The main areas of challenge are;
    - Continued focus of operational team on prioritising compliance with operational performance standards for 18 weeks and cancer - see separate board report.- which has meant that some developments have had to be delayed
    - Introduction of the new national e-referral system replacing Choose and Book being postponed until Spring 2015 and lack of electronic document management storage space on Patient Centre has meant we are not able to move towards implementing using electronic referrals within the Trust during 14/15..

11. It is recognised that this document provides evidence of progress against the short term plan for KSO 3. Detailed plans regarding the longer term goals for Operational Excellence have been developed with the relevant teams with the support of the QVH 2020 Programme office and are being updated regularly.

Link to Key Strategic Objectives

12. The above information relates to the key strategic objective – Operational excellence.

Implications for Board Assurance Framework or Corporate Risk Register

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

14. No new risks have been identified.

Regulatory impacts

15. Nothing within the paper attached indicates that the organisation is not fully compliant with the Care Quality Commission's requirement for the Trust to be
    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

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

Recommendation

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

KEY STRATEGIC OBJECTIVE 3 Operational Excellence

Improving Productivity and reducing costs – through pathway redesign, delivery of operational plan and stakeholder engagement

	KEY ACTIONS 2014/15	Owner	Measure	Due	Progress	RAG
	Pathway redesign					
1	Implement pre-assessment IT system	JM + AN/TV/JD	Pre-assessment steering group minutes. Synopsis project update reports	Oct-14	Pilot of system has now been confirmed for 26th Jan 2015. Delay has been due to combination of factors including November push on 18 weeks and new scheduling theatre booking process being implemented in Dec	A
2	Introduce electronic referrals	JM	No paper referrals being used within trust to book OPD appointments	Dec-14	Software solutions were put in place to scan referrals electronically into Patient centre. However storage issues have been highlighted. Alternative solutions being sought. Single point of receipt of referral put into place from July and referrers encouraged to send electronically rather than paper copies. Upgrade of Patient Centre now taken place. New national e-referral system now been delayed until Spring 2015	R
3	Introduce dedicated LA DC / See and Do unit	JM / GM for Surgery & Anaesthetics	Opening of Theatre 11	Jul-14	Theatre 11 is now seeing 80% sessions utilised. Further see and do sessions are planned to come on line during Q4	G
			Movement of activity from main theatres	By Sept 2014	Plans in place to facilitate these lists once theatre 11 open as theatre staff ill be available	G
			Reduction in waiting list backlog	From July 2014	Backlog clearance has begun. Trajectories in place to monitor progress and weekly patient access meeting set up to focus team on booking patients without TCI's waiting over 13 weeks	G
4	Review and implement revised theatre scheduling systems	JM/PS/SJ	Pilot to be completed and reviewed by theatre user group	Pilot completed by October 2014	Push on reducing 18 week waiting times and seeking replacement theatre scheduling system has meant that pilot has been put on hold. However in the meantime generla improvements to scheduling are being implemented and nearly 60% of patients now have TCI booked over 3 weeks notice. Teams are striving to meet 80% by the end of March 2015	G
5	Introduce internal service improvement training modules	JM/AN	Training proposal for service improvmenet to be devised	Sep-14	Opportunity has arisen to have two members of staff trained to deliver Organising for Quality programme in house. All materials and resources will be made available to QVH to use and is the same programme that was run in the Trust by the NHS Institute in 2012/13 for two cohorts. Strategy for continous improvement training is being revamped to include this latest development. Aim is to start a training programme now in Q1 15/16.	A
			Programme to be launched	October 2014 onwards		
	Delivery of annual operational plan					
6	Delivery of annual operational targets as agreed by Trust board for clinical spoeciality areas	JM	a. 18 weeks standard, inc. 28 day guarantee	Monthly	Weekly Operations and patient access meetings put into place	G
					Proactive validation of admitted 18 week pathways adopted	
			b. Service lines performance		Ops restructure to taken place in May 2014, and will be fully established from Aug 14	
			c. Mandatory training and ADR compliance		Detailed action plan devised in response to IST visit in April and now being implemented	
7	Delivery of streamlined pathways of care for cancer patients particularly off site	JM	Average waiting time for cancer patients off site to be reduced	Monthly	Trend analysis to be undertaken	G
			Compliance with cancer waiting time targets		Process map of delays in off site planned	
			COSD completion rates		COSD action plan to be reviewed for progress	
					Agreed will use Infoflex for Trust cancer database which will help streamline data sources for CWT, DAHNO, COSD	
8	Capacity versus demand review to be undertaken quarterly	JM	IST Demand and capacity tools to be completed for each Speciality quarterly	Quarterly	Q1 models completed and trajectories developed	G

	Delivery of increased productivity					
9	Introduce Productive OPD series	Service Manangers and Matrons	Start and finish times Throughput per OPD clinic	Monthly	Monthly dashboard has been devised. Zero tolerence to late starts introduced from Nov, audit undertaken in Dec and results being analysed. Action plan will then be implemented and supported by OPD redesign group.	A
10	Internal review of theatre productivity and introduce productive theatre series methodology	Service Manangers and Matrons	Implement recommendations from recent theatre review	Monthly	Metrics has been agreed by Theatre user group and dashboard now in place. Three theatre productivity pilots underway and will be monitored by Theatre User group. External review undertaken in October, initial results feed back to Trust Board in Dec. Action plan being devised	A
11	80% of elective operating lists to be scheduled at least 3 weeks in advance of operating list, excluding cancer and those requiring donor tissue (QA)	JM /GM Surgical and Anaes Directorate	% of elective operating lists booked on ORSOS upto 3 weeks in advance of date Number of elective surgical cases cancelled and rebooked before admission for the convenience of QVH i.e. non clinical hospital cancellations rather than at the request of the patient or for clinical reasons.	Monthly	Metrics devised and reported regularly Q2 - from data specific areas will be targetted who are booking patients less than 3 weeks notice (excluding cancer) and processes used by secretaries will be reviewed Version 4.3 Patient Centre to be introduced in Q3 Cancellation process – policy in final draft and to be agreed by the end of July	G G G G
12	Review of clinic templates for all clinical services and implement alternatives to FU's to release capacity	JM + GM's + SM's	New to FU ratio's to decrease from current levels Capacity for OPFA to increase Waiting times for OPD to be at 6 weeks for all specialities	Monthly	Audit into N:FU ratio for Corneo has been undertaken and actions being progressed by GM for Surgery and Anaesthetics . Reducing N:FU ratios is being discussed as part of business planning with all specialities.	A
13	Off site spoke review (cross reference with clinical strategy)	JM/ER	Development of clear strategy for off sites	Quarterly	Review of existing sites in terms of activity, income, costs, referral catchment areas is being incorporated into the wider QVH Clinical Strategy work being co-ordinated by E Richardson	G
14	Introduce one stop services for trauma	JM	Number of patients who are treated on the same day as initial assessment Reduction in the number of visits to QVH for NEL patients	Quarterly	Q1 Proposal put forward to Clinical Cabinet for discussion and was in principle approved in May 2014. Options appraisal presented to Clincal Cabinet in Sept 14 with plans for increasing trauma capacity to facilitate improvement for these measures. Futher update provided in Oct 14 highlighting staffing requirements, costs and estate needed. Final paper due to be presented in Dec for implementation in 2015	G
15	Review options around centralized referrals / appointments/scheduling function	JM/PS	Proposal for options for centralized a) Referrals b) Appointments c) Scheduling function put forward for consideration by Clinical Cabinet Implementation of recommended option for the above	Quarterly	Due to operational focus on 18 weeks administrative review and options appraisal for discussion will now take place after the Operational restructure has been completed. In the meantime three times a week Operational scheduling meeting is taking place to ensure complaince with waiting times and maximise theatre utilisation	A
16	Review and implement colocation of departments to reduce duplicaton or delay in process	JM + GM's	Proposal for colocation put forward following a review Implementation of proposal within exisiting estate with minimal capital costs	By March 2015	Work on this objective will beginning once the outcome of the above review of admin teams is known	G
17	Implementation of key IT projects which enhance the Trust's ability to operate more efficient and cost-effective systems that result in improved patient experience, eg outsourced mailing, self check-in, smart scheduling (OPD), patient portal, electronic patient records, as well as maximising use of ORSOS and electronic theatre boards.	JM and service improvement team	Outsourced mailing to be used for 80% of end user letters from Patient centre 80% of patients to use Self check-in kiosks Procurement of OPD smart scheduling system Procurement of electronic patient record system	Monthly Monthly By March 2015	Existing letters been updatd and currently now sending out 77% of letters using outsourced mailing . Project plan being devised to extend system to Sleep and Orthodontics in order to achieve 80% Most recent metrics show improvement each month. Trust wide we have now achieved 75.42% from 54% in July 2013. Team leader for appointments team is asking staff to encourage patients to use the system where possible. OPD Smart scheduling system specification and tender document is being finalised with aim to go out to procurement before Sept 14 QVH staff involved with collaborative in SaCP process. Demonstration and evaluation completed. FBC now being finalised including benefits realisation	G A G
18	Ensure operational teams are able to respond to key strategic service	JM	5 day trauma cover implemented at BSUH Medway ENT all day list from	Jul-14 Oct-14	Q1 Plastic Lower leg consultant in post from June July. Medway ENT post recruited and due to start in Oct. Theatre capacity being facilitated	G
19	Development of QVH 2020 programme management office	JM / QVH 2020 Programme manager and other QVH2020 leads	Programme office established with progress reports tracking key milestones	From July 2014	Q1 Programme manager appointed and office set up. Met with all Leads and devising detailed action plans to establish current progress	G

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29 January 2015
Reference number:	013-15
Report from:	Interim Director of Finance
Author:	Dominic Tkaczyk
Report date:	21 January 2015
Appendices:	A: KSO 4 Report

Quarterly update on delivery of Key Strategic Objective 4

Financial Sustainability and Standards

Introduction

1. The attached paper is an update on the progress with the specific actions designed to provide assurance to the Trust Board on the financial sustainability of the trust.

2. As can be seen from the paper many of the actions are in progress and by definition are 'on-going'. The financial position in year remains healthy with the financial surplus ahead of plan at M9 and forecast to meet the targets agreed within the annual plan.

3. There continue to be underlying variations that are identified through a retrospective review of the financial or operational performance, so it is the area of proactive financial management that requires greater emphasis. An inability to accurately forecast (and deliver to the forecast) potentially undermines the ability of the trust to invest in a timely way and will result in an increasing risk adverse approach to future planning.

4. The development of robust operational budgets, cost improvement plans, a clear understanding of non-recurrent expenditure, the consistent delivery of operational and financial targets will all help to build confidence and reduce the reliance on the need for short term reactive decision making.

5. The actions identified within this paper seek to ensure that future planning is improved and that the current controls are strengthened. The plans are not designed to represent quick fixes but to provide an overarching framework where best practice, transparency, timely reporting and robust controls exist as routine.

6. It should be noted that much of this is already in place and strong financial performance continues, however in striving to meet the future economic challenges faced by NHS providers the trust will need to improve all aspects of performance to remain competitive in the coming years.

Link to Key Strategic Objectives

7. The above information relates to all key strategic objectives.

Implications for Board Assurance Framework or Corporate Risk Register

8. Risks are already included within the current Corporate Risk Register and Board Assurance Framework.

Regulatory impacts

9. Nothing within this report would suggest that the organisation is not fully compliant with the Care Quality Commission's requirement for the Trust to be

    - Safe
    - Effective
    - Caring
    - Well led
    - Responsive

10. There is no impact on the Trust's Monitor governance risk rating or continuity of service risk rating as a result of this paper.

Recommendation

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

Key Strategic Objective 4 – Financial Sustainability

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

KEY STRATEGIC OBJECTIVE 4 – Financial Sustainability							
	KEY ACTIONS 2014/15	**Owner**	**Measure**	**Due**	**Progress**	**RAG**	**Risk**
Delivery of the Annual Financial Plan							
	Financial Planning						
1	Organisational Structures	RT/DT	Agreed operational structure in place and effective	Mar 15	Work continues to develop plans for engagement and future consultation on the optimum structure for delivery of strategic and operational objectives		
2	Annual Budgets	BS	Annual Budgets agreed and published	Mar 14	Complete		
3	Contracts	ER	Contracts signed with all commissioners	Mar 14	Complete		
4	Service Level Agreements	ER	SLAs signed with other providers	Mar 14	Complete but subject to a wider review during 14-15 to ensure these agreements meet the needs of the trust and represent value for money		
5	Cost Improvement Plans	RT/DT	Agreed savings plans for the year 14-15	Mar 14	Complete		
6	Capital Planning and Investment	RT/DT	Capital plans for estates, IT and equipment agreed	Mar 14	Complete		
7	Performance Standards	JM/DT	Confirmation of agreed performance standards – national and local	Mar 14	Complete		

	Financial Control						
8	Financial Support & Advice	BS	Provision of expert financial advice and assurance that financial plans are widely understood	On-going	The finance team has been undertaking regular meetings with all budget holders and have introduced routine drop in clinics to support understanding. Work continues to ensure that all budget holders fully understand the basis of the budgets and associated responsibilities. Further training is being offered to all in the finance team where this is required.		
9	Accountability Agreements	BS	Development and production of accountability agreements for all directorates	On-going	The finance, workforce, activity and performance information has been collated and is being developed to inform the basis of formal agreements in 15-16. This agreement will specify the targets for compliance e.g. financial budget and the responsibilities of the directorate leads.		
10	Establishment Controls	DT/GA	Assurance that robust establishment controls exist, complied with and monitored regularly	On-going	A review of the Establishment Control panel has been completed and changes to the operational arrangements for approval and authorization of changes to pay terms and conditions implemented. Further work to align workforce and financial systems is being progressed.		
11	Discretionary Spend	BS	To identify discretionary spend from within existing budgets and create a framework for the enhanced control of this expenditure	On-going	Discretionary spend relates in the main to estates, IT and equipment. The nature of this spend by definition is non-recurrent and would not routinely sit within a departmental cost centre. Work is underway to identify these budgets for the creation of 'programme' budgets in 15-16.		
12	Financial Reporting	BS	To ensure financial reports are clear, transparent and understandable to their target audience	On-going	Significant work has been completed to provide enhanced reporting at all levels in the organization, including Trust Board reports. The increased focus on directorate level reports has		

					improved understanding but further changes may be required should structures change in the future.		
13	Capital Plans and Monitoring	BS	To produce detailed capital plans that are priortised, provide spend profiles and include contingencies should project cost or timescales change	On-going	The key groups (Estates and Facilities, IM&T and Medical Devices) tasked with oversight of capital planning have all reviewed their T&Cs to ensure clarity about their role and responsibilities. The groups receive regular updates on the latest plans and progress with specific projects. Consideration is being given to the project resources required to ensure delivery of material projects in the short and longer term.		
14	Service Line Reporting	BS	To provide the organisation with detailed directorate profitability statements for each of the key profit centres	Mar 15	Work has yet to commence, outline plans for the future of service line reporting will be developed before Xmas.		
15	Benchmarking	BS	To make greater use of benchmarking to support decision making and the identification of opportunities for savings	Mar 15	The publication of reference costs is due and initial findings will be presented to Trust Board in November. Other examples of benchmarks are being explored.		
16	Internal and External Audit	DT	To make best use of internal and external audit to assure the Trust Board of best practice and compliance with all financial controls	On-going	Audit plans have been agreed and the review findings are routinely presented to Audit Committee. A log of all outstanding recommendations is maintained and provided to evidence progress.		
Cost Improvement Program – 2015-16 to 2019-20							
17	CIP Strategy	RT/DT	To outline the approach to future cost improvement targets that recognises the	Oct 14	The latest agreement reflects the need for a 1.5% saving across all budgets (consistent with the proposed tariff deflator for next year) and 2.5% to		

			need for financial savings but is balanced against quality and future sustainability		come from growth/transformation of our services. Future year savings are planned to be applied in the same way.		
18	CIP Targets	DT/BS	To calculate and provide all budget holders with the impact of the financial savings proposals	Oct 14	A draft of the roll forward 15-16 budgets has been produced including CIP targets and will be shared widely by the end of October. The CIP targets feature as part of the wider business planning framework.		
19	Programme Development	SMT	To work up a range of transformational schemes for discussion and agreement	Oct 14	A number of schemes have been developed in recent weeks and following review at SMT a shortlist created. These transformational schemes will be worked up in detail and form the basis of the cross cutting projects to be implemented in 15-16.		
20	Project Support	JJ	To provide the necessary resources to support and deliver agreed transformational projects	Aug 14	Complete – a project manager has been appointed on a fixed term contract to work with operational teams to develop plans		
21	Quality Impact Assessments	AP/SF	To ensure all CIPs are subject to robust assessments	Mar 15	Not yet due but as projects are progressed the Nursing and Medical Director will be engaged to ensure the savings proposal do not adversely affect safety/quality prior to formal sign off prior to the implementation of any approved project		
22	CIP Monitoring	BS	To routinely report and monitor compliance with CIP targets	Apr 14	Complete – existing Board reports provide details of the current plans and progress to date		
23	Contingencies	DT/BS	To develop plans that provide for slippage in the delivery of any or all CIP projects	On Going	CIP plans are constantly reviewed and where shortfalls are anticipated alternative schemes are considered. In 15-16 the aim is to develop project plans for 150% of the required target to allow for any slippage in savings or increase in the cost of delivery.		

Performance and Standards							
23	Performance Management	DT/JM	To develop and deliver a robust performance management framework for all standards	On Going	The performance management framework has still to be fully defined, including roles and responsibilities. However early work, including the development of senior management team meetings is proving beneficial. The challenge of 18 week and cancer standards has highlighted the need for improved forecasting tools, earlier involvement of senior management and training for staff involved in some of the more complex aspects of the business. These challenges are being addressed and further updates will be provided in the next quarter.		
24	Performance Monitoring	DT/ER	To enhance the quality and timeliness of all performance information in a way that best supports the needs of the target audience	On Going	The appointment of an interim information manager and a RTT analyst has seen positive improvements within information. PTL reports continue to develop and the end of October will see the introduction of a new weekly flash report.		
Business Development Program 2015-16 to 2019-20							
	Reducing the Potential for the Loss of Existing Activity						
24	Contract Management	ER/BS	To actively monitor the contract and ensure both commissioners and the trust are aware of potential risks and opportunities	On Going	The trust continues to comply with the formal requirements of the contract e.g. data submissions and regular contractual updates are provided to the Trust Board routine.		
25	Compliance contractual performance standards	ER/JM	To ensure that the contractual standards are widely understood in the trust and systems for monitoring performance are in place	On Going	The contractual standards cover national and local agreements; whilst national standards are routinely reported/monitored some local standards require further development. As an example the requirement to comply with new to follow up ratio's is an area of financial risk and		

					work is underway to both understand and routinely report our position at a specialty / pathway level		
26	Provide high quality services and excellent patient experience	AP/SF	This is covered in KSO's 1&2	On Going	The safety, quality and experience of our patients all play an important part in the retention of clinical services and the support of commissioners.		
	Maximising the Potential for Growth						
27	Maintain excellent working arrangements with commissioners	ER	To respond proactively to the needs of commissioners and promote the service provided at QVH	On Going	All staff that have an interaction with commissioners have a role to play in maintaining and development good working relationships. This work continues with good progress in many areas and is being reflected in our stakeholder engagement work.		
28	Ensure waiting times, performance, patient experience and outcomes are better than competitors	DT/ER	To move beyond agreed standard and strive to become the preferred provider for commissioners and patients	On Going	Planning and the necessary resources are being identified to ensure that the trust is able to deliver performance better than agreed standards. This is a longer term aspiration but is an integral part of the wider QVH2020 strategy.		
	Developing Opportunities to Attract and Deliver New Services						
29	QVH - Business Case Development	ER	To develop	On Going	Work to develop the specific QVH2020 projects continues with business cases being reviewed at presented to trust Board at each stage in the planning process.		
30	Localised Developments	ER	To provide a framework whereby new ideas and opportunities can be progressed	Mar 15	The 2015-16 business planning process will consider all potential service developments or ideas to generate additional revenues. These will be subject to review at SMT with approved plans being developed into detailed business cases for wider consideration		

Queen Victoria Hospital NHS
NHS Foundation Trust

Meeting date:	29th January 2015
Reference number:	014-15
Report from:	Beryl Hobson, NED & Chair Designate, and Richard Tyler, CEO
Authors:	Beryl Hobson, NED & Chair Designate, and Richard Tyler, CEO
Report date:	22nd January 2015
Appendices:	a) ToRs of working group b) Current structure c) Other Trusts committees d) Example ToRs for Finance & Performance committee e) Proposed revised governance structure

QVH Board Governance Review: interim update

Background

1. This paper is an interim report on progress of the working group examining board governance structures. It provides the board with the opportunity to comment on the direction of travel in advance of the final report.

Development process

2. The working group has examined the current QVH board committee structure in the light of Monitor's Well-Led framework and the governance structures of other trusts and best practice in governance generally.
3. Comments received from the board will shape the future plans of the working group

Key issues (proposals)

4. The paper proposes the addition of a monthly board Finance and Performance committee to ensure detailed probing of financial and performance issues as an additional source of assurance to the board.
5. It also proposes that the Quality and Risk committee should meet more frequently and a monthly basis is proposed. In addition to recognising the substantial agenda for this committee, this is also a reflection of the emphasis that the board places on the quality and safety of our services
6. On the basis of strengthening the existing assurance processes, it is proposed that formal board meetings should be held every two months rather than every month as at present.

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

7. There are no implications at this stage.

Regulatory impacts

8. The Well-Led Framework states that board should regularly review their governance structures.

Recommendation

9. The Board is recommended to discuss and the contents of the report and provide feedback for further consideration by the working group.

10. In particular the board is asked to note the proposal that a further interim report should be prepared for the March board meeting, with a final report in June in preparation for an implementation date of 1st October

QVH Board Governance Review: interim update

1. INTRODUCTION

1.1 The Board chair (designate) was charged with undertaking a review of existing Board governance structures. The terms of reference (appendix A) included the requirement for an interim report to be received by the Trust Board in January 2015. This paper aims to meet that requirement, providing an update on the emerging findings and giving the Board an opportunity to comment prior to final recommendations being made later in the year.

2. CONTEXT

2.1 Foundation Trust governance requirements have changed considerably in recent years. Since August 2010 all aspirant Foundation Trusts have been required to undertake a Board governance assessment as part of the Monitor *Quality Governance Framework*. This process has undergone a number of iterations culminating in the publication of the *Well-led framework for governance reviews* which was published in May 2014. As part of Monitor's *Risk assessment framework* all foundation trusts are expected to carry an external review of their governance every three years. The *Well-led framework for governance reviews* is the framework within which any external review should be commissioned.

2.2 NHS Trust governance regimes have also been the subject of scrutiny in the aftermath of the Francis Report. The Care Quality Commission (CQC) includes a 'well led' dimension within its inspection regime and it is expected that, as part of this regime, the CQC will ask foundation trusts how they have assured their governance arrangements.

2.3 Queen Victoria Hospital (QVH) NHS Foundation Trust was one of the first foundation trusts to be established and its governance arrangements have been adapted continually to meet the needs of the Trust and its external regulators. This is consistent with the requirements of the NHS FT Code of Governance which states that ' the board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS FT's effectiveness, efficiency and economy as well as the quality of its healthcare delivery'. However it needs to be noted the Trust has not been subject to the external assurance process required of more recent foundation trusts.

2.4 In this context and against the backdrop of recent changes to the Board at both executive and non-executive level it is timely to undertake an internal review of existing governance arrangements. This does not preclude a future external review, rather it provides an opportunity for the Board to consider the strengths and weaknesses of its existing regime prior to the commissioning of any such review.

2.5 Finally it is worth reminding the Board that good governance does not of itself make a safe, well-managed organisation and that Monitor acknowledges that trusts should feel free to 'tailor the approach to suit their own organisational circumstances'.

3. PROCESS

3.1 Following sign off by the trust board, the chair (designate) established a small working group (see appendix A). The group has met four times and reviewed existing trust arrangements (appendix B), and the structures of other foundation trusts, notably those of similar size and of a specialist nature and those newly authorised (appendix C).

4. INITIAL FINDINGS

4.1 Statutory requirements

Monitor defines the role of the trust board as 'to set strategy, lead the organisation and oversee operations, and to be accountable to stakeholders in an open and effective manner'. However beyond the statutory requirement to establish

- an audit committee and
- a nominations and remuneration committee

it leaves any further decisions on appropriate governance structures for local determination. There is however a clear steer provided in the *Well-led* guidance that 'quality receives sufficient coverage both in board meetings and in relevant committees/sub committees below board level'.

4.2 Quality & Risk (Q&R)

In our review of other trusts it was evident that every trust has some form of quality and risk committee. Whilst sometimes called an integrated governance committee, it is standard practice to have a committee providing additional assurance and review on the key domains of quality and the management of associated risks. The main variation was in the number of times the committee meets. At QVH the committee meets bi-monthly, in other organisations it ranges from monthly to quarterly.

4.3 Finance & Performance (F&P)

This is the main area where QVH is an outlier. The majority of trusts that were reviewed had a sub-committee dealing with finance and performance / investment. The role of the committee is generally to provide additional scrutiny and assurance on all aspects of finance, performance, contracts, estates, IT and business development. In most cases this committee meets monthly with the aim of providing assurance to each Board meeting as to the robustness of in-year performance across these key areas.

In deciding whether or not to create an F&P committee we have considered the advantages and disadvantages of our current approach. There is no doubt that our existing approach provides the full board with a clear line of sight on finance and performance issues. However it is less obvious whether the Board is able to spend sufficient time assuring itself

as to the detail of the performance or if in doing so it is spending less time on the equally important issues of quality and strategy. In addition the Board often struggles to have sufficient time to consider issues relating to estates, facilities and IM&T.

4.4 **Human Resources & Organisational Development (HR&OD)**

The status of HR&OD varies across organisations. A number of trusts have a separate board committee chaired by a non-executive director. In other organisations this is an executive led committee that feeds into a board committee in much the same way as our governance sub-committees feed into Q&R. HR & OD is an important area for the Trust however the need for a board level committee needs to be weighed against demands on non-executive time in a small organisation.

5. INITIAL RECOMMENDATIONS

5.1 Role of the Trust board

The trust board is the primary decision making body and the board of directors has joint responsibility for board decisions with each director taking responsibility for satisfying themselves that appropriate scrutiny and challenge has taken place prior to such decisions being made. The role of the board is to

- Ensure the quality of patient care.
- Provide strategic direction & development of the Trust
- Ensure that assurance is provided on 'in year' performance by the executive and board subcommittees.
- Ensure the availability and quality of people, finance, technology, and the estate.
- Ensure communication with key stakeholders

In exceptional circumstance the board will instigate and participate in 'deep dive' investigations into specific areas of concern

Any changes to the committee structure have to be proposed within this context.

Similarly, as a small trust with a relatively small board any additions to the committee structure have to be considered in the context of non-executive and executive time commitments and work load.

Committees exist to provide an additional level of scrutiny and assurance beyond that which can be provided at a Board meeting. However in delegating these functions the trust board must be assured that committees are being provided with timely and accurate information that allows adequate scrutiny and that they are meeting sufficiently frequently to advise the Board in a timely manner.

Finally in delegating these functions to individual committees the Board must reserve to itself the right to call in reports on any area of the trust business for which it may have a concern. Therefore any changes must be accompanied by a clear scheme of delegation and

reservation with appropriate changes to standing orders (SOs) and standing financial instructions (SFIs) as required.

Within this context we have considered both the content of our committee structure and the frequency of meetings.

5.2 **Quality & Risk (Q&R)**

We propose that Q&R continues in its current form but moves to a monthly meeting prior to the trust board to ensure that quality receives the same emphasis as finance and performance (see quote from Monitor in 4.1). At the moment Q&R meetings are out of sync with the Trust board meaning that on occasion information is considered at the Board prior to being reviewed at Q&R. We would also propose that a clear work programme should be established for the committee to ensure a sufficient balance between monthly review and longer term trend analysis and this would be reflected in a revised terms of reference.

5.3 Finance & Performance (F&P)

We propose that we should establish an F&P committee. The committee would provide additional scrutiny and assurance on the areas listed above. Draft terms of reference are attached (Appendix D). It is suggested that the committee meets monthly prior to the trust board. As with quality & risk we would propose that a clear annual work programme is established to ensure a sufficient balance between monthly review and longer term trend analysis.

To ensure that the board remains in full sight of the work of this committee it is proposed that the monthly performance pack will be circulated to all board members. Additionally board members will receive a summary of the key issues and concerns raised by the committee and proposed actions.

5.4 **Human Resources & Organisational Development (HR & OD)**

We propose the establishment of an executive level HR & OD sub-committee that will feed into F&P. This reflects the need to ensure HR&OD has a sufficient profile within the Trust but recognises the limitations on non-executive time.

5.5 Impact on Trust Board

Taking into account the comments made under 'general considerations' regarding

- the primacy of the trust board;
- the obligation on directors to challenge and seek assurance;
- and the constraints on non-executive time

we have considered the frequency of full board meetings. It is our initial view that, given the proposed committee structure, we could reduce the frequency of formal board meetings to every two months without reducing the primacy of the board or the ability of its members to challenge and seek assurance on in-year performance and strategic direction.

6. SUMMARY PROPOSALS

The following summarises our initial recommendations for further discussion by the Board (for structure see appendix E):

6.1 Board Committees

Move to 5 board sub-committees as follows:

6.1.1 Finance & Performance Committee
Membership – 2 NEDs (and a nominated substitute to cover absence), DoF, CEO, plus in attendance AD Operations and one Governor
Frequency – monthly

6.1.2 Quality & Risk Committee
Membership – 2 NEDs (and a nominated substitute to cover absence) Medical Director, Director of Nursing plus in attendance AD Operations & one Governor
Frequency – monthly

6.1.3 Nominations & Remuneration Committee
Membership – all NEDs plus in attendance CEO, AD HR&OD
Frequency – quarterly

6.1.4 Charitable Funds Committee (no change)
Membership – 2 NEDs, FD, MD, 2 Governors
In attendance – Co Secretary, LOF, Chair of consultants committee, Charitable fund manager and CF co-ordinator
Frequency – quarterly

6.1.5 Audit Committee (no change – apart from increase NED membership)
Membership – 3 NEDs (currently 2). In attendance - FD, auditors and other staff
Frequency – quarterly

6.2 Meeting frequency and timings

As was noted above the introduction of additional committees does have an impact on both NED and Executive time and appropriate support and therefore we need to consider the frequency of meetings, potentially reducing the number of formal board meetings to six a year.

In addition, it is considered that this structure is only feasible when the NED and Executive Director team are up to full complement.

At this stage, the board is asked for agreement in principle to these proposed changes and to ask the Working Group to develop further the proposals regarding board and committee meeting frequency, timing and support

6.2 **Next steps**

Assuming broad agreement on these proposals the Working Group will be continuing its work by developing further the following issues

- The process of committee assurance
- Board assurance and the avoidance of duplication
- The monthly committee and board cycle, the number of meetings and support needs
- The structure of board agendas and papers

Alongside this, the CEO will be reviewing

- the alignment of the executive decision making structures (including Clinical Cabinet) with the proposed governance structures

It is proposed that the next report to the board in March will include more information on these issues. However, given the current recruitment of Non-Executive Directors and Executive board members, and also the current organisational re-structure, it is proposed that a final report should be received by board in June with a proposed implementation date of 1st October. This will enable the working group to identify members of each committee, bearing in mind the skills and experience of the new NED (due to be appointed in April) and set out an implementation timetable.

Appendices

A – ToR of Working group

B – Current structure

C – Other Trusts committees

D – Example ToRs for Finance & Performance committee

E – Proposed revised governance structure

QVH – REVIEW OF BOARD GOVERNANCE STRUCTURES
TERMS OF REFERENCE /SCOPE

Name of Group

GOVERNANCE REVIEW GROUP

Purpose

1. To ensure an effective governance structure which will enable and support QVH to meet its strategic objectives and ensure compliance with regulatory requirements, including those of CQC and Monitor
2. To ensure the governance structures are fit for purpose and in line with best practice in the NHS and other sectors

Scope

To review the current governance arrangements including

- Board committees
- Board meetings
- Board papers
- Assurance frameworks (systems and processes)
- Interface with Clinical Cabinet and Senior Management Team
- Interface with the Council of Governors

By

- Mapping existing arrangements, identifying areas of overlap, gaps and strengths and weaknesses
- Reference to the NHS Foundation Trust Code of Governance; Monitor's 'Well-led framework for governance reviews: guidance for NHS foundation trusts'; QVH constitution
- Inclusion of feedback from the survey of governors currently being undertaken
- Researching the governance structures of other successful Foundation Trusts

Membership

Beryl Hobson
Richard Tyler
Lester Porter, NED (SID)
Brian Goode, Governor
Lois Howell
(input from other NEDs, Exec Directors etc by interview)

Accountability

Reporting to the Board
Interim report to the Board – January 2015
Final report & recommendations to March 2015 board with a view to implementing any agreed changes wef 1/4/15

Secretariat

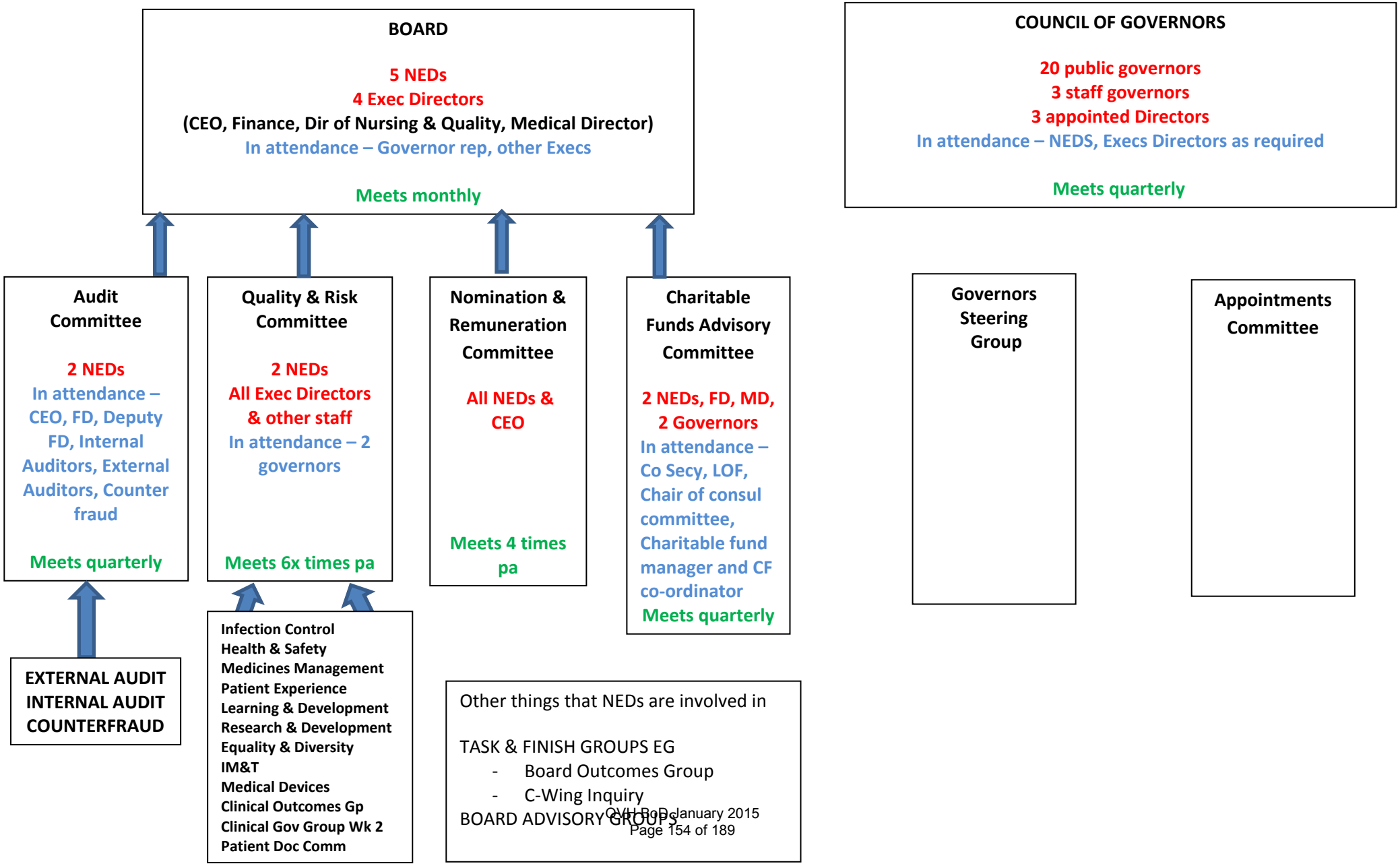
Hilary Saunders
Jean Blunt

Frequency of meetings

Monthly for 5 months

Review Date

WHERE ARE WE NOW?



Best practice elsewhere

Trust reviewed	**Board frequency**	**Board committees** * Terms of reference available
SPECIALIST TRUSTS		
Great Ormond Street Hospital NHS FT	Monthly	Audit * Clinical governance * Finance & investment Risk assurance & compliance
Papworth Hospital NHS FT	Monthly	Audit Finance & business Quality & risk
Royal Nat Orthopaedic Hosp NHS FT	Monthly	Audit Finance & performance Clinical quality & governance Health, safety & environment
Liverpool Women's NHS FT	Monthly	Audit * Putting People First (HR&OD) * Finance, performance & business development * Governance & clinical assurance * Nominations * Charitable funds *
Sheffield Children's NHS FT	Monthly	Finance & resources Risk & audit Clinical governance Board noms & rem
Royal Nat Hosp for Rheumatic diseases NHS FT	Monthly	Finance & activity Integrated governance& quality assurance Clinical risk Audit
RECENTLY AUTHORISED TRUSTS		
Western Sussex Hospital s NHS FT	Monthly	Quality & risk Finance & investment Patient experience and feedback Audit SUI scrutiny panel Charitable funds Appts and remuneration
Kingston Hospital NHS FT	Monthly	Audit Finance & investment * Quality assurance * Remuneration * Trust & charitable funds *
Bridgewater Community NHS FT	Monthly	Audit Trust efficiency assurance Quality & safety Noms & rem
West Midlands Ambulance NHS FT	Monthly	Audit Operational & financial performance review

		Quality governance Noms & rem
Royal United Hospitals Bath NHS FT	Monthly	Management board Non-clinical governance Clinical governance Audit Remuneration
SIMILAR TURNOVER		
Robert Jones & Agnes Hunt NHS FT	Monthly	Audit * Business risk and investment * Quality & safety * Exec Appts * Exec Remuneration * NED Appts * NED Remuneration *
Wirral Community NHS	8 x pa	Audit Remuneration Quality & governance (monthly) Finance & performance (monthly) Workforce & education (monthly)
Hounslow & Richmond Community NHS Trust	Monthly	Integrated governance Finance & performance Audit Mons & rem FT Committee Charitable funds
Cornwall Partnerships NHS FT	Monthly	Remuneration & terms of service Mental Health Act Audit Charitable funds Performance, finance & investment Quality & governance
Shropshire Community NHS Trust	Monthly	Audit Quality & safety Resources & performance Information governance Nominations, appointments and remuneration
Calderstones Partnerships NHS FT	Monthly	Remuneration Audit Quality & risk Strategy & performance
Dudley & Walsall Mental Health NHS FT	Monthly	Remuneration Audit Mental Health Act scrutiny Finance & performance Governance and quality Management executive team

APPENDIX D

TERMS OF REFERENCE

FINANCE AND OPERATIONAL PERFORMANCE COMMITTEE of the Board of Directors

Purpose

The prime purposes of the Finance and Operational Performance Committee are

- the consideration and approval or recommendation of (in line with delegated powers)
  - Cost Improvement plans
  - Business cases and other business opportunities
  - The Trust's investment programme
  - Specified key strategies
- the overview and scrutiny of
  - performance against the plans, programmes and strategies listed above
  - the Trust's financial and operational performance
  - delivery against the Estates and Information Management and Technology programmes
  - progress towards achievement of, and management of risks to, allocated Key Strategic Objectives

Responsibilities

1. Finance

a. Oversee and evaluate the development of the Trust's financial strategy to deliver its integrated business plan and ensure that the current and planned shadow financial risk rating remains robust and satisfactory

b. Review the annual Trust strategic and financial plans: revenue, capital, working capital and key performance targets

c. Oversee major projects (that have a value of over £500k) from business development to operational readiness reporting findings and providing assurance or exception reports as appropriate to the Trust Board at to their progress

d. Review and maintain an overview of the Trust's financial and service delivery agreements and key contractual agreements

e. Oversee the development, management and delivery of the Trust's annual capital programme

f. Review the Trust's in-year financial and performance position and any plans for corrective action

g. Consider key financial policies, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately

2. Operational performance

a. Oversee and evaluate the development of a Trust performance management strategy to

ensure a framework is in place which allows the Trust to performance manage against strategy and against plan

b. Review the Trust's performance reporting and support the development of appropriate performance measures, including Key Performance Indicators (KPI's) particularly around the quality of services and patient experience

c. Receive the combined integrated finance and performance and quality report including monthly dashboard reports on the trust's delivery of agreed key performance indicators in relation to quality, operations, finance and human resources

d. Monitor the costs associated with bank and agency spend

e. In the event of a KPI showing a red RAG rating over two consecutive months in any three month rolling period, seek assurance that an action plan has been put in place and monitor the KPI until performance has improved

f. In respect of performance issues relating to quality or specific aspects of the Quality & Risk Committee's remit, refer such issues to the Quality & Risk Committee to ensure that action plans are in place

g. Agree a data quality policy and report its approval to the Trust Board

3. Information Technology

a. Ensure the development of information systems to support the business interests of the Trust, including the review and development of performance and financial reporting and overseeing the realisation of benefits from key IT developments.

4. Estates

a. Review performance towards delivery of the Trust's estates strategy, and review and propose future land and property transactions. This will include receiving reports from time to time from the Director of Finance on estates issues identified as strategic risks by the Estates and Facilities Teams and the Quality & Risk Committee

b. Review performance against planned maintenance programmes. This will also include receiving reports from time to time from the Director of Finance on estates issues identified as strategic risks by the Estates and Facilities Teams and the Quality & Risk Committee

5. Strategic Goals

The committee will hold lead responsibility for the following strategic goals, including the management and mitigation of risks identified to these goals:

a. KSO 3 – Operational Excellence

b. KSO 4 – Financial Sustainability

c. Overarching strategic objective – Strategy and Sustainability

6. Investment

a. Review and approve the overall methodology, processes and controls which govern investments

b. Ensure that robust processes (e.g. evaluation of fit with the trust's overall strategy, use of appropriate independent professional advisers) are followed

c. Evaluate, scrutinise and monitor investments

d. Review investment proposals to ensure that the Trust has the legal power to make them

e. Ensure engagement early on in the investment evaluation process of independent external advisers with demonstrated expertise in advising on transactions of the size and nature being proposed

f. Evaluate of all proposed major investments using a thorough evaluation, execution, and monitoring process

g. Ensure that the Trust follows best practice in developing, planning and implementing investment decisions, in line with Treasury Guidance and Monitor's guidance as included within Risk Evaluation for Investment Decisions by NHS Foundation Trusts)

7. Cost Improvement Plans (CIP)

a. Oversee the approval and delivery of the Trust's CIP (subject to the conduct and approval, via the proper process (TO BE CONFIRMED), of quality impact assessments) and the development of the Trust's efficiency and productivity processes

8. Business Development

a. Evaluate emerging commissioning plans and the potential opportunities for the trust

b. Consider and sign off business cases for new service developments, subject to satisfactory Quality Impact Assessments (QIAs)

c. Consider and sign off business cases for service disinvestment, subject to satisfactory QIAs

d. Consider any matters of commercial confidence in relation to the provision of clinical services

The following limits will be applied when considering all business development opportunities:

Estimated annual value (excluding VAT)	**Decision on expression of interest**	**Decision on pre-qualifying questionnaire state (or equivalent)**
Between £500,000 and £1million	Chief Executive in consultation with the Chairman	FPC
Over £1M	Finance and Performance	Board

	Committee	

9. Strategies

a. The Trust Board is responsible for final approval of Trust strategies. However the Finance and Operational Performance Committee will review the following draft strategies and recommend as appropriate their amendment and/or adoption by the Trust Board:
   - Estates
   - Information Management and Technology
   - Investment
   - Market and performance management

b. The committee will ensure that the strategies are being implemented in accordance with their associated action plans.

10. Other duties

The Committee will

a. Following each meeting, via the Committee Chair, provide an assurance report to the Board highlighting areas where assurance was obtained or further assurances sought or areas that require executive action.

b. Support and monitor the preparation of the Annual Report

c. Self-assess performance annually, and draw up and implement a plan for improvement as required

d. Receive training and development to assist the Committee in its responsibilities. This will include sessions from the Trust finance team and where appropriate from external sources

Level of Authority
Sub-Committee of the Board

The Committee is authorised by the board to seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Membership
Up to three non-executive directors.

Attendees
Chief Executive
Director of Finance
Associate Director of Performance
Deputy Director of Finance

Deputy Company Secretary (secretariat) Other executive directors and senior managers may be asked to attend to provide assurance to the Committee.
Quorum Two non-executive directors
Frequency of Meetings Meetings will be held monthly. The Chair of the Finance and Operational Performance Committee may convene additional meetings as deemed necessary.
Reporting Arrangements The Committee will report to the Board of Directors The minutes of the Committee to be reported to the Board after each meeting, along with the summary mentioned at paragraph 9 a The Committee will provide an Annual report to the Board.
ToR Review: Annual These Terms of Reference adopted INSERT DATE, to be reviewed annually thereafter as part of the Committee's self-assessment.

Appendix E

Board

Sub-committees

BOARD

Frequency – (Suggested last meeting- every 2 months)

Who? NEDs (5)

Exec Directors (4)

In attendance

Governor rep

Other Execs

Support teams

Alternative month – informal meeting of board members

FINANCE & PERFORMANCE

Membership – 2 NEDs (and a nominated substitute to cover absence), DoF, CEO, plus in attendance AD Operations and one governor
Frequency – monthly

QUALITY & RISK

Membership – 2-3 NEDs, Medical Director, Director of Nursing plus in attendance AD Operations & one governor
Frequency – monthly

NOMINATJON & REMUNERATION

Membership – all NEDs, Chief Executive plus in attendance AD HR&OD
Frequency – quarterly

CHARITABLE FUNDS

Membership – 2 NEDs, FD, MD, 2 Governors
In attendance – Co Secretary, LOF, Chair of consultants committee, Charitable fund manager and CF co-ordinator

AUDIT

Membership – 3 NEDs (currently 2). FD, auditors and other staff in attendance
(question re Governor to attend?)
Frequency – quarterly

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29 January 2015
Reference number:	015-15
Report from:	Amanda Parker, Director of Nursing
Author:	Alison Vizulis, Head of Risk
Report date:	13 January 2015
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. Fourteen new risks rated 12 and above were added to the risk register in December
3. Two risks were closed.
4. One risk score was reduced from 16 to 12 as repairs had been undertaken to the clean room which reduces the likelihood of failure (identified risk).
5. The corporate risk register was reviewed at the monthly clinical governance group and Clinical Cabinet in January.

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives (delete those not applicable)

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

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

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

Recommendation

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

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

December 2014 data (01/12/2014 – 31/12/2014)

For the period of 01/12/2014 – 31/12/2014 there were 40 open risks scoring 12 and above, which is an increase from 30 for November 2014. The main reason for this is due to the addition of the Board Assurance Framework (BAF) Risks scoring 12 and above to the Datix System.

A summary of any new risks added, closures and rescores is given in this report. The movement of risks is summarised briefly below:

- November open 12+ risks = 30
- Number of 12+ risks closed during December 2014 = 2
- Number of 12+ risks downgraded during December 2014 = 1
- Additional 12+ risks closed due to duplication = 1 (ID 767)
- Revised total of 12+ risks = 26
- Number of new 12+ risks added during December 2014 = 14
- Revised 12+ December 2014 total = 40 open 12+ risks

The Trusts top six 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)
- Cancer – Risk ID 474 – Cancer target breaches (Score=20)
- Performance Standards – Risk ID 765 - Performance against national standards including Cancer, 18 weeks and information/data (Score=20) **BAF Risk**
- Recruitment - Risk 749 – Recruitment of appropriate nursing, non-clinical and medical staff/skill mix (includes staffing numbers) (Score=16) **BAF Risk**
- Clinical Strategy and Clinical Outcomes - Risk ID 759 - Failure to meet Trusts Clinical Strategy and Clinical Outcomes (Score=16) **BAF Risk**
- Annual delivery - Risk ID 760 - Inability to Deliver Annual Operational Plan (Score=16) **BAF Risk**

New Risks added between 01/12/2014 and 31/12/2014 – Fourteen new risks were added during December 2014.

Risk register	Risk Score (C/L)	Risk ID	Risk Description	Rationale and/or Where identified/discussed
Corp	3x5=15	756	Potential impact on core service delivery	Peri-op Matron
Corp	4x4=16	750	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national guidance includes additional recruitment to post of Head & Neck Oncology Consultant.	12/12/2014 - General Manager - Anaesthetics and Surgery, Operations
Corp	4x3=12	758	Risk to the Trust of not meeting its Key Strategic Objectives (KSOs)	03/12/2014 AC & BAF
Corp	4x4=16	759	Failure to meet Trusts Clinical Strategy and Clinical Outcomes	03/12/2014 AC & BAF

Corp	4x4=16	760	Inability to Deliver Annual Operational Plan	03/12/2014 AC & BAF
Corp	4x3=12	761	Inability to Deliver Increased Productivity to Meet Demand	03/12/2014 AC & BAF
Corp	4x3=12	762	Scope and Provision of Clinical Services	03/12/2014 AC & BAF
Corp	4x3=12	763	Financial Control	03/12/2014 AC & BAF
Corp	4x3=12	764	Infrastructure and Investment	03/12/2014 AC & BAF
Corp	4x5=20	765	Performance Standards	03/12/2014 AC & BAF
Corp	3x4=12	766	Risk of Poor Quality Care Resulting from Low Mandatory Training and Appraisal Rates	03/12/2014 AC & BAF
Corp	4x4=16	767	Recruitment of Appropriate Nursing and Non-Clinical Skill Mix (includes Staffing Numbers) *Duplicate risk of ID 749 – Closed 06/01/2014*	03/12/2014 AC & BAF
Corp	3x4=12	768	Risk of Staff Not Complying and Promoting the Trust Core Values	03/12/2014 AC & BAF
Corp	3x4=12	769	Inability to Support Staff Educational Requirements due to Financial Costs and Pressures	03/12/2014 AC & BAF

Risks Closed between 01/12/2014 and 31/12/2014 – Two risks were closed during December 2014.

Risk register	Risk ID	Risk Description	Risk Score (C/L)	Rationale for closure	Committee where closure agreed/proposed
Corp	744	Risk of non compliance with HSE/IRMER due to vacant RPS post in Radiology	4x3=12	Combined with Risk ID 745 (Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources)	CSS-02/12/2014
Corp	710	Increasing bed occupancy on MD ward restricting the trusts ability to deliver care	3x5=15	Focus of risk has changed – Detail now included within Risk ID 749 (relating to staffing)	To be agreed at CGG – 12/01/2015

Changes to Risk Scores for December 2014 – One risk (ID 681) was given a reduction in its risk score:

Risk Register	Risk ID	Risk Description	Previous Risk Score (CxL)	Updated Risk Score (CxL)	Rationale for Rescore	Committee where change(s) agreed/ proposed
Corp	681	Failure of cleanroom air handling unit due to wear and tear and age of unit - ongoing issues	4x4=16	↓4x3=12	Discussion with Medical Director following discussions at November Trust Board. Decrease due to completion of repairs.	As previous column (TB)

Committee Key:

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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
159	29/11/2006	Ability to operationally meet 18 week target for all directorates	Failure to meet referral to treatment time of 18 weeks (RTT18)for a second month could result in reduced Monitor rating and a financial loss of 1.2 million. This could be for the trust aggregate failing to meet target which could be more than two specialties failing in one month.	1. Failure to update booking system on changes during pathway - administration errors 2. Failure to update system on patients declining treatment dates 3. Increased number of patients requiring treatment 4. Inadequate number of surgeons or Consultant absence 5. Lack of theatre space (capacity) 6. Poor validation of data.	1. RTT18 PTL established and now circulated daily. 2. Weekly escalation process now established via clinical specialties managers, OPG meeting twice a week to ensure all capacity is fully utilised. 3. 18 week steering group, each specialty highlighting capacity issues in issues log. 4. RTT 18 action plan being reviewed at steering group. 5. Additional theatre lists provided on Saturdays 5. RTT18 clinical outcome recorded on PAS 6. Additional data analyst post to provide cover for DH returns. 7. Clinical outcome forms revised for each specialty. 8. Develop reports to monitor specialty performance, planned w/l with expected TCI, backlog and open pathways monthly. 9. Validation of PTL lists weekly including admitted, non admitted and open pathways. 10. Amended policy incorporates new guidance re planned cases. 11. Training and guidance issued. 12. Monthly review of planned cases without date for attendance at QVH. 13. Develop early warning systems to track increased demand and mismatch with future capacity 14. Proactively discuss W/L each week at OPG for patients 10 weeks plus who do not have TCI date to avoid breach in each speciality 15. Review and validate all pending TCI's for Apr, May, June to ensure patients booked within 18 weeks 16. Complete modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably 17. Introduce new LA DC facility by July to increase capacity in main theatres for more complex work.	Dominic Tkaczyk	Jane Morris	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	14/11/2014

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	Dominic Tkaczyk	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
765	22/12/2014	Performance Standards	Performance against national standards including Cancer, 18 weeks and information/data		1. External reporting and Sign Off - Senior management and review of all external submissions 2. Information infrastructure and/or inability to produce information internally - Provision of information to the wider organisation, including timetables for publication 3. Data quality - All information to be subjected to standardised validation and verification checks 4. Offsite data (Provider SLAs) 5. Performance against national standards (including RTT) 6. Cancer - Statutory reporting of compliance / Provision of information to demonstrate compliance with standards and processes for identifying variance from desired position 7. Contractual penalties - Monthly reporting of compliance and financial impact to Trust Board 8. Training and Development	Dominic Tkaczyk	Alison Vizulis	20	12		

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
749	10/10/2014	Recruitment and retention of appropriate nursing, medical and non-clinical staff (includes skill mix and safe staffing requireme	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	Recruitment Task and Finish Group in place Recruitment open day on Jan 27th 2015 Regular agency staff complete an oral drug administration competency. Use regular agency staff to reduce the risk Updated the induction checklist for bank and agency staff - Completed and inuse in all areas.	25/11/2014
759	22/12/2014	Failure to meet Trusts Clinical Strategy and Clinical Outcomes			1. Committee reporting structure in place from Directorate levels to Trust Board and back and includes assurance committees e.g. Quality & Rick Committee and Audit Committee clinical indicators, incidents and other data reviewed. 2. Assurance Committees receive minutes from sub-committees 3. Incident & Risk Management Policy in place 4. Risk Management strategy in place 5. Clinical Outcomes Committee in place to review clinical audit and M&M data 6. Clinical audit process and Department in place 7. Directorate M&M meetings in place 8. Regular review of incidents, complaints and claims to triangulate with audit data (Q&RC) 9. Incidents, complaints and claims reviewed as part of the revalidation process 10. Compliance with CQC requirements (2009 and update of 2013) 11. Annual Department risk assessment process to monitor HSE compliance 12. Policy monitoring system in place 13. Incident reporting system in place 14. Incident reporting to National Reporting & Learning System (NRLS) 15. Regular review of complaints by CEO and DoN 16. Monitoring by commissioning CCGs 17. National and local guidance/policy discussed at Directorate meetings and Clinical Cabinet 18. Clinical Governance Group in place for review and monitoring of incidents, complaints, policies, learning, management of risks and key performance indicators etc.	Steve Fenlon	Alison Vizulis	16	8		

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
760	22/12/2014	Inability to Deliver Annual Operational Plan			1. Trust Board and Audit Committee minutes for monitoring of QVH Annual Plan. 2. Programme Board meeting with CCGs to monitor performance and Quality account delivery. 3. Monitor quarterly return Monthly Trust Board reporting of Operational and Financial performance. 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. Monthly 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 mew CCG MSK service e) Open Theatre 11 for LA DC's	Jane Morris	Alison Vizulis	16	9		
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
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	16/12/2014

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	Dominic Tkaczyk	Bill Stronach	12	6	Risk being reviewed and transferred to 2014/15 BAF - Completed 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
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	Dominic Tkaczyk	Nasir Rafiq	12	8	IT Capital bids programme for 2014/15 monitored at Information Management and Governance Committee IT annual plan for 2014/15 in place to monitor progress on IT renewal Looking to procure new network (by 31/03/2016) Purchase and install 2nd core switch which is connected to all edges and other core switch New equipment to be rolled out within 12 months covered by life time warranties	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	Dominic Tkaczyk	Nasir Rafiq	12	6	Implement data leakage prevention software Monitoring of compliance with IG Toolkit Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	07/10/2014
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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
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
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

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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	10/11/2014
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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
27	07/01/2005	Infection risk to individual patients due to poor systems and practice of control	Increased risk of patient(s) contracting a HCAI such as MRSA, C.diff, MRAB or Norovirus.	1. Unknown infection to patients admitted to hospital. 2. Infected patients not isolated on admission. 3. Poor hand hygiene / environmental cleaning.	1. Mandatory training of all staff and awareness raising sessions. 2. Implementation of trust policies - isolation, screening, treatment including root cause analysis for all C Diff / MSSA/Ecoli bacteraemia cases and PIR review for all MRSA bacteraemia. 3. Routine audit of practice, and monthly PLACE inspections. 4. Cleaning strategy implemented including deep clean arrangements 5. Monitoring of trajectory targets for MRSA bacteraemia, MSSA, E Coli and C.diff. 6. Monthly monitoring and Board reports from DIPC to inform organisation of acquisition of infection 7. Failure to achieve 90% or more in any staff group for hand hygiene leads to 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
745	09/09/2014	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources	Risk of non compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources From Risk ID 744 (Closed 02/12/2014 to combine with Risk ID 745): Recent vacancy of Head of Radiology and RPS have led to there being a vacant RPS post within Radiology.		Provision of an additional day included in the BSUH Radiology SLA. Radiation Protection Committee reporting and governance structures and reporting Positive outcome of 2014 IRMER inspection From Risk ID 744 (Closed 02/12/2014 to combine with Risk ID 745): Nominated RPC in place Extended SLA with MTW physics for on-site presence and support on half day a month RPS role is written into the job description of the new band 6 role. Until this person is in post the service manager, operational lead and existing band 6 will share this role. Physics to provide a course for these staff members.	Steve Fenlon	Kirsty Humphry	12	8		02/12/2014

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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		02/12/2014
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
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
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	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 the LSMS - Completed Identification of a local case/incident that may be relevant - completed	08/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
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
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 Ongoing audit reports to demonstrate CQUIN compliance e.g. WHO checklist and MaPSaF Provide Q3 update to quality and Risk Committee and Board	08/12/2014
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
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 - Completed Ongoing updates at Theatre User Group Meeting regarding this risk Willmott Dixon agreed to replace doors - Date to be agr Trial of replacement door-motors on doors on Theatre 1 and Theatre 4 Increased follow-up with Estates & Willmott Dixon Notices to be put up in Theatres to alert staff of defective doors - Completed Staff utilised to retain privacy and dignity - in affecetd areas - Completed Raise staff awareness at team meetings - completed	09/12/2014

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
727	21/07/2014	Limited on site Physician cover and non compliance with NCEPOD standards	Limited on site Physician cover and non compliance with NCEPOD standards		Cover arrangements managed by Consultant Plastic Surgeon Onsite cover available on Monday, Wednesday and Thursdays (Part BSUH, part agency locum) Telephone cover provided as part of SLA with Brighton. Geriatrics Clinic covered by Locum Geriatrician from SASH Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Mr Asit Khandwala	Paul Gable	12	6	Explore GPSI option and cover from London Trusts SLA proposal from East Surrey Hospital Arrangements agreed in principal with ESH Meeting between QVH Medical Director and Head of Geriatrics at ESH	09/12/2014
750	12/12/2014	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national gu	Risk of adverse patient outcome when undergoing head and neck surgery (10 hours+) due to limited compliance with the national guidance includes additional recruitment to post of Head & Neck Oncology Consultant.	Single consultant surgeon operating	Clinical audits undertaken on key outcome data on a monthly basis Data submission to DAHNO Consultant Outcomes Publication (COP) database Local review undertaken to identify options for resolution e.g. appointment of a second surgeon and review of job planning. Major Oncology H&N cases to only be run with 2 x surgeons from Jan 2015	Steve Fenlon	Nicola Reeves	12	8	Actions identified from completed review Major Oncology H&N cases to only be run with 2 x surgeons from Jan 2015 - Completed Major cases moved to Monday for joint sessions	12/12/2014
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	16/12/2014
758	22/12/2014	Risk to the Trust of not meeting its Key Strategic Objectives (KSOs)			1. Trust Board Reporting - Weekly flash report on key performance indicators / Board Assurance Framework / Risk Registers. 2. KSOs aligned to QVH2020 - Trust Board and Committee reporting. 3. Governance structure and escalation framework in place within the Trust - Trust Board / External Reporting (e.g. Monitor, External Audit) / Monitor Quality Governance Review. 4. Reporting of a range of trigger data including incidents, complaints, claims, workforce etc. in place - Trust Board and Committee Reporting. 5. Executive Director/Senior Management personnel has responsibility for delivery of each one - Board Assurance Framework / ED appraisals. 6. Daily 18 week monitoring meeting	Richard Tyler	Alison Vizulis	12	12	Clinical Strategy in place QVH20/20 Operational excellence work programme in place Governance Review underway	

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
761	22/12/2014	Inability to Deliver Increased Productivity to Meet Demand			1. Annual business planning process 2. Monthly and Quarterly Directorate reviews 3. QVH2020 - Delivering 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 5. Annual Job Planning 6. Theatre 11 - progress on opening new facility and increase numbers of one-stop LOPA clinics 7. Services delivered off site	Jane Morris	Alison Vizulis	12	9		
762	22/12/2014	Scope and Provision of Clinical Services			1. Inability to provide information externally e.g. failure to submit to SUS / CCGs / national returns on UNIFY etc. 2. Commissioner behaviour when under extreme financial pressure / financial position of the CCGs 3. Increased use of standardised service specifications (i.e. not allowing for local variation) with significant focus on co-location of DGH-type services 4. Commissioner led service redesign and tendering of existing QVH services 5. Invoicing arrangements of NHSE 6. Non elective/ ERT 7. SLAs with other providers (P2P) 8. Contract monitoring meetings	Dominic Tkaczyk	Mike Sexton	12	8		
763	22/12/2014	Financial Control			1. Financial plans, budgets and activity targets communicated and understood 2. Robust budgetary reporting 3. CIP plans - delivery of 14-15 savings 4. Monthly reviews of financial performance including CIP at weekly meetings 5. Monthly finance reports for each Department showing income, pay and non-pay costs 6. Monthly Board Report on financial position with supporting narrative 7. Monthly production of SLR reports	Dominic Tkaczyk	Alison Vizulis	12	8		
764	22/12/2014	Infrastructure and Investment			1. Site strategy 2. Capital plans and programmes 3. Project management 4. Backlog maintenance programme 5. PLACE Reports 6. System downtime 7. Routine maintenance of clinical equipment 8. Medical device alerts 9. Operational continuity 10. Helpdesk responsiveness and themes	Dominic Tkaczyk	Alison Vizulis	12	8		
766	22/12/2014	Risk of Poor Quality Care Resulting from Low Mandatory Training and Appraisal Rates			1. Statutory and Mandatory training reviewed monthly 2. Departmental feedback from (1) above 3. Utilisation of bank and agency staff to release others to attend training 4. Ward staffing levels monitored locally and reported to the Board monthly	Graeme Armitage	Dominic Tkaczyk	12	6		

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	CRR	RRR	Actions	Date Reviewed
768	22/12/2014	Risk of Staff Not Complying and Promoting the Trust Core Values			1. Values Based interviews introduced 2. Patient experience survey feedback - staff attitude 3. Values included within revised Appraisal process review and feedback 4. Training for managers on addressing performance 5. Staff Friends & Family questionnaires 6. Monthly HR best practice sessions 7. MaPSaF outcomes	Graeme Armitage	Alison Vizulis	12	6		
769	22/12/2014	Inability to Support Staff Educational Requirements due to Financial Costs and Pressures			1. Bi-Monthly funding panels ensure robust management 2. Study leave policy amended to include expectations from staff 3. At present, essential education funded from SHA; All other applications considered by League of Friends (Rosemary Wooten Bursary) 4. Funding allocation from Trust budget 5. Funding confirmed for 2013/14 from HEKSS - increase from 2012/13 6. 2014/15 remains on target as Brighton University costs are reduced due to a structure change 7. A review of the 2013/14 training provision showed low refusal rates for part-time courses	Graeme Armitage	Alison Vizulis	12	6	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	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29 January 2015
Reference number:	016-15
Report from:	Dominic Tkaczyk, Director of Finance and Commerce
Author:	Dominic Tkaczyk, Director of Finance and Commerce
Report date:	21 January 2015
Appendices:	NA

Monitor Declaration: Quarter 3 of 2014/15

Key issues

1. The Trust is required to submit its Quarter 3 (Q3) monitoring return by the end of January.
2. The paper confirms the In Year Governance Statement from the Board contained in the Q3 return.
3. For finance the declaration that "The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months" is **Confirmed**.

   In Q3 the COSRR is submitted as 4: No evident financial concerns.

   In the annual plans submitted to Monitor the planned rating from Q4 onward is 4 and the forecast remains at 4.

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

   For Q3 the trust is expecting not to meet the 18 week targets. The forecast is non-compliance in Q3 for 18 weeks as we expect to fail the standards in M7-8 with a compliant position in M9.

   As the Board is unable to confirm this declaration a response has to be included in the return. The draft response is "The trust continues to focus resources on meeting the 18 week targets and expects to be compliant in Q4 although the risks to delivery are such that a Confirmed assurance cannot be given".

5. The Governance Rating for Q2 was Green: No evident concerns.

   The actual and forecast performance against targets may trigger a downgrading of this rating.

6. For Otherwise the declaration "The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page22, Diagram 6) which have not already been reported" is **Confirmed**.

7. For Consolidated subsidiaries the response is **Nil** to the question the “Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds”.

Implications for BAF or Corporate Risk Register

8. Nothing new to add.

Regulatory impacts

9. Implications for Continuity of Service Risk Rating and Governance Rating noted in the report.

Recommendation

10. The Board is asked to **NOTE** the contents of this report and **APPROVE** that the above declarations be made to Monitor.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Trust Board
Meeting date:	29th January 2015
Reference number:	018-15
Report from:	Clinical Cabinet
Author:	Richard Tyler
Report date:	21st January 2015
Appendices:	None

Report from meeting of the Clinical Cabinet held on 15th December 2014

Key issues and Actions

1. Organisational restructuring: Cabinet discussed the proposed restructuring. There was broad support for the proposed re-structuring with a view that the current proposals should be kept under review as the organisation develops over the next 3-4 years.
2. Operations: Cabinet received an update on current operational issues including RTT18 compliance, the November waiting list initiative and proposed January theatre pilots.
3. Quality & Risk: Cabinet signed off the December Q&R report and received an update on the Synergy incident.

Link to Key Strategic Objectives

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

Implications for BAF or Corporate Risk Register

4. None

Regulatory impacts

5. 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

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 29 January 2015
Reference number: 019-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: 18 December 2014

Report of the Chair of Charitable Fund Advisory Committee

Key issues discussed

1. Internal audit report
   The committee reviewed the final audit report from internal auditors, Chantrey Vellacott, and noted the updated action plan and ongoing work to improve the processes. A further report will be provided on progress at the next meeting.

2. Research post
   The committee were updated on the decision made by the board of directors, in their capacity as corporate trustee, at their meeting on 30 November regarding the research post. Following a very successful first year, the charity will continue to support the post for a maximum of two years with a total cost not exceeding a further £200k, by which time it is intended the post will be either self-funding or passed over to be supported directly by the Trust.

3. Staff awards
   The charity will continue to support the trust's annual staff awards event to be held in March 2015.

Items to be referred to the Board of Directors

4. There are no matters to be referred to the board of directors, in their capacity as corporate trustee, at this stage.

Additional information or assurance sought

5. Following the audit recommendations, the committee continued discussions regarding a simplified application process and also highlighted the need to undertake a review of the current funds structure which appear not to be meeting the needs of the charity or the trust. A small working party comprising LP / Claire Charman / Sheila Kane and Lois Howell has been set up to review and report back on this issue.

6. Following several applications by staff for funds to be used for Christmas parties the committee has asked for further discussion to agree a policy that is fair to all staff. The Trust will be asked to ensure there is an appropriate policy, agreed with the Charitable Fund, made available to all staff.

Implications for Board Assurance Framework or Corporate Risk Register

7. There were no items identified which should be added to the Board Assurance Framework or the Corporate Risk Register.

Recommendation

8. The Board is recommended to note the committee's actions and findings.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	29/1/15
Reference number:	020-15
Report from:	Ginny Colwell, Chair Quality and Risk Committee
Committee meeting date:	8/1/15
Appendices:	NA

Report of the Chair of Quality and Risk Committee
NB No Minutes available

Key issues discussed

1. The quarterly quality risk report was discussed. Part of the report detailed the reporters of incidents. It was noted that no Doctors had reported incidents in the quarter.
2. The style and use of the Risk Register was noted to continue to improve with the overview of movement and corporate sense checking of the scores It was agreed to add the current level of interims and movement in the SMT to the BAF.
3. CQC update- the recent Compliance in Practice scores were noted. A request was made for the way forward in this area to come to the next meeting re frequency of inspections, roll out to other clinical areas etc.
4. The Quality Account timetable was received. It was agreed that due to other priorities and the interim DoN that the same format would be used as last year and be reviewed for the following year.
5. The Patient Experience Report included concerns re signage on the site. CE will bring back improvement plan

Additional information or assurance sought

1. It was requested that following discussion with the MD to include the actions to be taken to increase Medical incident reporting.
2. A junior Dr is currently undertaking an audit on the recurring error involving drugs being prescribed for the wrong eye. Assurance was asked that the lessons that this highlighted were formally received and actioned.
3. Due to variable attendance the Chair has asked for a breakdown of attendance for the year to see how this needs to be taken into account for the future

Implications for BAF or Corporate Risk Register

1. It was agreed to add the current level of interims and movement in the SMT to the BAF.

Recommendation

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

Report to:	Board of Directors
Meeting date:	29 January 2015
Reference number:	021-15
Report from:	Governor Representative on the Board
Council meeting date:	11 December 2014
Appendices:	None

Report of the Governor representative on the Board on the Council of Governors meeting

Key issues discussed

1. The Council of Governors' meeting of 11 December was the first held using a new agenda format, developed after discussion at a Governor Forum in October 2014 and at the Governor Steering Group. The agenda items had been identified by the Governor Steering Group in advance of the Council meeting.

2. In the "Formal Business" part of the agenda, the Council received an update from the Chief Executive on the recruitment processes in hand to address current and upcoming vacancies amongst the Executive Director Team: Director of Finance and Director of Nursing. The Council also noted that a new Deputy Director of Nursing and an Associate Director of Operations would also be recruited in the coming months. The Council sought and received assurance that the existence of the vacancies was coincidental, rather than indicative of any underlying problem.

3. The Council also received an update from the Chair Designate on the review of corporate governance currently underway, and heard that there will be an interim report to the Board of Directors in January. The Council is represented on the Governance Review Group by Brian Goode.

4. The Council noted that the model election rules for Councils of Governors across the country had been revised to allow Trusts to introduce electronic forms of voting if they chose to do so.

5. In the section of the agenda on feedback form committees, the Council heard from the Governor Steering Group (GSG) about the new process for agreeing the Council agenda and approved associated amendments to the terms of reference of the GSG. The Chairman of the Appointments Committee updated the Council on progress towards appointment of a replacement Non-Executive Director (required from April 2015 onwards) and confirmed that the Appointments Committee had agreed a timetable for the process, as well as the advertisement, job-description and candidate brief.

6. The Council then heard from two of the Non-Executive Directors (NEDs) on the Board: John Thornton gave a presentation on addressing the challenges of meeting 18-week targets, and Ginny Colwell spoke about the Board's actions to ensure that current staff recruitment difficulties are understood and overcome. Governors then had the opportunity to ask questions and to hold the NEDs to account for the performance of the

board on these issues.

7. In the section of the meeting intended to support Governors in representing the interests of members and the public, the Council heard from the Chief Executive about the Trust's plans to investigate the feasibility of Community Services being provided on the Queen Victoria Hospital site. Although there was also an item on this section of the agenda during which the Director of Nursing was expected to introduce planning for the 2015/16 Quality Account, the meeting had run over time, and it was agreed that proposals would be circulated by email for consideration by all Governors.

8. The Council meeting moved into private session to consider a recommendation from the Appointments Committee concerning the remuneration of the Chair Designate. The Council agreed that, in light of the additional hours involved, the Chair Designate should be remunerated at the same level as the Chairman while she was acting up into the Chairman's role during his absence on leave.

Implications for BAF or Corporate Risk Register

9. Nothing raised at the Council of Governors requires to be added to the Corporate Risk Register or Board Assurance Framework; a number of the items mentioned above already appear on these documents.

Recommendation

10. The Board is recommended to note the Council's actions and findings

Queen Victoria Hospital NHS
NHS Foundation Trust

Proposed Schedule February Board of Directors

Thursday 26th February 2015

The Council Chamber, East Court, College Lane, East Grinstead RH19 3LT

09.00 – 10.30	**Staff Awards Panel**	
INFORMAL SEMINAR		
10.30 – 11.30	**Electronic Patient record Presentation**	Interim Head of Operations
11.30 – 12.00	**Eye Bank Presentation**	Nigel Jordan,
13:00	**FORMAL BOARD AGENDA**	
	PATIENT STORY	
	Experience	Interim Director of Nursing & Quality
	RESULTS AND ACTIONS	
	Patients	Interim Director of Nursing & Quality
	Operational Performance	Interim Head of Operations
	Financial Performance	Interim Director of Finance & Commerce
	Contract update (Pt II)	Interim Director of Finance & Commerce
	Workforce	Head of HR & Organisational Development
STRATEGIC PRIORITIES		
	Quarterly update on delivery of KSO5: Organisational Excellence	Head of HR & Organisational Development
	Quarterly update on delivery of Strategy and Sustainability (Pt II)	Chief Executive
GOVERNANCE		
	Corporate Risk Register	Interim Director of Nursing & Quality
	Approval of Annual & 5-year plan	Interim Director of Finance & Commerce
SUB-COMMITTEE REPORTING		
	Nomination & Remuneration Committee	Committee Chair
	Clinical Cabinet	Chief Executive
	Audit Committee (from December)	Committee Chair