Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 30 July 2015

Session in public at 13.00
Session in private at 16.00

The Cranston Suite
East Court
College Lane
East Grinstead
West Sussex
RH19 3LT

Queen Victoria Hospital NHS
NHS Foundation Trust

MEETINGS OF THE BOARD OF DIRECTORS: 30 July 2015

Members (voting):

Chair	-	Beryl Hobson
Senior Independent Director	-	Lester Porter
Non-Executive Directors:	-	Ginny Colwell
	-	Ian Playford
	-	John Thornton
Chief Executive:	-	Richard Tyler
Medical Director	-	Stephen Fenlon
Director of Nursing and Quality	-	Joanne Thomas
Director of Finance and Performance	-	Clare Stafford

In full attendance (non-voting):

Director of Human Resources & OD	-	Graeme Armitage
Director of Operations	-	Sharon Jones
Head of Corporate Affairs & Company Secretary	-	Kathleen Dalby
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Brian Goode

QVH 2020 – 15/16 Priority List

THEME	PRIORITY AREA	BRIEF DESCRIPTION	EXECUTIVE LEAD
Organisational culture	Board to Ward engagement	Increase staff engagement at all levels across QVH	Chief Executive
Major role in trauma networks	Burns derogation – paediatrics	Sustainable future for burns @ QVH	Operations
'Hub & Spoke 'delivery model	'Super Spoke' model	Feasibility study/business case	Chief Executive
Community facing provision	Primary care development	Decision on future location of EG GPs	Chief Executive
New Markets & Relationships	Alternative income streams	Develop private/international offering	Chief Executive
Productive advantage	Theatre productivity	Evaluate and roll out productivity pilots	Nursing
	CIP programme	Robust programme for 16/17 & beyond	Finance
	IT infrastructure	Commission and implement new infrastructure	Finance
	EPR	Initiate implementation project	Operations
	Site – development	Develop OBC on basis of agreed strategic framework	Finance
Operational Excellence	Access & activity	Deliver in-year access and activity targets	Operations
Organisational Excellence	Non-clinical infrastructure	Sustainable staffing solutions for estates, facilities & IT	Finance
	Non-consultant grade doctors	Sustainable staffing solutions for non-consultant grades	Medical Director
	Leadership development	Programme for middle managers & clinical leaders	HR & OD
Financial sustainability	Income & expenditure	Deliver in-year income & expenditure targets	Finance
World class clinical services	Improving patient safety	Introduce human factor training into theatres	Medical Director
Outstanding patient experience	Catering	Catering improvement & sustainability plan	DN

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Thursday 30 July 2015 at 13:00
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

Agenda: session held in public		
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Welcome		
167-15	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Patient story		
168-15	**Patient safety** *Jo Thomas, interim Director of Nursing and Quality*	-
Standing items		
169-15	**Draft minutes of the meeting session held in public on 25 June 2015 (for approval)** *Beryl Hobson, Chair*	1
170-15	**Matters arising and actions pending** *Beryl Hobson, Chair*	10
171-15	**Update from the Chief Executive** *Richard Tyler, Chief Executive*	15
Results and actions		
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173-15	**Operational performance: targets, delivery and key performance indicators** *Sharon Jones, Director of Operations*	49
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175-15	**Workforce report** *Graeme Armitage, Director of Human Resources and Organisational Development*	76
Strategic priorities		
	No key strategic objective updates this month	-
Governance		
176-15	**Monitor declaration: Q1 2015-16** *Clare Stafford, Director of Finance and Performance*	92

177-15	**Consultant re-validation** *Steve Fenlon, Medical Director*	93
178-15	**Corporate risk register** *Jo Thomas, Director of Nursing and Quality*	113
179-15	**CQC inspection: update** *Jo Thomas, Director of Nursing and Quality*	-
180-15	**Annual report: emergency preparedness, resilience and response, and business continuity** *Jo Thomas, Director of Nursing and Quality*	121
181-15	**Council of Governors: report from the last meeting** Brian Goode, Governor Representative	-
Reports from the chairs of the sub-committees to the board of directors		
182-15	**Charity Committee: meeting held on 25 June 2015** *Lester Porter, Senior Independent Director and Committee Chair*	129
183-15	**Nomination and Remuneration Committee: extraordinary meeting held on 25 June and meeting held on 30 July 2015** *Lester Porter, Senior Independent Director and Committee Chair*	130
184-15	**Quality and Risk Committee: meeting held on 2 July 2015** *Ginny Colwell, Non-Executive Director and Committee Chair*	131
185-15	**Finance and Performance Committee: meeting held on 20 July 2015** *John Thornton, Non-Executive Director and Committee Chair*	133
Next meeting agenda		
186-15	**Draft agenda for next business meeting** *Kathleen Dalby, Company Secretary*	138
Observations and feedback		
187-15	**Feedback from key events and other engagement with staff and stakeholders** *All board members – please submit list in advance to the Deputy Company Secretary*	-
188-15	**Observations from members of the public** *Beryl Hobson, Chair*	-
189-15	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. *Beryl Hobson, Chair*	-

190-15	**Observations and feedback on the meeting** *Ian Playford, Non-Executive Director*	-

Agenda: session held in private		
Commercial-in-confidence		
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Any other business (by application to the Chair)		
193-15	*Beryl Hobson, Chair*	-

Date of the next meetings		
Board of Directors: **Public**: 24 Sept at 13:00	**Sub-Committees** **F&P:** 17 August 2015 at 14:00 **Q & R:** 03 Sept 2015 at 09:00 **Audit**: 09 Sept 2015 at 14:00 **N & R:** 01 Oct 2015 at 09:00 **CCT**: 05 Nov 2015 at 09:00 **Charity:** Dec 2015 (tba)	**Council of Governors** **Public**: 08 October 2015 at 15.00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 25 June 2015, 13.00 – 16.00, The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT** *Please note that at the Chair's request, agenda item 159 was taken ahead of item 153*	
Present:	Beryl Hobson, (BH)	Trust Chair
	Steve Fenlon (SF)	Medical Director
	Ian Playford (IP)	Non-Executive Director
	Lester Porter (LP)	Non-Executive Director
	Clare Stafford (CS)	Director of Finance and Performance
	Jo Thomas (JMT)	Director of Nursing & Quality
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources & Organisational Development
	Kathleen Dalby (KD)	Head of Corporate Affairs & Co Sec
	Sharon Jones (SJ)	Director of Operations
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Apologies:	Ginny Colwell (GC)	Non-Executive Director
	Brian Goode (BG)	Governor Representative
Public Gallery:	None	

WELCOME

143-15 **Welcome, apologies and declarations of interest**

The Chair welcomed CS and SJ to their first public board meeting since being appointed to the trust.

Apologies had been received from Ginny Colwell and Brian Goode

There were no new Declarations of Interest.

PATIENT STORY

144-15 **Patient Safety**

JMT apprised the board of her observations during visits to clinical areas in recent weeks. In particular, she highlighted contributions made by staff to patient safety on Peanut ward and felt assured by the ability and responsiveness of the Paediatric team.

The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.

STANDING ITEMS

145-15 **Draft minutes of the meeting session held in public on 21 May 2015 for approval**

For consistency, the board agreed that reference to chairmanship of the audit committee should be included in the public minutes. With this adjustment, the minutes were **APPROVED** as a correct record.

146-15 **Matters Arising & Actions Pending**

The board reviewed the current record of matters arising and actions pending. The update was received and **APPROVED**.

147-15 **Update from the Chief Executive**

RT presented his monthly update. Highlights included:

	• On the basis that the majority of recommendations contained within the Canadian Wing action plan had been completed, (with the remainder close to being finalised), RT sought and received approval from the board that the action plan be formally closed; • Clinical Cabinet would be debating the Estates strategy on 20th July. An invitation to attend the meeting would be extended to all members of the board **[Action: RT]** • In light of changes to burns services, a paediatric review, chaired by GC, was to be undertaken; • The inaugural trust leadership forum, attended by senior managers, had taken place the previous day; • The next phase of the new care models programme had been launched. QVH would be bidding to become part of new vanguard model in acute care collaboration, which would align well with the QVH 5-year plan. NHS England had indicated it would particularly welcome interest from smaller hospitals; RT also apprised the board of current national issues. These included proposals to improve current financial controls and productivity, a review of the 18-week referral to treatment times (RTT18), and a review undertaken by Lord Carter into saving money and driving efficiencies within the NHS. BH thanked RT for his report, the contents of which were **NOTED** by the board.
RESULTS AND ACTIONS	
148-15	**Patients: safe staffing and quality of care** JMT opened by explaining why the corporate risk register hadn't been circulated to the board in time for today's meeting. It was agreed this would be circulated prior to next month's meeting. **[Action: JMT]** Key issues highlighted as part of this month's update were as follows: • Safe staffing levels had been achieved throughout May. Areas of concern continued to be vacancy rates on Canadian Wing. However, sickness levels on Canadian Wing had reduced significantly this month. • Whilst there was an increase in incident reporting in May, the rise had merely returned reporting to more normal levels. (JMT reminded the board that high levels of reporting were actually a good sign as staff were encouraged to highlight concerns where necessary); • Three grade 2 QVH acquired pressure ulcers had developed in May. JMT assured the board this situation was being carefully monitored; • SF explained why an incident originally classed as a 'never event' had been reclassified as a serious incident. A formal report would be provided to the board in due course; • Five new complaints opened in May; one related to medical communication; two related to communication and two related to clinical care. Three of the five have been graded as potentially moderate; complaints included delay in treatment and a missed diagnosis of a child which had been referred to the NHS Litigation Authority. • JMT noted that statutory and mandatory training data contained within the workforce report did not correlate directly with that in the safe staffing report. This was because workforce data was trust wide, whereas the safe staffing report focused on ward staff only. A footnote would be included in future board reports to this effect. **[Action: JMT]** • Conclusions as to whether both infection control incidents reported this month (VRE and MRSA) were unavoidable would be reported back to board.. **[Action: JMT]** • Although the CQC Hospital Intelligent Monitoring rating for QVH had been reduced from 6 to 5, no new issues had occurred to adversely impact on the trust's ability to comply with CQC registration or our Monitor governance risk rating. • It was noted that Friends and Family Test scores were high, with improved response rates. Finally JMT reported that Horsham and Mid-Sussex Clinical Commissioning Group (CCG) had

	congratulated QVH on its recent national inpatient survey results. The Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
149-15	**Operational performance: targets, delivery and key performance indicators** SJ introduced her report, asking the board to note the following: • In month 2, the main discrepancy to plan was within Plastics. Diagnostic work across all business units was underway to gain a better understanding of the issues. This would be followed by corrective actions and development of longer term sustainable plans. SJ assured the board that focus would remain on income and activity; • The trust continued to forecast compliance at an aggregate level for all three 18-week targets, with all targets met in May. In the meantime, work was underway to ensure continued resilience over the summer period; • As reported earlier by the CEO, changes to reporting of the 18-week RTT targets were to be implemented. Focus would be on open pathways which would be beneficial to the trust; • The trust achieved all cancer waiting times in April except for the 62-day target where there were a total of 7 breaches. Five of these involved patients on a shared pathway with other hospitals, (four of which sat with Medway). SJ reminded the board that although contact and conversations continued, breaches for patients on joint pathways with Medway would remain a risk. The Chair thanked SJ and the board **NOTED** the contents of the report.
150-15	**Financial performance** CS presented details of the trust's financial performance up to 31st May. Main areas for the board's consideration included: • The trust's delivery of a surplus of £126k for the month, which was slightly lower than planned. Although action had been taken to mitigate the MO1 deficit, this had not been sufficient to address the situation and the cumulative deficit now stood at £109k. As reported under item 149-15, an investigation into elective activity, led by SJ, was underway to address the position. The current situation had been compounded by a pay overspend in Plastics. (This was from 2014-15 but had not been captured in year-end accruals). Finance teams continue to work closely with Human Resources to monitor pay and agency spends. • The capital programme remained behind plan. The timing of the programme would be reviewed to ensure schemes were delivered to realistic timescales; • Despite the deficit, the MO1 financial performance retained a Monitor Continuity of Service Risk Rating (CSRR) of 4 and did not impact negatively on the trust's governance rating. In response to a number of queries raised by the board, CS explained that: • Given the significant increase in the levels of challenge this year, plans were in place to deliver CIPs. However, CIPs would be monitored separately and a rolling programme would be introduced in due course; • Whilst new clinical directors were fully engaged in their roles, additional work would be necessary to improve the current level of information available to them; • More work was required to improve current capacity, systems and processes within the finance team. Additional investment in business management skills would be necessary across other departments including HR, IT and Operations; RT advised that once the new executive team had time to acclimatise, he would be implementing a management programme to incorporate key strategies such as the Electronic Patient Record system, growth, productivity and capital expenditure. BH thanked CS for her update. The board **NOTED** the contents of the report and actions

	undertaken to address prevailing issues.
151-15	**Contracts update** CS presented an update on commissioner contracts for 2015/16 with background information on activity assumptions. The board was asked to note the following: • The trust was currently under performing against commissioned activity by £70k, largely due to underperformance in specialised services. (However there was one long stay burns critical care patient that had not been accrued for in these figures. CS noted that the majority of underperformance would be removed once the patient was discharged). • The number of contracts was increasing despite roughly the same levels of activity. This placed a huge administrative burden on the trust and introduced a risk for increased data challenges. The situation would require careful monitoring; • Not all commissioners had provided activity plans with sufficient detail required by the trust's contract management system. Therefore, analysis by commissioner, by activity line, was not available this month, although this should be addressed in future; • Whilst acknowledging this report was useful to the board, it would in future be integrated into finance & performance committee reporting and no longer presented in its current format. BH thanked CS for her update. The board **NOTED** the contents of the report and actions undertaken to manage any issues.
152-15	**Workforce** GA provided the board with an update on workforce key performance indicators, highlighting the following: • Turnover had fallen to just over 15% following a downward trend towards the trust target of 11%. This indicated that improvements in recruitment and retention were starting to have a positive effect; • Changes to the recruitment process were now being implemented. Rotational posts in nursing had been advertised and supported by Brighton University. The trust had over-recruited plastics junior doctors to minimise the impact of the reduced number of doctors being provided by the Deanery; • As reported last month, agency costs had reduced following the introduction of overtime rates for bank work. This 3-month pilot would be extended to allow for consultation with staff side on the introduction of a single enhanced flat rate for substantive QVH staff undertaking bank work; • Sickness absence rates had increased slightly. However, changes within Occupational Health provision will help to support an overall reduction this year. HR would continue to support managers in managing sickness more effectively. CS noted that the cost of sickness absence to the trust would be higher if the cost of backfill staff was included. (It was noted that there was an error in the metric for sickness absence days in April. GA agreed to correct this); and, • Feedback from General Medical Council Survey (completed by junior medical staff) was positive, reflecting actions taken to address concerns raised by junior doctors in previous years. GA agreed to circulate details to the board. **[Action: GA]** BH raised concerns regarding the overall drop in statutory and mandatory training compliance. CS concurred that, as Senior Information Risk Owner (SIRO), she would wish to see an improvement in current levels of Information Governance (IG) compliance. This was particularly pertinent in view of the recent spate of IG breaches. GA agreed to look into this. He also agreed to include a commentary with details of action being taken in future reporting **[Action: GA].** In the meantime, BH asked KD to undertake a review of NED statutory and mandatory training to ensure compliance. **[Action: KD**] BH reminded the board that a Human Resources committee had now been established, reporting into

	the new Finance and Performance committee. With this in mind, she suggested future workforce reporting could be streamlined. GA assured her that he was already working with JMT, CS and SJ to produce a more integrated report for future board discussions. The Chair thanked GA for his update, the contents of which were **NOTED** by the board.
STRATEGIC PRIORITIES	
153-15	**Staff survey action plan** GA presented to the board an action plan which had been developed following detailed analysis of the last three years' staff survey results. This addressed the six main themes from analysis presented to the board last month. Whilst the plan included a number of initiatives, managers across the organisation would be tasked to review and address the detail of the report relevant to their areas of responsibility. GA assured the Chair that the Leadership Toolkit would incorporate a business development module designed to improve delivery of the appraisal process. He also advised that progress would be monitored on a quarterly basis but warned that the impact of changes would be unlikely to impact immediately on the 2015 staff survey. Finally, the board was cautioned not to underestimate the amount of work involved. GA warned that the organisation would need to work effectively within current resources in order to achieve a successful outcome. The Chair thanked GA for the action plan update, the contents of which were **NOTED** by the board.
154-15	**Board development programme** GA presented the board development programme. The purpose of this was to make best use of the resources available to the board thus enabling it to ensure that QVH remained an innovative and high-performing organisation. He explained that the programme aimed to complement the existing personal development plans and back- to-the-floor visits currently undertaken by directors. Account would also be taken of stakeholder feedback to influence the board's methodology. It was hoped the programme would support the board's operation as a unitary model, working to the principles of Monitor's well-led governance framework. It had also been designed to align with trust values and behaviours. IP queried how this would shape organisational culture. BH acknowledged that this was a recurrent theme and reminded the board that the away-day in September would be dedicated to this topic. Whilst acknowledging that board development sessions (set out in Appendix A of the report) were in no particular order, JT stressed the importance of item 5, (strategic direction). LP also asked the board to remain mindful of quality over quantity. The Chair thanked GA for his presentation and the board **APPROVED** the contents of the programme.
155-15	**Quarterly update on delivery of KSO1: outstanding patient experience** JMT presented a summary of the Q1 actions. She asked the board to note that progress was continuing against each objective, and highlighted in particular the following: • All directors, NEDs and some governors were now undertaking Compliance in Practice sessions, increasing their visibility throughout the trust; • Safe care modules were now part of the e-roster;

	• Compliance with WHO checklist continued to be monitored; • Monday to Friday cover on volunteers reception desk (between 0900 and 1600) had now been achieved; and, • Early warning information was now being used across operational teams including SafeCare (it had been agreed that no further system was required at this stage). Main challenges to achievement of the KSO1 objectives remained recruitment and retention of staff, and the effective allocation of estates resources to those projects facilitating safe care. The board sought and received assurance on the following: • Whilst there was still much work to be done in respect of estates and facilities, an integrated programme was being developed to combine the capital programme and the QVH Charity, with clear prioritisation of objectives; and • That KSO1 was not overly ambitious. Internal and external benchmarking would continue in order to demonstrate clear improvements in patient experience. (Further to comments made earlier by the board in respect of communication of trust vision and values, it was noted that the KSO1 report strapline should be updated to ensure consistency)**.** The Chair thanked JMT for her presentation, the contents of which were **NOTED** by the board.

156-15	**Quarterly update on delivery of KSO2: clinical excellence**
	SF presented a quarterly update on KSO2, noting the strategy would continue to be flexible to meet the needs of the organisation. Current themes were:
	• Maximising performance and developing new surgical and community facing services on site;
	• Development of off-site spokes; and
	• Network development (eg trauma) both on and off site.
	
	Achievements this quarter included:
	
	• Education and training:
	  • Good progress had been made thanks to the support of Ed Pickles, Director of Medical Education and Helen Moore, Medical Education Manager. As reported earlier under item [152-15], the trust had received positive feedback from the General Medical Council, reflecting actions taken to address concerns raised by junior doctors in previous years.
	  • Despite a shortage of deanery supported trainees, thanks to excellent consultant engagement in recruitment, retention (and management of trust grade doctors in difficulty), the position was improving, with an enhanced relationship between the deanery and the trust;
	  • Work on improving the trust induction programme for trainees doctors was continuing.
	
	• Clinical research and development:
	  • Grants conferred from bids made during 2014-15 included a successful £1.1m MRC award and a contribution from the University of Brighton for £18k to assist setting up a QVH tissue bank.
	
	SF also provided an update on progress in respect of 2015-16 priorities. In addition, he advised that a third priority (a review of spoke sites' governance) would be added to the existing KSO2 action plan**.**
	
	Further to last month's meeting, SF reminded the board that QVH would no longer be making a contribution to the Academic Health Science Network. Due to the high levels of contribution made in recent years however, it was anticipated that trust membership would continue routinely

	for the foreseeable future. SF agreed to investigate further the implications of the 'I want great care' data and report back to the board. **[Action: SF]** The Chair thanked SF for his update, the contents of which were **NOTED** by the board.
GOVERNANCE	
157-15	**Board governance review** KD presented a paper describing progress on the board governance review. The board was asked to consider the report and its recommendations so that logistical arrangements could be put in place for implementation from October 2015. These recommendations were as follows: • Meeting agendas for the board of directors will alternate between formal business and informal seminars; • Meetings will take place in the first week of the calendar month; • Meetings will follow the schedule proposed at appendix 2; and, • The quality and risk committee will meet monthly from October 2015. IP sought and gained assurance that health and safety is an integral part of the quality and risk committee's remit and estates matters were being carefully monitored. CS confirmed she was also undertaking a review of estates to ensure mechanisms were in place to provide sufficient assurance. After a short discussion about whether the finance and performance committee would meet in every month of the calendar year, CS and JT agreed to review and make a recommendation to the board. **[Action: CS]** It was noted that the current frequency of the quality and risk committee's meetings should be corrected to bi-monthly, instead of quarterly **[Action: KD]** Discussion of additional logistical considerations was precluded due to time constraints. Therefore, KD agreed to circulate a list of practical questions for board response **[Action: KD]** A further update would be provided in September when the board would be asked to sanction final changes arising from the governance review. In the meantime the board **APPROVED** the recommendations contained within the interim update. The Chair thanked KD for her report.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
158-15	**Clinical cabinet** RT presented a report on the Clinical Cabinet meetings which had taken place in the last month. He also apprised the board that a presentation on the organisational structure aligned to the trust's strategic direction had been well received by Cabinet There were no questions and the board duly **NOTED** RT's update.
159-15	**Financial and Performance committee** JT introduced the report as Chair of the new Finance and Performance (F & P) committee. He explained the format of this report, (drafted by the governance committee), sought to provide assurance to the board in real time. It was currently designed to report by exception only. As this was the inaugural committee meeting, the focus of discussion was on terms of reference etc.

	JT noted the meeting had a different tone to usual board updates, permitting a more detailed discussion. Approval had been sought from, and received by, the committee to split the business case for the IT infrastructure into two. This would allow an initial case to be brought to the July board to authorise the enabling works which includes the cabling, cabinets and data centres. The board discussed the implications of the new report and agreed the following: • Whilst the report's format was currently designed to provide assurance only, it was suggested this could be adapted to highlight areas for escalation to the board; • The board would ascertain what key areas of assurance it needed to enable it to adopt a strategic approach at its business meetings. The report could then be modified to include recommendations and outcome of each discussion; • Although a request had been made for minutes to be included within the report, it was noted that scheduling of the F & P meetings would preclude this. However, it was anticipated that minutes of all sub-committees would be made available to board members in due course once a suitable board portal system had been identified There were no further questions and the board duly **NOTED** the contents of the update.
160-15	**Audit committee** JT provided a brief update on matters arising at the Audit committee meeting held earlier in the month. After a brief debate, the following was agreed: • The Audit plan for 2015-16 would be circulated to the board for information and assurance once it had been approved by the committee **[Action: CS]** • Discussion on the function of the Audit committee and assurance required by board would be scheduled into the board work programme **[Action: KD]** There were no further questions and the board duly **NOTED** the contents of the update.
161-15	**Board outcomes group** LP reminded the board that the Outcomes Group had been established in 2014 initially to oversee delivery of robust and accessible outcomes for our consultants, for the benefit of commissioners, patients and staff. Originally intended to operate in a supervisory capacity, the group was regularly drawn into discussion on detailed operational matters outside its remit. So, earlier this year a project steering group was established to manage day to day operations. Accountability for delivery had been assigned to the executive team who would now assume responsibility for apprising the board of progress in the future. Accordingly, after brief discussion, the board **APPROVED** the group be disbanded with immediate effect. A supplementary report had been prepared by SF on the status of the outcomes project. This also contained a series of recommendations on the way forward. After due consideration of the options contained within the report, the board **AGREED** to continue with Option 1 for the time being, whilst progressing Option 2 for the remainder of the year. Additionally, bi-annual updates on outcomes work would be scheduled into board work programme **[Action: KD]** The Chair thanked LP and SF for their report.
NEXT MONTH'S AGENDA	
162-15	A draft of next month's agenda was duly **NOTED** by the board.

STAKEHOLDER AND STAFF ENGAGEMENT	
163-15	**Feedback from events and other engagement with staff and stakeholders** • BH asked the board to note that in the last month she had made systematic visits with the CEO to all areas of the hospital, (including Compliance in Practice visits), attended trust induction, met with various consultants, met with chairs of other NHS organisations, attended the League of Friends AGM, and also the Guinea Pig AGM and lunch; • KD noted that the level of staff engagement following the launch of 'Qnet' (the trust's new intranet) had been encouraging; • SF had attended a medical director conference in London; • CS had attended the trust induction, and taken a tour of the estate. She had also made several unannounced visits to various departments within the hospital. External events included the NHS Providers Finance Directors network event where CS noted that the QVH strategy aligned well with the 5-year forward national strategy; • JMT had taken part in the trust recruitment day which had proved a very successful event thanks to the support of matrons and the Human Resources team; • IP had also attended the trust induction. He noted that the core programme, including mandatory aspects, was presented well. However, trialling of new components and timings had made for a slightly disjointed experience. IP also reported that he had yet to meet with the Head of Estates who had been absent through sickness; • GA reported that he had undertaken two Compliance in Practice visits on Canadian Wing and was encouraged by feedback received from staff; • RT reported on some positive patient feedback which he had received in recent weeks; • JT had attended a KPMG breakfast seminar and also undertaken two Compliance in Practice visits; • SJ had also attended the trust induction. In addition, she had visited the Prosthetics Department and commended the work undertaken there. External visits had been made to trusts in Lewes and Brighton. • HS updated the board on a recent NHS Providers CoSec Network event at which a presentation on the Board Assurance Framework had been made by a representative from Baker Tilly.
MEMBERS OF THE PUBLIC	
164-15	**Observations from members of the public** There were none.
165-15	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

Chair …… Date ……

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
ITEM	**REF.**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
June 2015 meeting						
	141-15	CS to confirm whether the settlement of outstanding MSC debts generated any "up-side" potential for the trust.	**CS**	July	22 06 2015 None, (due to the impact of prior year actions).	**Complete**
	147-15	BoD to be invited to attend Clinical Cabinet meeting scheduled for 20 July at which the trust estates' strategy will be discussed.	**RT**	July	**26 06 2015** RT actioned via email	**Complete**
	148-15	Latest Corporate Risk Register to be circulated to board prior to its next meeting	**JMT**	July		**Complete**
	148-15	Future safe staffing reports to include footnote explaining why statutory and mandatory data differs to that contained within the workforce report	**JMT**	July		
	148-15	Board to be updated as to whether both infection control incidents reported in June (VRE and MRSA) were unavoidable.	**JMT**	July	• Not possible to confirm if the VRE case was avoidable or not due to shared care. • The MRSA investigation concluded that it was not possible to determine the exact cause and therefore whether it was avoidable or not. There was a possibility that this could have been a community or hospital acquired infection.	**Complete**
	152-15	Results of this year's General Medical Council Survey to be circulated to the board.	**GA**	July		**Complete**
	152-15	Data anomalies within June workforce report to be corrected.	**GA**	July		**Complete**
	152-15	Commentary on statutory and mandatory training to include details of action being taken improve performance	**GA**	July	Included in the July workforce report	**Complete**
	152-15	Review of NED statutory and mandatory training records to be undertaken to ensure compliance.	**KD**	July		
	155-15	KSO report strapline to be updated to ensure consistency of trust vision throughout the organisation	**JMT**	July		
	156-15	Spokes governance review to be added to existing KSO2 action plan	**SF**	July		

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
	156-15	Board to be provided with further information about the 'I want great care' data	**SF**	July		
	157-15	Frequency of future finance and performance committee meetings to be reviewed. Board to be apprised of recommendation in due course.	**CS**	TBA		
	157-15	Correction to frequency of Q & R meetings currently shown as quarterly instead of bi-monthly	**KD**	July	**25.06.2015** Updated	**Complete**
	157-15	Questionnaire gathering preferences in relation to board meeting schedules to be circulated to board for response	**KD**	July	**08.07.2015** Email circulated to all members of board	**Complete**
	160-15	Audit plan for 2015-16 to be circulated to board for information and assurance once agreed by the committee	**CS**	TBA	Pending next audit committee meeting	**Pending**
	160-15	Discussion on function of audit committee and assurance required by board to be scheduled into board work programme	**KD**	TBA	To follow on from board governance review	**Pending**
May 2015 meeting						
	116-15	Incident reporting to be refined in line with annual reporting metrics.	**JMT**	~~June~~ July	**25 05 2015** JMT to seek additional clarification from GC. Board to be updated in July	**Pending**
	116-15	Identify any correlation between MIU waiting times and 'FFT' scores, (noting that plastics trauma patients are also sent to the same area)	**JMT**	June	FFT comments reviewed; no direct correlation. (See June Patient Experience report for further detail).	**Complete**
	116-15	Summary of 'never event' findings (as reported at May meeting) to be circulated to board	**SF**	~~June~~ Sept	**18 06 2015** To be presented in conjunction with Theatres Review update in September **25 06 2015** 'Never event' findings report to be circulated to board in advance of September meeting	**Pending**
	121-15	Formal action plan to address results of 2014 staff survey to be submitted to June board meeting	**GA**	June	On June agenda	**Complete**
	122-15	Link to 'Leadership and management development framework' to be circulated to the board for information	**GA**	June	**25 06 2015** Link circulated to board. Has also been uploaded to Qnet	**Complete**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
	127-15	Details of appraisal process, timescales and documentation to be circulated to board for information	**GA**	June	**25 06 2016** NED paperwork updated, and timescales revised accordingly.	**Complete**
	130-15	Advice to be sought from Monitor in respect of KPMG recommendation regarding chairmanship of audit and finance and performance committees.	**RT**	July	**25 06 2015** Monitor have advised this is a local decision	**Complete**
	130-15	BH to meet with KPMG to discuss issues raised regarding chairmanship of audit and F & P committees.	**BH**	July	**25 06 2015** Meeting scheduled for 29 June. Verbal update will be provided next month.	**Pending**
	130-15	The board to reconsider chairmanship of audit and F & P committees once additional guidance has been received. To be included as part of future agenda.	**KD**	July	**25 06 2015** Trust board agreed that JT should remain as a member of the audit committee. LP will assume role of chair from September 2015 onwards. BoD advised that KPMG have approved this recommendation.	**Complete**
April 2015 meeting						
	100-15	Integrated procedural document to be drafted which will describe QVH policies and procedures to ensure that directors meet the 'Fit and Proper Person test' criteria.	**KD**	~~June~~ July	Pending ongoing work within HR department.	**On July agenda**
March 2015 meeting						
	73-15	As part of the current governance review, the group to reconsider establishing a board workforce sub-committee in order to improve board and corporate level focus on staff wellbeing.	**BH**	June	**30.04.2015** Today's agenda to include details of latest review **21.05.2015** On June agenda **25 06 2015** Human Resources committee to be established which will report into monthly F & P sub-committee of the board	**Complete**
February 2015 meeting						
	034-15	Whistleblowing policy to undergo further evaluation to incorporate new recommendations following *Freedom to Speak up* and returned to BoD for review in April.	**GA**	~~April~~ ~~July~~	**21.04.2015** The changes incorporated following the Freedom to Speak up review need to be agreed at the Quality and Risk Committee before this policy returns to the Board for ratification. The next meeting of the Q&R	**On July agenda**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
				Sept	committee is the 7th May 2015. **21.05.2015** Further review required, linked to 'Freedom to speak up'. To be returned to board in July. **21.07.2015** The policy has now been revised in light of the Freedom to Speak up recommendations and will now go to the next Quality and Risk Committee before final sign off by the Board in September 2015.	
	035-15	Future Safe Staffing reporting to include quality matrix for Theatres	**JMT**	~~March~~ June	**26.03.2015** This will be included no later than May **21.05.2015** Scorecard now enhanced but not populated due to early scheduling of May board meeting	**Complete**
	035-15	Board to receive update on progress for CQC inspection once visit is confirmed.	**JMT**	June	**26.03.2015** This will be scheduled for May **11 05 2015** BH and RT agreed this will now be scheduled for June **25 06 2015** Update provided during morning seminar. Will be formally noted at July BoD	**Complete**
	037-15	Board to be apprised how best the trust might to achieve sustainable waiting lists in the long term.	**RT**	June	**30.04.2015** RT undertaking broader review of demand and capacity. Will provide board with an update in June. **25 06 2015** Update provided as part of CEO briefing	**Complete**
	051-15	Recommendations following spoke site review to be implemented	**RT**	June	**30.04.2015** Ongoing. Update to be provided at June board. **25 06 2015** Update provided as part of CEO briefing	**Complete**
December 2014 meeting						
	331-14	Board to be apprised of criteria used when approving locations for off-site activity	**RT**	June	**30.04.2015** Update to be provided at June board. **25 06 2015** Update provided as part of CEO briefing	**Complete**

MATTERS ARISING FROM THE BOARD OF DIRECTORS (BoD) MEETINGS						
	338-14	C-Wing Action plan to be returned to board for review in June 2015	**KD**	June	Incorporated into CEO report to June meeting pf the board.	**Complete**
May 2014 meeting						
	136-14	Monitor's "Well-Led" assessment framework to be implemented as part of the governance review. LH to liaise with RT regarding next steps, and board to be updated accordingly.	~~**LH**~~ **KD**	~~Aug~~ ~~Oct~~ ~~Dec~~ ~~Mar~~ July	**08.07.14:** Presentation to be made to October Nomination & Remuneration Committee **15.09.14:** Well Led Review template to be used as framework for Board self-assessment commencing at December away day. **21.10.14:** Current Governance Review led by Chair Designate to be based on Well – Led Framework **01 02 2015** As LH has now left the trust this will be picked up by KD **17/06/15** Will be incorporated into CQC inspection planning to be discussed at July board meeting.	**Ongoing**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 July 2015
Agenda item reference no:	171-15
Author:	Richard Tyler, Chief Executive
Date of report:	22 July 2015

Chief Executive's report

1. Attached is the July report which covers key issues of operational performance and external issues of interest to the trust

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

Chief Executive's Report: July 2015

Quality

The trust continues to provide safe staffing levels across all its clinical areas and this is covered in detail later on the agenda. However, as the Board is aware safe staffing is not simply about the right number of staff, it is also related directly to the quality of staff. In this respect it is important that the trust monitors both the balance of registered and unregistered staff and the use of temporary staff. In respect of temporary staff the trust used the equivalent of 140wte or 5236 hours of bank and agency staff in May at a cost of just over £90k. Of concern is the fact that compliance with statutory and mandatory training for this group of staff is just over 41% compared with permanent staff at just over 74%. This was the subject of discussion at July's Finance and Performance Committee (F&P) and the Director of Human Resources and Organisational Development is working closely with both the Director of Nursing and Director of Operations to ensure that compliance is improved within this key area of staff.

Financial performance

I am pleased to report that the trust delivered a surplus of £196k in month three. However this was £46k lower than planned and, when taken with performance in the first two months the cumulative deficit stands at £155k. This underperformance continues to be driven by lower than planned in-patient elective activity and, as was reported in June, considerable work is being undertaken by the Director of Operations and her team to understand the reasons for current performance and to ensure that a robust delivery plan is in place. A detailed report is planned for August's F&P Committee with an updated delivery plan scheduled for the September meeting of the board.

Operational performance

Activity

Whilst in-patient elective activity levels remain a concern, overall activity levels are increasing. Quarter one non-elective activity and new out-patient attendances were higher than in any of the previous four quarters whilst June's total elective activity (in-patients and day-cases) was higher than in any of the previous 14 months. It is obviously important that we continue to achieve these activity levels but it is also important that we maintain the highest levels of patient experience. To this end I have asked the Director of Nursing to review our current out-patient and MIU capacity to ensure that capacity constraints are not causing undue waits and to review comments on NHS Choices and new complaints to see if clinic waiting times are raising any concerns.

RTT18 and cancer waiting times

The trust continues to forecast compliance at an aggregate level for all three 18 week targets and was compliant with all cancer waiting time targets in June. As reported last month changes have been made to reporting of 18 week targets with the incomplete pathway standard the sole remaining target.

Improving and sustaining cancer performance

Monitor, the Trust Development Agency (TDA) and NHS England have initiated a national delivery group for improving 62 day cancer performance. As part of this programme, the Cancer Waiting Times Taskforce (CWTT) has identified eight key priorities for local health systems to implement as a matter of urgency. All acute trusts are being asked to complete a self-assessment of compliance and return a plan to achieve full compliance by the end of August. I have asked our Director of

Operations to lead on this piece of work and we will report the action plan to the September meeting of the board.

Strategic developments

Burns Services
The second meeting of the Burns Steering Group was held on 15 July. Good progress is being made and we have agreed to appoint a senior project manager to complete the service review and develop a detailed mobilization plan. The post will be funded jointly by the trust and Brighton and Sussex University Hospitals (BSUH) and will report directly to our Director of Operations.

Vanguard bid
The trust is in the process of submitting a bid to the national vanguard programme. The bid is being made in partnership with BSUH and will focus on our collaboration on burns and head and neck services and, through these, on the lessons that can be learnt for the development of accountable clinical networks and speciality franchises. The vanguard programme is supported by the Department of Health new models of care team and links directly to the findings of the Dalton Review which were reported to the Board earlier this year. The deadline for applications is 31 July and I will update the board on progress at its September meeting.

Executive Management Team
Following the board governance review I have reviewed the current executive decision making structures and introduced a monthly Executive Management Team (EMT) meeting. EMT will meet on the 3rd Monday of every month and a summary of the main items for discussion will be included in this report. The detailed terms of reference and supporting structures will be reported to the trust board in September as part of the final stage of the board governance review.

The first meeting of EMT took place on 20 July. Items discussed included; trust objectives 2015/16; outstanding audit reports; the board assurance framework; CQC inspection; F&P papers; business case for additional ultrasonography and radiography staff; improving cancer performance initiative; board agenda.

Clinical Cabinet
In line with the changes to executive decision making structures, I have amended the existing cabinet arrangements. Previously cabinet met twice a month on the first and third Monday. This has been revised and cabinet will now meet once a month on the third Monday and a summary of the main items discussed will be included in this report. Revised terms of reference will be included with those of EMT and reported to the trust board in September. The cabinet meeting previously held on the first Monday is being replaced by a meeting of the trust's Medical Director and the clinical directors.

The first meeting of the revised Clinical Cabinet took place on 20 July and was devoted to a discussion of the trust's emerging estates strategy and the development of the strategic outline case (SOC).

Trust Leadership Forum
The final change to the executive decision making structure is the introduction of a Trust Leadership Forum (TLF). The meeting consists of the trust executive team and 28 managers from across the organisation. It operates as an information sharing forum and an advisory body to EMT. Terms of reference will be included in the EMT

pack to be reported to the trust board in September. The forum started in June and meets monthly on the fourth Wednesday of the month.

Richard Tyler
July 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 July 2015
Reference number:	172-15
Report from:	Director of Nursing & Quality
Author:	Director of Nursing & Quality
Report date:	20 July 2015
Appendices:	Reports on: 1: Safe Staffing 2: Patient experience, complaints & claims 3. Theatre metrics

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 recommendation and information on how safe and well led each ward is (Appendix 1).
   - Quality and risk management with information provided on quality and safety metrics.
   - Information on new and closed complaints, claims and patient experience feedback (appendix 2).
   - Quarterly update on quality account progress and quality initiatives (CQUIN).

Safe staffing

2. Safe staffing levels were achieved throughout June.
3. Still high use of agency on Canadian wing though recruitment of staff has taken place with 2.6 WTE starting in October.
4. Decreased non substantive usage on burns ward due to lower occupancy in month.
5. Increase in sickness in burns due to multiple short term issues.

Quality and risk management

6. Of the 134 incidents reported in June 84 related to patient safety incidents; 71 are graded as no harm near misses, 11 are graded as minor harm and 2 are graded moderate harm.
7. One grade 2 QVH acquired pressure ulcers developed in June following review this was unavoidable.
8. Four falls were reported June; one on Ross Tilley; one in MIU, one in rehabilitation unit and one in corneoplastic OPD. All were graded as no harm to patient.
9. One serious incident has been logged in June which related to failure of company providing our outsource mailing to maintain data protection of a patients details; RCA is underway.
10. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.

Infection control

11. Three cases of MSSA bacteraemia during June, two hospital acquired one non hospital acquired. RCAs completed on all and panel have deemed all tree cases unavoidable.

Complaints, claims and patient experience

12. There were two new complaints opened in June; both related to attitude of medical staff, one about satisfaction with dental service and one about scarring both have been initially assessed and are graded as minor.
13. Five complaints were closed; of which three were upheld in part one was fully upheld and one was found to be unsupported.
14. One new claim is under investigation and two claims were closed as discontinued by the complainant.
15. The average FFT percentage for patients extremely likely/likely to recommend was 99%.

Implications of results reported

16. Additional agency and bank staff continue to be used however there is a general decrease in the number of booked agency shifts (non RMN) in most areas during June.

Action required

17. Continue with plans for recruitment and retention of substantive staff to reduce agency use.
18. Continue to work with ward leads to further improve budget management.

Link to key strategic objectives

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

19. 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 the board assurance framework (BAF) or corporate risk register (CRR)

20. No new implications for either the BAF or the CRR.

Regulatory impacts

21. No new changes

Recommendation

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

Patients: Safe Staffing and Quality of Care July Report (June 2015 data)

Introduction

1. 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.

2. Since the last board report I have spent some clinical time working with one of our trauma co-ordinators and some time in maxillofacial outpatients department. Working with the trauma co-ordinator provided insight into the trauma pathway which started with the hospital handover from night to day team, updates on trauma patients already on our site, those in transit to our site and others awaiting an agreed transfer date. I joined the trauma round which is multidisciplinary and then followed patients through to theatre or discharge. Patients were very positive about the experience they had at QVH. The pathway is complicated and is reliant on the skills of the trauma co-ordinator being able to effectively manage their time and influence consultants and clinicians particularly during calls to other sites. Patients requiring review but not admission are offered an appointment at the time of the call with appropriate documentation being completed. Feedback on the time spent with the trauma co-ordinator was given at the time and I have arranged to meet with the lead trauma co-ordinator to give further feedback and look at ways in which we can measure patient satisfaction with this service. I spent some time in maxillofacial outpatient clinic following some verbal feedback that some patients were waiting for long periods for pain relief. Speaking to the department manager, dental nurses and one of our associate specialists and observing the clinic in progress, I was provided with assurance that patients are not routinely waiting for local anaesthetic/pain relief. During the course of the morning actions were identified which would facilitate the co-ordination of drug access in this area which is being taken forward with pharmacy, the matron and the nurse manager. There was meticulous attention to the checking of consent prior to the procedure starting. Discharge advice was given clearly and plenty of time allowed for questions; in addition written advice was given to the patient.

Safe Staffing

During June 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. The revised safe staffing charts are included in this report in Appendix 1

Recruitment day in June 2015 was very successful; we offered 10 posts to nurses and theatre practitioners.

3. Canadian Wing staffing continues to be reviewed daily in response to demand and capacity and managed via the safer care module on the e-roster system. There was an increase in agency and a decrease in bank usage in the month, with less hours being replaced than total vacancies. The ward manager and matron view workforce management as a priority and are contemporaneously reviewing the acuity data to ensure the quality and safety of patients with the financial requirements of the budget.

4. ITU have offered all of the vacant posts.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 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 - % of staff actually on duty against those planned	Margaret Duncombe Registered staff Day shift	103%		99%	100%	101%										100%
	Margaret Duncombe Support staff Day shift	98%		98%	102%	100%										100.1%
	Margaret Duncombe Registered staff Night shift	99%		97%	99%	100%										98.7%
	Margaret Duncombe Support staff Night shift	99%		95%	100%	97%										97.2%
	Ross Tilley Registered staff Day shift	96%		99%	98%	98%										98.5%
	Ross Tilley Support staff Day shift	94%		103%	100%	102%										101.7%
	Ross Tilley Registered staff Night shift	95%		99%	98%	100%										98.8%
	Ross Tilley Support staff Night shift	89%		100%	91%	100%										96.9%
	Peanut Registered staff Day shift	98%		98%	96%	100%										97.9%
	Peanut Support staff Day shift	99%		92%	100%	97%										96.2%
	Peanut Registered staff Night shift	97%		97%	98%	98%										97.7%
	Peanut Support staff Night shift	100%		100%	100%	100%										100.0%
	Burns Registered staff Day shift	96%		98%	97%	99%										97.6%
	Burns Support staff Day shift	101%		94%	97%	90%										93.5%
	Burns Registered staff Night shift	99%		98%	100%	100%										99.4%
	Burns Support staff Night shift	104%		100%	100%	100%										100.0%
	ITU Registered staff Day shift	96%		98%	100%	100%										99.2%
	ITU Support staff Day shift	103%		100%	100%	100%										100.0%
	ITU Registered staff Night shift	95%		103%	100%	100%										100.8%
	ITU Support staff Night shift	100%		100%	100%	100%										100.0%

CQUINS

5. There are three 2015/16 National CQUIN Goals applicable to QVH, dementia and two new indicators: care of patients with acute kidney injury (AKI), and identification and early treatment of sepsis. We also identified 2 local initiatives: human factors training and application and improved mental health patients experience of trauma pathway.

6. June updates show assessments are reaching our expected targets for dementia. A draft dementia strategy has been written and QVH has signed up to the Dementia Friendly Hospital Charter which is being run by Dementia Action Alliance (DAA) and the Alzheimer's Society. The trust scored well on the self-assessment sent from DAA and this evidence shows the progress and commitment of staff to raising awareness of dementia and making adjustments to environment and services to safely care for our patients with dementia.

7. AKI: The goal of the AKI initiative is to improve the follow up and recovery for individuals who have sustained AKI - by reducing the risks of readmission, by re-establishing medication for other long term conditions and improving follow up after episodes of AKI. In order for QVH to meet this target we need to have robust means to identify patients developing AKI on site at QVH. As AKI is defined by changes in blood chemistry we are dependent on the incorporation of a nationally defined algorithm into our Pathology LIMS, provided from Brighton and Sussex University Hospitals Trust (BSUH). There has been a delay in BSUH achieving compliance with the new system which impacts on QVH not receiving the appropriate alerts as yet, negotiations continue with BSUH.

8. In the meantime we have undertaken the following steps in Q1 to increase assurance that the detection, treatment and onward referral of patients developing AKI follow regional and national guidance.

- Attendance at KSS Academic Health Science Network Regional AKI meeting in March 2015, contact with Dr E Kingdon, Renal Lead at BSUH.
- Review of Patient Safety Alert "Standardising the early Identification of Acute Kidney Injury" June 2014; review NICE Clinical guidelines 169 and 174 – "Acute Kidney Injury" and "Intravenous Fluid Therapy in Adults in Hospital"
- Preparation of summary presentation outlining assessment and initial management of patients at risk of AKI.

9. Next steps include the development of an AKI algorithm directing management plans to be followed by medical and nursing outreach staff, this to include pharmacy review and standardised handover for follow up renal function review. As AKI patients are identified by LIMS we can review our discharge summary against the CQUIN guidance from that point. Progress has met Q1 milestones.

10. Sepsis: Our goal is, all new septic episodes to be identified early, for initial management to follow standard sepsis bundle protocols, and for senior staff to agree and document further treatment options. This may include, where appropriate, early referral out for specific care not available on the QVH site. Our process should include means to flag and track acutely ill or deteriorating patients who trigger the use of a local sepsis screening tool. Progress in Q1 to support this objective.

    - Meeting of the multi-disciplinary Sepsis Working Group to standardise recognition, early treatment, escalation and data tracking for all new suspected septic episodes on site.
    - Nomination of Dr Kenneth Sim, Critical Care Lead as the Trust clinical lead for Sepsis
    - Identification of preferred sepsis screening tool for adult patients, to be triggered by NEWS score.
    - Written Description of QVH Sepsis Pathway
    - An outline for the local clinical management strategy in sepsis has been agreed. This algorithm steers decisions about diagnosis, early management and referral to senior staff in suspected cases of sepsis (it follows published national guidance from the UK and Ireland).

    Next steps are to review use of sepsis box and review antibiotics for sepsis pathway. Progress has met Q1 milestones.

11. Human Factors: Human factors encompass all those factors that can influence people's behaviour. In a work context human factors are the environmental, organisational and job factor, and individual characteristics which influence behaviour at work. The benefit of applying human factors in healthcare can help us to understand why healthcare staff make errors and which "system factors" threaten patient safety, improve the safety culture of teams and organisations, enhance team working, improve communication, improve design of healthcare equipment, identify "what went wrong" and predict "what could go wrong" and appreciate how certain tools can lessen the likelihood of patient harm.

12. The risk manager has attended a human factors education and training course and is currently formulating a plan to prioritise key areas for human factors training and looking at a range of human factor tools and methodologies to improve identification of error and sustained learning. Progress is on track for this initiative in Q1.

13. Improving mental health patient's experience of trauma pathway; the specification for this initiative has been revised due to absence of CQUIN funding and some long term sickness in the team that are leading on this work. The plan now is to revise the referral pathway into QVH to ensure safe, timely treatment for this cohort of patients with the focus being on the psychiatric assessment being undertaken on the day by the referring organisation, review of trust policy and prioritisation of the patient to minimise time spent at QVH site. Progress against the new specification will be presented at the end of Q2.

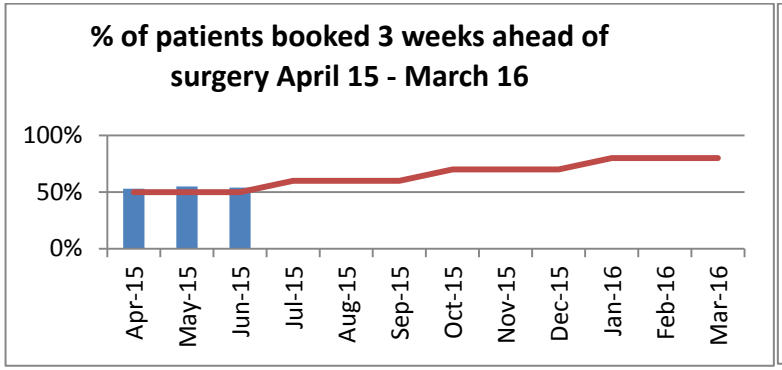
Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
CQUINS	Dementia >75 trauma asked indicative question	93%	90%	87%	90%	100%										
	Dementia >75 having diagnostic assessment	95%	90%	100%	100%	100%										
	Dementia >75 referred for further diagnostic advice	100%	90%	100%	100%	100%										
	Dementia training for staff	87%	65%	92%	94%	93%										
	Dementia strategy	_	NA	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	AK1 Acute Kidney Injury	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Sepsis	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Human factors training	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Improving patients with mental health experience of trauma pathways at QVH	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			

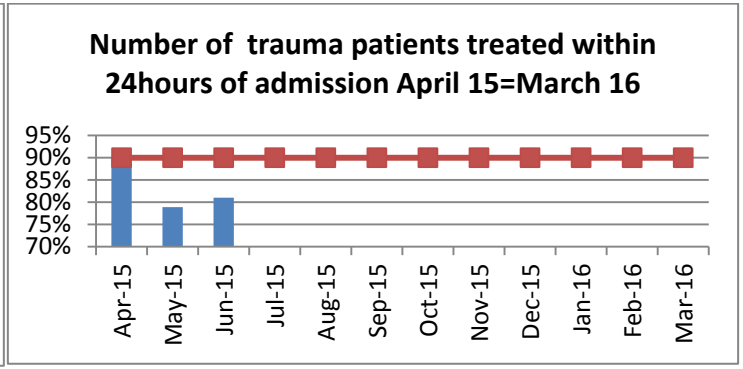
Quality Account Priorities for 2015/16

14. Priorities for 2015/16 have been influenced by our progress against our 2014/15 priorities, the trust's governors, our lead clinical commissioning group and staff from across the organisation through their contributions to *QVH 2020*, our long-term strategic plan. In addition, information was considered from national reports, our results from national inpatient and cancer surveys, in-house patient experience reviews, NHS friends and family test feedback, clinical incident reporting, complaints, patient safety reviews and clinical audit. Three priorities were identified, covering patients' experience, patient safety and operational excellence. Having monitored and reviewed last year's priorities, we have decided that we will also retain the scheduling of elective surgery as a priority again for the coming year. The three priorities 2015/16 are:

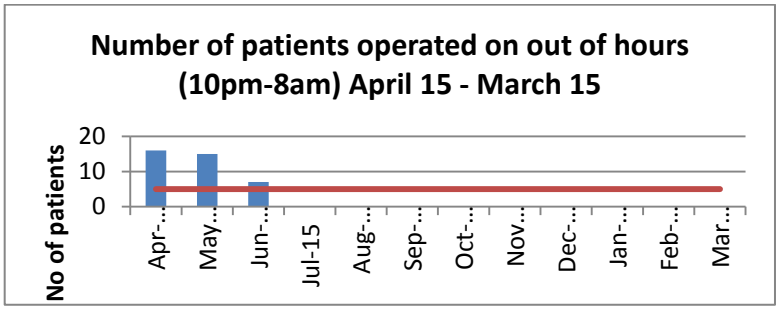
- Scheduling of elective surgery, with 3 weeks' notice
- Expand trauma capacity to increase number of trauma patients treated within 24hours of admission
- Improving patient experience of QVH food.

The Q1 target of at least 50% of patients booked with three weeks' notice has been met; this increases to 60% in Q2.





15. The number of trauma patients treated within 24 hours of admission has decreased; the data is currently being reviewed by the director of operations as part of a wider review of data reporting. There has been a decrease in the number of patients operated on out of hours.



16. Improving patient experience of Food: A food task and finish group has been commissioned to identify and implement actions to improve patient satisfaction with food that the Queen Victoria Hospital provides. This group reports to the Patient Experience Group and is chaired by one of our Governors. New summer menu commenced 1 June 2015, the feedback has been varied; some patients enjoy their meals where as others find the food lacks taste. In order to gain some clear descriptive patient feedback it was felt that a questionnaire specifically relating to food would enable the group to work together in improving patient experiences. The Dietetic team have agreed to design a questionnaire and will bring this to the next group meeting at the end of July. Progress in Q1 includes:

- Each course of the meal is served individually, staff move from bay to bay to offer individual courses to the patients, providing them with a greater menu choice enabling patients to eat their food whilst it remains hot.
- Kitchen and ward staff are working together, to enhance the overall mealtime experience. The Head Chef has agreed to support the nursing staff to improve the presentation of dishes being served to patients. The Ward Managers are contacting the Kitchen at 09:00hrs and 13:00hrs to identify patient numbers for those requiring meals, ascertaining how many patients require a soft or pureed option in advance.
- Matron for Perioperative services is designing a patient menu leaflet in conjunction with the photographic department. This will be available as a bedside guide. Pictures of food will be included to enable patients to identify their choice of food in a more informed manner and assist our patients with learning disabilities.
- Dietetics and the Catering team are currently working on several “Specials” meal choices. Special meals will provide patients with an alternative meal choice to those provided on the weekly menu. This option will initially be trialled weekly, rolling out more frequently depending upon its success and the availability of seasonal dishes.
- Dementia friendly crockery has been purchased through the Trust charitable funds to aid patients with Dementia. This includes red cups and water jugs for those patients requiring assistance with their oral intake. Matron Brasier will discuss with the Ward Managers how to identify those patients requiring assistance on the Patient Whiteboard.
- Re profiling protected mealtimes on the wards and clinical areas has taken place with staff updates to promote the importance of uninterrupted mealtimes.

17. We have a new contractor administering the FFT data collection and analysis. Inadvertently during April and May they omitted the part of the patient data section on rating for food. This was rectified in June so current position against the base line at Q3 of 2014/15 is only one month’s data not one quarter. Baseline Q3 2014/15 of fair and poor ratings 34% (poor rating 11%) June 2015 fair and poor ratings 12% (poor rating 3%). The aim is to have a sustained position with ‘fair’ or ‘poor’ ratings at 20% or less with ‘poor’ rating not greater than 5% by the end of Q4.

Patient Experience

18. There were two complaints opened in June 2015 both featured attitude. One was from a maxillofacial patient having an outpatient treatment at Medway and related to perceives rudeness of the consultant and concern about overall dental care. The other was a plastic surgery patient attending for an outpatient appointment and perceived that there was poor “bedside manner” from the doctor. Investigations are in progress for both incidents and outcomes will be presented at clinical governance group. Five complaints were closed in June, three were upheld in part (initial complaints graded as two minor and one moderate) one unsupported (initial complaint graded as moderate) and one upheld (initial complaint graded as minor).

19. There was one new claim opened this month, 2 claims were closed due to complainant rescinding the original claim.

20. Parliamentary and Health Service Ombudsman (PHSO) published October to November 2014 report in June 2015. The report identifies a variety of themes of poor or substandard care as well as themes seen in poor complaint handling. QVH has some occasional delays in sending out complaints responses however patients are kept informed of any delays. The themes of poor complaints handling are not identified in QVH handling of complaints.

21. We were recently approached by NHS England South East Region to ask for permission to use our Friends and Family page on the Trust website as a an exemplar of excellence in practice, particularly the way the FFT results were clearly and prominently placed together with the actions we have taken as a result of patients’ comments.

22. The Trust wide FFT scores for in-patients in June was 99% of our patients would recommend us. 126 inpatients out of a possible 580 inpatients completed the questionnaire which is a disappointing response rate of 21.7%. All our inpatients are handed a questionnaire on discharge however the nursing staff have noticed that many patients for some reason have chosen not to take part this month with forms being left on the lockers and bedside. The patient experience manager is meeting with the ward managers and staff before the end of July to discuss ways in which we can improve this. The FFT score for out-patients in June was 95% of patients would recommend us. 2168 outpatients out of a possible 13552 completed the questionnaire either by paper, SMS or integrated voice message. The response rate has therefore greatly improved from 9.8% to 16% this month.

Patient Safety

23. There were 134 incidents reported in the trust for June 2015 of which 84 related to patient safety, 71 of these were near misses or no harm, 11 were minor harm and 2 moderate. The 2 moderate cases are a fracture during manipulation under anaesthetic (known possible consequence and documented on the consent form and collapse and cardiac arrest of a woman attending for an OPA. There has been some fluctuation in reporting so a review of the last six months of data has been reviewed. The reporting has returned to an expected level following a slight dip (not a trend). No reasons have been identified for this. Staffing levels have been consistent there is no increase in complaints and FFT scores have remained at about the same level.

Incident Reporting Summary 2015						
	January	February	March	April	May	June
Total number of incidents	134	101	112	98	149	134
Total patient safety incidents	81	55	70	64	97	84
Patient safety: near miss / no harm	67	47	60	58	87	71
Patient safety: minor harm	14	8	10	6	7	11
Patient safety: moderate or above	0	0	0	0	3	2

24. There was one SI declared in June which related to an information governance breach. The incident was discovered after a patient received an appointment letter with a day case admission letter addressed to another patient. The trust commissioned a company for this outsource mailing and the company was contacted immediately and asked to review to see if other errors had occurred and what was the likelihood of this happening again. No other errors of this type have been found and the company have reported that this type of error has not happened before with QVH patients. The company are complying with a full root cause investigation. The Board is asked to note the change from 1 to 0 for Never Events (reported in May) in the Patient Safety metrics. This is due to NHS England requesting the Never Event to be logged by the provider at which the incident occurred. Due to the serious nature of the incident the trust continues to report this as an SI and is contributing to the RCA.

25. There were four falls in June all graded as no harm to the patient, One on Ross Tilley, one in MIU, one in Rehab unit and one in Corneoplastics. There was 1 grade 2 PU on Margaret Duncombe ward, RCA completed, findings deemed this unavoidable.

26. Theatre metrics quarterly update: The matron and clinical director for theatres have been working with the theatre teams to set up some quality metrics specific to theatre. Following discussion within the team there was agreement to do some work with measurable outcomes for reducing nil by mouth time, pressure ulcers and perioperative thermoregulation management. The ownership and detail that has been applied to setting up the these metrics is noted and is in part due to the fact that theatre staff appreciated being approached about developing some metrics which would measure quality which they selected as important to the patients rather than being told what to collect.

27. Reducing nil-by-mouth time to improve patient experience: The phrase nil by mouth from midnight is still in use. A mix of in patients, day surgery and trauma patients in close proximity further complicates matters. It is important that fasting advice is individual, clear and consistent; if it is not we risk dehydration, discomfort and technical complications or we put patients at risk of aspiration. The goal is to review what instructions patients receive, review relevant policies and guidelines available to staff, and to audit current practice. Appropriate changes can then be made to improve the clarity and consistency in the advice that is given to patients and thereby improve the patient experience. Q1 progress for reducing nil by mouth time

- Reviewed QVH patient information guidance for inpatient and day surgery admissions.
- Reviewed national guidelines (RCN 2005, ESA 2011)
- Compared local instructions to patients with national guidelines
- Confirmed no separate peri-operative fasting policy at QVH
- Beginning audit of current fasting experience for patients (day surgery, inpatient and trauma cases; morning and afternoon lists)
- Informal conversations with theatre, ward and secretarial staff prior to preparation of presentation outlining best practice in fasting policy.

28. Q1 progress for reducing pressure ulcers associated with theatres

- Data review head and neck cases versus pressure ulcer damage Datix- 15 month retrospective review. Jan 14 – April 15, 83 major head and neck patients 11 patients sustained a hospital acquired pressure sore (grade 1 or 2).
- In Q1 2015/16 four patients sustained hospital acquired pressure sore x 2 sacral x 2 nostril (grade 1 or 2)
- Literature review undertaken, limited literature relating to specifically intraoperative head and neck patient pressure area management. Intraoperative pressure management specifically related to co morbidities and length of surgical time and the risk of pressure damage.
- Review of current practice in theatres. Policy and pressure care assessment review (adapted Waterlow, skin care bundle). Review of what practice is in place in respect of pressure relieving devices and physical intervention i.e. passive exercise and preventive sacral area dressings.
- Review of 'Purpose T' new pressure area assessment process (risk assessment work package to develop a new evidence based decision tool for the prevention and management of pressure damage)
- Next steps further engagement of clinicians as part of any enhance recovery pathway for head and neck patients we hope to include a standardised system for assessed, preventing, managing and documentation of pressure care in head and neck patients.

29. Q1 progress for perioperative thermoregulation management

- Limited audit to review current practice which found variability in understanding as to which patients require active warming measures peri-operatively, some inconsistency in choice and use of temperature monitoring devices and warming under- mattresses out of service in two theatres. No specific policy reflecting the relevant NICE guidance was identified.
- Baseline assessment of education needs undertaken.
- Pre-operative temperatures were recorded for all patients on the standard checklist, but there was no evidence of any corrective action taken for two patients whose temperature was below 36 degrees.
- All major cases had temperatures measured peri-operatively, either centrally by catheter thermistor or by nasal temperature probes. Practice was less consistent for cases of between 30 minutes and three hours duration, with evidence of peri-operative temperature measurement (as seen on ARC records) in less than 50% of patients. There was little demand for warmed intravenous fluids for shorter cases, despite NICE recommendations and consequently stocking of the warming cabinet with fluids was variable.
- 100% of patients had temperatures measured in recovery post-operatively. No patients were discharged from Recovery with a temperature of less than 36 degrees.
- Agreement that an updated version of practice standards would be worthwhile, with emphasis on consistency in practice and record keeping. This will be addressed in Q2, with a focus on which cases receive forced air warming, now that use of under-mattress heating has become the local standard of care, and efforts to increase the use of warmed intravenous fluids intra-operatively. The project manager for audit and outcomes has suggested that temperature could be added to the parameters collected in the Additional Care study run through recovery, thus giving access to pre- and post-op data for patient groups or demographics.

Source		Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
					April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Patient Safety	Safety Thermometer	Safety thermometer data submission	100%	Y/N	Y	Y	Y										
		Harm free care rate (NATIONAL) - one month delay	NEW		93.8%	94%	94.1%										94.0%
		Harm free care rate (QVH)	97%	>95%	97%	95%	94%										95%
		New harm free care rate (acquired at QVH)	99%	>95%	97%	97%	94%										96.2%
		VTE initial assessment (Safety Thermometer)	100%	>95%	100%	100%	100%										100.0%
		Patient Falls assessment completed within 24 hrs of admission	90%	>95%	100%	97%	88%										94.9%
		% of completed nutritional screening assessments (MUST) within 24 hours of admission	99%	>95%	100%	100%	100%										100.0%
		% of patients who have had a (MUST) reassessment after 7 days	92%	>95%	86%	100%	86%										90.6%
		Patient Falls resulting in no or low harm	49	—	2	4	4										3.3
		Patient Falls resulting in moderate or severe harm or death	1	—	0	0	0										0
		Number of Pressure ulcer development Grade 2 or over acquired at QVH	11		2	2	1										5
		Serious Incidents	10		0	1	1										2
		Never Events	2		0	0	0										0
		Total number of incidents involving drug / prescribing errors	210		19	21	15										55
		No & Low harm incidents involving drug / prescribing errors	209		19	21	15										55
		Moderate, Severe or Fatal incidents involving drug / prescribing errors	1		0	0	0										0
		Medication administration errors per 1000 spells	2.2		4.9	3.9	1.1										9.9
	Consent	To take consent for elective surgery prior to the day of surgery (Total)	74%	75%	67.1%	72.4%	79.6%										73.0%
		To take consent for elective surgery prior to the day of surgery (Max Fax)	70%		73.9%	87.1%	83.3%										81.4%
		To take consent for elective surgery prior to the day of surgery (Plastics)	72%		61.5%	66.7%	78.8%										69.0%
		To take consent for elective surgery prior to the day of surgery (Corneo)	84%		83.3%	80.0%	78.6%										80.6%
		Number of outstanding CAS alerts	2		0	0	0										0
		Number of reported incidents relating to fraud, bribery and corruption	1		0	0	0										0
	Theatres	Perioperative patient thermoregulation management	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		Pressure ulcer management	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		Reducing nil by mouth times	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		WHO Checklist compliance - Quantitative (100% compliance is CCG target)			95%			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
		WHO Checklist compliance - Qualitative (100% compliance is CCG CQUIN)	96%	>95%	_	98%	99%										98%

Staff Safety

30. Twelve staff incidents were reported during June, ten of the twelve were needlestick injuries. Five of these were injury from suture needle or removal of wire from a patient's mouth. A further piece of work has been commissioned to undertake a more detailed analysis on needlestick injuries as these numbers remain consistent and there are no trends in location or speciality. The finding will be presented to the Health and Safety Committee in July. There are no RIDDOR reportable staff incidents for June.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 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	
Staff Safety	Staff incidents causing harm	96		7	10	12										29
	RIDDOR (Patients & Staff)	2		1	0	0										1
	Mandatory training attendance for H&S and Risk	78%	80%	70%	76%	82%										76.0%
	Flu vaccine uptake	53%	60%	Not due until October												

Infection Control

31. A detailed infection control report was presented to Quality and Risk Committee in July 2015. The headlines of this report were:

- Period of increased incidence has been declared as per national guidance following three patients confirmed with Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia in June. One patient tested positive on admission and the two other patients have been confirmed as hospital acquired infections. Both of these two patients had staphylococcus aureus (SA) in numerous sites therefore probable root cause, skin/soft tissue infection as SA migrated into sites. RCAs completed, typing results awaited, time line identified no obvious links between the cases at this time. Consultant Microbiologist advised on treatment. No specific infection control measures required.
- Legionella sampling at the end of May all confirmed as non-detectable (clear).
- Pseudomonas sampling next due in August.
- Cleaning standards continue to be monitored closely and the standard of cleaning is improving in the trust. Overall Trust cleanliness score in June was 90%.
- Letter received from NHS England with information on the investigation and public health management of possible cases of severe acute respiratory illness associated with Middle East respiratory syndrome coronavirus (MERS-CoV). Information sent to Managers/Site Practitioners, included in mandatory training and an information folder set up on Qnet.

Source	Description (Activity per 1000 spells is based on HES Data: the number of inpatients discharged per month including ordinary, day case and emergency - figure /HES x 1000)	2014/15 total / average	Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Year to date actual
				April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Infection Control & Prevention	MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	0	0										0
	Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	0	0	0										0
	E-coli bacteraemia	0	0	0	0	0										0
	MSSA bacteraemia	1	0	0	0	3										3
	MRSA screening - elective	96%	>95%	99%	98%	98%										295%
	MRSA screening - trauma	97%	>95%	97%	96%	97%										290%
	Trust hand hygiene compliance	98%	>95%	99%	99%	99%										297%

Care Quality Commission (CQC)

32. CQC Inspection of QVH confirmed as 10 - 13 November 2015. The trust has submitted an all the required initial paper work which describes the trust wide context of the organisation and the core services provided. A more detailed information request from the CQC will be sent 12 weeks prior to the inspection. Work is in progress to commission an external mock CQC inspection and appoint a project manager for to co-ordinate this work. Weekly communications for the whole of our staff will commence from 27 July 2015 to keep staff updated on all plans. We will use the newly formed leadership forum to provide two way communications on the CQC preparedness as well as other key organisational priorities

Appendix 1

Please note the statutory and mandatory training figures and appraisals relate to ward managers database and not Trust Staff Development Centre figures.

SAFE STAFFING DATA

CANADIAN WING 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	10.34	10.3	9.54										7.5%	18%				2.6 WTE Band 5 Staff recruited, start dates October 2015
Est = (hrs)	1680	1673	1550															
Temp staffing Bank	680.8	662	613										10% 235.8+ vac	-12%				increase in agency and decrease in bank, less hours booked than vacancies safe staffing achieved
exc RMN Agency	508	527	621															
Sickness %	6.1%	1.7%	2.5%										2%					This figure is based on the CW Establishment of 60.8 WTE
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	74.5%	93.5%	100%										85%	-19%				Improved from 93.5% in May
Statutory & Mandatory%	77.6%	68.1%	86.0%										85%	-7%				Figures taken from CW spreadsheet, not SDC
Drug Assessments %	100%	100%	100%										95%					
Staff FFT Score %	_	_	_										_					
Budget (YTD)	6,866	2,607	24,950										<0					Overspend on pay due to agency spend
Margaret Duncombe																	Trend	Improvement Plan/Actions
Shift meets est % RN	99%	100%	101%										95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day HCA	98%	102%	100%										95%					
Shift meets est % RN	97%	99.1%	100%										95%					
Night HCA	95%	100%	97%										95%					
Ross Tilley																	Trend	Improvement Plan/Actions
Shift meets est % RN	99%	98.2%	98.2%										95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day HCA	103%	100%	102%										95%					
Shift meets est % RN	99%	97.6%	100%										95%					
Night HCA	100%	90.6%	100%										95%					

CANADIAN WING 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Margaret Duncombe (& Step Down)																		
Pressure Ulcers	2	3	1										0					Grade 2PU due to moisture and x3 returns to theatre
Falls	0	1	0										0					Improvement from last month
Medication Errors	8	8	7										0					No significant changes. Pharmacy rolling out teaching sessions
MRSA / C. diff	0/0	0/0	0/0										0 / 0					
Incidents Reported (Datix)	14	19	20															
VTE reassessment %	100%	100%	85.7%										95%					Recording down due to bank ward clerks, need further training
Nutrition MUST assessment	100%	100%	100%										95%					100% compliance
7 day review	100%	100%	100%															
Patient numbers	146	143	160										N/A					Increasing in activity in month
Patient FFT Score %	97%	99%	100%										95%					Improvement in month
Ross Tilley																		
Pressure Ulcers	1	0	0										0					
Falls	1	1	1										0					Patient falls due to mobility issues, all actions taken
Medication Errors	8	8	4										0					Pharmacy have done several teaching sessions on medication
MRSA / C. diff	0/0	0/0	0/0										0 / 0					No MRSA in 2014/15 no CDI since October 2014
Incidents Reported (Datix)	9	16	6															monitoring this
VTE reassessment %	100%	100%	71.4%										95%					Working with CW to improve the recording on PAS out of hours
Nutrition MUST assessment	100%	100%	100%										95%					100% compliance since December 2014
7 day review	100%	100%	100%															
Patient numbers	170	175	210										N/A					Increase in activity in month
Patient FFT Score %	98%	100%	100%										95%					No change in performance in month

BURNS WARD 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	0	0	0										0					No grade 2 PU since August 2014
Falls	0	2	0										0					
Medication Errors	1	0	0										0					
MRSA / C. diff	0/0	0/0	0/0										0 / 0					
Incidents Reported (Datix)	2	7	3															
VTE reassessment %	100%	66.7%	100%										95%					improvement noted
Nutrition MUST assessment	100%	100%	100%										95%					
7 day review	50%	100%	N/A															
Patient numbers	21	25	23										N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	2.07	3	3										7.5%	6.8%				all vacancies have been offered to prospective employees who will commence during next 3 months
Est = (hrs)	337.30	450	450															
Temp staffing Bank	464.15	95	168										10%	62.5%				lower bed occupancy reflects reduction in bank/agency
exc RMN Agency	84	208.5	60															
Sickness %	NA	1.7%	2.7%										2%					Increase in short term sickness
Shift meets est % RN	98%	96.6%	98.8%										95%					due to short term sickness
Day HCA	94%	96.9%	90%										95%					
Shift meets est % RN	98%	100%	100%										95%					
Night HCA	100%	100%	100%										95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	64.5%	100%	97.0%										85%	-20%				
Statutory & Mandatory%	83.9%	84.0%	87.0%										85%	-1%				attendance steadily improving
Drug Assessments %	100%	100%	100%										95%					
Patient FFT Score %	100%	100%	100%										95%					
Staff FFT Score %	_	_	_										_					
Budget (YTD)	72,094	90,508	84,296										>0					paid in errars for burns activity, 92 accrual

BURNS ITU 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	0	0	0										0					
Falls	0	0	0										0					
Medication Errors	2	4	1										0					Improved position
MRSA / C. diff	0/0	0/0	0/0										0 / 0					
Incidents Reported (Datix)	8	5	7															
VTE reassessment %	100%	100%	100%										95%					
Nutrition MUST assessment	100%	100%	100%										95%					
7 day review	100%	100%	66.7%															The % decrease relates to 1 patient was
Patient numbers	N/A	N/A	20										N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	0	6.6	5.6										7.5%					5 wte posts offered to candidates
Est = (hrs)	0	984	910															
Temp staffing Bank	191	28.5	120										10%					
exc RMN Agency	504	709	592.5															
Sickness %	N/A	5.7%	6.3%										2%					1long term sickness (2 maternityleave) and increased short term sickness
Shift meets est % RN	98%	100%	100%										95%					Achieved on or above standard since November 2014
Day HCA	100%	100%	100%										95%					
Shift meets est % RN	103%	100%	100%										95%					Achieved on or above standard since January 2015
Night HCA	100%	100%	100%										95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	66.7%	95.0%	95.0%										85%	-18%				Significantl improvement from April
Statutory & Mandatory%	71.9%	84.0%	86.0%										85%	-13%				Improvement from April
Drug Assessments %	87%	77%	88%										95%					improvement in assessments this month
Patient FFT Score %	_	_	_										95%					
Staff FFT Score %	_	_	_										_					
Budget (YTD)	159	2,378	6,357										>0					slightlyworse budget position in month

PEANUT WARD 2015 / 2016	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	DoN Rating					
Safe Care	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Pressure Ulcers	0	0	0										0					No PU during 2014/15
Falls	0	0	0										0					No falls during 2014/15
Medication Errors	0	0	1										0					matron reviewing incident
MRSA / C. diff	0/0	0/0	0/0										0 / 0					No MRSA/CDI during 2014/15
Incidents Reported (Datix)	2	1	3															
Patient numbers	N/A	206	187										N/A					includes in patient and day cases
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	1.75	3	2										7.5%	7.0%				Recruited to full establishment start dates between June and August
Est = (hrs)	285.16	450	325															
Temp staffing Bank	240.45	119.5	116.9										10%	*9%				
exc RMN Agency	71.3	54.75	63.75															
Sickness %	N/A	5.5%	1.7%										2%	0%				long term sickness reolved
Shift meets est % RN	98%	96.2%	100%										95%					Decrease in HCA cover on day shift, covering ward clerk leave
Day HCA	92%	100%	97%										95%					
Shift meets est % RN	97%	98.4%	98%										95%					Improved trained night nurse cover
Night HCA	100%	100%	100%										95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	80.0%	98.0%	98.0%										85%	-5%				
Statutory & Mandatory%	82.0%	93.5%	92.0%										85%	-3%				
Drug Assessments %	100%	90%	100%										95%					
Patient FFT Score %	100%	100%	100%										95%					Achieved 100% since September 2014
Staff FFT Score %	_	_	_										_					
Budget (K)	1,663	9,440	5,937										>0					

Appendix 2 Patient Experience Report

Monthly complaints, claims and patient experience report

1 January 2015 – 31 January 2015

This report provides an overview of all activity during this period. During this period there were 5 formal complaints received. This is the same as last month. The following is a summary of the complaints that were received during this period:

Monthly complaints, claims and patient experience report

1 January 2015 – 31 January 2015

Complaints

Open complaints: There were 2 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.

Maxillofacial (off-site clinic at Medway)

1. **Outpatient - Medical – clinical care/attitude** – The patient has raised concerns about the overall dental care that they received and also felt that the clinician was 'rude'. I**nvestigating lead – Consultant and Clinical Director**

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

   Comment/Action – Still undergoing investigation.

Plastic Surgery

2. **Outpatient - Medical – communication/attitude –** The patient is upset about the size of the scar that they have following carpal tunnel surgery. When they attended for their follow up appointment they wished to seek reassurance that the scar would settle over time. The patient found the 'bedside manner of the doctor appalling and deplorable.' The doctor did not know what surgery the patient had had giving the impression that they had not read the patients notes prior to the consultation. During the consultation the patient was given no reassurance about their scar and they also found the doctor very difficult to understand. I**nvestigating lead – Clinical Director**

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

   Comment/Action – Still undergoing investigation. Arrangements have been made for the patient to be reviewed by a consultant in the forthcoming weeks.

Closed complaints: There were 5 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. **Inpatient - Medical – clinical care -** Following hand surgery the patient is undergoing further surgery due to complications. Patient feels that initial surgery was inadequately performed and would like a full explanation. **Investigating lead – Clinical Lead**

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

   Comment/Action – Patient has undergone several surgeries in the past for a congenital disorder. It is considered that the surgery was performed appropriately and that it would appear that the K-wire may have become loose and moved position. It is considered that the surgery was carried out appropriately. **Outcome – unsupported**

2. **Outpatient - Medical – communication -** Felt that the consultant was stressed and lacked concentration and made mistakes when making notes about medical history. When patient asked who would be performing surgery, consultant said 'that it probably wouldn't be him as he is moving on.' Consultant appeared vague about the experience of the surgeon that would be taking over from him. Patient would like reassurance that any future surgery is performed by a surgeon with experience in hand joint replacement surgery. **Investigating lead – Clinical Lead**

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

   Comment/Action – There were issues with the running of the clinic and delays that were incurred appear to have been due to the patient being overlooked by the nursing staff. Apologies given as this should not have occurred. There appears to have been a lack of information exchange between both the patient and the clinician in relation to medical history and future surgery. The patient has been offered an appointment with the clinician who will be performing surgery. Due to the communication issues and the overall patients experience this complaint was found to be upheld in part. **Outcome – upheld in part**

3. **In-patient - Medical – clinical care/communication** – Following surgery patient was re-admitted as an emergency. The patient claims that the doctor asked the patient whether they had contacted their family as they 'only had minutes to live'. Patient feels that this term should not have been used as the patients entire family were worried by this. Patients has advised us that they have discussed their case with the Ombudsman who have advised the patient that they had a valid point in that this should not have been said. Patient would like this matter reviewed. **Investigating lead – Consultant and Clinical Lead**

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

   Comment/Action - Apologies have been conveyed to the patient for the way that they perceived their treatment was handled and for the misunderstanding of the wording that the clinician used on the consent form (lifesaving), this was based upon the patients' symptoms and sudden decline it was considered that they required immediate surgery. However the doctor is adamant that they did not say to the patient that they 'only had minutes to live'. **Outcome – upheld in part**

Corneo Plastics

4. **Outpatient – Nursing/Reception – communication –** Concerns were raised by the mother of a patient with special requirements about the length of time that they had to wait in clinic to be seen. There was a lack of communication from the staff in keeping them informed that there were delays.

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

   Comment/Action – Apologies given and complainant information that recommendations have been made that staff in the unit are to undergo further training in dealing with patients with special requirements. Outcome – upheld

Sleep Disorder Centre

5. **Outpatient - Medical – communication -** When patient telephoned and spoke with clinician, the patient felt that he laughed at her disability of MS. **Investigating lead – Patient Experience Manager**

   Initial risk grading: **Minor** Likelihood of recurrence as**: Rare**

   Comment/Action – The **c**linician involved is adamant that they did not laugh at the patient's disability but rather with the circumstances that they found themselves in when speaking to both the patient and her husband. An apology within the letter was conveyed to the patient on behalf of the Trust for any upset that may have been caused.

Parliamentary and Health Service Ombudsman (PHSO)

On 17 June 2015, the PHSO published her latest report into the investigation of complaints concerning healthcare provision and treatment. The period covered by the report is October to November 2014.

The report, which can be read here, provides selected summaries of cases upheld or partially upheld by the Parliamentary and Health Service Ombudsman and shows a variety of themes of poor or substandard care, including:

- Poor consent practice
- Poor management of NHS continuing healthcare funding
- Inadequate pain relief
- Poor understanding and implementation of the Mental Capacity Act 2005

- Not following correct procedures to remove a patient from a GP or Dentist's List
- Poor care planning
- Poor record keeping
- Inappropriate sharing of confidential information
- Poor pressure sore management
- Lack of falls assessments and planning.

The report also highlights themes seen in poor complaint handing, including:

- Destruction or loss of medical records or key documents
- Not acknowledging complaints
- Delays in offering meetings with complainants to understand fully their concerns
- Unclear and incomplete responses to complaints
- Poor communication with complainants
- Delays in responses to complaints (for example due to administrative difficulties including authorising the final response)
- Not clearly slowing actions taken to remedy issues identified
- Insufficiently robust investigation
- Not being open, accountable and customer focused when handling a complaint
- Lack of appropriate apologies where needed.

It is considered that although they are some delays in sending out complaint responses, patients are kept informed of any delays. All the other highlighted themes in the PHSO report are not considered to be issues at the Trust.

Claims

Open claims: There was 1 new claims opened during this period. Overall there are 55 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.

Incident date	Claim date	Directorate	Service	Description	Initially Complaint
01/06/2012	10/06/2015	Anaesthetics	Medical	Complication occurred during wisdom tooth extraction resulting in patient being blue lighted to Royal Sussex. Noted that patient experienced a very rarely reported reaction to ondansetron.	Yes

Closed claims: There were 2 claims closed during this period.

Incident date	Claim date	Directorate	Service	Description	Initially Complaint	Outcome
24/03/2012	24/03/2015	Plastic Surgery	Medical	It is alleged that we failed to deal with an urgent referral sent by GP and failed to take adequate care of patient. Due to failure to arrange an urgent referral to the appropriate specialist in respect of a biopsy in relation to diagnosing cancer this has caused a delay in the patient receiving treatment.	No	Claim withdrawn by Claimant. Discontinued.
01/11/2011	19/08/2013	Plastic Surgery	Medical	Claim being made in relation to the management of the pressure sore.	Yes	Claim withdrawn by Claimant. Discontinued.

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 6 new comments posted onto the NHS Choices/Patient Opinion websites this month. The following is the link to Patient Opinion

Patient's comments – food

The Patient Experience Manager recently met with some of the patients on Canadian Wing to obtain their comments on the food that is served to them. One patient in particular that was spoken to had been an inpatient on Canadian Wing for several weeks and was also able to comment on the difference between the old and new menus.

To give you an overview of the types of things that the patients were asked:

Was there enough choice of food - breakfast/lunch/dinner? Overall the choice was felt to be enough although it was considered that for dinner there should be at least 3 options to choose from.

Were the menu choices offering the kind of foods you like to eat? Generally the answer was yes although it was suggested that having whole pieces of chicken in a dish would be nice and substantial i.e. leg, thigh etc.

How would you rate the taste and flavour of the food? Patients found the food to be bland and lacking in flavour. E.g. lasagne lacking in seasoning and tomatoes.

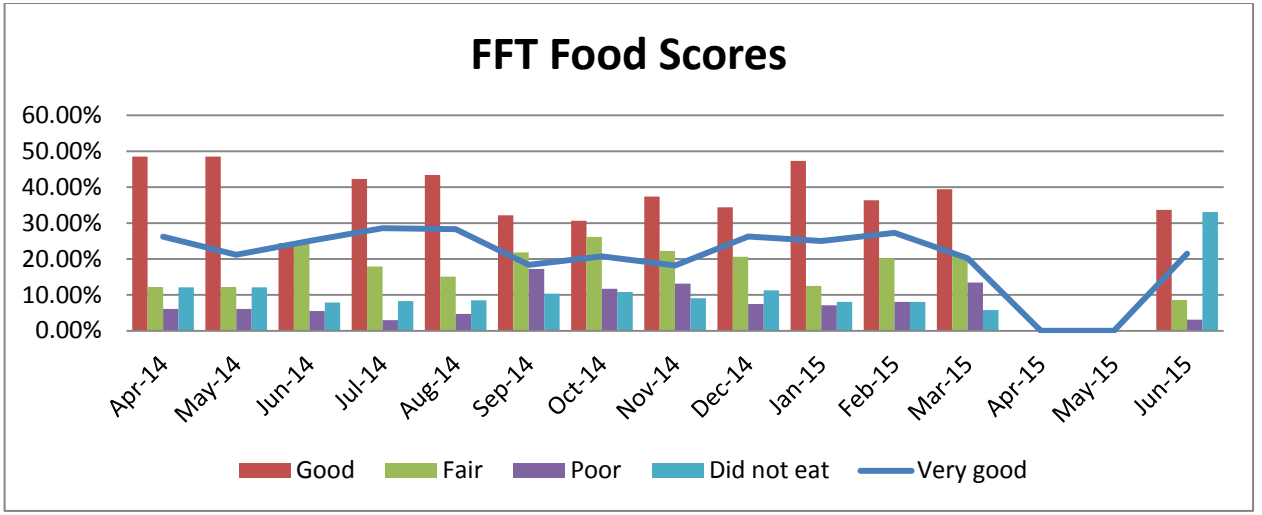
Were your meals hot enough? Generally it was felt no, not always. I spoke with patients in the middle and at the ends of the wards and it was the patients at the end who felt the food was not hot enough. This will need to be reviewed.

Were you offered enough drinks in a day? Patients felt that not enough tea was given throughout the day especially for the patients who were unable to get out of bed. Also the majority of those that I spoke with would like a cup a tea with their breakfast as well as having one first thing in the morning.

Overall, how would you rate the standard of catering service provided for you? The patients felt that the food was good and that the menus had improved.

This information has been relayed the Public Governor and Matron for Canadian Wing who are leading a sub-committee of the Patient Experience Group that are looking at food.

The following is the food scores based upon the feedback from the FFT questionnaires. Since we have outsourced the data processing to an external company they have only been able to provide us the data for June in Qtr. 1 but will be able to provide full data for the forthcoming Qtrs.



Friends and Family Test

We were recently approached by **NHS England South East Region** who were looking for examples of good practice to use as case studies for the NHS England website. While looking for some Friends and Family results on Trust websites in the region they noticed that our website has FFT results very clearly and prominently placed together with the actions we have taken as a result of patients' comments. They therefore asked to use our website for a case study on excellence in feeding back FFT results which has been authorised.

The Trust wide FFT scores for in-patients in June was **99%** of our patients would recommend us. 126 inpatients out of a possible **580** inpatients completed the questionnaire which is a disappointing **response rate of 21.7%.** All our inpatients are handed a questionnaire on discharge however the nursing staff have noticed that many patients for some reason have chosen not to take part. The ward managers and I will be meeting with the staff in the next week to discuss ways in which we can improve this.

The FFT score for out-patients in June was **95%** of patients would recommend us. 2168 outpatients out of a possible 13552 completed the questionnaire either by paper, SMS or integrated voice message. The response rate has therefore greatly improved from 9.8% to **16%** this month.

The following are the specific area/wards FFT score, % score for extremely likely/likely and return rate, which are considered to be very disappointing with the response rate scores for some areas:

Area	Total Responses	Total Eligible	Response rate	Percentage recommended	Percentage Not recommended
MD ward	58	160	36.3%	100%	0%
RT ward	55	210	26.2%	98%	2%
Peanut ward	12	187	6.4%	100%	0%
Burns ward	1	23	4.3%	100%	0%
Sleep centre	37	148	25.0%	97%	0%
MIU	327	1104	29.6%	96%	0%
Trauma	136	691	19.7%	98%	0%
OPD	2491	14243	17.5%	95%	2%
DSU	128	688	18.6%	94%	3%

Again it is a disappointing response rate for both Peanut and Burns this month. Both areas have been spoken to on this matter and we hope that their response rates will improve next month.

The following chart is a comparison of specialist hospitals and their FFT scores for May 2015 (please note that NHS England publishes their statistics 1 month behind).

Trust	Total Responses	Total Eligible	Response Rate	Percentage recommended	Percentage Not recommended
Moorfields Eye Hospital NHS Foundation Trust	825	1334	61.8%	99%	0%
Papworth Hospital NHS Foundation Trust	593	992	59.8%	97%	0%
Queen Victoria Hospital NHS Foundation Trust	315	549	57.4%	100%	0%
The Royal Marsden NHS Foundation Trust	183	1377	13.3%	97%	1%
Royal National Orthopaedic Hospital NHS Trust	468	800	58.5%	95%	2%
Stoke Mandeville Hospital	437	3694	11.8%	97%	0%

Appendix 3 Theatre metrics

PERI-OPERATIVE FASTING

Clinicians, patients and carers hold different perspectives on the requirements for peri-operative fasting. Differing advice may be offered depending on the mode of anaesthesia or sedation that is proposed.

The aim of fasting before surgery is to minimise the volume and acidity of stomach contents. Regurgitation of stomach contents with subsequent aspiration is an inherent risk during general anaesthesia, regional anaesthesia and sedation. This risk can be reduced by the planned fasting of patients.
Prolonged fasting is unpleasant and should be avoided. It may cause dehydration, electrolyte abnormalities, hypoglycaemia (particularly in children), insulin resistance, headaches, confusion, irritability, anxiety, and nausea and vomiting. The young and the elderly are particularly vulnerable to the adverse effects of prolonged fasting and staff involved in their care need to be sensitive to the risk and safety issues involved. We know that clear fluids are cleared rapidly from the normal stomach. Opinion has moved away from simply specifying ‘safe’ periods of fluid fasting to actively encouraging patients to drink.

National guidelines on pre-operative fasting were published by the Royal College of Nursing in 2005. They sought to resolve inconsistencies in fasting policies. Importantly they stated that intake of water up to two hours before induction of anaesthesia for elective surgery is safe in healthy adults, and improves patient well-being.

The surgical case-mix at QVH includes elective and trauma patients, a mix of ages and co-morbidities, in patient and day case surgery and differing admission times during the day to more than one location. It is not surprising that it is difficult to monitor and control fasting times for this broad mix of patients. However, the current tendency for staff and patients to err on the side of excessive fasting is worth challenging. The following steps are proposed to encourage consistent fasting practices in QVH surgical patients.

GOALS:

For Q1 - 2015/16 – review current local fasting guidelines including information sent to patients. Interview selected staff members about knowledge of current guidelines, and audit fasting times for sample of representative patient groups (trauma, day case, morning and afternoon elective cases, major cases)

For Q2 – Update local guidelines to emphasise benefits of clear fluids up to two hours pre-operatively. Remove all references to “Nil by mouth from midnight” in signage and literature throughout the trust. Review current use of pre-operative carbohydrate loading in major surgical cases.

For Q3 – Teaching sessions to update staff on current peri-operative fasting guidelines. Production of comprehensive, reader friendly patient information leaflet. Further audit of impact of updated policy. Indicators to include:

- Number of patients to whom fluid was given inappropriately.
- Number of patients denied fluid when it is indicated by the above guidance.
- Incidence and nature of organisational problems caused by new policy.
- Nurses and patients not aware of policy.

For Q4 – Review staff and patient experience of new policy. Summarise experience for Joint Hospital Audit presentation, consider poster presentation at national Patient Safety / Experience meeting?

PERI-OPERATIVE TEMPERATURE MANAGEMENT

Maintaining patient's temperature throughout the peri-operative period is recognised as important, and staff and patients can take appropriate measures to achieve this. Inadvertent hypothermia remains a common complication however, and the consequences are clearly outlined in the literature on the subject. Adverse effects include prolonged recovery and hospital stay, increased blood loss, and a higher incidence of post-operative infections, pressure sores and cardiac events.

There was a flurry of attention paid to this topic when the NICE guidelines on "*The management of inadvertent perioperative hypothermia in adults*" was released in 2008. Whilst the measured QVH experience at that time suggested our temperature control practices were broadly successful there has been significant staff turnover since that time and some changes both to the theatre patient pathway and the equipment available to measure and maintain temperature in the peri-operative period. We would like to return to this subject and propose a plan to monitor and improve our compliance with locally approved guidelines and to assess the patient experience of this agreed strategy.

In keeping with NICE methodology we will divide the peri-operative pathway into three phases. The pre-operative phase is the one hour before induction of anaesthesia (the time when the patient is prepared for surgery); the intra-operative phase is the period while the patient is under anaesthesia and the post-operative phase includes the time spent in the recovery area and subsequent transfer for discharge or ward care.

Issues to be addressed include:
Pre-operative phase - patient information and preparation; identification of high risk patients; clothing and covering

Peri-operative phase – standardised measurement and monitoring; warming of intravenous fluids; availability and use of warming devices

Post-operative phase – transfer to recovery; measurement and maintenance of postoperative temperature control; warming devices including compatibility.

GOALS:

Q1 2015/16 – audit current practice including staff and patient understanding of required measures, chart and electronic records of patient temperature. Review current means of monitoring temperature and availability of warming devices. Set practice standards.

Q2 – Review information given to patients pre-operatively. Audit compliance with practice standards through review of anaesthetic records and recovery data.

Key measures to be reported include

- Percentage patients having temperature recorded prior to induction of anaesthesia
- Percentage patients with operative time over 30 minutes having active warming measures noted in theatre record
- Percentage patients admitted to recovery having core body temperature of 36 degrees C or below.
- Narrative record of actions taken for all patients with core temperature below 36 degrees C in recovery.

Q3 – Report practice to departmental audit meetings, theatre team meetings and clinical governance group.
Audit patient experience.
Review outcomes and complications in any patients identified with core temperatures below 36 degrees in postoperative period

Q4 – Review practice standards, staff attitudes and equipment availability. Prepare report for Joint Hospital Audit presentation.

Dr Kenneth Sim FRCA
Consultant Anaesthetist

June 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 July 2015
Reference number: 173-15
Report from: Sharon Jones, Director of Operations
Author: Sharon Jones, Director of Operations
Appendices: A: Commerce Performance
Report date: 21 July 2015

Operational Performance: Targets, Delivery and Key Performance Indicators

CQC Domains – Responsiveness to People's Needs & Effectiveness

Key Performance Indicators

1. In patient elective activity remains under plan. Diagnostic work across all the business units has commenced to understand the issues so that short term corrective actions can be taken and longer term sustainable plans developed. Work is in train between the operations, information and finance teams looking at a range of issues including:-
   - Conversion rate changes;
   - Elective versus Day Case trends;
   - Referral pattern changes;
   - Data capture and a range of general issues.

2. Some of the areas of operational focus to date include:-
   - Within Orthodontics concern had been raised with respect to the contracted level of activity planned for 2015/16. This is felt by the team to be significantly higher than originally agreed by a total year value of £300k. However performance to date, whilst showing a shortfall against the £300k, is showing a more positive position. The unvalidated quarter one figure is a shortfall of £22k. If this performance continues at this rate across the year, then this will go some way to mitigate the shortfall;
   - The Corneoplastic team have had a poor response to the advert for the 5th Consultant who was anticipated to start in September 2015. The team is now working on plans to mitigate against the resultant reduction in capacity;
   - Recruitment into Oral Maxillofacial Surgery Specialty Doctor (Middle Grades) continues to be a challenge;
   - In order to increase trauma theatre capacity, the Trust approved (as part of the planning for 2015/16) the creation of a day treatment centre (DTC). The DTC will be in a refurbished disused changing room in the Rowntree area. This will improve patient experience, allowing local anaesthetic cases to be seen in a dedicated area ensuring all

trauma cases are treated in main theatres. The original plan and associated activity planning was for this to be live by 3rd August. However due to delays in the tendering process the go live date now is planned for 1st Sept.

3. The Trust continues to forecast compliance at an aggregate level for all three 18 week targets and all targets were met for the month of June. However, as highlighted at the last meeting, there is an issue with the leave period particularly, both in terms of bookers and schedulers being available, as well as clinical staff. At July 10th, the admitted pathway was showing 89.82% compliance against the standard of 90%. However work is being undertaken to ensure that the standard is reached over the next 21 days. There does appear to have been a reduction in the waiting list numbers in some areas such as hands and skin. This is being investigated as a lower denominator will impact upon our percentage achievement. It looks predominately like it is hands and skin. The main contributing factors in the last couple of weeks are sick leave and a gap between one consultant leaving and another starting. In some areas such as skin, work has been undertaken to ensure that the long waiters were booked ASAP. The number of long waiters booked can negatively affect the admitted performance but it has a positive impact on the waiting list in the medium to long term, as well as offering a more positive experience for patients. Between June 12th and July 13th the number of patients waiting 11 weeks or more without a TCI in the Plastics business unit has fallen from 97 to 64, and between the same dates the number of patients on the waiting list without a 'to come in date' (TCI) has fallen from 278 to 219. Of the 64 patients that are currently waiting over 11 weeks 59 are hands. Work is ongoing with the clinical lead for hands to identify additional capacity for hands and this will be implemented in Aug / Sept. One plan to reduce the waits was to use an external locum to help recover the hands position as he had worked here previously, was trusted by the clinical team and had listed some patients for surgery who were still waiting. His particular method is different to the procedure which would be carried out by the replacement consultant and so the plan was to ask him to do the surgeries to avoid patients having to have another OPD before being listed for surgery. However the locum has requested an hourly fee far in excess of what the Trust offers and so this plan is not being followed up.

4. New national guidance relating to changes in the reporting of the 18 week referral to treatment target has now been released. The non-admitted and admitted targets have been dropped in terms of sanctions being applied for non-performance. The incomplete standard is now the sole measure of patients' constitutional right to start treatment within 18 weeks. The incomplete target is that 92% of patients who have not yet started treatment should have been waiting no more than 18 weeks. However, patients' legal right to start

consultant led treatment within 18 weeks of referral is unchanged i.e. the non-admitted and admitted targets. This right is a legal entitlement protected by law and part of the NHS Constitution. Achieving all three targets is also the right thing to do for our patients, ensuring that their wait for treatment is as short as possible. It also remains an important quality measure. Therefore, all the hard work the Trust has done and is still undertaking to ensure that the non-admitted and admitted targets are successfully met will continue. These changes have been applied retrospectively from April 2015. Data reporting on all three standards will remain in place.

5. There were no breaches of 52 weeks in May or forecast for June;

6. The Trust achieved all cancer waiting times in May;

7. There were no urgent operations cancelled for a second time in May;

8. There were 15 operations cancelled on the day of admission in June, all of which have either been treated as per NHS 28 days guarantee or have chosen to wait;

9. The current MIU performance is at 99%;

10. The Trust continues to achieve the 99% diagnostics performance standard. There has been one Sleep breach. The Business Manager is working with the Sleep team to look at opportunities to ensure the pathway is as efficient as possible.

Actions being taken to sustain compliance

Activity

11. Each business unit is undertaking a review of the causative factors resulting in lower than planned performance. Plans will be developed to increase capacity and reviewed by executives.

18 weeks

12. Key actions in place:-

- The Trust has opened a further Orthodontic treatment room last month alongside the appointment of a locum consultant to support the achievement of sustainable waiting times within the department. The impact of this against the current activity levels will be closely monitored;

- Extra clinics are being held to reduce waiting times at off sites particularly for oral surgery;

- Corneo Plastic team will use Clinical Fellows to cover the outpatient clinics and operating sessions of the 5th Consultant in the short term whilst alternative options to fill the post are explored;

- Work is ongoing with the clinical lead for hands to identify additional capacity for hands and this will be implemented in Aug / Sept.

Cancer

13. Whilst all targets were achieved in June, the Trust stills needs to work as follows to ensure the risks to achieving compliance with cancer waiting times are minimised:-

- 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 are a recurrent issue;
- Incorrect listing of patients as routine rather than urgent and or suspected cancers.

14. Actions being taken to mitigate the risks include:-

- Liaising with management teams off site to improve processes for joint pathways;
- Contacting individual trusts when an immediate breach has occurred due to unavailability of visiting consultant or any other reason, raising our concern and asking them to review systems;
- New data collection process surrounding cancer waiting times and the cancer outcomes & services dataset (COSD) have been introduced using Infoflex as the single cancer database source for waiting times within the Trust, which will be supported with a revised tracking system in the next few months;
- Ongoing training of admin teams and reinforcing to junior doctors about the correct listing of patients.

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

15. The performance in month contributes to the financial sustainability objective however there will be penalties applied for failing the 62 day cancer target.

16. 18 RTT and access are an important reflection of QVH's responsiveness to people's needs and effectiveness.

Implications for BAF or Corporate Risk Register

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

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.

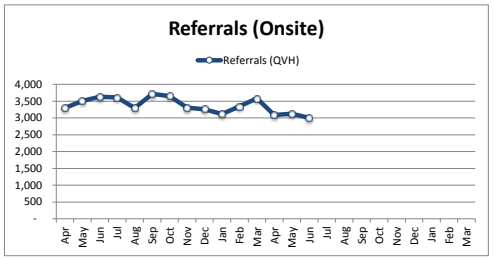
Queen Victoria Hospital NHS
NHS Foundation Trust

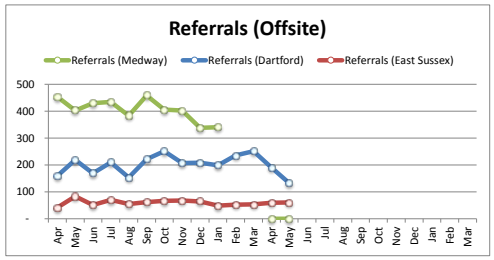
Author (charts): Rob Lock (Information Manager)
Author (narrative):

Trust Level Report (All Services)

Period : 2015-16 Month 2 (May)

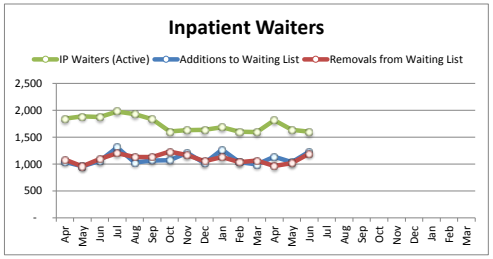
DEMAND

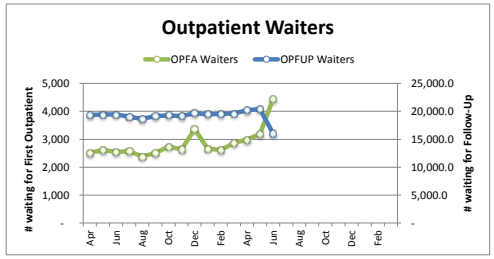




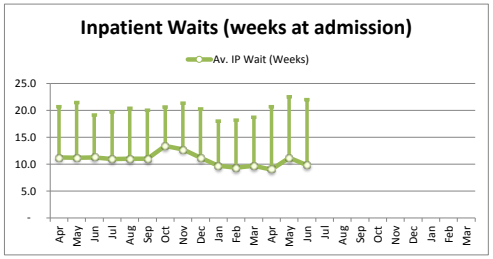
Medway referrals data not yet available since their PAS Upgrade - expected to be resolved this month

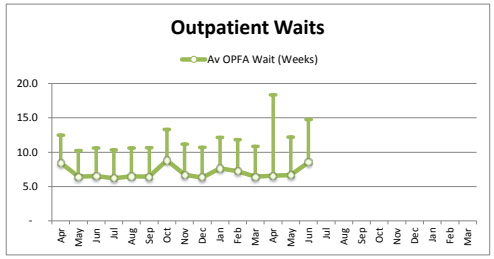
WAITING LIST





WAITING TIMES





Sudden spikes in wait-time variation (bars) are due to data entry errors on the waiting list - e.g. entering a patient DoB in the referral date field. These outliers should vanish after validation.

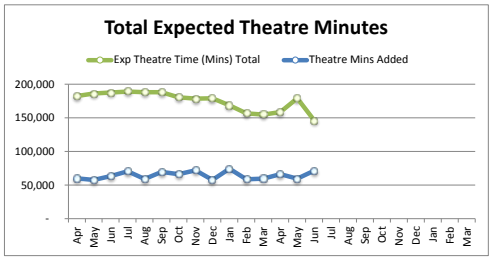
Queen Victoria Hospital NHS
NHS Foundation Trust

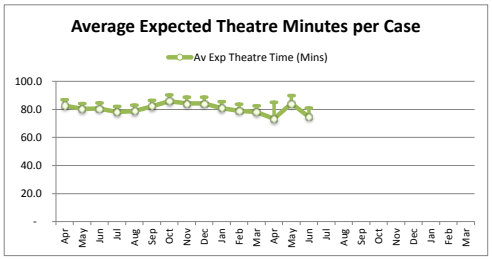
Author (charts): Rob Lock (Information Manager)
Author (narrative):

Trust Level Report (All Services)

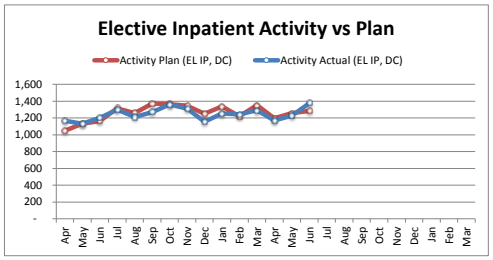
Period : 2015-16 Month 2 (May)

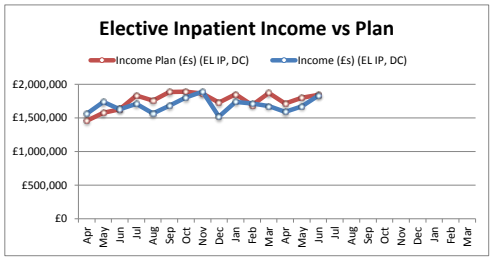
THEATRE MINS



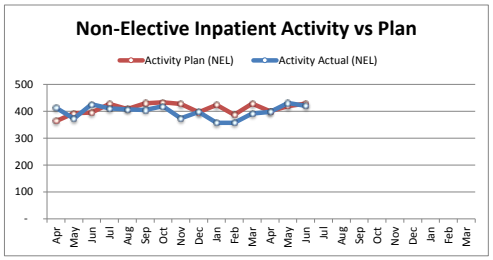


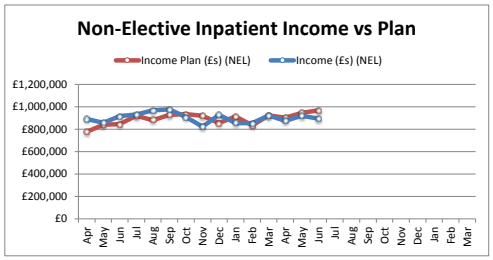
Elective Inpatients





Non-Elective Inpatients





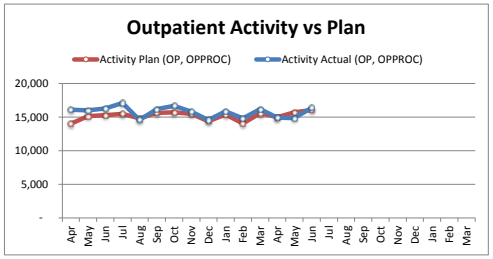
Queen Victoria Hospital NHS
NHS Foundation Trust

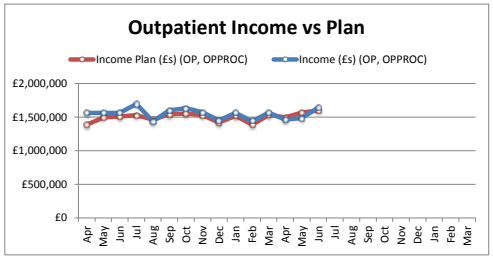
Author (charts): Rob Lock (Information Manager)
Author (narrative):

Trust Level Report (All Services)

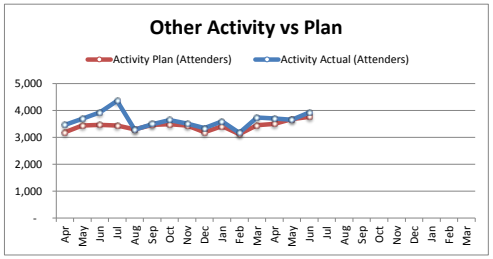
Period : 2015-16 Month 2 (May)

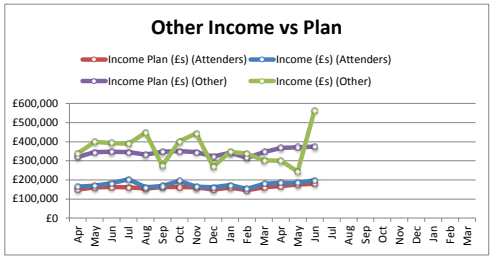
Outpatients





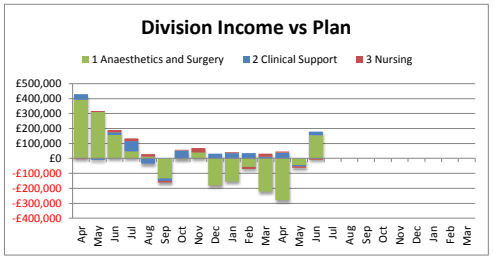
Other Activity/Income

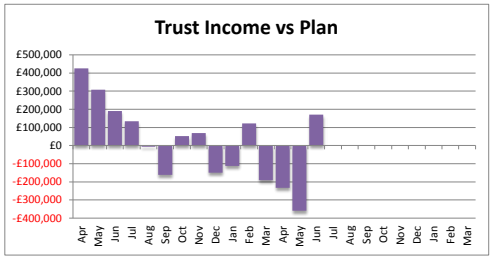




"Other" income is Excluded Drugs and Devices
"Attenders" is a combination of Radiology and MIU activity

Income vs Plan





N.B. This graph has been changed from YTD to 'in-month' figures

Queen Victoria Hospital NHS
NHS Foundation Trust

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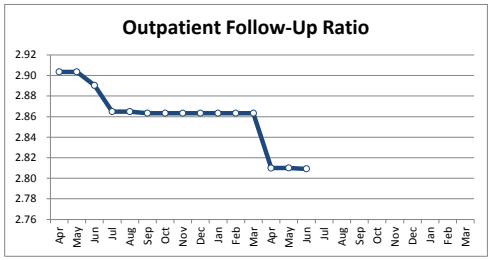
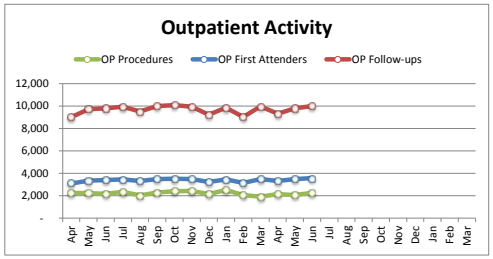
Trust Level Report (All Services)

Period : 2015-16 Month 2 (May)

Follow-up Ratios





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	Apr-15	May-15	Jun-15	Operational Standards	Threshold
90.5%	90.8%	88.0%	85.0%	83.0%	84.7%	86.9%	86.7%	91.6%	91.99%	94.13%	93.04%	91.71%	92.63%		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%	95.70%	96.38%	95.74%	95.52%	96.38%		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%	96.16%	96.00%	96.95%	96.98%	96.98%		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%	99.8%	99.7%	99.5%	100.0%	99.6%	99.8%	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%	98.76%	99.64%	99.47%	99.51%	99.22%	99.06%	98.64%	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%	94.9%	94.2%	96.8%	98.3%	98.2%	96.9%	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	#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%	98.0%	96.2%	97.7%	96.5%	98.6%	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%	100.0%	100.0%	100.0%	94.9%	97.5%	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%	94.4%	88.4%	75.0%	83.0%	77.5%	91.3%	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	100.0%	100.0%	#N/A	#N/A	#N/A	100.0%	TBC	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	#N/A	100.0%	100.0%	#N/A	100.0%	TBC	% 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 c	85%
1			0			0			0			TBC	TBC	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	0	0	0	0	0		Zero tolerance MRSA	0
0	0	0	0	0	0	1	0	0	0	0	0	0	0		Minimise rates of Clostridium Difficile	0
0	1	3	2	0	1	1	0	TBC	0	0	1	0	0		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%	99.5%	99.5%	99.5%	99.5%	99.5%	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	99%
99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.7%	99.7%	99.7%	99.7%	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	99%
99.4%	99.0%	98.7%	98.4%	98.4%	98.3%	98.3%	98.3%	98.4%	98.4%	98.4%	98.4%	98.5%	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	0	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%	100.0%	100.0%	100.0%	TBC			VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95%
TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	Publication of Formulary	TRUE
0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	Never Events	0

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 July 2015
Reference number: 174-15
Report from: Clare Stafford, Director of Finance and Performance
Author: Jason McIntyre, Deputy Director of Finance
Report date: 15 July 2015
Appendices: A: Finance report M03

Finance Report M03 June 2015

Key issues

1. The financial performance report details the Trust's financial performance for the three months to 30th June 2015.

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	5,497	5,379	118	15,513	15,682	(169)
EBITDA	533	571	(39)	1,107	1,263	(157)
Surplus	196	242	(46)	120	275	(155)
Continuity of Service risk rating (CoSRR)				4	4	-

NB table subject to rounding differences.

2. The Trust delivered an actual surplus of £196k for the month, £46k lower than planned. The cumulative deficit now stands at £155k.

3. The Trust has maintained a Continuity of Service Risk Rating of 4.

4. The current format of the Finance report is being reviewed and will be developed during forthcoming months. An action log will be included in future reports to track progress against actions agreed in the report.

Implications of results reported

5. The Trust must continue to improve the throughput of activity to meet Income plan and ensure full delivery of CIP programme in order to achieve the planned surplus.

Action required

6. An activity delivery plan needs to be fully developed and implemented to recover patient treatment income underperformance by the end of the financial year.

7. The current CIP programme needs to be reviewed in order to validate the current plans, and identify areas of slippage. Further schemes need to be identified to mitigate the shortfall; some of which is in train.
8. The current purchasing practices need to be reviewed and current expenditure controls assessed.

Link to Key Strategic Objectives

- Operational excellence
- Financial sustainability

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

Implications for BAF or Corporate Risk Register

10. Nothing new to add.

Regulatory impacts

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

Recommendation

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

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
June 2015

Executive Director: Clare Stafford

Contents

Queen Victoria Hospital
NHS Foundation Trust

3. Summary Actual Position
4. Surplus Trend Position
5. Activity Performance
6. Divisional Financial Performance Position
7. Cost Improvement Programme (CIP)
8. Balance Sheet
9. Capital
10. Debtors
11. Cash
12. Creditors
13. Appendices
14. Appendix 1: Departmental Performance Table - Operations
15. Appendix 1: Departmental Performance Table - Nursing & Clinical Infrastructure
16. Appendix 1: Departmental Performance Table - Finance & Non Clinical Infrastructure, Human Resources, Corporate, Research.

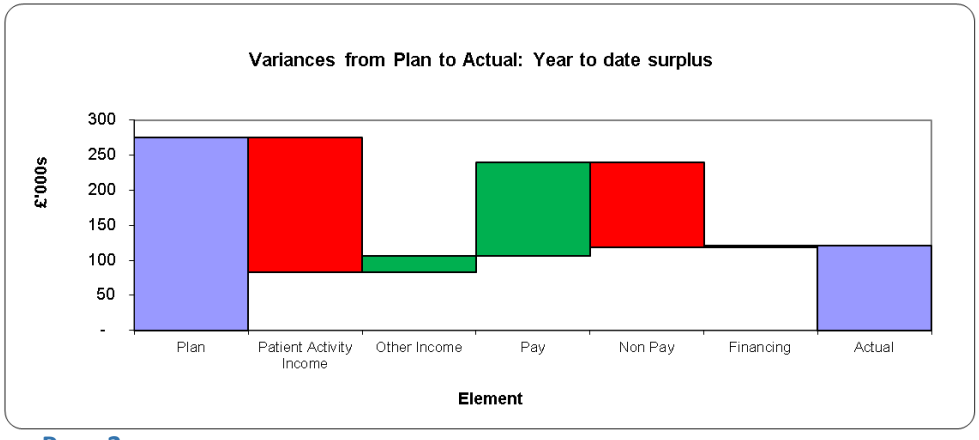
Summary Actual Position – YTD M03 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance	2015-16	June 15-16			Year to Date 2015-16		
Income and Expenditure	Annual Plan £k	Actual £k	Budget £k	Variance (Favourable/ (Adverse))	Actual £k	Budget £k	Variance (Favourable/ (Adverse))
Patient Activity Income	58,605	5,194	5,052	142	14,514	14,706	(192)
Other Income	4,346	303	326	(24)	999	976	23
Pay	(40,994)	(3,415)	(3,397)	(19)	(10,055)	(10,189)	134
Non Pay	(16,987)	(1,549)	(1,411)	(139)	(4,351)	(4,230)	(121)
Operational EBITDA	**4,970**	**533**	**571**	**(39)**	**1,107**	**1,263**	**(157)**
as a %	*7.9*	*9.7*	*10.6*	*-0.9*	*7.1*	*8.1*	*-0.9*
Financing & Donations	(3,953)	(337)	(329)	(8)	(987)	(988)	2
Current Year Surplus / (Deficit)	**1,017**	**196**	**242**	**(46)**	**120**	**275**	**(155)**
Surplus (Deficit) %	1.6%	3.6%	4.5%	-0.9%	0.8%	1.8%	-0.98%

Note: Financing costs consist mainly of depreciation, dividends, theatre loan interest, and any impairments to assets.

Continuity of Service Risk Rating	Metric	Score	Weighted Score	
Liquidity days	45	4	50%	2
Avg Debt Service Cover	2.2	3	50%	1.5
Combined Score (1 to 4)				**4**



Summary

- The Month 3 position is a surplus of £196k; £46k behind the plan for the month.
- The year to date position is a surplus of £120k against a planned surplus of £275k ; £155k worse than plan.
- The key variance YTD plan is a shortfall of inpatient income. There are also significant pressures within non pay expenditure, some non recurrent, which is being fully offset by underspends on pay expenditure due to vacancies not being filled. There is also slippage of Cost Improvement Programme (CIP) delivery, largely within non pay expenditure., which is contributing to the position.
- The Continuity of service risk rating is 4, as planned.

Issues

- The planned surplus is not being delivered
- Activity income is below plan and at a reduced casemix complexity
- The CIP delivery is £72k behind plan.

Risk

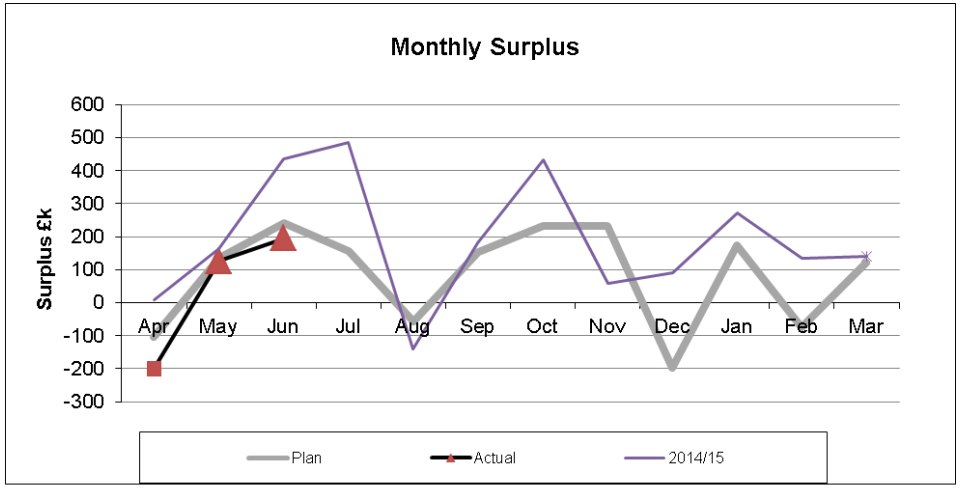
- The non achievement of the planned surplus would adversely affect future capital and revenue investment and our Monitor financial ratings
- The activity plan must be recovered quickly or further expenditure reductions will be required to ensure the Trust delivers the planned surplus.

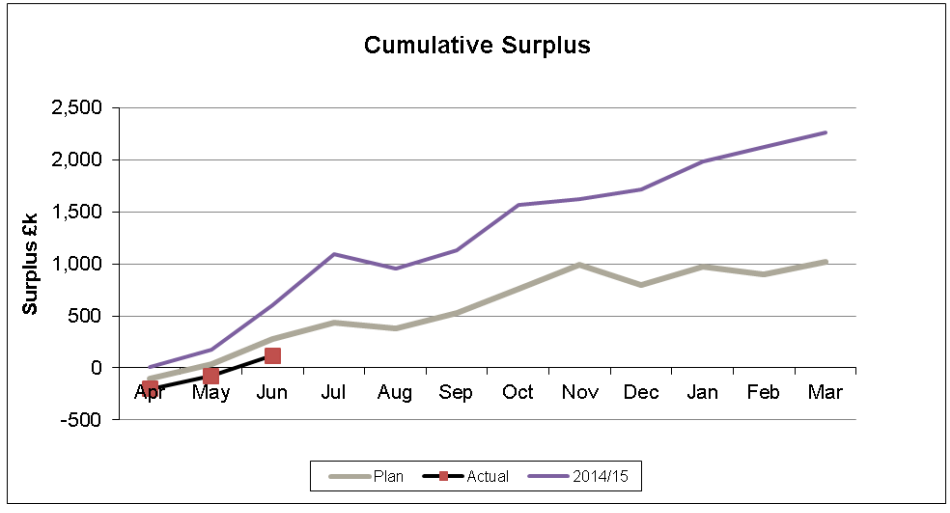
Action

- Develop and implement an activity delivery plan to achieve the planned surplus by end of the financial year .
- CIP review to identify areas of slippage and develop areas to mitigate the shortfall.
- Review current purchasing practices and assess current expenditure controls.

Surplus Trend Position – M03 2015/16

Queen Victoria Hospital NHS Foundation Trust





Summary

- The in month surplus is £196k, increasing the year to date surplus to £120k.
- A straight line forecast indicates a full year surplus of £480k against the plan of £1,017k. This is an adverse movement of £537k which represents an under delivery of 53%
- The Trust needs to generate an average monthly surplus of £100k in the remaining months of the year to deliver the planned surplus.

Action

- A detailed forecast is currently being completed and will be available for Month 04 reporting.

Activity Performance – (Source: Weekly Dashboard (Flash Reporting) 12 July)

Period to (week ending) 12 July 2015	Plan	Perform. Standard	Plan Wkly Avg.	YTD wkly Avg.	Week ending 07-Jun 23	14-Jun 24	21-Jun 25	28-Jun 26	05-Jul 27	12-Jul 28	Trend (of period)	
Activity												
MIU Attendances	12068		231	245	244	248	253	251	328	238		
Emergency Admissions	5120		98	95	99	100	98	93	110	96		
Day Cases Onsite	9918		190	188	223	213	205	207	201	197		
Elective Inpatients	4917		94	75	81	79	74	83	59	66		
Outpatient Attendance 1st Onsi	35435		680	699	746	729	757	706	690	693		
Outpatient Attendance F/U Onsi	107127		2054	2520	2764	2761	2463	2405	2366	2309		
DNAs	-		-	157	186	147	154	189	160	122		
Outpatient Attendance 1st Offsit	7109		136	105	-	-	-	-	-	-		Offsite - repc
Outpatient Attendance F/U Offsi	11871		228	226	-	-	-	-	-	-		
Outpatient DNAs Offsite				102	-	-	-	-	-	-		
Referrals	n/a		1196	1079	1071	1088	1163	1025	787	-		Onsite only fr

Summary

The table highlights the continued under performance in elective inpatients which is not compensated for by the increase in day cases.

Issues

Other data activity analysis indicates a significant reduction of £280k in casemix value for elective, non elective and daycase work.

Risks

The continued under achievement of activity income plans will impact on the Trust's I&E position.

Action

- Further work is required to understand the reasons for underperformance and explain the reduction in the casemix of activity completed compared to plan which will form the basis of the activity recovery plan.
- The activity reporting is currently indicative within this report and is undergoing some development and future reports will have a revised format.

Divisional Performance Position – YTD M03 2015/16

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Operations													
1.1 Plastics	65	(122)	(21)	(72)	(23)	(18)	25,338	2,223	2,202	21	6,153	6,364	(211)
1.2 Oral	12	(61)	17	66	19	51	6,912	663	615	48	1,797	1,741	56
1.3 Eyes	41	6	2	24	(54)	(48)	2,741	232	243	(11)	673	690	(17)
1.4 Sleep	(10)	(103)	(2)	1	(13)	45	2,013	155	179	(24)	450	507	(57)
1.5 Clinical Support	(6)	27	(0)	9	(14)	(25)	(2,168)	(192)	(172)	(20)	(528)	(539)	12
1.6 Other Med & Admin	8	8	(2)	(14)	(4)	27	204	21	19	2	74	52	22
Operations Total	**111**	**(244)**	**(7)**	**14**	**(89)**	**33**	**35,040**	**3,102**	**3,086**	**16**	**8,618**	**8,814**	**(196)**
Nursing & Clinical Infrastructure													
2.1 Clinical Infrastructure	(18)	(25)	29	77	(37)	(118)	(18,985)	(1,603)	(1,578)	(25)	(4,812)	(4,745)	(67)
2.5 Director Of Nursing	3	5	11	24	14	27	(1,466)	(95)	(122)	28	(311)	(367)	56
Nursing & Clinical Infrastructure	**(15)**	**(20)**	**40**	**100**	**(23)**	**(91)**	**(20,451)**	**(1,698)**	**(1,700)**	**2**	**(5,122)**	**(5,111)**	**(11)**
Corporate Departments													
3.1 Non Clinical Infrastructure	(1)	(7)	3	13	(3)	7	(4,289)	(359)	(357)	(2)	(1,060)	(1,072)	13
3.2 Commerce & Finance	35	35	(29)	(67)	(34)	(37)	(1,556)	(157)	(130)	(28)	(459)	(389)	(70)
3.4 Finance Other	(7)	86	-	55	(14)	(20)	(5,086)	(457)	(436)	(20)	(1,185)	(1,306)	121
4.1 Human Resources	(5)	(10)	2	1	13	5	(755)	(54)	(63)	9	(194)	(189)	(5)
5.4 Corporate	-	-	(28)	13	3	(17)	(1,846)	(179)	(154)	(25)	(465)	(461)	(3)
6.1 Research	0	(8)	(1)	5	0	1	(41)	(3)	(3)	0	(13)	(10)	(3)
Corporate Total	**22**	**95**	**(52)**	**19**	**(35)**	**(62)**	**(13,573)**	**(1,208)**	**(1,144)**	**(65)**	**(3,375)**	**(3,428)**	**53**
QVH Total	**118**	**(169)**	**(19)**	**134**	**(146)**	**(120)**	**1,017**	**196**	**242**	**(46)**	**120**	**275**	**(155)**

Summary

Material Variances in month:

- Income - Whilst patient activity income looks positive (£142k favourable) the underlying position is masked by income related to 2 long-stay burns patients (£197k). Elective activity continues to be below plan and a potential casemix change requires further investigation.
- Non-pay – £139k overspend in month (£89k in Operations, £23k in Nursing and Clinical infrastructure and £35k across the corporate areas). Further work required to understand how much of this spend is off-set by income, the impact of purchasing practices and one-off costs in relation to recruitment and double running. The non-pay CIP is behind plan adding to the current pressure on theatre supplies and anaesthetics.
- Pay - £19k overspend in month. Overall the position is not material; but significant underspends in clinical infrastructure and oral are masking overspends in plastics and corporate. A particular risk if underspending areas recruit and the overspending areas have not been addressed.

Year-to-date:

Operations performance is driving the position. £196k overspent year-to-date overall; (plastics £211k, eyes, £17k and sleep £57k offset by underspends on oral, clinical support and admin). The YTD position includes non recurrent recruitment expenses. In addition corporate areas are incurring agency costs covering vacancies (i.e. Business Managers) that will reduce in future periods as permanent staff are recruited to these positions.

Cost Improvement Programme – YTD M03 2015/16

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes	Annual Plan £000's	Year to date plan Month 3	Achieved £000's	Achieved %	Shortfall
Other Income	74,000	18,500	12,300	66%	6,200
Pay	231,852	57,963	45,084	78%	12,879
Non Pay	818,843	204,711	151,848	74%	52,862
Total Cost Improvement Programmes	**1,124,695**	**281,174**	**209,232**	**74%**	**71,941**

Cost Improvement Programmes	Annual Plan £000's	Year to date plan Month 3	Achieved £000's	Achieved %	Shortfall
1 Operations	199,422	49,856	41,782	84%	8,074
2 Nursing & Clinical Infrastructu	215,405	53,851	42,048	78%	11,803
3 Finance and Non Clinical Infra	673,618	168,405	116,340	69%	52,064
4 Human Resources and Organ	250	63	63	100%	-
5 Corporate	36,000	9,000	9,000	100%	-
Total Cost Improvement Programmes	**1,124,695**	**281,174**	**209,232**	**74%**	**71,941**

Summary

- At M3 the Trust has achieved saving of £209k YTD which represents 74% of the CIP plan. There is slippage of £72k in Q1

Issues

- The CIP programme is materially behind plan.

Risks

- CIP delivery is critical to achieve the Trusts financial plan for the year.

Actions

- All current CIP plans need to reviewed to assess in year delivery.
- The Trust needs to understand the key drivers of slippage and actions to be taken to recover in year.
- New schemes need to be developed in order to mitigate against CIPs underperformance and unforeseen cost pressures.

Balance Sheet – YTD M03 2015/16

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet for: Month 3 2015/16	2014/15 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,705	37,273	37,382
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,705	37,273	37,382
Current Assets			
Inventories	440	442	440
Trade and Other Receivables	8,351	7,879	7,119
Cash and Cash Equivalents	6,548	5,912	6,718
Current Liabilities	(7,880)	(6,582)	(6,541)
Sub Total Net Current Assets	7,459	7,651	7,736
Total Assets less Current Liabilities	45,164	44,924	45,118
Non-Current Liabilities			
Provisions for Liabilities and Charges	(588)	(616)	(616)
Non-Current Liabilities >1 Year	(8,156)	(7,767)	(8,156)
Total Assets Employed	**36,420**	**36,541**	**36,346**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	18,382	18,504	18,309
Revaluation Reserve	5,801	5,801	5,801
Total Tax Payers Equity	**36,420**	**36,541**	**36,346**

NB Analysis is subject to rounding differences

Summary

- Net current assets are stable in month.
- Cash has reduced in month by £806k whereas debtor have increased by £760k
- Non-current liabilities will reduce in year due to theatre loan repayments in June and December with a corresponding cash reduction of £778K.
- The loan principal of £11.1million is repayable over 13 years from Dec 2013 to June 2026
- The loan interest is payable from revenue, currently £240k PA.

Issues

- The Trust needs to ensure there is sufficient cash balances to provide liquidity, service the capital plan and meet the requirements of Monitor's Continuation of Services measures.

Actions

- Cash balances rely on prompt payment by commissioners. Further details of actions taken are included in the debtors section of the report.

Capital – M03 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Capital Programme	2015/16 Plan £000s	YTD Spend £000s	Ordered £000s	2015/16 Total Spend £000s	Variance from Plan £000s
Estates projects					
14/15 Projects:	58	39	-	39	(19)
15/16 Projects:					
Corneoplastic electrical upgrade	218	-	9	195	(23)
Jubilee refurbishment	377	2	52	318	(59)
Consultants' offices	72	-	-	75	3
Other projects	155	43	21	253	98
Estates Total	880	84	82	880	-
YTD Plan		200			
YTD Estates variance		(116)			
Medical Equipment	690	196	-	690	-
YTD Plan		150			
YTD Medical Equipment variance		46			
IT Equipment & Software					
Infrastructure improvement	2,000	8	-	2,000	-
Electronic Document Management (EDM)	590	7	100	591	1
Other projects	360	31	-	359	(1)
IT Total	2,950	46	100	2,950	-
YTD Plan		320			
YTD IT variance		(274)			
Total capital spend	**4,520**	**326**	**182**	**4,520**	**-**
YTD Plan		**670**			
YTD Total Variance		**(344)**			

Summary

- Capital YTD expenditure is £326k which is £344k (51%) below plan, but at this stage it is expected that the annual plan will be achieved.
- The draft phasing of the plan assumed early starts to the two main Estates projects. The Jubilee works are now out to tender and the Corneo electrical project will follow shortly. Both jobs will be completed within the year.
- The Medical Equipment budget is ahead of plan and still has £350k unallocated against bids in excess of £1m awaiting business cases.
- IT expenditure has not started as quickly as anticipated in the plan. The EDM project must be completed within the year and is partly dependent on the infrastructure project. Expenditure is phased towards the second half of the year.

Issues

- There is a lack of clarity with the programme on what projects have and have not been approved.
- Capital expenditure has slipped against nominal phasing of the Estates and IT projects.
- The outstanding bids against the Medical Equipment budget will need careful prioritisation, taking account of the need to maintain a reserve for unforeseen requirements.

Risks

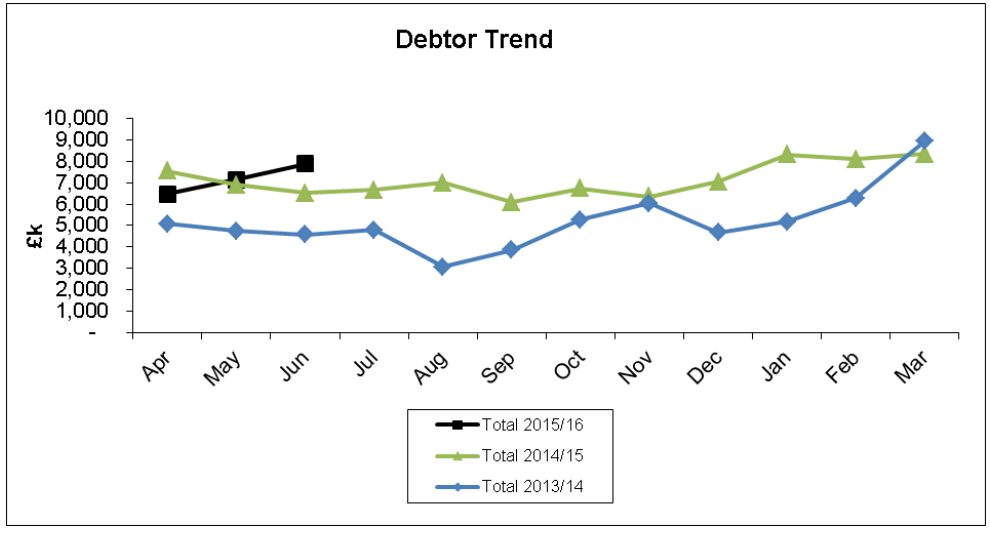
- The Trust may not fully spend its agreed capital programme which will impact on quality of service, reputational risk and the ability to maintain the appropriate risk rating.
- The IT project include a number of critical infrastructure developments where delay would impact the delivery of the EDM project.

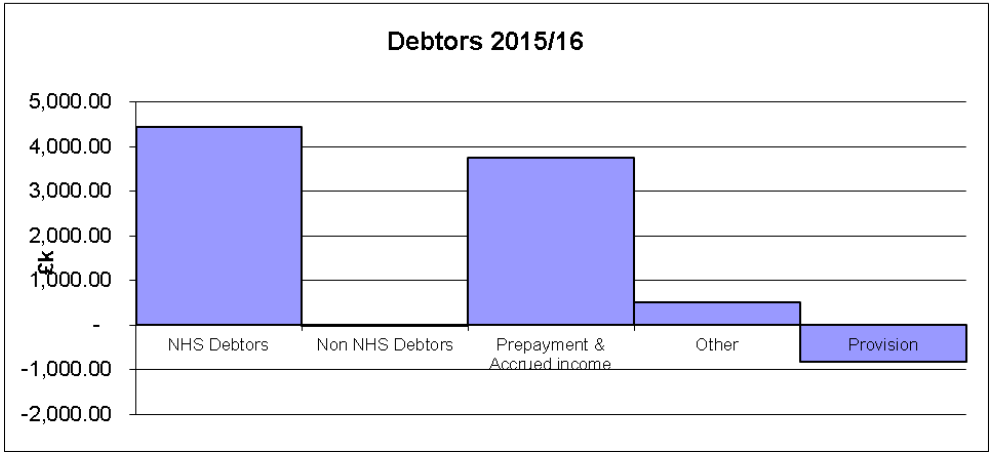
Actions

- Review and formally agree capital programme for 2015-16
- Assess the impact of agreed programme on available resources for the remainder of the year ensuring full delivery of critical schemes .

Debtors – M03 2015/16

Queen Victoria Hospital NHS Foundation Trust





Summary

- The in month debtor balance of £7.9m which is greater than the average monthly balances from 2014-15 of £7.1m. The debtor balance increased by £760k from those reported Month 2.

Issues

- There is currently a £1.8m debt due to prior year over performance invoices for specialist commissioning.
- There is £1,983k levels of accrued income due to income over-performance and NCAs.
- There is a general issue of delayed payment of invoices by NHS England on specialised services invoices, constituting 41% of invoiced income.

Risks

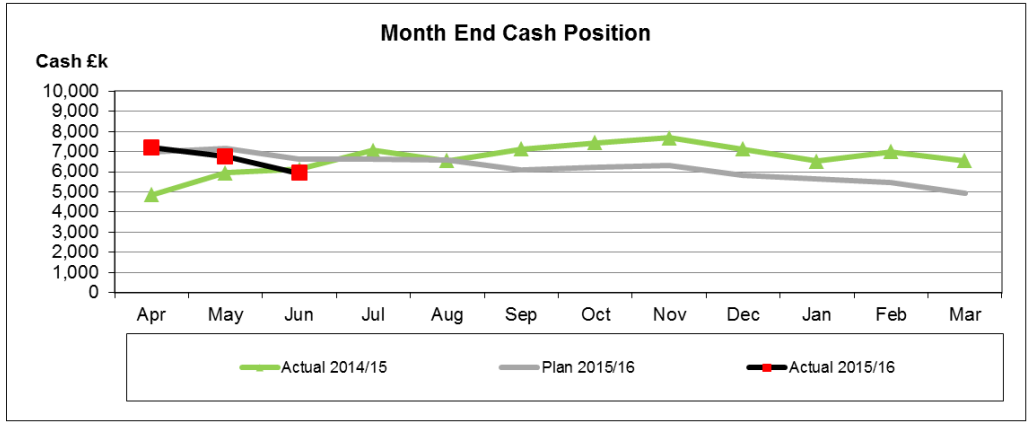
- Delayed payments of over-performance negatively affects cash balances.

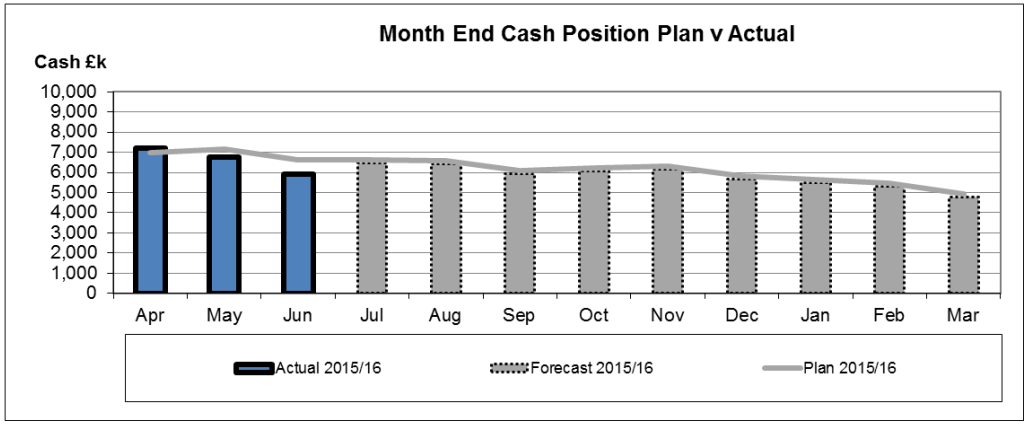
Actions

- The level of accrued income needs to be reviewed continually to ensure that invoices are raised, where appropriate, immediately.
- The billing process needs to be reviewed to ensure that there are sufficient controls to ensure that billing timetables are adhered to.
- Financial services will meet urgently with NHS England to secure payment of outstanding debts and agree a mechanism to ensure prompt payment going forward.

Cash – M03 2015/16

Queen Victoria Hospital NHS Foundation Trust





Summary

- Cash levels are healthy as on the basis of current liquidity and debt service ratios.
- The cash balance at month 3 is £5,912k, £806k lower than month 2. There was a £504k loan and interest repayment paid in month and increased debtors in periods which explain in month movement.

Issues

- There was an increase in pay and non pay invoices paid in month compared to plan.
- In addition there is an improvement in Better Payment Practice code performance which resulted in cash outflow.

Risks

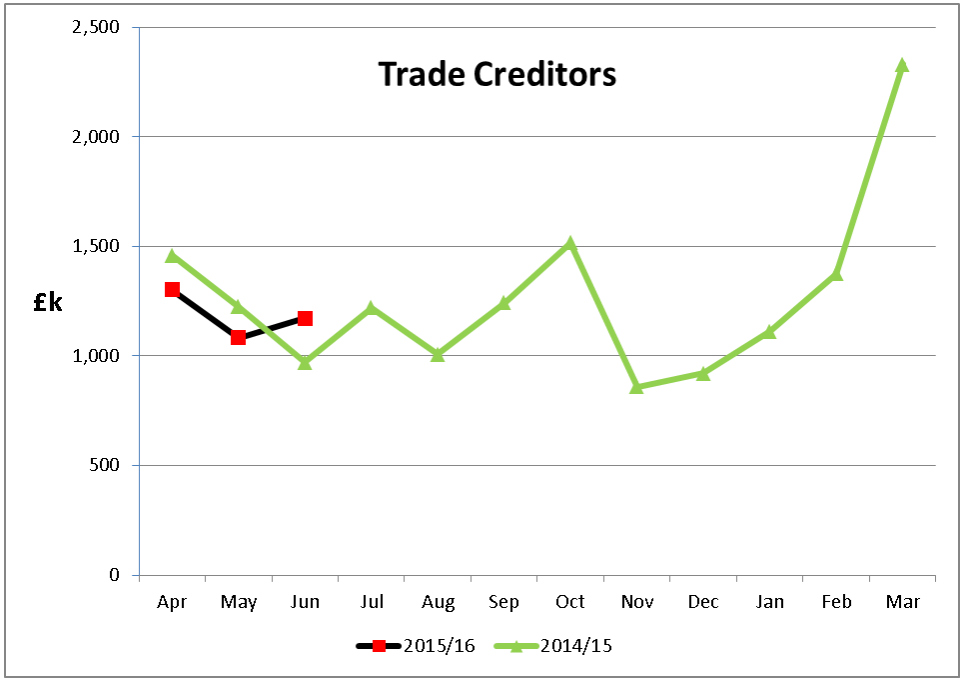
- The deterioration in I&E performance or delays in payment of debt will impact on liquidity and ability to maintain appropriate Monitor ratings.

Actions

- The Trust will review short term cash flow on a daily basis to manage liquidity.
- The continuous monitoring of the capital programme and schemes to assess impact on Trust's cash balances.
- Financial services will focus efforts to reduce level of debts (see debtors).

Creditors – M03 2015/16

Queen Victoria Hospital NHS Foundation Trust



Better Payment Practice Code June 2015	2014/15 Outturn # Invs	2014/15 Outturn £k	Current Month # Invs	Current Month £k	YTD # Invs	YTD £k
Total **Non-NHS** trade invoices paid	15,882	16,661	1,417	1,545	4,332	5,491
Total **Non NHS** trade invoices paid within target	10,806	11,312	1,192	1,183	3,673	4,677
Percentage of Non-NHS trade invoices paid within target	**68%**	**68%**	**84%**	**77%**	**85%**	**85%**
Total **NHS** trade invoices paid	933	5,241	60	371	230	1,148
Total **NHS** trade invoices paid within target	505	3,037	39	247	168	858
Percentage of NHS trade invoices paid within target	**54%**	**58%**	**65%**	**67%**	**73%**	**75%**

Summary

- Q1 expenditure is below the average for 14/15, which is largely due to capital expenditure weighted towards the end of the last financial year.

Issues

- Better Payment Practice code (BPPC) YTD performance against the 30 day target has improved significantly this year, currently at 85% non NHS and 73% NHS, but is still below the 90% target. This does have an adverse impact on cash balances.
- There has been higher than average agency invoices that currently require increased approval times.

Risks

- Failure to achieve national BPPC target within the financial year.

Actions

- Daily monitoring of invoices on hold , allowing analysis and targeting of efforts to increase BPPC.
- Pilot testing of online invoice approval software to re-commence 3rd August in nursing directorate before Trust wide roll out; once complete this should reduce approval times for invoices that don't require a purchase order (average of 52% of all invoices on hold during month 3).
- Specific focus on work to improve approval times of NHS invoices and invoices of large value. This focus is derived from analysis of current BPPC performance.

Appendices

Variance by type: in £ks	Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
1 Operations													
1.1 Plastics													
1.11 Breast	(13)	(15)	(1)	(1)	(8)	(2)	3,850	312	334	(22)	949	967	(18)
1.12 Burns	139	30	(2)	(0)	(1)	(1)	7,527	787	650	136	1,919	1,889	30
1.13 Hands	(37)	(117)	(0)	(4)	(13)	(18)	12,890	1,064	1,115	(51)	3,098	3,236	(138)
1.14 Skin	(24)	(20)	0	1	(1)	(2)	4,427	358	382	(24)	1,090	1,111	(21)
1.15 Plastics	-	-	(19)	(68)	0	4	(3,355)	(298)	(280)	(18)	(903)	(839)	(64)
1.1 Plastics Total	**65**	**(122)**	**(21)**	**(72)**	**(23)**	**(18)**	**25,338**	**2,223**	**2,202**	**21**	**6,153**	**6,364**	**(211)**
1.2 Oral													
1.21 Head & Neck	22	(18)	(1)	1	18	48	5,605	534	496	39	1,441	1,411	30
1.23 Orthodontic	(23)	(63)	14	42	(2)	(1)	1,739	142	154	(11)	415	438	(22)
1.24 Prosthetics	13	21	5	24	3	4	(432)	(14)	(35)	21	(59)	(107)	48
1.2 Oral Total	**12**	**(61)**	**17**	**66**	**19**	**51**	**6,912**	**663**	**615**	**48**	**1,797**	**1,741**	**56**
1.3 Eyes													
1.31 Corneoplastic	33	2	3	27	(47)	(40)	2,553	215	226	(10)	630	643	(12)
1.32 Oculoplastic	9	13	0	1	0	(4)	137	22	13	10	44	35	9
1.33 Eye Bank	(1)	(8)	(2)	(3)	(7)	(3)	52	(6)	4	(10)	(1)	13	(14)
1.3 Eyes Total	**41**	**6**	**2**	**24**	**(54)**	**(48)**	**2,741**	**232**	**243**	**(11)**	**673**	**690**	**(17)**
1.4 Sleep													
1.41 Sleep	(10)	(103)	(2)	1	(13)	45	2,013	155	179	(24)	450	507	(57)
1.4 Sleep Total	**(10)**	**(103)**	**(2)**	**1**	**(13)**	**45**	**2,013**	**155**	**179**	**(24)**	**450**	**507**	**(57)**
1.5 Clinical Support													
1.51 Imaging	10	7	(4)	(10)	0	3	299	35	29	6	76	76	(0)
1.52 Pathology	3	12	(16)	(34)	10	13	(1,493)	(127)	(124)	(3)	(382)	(373)	(9)
1.53 Therapies	(21)	(8)	16	39	(5)	(6)	(711)	(66)	(56)	(11)	(153)	(177)	24
1.54 Pharmacy	2	18	1	6	(19)	(33)	(80)	(21)	(5)	(15)	(29)	(20)	(10)
1.55 Medical Photography	1	(2)	2	8	(1)	(1)	(183)	(13)	(15)	2	(40)	(46)	6
1.5 Clinical Support Total	**(6)**	**27**	**(0)**	**9**	**(14)**	**(25)**	**(2,168)**	**(192)**	**(172)**	**(20)**	**(528)**	**(539)**	**12**
1.6 Other Med & Admin													
1.61 Ops Admin	4	4	(1)	(1)	(10)	9	35	(2)	4	(6)	22	9	12
1.62 Elderly	5	8	(2)	(14)	5	16	5	9	1	8	12	1	10
1.63 Rheumatology	3	(2)	0	(1)	-	-	80	10	7	3	18	20	(3)
1.64 Cardiology	(4)	(1)	0	2	1	2	83	4	7	(3)	23	21	2
1.6 Ops Admin Total	**8**	**8**	**(2)**	**(14)**	**(4)**	**27**	**204**	**21**	**19**	**2**	**74**	**52**	**22**
1 Operations Total	**111**	**(244)**	**(7)**	**14**	**(89)**	**33**	**35,040**	**3,102**	**3,086**	**16**	**8,618**	**8,814**	**(196)**

Appendix 1: Departmental Performance Summary – M03 2015/16

Variance by type: in £ks	Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
2 Nursing & Clinical Infrastructure													
2.1 Clinical Infrastructure													
2.11 Perioperative Care	1	0	25	103	(23)	(70)	(6,949)	(576)	(579)	3	(1,704)	(1,737)	33
2.12 Elective Care Nursing	3	7	(9)	3	9	26	(4,916)	(407)	(410)	3	(1,194)	(1,229)	36
2.13 Emergency Care Nursing	(19)	(25)	10	(39)	(17)	(47)	(3,180)	(287)	(261)	(26)	(904)	(794)	(111)
2.14 Anaesthetics	(2)	(7)	4	8	(9)	(28)	(3,292)	(282)	(274)	(7)	(849)	(823)	(26)
2.15 Appointments & Records	-	-	(1)	1	3	1	(648)	(52)	(54)	2	(160)	(162)	2
2.1 Clinical Infrastructure Total	**(18)**	**(25)**	**29**	**77**	**(37)**	**(118)**	**(18,985)**	**(1,603)**	**(1,578)**	**(25)**	**(4,812)**	**(4,745)**	**(67)**
2.21 Risk	4	6	3	7	17	14	(704)	(35)	(59)	24	(148)	(176)	28
2.22 Clinical Audit	-	-	3	7	0	1	(119)	(7)	(10)	3	(22)	(30)	8
2.41 Practice Development	(1)	0	0	0	(6)	7	124	4	10	(7)	38	31	7
2.51 Director of Nursing	(0)	(1)	6	9	2	5	(767)	(57)	(64)	7	(179)	(192)	13
2.5 Director of Nursing Total	**3**	**5**	**11**	**24**	**14**	**27**	**(1,466)**	**(95)**	**(122)**	**28**	**(311)**	**(367)**	**56**
2 Nursing & Clinical Infrastructure Total	**(15)**	**(20)**	**40**	**100**	**(23)**	**(91)**	**(20,451)**	**(1,698)**	**(1,700)**	**2**	**(5,122)**	**(5,111)**	**(11)**

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

Appendix 1: Departmental Performance Summary – M03 2015/16

Variance by type: in £ks	Income		Pay		Non Pay			Total Current Month			Total Year To Date		
Budget Performance	**CMV**	**YTDV**	**CMV**	**YTDV**	**CMV**	**YTDV**	**Annual Budget**	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
3 Finance and Non Clinical Infrastructure													
3.1 Non Clinical Infrastructure													
3.11 Hotel Services	(5)	(8)	(1)	(0)	(23)	(31)	(1,748)	(176)	(146)	(30)	(476)	(437)	(39)
3.12 Estates	4	1	2	8	3	21	(1,995)	(157)	(166)	9	(469)	(499)	30
3.13 IMT	(0)	(1)	2	5	18	18	(546)	(26)	(46)	19	(115)	(137)	22
3.1 Non Clinical Infrastructure Tot	(1)	(7)	3	13	(3)	7	(4,289)	(359)	(357)	(2)	(1,060)	(1,072)	13
3.2 Commerce & Finance													
3.22 Commerce	35	35	(12)	(25)	(14)	(14)	(563)	(38)	(47)	9	(145)	(141)	(4)
3.31 Finance	0	0	(17)	(42)	(20)	(24)	(992)	(119)	(83)	(36)	(314)	(248)	(66)
3.2 Commerce & Finance Total	35	35	(29)	(67)	(34)	(37)	(1,556)	(157)	(130)	(28)	(459)	(389)	(70)
3.4 Finance Other													
3.41 Financing	-	-	-	-	(8)	2	(3,953)	(337)	(329)	(8)	(987)	(988)	2
3.42 Reserves	37	111	-	-	-	-	(784)	(41)	(78)	37	(119)	(230)	111
3.43 Exceptionals	-	-	-	55	28	42	(23)	26	(2)	28	91	(6)	97
3.44 Contract Penalties	-	-	-	-	-	-	(650)	(54)	(54)	-	(163)	(163)	-
3.45 Other Income	(38)	(25)	-	-	(1)	(8)	323	(12)	27	(39)	48	81	(33)
3.46 Activity Income	(6)	-	-	-	-	-	-	(6)	-	(6)	-	-	-
3.48 Closed	-	-	-	-	-	-	-	-	-	-	-	-	-
3.49 Suspense	-	-	-	-	(33)	(56)	-	(33)	-	(33)	(56)	-	(56)
3.4 Finance Other Total	(7)	86	-	55	(14)	(20)	(5,086)	(457)	(436)	(20)	(1,185)	(1,306)	121
3 Finance and Non Clinical Infrastructure Total	**27**	**114**	**(26)**	**0**	**(50)**	**(50)**	**(10,931)**	**(973)**	**(923)**	**(49)**	**(2,703)**	**(2,767)**	**64**
4 Human Resources and Organisational Development													
4.11 Human Resources	(0)	1	2	2	11	4	(761)	(50)	(63)	13	(184)	(190)	6
4.21 Education	(5)	(11)	(0)	(1)	1	1	5	(4)	0	(4)	(10)	1	(11)
4 Human Resources and Organisational Development Total	**(5)**	**(10)**	**2**	**1**	**13**	**5**	**(755)**	**(54)**	**(63)**	**9**	**(194)**	**(189)**	**(5)**
5 Corporate													
5.11 Board	-	-	(14)	14	1	(0)	(654)	(67)	(54)	(13)	(150)	(163)	13
5.21 Op Mgmt	-	-	(14)	(2)	0	0	(855)	(85)	(71)	(14)	(216)	(214)	(2)
5.31 Corporate Affairs	-	-	1	2	1	(16)	(337)	(26)	(28)	2	(99)	(84)	(15)
5 Corporate Total	**-**	**-**	**(28)**	**13**	**3**	**(17)**	**(1,846)**	**(179)**	**(154)**	**(25)**	**(465)**	**(461)**	**(3)**
6 Medical Director													
6.11 Research	4	4	0	8	(0)	(0)	(99)	(4)	(8)	5	(13)	(25)	12
6.12 Research Projects	(4)	(12)	(1)	(3)	0	1	58	0	5	(4)	0	15	(15)
6 Medical Director Total	**0**	**(8)**	**(1)**	**5**	**0**	**1**	**(41)**	**(3)**	**(3)**	**0**	**(13)**	**(10)**	**(3)**
Non Clinical Total	**22**	**95**	**(52)**	**19**	**(35)**	**(62)**	**(13,573)**	**(1,208)**	**(1,144)**	**(65)**	**(3,375)**	**(3,428)**	**53**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th July 2015
Reference number:	175-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	22nd July 2015
Appendices:	Workforce report

Workforce Report – July 2015 Update

Key issues

1. The format of the workforce report has been revamped to provide greater clarity and to address some of the anomalies which previously existed in the data. This includes a Trust level summary and more detailed analysis at Business Unit level. Further work is necessary to align some of the reporting i.e. vacancy information has to date been 2 months in arrears and establishment figures has been 4 weeks in arrears. This is being addressed for the August and September and therefore the current data included in this report is either 31st May or 30th June 2015. Highlighted below are the main issues from the report.

2. Sickness in June fell markedly from 3.16% to 2.22%. This is close to the Trust target of 2% and whilst this represents good performance and good sickness absence management, we would traditionally expect the rate to fall at this time of year. HR will be working with managers to look ahead to the autumn in order to help minimise any likely increase at that time of year e.g. promotion of the flu vaccine take up, Occupational Health support with stress and anxiety (where appropriate) and more robust use of the sickness absence policy i.e. consistent application of trigger points.

3. The impact of a more proactive approach to recruitment e.g. recruitment days, has resulted in a number of vacancies being filled especially in areas where turnover has been high. However, the number of vacancies is still behind the gap in our establishment and in post figures. Approximately 50% of the 121.15 wte gap is being actively recruited to and the remainder is a combination of resources being used flexibly within establishment and some posts which are being held. The detail is being investigated between HR and Finance so that posts which have not been vacant for longer than 4 to 6 months may be reviewed to determine if the post can be used more effectively or whether this should contribute to savings across the organisation.

4. Bank and Agency remains low overall, there have been some increases in agency expenditure mostly due to covering medical vacancies. The overtime pilot running across nursing continues to have a positive impact on covering shifts with our own bank staff and providing more consistency of care to patients. Consultation with staff on introducing a new single bank rate will begin in August 2015.

5. The new look report has a clearer breakdown for statutory and mandatory training and for June we have seen an improvement in compliance levels to 74.5% with a further 4.5% booked on to courses to become compliant. We are now focussing on temporary staffing where compliance

rates are low; these staff have not been subject to the same levels of scrutiny in the past and so this is now being addressed.

NB: Board level reporting for statutory and mandatory training covers compliance against the national skills passport whereas the training levels reported in the Director of Nursing's safe staffing report cover compliance against all training for a specific area.

Implications of results reported

6. The report provides the Board with assurance against the workforce key performance indicators.

7. The information contained within the report will be available to our Commissioners and the general public.

Action required

8. Management and progress of the areas outlined in this report is the responsibility of the Director of HR/OD. Consequently, day to day delivery is addressed through the HR and Learning and Development teams as part of their individual and team objectives. A system of monthly update meetings has been introduced to monitor progress closely.

9. In addition to the above progress is also reported to the Finance and Performance Committee on a monthly basis.

Link to Key Strategic Objectives

- Outstanding patient experience
- World Class Clinical Services
- Operational Excellence
- Financial sustainability

Implications for BAF or Corporate Risk Register

10. The issues raised in paragraphs 1 – 5 above are not so serious as to merit inclusion on the Corporate Risk Register or Board Assurance Framework at this stage, although the potential for matters to escalate will be monitored and recommendations will be made if appropriate.

Regulatory impacts

11. Progress to date is sufficient to assure the Board that good progress is being made in all areas and there is unlikely to be any adverse implications for the Trusts delivery of high quality patient care. Consequently there is no adverse impact for regulatory compliance.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Workforce Board Report

Trust

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

	<2.25%	On target / slightly over
	>2.25% < 3.0%	Near target
	>3.0%	Off target

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Trends	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
952.06 WTE	830.91 WTE		980	560	420

2. Sickness Absence Data

Business Unit / Department	Percentage of sickness absence in May 2015	Trends	Average number of sickness days per employee in Trust in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness days per employee in 12 month rolling period	Estimated costs related to sickness absence for May 2015
Nursing & Clinical Infrastructure	2.56%		0.79	368	3.87%	14.11	£30,235
Corporate, Finance & Non Clinical Infrastructure	2.06%		0.64	83	2.97%	10.86	£7,952
Clinical Support	2.22%		0.69	61	3.17%	11.57	£5,531
Eyes and Sleep	6.93%		2.15	50	1.74%	6.35	£2,899
Oral	0.98%		0.30	25	1.86	6.79	£3,200
Plastic Surgery	2.55%		0.79	67	3.70%	13.49	£6,321
Trust	**2.22%**	↓	**0.69**	**654**	**3.32%**	**12.12**	**£56,139**

3. People Management (Employee Relations)

Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	6	0
Disciplinary	0	0
Capability	2	0
Grievance	5	0
Conduct	1	0
Whistleblowing / Raising Concerns	0	0
Total	**14**	**0**

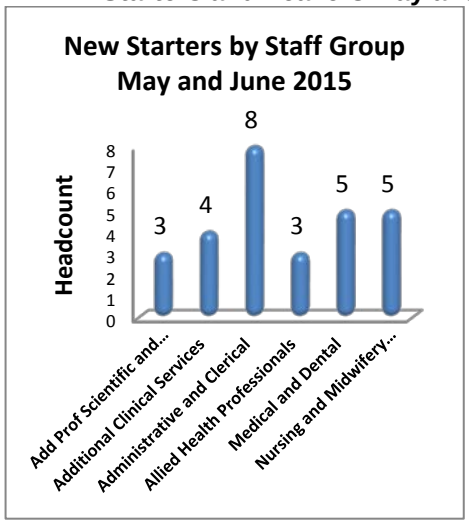
QVH – Statutory and Mandatory Training Compliance as at 1.7.15

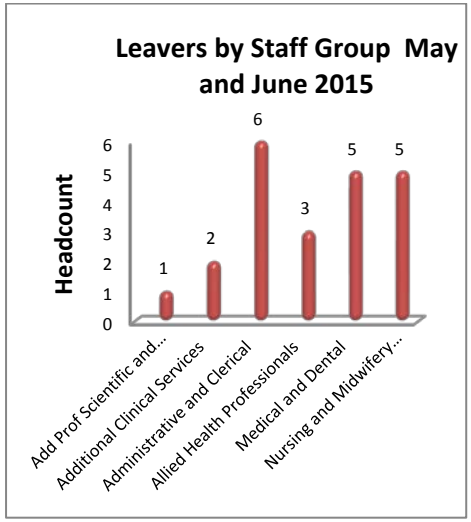
Area	Permanent Staff % Compliance		All staff % compliance		Trends
QVH Overall	74.57		67.36		↓
Corporate	75.34		54.70		
Plastic surgery	64.67		58.67		
Oral	68.72		63.54		
Sleep	69.17		61.54		
Eyes	70.72		64.62		
Clinical Support & General specialities	83.10 36.36	} 83.16	81.96 36.36	81.13	
Nursing & Medical Director	74.76 93.60	} 76.13	73.42 96.30	73.52	

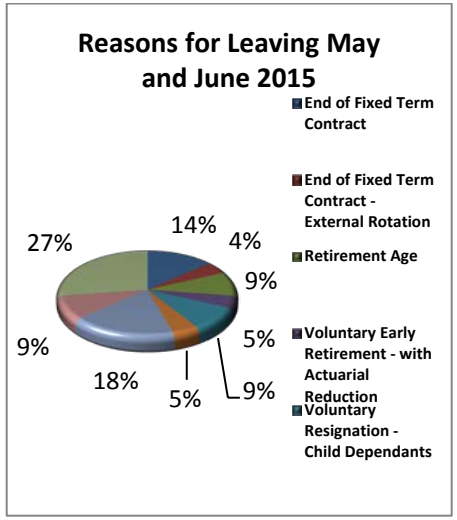
QVH Overall compliance target 80%

Green - 80% &higher
Amber - 70-79%
Red - 0-69.99%

4. Starters and Leavers May and June 2015







Vacancy Information as at 31st May 2015

The vacancy rate for May is 11.3% (information is based on 2014/2015 establishment figures). The staff establishment figure for May 2015 was 952.06 WTE, and the number of staff in post was 830.91 WTE. During the month of May the Trust used approximately 142.01 WTE (excluding RMN) Bank staff and agency workers. This represents approximately 20 WTE over establishment which takes into account cover for those staff on long term sickness. The reason for use of Bank and Agency staff was due to establishment vacancies and sickness absence (the rate of absence in April was higher at 3.16%).

5. Bank and Agency Usage

Staff type	% of monthly budget	Trend	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	1.25%	↓	102.7 WTE	£38,184.95	3852.70
Agency (Target < 5%)	1.49%	↑	39.31 WTE	£52,655.34	1474.15

6. Recruitment

There were 25.8 WTE vacant positions advertised in June that included 3.0 WTE Nursing, 3.2WTE Admin and Clerical, 3.1 Medical & Dental, 3.7 Allied Health Professionals, 8 Additional Clinical Services (HCA's and Nursing Auxiliaries) posts. In addition the Recruitment Day focused on an additional 12 WTE vacancies.

26 job offers were made during June and 9 of these offers were as a direct result of the Staff Nurse and Theatre Practitioners Recruitment Day held in June.

QVH Workforce Summary

Headcount: there is clearly a gap (121.15WTE) between the WTE establishment number and WTE employed. This has been the case for some months, and contributes to the usage of Bank & Agency staff (142.01 WTE). Turnover of staff remains above target and actions to address this are included in the Staff Survey Action Plan.
Absence: the rate for May has improved significantly and this is not unusual given the warmer climate. There are three areas within the trust that are on target (2%) during May and one area Eyes and Sleep where the rate is significantly higher (below target). It should be noted that the establishment for this area is relatively small (62.70) therefore the implications of long-term sickness impacts more significantly. HR have further revised the Managing Sickness Absence Procedure so that there will be a more robust approach to absence. Publication is expected in August 2015.
Statutory & Mandatory Training: we have changed the way information is presented as shown in the table on the previous page. The target is 80% and there is only one department that is on target overall. The key area of concern is temporary and Bank staff and to address this whenever a Bank Staff is hired both the individual and manager will be advised of their Statutory and Mandatory rate and where it is low will be advised to complete training before their next hire. HR are also changing the way that it presents information to managers so that they find it easier to access details about their team members, and have discussions about the importance of compliance
Bank and Agency Usage: both on target – spend can be further reduced by filling the number of vacancies within the organisation and developing a robust retention strategy. Further work is being undertaken to ensure the establishment figures and the HR records (i.e. ESR) accurately reflect the use of agency and the potential benefit if vacancies are being held for periods longer than 4 to 6 months.
Recruitment: a successful recruitment open day resulted in 9 job offers to nurses. A further recruitment day is being planned for the autumn.
Employee Relations medical Staffing : Two formal case were investigated during May, one involving conduct of a Consultant and the other a higher trainee and wrong site surgery (tooth extraction) have been investigated, both have concluded with no further formal action.

Nursing & Clinical Infrastructure

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
484.96 WTE	406.43 WTE	487	270	217

2. Sickness Absence Data

Percentage of sickness absence in May 2015	Trend	Average number of sickness days per employee in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in a 12 month rolling period	Estimated costs related to sickness absence for May 2015
2.56%	↓	0.79	368	3.87%	14.11	£30,235

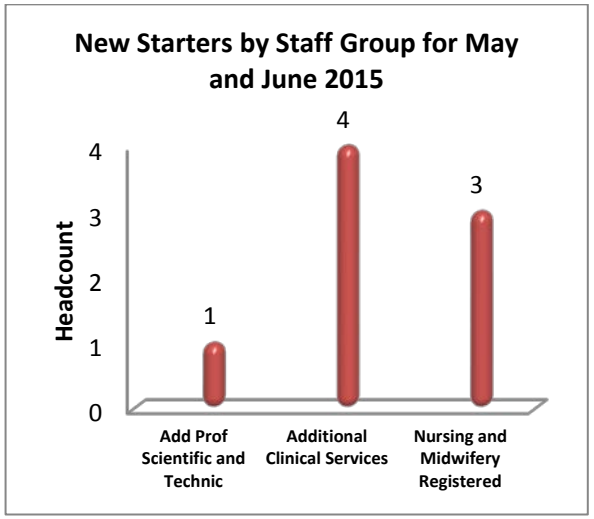
3. People Management (Employee Relations)

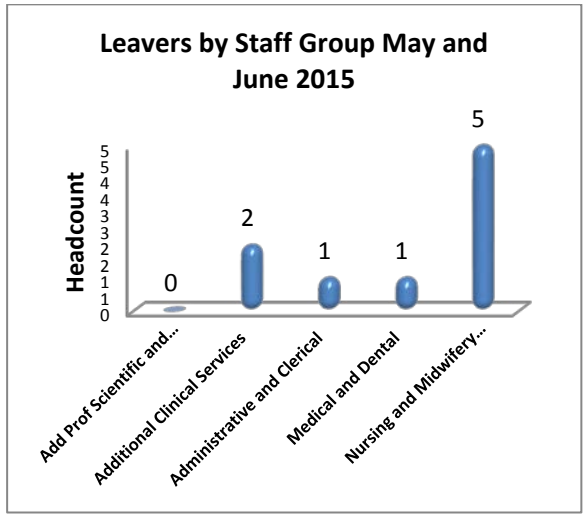
Type of Case (Formal)	Number of Cases opened	Number closed
Sickness Absence	5	0
Disciplinary	0	0
Capability	2	0
Conduct	1	0
Grievance	2	0
Whistleblowing / Raising Concerns	0	0
Total	**10**	**0**

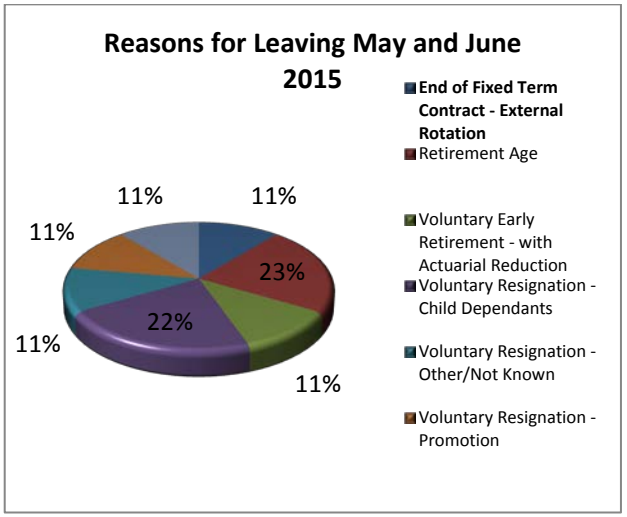
QVH – Statutory and Mandatory Training Compliance as at 1.7.15

Area	Headcount	Required	Achieved	Compliance %
200009 Healthcare Records	16	144	93	64.58
200012 Admissions	15	135	128	94.81
200021 MacMillan Centre	2	21	14	66.67
210001 Anaesthetics	46	590	271	45.93
210002 Theatres	140	1,781	1,246	69.96
210005 Paediatrics	31	414	335	80.92
210022 SLR MIU	19	236	173	73.31
210027 Maxillofacial Nursing	27	326	272	83.44
210028 Corneo Plastic Nursing	20	245	190	77.55
210029 Main Outpatients	19	228	190	83.33
210030 Pre Assessment	9	111	92	82.88
210031 Canadian Wing	57	617	499	80.88
210032 Burns Centre	33	404	314	77.72
210033 SLR ITU	15	180	141	78.33
250001 Nurse Management	14	154	121	78.57
250002 Site Practitioners	15	194	151	77.84
250004 Safeguarding	1	14	12	85.71
250005 IPACT	3	35	32	91.43
250007 Clinical Audit	2	18	12	66.67
250008 Research	3	27	26	96.30
250009 Risk Management	3	27	22	81.48
260037 Matrons	3	36	31	86.11
Business Unit Total				76.40

4. Starters and Leavers May and June 2015







5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	3.41%	↓	61.71 WTE	£25,726.68	2314.30
Agency (Target < 5%)	3.91%	↑	39.31 WTE	£52,655.34	1474.15

6. Recruitment

Job title of post advertised in June 2015	Band
Emergency Nurse Practitioner	7
Staff Nurse (Corneo)	5
Staff Nurse (Outpatients)	5

Workforce Summary

Headcount / Bank & Agency Usage: this department has the biggest gap (78.53WTE) between the establishment WTE and number of employees in post, and this clearly contributes to the bank and agency usage (101.02 WTE) in May. Recruiting to nursing posts still remains difficult given a number of factors such as location and lack of fringe benefits. HR will need to work closely with the Director / Deputy of Nursing and Clinical Infrastructure to develop a nursing recruitment and retention strategy.
Sickness Absence: this is just above target (2.56) for May. The average number of sickness absence days per employee in this department over the last 12 months is the highest 14.11 days. This can be correlated to the highest usage (within the Trust) of bank and agency staff, and the gap between establishment and numbers of staff employed.
Recruitment: the new Corneo advertisement and social media campaign has resulted in 2 WTE posts being offered, with one other full time post offered from the Recruitment Day. Theatres also offered 4 nursing posts from the Recruitment Open day with Burns, ITU, Corneo, Maxillofacial and MIU all offering one position each.
Statutory and Mandatory Training: The compliance rate for temporary staff is relatively low (42.36%) whereas the rates for permanent staff are much more encouraging 74.76%.
Employee Relations: A disciplinary hearing took place during May where a first level warning was issued. Two grievances were raised in May; both were raised against line managers and are due to be investigated in June.

Corporate, Finance & Non Clinical Infrastructure

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
156.02 WTE	139.85 WTE	159	97.0	62.0

2. Sickness Absence Data

Percentage of sickness absence in May 2015	Trend	Average number of sickness days per employee in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in a 12 month rolling period	Estimated costs related to sickness absence for May 2015
2.06%	↓	0.64%	83	2.97%	10.86	£7,952

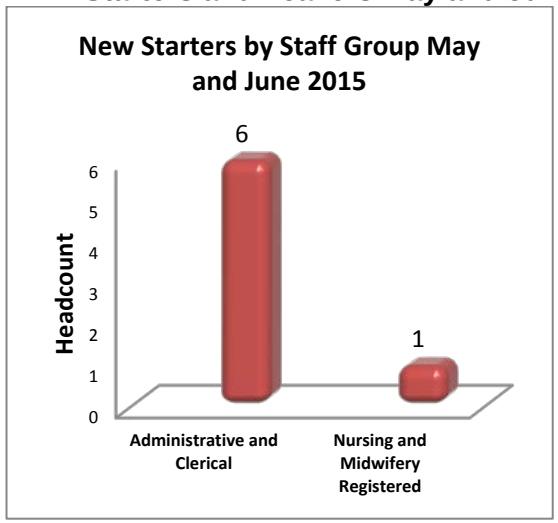
3. People Management (Employee Relations)

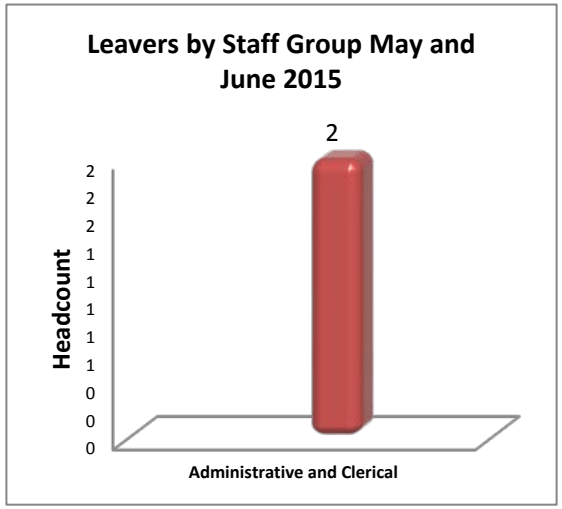
Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	0	0
Disciplinary	0	0
Capability	0	0
Grievance	0	0
Whistleblowing / Raising Concerns	0	0
Total	**0**	**0**

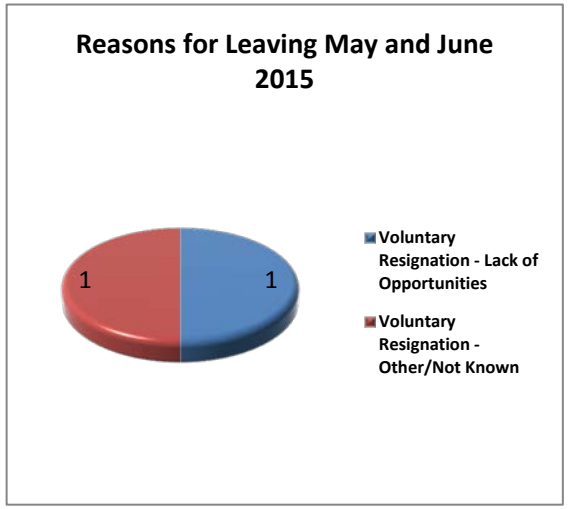
QVH – Statutory and Mandatory Training Compliance as at 1.7.15

Area	Headcount	Required	Achieved	Compliance %
220001 Catering	11	99	74	74.75
220004 Domestics & Portering	38	342	236	69.01
220005 Hotel Services	4	36	29	80.56
220006 Telephones	6	60	52	86.67
220007 Building & Engineering	10	90	73	81.11
230001 Trust Board	9	82	52	63.41
230002 Operational Management	12	106	81	76.42
230003 Corporate Affairs	5	45	35	77.78
240001 Human Resources	21	189	158	83.60
240002 Medical Education	3	27	24	88.89
240003 Library	3	27	22	81.48
260001 Finance Department	19	171	137	80.12
260002 Commerce	5	45	38	84.44
260003 Coding & Contracts	6	54	31	57.41
260004 IMT Department	7	63	42	66.67
260025 Non Clinical Bank	71	645	226	35.04
260026 Clinical Bank	83	868	303	34.91
Business Unit Total				76.40

4. Starters and Leavers May and June 2015







5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	1.50%	→	12.08 WTE	£4272.58	453.05
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in June 2015	Band
Human Resources Assistant	3
PA to Business Managers	4

Workforce Summary

Headcount / Bank & Agency Usage: usage is well below the target of less than 5%. The gap between establishment and numbers in post is also low (16.17WTE)
Sickness Absence: this is just above target (2.06%) for May. The average number of sickness absence days per employee in this department over the last 12 months is 10.86 days. When compared with other public sector corporate functions, this could be considered as high. The average number of sickness absence days per employee target in the public sector ranges between 4 and 7.
Recruitment: although there are 16.17 WTE vacant positions, there are only 2 job advertisements placed – HR Assistant and PA for the Business Managers.
Statutory and Mandatory Training: the compliance rates within most teams / sections are on target or nearly at target.

Workforce Board Report

Business Unit: Clinical Support

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
93.69 WTE	86.16 WTE	108	59	49

2. Sickness Absence Data

Percentage of sickness absence in May 2015	Trend	Average number of sickness days per employee in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in a 12 month rolling period	Estimated costs related to sickness absence for May 2015
2.22%	↓	0.69	61	3.17%	11.57	£5,531

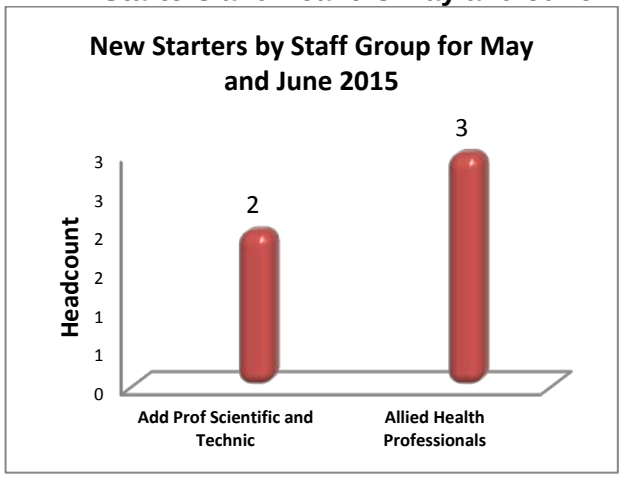
3. People Management (Employee Relations)

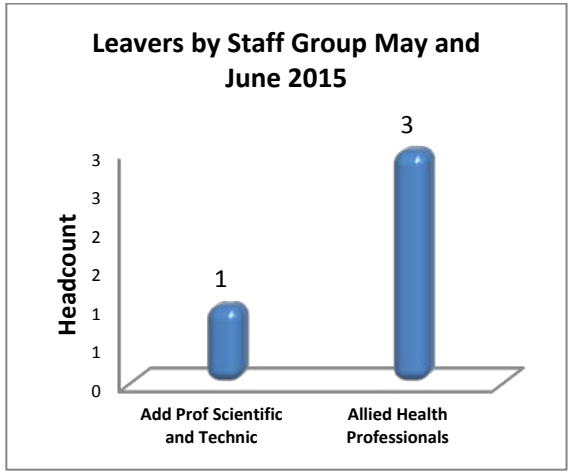
Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	0	0
Disciplinary	0	0
Capability	0	0
Grievance	0	0
Whistleblowing / Raising Concerns	0	0
Total	**0**	**0**

QVH – Statutory and Mandatory Training Compliance as at 1.7.15

Area	Headcount	Required	Achieved	Compliance %
200005 SLR Rheumatology	1	13	0	0.00
210006 Radiography	21	263	218	82.89
210008 Histopathology	10	109	61	55.96
210009 Pharmacy	14	147	132	89.80
210010 Surgical Appliances	1	9	9	100.00
210013 Medical Photography	6	60	42	70.00
210014 Therapies	39	454	389	85.68
210015 Speech & Language Therapy	3	39	30	76.92
210016 Psychotherapy	7	83	70	84.34
210017 Dietetics	2	22	21	95.45
260030 Elderly	1	9	8	88.89
Business Unit Total				83.51

4. Starters and Leavers May and June 2015





Reasons for leaving:

1 – Add Prof Scientific and Technic – Voluntary Resignation (not known)

2 – Allied Health Professionals – Voluntary Resignation (not known)

5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	0.2%	↓	**8.5 WTE**	**Not available**	**320.75**
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in June 2015	Band
Advanced Physiotherapist	7
Radiography Administration Assistant	3
Specialist Speech & Language Therapist	6
Highly Specialist Speech & Language Therapist	7
Radiology Administration Assistant	3
Trust Specialty Doctor in MIU	MC46

Workforce Summary

Headcount/Bank and Agency: bank and agency expenditure remains well below the Trust target of 5%. The gap between establishment and numbers in post is very low at (7.53WTE). There are currently 5 posts advertised and if recruited to will bring the number of WTE in post in line with agreed establishment.
Absence: this is just above target at (2.22%) for May. The average number of sickness days per employee in the department over the last 12 months is also high at 11.57 days.
Recruitment: An additional Specialist Speech & Language Therapist post has been advertised this month. Recruitment for a fixed term Band 5 to cover maternity leave has not been successful and will be re-advertised. A permanent Band 5 nurse post has been filled.
Statutory and Mandatory Training: The majority of departments' compliance rates are within target apart from Histopathology at 55.96% and Rheumatology at 0% (1 individual) and HR will be raising this with the line manager.
Employee Relations: There are two informal conduct issues in relations to accreditation and one application has since been submitted with the other unable to be progressed due to long-term sickness. One case of Long-term sickness following planned surgery, the employee is still in hospital since surgery in April and therefore management of the case has been unable to commence.

Workforce Board Report

Business Unit: Eyes and Sleep

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
62.70 WTE	42.64 WTE	53	26	27

2. Sickness Absence Data

Percentage of sickness absence in May 2015	Trend	Average number of sickness days per employee in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in a 12 month rolling period	Estimated costs related to sickness absence for May 2015
6.93%	↑	2.15	50	1.74%	6.35	£2,899

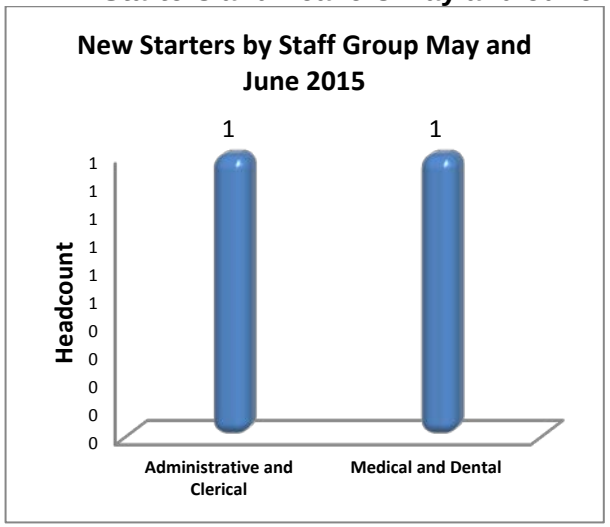
3. People Management (Employee Relations)

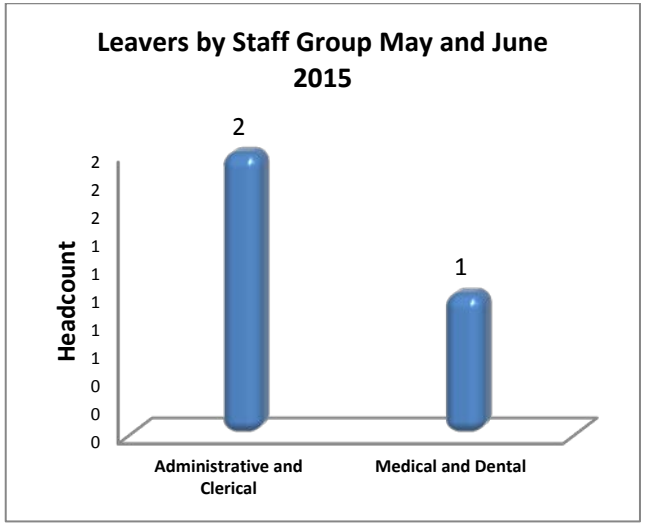
Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	0	0
Disciplinary	0	0
Capability	0	0
Grievance	2	0
Whistleblowing / Raising Concerns	0	0
Total	**2**	**0**

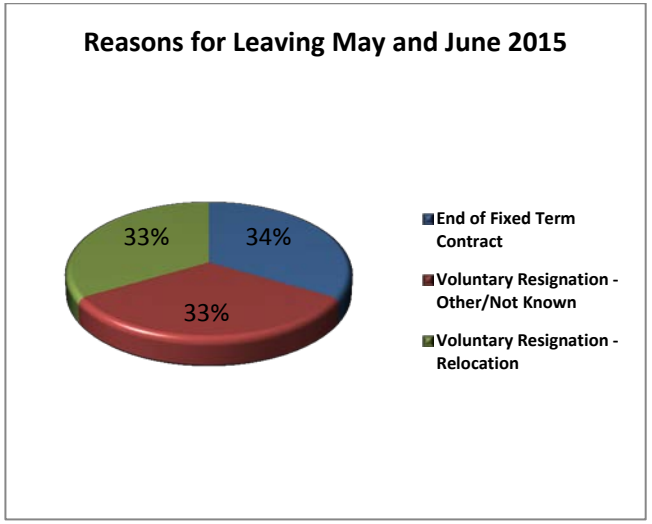
QVH – Statutory and Mandatory Training Compliance as at 1.7.15

Area	Headcount	Required	Achieved	Compliance %
200014 SLR Optical	2	22	11	**50.00**
200015 SLR Corneo Plastics	26	284	186	**65.49**
210018 SLR Clean Room	4	36	24	**66.67**
200013 SLR Sleep Studies	27	312	192	**61.54**
Business Unit Total				**69.96**

4. Starters and Leavers May and June 2015







5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	1.30%	↑	12.2 WTE	£4113.60	459.15
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in June 2015	Band
Medical Typists	3

Workforce Summary

Headcount: there is a gap of (20 WTE) between establishment and number of staff in post. This is high and equates to an under establishment of almost 1/3rd of the workforce for the department.

Bank/Agency: well within Trust agreed target of lower than 5%. However if the 12.2 WTE used on bank were recruited to this would reduce the gap between establishment and staff in post, and costs.

Absence: this is very high at (6.93) and is well above agreed target. There is a case of long-term sickness which may be keeping the sickness absence percentage high. The average number of sickness days per employee in the department over the last 12 months is 6.35 days. Although the figure for May is above the target the average number of days per employee over the last 12 months is low compared to other departments at QVH

Recruitment: Interviews were held in early June for Medical Typists but the interviews resulted in only one offer. The remaining 1.4 WTE posts have now been re-advertised.

Statutory and Mandatory Training: All departments are well below the agreed targets. In Sleep and Corneo Plastics 1/3rd of staff in the departments are not compliant. This will need to be addressed with Senior Managers as a matter of concern.

Employee Relations: There is one long-term sickness absence case during May which was being managed at the first formal stage; a grievance was raised by the same individual at the end of May which is being investigated.

Workforce Board Report

Business Unit: Oral

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
84.46 WTE	73.64 WTE	89	50	39

2. Sickness Absence Data

Percentage of sickness absence in May 2015	Trend	Average number of sickness days per employee in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in a 12 month rolling period	Estimated costs related to sickness absence for May 2015
0.98%	↓	0.30	25	1.86	6.79	£3,200

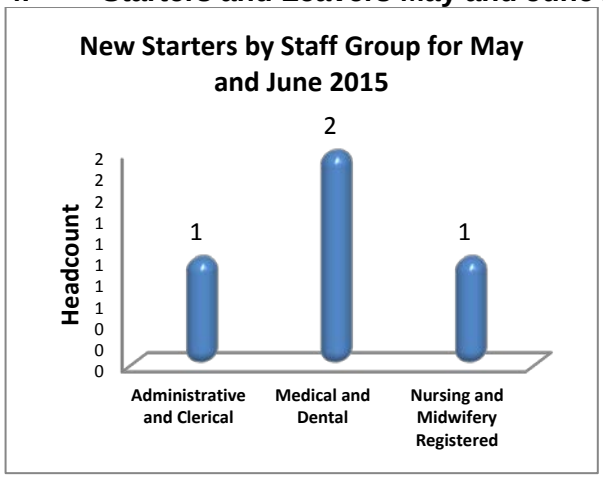
3. People Management (Employee Relations)

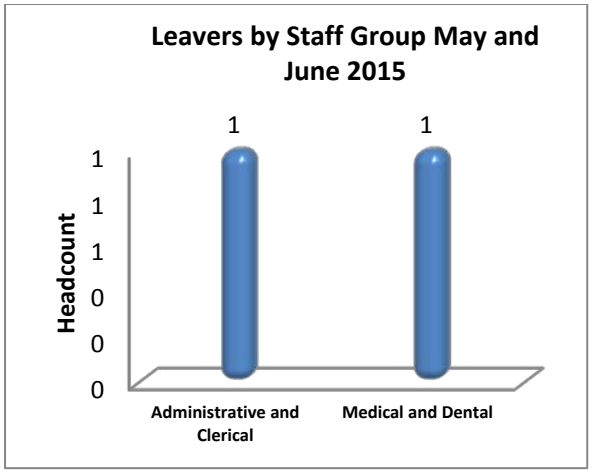
Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	0	0
Disciplinary	0	0
Capability	0	0
Grievance	0	0
Whistleblowing / Raising Concerns	0	0
Total	**0**	**0**

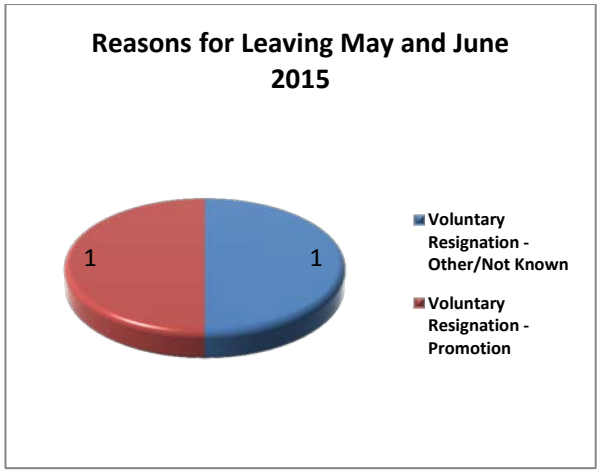
QVH – Statutory and Mandatory Training Compliance as at 1.7.15

Area	Headcount	Required	Achieved	Compliance %
200018 SLR Orthodontics	21	255	182	**71.37**
200019 SLR Maxillofacial	63	733	422	**57.57**
210012 Prosthetics Laboratory	16	175	135	**77.14**
Business Unit Total				**68.85**

4. Starters and Leavers May and June 2015







5. Bank and Agency Usage

Staff type	% of monthly budget	Trend	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	0	→	0	0	0
Agency (Target < 5%)	0	→	0	0	0

6. Recruitment

Job title of post advertised in June 2015	Band
N/A	

Workforce Summary

Headcount and Bank and Agency: There is no usage of bank and Agency expenditure for the month of May. The gap between establishment and number of staff in post is low at (10.82 WTE).

Absence: is well below target (0.98%) for May. The average number of sickness absence days per employee in this department over the last 12 months is 6.79 days.

Recruitment: No posts were advertised for the May.

Statutory and Mandatory Training: The compliance rates within most departments are nearly on target, with SLR Maxillofacial well below target with just over half its members of staff being compliant.

Employee Relations: Informal sickness cases to commence with the managers covering the Medical Secretaries in the Maxillofacial Department.

Workforce Board Report

Business Unit: Plastic Surgery

All the workforce information in this report is as at **31st May 2015** unless otherwise stated.

1. Workforce Profile

Agreed WTE Establishment (as at 1 May 2015)	Number of WTE in post as at date of report	Headcount as date of report	Number of full time staff as at date of report	Number of part time staff as at date of report
78.19 WTE	76.58 WTE	84	58	26

2. Sickness Absence Data

Percentage of sickness absence in May 2015	Trend	Average number of sickness days per employee in May 2015	Number of absence days lost in May 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in a 12 month rolling period	Estimated costs related to sickness absence for May 2015
2.55%	↓	0.79	67	3.70%	13.49	£6,321

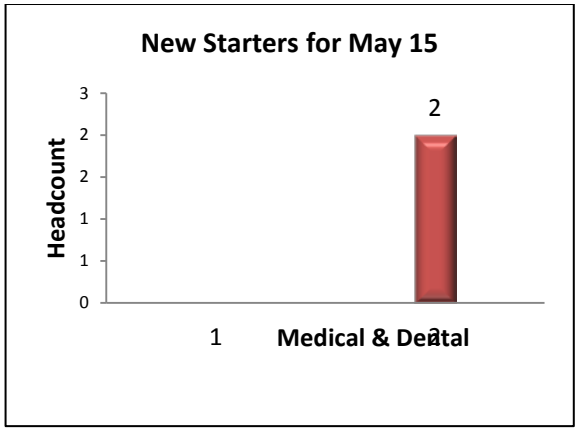
3. People Management (Employee Relations)

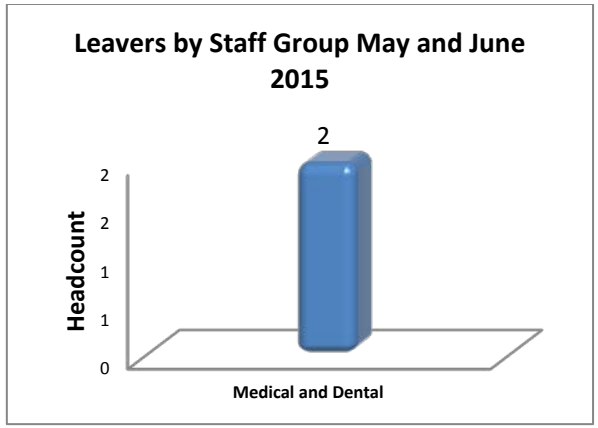
Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	1	0
Disciplinary	0	0
Capability	0	0
Grievance	1	0
Whistleblowing / Raising Concerns	0	0
Total	**2**	**0**

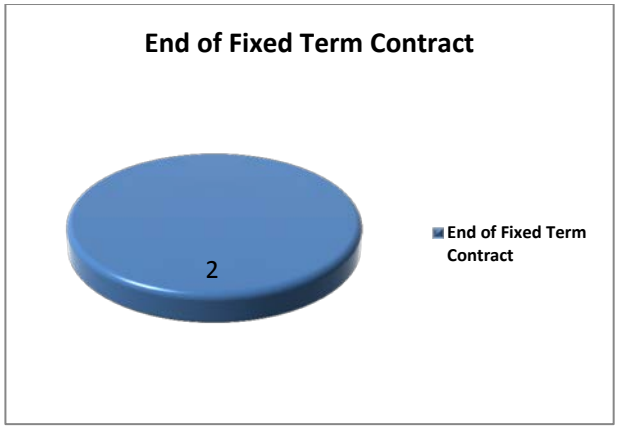
QVH – Statutory and Mandatory Training Compliance as at 1.7.15

Area	Headcount	Required	Achieved	Compliance %
200001 SLR Skin	9	102	63	**61.76**
200002 SLR Breast	17	177	130	**73.45**
200003 SLR Hands	11	119	71	**59.66**
200004 SLR Burns	10	110	62	**56.36**
200011 Plastic Surgery	38	475	253	**53.26**
200020 RTT & Cancer Team	1	9	3	**33.33**
Business Unit Total				**66.27**

4. Starters and Leavers







5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during May	Total cost during May	Total number of hours during May
Bank (Target< 5%)	0.2%	↓	8.15 WTE	£2,885	305.75
Agency (Target < 5%)	0.0%	→	0.0	0.0	0.0

6. Recruitment

Job title of post advertised in May	Band
Locum Plastic Surgery Registrars	NM37
Trauma & Reconstructive Fellows	NM37

Workforce Summary

Headcount and Bank and Agency: The gap between establishment and number of staff in post is low at (1.61WTE). However during the month of May 8.15 WTE Bank Staff where utilised. There are a number of long sickness absence cases in this area which has contributed to the Bank staff usage.

Absence: This is just above target (2.55%) for May. The average number of sickness absence days per employee in these departments over the last 12 months is the second highest within the Trust 13.49 day. There have been an increased number of long-term sickness cases over previous months accounting for the higher number of sickness days over a 12 month period, and increase in Bank staff usage

Recruitment: The Trauma and Reconstructive Fellows are new posts that will be divided between QVH and BSUH, and interviews are scheduled to take place at the end of July. Plastics have struggled to fill the Hand Fellow post and the locum agency doctors have not met our requirements. These posts have been placed on NHS Jobs, and it is our intention to fill the posts on a short term basis until such time that long term solutions can be found.

Statutory and Mandatory Training: The compliance rates within most departments are well below agreed target. This will need to be addressed with Senior Managers as a matter of concern.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th July 2015
Reference number:	176-15
Report from:	Clare Stafford, Director of Finance and Performance
Author:	Jason McIntyre, Deputy Director of Finance
Report date:	27nd July 2015
Appendices:	NA

Final Monitor Declaration: Quarter 1 of 2015/16

Key issues

1. The Trust is required to submit its Quarter 1 (Q1) monitoring return on the 31st July. The draft was circulated with the board papers which has been replaced by this final version. This paper will be circulated to the board electronically when available going forward.

2. The paper confirms the In Year Governance Statement from the Board contained in the Q1 return.

3. For finance the declaration that "The board anticipates that the trust will continue to maintain a Continuity of Service risk rating (COSRR) of at least 3 over the next 12 months" is **Confirmed**.
   a) The draft COSRR previously circulated was calculated as 4 which was revised to 3 when the comprehensive quarterly monitor return was completed. There is a timing delay as all the information required for the return is not available when the monthly financial reports are produced.
   b) The COSRR measure is a liquidity measure which reflects capital servicing and liquidity days. (i) liquidity: days of operating costs held in cash or cash-equivalent forms, and (ii) capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.
   c) The movement from 4 to 3 is due to a change in the capital servicing capacity measure arising from the treatment of the loan repayment in the period. The loan repayment is allocated in the period it was paid Q1 (cash basis) rather than period to which it relates Q1 and Q2 (accrual basis). If this was treated on an accrued basis then the rating would increase to 4.
   d) The Trust has planned a risk rating of 4 for 2015/16. The implication of movement from risk rating of 4 to 3 is that Monitor may ask the Trust to provide a limited amount of financial information on a monthly basis. The risk rating is impacted directly by surplus generated by the Trust and any reduction in planned surplus will adversely impact the risk rating in future periods.

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 C**onfirmed**.

For Q1 the trust is expecting to meet the 18 week targets. The forecast is compliance in Q1 for 18 weeks as we expect to meet the standards.

5. The Governance Rating for Q1 was Green: No evident concerns.
6. For 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:	Board of Directors
Meeting date:	30 July 2015
Reference number:	177-15
Report from:	Steve Fenlon, Medical Director
Author:	Juliette Stern, Medical Workforce Manager
Report date:	17 July 2015
Appendices:	A: Annual Report B: Statement of Compliance

Consultant re-validation

Annual Board Report

Key issues

This is the annual report to the Board laying out the role and responsibilities of the Responsible Officer and detailing how the revalidation team at QVH has delivered, documented and assured the process has been carried out in accordance with national requirements.

The report will highlight areas where improvement is needed, particularly in relation to the quality assurance of appraisals and mechanisms for appraisers to quality assure their practice.

It contains an action plan setting out areas for improvement with actions and realistic timescales for achievement.

Implications of results reported

The actions are essential to ensure that the Trust can meet its responsibilities as a 'designated body' in line with NHS England requirements and those responsibilities afforded to Responsible Officers.

These actions will ensure that performance issues are identified at the earliest stage and corrective measures put in place in the interests of patients.

Action required

There is still a need to provide appraisers and appraisees with up-to-date job plans and training compliance. In addition investigations, incidents and complaints systems remain disjointed and whilst they are being dealt with appropriately within the organisation and by the individuals themselves, better systems would better inform annual appraisal and lead to more productive, measurable outcomes.

Link to Key Strategic Objectives

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

- Organisational excellence

Provision of safe effective efficient care is central to good medical practice which is central to appraisal; objectives arising from KSO2 are linked to appraisal personal development plans

Implications for BAF or Corporate Risk Register

Already in place

Regulatory impacts

None

Recommendation

The Board is asked to **NOTE** the report and to be aware that it will be shared, together with the annual audit, with the High Level Responsible Officer representing NHS England.

It is also asked to **APPROVE** the 'Statement of Compliance' which confirms that the Trust is in compliance with the regulations.

Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report

1. Executive summary

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are compliant with relevant professional standards, have up to date skills and competencies and are fit to practice. Revalidation of licenced doctors will be required every 5 years.

Appraisal and revalidation are the focal point of ensuring and enhancing the delivery of high quality care to our patients. Additionally, it is intended to assist in the early identification of performance issues.

Doctors in both training and non-training grades are required to participate in the revalidation process. However, doctors in training are revalidated through HEEKSS/KELON

As of March 2015, 81 doctors had a 'prescribed connection' with the Responsible Officer (RO) with 73 doctors completing an appraisal within the same year.

2. Purpose of the Paper

Appraisal for the purposes of revalidation is made up of two elements:

- The appraisal element, which is the process by which a doctor is supported in their continuing professional development

- The revalidation element, whereby a doctor demonstrates that they remain up to date and fit to practice.

The purpose of this report is to provide the Board with information regarding the current position as of March 2015 in respect of the numbers of doctors who have been revalidated, any pertinent issues and general assurance regarding the revalidation process including future plans for improvement.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in

discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

This is the second formal report to the Board laying out the role and responsibilities of the Responsible Officer and detailing how the revalidation team at QVH have delivered, documented and assured the process has been carried out in accordance with national requirements.

The Responsible Officer regulations are wide-ranging but in summary cover the whole governance system that exists around the recruitment, monitoring, training and development of all medical staff at the QVH. The revalidation system is still in its first 5 year cycle and is growing in complexity year on year. The RO is obliged to attend regional meetings and events to ensure the organisation is kept up to date with new developments. The QVH revalidation team are also instrumental in ensuring our systems and processes are reviewed and continue to deliver the changing requirements.

4. Governance Arrangements

A report on completed and missed appraisals is submitted on a quarterly basis to NHS England. Incidents/complaints relating to medical and other staff are reviewed monthly at the Clinical Governance Committee, to which the Medical Director (Responsible Officer) is joint Chair. Concerns raised through any other mechanism, such as whistle-blowing, are managed according to Trust policy but within the Responsible Officer regulations.

The Trust has systems in place to collect the information in line with revalidation requirements. Doctors have access to their individual revalidation file in which they are expected to upload and maintain their own appraisal and revalidation documents. The system is administrated by dedicated staff in the Medical Workforce Office who provides assistance and advice on revalidation issues both to the doctors and the Responsible Officer.

The Responsible Officer is required to submit an Annual Organisational Audit in May of each year which is designed to provide assurance to the Board, High Level Responsible Officers and other interested bodies. Crucially, it provides a mechanism for assuring NHS England, the England Revalidation Implementation Board and the

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practice and Revalidation) Regulations Order of Council 2012'

GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent. The Responsible Officer is subject to annual audit covering his "total practice" but primarily focused on the governance systems and quality control in place within the organisation. The appraiser is appointed from outside the Trust by NHS England.

An accurate list of prescribed connections is managed by the Medical Workforce Office. When a new doctor is recruited information on their RO is sought from their current employer. The new doctor is added to the list. When a doctor leaves the Trust the doctor is removed from the list.

a. Policy and Guidance

The Trust has introduced a number of changes to its recruitment procedures and more are planned. All new applicants are asked questions based on the Trust's values, in additional to the standard clinically based questions. The purpose of this is to assess organisational fit and ensure that they are able to converse and understand medical terminology at an appropriate level in English. References follow a set format and must include last employer, most recent Responsible Officer declaration.

A similar although more extensive assessment process using Stakeholder Panels has been introduced as part of the recruitment process for Consultants and will be introduced for permanent non-consultant career grade staff.

Job descriptions and personal specifications have been rewritten to provide explicit guidance on the expectations of the role and provide clarity on lines of responsibility & accountability.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data as at 31 March 2015

Depts	Number of doctors	Number of completed appraisals	% Compliance
Head & Neck	8	7	87.5%
Plastic Surgery	40	35	87.5%
Anaesthetics	20	18	90.0%
Corneo-plastics	7	7	100.0%
Radiology	2	2	100.0%
Histopathology	1	1	100.0%
Sleep Studies	3	3	100.0%

Level	Number of doctors	Number of completed appraisals	% Compliance
Consultants	52	50	96.2%
Staff grade, Associate Spec, Specialty Drs	6	5	83.3%
Doctors on temporary or short-term contracts	23	18	78.3%
TOTAL	**81**	**73**	**90.1%**

(See **Annual Report Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

There are currently 24 trained appraisers. The Trust is currently rotating appraisers in compliance with GMC guidelines.

An annual survey was undertaken to identity further training needs and appraiser training support was provided in house. The training aimed at improving the documentation of evidence, evaluation and completion of the Medical Appraisal Form by both Appraiser and Appraisee plus an understanding of the NHS England's audit process. The Quality assurance audit of appraisal inputs and outputs (Appendix B) shows significant improvement in quality of documentation in particular. It has been agreed to provide this training on a more regular basis 3 times a year.

c. Quality Assurance

The Trust has begun the process of sampling appraisal outputs and triangulation of data from incident and complaint reporting to the appraisal documentation.
Separate records of mandatory and statutory training are used to confirm compliance. Quality assurance of appraisals has begun by monitoring feedback from appraisers using Survey Monkey as a tool for collecting data. Response rate was low and needs improvement. This data plus feedback from appraises will be used to identify the key areas for appraiser network groups.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

There are secure systems in place for access to revalidation files. The file of each doctor can only be accessed by the individual doctor themselves, the Responsible Officer, the Medical Workforce Manager and the Medical Workforce Administrator.

Doctors are required to anonymise correspondence with patient identifiable data which is then submitted for the purposes of revalidation. Further action needs to be taken in this respect to ensure that all doctors undertake this prior to submission.

No information governance breaches reported.

e. Clinical Governance

Currently the organisation lacks the capacity to supply individual corporate data such as incidents, complaints and performance metrics. We remain dependant on the doctors to collect and present this information themselves as a result of the disparate information systems currently in existence. The RO can make requests on each doctor's behalf and is in the process of constructing a spreadsheet to merge data sources under the project to provide Consultant level outcomes; this is a manual process at the current time and subject to the risk of error and delay.

6. Revalidation Recommendations

All recommendations were made on time.

See **Annual Report Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

All doctors including locums are recruited in line with NHS Employment Check Standards.

All locum doctors are sourced through the Crown Commercial Service (formerly Government Procurement Service) or Health Trust Europe. These bodies are required to meet the NHS Employment Check Standards.

Receipt of information relating to previous appraisals and revalidation data is low but improving steadily.

See **Annual Report Appendix E**: Audit of recruitment and engagement background

8. Monitoring Performance

All doctors are required to have an annual appraisal which is undertaken with a designated, trained appraiser. Should issues arise in the interim these are fed back through the Clinical Directors and Clinical Leads and are, where possible, dealt with informally in the first instance.

Incidents and trends relating to performance will also be fed back through the Clinical Governance Committee which reports on a monthly basis.

Any serious concerns regarding practice from any other source will be reported to the Medical Director.

9. Responding to Concerns and Remediation

The Trust has an Appraisal & Revalidation Policy which is in the process of being updated which will include the Trust's approach to remediation and will link with other related policies. The Trust manages concerns raised about doctors and dentists in accordance with the NHS Framework, Maintaining High Professional Standards.

As of March 2015 there was 1 doctor in remediation or subject to a disciplinary process.

See **Annual Report Appendix D**; Audit of concerns about a doctors practice

10. Risk and Issues

The key risks that have been identified are as below:

- That the Trust's information systems do not adequately capture and report all concerns and incidents relating to performance.
- That the appraisal system is not sufficiently robust to detect and manage concerns of poor performance.
- That Trust recruitment, induction and monitoring of medical staff do not detect and manage poor performance.

11. Board Reflections

The Responsible Officer regulations are being introduced and in part adapted over time. The process has highlighted nationally the resources needed at organisational level to support the process are greater than expected and fall to organisations themselves to provide. The identification of concerns and their subsequent management has brought to the fore the need to provide robust systems to manage those doctors with capability or conduct issues. It is likely that organisations will be required to work together to address this, though placing greater demands on the RO and team.

12. Corrective Actions, Improvement Plan and Next Steps

The following table reflects the result of the Annual Organisation Audit (AOA) 2014/2015 plus the 2014 NHS Comparable Report. It will be amended to include a further areas identified in the NHS 2015 Comparable Report due shortly.

Corrective Actions/Areas for Improvement/Further development	**Action/Timescales**

To conduct an external QA Review as required by NHS England	To organise an external QA review to be completed by 31st December 2016. Following external review consider and implement recommendations as required
Development of a robust appraisal policy which meets the requirements stipulated by the GMC and NHS England. Feasibility of Appraisal Lead observing appraisals being conducted at random.	Completed review of previous policy to ensure it meets GMC and NHS England requirements. Put in place measures to QA appraisal inputs and outputs which enable the RO to clearly identify performance/issues of concern. Rotation of appraisers To be completed by quarter 2 2015
Set up systems which enable appraisers to QA their practice. Completed review of current appraisal training provided to ensure that the system can identify performance issues including self-reflection. 3 annual training sessions to be delivered focusing of needs identified.	Set up a peer/network support group to share good practise, discuss approaches and concerns regarding consistency. Set up effective systems of appraisee feedback which identify improvements and result in changes to practice. Set up Revalidation Dashboard tool to record all relevant appraisal and revalidation recommendations to assist RO To be completed by quarter 2 2015
To ensure that the process of recruiting doctors is robust and identifies conduct/performance issues prior to commencement with the Trust. Corrective action to mitigate risk of performance for locum agency doctors now includes a phone interview as a minimum with the Clinical Director or Supervising Consultant prior to appointment. Plus details of RO requested from agency. To ensure the capture of RO and	When recruiting an oversea doctor, in addition to a “Certificate of Good Standing” from the local police of the resident country which must have a notarised translation will be sought which should identify any conduct issues a DBS check will be instigated. Immediate Immediate Set up effective systems to capture

appraisal data from previous employer within 28 days of start date for all new doctors.	previous appraisal data. To be completed by quarter 2 2015

13. Recommendations

The Board is asked to accept the report and note that it will be shared, along with the annual audit with the High Level Responsible Officer.

It is also asked to approve the 'Statement of Compliance' which confirms that the Trust is in compliance with the regulations.

Audit of all missed or incomplete appraisals audit*

Doctor factors (total)	**16**
Maternity leave during the majority of the ‘appraisal due window’	0
Sickness absence during the majority of the ‘appraisal due window w’	0
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	2
Postponed due to incomplete portfolio/insufficient supporting information	13
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	1
Describe doctor under investigation	
Appraiser factors	**0**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**1**
Administration or management factors	1
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

*Headcount basis

Annual Report Appendix B

Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		Number
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	10	10
Scope of work: Has a full scope of practice been described?	10	8
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	10	8
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	10	10
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes 9 out of 10	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	10	10
Review of complaints: Have all complaints been included?	10	10
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	10	10
Is there sufficient supporting information from all the doctor's roles and places of work?	10	10
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	10	10
Appraisal Outputs		
Appraisal Summary	10	10
Appraiser Statements	10	10
Personal Development Plan (PDP)	10	10

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	29
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	0
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	0

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[2]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				0
Capability concerns (as the primary category) in the last 12 months			1	1
Conduct concerns (as the primary category) in the last 12 months			1	1
Health concerns (as the primary category) in the last 12 months		1		1
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				1
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				1
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical				0

[2] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc.) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All Designated Bodies	0
TOTALS	1
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2014 and 31 March 2015: Explanatory note: All suspensions which have been commenced or completed between 1 April 2014 and 31 March 2015 should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	0
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	0
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	0

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	7
Temporary employed doctors	28
Locums brought in to the designated body through a locum agency	13
Locums brought in to the designated body through 'Staff Bank' arrangements	10
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc.	0
TOTAL	58

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors	7	7	7	7	7	6	7	4	0	7	7	7	4	0	0	0
Temporary employed doctors	28	28	28	28	28	20	28	23	0	28	28	28	23	14	0	0
Locums brought in to the designated body through a locum agency	13	13	13	13	13	13	13	0	0	0	13	0	0	0	0	0

Locums brought in to the designated body through 'Staff Bank' arrangements	10	10	10	10	10	7	8	4	0	10	10	10	0	4	0	0
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	58	58	58	58	58	46	56	31	0	45	58	45	27	18	0	0

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	82.53	0.00	166.00	110.00	276.00
Medicine	0.52	37.50	0.00	0.00	37.50
Psychiatry	0.00	0.00	0.00	0.00	0.00
Obstetrics/Gynaecology	0.00	0.00	0.00	0.00	0.00
Accident and Emergency	0.00	0.00	0.00	0.00	0.00
Anaesthetics	28.53	0.00	0.00	0.00	0.00
Radiology	2.00	0.00	0.00	0.00	0.00

Pathology	3.00	0.00	0.00	0.00	0.00
Other	1.70	0.00	0.00	0.00	0.00
Total in designated body (This includes all doctors not just those with a prescribed connection)	**118.28**	**37.50**	**166.00**	**110.00**	**314.00**
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	1	1	0	0	0
3 days to one week	2	2	2	0	0
1 week to 1 month	5	5	5	0	0
1-3 months	4	4	4	0	1
3-6 months	0	0	0	0	0
6-12 months	1	1	1	0	0
More than 12 months	0	0	0	0	0
Total	**13**	**13**	**12**	**0**	**1**

Annex E – Statement of Compliance

Designated Body Statement of Compliance

The board of Queen Victoria Hospital NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   MD attended RO training March 2013 & also attends regional RO networking sessions.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   GMC Connect regularly reviewed by RA and RO

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Developing in house training and processes

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Completed appraisal rate 90.1% appraisal consistency to be addressed

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   RO sources this information from separate data at present

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

Concerns elevated to RO and addressed through Trust policy (MHPS)

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Through the medical transfer of information document.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Employment guidelines are met and RO guidelines still to be fully enacted.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes

Signed on behalf of the designated body

Name: Richard Tyler Signed: _ _ _ _ _ _ _ _ _ _

Chief Executive

Queen Victoria Hospital NHS Foundation Trust

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30th July 2015
Reference number: 178-15
Report from: Jo Thomas, Director of Nursing
Author: Jo Thomas, Director of Nursing
Report date: 7th July 2015
Appendices: Corporate Risk Register

Corporate Risk Register

Key issues

1. No new risks were added to the Corporate Risk register rated as a 12 or above during June 2015.

2. Five risks scoring 12 or above were closed during June 2015.

   - ID 745 - Risk of non-compliance with CQC, HSE and IRMER requirements due to level of Radiology capacity/resources (4x3=12). Closed at June 2015 CSS Directorate meeting as staff now in place, in addition to increased training levels.

   - ID 27 - Increased risk of patient(s) contracting a HCAI such as MRSA, C.Diff, MRAB or Norovirus (4x3=12). Closed at IPCC and via discussions with DoN.

   - ID 623 - Failure to meet CQUIN requirements for 2014/15 (3x4=12). Closed due to year end, following discussions with DoN.

   - ID 711 - Defective Theatre doors and impact on staff and patients (3x4=12). Closed following discussions with the Medical Director as repairs now in place.

   - ID 742 - Limited ability to disseminate information on criminal sanctions (3x4=12). Closed following discussions with DoN due to NHS Protect guidance and application of neutral grade during assessment.

3. One risk had the score decreased from a 12 to reflect action taken and increased controls:

ID 756 - Impact/disruption to the delivery of core surgical services due to Synergy healthcare relocation of the sterilisation unit (3x4=12 reduced to a 3x3=9). Discussed with Decontamination Lead and as transfer of decontamination services now transferred.

4. The corporate risk register was reviewed at the monthly Clinical Governance Group and Clinical Cabinet in June.

Implications of results reported

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

Action required

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

Link to Key Strategic Objectives (delete those not applicable)

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

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

Implications for BAF or Corporate Risk Register

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

Regulatory impacts

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

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

Recommendation

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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Changes during month	Current Rating	Residual Rating	Actions	Date Reviewed
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	Clare Stafford	Nasir Rafiq	Information Governance	↔	12	6	Monitoring of compliance with IG Toolkit Implement data leakage prevention software Data test to be completed using Data leakage prevention software by 31/03/2015 Monitor IG training compliance Deploy encryption software to manage use of unauthorised email accounts - Not required after all	02/06/2015
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	Clare Stafford	Nasir Rafiq	Information Governance	↔	12	8	Looking to procure new network (by 31/03/2016) IT Capital bids programme for 2014/15 monitored at Information Management and Governance Committee IT annual plan for 2014/15 in place to monitor progress on IT renewal Purchase and install 2nd core switch which is connected to all edges and other core switch New equipment to be rolled out within 12 months covered by life time warranties	02/06/2015
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	Steve Fenlon	Mr Asit Khandwala	Patient Safety	↔	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	07/04/2015
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	Jo Thomas	Alison Vizulis	Patient Safety	↔	12	8	Annual CiP assessments to continue at spoke sites revised programme of infection control and decontamination annual assessments in place for 2015/16 Ongoing monitoring via KPIs Feedback to DoNs at sites Focus on completion of off site spoke H&S assessments during 2015 and Trust Board reporting Correlation of CQC results against assessment results	07/07/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Changes during month	Current Rating	Residual Rating	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.	Sharon Jones	Sharon Jones	Compliance (Targets / Assessments / Standards)	↔	12	8	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 3. Ensure all Planned cases have estimated TCI's when placed on list - Ongoing 1. Expedite Medway hub 5. Clinical pathways for top 3 procedures within specialities with clock stops being devised with CD's - agreed, being put into trust format Develop early warning systems to track increased demand and mismatch with future capacity modelling tool to monitor backlog reduction and provide assurance to the board of when compliance will be achieved sustainably Develop referral management and booking process in all specialties to ensure 18 week target achieved Improve pre-assessment service through web based technology Maintain detailed demand and capacity work to ensure resources meet demand and reduce overall waiting times and extend methodology for out patients	09/07/2015
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 receiving referrals 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	Sharon Jones	Sharon Jones	Compliance (Targets / Assessments / Standards)	↔	12	8	Streamline current referral pathways for all types of cancer Expand use of Infoflex system across Trust Ensure off site 2 week H&N cancer appointments are booked efficiently	09/07/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Changes during month	Current Rating	Residual Rating	Actions	Date Reviewed
627	19/07/2013	Failure to embed safer surgery checklist process due to lack of engagement	1. Patient harm due to incorrect procedure 2. Litigation 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	Patient Safety	↔	12	4	Ongoing monitoring at Patients Safety Forum and reporting as an indicator on the Quality Metrics dashboard - Completed Audit tool amended following pilot to improve robustness - Completed WHO CQUIN audit reports fro Q3 & Q4 to be submitted Quality audit of Time out and sign out process to be reviewed monthly at Theatres and anaesthetics Meeting - Completed and ongoing	08/06/2015
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 separate blood fridge and blood gas analysis machine for theatres	Jo Thomas	Kate Saunders	Patient Safety	↔	12	2	Identification 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	13/04/2015
794	30/03/2015	Possession of Drug Cupboard Keys - Maxillofacial/Orthodontics OPD	Potential misuse of access to drugs cupboard and safety of drugs	1. Abuse of drugs 2. Loss of keys	1. Keys locked in safe 2. Ward staff all have access	Jo Thomas	Kathy Brasier	Compliance (Targets / Assessments / Standards)	↔	12	4	Keys locked in safe - one person to be in charge of keys for day Cascade of Responsibility - B7 to B6 to B5 to - in the event of no B5 - Senior B4 Dental Nurse	14/04/2015
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	Clare Stafford	Kathy Brasier	Staff Safety	↔	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	22/04/2015
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 occurring 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).	Clare Stafford	Dumiso Ncube	Estates Infrastructure & Environment	↔	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 & Facilities Steering Group on 08/09/2014 with quotes for decision 24/02/2015: Orders Raised to enable repair to existing system as per Business Plan by Eye bank Manager and Interim General Manager - Clinical Support Services (works to commence subject to agreement with Eye bank Manager) 24/02/2015: Consideration for relocation of Cleanroom and combining with Histopathology proposals Business Case/options appraisal being drafted by General Manager for 3 Options	28/04/2015
796	30/04/2015	Risk of car collision at site junction on QVH property due to faded white lines	Risk of car collision at site junction on QVH property due to faded white lines		Limited driving speed signs in place	Clare Stafford	John Trinnick	Estates Infrastructure & Environment	↔	12	6	Review of current arrangements as part of Annual Site Survey	30/04/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Changes during month	Current Rating	Residual Rating	Actions	Date Reviewed
748	03/10/2014	Field safety notice FSN83000189 patient data may not be updated when exporting to 3rd party devices using the auto export feature	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/Risk solution dated 27/07/2014 stating that when a study requires patient information be updated the updated information is not always passed to the VNA. There is no fix 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 integration 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-matched data	Sharon Jones	Paul Gable	Information Governance	↔	12	6	Discussed at CSS Mtg 05/05/2015: Current score of 12 to remain until PACS upgrade completed (due at end of May 2015) Range of information awaited from Phillips (as per controls column)	05/05/2015
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 process 4. Destruction of records less than 10% of new records created 5. Departments following different storage methods 6. Existing 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	Sharon Jones	Mrs Avis Warburton - Pullen	Patient Safety	↔	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 utilised 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	11/05/2015
799	20/05/2015	Risks associated with non medical Consultant staff providing services offsite	Risks associated with non medical Consultant staff providing services offsite		1. Accompaniment by an onsite Consultant 2. Access to Consultant guidance/support	Steve Fenlon	Alison Vizulis	Patient Safety	↔	12	8	review to be undertaken of non consultant medical staff work offsite - Led by medical staffing	20/05/2015
753	27/11/2014	Inaccurate search results for specimens	V number searches do not always highlight the results; searches required both on V number and names. Not all results on Winpath are on ICE (and vice versa).		1. Two searches carried out. 2. Staff reminded to accurately complete request forms.	Jo Thomas	Emma Kerr	Compliance (Targets / Assessments / Standards)	↔	12	2	BSUH to devise new electronic reporting system for ICNs - ongoing issue	28/05/2015
786	23/02/2015	Impact arising from the vacancy for the role of Medical Devices Liaison Officer	Impact of the vacancy for the role of Medical Devices Liaison Officer. Remit being covered by the remainder of the Risk Management Department. Potential impact upon medical device purchase applications and recording of medical device training/competencies.		1. Risk Management and Procurement Depts covering remit of role on an interim basis. 2. No change to CAS alert receipt and dissemination procedures 3. MHRA notified of vacancy and current arrangements	Steve Fenlon	Alison Vizulis	Patient Safety	↔	12	8	Assistance provided by redeployed staff Bank staff member recruited to assist on an interim basis- Completed Areas identified for new EME contract provider to undertake	10/06/2015
779	21/01/2015	Inadequate emergency alarm system (sirens and lights) to direct staff to where the emergencies are occurring.	Inadequate emergency alarm system (sirens and lights) in place to direct staff to where the emergencies are occurring.		Ward grade system currently in place (incorrect level of alert given). Staff attend as required (where available) Admission/Discharge Nurses test the alarms every day at 08:00hrs Staff awareness raised regarding sirens etc. and also progress of improvement	Dr Ken Sim	Jo Davis	Patient Safety	↔	12	8	Full Estates review and replacement of system Emergency alert drill to be developed and put in place Estates Dept. reviewed current system - Completed - increased level of sirens (slightly) Hardware upgrade to be installed during the Summer of 2015. Review completed by company responsible for managing sirens etc. and actions identified. Progress underway	10/06/2015
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 RCA training provided to staff on 2 dates in April 2015	Jo Thomas	Alison Vizulis	Compliance (Targets / Assessments / Standards)	↔	12	8	Revisions scheduled for CQC regulations in 2015 Governance reporting review underway Human Factors CQUIN agreed and training to be developed and implemented	10/06/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Changes during month	Current Rating	Residual Rating	Actions	Date Reviewed
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	Sharon Jones	Mr Mark Savage	Information Governance	↔	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	10/06/2015
804	06/07/2015	some periodic testing of electrical systems out of date (5 yearly)	• Undetected electrical faults. • Undetected damage to electrical systems and circuits. • Deterioration of installation due to age. • Installation not complying with latest regulations and good practice. • Safety systems not working within design perimeters. (e.g. Breakers.) • Earth faults.	• Increased fire risk due to undetected electrical faults • Injury to patients visitors and staff from electrocution. • Noncompliance. • Loss of business continuity due to electrical faults. • Loss of reputation.	• Areas requiring testing have been identified and prioritised. • Quotes have been obtained for periodic testing. • Programme of testing established to bring all areas up to date. • Orders raised for first areas on programme.	Clare Stafford	John Trinick	Estates Infrastructure & Environment	↔	12	8		

Status	Description
↔	No change to score/assurance
↑	Score increased/assurance
↓	Score decreased/assurance

Risks 12 and above June 2015

Risk Assessment Matrix

This is formed from the Likelihood x Severity = Risk Grading

		Severity				
		Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Likelihood	5 Almost Certain	5	10	15	20	25
	4 Likely	4	8	12 604 794 727 753 732 748 733	16	20
	3 Possible	3	6	9	12 159 681 475 728 602 743 627 779 629 786 639 796 799	15
	2 Unlikely	2	4	6	8	10
	1 Rare	1	2	3	4	5

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th July 2015
Reference number:	180-15
Report from:	Jo Thomas, Director of Nursing
Author:	Fiona Long, interim Director of Nursing
Report date:	20th July 2015
Appendices:	Corporate Risk Register

Emergency Preparedness Resilience & Response

Purpose of Item

Note/Information

Areas to Highlight or Key Decisions required)

1. The Emergency Preparedness Resilience & Response Annual Report 2014/15 was presented at the July Quality and Risk Committee
2. The Heatwave Plan has been reviewed in line with recent national guidance and was approved at the Clinical Governance Committee on Monday 8 June; it has been uploaded on to the Intranet.
3. An annual table top exercise has been planned for October 2015.
4. Training continues to be delivered at Induction and clinical and non-clinical mandatory update sessions. Mandatory training for non-clinical staff will now be delivered every 3 years instead of annually.

Action required

None

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

No data is required to be reported or be fed through to the Corporate Risk Register or Board Assurance Framework

Regulatory impacts

Does what you have reported have any impact on our ability to comply our CQC authorisation? i.e., does what we are reporting indicate that the Trust is NOT:

- Safe - No
- Effective - No
- Caring - No
- Well led - No
- Responsive – No

Does what we are reporting have any impact on our Monitor governance risk rating or our continuity of service risk rating? No

Recommendation

The Board is recommended to note the contents of the report

Queen Victoria Hospital NHS
NHS Foundation Trust

Emergency Preparedness Resilience and Response and Business Continuity Annual Report 2014 - 2015

Fiona Long
Interim Deputy Director of Nursing
May 2015

Introduction

The Civil Contingencies Act 2004 placed a number of duties on responding agencies to a Major Incident. QVH are categorised as a Category One responder which include the following responsibilities:

- To carry out a risk assessment of our operational areas
- To make emergency plans
- To make business continuity plans
- To warn and inform the public
- To cooperate with other responders through a Local Resilience Forum
- To share information with other responders

During 2014/15 Emergency Preparedness Resilience and Response and Business Continuity Executive leadership within QVH was held by the Director of Nursing and Quality whilst the role of Emergency Planning Officer was enacted by the Deputy Director of Nursing. The Director of Nursing has represented QVH at the Local Health Resilience Partnership (LHRP) meeting and the Deputy Director of Nursing has attended the Sussex Health Resilience Group (SHRG).

Throughout the year, QVH has a responsibility not only to update policies and plans related to Emergency Planning, but also to test these plans and conduct exercises in resilience and Business Continuity. Maintaining effective continuity of our business is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management (BCM).

The Quality and Risk Committee has received quarterly updates in 2014/15 to provide assurance that this work has been undertaken. This report provides a summary of the work undertaken in relation to Emergency Planning and Business Continuity within QVH in 2013415.

Emergency Preparedness Resilience and Response (EPRR)

Policy

Emergency Preparedness policies are held centrally on the Trust intranet pages; for ease they are divided into sections to reflect specific guidance. Policy review is ongoing; seasonal policies (Cold Weather and Heatwave) have been changed in line with national guidance and local action cards for major incident have also been revised; this work is ongoing and administered by the compliance officer. The bomb threat policy has been revised to include a section on terrorist threat.

Incident Co-ordination Centre (ICC)

The ICC remains located in the Jubilee Meeting room. The ICC contents and function was tested by the emergency planning officer (EPO) in December 2014; and in March by the site practitioners as a pre-test to a planned telephone upgrade; the exercises demonstrated that all necessary equipment was in good working order including the fax machine; telephone lines; computer and television.

Assurance process

Internally:

Bi-monthly on-call manager meetings continue; this ensures on-call logs and incidents are reviewed and learning has been captured and actioned. The inclusion of new on-call managers within the rota with limited operational experience makes these bi-monthly meetings a useful forum for discussion and sharing experience. To ensure mangers receive the support required a buddy system is in place whereby all on-call managers without an operational remit have the contact details of a clinical manager to call for advice as required.

EPRR updates have been received at the week 3 Clinical Cabinet meetings; quarterly Quality and Risk Committee and the Board. The updates have been presented by the Director of Nursing or Deputy Director of Nursing during 2014/15 to provide assurance.

Externally:

All NHS Trusts who are category 1 and 2 responders (Civil Contingencies Act 2004) are required to complete a self-assessment and submit a statement of readiness to NHS England stating compliance against the national requirements of EPRR. The Trust reviewed its compliance with the EPRR Core Standards and the Statement of Readiness was approved by the Board in September and submitted to NHS England on 30 September 2014. An assurance meeting was held with NHS England in October 2014 to challenge and approve. This process will be repeated in 2015.

Practice Exercises and Live Events

A planned shutdown of electricity supply was undertaken in April 2014 overall this was managed successfully. Theatres had full electricity supply during the shutdown but no surgery took place during this time; ITU patients were transferred to the recovery area in theatres. Due to an unforeseen refrigerator issue some refrigerated medications were ruined and needed to be disposed of. When the power was reinstated to the trust site a problem occurred with the telephone lines highlighting an issue with the contract QVH has for support from the telephone provider. This has since been reviewed and the level of cover is being increased to cover 24/7. The telephone service fault was repaired by midnight of the same day the issue was detected and had minimal impact on the running of the hospital.

A table top exercise took place in October 2014 to test the trust Pandemic and Emerging Diseases Plan. The exercise demonstrated that the Trust has a plan in place which is

easy to follow, along with the Local Health Resilience Partnership (LHRP) Strategic Pandemic Influenza Plan. These are available on the Intranet. The session was evaluated well by those in attendance; some minor alterations to the plan were identified through the testing. These amendments were made to the plan and ratified in Clinical Cabinet.

In November a communications exercise was undertaken to test the knowledge and actions to be carried out by staff should a patient with suspected Ebola attend QVH. Clinical areas contacted included Canadian Wing; MIU; Theatres and Peanut. On the whole knowledge was good amongst clinical staff that were spoken to. There were gaps in knowledge mostly amongst theatre staff. The action plan includes refresher training to all clinical areas and more focussed training the theatre staff. The IPACT team have already provided this since the test.

A planned telephone upgrade communication exercise was planned and carried out in April (2015). Part of the planning included a communications test in March; this went well and included practice for going live and using trust mobile phones in the event of an emergency situation.

Exercise, testing and planned updates to QVH policy are planned for 2015/16 and are detailed in **Appendix 1**.

Winter Planning

Snow
There had been no snow in the winter of 2014/15 that had impacted on QVH.

Flu
Final submission of Flu vaccination data has been made to IMMFORM. Our final flu figures for staff vaccination in 2014/15 were 517 (53%) against 516 (55%) in the previous year. We did not achieve our internal target of 60% however nationally uptake has been low in 2014/15; one of the reasons being the publicised component miss-match in the vaccine in relation to the predicted strains of flu for this year.

Staff Group	No. Vaccinated
Trained Nurses	118
Doctors	50
Other qualified clinical professionals	81
Support Staff	50
Administration	172
Other	46

Training
Training continues to be delivered at Induction and clinical and non-clinical mandatory update sessions. Mandatory training for Non-clinical staff is delivered every 3 years not annually.

Fit testing
Fit testing has taken place in all services throughout 2014/15 and this was managed at a departmental level.

Business Continuity
Maintaining the effective continuity of our business operations is of critical importance to QVH. We are committed to the implementation, maintenance and continual improvement of an effective Business Continuity Management capability in line with BS 25999 Business Continuity Management. This includes the development of BC Plans for core business activity.

A total of thirty three Business Continuity Plans are required to cover the forty two separate areas or services identified within the Trust. All plans can be accessed from the shared drive in the Risk Management folders and all departmental leads have a copy of their plan.

Other activity undertaken over the year:

- Training sessions on Emergency Planning Preparedness were delivered for all new employees on induction and current employees at mandatory training as an ongoing rolling programme.
- Bi monthly meeting for on-call managers, control personnel and bleep holders.
- The Trust maintained its membership with the Sussex Resilience forum and has now registered with the National Resilience Extranet replacement system Resilience Direct

Appendix 1

Queen Victoria Hospital Emergency Planning Exercises 2015/2016							
	Activity	**Timeframe Requirements**	**Date Planned**	**Staff Required**	**Date Achieved**	**Report Written**	**Report to Q&R**
1	**Communication exercise**	*Every 6 months*	**28th April 2015** **13.00 - 15.00** Jubilee Meeting Room	DoN EPO Site Practitioner team	**22.4.15**	**Yes**	**7.5.15**
2	**Review system wide heatwave resilience plan**	*Yearly*	**20th May 2015** _ _	EPO - -	**3.6.15**	**N/A**	
3	**Lockdown exercise**	*Yearly*	**24th June 2015** **12.00 - 13.00** Jubilee Meeting Room	DoN EPO Head of Risk Site Practitioner team			
4	**LIVE EXERCISE**	*Every 3 years*	**Not required until 2017 as live event in 2014**	*N/A*	*N/A*	*N/A*	*N/A*
5	**Review system wide pandemic SOP**	*Yearly*	**1st July 2015** _ _	EPO - -			
6	**Review system wide winter resilience including Cold Weather Plan**	*Yearly*	**24th September 2015** _ _	EPO - -			
7	**System wide Table Top Exercise to cover Emergency Planning and Business Continuity**	*Yearly*	**2nd October 2015** **08.30 - 13.00** Jubilee Meeting Room	Matrons On call managers Site Practitioner team			
8	**Communication exercise**	*Every 6 months*	**6th November 2015** **09.00 - 11.00** Jubilee Meeting Room	DoN EPO Site Practitioner team			
9	**Incident room set up exercise**	*Yearly*	**9th December 2015** **11.00 - 12.00** Jubilee Meeting Room	EPO Site Practitioner team -			

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 30 July 2015
Reference number: 182-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: 25 June 2015

Report of the Chair of the Charity Committee

Key issues discussed

1. The proposed new application process and fund structure was discussed and agreed by the committee. In view of the significant changes proposed affecting staff across the Trust it was agreed that these proposals, together with the planned communication of them, should be submitted to the Corporate Trustee for approval at its next meeting.

2. A draft engagement policy for celebrity, VIP and other high profile visitors to the Trust in connection with the work of the Charity was tabled and approved by the Committee.

3. A discussion paper on the Charity's approach towards support for staff events was submitted and it was agreed that the corporate affairs team should draft a policy focussed around meeting specific requests from donors and the annual staff awards event.

Items to be referred to the Board of Directors

4. The Board may wish to consider whether the Celebrity/VIP visit policy mentioned above, which was drafted to manage Charity related visits, should form the basis for a similar policy across the Trust generally.

5. The proposal for the Charity to support the purchase of Confoscan and Endoscope equipment will be submitted to the next meeting of the Corporate Trustee, together with an updated quotation and justification.

Additional information or assurance sought

6. None

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: 30th July 2015
Reference number: 183-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: 25th June 2015

Report of the Chair of Nomination & Remuneration Committee

Key issues

1. The Committee met to discuss the letter from the Secretary of State for Health to Trust Chairs, requesting certain data relating to Very Senior Management [VSM] salaries. It was confirmed that response was to be provided on a standard pro forma which was in the process of being completed and which would be circulated to members of the Committee for comment well before the 7th July deadline. It was confirmed that requests for trusts to justify VSM salaries only applied on initial appointment and not to subsequent increases. The request that Trusts review their policies for executive remuneration is covered, for the most part, by work already commissioned by the Committee including the benchmarking of all executive roles/salaries against similar roles elsewhere within the NHS.

2. Until any new guidance is received from the Department of Health, the legal responsibility for setting and reviewing VSM salaries within the Trust remains with the Trust Board through its statutory N&R Committee.

3. The salaries of the CEO and his direct reports will be reviewed at the next meeting of the N & R Committee on the 30th July.

Items to be referred to the Board of Directors

There are no matters to be referred to the board of directors at this stage.

Additional information or assurance sought

None.

Implications for Board Assurance Framework or Corporate Risk Register

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

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30th July 2015
Reference number:	184-15
Report from:	Ginny Colwell, NED
Committee meeting date:	2nd July 2015
Appendices:	NA

Report of the Chair of the Quality and Risk Committee
NB Draft minutes not available

Key issues discussed

1. Concerns continue to be raised by committee members around the number of pressure sores our patients are developing. Whilst it was acknowledged that this is a complex issue with many contributing factors we will continue to monitor this carefully and ensure that we are utilising best practice in this area.

2. There was concern over what appeared to be an increase in incident reports. Some of this was explained in the way the information is presented and JMT will agree the future format.

3. There continue to be a number of incidents reported under information governance. It was agreed that JMT and CS will agree an action plan with an agreed target for compliance. To return to the September meeting.

4. Human factors training- this is being implemented throughout the Trust and will come to the Board in September.

5. It was noted that the CQC visit is now scheduled for 10th – 13th November. RT has set up a leadership forum to manage the work involved.

6. A verbal update was received on the progress with the “internal CQUINS”. A quarterly report will be submitted to Q&R and the Board.

7. SF is currently undertaking a governance review of our spoke sites. A report is due at the September Board.

8. The annual Safeguarding Adults and Children’s report was received

Additional information or assurance sought

1. Additional information around the prevention of pressure damage was requested in the quarterly report.

2. The committee agreed that with the governance review further analysis was required to ensure effective reporting/assurance to Q&R and the Board.

3. Further checking was requested around the Children's safeguarding report to ensure the statistics were correct.

4. Out of date policies continue to be a concern. The committee requested that the executive team risk assess the ones that fall under their area of responsibility and agree with the named authors when the policies will be completed.

Implications for BAF or Corporate Risk Register

1. Main areas of concern are already fed through to the Corporate Risk Register or Board Assurance Framework

Recommendation

The Board is recommended to **NOTE** the Committee's actions and findings

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	30 July 2015
Reference number:	185-15
Report from:	John Thornton, Chair of the Finance and Performance Committee
Author:	John Thornton, Chair of the Finance and Performance Committee
Report date:	23 July 2015
Appendices:	A: Board of Directors' sub-committee: chairperson's assurance report

Board of Directors' sub-committee: chairperson's assurance report for the finance and performance committee

1. Enclosed report to provide assurance to the board following the meeting of the finance and performance committee held on 20 July 2015.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust	
Board of directors' sub-committee: chairperson's assurance report	
Sub-committee:	Finance and Performance Committee
Meeting date:	Monday 20 July 2015
Meeting chaired by:	John Thornton, Non-Executive Director
Quorate:	Yes

Meeting attendance	
Committee members present	
Graeme Armitage (GA)	Director of HR&OD
Beryl Hobson (BH)	Trust Chair
Sharon Jones (SJ)	Director of Operations
Clare Stafford (CS)	Executive Director of Finance and Performance
John Thornton (JT)	Non-Executive Director (Chair)
Richard Tyler (RT)	Chief Executive
In attendance	
Chris Orman (CO)	Vice Chairman of the Council of Governors
Claire Charman (CC)	Executive Assistant to the Director of Finance (Minutes)
Not present/apologies	
Jason McIntyre (JM)	Deputy Director of Finance
Ian Playford (IP)	Non-Executive Director
Elin Richardson (ER)	Head of Commerce
Jo Thomas (JMT)	Director of Nursing

Meeting summary	
Agenda item:	**20-15 Revised workplan**
Assurance:	The committee reviewed the revised draft workplan which had been updated to reflect the recommendations made at the last meeting.
Decision:	Looking ahead, the committee reflected on the timings of items for discussion over the next few months and made adjustments accordingly.
Referral/escalation:	The committee will review the workplan at each meeting and use to plan the agendas for future meetings.

Agenda item:	**21-15 Operational Performance**
Assurance:	SJ presented the operations report. The committee particularly sought assurance that the trust would not find itself in the same position as last year with regard to the 18 week waiting times. SJ reported that there had been some slippage which has been addressed early on and therefore should meet targets. The committee were given assurance that there has been good engagement with clinical directors and team leaders. Following a review of diagnostics, the Sleep pathway has been reduced by two weeks.

	SJ explained that it was proving difficult to access some historical data. Will use what data is available to bring an outline report on activity, performance and actions to the F&P in August.
Decision:	The committee NOTED the operational performance report.
Referral/escalation:	SJ to bring diagnostic and progress update to the next F&P meeting.

Agenda item:	**22-15 Workforce metrics**
Assurance:	The committee noted the new dashboard style reports and sought assurance around the number of staff in post and the expected establishment total. GA confident that 50% of the vacant posts are in the recruitment process but work will be undertaken to understand where some of the gaps are and the reasons for not recruiting. However, the committee were reassured that safe staffing levels are being maintained and therefore these gaps should not be having an impact on patient safety. A further recruitment day is to be held in September and the committee were pleased to see the success of the last two events. Each area will receive their own dashboard report which will show levels of compliance within the teams and in comparison to trust averages. This will be used as a proactive tool to encourage staff to update their mandatory training.
Decision:	The committee NOTED the HR report.
Referral/escalation:	N/A

Agenda item:	**23-15 Finance – Month 3**
Assurance:	CS presented the finance board report for June 2015 (Month 3) and noted that it includes additional analysis and more narrative. Month ended with 196k surplus (actual) which is an improvement on the last two months although behind plan. The current underperformance was discussed and following a review of activity in August a presentation will be made in September on remedial plans required to meet budget surplus. JT noted that comparative data from the previous year is no longer included. CS explained that this information is not an indication of our position and does not add value as there are many variances. It is better to see this data in activity with a view to understanding why there are variances which is more important. CS assured that they are working towards this level of understanding and to show a rolling position of the last six months in the finance reports would be more useful.
Decision:	The committee NOTED the finance report.
Referral/escalation:	N/A

Agenda item:	**24-15 Capital Programme**

Assurance:	Further to discussion at the last meeting, CS assured that work has started on understanding the capital plan and the phasing. Whilst the board agreed a high level capital plan it is not reflected back to individual budgets. CS presented the draft terms of reference for a new capital planning group which meet to monitor all aspects of capital closely. In order to provide assurance to the Finance and Performance Committee business cases will be reviewed through the Executive Management Team (EMT) who will prioritise projects while robust processes are established.
Decision:	The Committee NOTED the capital programme update.
Referral/escalation:	Will continue to report to the Finance and Performance Committee.

Agenda item:	**25-15 Cost Improvement Programme (CIP)**
Assurance:	CIP at £72k at month 3 but will pick up momentum later in the year. The committee sought assurance that the CIP will be achieved. CS concerned that not all savings are being articulated in plan, for example a decision not to recruit to a post in this financial year. Need to set-up processes. Should deliver target but will come back to the committee with further assurance.
Decision:	The committee NOTED the report.
Referral/escalation:	This item will remain a high priority for the F&P Committee and will continue to be reviewed monthly.

Agenda item:	**26-15 Outline Business Case – I.T. Infrastructure Programme**
Assurance:	CS gave a background to the project to-date which started with an initial review of the IT infrastructure in November 2013. The committee agreed that investment in the past has been minimal and this work is essential in order to develop a network to support future developments such as EDM, a data warehouse etc. The committee sought assurance that this work will continue at pace and the capital will be spent in this financial year. In order to achieve this CS recommended a move to full business case as soon as possible and to undertake a costing exercise with procurement to provide indicative costs, in order to give a clearer picture.
Decision:	The committee AGREED for the team to start the costings exercise through procurement which will provide indicative costs and to make a recommendation to the Board of Directors at their meeting to move to full business case.
Referral/escalation:	The Board of Directors are asked to approve the move to a full business case and to start a costings exercise through procurement.

Agenda item:	**27-15 Estates Strategy Update**
Assurance:	RT reported that the clinical cabinet received a presentation of the broad plans to develop the hospital street. Clinicians were

	supportive overall and Green and Kassab will engage with clinical directors while they continue to work to develop a Strategic Outline Case for the November Board
Decision:	The committee NOTED the update.
Referral/escalation:	Ongoing monitoring by the F&P Committee

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 24 September 2015
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

PROPOSED SCHEDULE		
MEETING OF A BOARD SUB-COMMITTEE		
09.00 – 10.00	**QVH Corporate Trustee meeting**	
INFORMAL SEMINAR MEETING OF THE BOARD OF DIRECTORS HELD IN PRIVATE		
10.00 – 11.00	**CQC update**	Director of Nursing & quality
11.00 – 12.00	**Head and neck strategy**	Head of Commerce and Ian Francis, consultant radiologist
12.00 – 12.30	**Presentation: head and neck**	Brian Bisase, Consultant Oral and Maxfacs Surgeon
BUSINESS MEETNG OF THE BOARD OF DIRECTORS: SESSION HELD IN PUBLIC		
13:00 – 16:00		
	PATIENT STORY	
	Experience	Director of Nursing & quality
	RESULTS AND ACTIONS	
	Patients: safe staffing and quality of care	Director of Nursing & quality
	Operational performance	Director of Operations
	Financial performance	Director of Finance & performance
	Workforce	Director of Human resources & OD
	Analysis of theatre review	Medical Director
STRATEGIC PRIORITIES		
	Quarterly update on delivery of KSO5: organisational excellence	Director of Human resources & OD
	Strategy & sustainability (*CiC)	Chief Executive, and Head of Commerce
	Private patient policy (*CiC)	Chief Executive
GOVERNANCE		
	Corporate risk register	Director of Nursing & quality
	Board assurance framework	Director of Nursing & quality
	Whistleblowing policy	Director of Human resources & OD
	Board governance review – final recommendations	Company secretary
	Fit and Proper Persons Test	Company secretary
	Statutory duties of co-operation	Company secretary
	Annual seal register	Company Secretary
SUB-COMMITTEE REPORTING		
	Clinical cabinet	Chief Executive
	Audit committee	Committee Chair
	Finance & performance	Committee Chair
	Quality and risk	Committee Chair
	Nomination & remuneration	Committee Chair
	QVH Charity	Committee Chair

*CiC = commercial in confidence