Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 24 September 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: 24 September 2015

Members (voting):

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

In full attendance (non-voting):

Director of Human Resources & OD	-	Graeme Armitage
Director of Operations	-	Sharon Jones
Company Secretary	-	Kathleen Anderson
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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Agenda: session held in public		
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Welcome		
194-15	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Patient story: experience		
195-15	*Jo Thomas, Director of Nursing and Quality*	-
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197-15	**Matters arising and actions pending** *Beryl Hobson, Chair*	10
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Results and actions		
199-15	**Assurance report: quality and risk committee meetings held on 03 September 2015** *Ginny Colwell, Non-Executive Director and Committee Chair*	-
200-15	**Patients: safe staffing and quality of care** *Jo Thomas, Director of Nursing and Quality*	15
201-15	**Assurance report: financial and operational performance committee meetings held on 17 August and 21 September 2015** *John Thornton, Non-Executive Director and Committee Chair*	-
202-15	**Operational performance: delivery, targets and key performance indicators** *Sharon Jones, Director of Operations*	35
203-15	**Financial performance** *Jason McIntyre, Deputy Director of Finance Executive on behalf of Clare Stafford, Director of Finance and Performance*	42
204-15	**2015/16 delivery plan** *Sharon Jones, Director of Operations*	82

205-15	**Workforce report** *Graeme Armitage, Director of Human Resources and Organisational Development*	66
Governance		
206-15	**Board governance review: final report** *Beryl Hobson, Chair*	97
207-15	**Board assurance framework: development update** *Richard Tyler, Chief Executive*	103
208-15	**Corporate risk register** *Jo Thomas, Director of Nursing and Quality*	113
209-15	**Child protection and safeguarding annual report 2014-2015** *Jo Thomas, Director of Nursing and Quality*	118
210-15	**High priority cancer actions: self-assurance statement** *Sharon Jones, Director of Operations*	129
211-15	**Whistleblowing policy** *Graeme Armitage, Director of Human Resources and Organisational Development*	138
Reports from the chairs of the sub-committees to the board of directors		
212-15	**Nomination and Remuneration Committee: meeting held on 30 July 2015** *Lester Porter, Senior Independent Director and Committee Chair*	164
213-15	**Audit Committee: meeting held on 9 September 2015** *Lester Porter, Senior Independent Director and Committee Chair*	165
214-15	**QVH Charity Corporate Trustee: meeting held on 24 September 2015** *Beryl Hobson, Chair*	-
Next meeting agenda		
215-15	**Draft agenda for the November 2015 business meeting** *Kathleen Anderson, Company Secretary*	167
Observations and feedback		
216-15	**Feedback from key events and other engagement with staff and stakeholders** *All board members – please submit list in advance to the Deputy Company Secretary*	-
217-15	**Observations from members of the public** *Beryl Hobson, Chair*	-
218-15	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*	-
219-15	**Observations and feedback on the meeting** *Sharon Jones, Director of Operations*	-

Agenda: session held in private		
Commercial-in-confidence		
220-15	**Draft minutes of the meeting session held in private on 24 September 2015 (for approval)** *Beryl Hobson, Chair*	168
221-15	**IT infrastructure improvement programme: full business case** *Richard Tyler, Chief Executive on behalf of Clare Stafford, Director of Finance and Performance*	170
Any other business (by application to the Chair)		
222-15	*Beryl Hobson, Chair*	-

Date of the next meetings		
Board of Directors:	**Sub-Committees**	**Council of Governors**
Away-day: 29 Sept at 09:00	**Q&G:** 15 Oct 2015 at 09:00	**Public**: 08 October 2015 at 15.00
Public: 05 Nov at 10:00	**N&R:** 15 Oct 2015 at 11:00	
	F&P: 19 Oct 2015 at 14:00	
	Audit: 02 Dec 2015 at 14:00	
	Corp. Trustee: 03 Dec 2015 at 09:30	
	Charity: 17 Dec 2015 at 09:00	

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Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 30 July 2015, 13.00 – 16.00, The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT**	
Present:	Beryl Hobson, (BH)	Trust Chair
	Ginny Colwell (GC)	Non-Executive Director
	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 and Quality
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources and Organisational Development
	Kathleen Dalby (KD)	Head of Corporate Affairs and Co Sec
	Brian Goode (BG)	Governor Representative
	Sharon Jones (SJ)	Director of Operations
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Public Gallery:	John Belsey (JEB)	Public Governor
	Chris Halloway (CH)	Public Governor
	Anne Higgins (AH)	Public Governor

WELCOME

167-15 **Welcome, apologies and declarations of interest**

BH opened the meeting and welcomed three members of QVH Council who were attending the public session of the board today.

There were no apologies and no new declarations of interest.

PATIENT STORY

168-15 SF apprised the board of a patient who, due to the severity of his condition, had been required to undergo a particularly complex patient pathway. SF drew the board's attention to the disparate levels of care available to this patient. He then stressed the importance of maintaining and improving strong interpersonal links with surrounding trusts to better support such patients.

The Chair thanked SF for his observations which were **NOTED** by the board.

STANDING ITEMS

169-15 **Draft minutes of the meeting session held in public on 25 June 2015 for approval**

The minutes of the meeting held on 25th June 2015 were **APPROVED** as a correct record.

170-15 **Matters Arising & Actions Pending**
The board reviewed the current record of matters arising and actions pending. The update was received and **APPROVED**.

171-15 **Update from the Chief Executive**

	RT presented his monthly update. Highlights included: • An incongruity between activity and income plans. Q1 non-elective activity and new outpatient attendances were higher than in any of the previous four quarters, whilst June's total elective activity was higher than in any of the previous 14 months. However, income remained behind plan; • The importance of sustaining such activity levels whilst maintaining the highest quality. RT had therefore asked JMT to review current outpatient and MIU areas to ensure that capacity constraints were not causing undue waits; • Whilst the trust continued to provide safe staffing levels across all its clinical areas, RT reported that in May its use of bank and agency equated to 140 whole time staff. He highlighted concerns that compliance with statutory and mandatory training for these staff was just 41% (compared with permanent staff at 74%) but confirmed that GA was working closely with JMT and SJ to ensure compliance rates improved. • RT reminded the board that the trust was in the process of submitting a bid to the national vanguard programme. This was being made in partnership with BSUH and would focus on the trust's collaboration on burns and head and neck services. (Also, through these, on the lessons that could be learnt for the development of accountable clinical networks and speciality franchises). Benefits to the trust would include project management support, funds to provide backfill support and access to policy makers; • RT reminded the board that QVH was a member of the Federation of Specialist Hospitals (FSH) which enabled it to exert greater influence on such matters as the national tariff. (In response to questions from the board, RT advised that officially the tariff issue had been referred to the CMA. although, the likelihood was that CQUINS would be reinstated next year). • The McIndoe Surgical Centre (MSC) had been acquired officially by Horder Healthcare (HH) on 1st July. RT would be meeting with HH shortly to develop further ideas for collaboration; • The board had been advised that the regular updates on the trust's Key Strategic Objectives (financial sustainability and organisational excellence) would not be included on this month's agenda. Updates would be suspended whilst RT decided how these might be presented in a more cohesive manner; • Finally, RT reported on this week's opening of the new Lancaster Lounge and plaque unveiling. This had been a very successful event and had emphasised the importance of the links the trust had with the military. The board commended RT for his update, the contents of which were **NOTED.**
RESULTS AND ACTIONS	
172-15	**Patients: safe staffing and quality of care** JMT introduced this month's report highlighting key issues as follows: • Achievement of safe staffing levels throughout June. There was still a high use of agency staff on Canadian wing. However, as a result of a recent recruitment day, new staff would be joining this area in October; • Sickness levels in burns had increased due to multiple short term issues; • An update on the number and type of incidents reported. Following discussion, the board was reminded that the increase in reporting shouldn't cause undue concern and was in fact returning to more normal levels; • One serious incident (SI) had been logged in June. This related to a failure by the company providing outsource mailing to maintain data protection of a patient's details. A root cause analysis (RCA) was currently underway; • The trust was making good progress on the national CQUIN goals, with the CCG commending QVH on good practice, (this despite the lack of financial incentives for the trust); • All data associated with the 2015/16 Quality Account priorities was currently being reviewed by SJ. JMT updated the board on progress in i) scheduling of elective surgery with three weeks' notice, ii) expanding trauma capacity to increase the number of patients treated within 24 hours of

	admission and iii) improving patient food. A task and finish group had been established to improve patient satisfaction with food, chaired by one of the public governors. Whilst some progress had been made, regrettably the new contractor administering the FFT data had inadvertently omitted the patient data section for food in April and May. This had been rectified for June, but the Q3 position was showing only one month's data (instead of one quarter); • A summary of patient complaints in June. JMT assured the board that these were under investigation, and the outcome would be reported at future meetings; • A disappointing response rate to the FFT scores in June with no clearly identifiable reason. However, this was being carefully monitored and rates had improved significantly in July; • A comprehensive infection control report had been presented to the Quality and Risk Committee, which provided additional detail of the increased incidence of MSSA bacteraemia in June. In addition, GC asked the board to note that work had been undertaken to establish some quality metrics specific to theatres. Agreed outcomes included reducing nil by mouth time, pressure ulcers and perioperative thermoregulation management. The board was advised that theatre staff had appreciated the collaborative approach. The Chair sought clarification regarding the 'trend' field within the DoN rating (appendix 1). It was agreed this would be removed from future reports. In conclusion, the Chair thanked JMT for her update, the contents of which were **NOTED** by the board.
173-15	**Operational performance: targets, delivery and key performance indicators** This month, areas of operational focus included: • In patient elective activity which remained under plan. SJ assured the board that diagnostic work across all business units was underway to understand the problems. Operations, information and finance teams were investigating a range of issues including conversion rate changes, elective versus Daycase trends, referral pattern changes and data capture. It was hoped that findings would result in short term corrective action, with longer term sustainable plans developed over time; • Whilst the trust continued to forecast compliance at an aggregate level for all three 18-week targets, SJ warned there were risks to achieving this in August. She reminded the board of changes in the reporting of the target, which were being applied retrospectively and explained how the number of 'long-waiters' booked could negatively affect the admitted performance. However, in the medium to long term this would have a positive impact on waiting lists and was better for patients. The board agreed that achieving all three targets was the right thing to do for our patients and remained an important quality measure; • Some slippage could be attributed to a current lack of resilience in the system. SJ presented a range of options which would help mitigate future issues, including improved communication and the appointment of a new Patient Access Manager from September; • Whilst all cancer targets were achieved in June, SJ reminded the board that the trust remained vulnerable to late off-site referrals (eg from Medway) and would need to continue to minimise risks in order to achieve compliance; • Following an unsuccessful recruitment campaign, the board was advised that in the short term the Corneo Plastic team would use Clinical Fellows to cover the outpatient clinics and operating sessions of the 5th Consultant, whilst alternative options to fill the post were explored. The Chair asked how long it would be before the diagnostic work was complete. SJ advised it would be presented to the F & P committee in August, although warned it would remain a work in progress. As there was no board meeting next month, it was agreed this information would be circulated to members electronically The Chair thanked SJ for her update, the contents of which were **NOTED** by the board.

174-15	**Financial performance** CS presented the finance report setting out the trust's recent performance. The board was asked to note that activity reporting was undergoing some development and in future would be presented in a revised format. Whilst the trust had delivered a surplus of £196k for the month, this was £46k lower than planned. The cumulative deficit now stood at £155k with the key issue being shortfall in inpatient income. (Although this appeared positive, the underlying position had been masked by income relating to 2 long-stay burns patients). There were also significant pressures within non pay expenditure, although these were being offset by underspends on pay due to vacancies not being filled. The Cost Improvement Programme (CIP) was also £72k behind plan whilst the Capital programme was currently £300k above plan. Key actions to ensure the trust remained on course included: • Development and implementation of an activity plan to achieve the planned surplus by end of the financial year; • A review of the CIP to identify slippage and develop areas to mitigate shortfall. • A review of current purchasing practices and assessment of current expenditure controls; • The establishment of a capital planning group which would review the current work programme and gain a better understanding of how investment decisions were being made; • Creation of a 'bottom drawer' to address challenges. CS stressed the need to start thinking about this as a board and as a trust. There was concern amongst members of the board that insufficient action was being taken to address the shortfall. However, CS maintained further work would be required to understand the reasons for underperformance and explain the reduction in the casemix of activity. Once this work was complete, it would form the basis of the activity recovery plan, but there was little to be gained from implementing short term 'slash and burn' tactics at this stage. SJ concurred that the trust was delivering more activity this year, but earning less and it was important to understand the reasons behind this anomaly. JT assured the board that the Finance and Performance committee had considered the report's findings in great detail. He was assured that performance review meetings were due to start next month and more information would be available then. RT went on to describe key considerations for the executive team in August and agreed the following: • Further analysis of income would continue; • Discussions to take place to bring expenditure under control in a targeted way; • Debate around long term future planning to be initiated; In the absence of a formal board meeting next month, it was also agreed that the board would receive the August Finance and Performance papers, followed by the draft minutes once they were available.[**Action: CS]** The Chair thanked CS for her report, the contents of which were **NOTED** by the board.
175-15	**Workforce** GA asked the board to note that the format of the workforce report had been revamped to provide greater clarity and address some of the previous anomalies. He reminded the board that this report had also been reviewed by the Finance & Performance Committee prior to coming to board.

	Main issues in this month's report included: • A marked reduction in sickness (now close to the trust target of 2%). However, GA noted a reluctance by some managers to apply the sickness absence policy (ie consistent use of trigger points); • The impact of recruitment days had resulted in vacancies being filled although the number of vacancies remained behind in establishment and in-post figures. GA reported that approximately 50% of current vacancies were being managed through flexible use of resources and also through holding back on recruitment. Those vacancies held back for some time were currently under review to ascertain if they could be used to contribute to savings across the organisation; • Bank and Agency use remains low overall. The overtime pilot running across nursing continues to have a positive impact with QVH bank staff, providing more consistency of patient care; • Echoing the CEO's report, GA reminded the board that statutory and mandatory compliance levels were lower for temporary than for permanent staff. Temporary staff who did not comply with the trust's expectations would be removed from the bank. GC queried how the current 30% vacancy level within the Eyes & Sleep business unit might be impacting on business. GA agreed to investigate and report back **[Action: GA]** The board went on to consider the new report format and agreed the following: • Short and long term sickness data would be presented separately in future; • More context (eg trend graphs) relating to the use of bank and agency staff to be included. This would provide assurance to the board that usage was within acceptable levels; • Further refinement of the report to ensure that the quantity of data was appropriate for the board's purpose. **[Action: GA]** There were no further questions and the board **NOTED** the contents of the update.
GOVERNANCE	
176-15	**Monitor declaration: Q1 2015-16** CS reminded the board that a draft declaration circulated in the board pack had been replaced with a final version. The following finance declaration was confirmed for Q1: '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. CS explained that the movement from 4 to 3 was due to a change in the capital servicing capacity measure arising from the treatment of the loan repayment and was therefore not a real issue. (However, she reminded the board that any deviation from planned surplus would have a real and serious impact on the COSRR). Due to inaccuracies in reporting, Monitor had advised that COSRR reporting would be reverting to its previous format in the future. The governance rating for Q1 remained as 'green' with no evident concerns. The board **NOTED** the contents of the report and **APPROVED** that the declarations made within it be made to Monitor.
177-15	**Consultant re-validation** A report setting out the role and responsibilities of the Responsible Officer, and detailing how the revalidation process had been undertaken in accordance with national requirements, was presented to the board**.** SF advised that NHS England was demanding this report be subjected to external audit. He noted that QVH would be challenging this decision as it had already undergone a thorough examination. However, this requirement would be built into the work programme.

	After satisfying itself on a couple of points of clarification, the board **NOTED** the contents of the report. It also **NOTED** that this would be shared, together with the annual audit, with the High Level Responsible Officer representing NHS England. The board **APPROVED** the 'statement of compliance' for signature by the Chief Executive. This confirmed that the trust was in compliance with the regulations.
178-15	**Corporate risk register** The Corporate risk register had been refined this month to improve presentation. A 'heat map' had also been included as part of this month's report which presented the risks in a more meaningful way. RT noted that several risks were still appearing on the register, although these had been addressed. JMT explained that this was likely to be as a result of time lags, and confirmed the report would be further streamlined next month. SF highlighted an inaccuracy within ID799 and asked this to be changed to 'non consultant medical staff'. For ease of reference, JT asked if the register could in future be sorted by ID number. JMT agreed to review. There were no further questions and the board **NOTED** the contents of the update.
179-15	**CQC inspection: update** JMT provided a verbal update on current preparations for the CQC inspection in November. This month's highlights included: • An experienced project manager would join the trust on 10th August to support the process; • PWC had been commissioned to undertake a mock inspection, in August. The board was also apprised of the selection process for the PWC appointment; • JMT reminded the board that QVH was part of the first wave of new inspections and data requirements could change. In the meantime, she stressed the huge volume of data which the CQC required. JMT undertook to circulate the next tranche of information once it became available; • A phased communications plan would be implemented with effect from tomorrow. JMT assured the board that it would be fully supported and prepared in advance of the inspection. There were no further questions and the board **NOTED** the content of the update
180-15	**Annual Report: Emergency Preparedness, Resilience and Response** The board was presented with the Emergency Preparedness, Resilience and Response annual report. JMT confirmed that the Heatwave Plan had been reviewed in line with recent national guidance and was approved at the Clinical Governance Committee last month. The Chair sought additional detail regarding the recent Lockdown exercise which JMT agreed to obtain.**[Action: JMT]** There were no further questions and the board **NOTED** the content of the update.
181-15	**Council of Governors: report from the last meeting** BG reported that at the last CoG meeting, discussions had focused on: • The board governance review; • Acquisition of the McIndoe Surgical Centre by Horder Healthcare; • The membership strategy, where it was agreed the trust would continue to investigate options for

	developing its database; • The CQC inspection in November, with assurance that governors would receive regular updates on progress; • The governor forum scheduled for 3rd September at which governor roles and responsibilities would be reviewed. The Chair thanked BG for his update, the contents of which were **NOTED** by the board.
REPORTS FROM THE CHAIRS OF THE SUB-COMMITTEES TO THE BOARD	
182-15	**Charity Committee: meeting held on 25 June 2015** LP presented an update following the Charity committee meeting held on 25 June. KD asked the board to note that the VIP policy mentioned in the update was in fact the trust policy drawn up to manage VIP events. This had been presented to the committee to see if it had any particular concerns from the Charity's perspective. There were no further questions and the board **NOTED** the contents of the report.
183-15	**Nomination and Remuneration Committee: extraordinary meeting held on 25 June and meeting held on 30 July 2015** LP reported on the extraordinary meeting of the committee held last month to discuss a letter received from the Secretary of State for Health regarding Very Senior Management (VSM) salaries. GA confirmed that the trust had subsequently responded to the letter but heard nothing further to date. It was noted that the N & RC meeting held earlier this morning had not yet concluded. A report would therefore be provided to the board in September. There were no further questions and the board **NOTED** the contents of the report.
184-15	**Quality and Risk Committee: meeting held on 2 July 2015** GC presented an update following the Q&RC meeting held at the beginning of the month. This also formed the basis of the joint update which she and the Q&RC governor representative had given to the Council of Governors on 9th July. GC asked the board to note that there had been some inaccuracies in the data relating to children's safeguarding. This would be corrected and represented to the Q&RC in September.
185-15	**Finance and Performance Committee: meeting held on 20 July 2015** JT presented the chairperson's assurance report for the Finance and Performance Committee. As reported under item 173-15, the committee would receive a diagnostic and 18-week progress update from the operations team at its August meeting. Also, as reported under 174-15, the committee had sought assurance with regard to the current financial performance and CIP. JT reiterated that these issues were of high priority to the committee and would continue to be scrutinised carefully. Although the board had agreed a high level capital plan, it had transpired that this was not reflected back to individual budgets. In order to tackle this and other issues relating to the capital programme, the committee had agreed to establish a new planning group to closely monitor all aspects of capital. This should facilitate a more co-ordinated process in future, with governance streamlined through the F & PC. The committee had also reviewed the Outline Business Case for the IT infrastructure programme

	which would be considered by the board at its closed session later today. LP queried why the comparative data from the previous year was no longer included within the finance reports. CS explained that this information was not an indication of the trust's position and did not add value as there were too many variances. RT concurred that it would be better to see this data in activity with a view to understanding why there were variances. CS assured LP that the team was working towards this level of understanding and would hope to show a rolling position of the last six months in the finance reports, which would be more helpful. GC agreed that time would be better spent on forecasting, and suggested further debate at a future F & PC. The Chair also indicated her view that previous year data was less useful than comparison of the current year to plan. BH thanked JT for his report, which was **NOTED** by the board.
NEXT MONTH'S AGENDA	
186-15	**Draft agenda for September business meeting** The board was reminded that there would be no meeting in August. The draft agenda for the September business meeting (the last in the current format) was **NOTED**.
OBSERVATIONS AND FEEDBACK	
187-15	**Feedback from key events and other engagement with staff and stakeholders** • BH had held a useful meeting with the new CEO of Blond McIndoe Research Foundation; • KD reported on the opening of the new Lancaster Lounge and plaque unveiling, jointly sponsored by the RAF and League of Friends. LP commended the Corporate Affairs team for such a successful event; • BG commented on the high level of consultant engagement in evidence at a recent Clinical Cabinet meeting (to which all members of the board had been invited recently); • GC reported on a good debate at the recent Joint Hospital Clinical Audit (JHCA) regarding the current clinical governance review; • JMT had attended a recent RCN meeting at which issues relating to oversees nurses had been highlighted which would increase current workforce risks. Discussions were also linked to the nursing revalidation process due for implementation next year; • GA had met with the CEO of Health Education Kent, Surrey, Sussex (HEKSS) and warned of a gap in community nursing which would impact on the trust's future strategy; • SJ reported on a cancer performance standards meeting which she had attended recently; • CS had now met with her counterpart at the Horder Centre to discuss collaborative opportunities such as joint procurement exercises. She had also attended a Vanguard 'models of care' session. The trust had applied for and been accepted on a Kings Fund pilot scheme involving finance and medical staff; • SF had attended the recent HSJ awards ceremony. Although not successful, the trust and one of its consultants, Rachel Liebermann, had been nominated for awards; • RT updated the board on a recent meeting of the Federation of Specialist Hospitals (FSH). He also asked it to note he had recent been appointed joint Chair of the Sussex Cancer board. Finally, he had met with the recently appointed CEO of Medway hospital and took the opportunity to visit the QVH spoke site. BH thanked the board for their updates, the contents of which were **NOTED**.
188-15	**Observations from members of the public** AH commended the board on a useful and comprehensive debate. CH suggested it would be helpful to provide a list of acronyms for those unfamiliar with NHS jargon. JEB queried figures relating to bank staff usage. JMT agreed to provide greater detail outside today's meeting.
189-15	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
190-15	**Observations and feedback on the meeting** In response to previous feedback about the board observation section, IP had indicated that he had experience of individual board members providing their own observations and feedback on the meeting. IP had been assigned to trial the new format this month. He noted that having members of the public in attendance had aided overall performance. Other observations included: • An improvement in content of reports; however IP echoed earlier comments relating to acronyms and asked the board to remain mindful when using these; • A good level of challenge during discussions, with an even balance between executive and non-executive directors; • The introduction of the new BAF should provide opportunities to reflect on the quality of the board agendas over time. BH concurred with his observations and thanked him for his input. There being no further business the public meeting was closed.

Chair …… Date ……

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
30 July 2015						
1.	**174-15**	August F & PC papers to be circulated to board, together with draft minutes as soon as available.	**CS**	Aug		**Pending**
2.	**175-15**	Investigation into how current 30% vacancy level within the Eyes & Sleep business unit might be impacting on business.	**GA**	Sept		**Pending**
3.	**175-15**	Workforce report to be further refined to include: • Separation of short and long term sickness data; • More context (eg trend graphs) relating to the use of bank and agency staff.	**GA**	Sept		**Pending**
4.	**180-15**	Additional detail regarding Lockdown exercise to be provided.	**JMT**	Sept	Confirmation that this is now scheduled for 18th October	**Pending**
5.	**192-15**	Implications of IT business case investment on capital planning and organizational sustainability to be scheduled for board discussion in Autumn 2015	**RT**	TBA	Awaiting exec team discussion to determine scheduling	**Pending**
25 June 2015						
6.	**152-15**	Review of NED statutory and mandatory training records to be undertaken to ensure compliance.	**KA**	TBA	**30 07 2015** Review complete and relevant NEDs are booked for necessary training updates. All NEDs will be fully compliant by 6 October.	**Ongoing**
7.	**155-15**	KSO report strapline to be updated to ensure consistency of trust vision throughout the organisation	**JMT**	Sept	**30 07 2015** Part of quality strategy to be completed by end of September	**Pending**
8.	**156-15**	Spokes governance review to be added to existing KSO2 action plan.	**SF**	July	**30 07 2015** Will be added	**Complete**
9.	**156-15**	Board to be provided with further information about the 'I want great care' data	**SF**	July	**30 07 2015** Link now circulated. However, it is not recommended that the trust should participate at this stage	**Complete**
10.	**157-15**	Frequency of future finance and performance committee meetings to be reviewed. Board to be apprised of recommendation in due course.	**CS**	July	**30 07 2015** Meetings will be held monthly until further notice	**Complete**
11.	**160-15**	Audit plan for 2015-16 to be circulated to board for information and assurance once agreed by the committee.	**CS**	Nov	**09 09 2015** On November board agenda	**Pending**
12.	**160-15**	Discussion on function of audit committee and assurance required by board to be scheduled into board work programme	**KA**	TBA	To follow on from board governance review	**Pending**
21 May 2015						
13.	**116-15**	Summary of 'never event' findings (as reported at May meeting) to be circulated to board	**SF**	~~June~~ Sept	**14 09 15** Circulated on 7 July 2015	**Complete**

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
14.	**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. **30 07 2015** KPMG have concurred this is a decision to be made by the trust. Further review will take place outside the board meeting.	**Complete**
15.	**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.	**KA**	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**
30 April 2015						
16.	**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.	**KA**	~~June~~ ~~July~~ ~~Sept~~ November	Director of HR leading finalisation of policy.	**On Nov agenda**
26 February 2015						
17.	**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~~ Sept	**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 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.	**On Sept agenda**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Agenda item reference no:	198-15
Author:	Richard Tyler, Chief Executive
Date of report:	16 September 2015

Chief Executive's report, September 2015

1. Attached is the September 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.

Queen Victoria Hospital NHS
NHS Foundation Trust

Chief Executive's report, September 2015

Trust issues

Quality: CQC inspection

As the Board is aware our CQC inspection is scheduled for 10 – 13 November 2015. The process is initiated with a data request know as a provider information request (PIR). Our PIR was submitted on 11 September. This involved a significant amount of work across the trust and I would like to thank formally Jo Thomas and her team for the considerable effort they put in to ensure that the data was submitted within the required deadline.

Financial performance

The year to date financial position is a surplus of £167k against a planned surplus of £379k. This continues to reflect lower levels of inpatient activity than planned alongside additional cost pressures. The baseline forecast indicates a potential shortfall of £310k against plan for the year. As highlighted in my July report the Director of Operations and Director of Finance have developed a revised delivery plan which outlines a number of actions in respect of both additional activity and reduced expenditure in order to ensure delivery of the planned annual surplus. This delivery plan will be discussed in detail at the September finance and performance committee which is scheduled to meet on 21 September and a verbal update will be provided at the Board meeting.

Burns services

As reported to the July Board meeting good progress is being made in developing a formal plan for the future of burns services in partnership with Brighton & Sussex University Hospitals (BSUH). A detailed project plan is being produced and it is intended that this is submitted to both Trust Boards in November for approval. As part of the development process we will be submitting the proposals to NHS England to obtain guidance on the required levels of public engagement. Their advice will inform the project plan that we intend to submit in November.

Vanguard bid

As reported to the board in July, we submitted a bid to the national vanguard programme. The bid was made in partnership with BSUH and focused 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.

I am pleased to report that we made it through to the final stages of the process which involved a formal presentation to all of those shortlisted. The presentation took place on 7 and 8 September. The outcome is expected around 20 September and I will update the Board as soon as the results are known.

Executive management team

EMT met on 17 August. Items discussed included; trust objectives 2015/16; outstanding audit reports; Board Assurance Framework; CQC inspection; F&P

papers, including the activity diagnostic; and a business case for additional investment to support the successful urology any qualified provider bid.

Clinical cabinet
Clinical Cabinet met on 17 August. Items discussed included month 3 performance, the activity diagnostic and the theatre productivity pilot.

Trust leadership forum
TLF has met twice since the last meeting of the board in July. Items discussed included; the CQC inspection; proposed management development programme; and statutory & mandatory training.

Accommodation moves
The Board will be aware that a decision was made not to renew the lease on the PKL building. Following protracted negotiations the company who owns the building served notice earlier than expected and the building is due to leave site on 27 October. In order to facilitate this we are moving staff earlier than planned. To this end the move will take place over the weekend of 19 & 20 September. Consultants will be provided with temporary offices on the ground floor of the Jubilee Centre building and the executive team will move into offices on the first floor.

External issues

Monitor: Q1 Submission
We had formal confirmation of our Q1 ratings: continuity of service rating 3 and governance rating green.

Monitor: changes in the relationship team
Following internal restructuring we have been informed that our relationship team has changed with Justin Collins being replaced as senior relationship manager by Al Glen.

Monitor: consultation on tariff objection process
Following the challenging 2015/16 tariff round Monitor are consulting on changes to the tariff objection process. The proposals include the removal of the objection threshold based on the providers' share of supply and a raising of the objective threshold level. The trust has responded formally disagreeing with both of these proposals.

Monitor: David Bennett letter of 3 August
Board members will recall that all foundation trusts were written to asking what improvement, if any, they felt able to forecast in their year-end position. Board members were copied into my reply which emphasized the challenges inherent in achieving our existing forecast. Monitor is currently reviewing all responses and will be contacting trusts in due course with the outcome.

Richard Tyler
September 2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Reference number:	200-15
Report from:	Director of Nursing and Quality
Author:	Director of Nursing and Quality
Report date:	15 September 2015
Appendices:	Reports on: 1: Safe Staffing 2: Patient experience, complaints & claims

Patients: safe staffing and quality of care

Key issues

1. This report provides information on:
   - Safe staffing and whether safe staffing levels are being achieved as per national 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).
   - The trust continues to prepare for the CQC inspection whilst maintaining the focus on high standards of care and effective operational delivery of services.

Safe staffing

2. Safe staffing levels were achieved throughout July and August.
3. Still high vacancy factor of 15% on Canadian wing though recruitment of staff has taken place with 2.6 WTE starting in October.
4. Decrease in temporary staffing usage reflects reduced patient numbers in burns services.

Quality and risk management

5. There was one moderate patient safety incident in August and a reduction in minor harm incidents during August.
6. Two grade 2 QVH acquired pressure ulcers developed in August; following review these were judged as unavoidable.
7. No significant changes in falls during July and August, all were graded as minor or no harm to patient.
8. No serious incidents in July or August.
9. Quality metrics that have not achieved their target have been addressed with the relevant staff groups.

Infection control

10. There was one case of hospital acquired MSSA bacteraemia during July and one non hospital acquired case during August (no national threshold for MSSA cases).
11. Cleaning standards have not sustained improvements, risk assessments have been undertaken including a review of standards against national guidance. Escalation have

taken place and an action plan with competencies for housekeeping team has been agreed between the Infection Control Team and the Hotel Services Manger

Complaints, claims and patient experience

12. There was one new complaint opened in August graded as moderate which is currently under investigation.
13. Five complaints were closed, one of which resulted in change of protocol for assessment of foreign bodies.
14. No new claims were opened or closed in August.
15. The average FFT percentage for patients extremely likely/likely to recommend was 99.9%.

Implications of results reported

16. The trust continues to use additional agency and bank staff to cover vacancies and long term absence; however, this is not above the 5% target for temporary staff.
17. There remain some budget discrepancies for burns and Canadian wing, which the matrons are working with the finance team to understand fully and address.

Action required

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

Link to key strategic objectives

20. The issues raised can potentially adversely affect all of the trusts KSOs; however, many also support the KSOs 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)

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

Regulatory impacts

22. No new changes

Recommendation

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

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

Introduction

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

Safe Staffing

During July and August there were 23 occasions when the actual staffing level did not meet the planned level.

Ward	Actual staffing level was less than planned level			
	July		August	
	Day	Night	Day	Night
Margaret Duncan	0	0	1	2
Ross Tilley	2	0	0	0
Peanut	7	2	0	0
Burns	7	1	1	0
ITU				

- The ward teams reported no unsafe care or omissions due to the workforce deficit. This was information was triangulated with Datix reports to review what was recorded on the incident form and what impact this had on patients and staff. From this review no evidence of unsafe care was found. Complaints data was also reviewed with no evidence of staffing levels being a source of complaint. Falls data was also triangulated with the workforce data and there was no correlation between the reduced staffing levels and the occurrence of falls during these shifts.

- Nursing workforce data is presented in the Director of HR workforce report as part of the Nursing and Clinical Infrastructure report. From October 2015 the nursing and health care assistant data will be presented as part of this safe staffing report

- All ward areas achieved safe staffing levels in July and August; the revised safe staffing charts are included in this report in Appendix 1

CQUIN

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%	93%	75%								89.0%
	Dementia >75 having diagnostic assessment	95%	90%	100%	100%	100%	100%	100%								100.0%
	Dementia >75 referred for further diagnostic advice	100%	90%	100%	100%	100%	100%	100%								100.0%
	Dementia training for staff	87%	65%	92%	94%	93%	86%	84%								89.8%
	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			

Patient Experience

- There were seven complaints opened in July and five closed. Four of these were partially or fully upheld one was not. As a result of one of the upheld complaints there has been a change in protocol for the assessment of foreign bodies. There was one complaint opened in August 2015.

- There were no new claims opened or closed in August.

- The FFT score for patients recommending us in August was 99.9%. 213 inpatients out of a possible 568 inpatients completed the questionnaire; the response rate of 37.5 % is a decrease from July's return of 73.8 %. This was due to a low return from paediatrics which represented a significant proportion of the percentage score in July. The patient experience manager has met with paediatric ward manager to feedback this information and offer support to assist with sustaining the children and parents completing the questionnaire.

- The FFT score for out-patients recommending us in August was 94%. 2356 outpatients out of a possible 11798 completed the questionnaire by paper, SMS or integrated voice message. The response rate is 20 % showing a steady increase in outpatient participation in FFT.

- The August patient experience report is included as appendix 2.

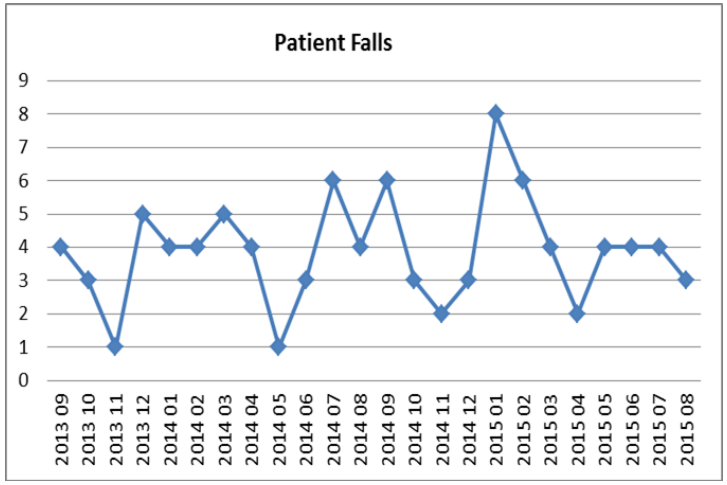
Patient Safety

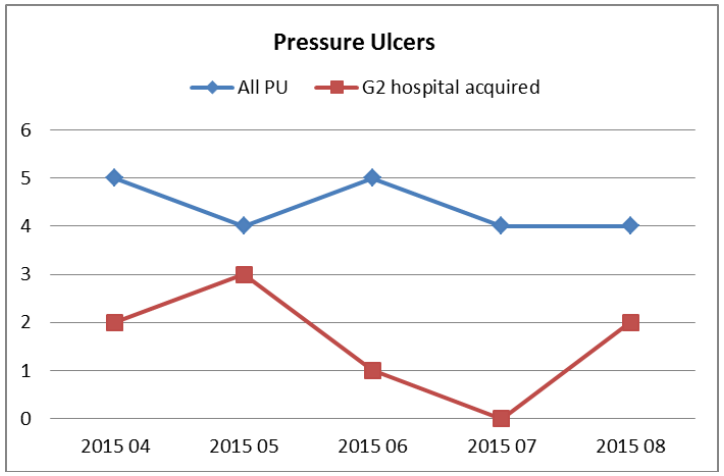
	January	February	March	April	May	June	July	August
Total number of incidents	134	101	112	98	149	134	134	131
Total patient safety incidents	81	55	70	64	97	84	72	73
Patient safety: near miss / no harm	67	47	60	58	87	71	57	67
Patient safety: minor harm	14	8	10	6	7	11	14	5
Patient safety: moderate or above	0	0	0	0	3	2	0	1

- All incidents logged on Datix are reviewed by risk management team incidents graded as no harm or minor are then allocated to the line manager for investigation and the risk management team review with the investigator and actions are identified and monitored. Incidents logged as moderate or above are also reviewed by risk management team and an appropriate investigator identified which may not be the line manager. There was one moderate incident in August regarding a cancelled procedure due to an estates and facilities issue, RCA in progress.

- There were no SIs declared in July and no SIs declared in August.

- There were 4 falls in July all graded as minor or no harm to the patient, review of Datix and staffing levels showed no correlation between shifts where actual staff was less than planned staff and a patient falling. There were 3 falls in August all graded as minor or no harm, review of Datix and staffing levels showed no correlation between shifts where actual staff was less than planned staff and a patient falling.





- The PU graph shows the number of reportable hospital acquired PU at grade 2 or above against a total of all non-hospital and hospital acquired PU.

- There were no hospital acquired grade 2 or above PU during July. There were two grade 2 or above hospital acquired pressure ulcers in August. An RCA has been completed and the outcome was that these were unavoidable (both occurred on same patient).

- Currently investigating the decrease in elective consent for maxillofacial services.

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	Y	Y								
		Harm free care rate (NATIONAL) - one month delay	NEW		93.8%	94%	94.1%	94.1%	94.1%								94.0%
		Harm free care rate (QVH)	97%	>95%	97%	95%	94%	95%	100%								96%
		New harm free care rate (acquired at QVH)	99%	>95%	97%	97%	94%	97%	100%								97.2%
		VTE initial assessment (Safety Thermometer)	100%	>95%	100%	100%	100%	97%	97%								98.9%
		Patient Falls assessment completed within 24 hrs of admission	90%	>95%	100%	97%	88%	92%	67%								88.6%
		% of completed nutritional screening assessments (MUST) within 24 hours of admission	99%	>95%	100%	100%	100%	100%	100%								100.0%
		% of patients who have had a (MUST) reassessment after 7 days	92%	>95%	86%	100%	86%	100%	56%								85.5%
		Patient Falls resulting in no or low harm	49	—	2	4	4	4	3								3.4
		Patient Falls resulting in moderate or severe harm or death	1	—	0	0	0	0	0								0
		Number of Pressure ulcer development Grade 2 or over acquired at QVH	11		2	2	1	0	2								7
		Serious Incidents	10		0	1	1	0	0								2
		Never Events	2		0	0	0	0	0								0
		Total number of incidents involving drug / prescribing errors	210		19	21	15	9	11								75
		No & Low harm incidents involving drug / prescribing errors	209		19	21	15	9	11								75
		Moderate, Severe or Fatal incidents involving drug / prescribing errors	1		0	0	0	0	0								0
		Medication administration errors per 1000 spells	2.2		4.9	3.9	1.1	0.6	1								2.4
	Consent	To take consent for elective surgery prior to the day of surgery (Total)	74%	75%	67.1%	72.4%	79.6%	79.0%	78.7%								75.4%
		To take consent for elective surgery prior to the day of surgery (Max Fax)	70%		73.9%	87.1%	83.3%	77.8%	62.5%								76.9%
		To take consent for elective surgery prior to the day of surgery (Plastics)	72%		61.5%	66.7%	78.8%	79.3%	75.6%								72.4%
		To take consent for elective surgery prior to the day of surgery (Corneo)	84%		83.3%	80.0%	78.6%	79.3%	100%								84.2%
		Number of outstanding CAS alerts	2		0	0	0	0	0								0
		Number of reported incidents relating to fraud, bribery and corruption	1		0	0	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%	99%	100%								99%

Infection Control

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	0								0
	Clostridium Difficile acquired at QVH post 72 hours after admission	1	0	0	0	0	0	0								0
	E-coli bacteraemia	0	0	0	0	0	0	0								0
	MSSA bacteraemia	1	0	0	0	3	1	1								5
	MRSA screening - elective	96%	>95%	99%	98%	98%	99%	98%								98%
	MRSA screening - trauma	97%	>95%	97%	96%	97%	96%	96%								96%
	Trust hand hygiene compliance	98%	>95%	99%	99%	99%	100%	99%								99%

- There was one case of hospital acquired MSSA bacteraemia during July and one non hospital acquired case during August (no national threshold for MSSA cases). RCAs completed on both the July case was judged unavoidable and the August case was judged as unknown.

- Cleaning standards have not sustained improvements. Infection Control Lead has reviewed the cleaning schedules against NPSA cleaning standards and British Standards Institution (BSI) and undertaken risk assessments throughout the site to refresh and clarify the cleaning standards requirements for clinical and non-clinical areas at QVH. The Hotel services manager is working with the IC team to implements the review and introduce competencies for domestic staff which will be requires at the start of employment and an annual check as part of appraisal.

Care Quality Commission (CQC)

- CQC Inspection of QVH confirmed as 10 - 13 November 2015.

- The project manager for the CQC inspection preparation commenced the week before the mock inspection on the 18 August. The inspection consisted of PWC, clinicians from other trust and a range of staff from QVH. Three teams visited the majority of our clinical areas speaking to staff, reviewing documentation, observation of care. There were also two staff focus groups and board interviews. The findings were in line with the pre assessment work already undertaken. The findings have been shared widely within the trust and individual feedback with areas for focus within teams and departments is currently in progress.

- Feedback from PWC regarding the mock CQC inspection will be presented at the September board seminar.

- The trust has submitted all the required second stage documents by the 11 September 2015 deadline.

Appendix 1

SAFE STAFFING DATA September Board Report

Please not the statutory and mandatory training figures and appraisals relate to ward managers records and not QVH staff development centre figures.

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	9.84	9.84								7.5%	18%				2.6 WTE Band 5 Staff recruited, start dates October 2015 - outstanding posts readvertised.
Est = (hrs)	1680	1673	1550	1599	1599													
Temp staffing Bank	680.8	662	613	651	495								10%	-12%				Agency decreased due to reduced inpatient activity in August. Ward managers actively ensuring safe staffing achieved with minimal agency use.
exc RMN Agency	508	527	621	476	294								235.8+ vac					
Sickness %	6.1%	1.7%	2.5%	3.8%	2.6%								2%					This figure is based on the CW Establishment of 62.98 WTE.
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	74.5%	93.5%	100%	100%	100%								85%	-19%				Improved from 93.5% in May
Statutory & Mandatory%	77.6%	68.1%	86%	88%	83.2%								85%	-7%				Figures taken from SDC central records
Drug Assessments %	100%	100%	100%	100%	100%								95%					
Staff FFT Score %	_	_	_	_	_								_					
Budget (YTD)	6866	2607	24950	38816	52234								<0					Corneo ward agency spend coming from CW budget, finance aware, data provided awaiting clarification
Margaret Duncombe																	Trend	Improvement Plan/Actions
Shift meets est % RN	99%	100%	101%	100.8%	98.4%								95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day HCA	98%	102%	100%	100%	96.8%								95%					
Shift meets est % RN	97%	99.1%	100%	99.1%	97.9%								95%					
Night HCA	95%	100%	97%	100%	90.9%								95%					
Ross Tilley																	Trend	Improvement Plan/Actions
Shift meets est % RN	99%	98.2%	98.2%	98.3%	97.0%								95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day HCA	103%	100%	102%	98.8%	97.3%								95%					
Shift meets est % RN	99%	97.6%	100%	96.4%	96.2%								95%					
Night HCA	100%	90.6%	100%	89.7%	96.7%								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	0								0					
Falls	0	1	0	0	1								0					1 patient fall, no harm, all required action taken
Medication Errors	8	8	7	1	4								0					monitoring impact of pharmacy sessions
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0								0 / 0					
Incidents Reported (Datix)	14	19	20	6	10													
VTE reassessment %	100%	100%	85.7%	91.7%	100%								95%					Recording down due to bank ward clerks, need further training
Nutrition MUST assessment	100%	100%	100%	100%	100%								95%					100% compliance
7 day review	100%	100%	100%	100%	100%													
Patient numbers	146	143	160	163	138								N/A					Reduction in inpatient activity due to holiday period
Patient FFT Score %	97%	99%	100%	99%	100%								95%					Improvement in month
Ross Tilley																		
Pressure Ulcers	1	0	0	0	0								0					
Falls	1	1	1	3	1								0					Patient falls due to mobility issues, all actions taken
Medication Errors	8	8	4	2	2								0					Pharmacy teaching sessions on medication continue as rolling
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0								0 / 0					No MRSA in 2014/15 no CDI since October 2014
Incidents Reported (Datix)	9	16	6	10	7													
VTE reassessment %	100%	100%	71.4%	90.9%	83.3%								95%					Working with CW to improve the recording on PAS out of hours
Nutrition MUST assessment	100%	100%	100%	100%	100%								95%					100% compliance since December 2014
7 day review	100%	100%	100%	100%	66.7%													Matron working with Head of risk to identify is figures are correct
Patient numbers	170	175	210	195	188								N/A					Activity slightly reduced due to holiday period
Patient FFT Score %	98%	100%	100%	97%	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	0								0					No grade 2 PU since August 2014
Falls	0	2	0	0	0								0					
Medication Errors	1	0	0	2	2								0					ward manager reviewing incidents
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0								0 / 0					
Incidents Reported (Datix)	2	7	3	7	4													incidents discussed at burns managemnt meeting for learning
VTE reassessment %	100%	66.7%	100%	100%	100%								95%					improvement noted
Nutrition MUST assessment	100%	100%	100%	100%	100%								95%					
7 day review	50%	100%	N/A	100%	50%													1 patient did not have reassessemnt on time
Patient numbers	21	25	23	10	43								N/A					ward manager is addressing this with band 6 nurses - clarity re expectations
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	2.07	3	3	3	4.36								7.5%	6.8%				vacancies x2 offered, remaining in recruitment process
Est = (hrs)	337.30	450	450	450	708.5													
Temp staffing Bank	464.15	95	168	138.5	137.5								10%	62.5%				increase use of agency to cover short term sick leave
exc RMN Agency	84	208.5	60	264	200.25													
Sickness %	NA	1.7%	2.7%	5.9%	4%								2%					Increase in short term sickness plus x2 long term sickness (both being managed
Shift meets est % RN	98%	96.6%	98.8%	96.6%	98.8%								95%					
Day HCA	94%	96.9%	90%	87.1%	96.3%								95%					
Shift meets est % RN	98%	100%	100%	95.7%	101.6%								95%					
Night HCA	100%	100%	100%	100%	100%								95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	64.5%	100%	97%	100%	80.5%								85%	-20%				appraisals booked, expect compliance rate increase for Sept
Statutory & Mandatory%	83.9%	84%	87%	78%	76.5%								85%	-1%				target of 100% complaince by end of September 2015
Drug Assessments %	100%	100%	100%	100%	100%								95%					
Patient FFT Score %	100%	100%	100%	100%	100%								95%					not yet avaialbe
Staff FFT Score %	_	_	_	_	_								_					
Budget (YTD)	72094	90508	84296	132972.4	172048.45								>0					overspend split equally pay/non-pay. Actively recruiting to reduce agency spend

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	2								0					1 grade 2 pu - RCA deemed unavoidable
Falls	0	0	0	0	0								0					
Medication Errors	2	4	1	0	0								0					Improved position
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0								0 / 0					
Incidents Reported (Datix)	8	5	7	8	7													Inident reviewed at burns meeting
VTE reassessment %	100%	100%	100%	66.7%	100%								95%					
Nutrition MUST assessment	100%	100%	100%	100%	100%								95%					
7 day review	100%	100%	66.7%	N/A	33.3%													The % decrease relates to 1 patient
Patient numbers	15	20	19	14	11								N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	0	6.6	5.6	7	6.7								7.5%					5 wte posts offered to candidates
Est = (hrs)	0	984	910	1137.5	1095													
Temp staffing Bank	191	28.5	120	264	31.5								10%					reduction in bank use reflects reduced patient bed days
exc RMN Agency	504	709	592.5	131.7	264													
Sickness %	N/A	5.7%	6.3%	3.3%	1.8%								2%					all short term sickness
Shift meets est % RN	98%	100%	100%	96.1%	93.7%								95%					Achieved on or above standard since November 2014
Day HCA	100%	100%	100%	100%	100%								95%					
Shift meets est % RN	103%	100%	100%	88.3%	93.0%								95%					Achieved on or above standard since January 2015
Night HCA	100%	100%	100%	100%	100%								95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	66.7%	95%	95%	92%	96%								85%	-18%				Significantl improvement from April
Statutory & Mandatory%	71.9%	84%	86%	78.3%	76.4%								85%	-13%				target of 100% complaince by end of September
Drug Assessments %	87%	77%	88%	88%	100%								95%					improvement in assessments this month
Patient FFT Score %	_	_	_	_	_								95%					
Staff FFT Score %	_	_	_	_	_								_					
Budget (YTD)	159	2378	6357	21828.92	24823.09								>0					slightly worse 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	0								0					No PU during 2014/15
Falls	0	0	0	0	0								0					No falls during 2014/15
Medication Errors	0	0	1	2	0								0					matron reviewed incidents
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0								0 / 0					No MRSA/CDI during 2014/15
Incidents Reported (Datix)	2	1	3	2	2													
Patient numbers	N/A	206	187	212	199								N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	1.75	3	2	1.32	2								7.5%	7.0%				
Est = (hrs)	285.16	450	325	214.5	325													
Temp staffing Bank	240.45	119.5	116.9	224.1	107.3								10%	*9%				
exc RMN Agency	71.3	54.75	63.75	90.7	50.75													
Sickness %	N/A	5.5%	1.7%	4.4%	4.5%								2%	0%				long term sickness resumed, being formally managed
Shift meets est % RN	98%	96.2%	100%	90.6%	100%								95%					Decrease in HCA cover on day shift, covering ward clerk leave
Day HCA	92%	100%	97%	100%	97.1%								95%					
Shift meets est % RN	97%	98.4%	98%	93.5%	98.3%								95%					Improved trained night nurse cover
Night HCA	100%	100%	100%	100%	200%								95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	80%	98%	98%	97%	84%								85%	-5%				
Statutory & Mandatory%	82%	93.5%	92%	80.9%	76.4%								85%	-3%				data cleansing in month, target of 100%
Drug Assessments %	100%	90%	100%	100%	100%								95%					
Patient FFT Score %	100%	100%	100%	100%	97%								95%					matrom investigating this result
Staff FFT Score %	_	_	_	_	_								_					
Budget (K)	1,663	9,440	5,937	1	2,891								>0					

Key for safe staffing data sheets

RAG Thresholds:	Red	Amber	Green
Pressure Ulcers	≥ 1	N/A	0
Falls	≥ 1 Fall - harm	≥ 1 Fall - no harm	0
Medication Errors	≥ 1	N/A	0
MRSA / C. diff	≥ 1	N/A	0
Incidents Reported (Datix)	TBC		
VTE reassessment (%)	< 95%	N/A	≥ 95%
Nutrition MUST assessment	< 95%	N/A	≥ 95%
7 day review	< 95%	N/A	≥ 95%
Patient numbers	N/A	N/A	N/A
Vacancies WTE Est = 62.88 (hrs)	TBC		
Temp staffing Bank	TBC		
exc RMN Agency	TBC		
Sickness (%)	> 2.5%	2.01% - 2.5%	≤ 2.0%
Shift meets est (%) RN	< 95%	N/A	≥ 95%
Day HCA	< 95%	N/A	≥ 95%
Shift meets est (%) RN	< 95%	N/A	≥ 95%
Night HCA	< 95%	N/A	≥ 95%
MAST Compliance (%)	< 80%	80% - 84.9%	≥ 85%
Appraisals (%)	< 80%	80% - 84.9%	≥ 85%
Drug Assessments (%)	< 90%	90% - 94.9%	≥ 95%
Patient FFT Score (%)	< 93%	93% - 94.9%	≥ 95%
Staff FFT Score (%)	TBC		
Budget (K)	TBC		

Appendix 2 Patient Experience Report

Monthly complaints, claims and patient experience report

1 August 2015 – 31 August 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 August 2015 – 31 August 2015

Complaints

Performance Indicators	July	August
Number of new formal complaints received in the month	7	1
Number of complaints resolved within agreed timeframe for response	4 (58%)	TBA
Number of complaints referred to the PHSO for 2nd stage review	0	0
Number of complaints re-opened	0	0

Please note that during the above period the Patient Experience Manager was on leave for 3 weeks.

Open complaints: There was only 1 complaint 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.

The number of complaints that have been received year to date is 21.

Diagnostics

1. **Radiology - Radiographer – Imaging** – Patient attended for an x-ray on 22/06/15 to ascertain whether foot was broken. No break on imaging was reported. Patient continued to experience pain and underwent a private MRI scan on 17/08/15 which showed that ankle was broken and as a result has tendovitus. **Investigating lead – Consultant and Clinical Director**

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

   Comment/Action – Still undergoing investigation. Copy of private MRI has been requested for comparison.

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.

MIU/Plastic Surgery

1. **MIU - Medical – clinical care -** Patient sustained a splinter injury to thumb on 9 April. Seen in MIU that day and returned on 11 April for removal of splinter. Seen again on 13, 17, 24 April where patient raised concerns that still felt that there was a foreign body still in situ. Was then seen on 8 May 2015 and again on 20 & 21 May. There was a delay in the full removal of the splinter which occurred on 22 May 2015. Patient upset by delay. Staff had been informed on several occasions that there was something in the thumb; patient feels that they were ignored. **Investigating lead – Clinical Director**

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

Comment/Action – Sincere apologies offered to patient. As a result of this complaint there has been a change in protocol. Where appropriate all images looking for a foreign body should be done by ultrasound and not x-ray. **Outcome – upheld**

Plastic Surgery

2. **Inpatient – Admin/secretarial – cancelled surgery -** Cancellation of breast surgery due to clinician being on trauma rota. This was not noticed by covering secretary and patient had made arrangements to be looked after during her recuperation. Patient would like a new date ASAP and also an explanation as to why this occurred.

Comment/Action - Patient was placed on list of another breast surgery and surgery undertaken on 4/08/15. Patient very happy with outcome. **Outcome - upheld**

Maxillofacial (off-site clinic at Medway)

3. **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'. **Investigating lead – Consultant and Clinical Director**

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

Comment/Action – Apology given if clinician appeared rude as this was not their intention. The patient had 26 teeth removed and wished to have dentures immediately placed in mouth. It was explained that due to the swelling this would not be and it is understood that patient was unhappy with this. The patient is still experiencing problems and a further appointment has been offered for a further review. **Outcome – upheld in part (communication with patient).**

Corneo Plastics

4. **Outpatient – Medical – clinical care –** Patient underwent eyelid surgery and since this patients vision has deteriorated. Patient would like to know whether this is connected to surgery.

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

Comment/Action – The patient's current condition is not in any way linked to the eyelid surgery that was performed. Since making complaint patient has met with consultant. **Outcome – unsupported**.

Maxillofacial

5. **Outpatient - Medical – communication –** Patient raised concerns about the cancellation of operation 6 days prior due to emergency. I**nvestigating lead – Consultant, Clinical Director**

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

   Comment/Action – Patient's surgery was cancelled due to a cancer patient taking priority. This was explained to the patient at a recent consultation and outlined within the response. The patient was changed to another surgeon's list so that there was no further delay to her surgery. Due to the lack of confidence in the hospitals systems the patient's care has been transferred to a specialist at UCH. **Outcome – upheld in part (communication issues/delivery of information).**

There have been no complaints referred to the Parliamentary and Health Service Ombudsman this month.

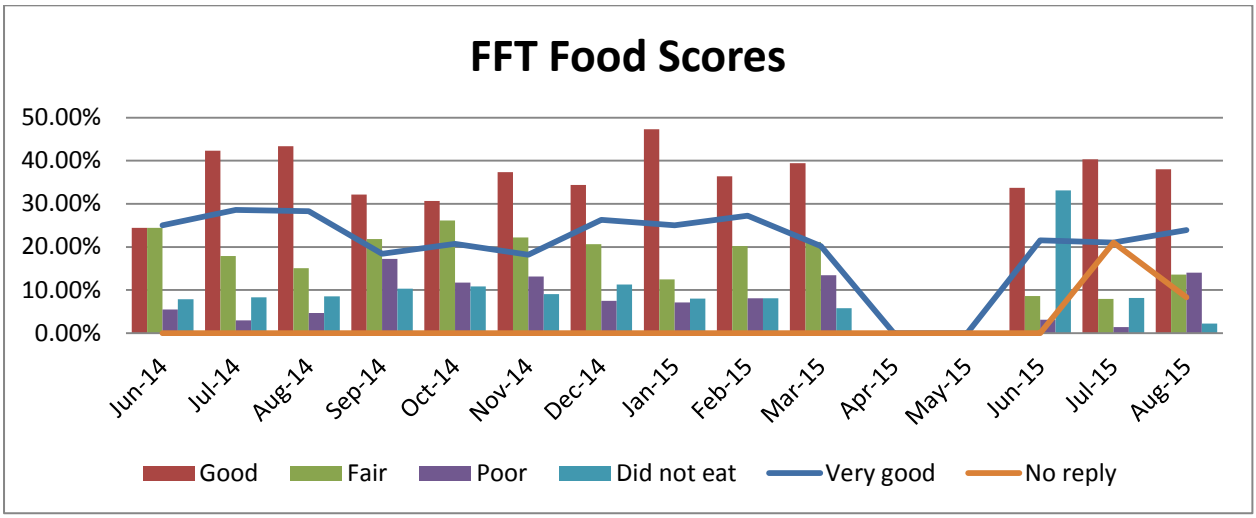
Claims

There were no claims either opened or closed during this period. Overall there are 54 claims.

Patient Experience – Food

Key issues to come out the recent meeting of the 'Food Group'.

- The winter menus are in place and are to be finalised on 07/09/2015.
- The new menu booklet is now in final draft.
- The senior catering staff are to show the nursing staff how to monitor temperature of food at the start and end of serving the inpatient meals. This will provide assurance that meals maintain their temperature throughout the entire process.
- The nursing staff are to ensure that the stainless steel lids remain on food at all times to ensure temperature of food is maintained.
- Senior chef has recently visited a neighbouring Trust to look at how they supply food, etc. Our aim is to increase the standard of patient and retail catering to the highest possible standard. Measure the catering, not just a snapshot but how can we look at benchmarking the process.
- PLACE - food scored slightly below average, but we are looking to improve this. The senior chef now sourcing local produce and now has full control of the staffing, ordering, etc. this should greatly improve the whole service as a package. This will be closely monitored to ensure continuous improvement.
- We now need to demonstrate in an objective way where we are now with the quality of food provided, plate needs to be consistent.
- It was agreed that salt and pepper sachets would be added to each patient's meal tray. This will allow patients to make their own choices whether to add this to their meal or not, increasing individual wishes, improving expectations of taste, etc.



Friends and Family Test

The Trust wide FFT scores for in-patients in August was **99.9%** of our patients would recommend us. 213 inpatients out of a possible **568** inpatients completed the questionnaire. This is a very disappointing **response rate of 37.5%** compared to **last month which was 73.8%.** We had a low return rate from paediatrics this month which made up a large part of the good return rate for the previous month. The Patient Experience Manager will be working with the ward manager to ensure that staff hand out the questionnaires to all patients on a regular basis.

The FFT score for out-patients in August was **94%** of patients would recommend us. 2356 outpatients out of a possible 11798 completed the questionnaire either by paper, SMS or integrated voice message. The response rate has therefore greatly improved from 16% to **20%** this month.

The following are the top 10 words used by patients (and the number of times) in the past week following completion of the Friends and Family surveys. This information provides the Trust with real time patient feedback analysis, both positive and negative.

Positive		**Negative**	
Care	1165	Time	51
Received	1025	Waiting	1348
Staff	724	Communication	16
Friendly	326	Care	15
Time	242	Received	15
Helpful	212	Appointment	14
Attitude	208	Hours	12
Waiting	168	Staff	11
Communication	161	Seen	9
Efficient	140	Attitude	9

Examples of real-time comments using the word ‘waiting’. The number 5 represents a score of ‘extremely unlikely’. The Patient Experience Manager reviews the comments on a daily basis and is able to send these through to the relevant areas either for review, comment or implement changes, where appropriate.

24/08/2015 14:30:00	OP|PLASTIC SURGERY|JWB QV	**5**	The Receptionist refused to book me in and pointed to a machine on the wall which I used. I waited in the waiting room for 2 hours after which I returned to reception and was informed that I was not booked in and that I had not used the machine or if I had not used the machine correctly. I missed an appointment at the doctors. What is the point of a receptionist who cannot or will not book in patients? I admit I probably made an error or the machine malfunctioned. Whatever the blame was firmly and loudly put at my door. Not a pleasant afternoon was made even less pleasant.
12/08/2015 09:00:00	OP|CORNEO-PLASTIC|CORNEAL	**5**	In and out different rooms every 5minutes and nowhere to park a pushchair in waiting room
19/08/2015 10:10:00	OP|PLASTIC SURGERY|HTRAUMA	**5**	I was waiting for 4 hours in pair to have my finger stitched back on in that time I received a parking ticket.

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	83	138	60.1%	100%	0%
RT ward	84	188	44.7%	100%	0%
Peanut ward	35	199	17.6%	97%	0%
Burns ward	11	43	25.6%	100%	0%
Sleep centre	74	133	55.6%	93%	3%
MIU	142	969	14.7%	96%	4%
Trauma	571	131	22.9%	98%	0%
OPD	2356	11798	20%	94%	2%
DSU	66	630	10.5%	100%	0%

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

Trust	Total Responses	Total Eligible	Response Rate	Percentage recommended	Percentage Not recommended
Queen Victoria Hospital NHS Foundation Trust	428	580	73.8%	98%	0%
Moorfields Eye Hospital NHS Foundation Trust	1362	2812	48.4%	99%	0%
Papworth Hospital NHS Foundation Trust	763	1080	70.6%	97%	1%
The Royal Marsden NHS Foundation Trust	468	4566	10.2%	95%	1%
Royal National Orthopaedic Hospital NHS Trust	571	917	62.3%	97%	2%
Stoke Mandeville Hospital	463	4004	11.6%	92%	4%

Report to:	Board of Directors
Meeting date:	24 September 2015
Reference number:	202-15
Report from:	Sharon Jones, Director of Operations
Author:	Sharon Jones, Director of Operations
Appendices:	A: Commerce Performance B: Datasheet
Report date:	14 September 2015

Operational performance: Targets, delivery and key performance indicators

CQC Domains – Responsiveness to People's Needs & Effectiveness

Key performance indicators

At the time of writing not all performance information was available and so verbal updates will be given at the meeting. Key points are as follows:

1. In patient elective activity remains under plan. There is a separate paper regarding this on the agenda.
2. The trust continues to forecast compliance at an aggregate level for two of the 18 week targets for the month of August. As highlighted at the last meeting, there was a concern that the August and September positions may show underperformance for the admitted and non-admitted pathways. Currently, due to actions taken over the last four weeks, it is only the non-admitted pathway that is under the target at 93.66%. Validation is still underway and this may change the position. The final submission date is 16 September 16.
3. There were no breaches of 52 weeks for this period.
4. Cancer targets were met with the exception of the "consultant upgrade" where one of the two patients on that pathway experienced delay. This is a locally target agreed with commissioners.
5. There were no urgent operations cancelled for a second time during this period.
6. There were 12 operations cancelled on the day of admission in August. One was a 28 day breach due to patient choice. The patient was offered three separate dates with sufficient notice and variation within the 28 day period and with notice but wished to come in on later date.
7. The trust's minor injuries unit (MIU) performance was not available at the time of writing.
8. The trust's diagnostics performance was not available at the time of writing but is on track to achieve 99%.

Actions being taken to sustain compliance

Activity

9. Please see separate paper.

18 weeks

10. Key actions in place:

- Extra clinics are being held to reduce waiting times at off sites particularly for oral surgery.
- Work is ongoing with the clinical lead for hands to identify additional capacity for hands and this will be implemented in August / September.
- Work is continuing to focus on reducing long waiters across the 18 RTT pathways.

Cancer

11. 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 with late referrals from off sites are a recurrent issue. This has been raised with the relevant commissioners.

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

12. The performance in month contributes to the financial sustainability objective.
13. 18 RTT and access are an important reflection of QVH's responsiveness to people's needs and effectiveness.

Implications for the Board Assurance Framework (BAF) or Corporate Risk Register (CRR)

14. Risks associated with this paper are already included within the CRR.

Regulatory impacts

15. 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

16. The board is recommended to **NOTE** the contents of the report.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 24 September 2015
Reference number: 203-15
Report from: Clare Stafford, Director of Finance and Performance
Author: Jason McIntyre, Deputy Director of Finance
Report date: 11 September 2015
Appendices: A: Financial Performance Report August 2015

Finance report: month 5 - August 2015

Key issues

1. The report details the trust's financial performance for the five months to 31 August 2015.

	Actual In Month £k	Plan In Month £k	Variance In Month £k	Actual YTD £k	Plan YTD £k	Variance YTD £k
Turnover	5,055	5,131	(76)	26,063	26,158	(85)
EBITDA	227	273	(46)	1,792	2,023	(231)
Surplus	(83)	(56)	(27)	167	376	(209)
Financial Sustainability Risk rating (FSRR)				3	4	(1)

NB table subject to rounding differences.

2. The trust delivered an actual deficit of £(83)k for the month, £27k lower than planned. The cumulative surplus now stands at £167k being £209k behind plan.

3. The trust has a Monitor financial sustainability risk rating (FSRR) of 3. This is reduced from 4 as reported in the previous month due to continued deterioration in the position and failing to achieve a 1% surplus.

Implications of results reported

4. The trust must maintain and continue to improve the throughput of activity to meet the income plan and ensure full delivery of its cost improvement (CIP) programme in order to achieve the planned surplus.

Action required

5. The activity delivery plan needs to be implemented and monitored to recover the forecast shortfall and deliver plan.
6. The trust has developed a more robust approach to planning and delivery that includes a sustainability and productivity group with monitoring through the performance review framework.

Link to key strategic objectives (KSOs)

- Operational excellence
- Financial sustainability

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

Regularity impact

8. The financial performance has reduced to a Monitor financial sustainability risk rating (FSRR) of 3. However this does not have a negative impact on our governance rating.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Finance Report
August 2015

Executive Director: Clare Stafford

Contents

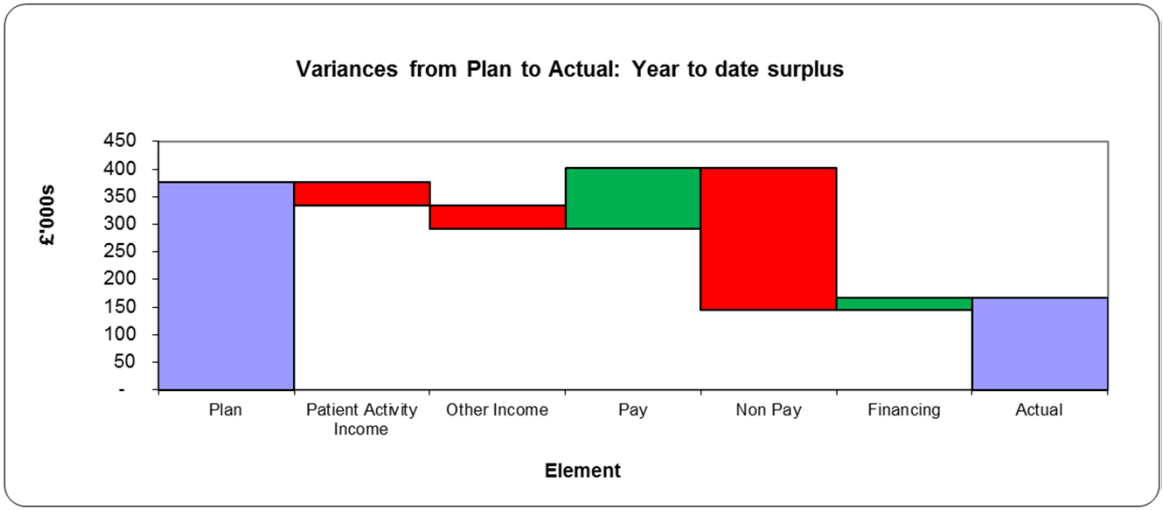
Queen Victoria Hospital
NHS Foundation Trust

Summary Actual Position – YTD M05 2015/16

Queen Victoria Hospital NHS Foundation Trust

Financial Performance	2015-16	August 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	4,720	4,770	(50)	24,415	24,458	(43)
Other Income	4,346	335	361	(26)	1,658	1,700	(42)
Pay	(40,994)	(3,443)	(3,436)	(7)	(16,951)	(17,061)	111
Non Pay	(16,987)	(1,384)	(1,422)	37	(7,329)	(7,073)	(257)
Operational EBITDA	**4,970**	**227**	**273**	**(46)**	**1,792**	**2,023**	**(231)**
as a %	*7.9*	*4.5*	*5.3*	*-0.8*	*6.9*	*7.7*	*-0.9*
Financing & Donations	(3,953)	(310)	(329)	19	(1,625)	(1,647)	22
Current Year Surplus / (Deficit)	**1,017**	**(83)**	**(56)**	**(27)**	**167**	**376**	**(209)**
Surplus (Deficit) %	1.6%	-1.6%	-1.1%	-0.5%	0.6%	1.4%	-0.80%

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



Summary

- The Month 5 position is a deficit of £(83)k; £27k behind the plan for the month. The year to date position is a surplus of £167k against a planned surplus of £379k; £209k worse than plan.
- In month 5 Patient Income under performed by £50k. Pay vacancies were offset by additional costs of interim cover. Non Pay reflects some reduction in the pressure on clinical supplies and a reduction of sleep device costs which is offset by reduced income.
- The key variance to the YTD plan is a shortfall of inpatient income which has been offset non-recurrently by over recovery against critical care income. There have also been significant pressures within expenditure largely within non pay expenditure, some non-recurrent, which have been partially offset by underspends on pay expenditure due to vacancies not being filled.
- The new format financial sustainability risk rating is 3 due to being behind plan and not achieving a 1% surplus. See Appendices

Issues

- The baseline forecast indicates a potential shortfall of £310k against plan for the year. The delivery plan identifies interventions to mitigate this under performance.

Risk

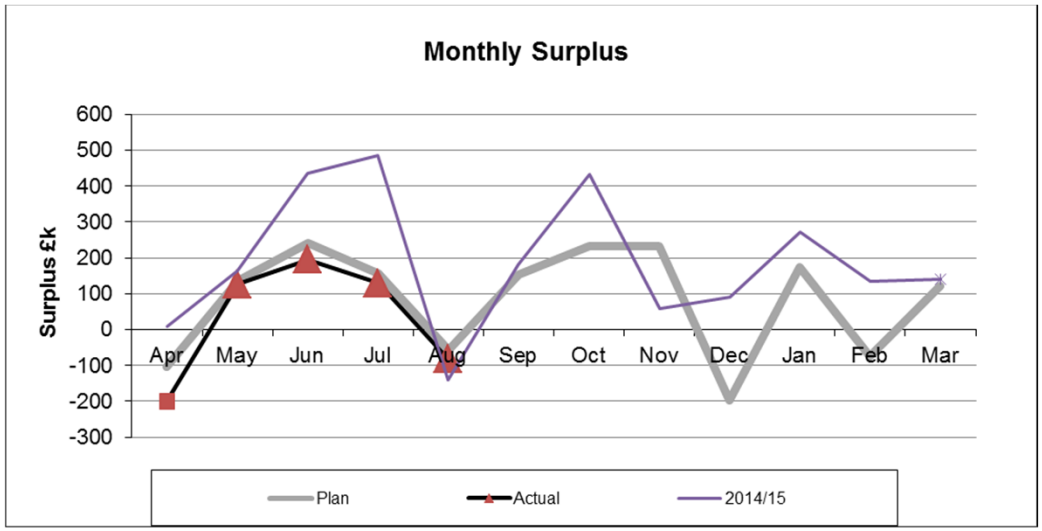
- The non-achievement of the planned surplus would adversely affect future capital and revenue investment and breach the continuity of service licence

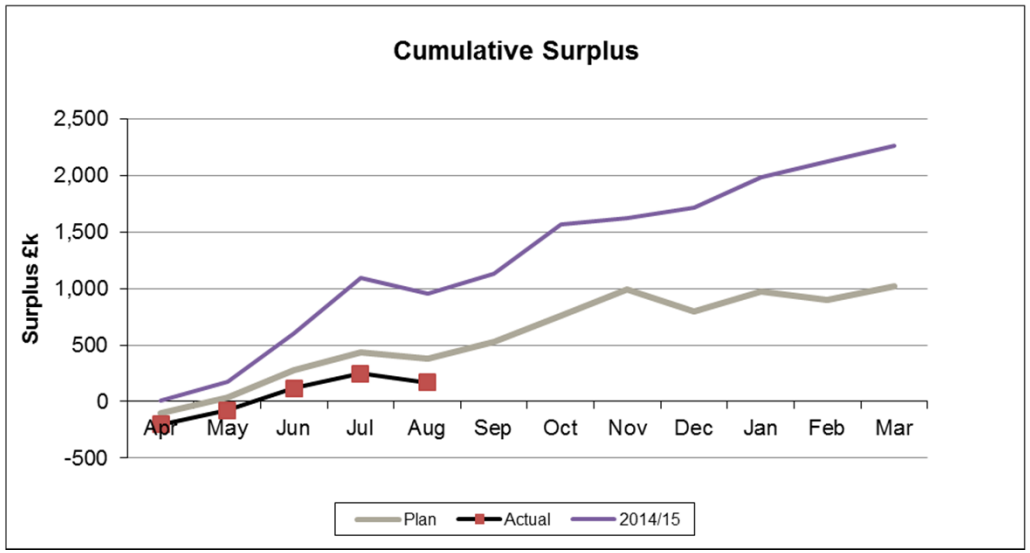
Actions

- The activity delivery plan needs to be implemented and monitored to ensure delivery.
- The Trust has developed a more robust approach to planning and delivery that includes a sustainability and productivity group with monitoring through the performance review framework.

Surplus Trend Position – M05 2015/16

Queen Victoria Hospital
NHS Foundation Trust





Summary

- The in month deficit is £(83)k against the plan of £(56)k, reducing the year to date surplus to £167k. The planned surplus increases for September, October & November. December and February are planned deficits which reflects limited income planned for these periods due to reduced working days and the impact of holidays.

- The baseline forecast indicates a full year surplus of £707k against the plan of £1,017k. This is an adverse movement of £310k which represents an under delivery of 30%. (Appendix 3)
- The delivery plan includes a series of interventions to deliver the plan by the end of the year.

- The Trust needs to generate an average monthly surplus of £121k in the remaining months of the year to deliver the planned surplus.

Activity Performance M05

Queen Victoria Hospital NHS
NHS Foundation Trust

August 2015	Current Month			Year to date		
Activity by Point of Delivery	Activity Actual	Activity Plan	Variance	Activity Actual	Activity Plan	Variance
Critical Care Days	14	46	-32	337	237	100
Day Case	916	918	-2	4,710	4,462	248
Elective	321	401	-80	1,811	2,054	-243
Exclusions	18	0	18	112	0	112
Minor Injuries	968	982	-14	5,320	5,037	283
Non Elective	419	417	2	2,258	2,137	121
Outpatient First Attendance	3,411	3,444	-33	17,865	17,311	554
Outpatient Follow Up	9,529	9,530	-1	50,441	48,501	1,940
Outpatient Procedure	2,247	2,634	-387	12,802	13,507	-705
Radiology	1,864	2,304	-440	11,149	11,818	-669
Grand Total	**19,707**	**20,676**	**-969**	**106,805**	**105,063**	**1,742**

The table contains different activity currencies which are not not comparable as activity or financial measures.

Summary

The table shows patient activity levels against plan by the point of delivery (POD) for the year to date, April to August 2015.

This highlights the continued under performance in elective inpatients .

The above- plan day case activity is greater than the elective underperformance but is only equivalent to about 50% of the financial value of the decrease in electives due to tariff, specialty and case mix.

Issues

The unusually high critical care bed day performance in the first four months has generated additional income of £364k which would not normally be expected to be repeated in the year.

Risks

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

Action

- An operational activity delivery plan has been developed and is currently being implemented and will be monitored through the performance review meetings.

Divisional Performance Position – YTD M05 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Operations															
1.1 Plastics	(70)	(85)	(2)	(10)	16	(51)	3	(22)	25,338	1,997	2,050	(53)	10,409	10,579	(169)
1.2 Oral	136	101	1	5	2	59	(17)	(16)	6,912	671	550	121	3,039	2,889	150
1.3 Eyes	(15)	18	(1)	(17)	3	35	7	(57)	2,741	212	219	(7)	1,124	1,146	(22)
1.4 Sleep	(50)	(177)	0	0	(0)	(1)	42	93	2,013	152	160	(8)	756	841	(86)
1.5 Clinical Support	(34)	37	(3)	(17)	22	52	16	(10)	(2,168)	(185)	(187)	1	(840)	(901)	61
1.6 Other Med & Admin	0	7	(4)	(22)	(2)	(20)	3	25	204	12	15	(3)	76	85	(10)
Operations Total	**(34)**	**(99)**	**(10)**	**(61)**	**41**	**73**	**54**	**12**	**35,040**	**2,859**	**2,808**	**51**	**14,564**	**14,638**	**(74)**
Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure	(3)	3	(3)	(8)	(20)	60	(47)	(312)	(18,985)	(1,658)	(1,585)	(73)	(8,167)	(7,909)	(257)
2.5 Director Of Nursing	-	-	(3)	3	3	24	6	29	(1,406)	(166)	(171)	5	(564)	(620)	56
Nursing & Clinical Infrastructure	**(3)**	**3**	**(6)**	**(5)**	**(18)**	**84**	**(42)**	**(283)**	**(20,391)**	**(1,824)**	**(1,756)**	**(68)**	**(8,731)**	**(8,530)**	**(201)**
Corporate Departments															
3.1 Non Clinical Infrastructure	-	-	(0)	(6)	7	28	(1)	56	(4,289)	(351)	(357)	6	(1,709)	(1,787)	78
3.2 Commerce & Finance	-	35	0	1	(17)	(114)	2	(35)	(1,556)	(144)	(130)	(15)	(762)	(648)	(114)
3.4 Finance Other	(13)	17	(1)	54	(17)	38	57	51	(5,023)	(361)	(387)	26	(1,982)	(2,143)	161
4.1 Human Resources	-	-	(5)	(6)	1	4	1	5	(755)	(66)	(63)	(3)	(311)	(315)	3
5.4 Corporate	-	-	0	-	(13)	(31)	(15)	(43)	(1,850)	(186)	(158)	(28)	(847)	(773)	(74)
6.1 Research	-	-	(4)	(18)	3	10	(0)	1	(41)	(6)	(3)	(2)	(24)	(17)	(7)
6.2 Clinical Audit	-	-	-	-	5	18	0	1	(119)	(4)	(10)	6	(30)	(50)	19
Corporate Total	**(13)**	**53**	**(11)**	**25**	**(30)**	**(47)**	**44**	**36**	**(13,633)**	**(1,118)**	**(1,108)**	**(10)**	**(5,666)**	**(5,732)**	**67**
QVH Total	**(50)**	**(43)**	**(26)**	**(42)**	**(7)**	**111**	**56**	**(235)**	**1,017**	**(83)**	**(56)**	**(27)**	**167**	**376**	**(209)**

Summary

Material Variances in month:

- Income: Patient activity income position is £(50)k behind plan for the month giving a year to date underperformance of £(43)k. Much of the underlying performance variances are an increase in day cases and out patients offset by under performance in electives. Within Plastics, Hands is significantly behind plan at £263k year to date.
- Pay: £7k overspend in month. Underspends in operational budgets are offsetting overspends in corporate departments. A particular risk is that if underspending areas recruit and the overspending areas have not been addressed then pay position will deteriorate.
- Non-pay: £44k underspent in the month: Previous pressures have been mitigated this month by a £42k underspend on Sleep devices in line with reduced activity. Clinical supplies pressures remain on Theatres and Burns.
- Year-to-date:
- Operations performance is £(74k) behind plan for the year-to-date but £51k positive on the month. Clinical infrastructure overspend is mainly on theatre and burns centre clinical supplies. These both suggest that achieving the patient income is coming at a higher than planned direct non-pay cost.
- The YTD position is a surplus of £167k, being £(209)k behind plan. The key ongoing issues are: achievement of activity income in Hands, Sleep and Orthodontics; clinical supplies costs pressures, management of agency costs covering vacancies (i.e. business managers) that will reduce in future periods as permanent staff are recruited to both these positions and clinical operational posts. (Forecast is detailed in appendix 3)

Cost Improvement Programme – YTD M05 2015/16

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes	Annual Plan £000's	Year to date plan Month 5	Achieved £000's	Achieved %	Shortfall
Other Income	74,000	30,833	5,720	19%	25,113
Pay	341,617	142,340	118,090	83%	24,251
Non Pay	818,843	341,185	273,596	80%	67,589
Total Cost Improvement Programmes	**1,234,460**	**514,358**	**397,406**	**77%**	**116,953**

Cost Improvement Programmes	Annual Plan £000's	Year to date plan Month 5	Achieved £000's	Achieved %	Shortfall
1 Operations	284,187	118,411	87,825	74%	30,586
2 Nursing & Clinical Infrastructure	240,405	100,169	81,338	81%	18,831
3 Finance and Non Clinical Infrastructure	673,618	280,674	213,138	76%	67,536
4 Human Resources and Organisational Development	250	104	104	100%	-
5 Corporate	36,000	15,000	15,000	100%	-
6 Medical Director	-	-	-		-
Total Cost Improvement Programmes	**1,234,460**	**514,358**	**397,406**	**77%**	**116,953**

Summary

- At M5 the Trust has achieved savings of £397k YTD which represents 77% of the CIP planned to start in April. There is slippage of £117k.
- The under delivery against income is mainly due to the cornea scheme not being realised.
- The non pay under performance is mainly due to time delays of implementing procurement schemes.

Issues

- The CIP programme is materially behind plan and a delivery plan has been developed which addresses the shortfall in performance.

Risks

- CIP delivery is critical to achieve the Trust's current and future financial plans.

Actions

- The Trust has put in place a more robust approach that includes a sustainability and productivity group and enhanced monitoring through the performance review framework.

Balance Sheet – YTD M05 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Balance Sheet for: Month 5 2015/16	2014/15 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,705	37,182	36,911
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,705	37,182	36,911
Current Assets			
Inventories	440	447	443
Trade and Other Receivables	8,351	6,405	5,581
Cash and Cash Equivalents	6,548	8,947	8,568
Current Liabilities	(7,880)	(7,145)	(6,449)
Sub Total Net Current Assets	7,459	8,653	8,144
Total Assets less Current Liabilities	45,164	45,835	45,055
Non-Current Liabilities			
Provisions for Liabilities and Charges	(588)	(616)	(616)
Non-Current Liabilities >1 Year	(8,156)	(7,767)	(7,767)
Total Assets Employed	**36,420**	**37,452**	**36,671**
Tax Payers Equity			
Public Dividend Capital	12,237	13,100	12,237
Retained Earnings	18,382	18,551	18,634
Revaluation Reserve	5,801	5,801	5,801
Total Tax Payers Equity	**36,420**	**37,452**	**36,671**

NB Analysis is subject to rounding differences

Summary

- Net current assets have increased in month by £781k.
- Receivables have increased in month by £824k reflecting the expected payment of new Public Dividend Capital of £864k due for the Electronic Document Management scheme.
- Non-current liabilities will reduce in year due to theatre loan repayments of £388.85k in June and December with a corresponding reduction in cash.
- 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 continues to be sufficient cash balances to provide liquidity, service the capital plan and meet the requirements of Monitor's Financial Sustainability measures.

Actions

- The maintenance of cash balances is dependant on robust billing and cash management process. Further details of actions taken are outlined on the debtor and cash slides.

Capital – M05 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:	65	39	-	39	(26)
15/16 Projects:					
Corneoplastic electrical upgrade	212	-	8	213	1
Jubilee refurbishment	377	53	14	377	-
Consultants' offices	130	-	115	125	(5)
Other projects	96	63	5	126	30
Estates Total	880	155	142	880	-
YTD Plan		567			
YTD Estates variance		(412)			
Medical Equipment	690	269	-	690	-
YTD Plan		250			
YTD Medical Equipment variance		19			
IT Equipment & Software					
Infrastructure improvement	2,000	37	-	2,000	-
Electronic Document Management (EDM)	590	35	75	603	13
Other projects	360	30	2	347	(13)
IT Total	2,950	102	77	2,950	-
YTD Plan		697		2,950	
YTD IT variance		(595)			
Total capital spend	**4,520**	**526**	**219**	**4,520**	**-**
YTD Plan		**1,513**			
YTD Total Variance		**(987)**			

Summary

- Capital YTD expenditure is £526k which is £987k (65%) below nominal plan, increasing the risk that the annual plan will not be achieved.
- The medical devices allocation will be fully spent as there is a backlog of bids to be reviewed and recommended for approval by the Medical Devices Committee.
- The IT allocation is dependent on the delivery of the IT Infrastructure Improvement Programme (IIP) and Electronic Document Management (EDM). These schemes are currently set to be delivered in line with forecast although due to the complexity and interdependencies there is a risk to delivery that is being managed through the programme boards.
- The Estates programme is largely driven by two key projects. Having been tendered, the Jubilee refurbishment, as originally conceived, is not affordable and will be reduced in scope. The tendering process for the Corneo electrical upgrade was delayed pending a decision on increasing the funding for the Jubilee project. Since this will not now happen, the tendering process will start shortly.

Issues

- The capital programme is behind the nominally phased plan and has suffered further delay because of the Jubilee project, making achievement of the annual plan more difficult.

Risks

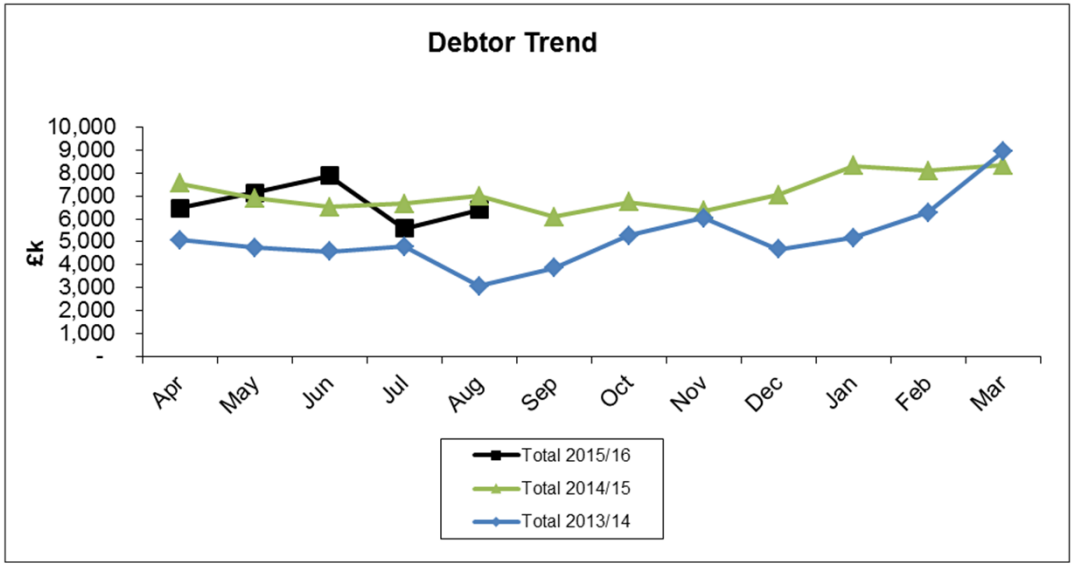
- The Trust may not fully spend its agreed capital programme which will impact on quality of service, reputational risk and additional scrutiny from Monitor.
- The IT projects include a number of critical infrastructure developments where delay would impact the delivery of the EDM project.

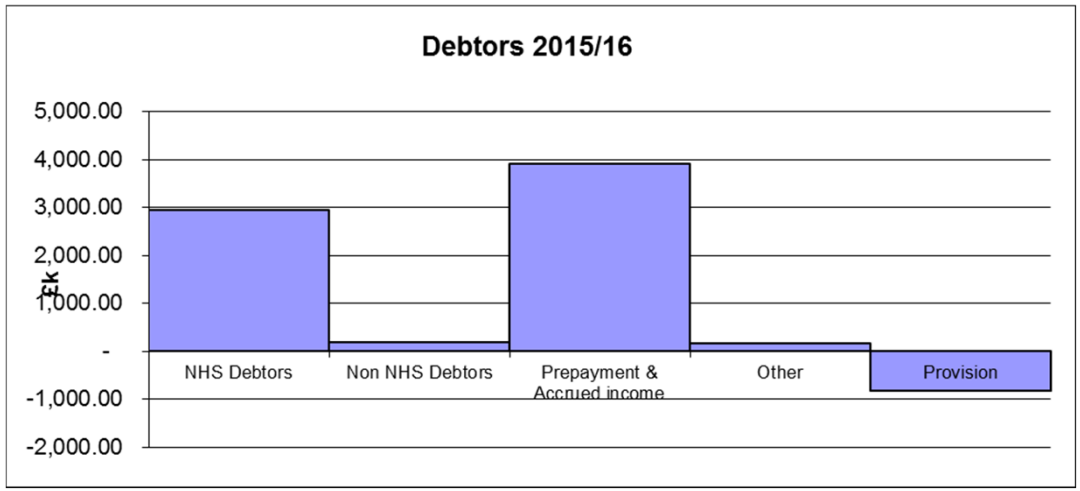
Actions

- The Capital planning group will meet on 15 October to review the capital programme for 2015-16 in the light of the above risks.
- Medical Devices Committee needs to prioritise capital bids in the next two months to ensure that they are included within the current year's capital program.
- The reduced Jubilee works are being carried through with all urgency to meet pressing operational needs.

Debtors – M05 2015/16

Queen Victoria Hospital
NHS Foundation Trust





Summary

- The debtor balance increased by £824k from month 4 due to the invoicing of additional Public Dividend Capital of £864k for the Electronic Document Management scheme.
- The in month debtor balance of £6.4m is below the average monthly balances from 2014-15 of £7.1m. This is largely due to the resolution of the historic £1.8m specialised commissioning debt in month 4.

Issues

- There is £1,829k of accrued income due to income over-performance and NCAs.
- There is an issue of delayed payment of 14/15 performance invoices by East Sussex CCGs, constituting approx. 17% of NHS income.

Risks

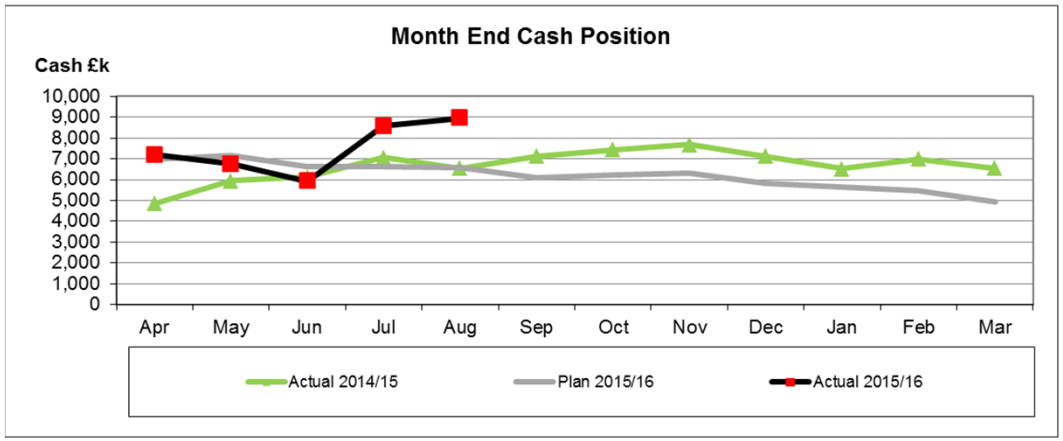
- Delayed payments of over-performance negatively affects cash balances.

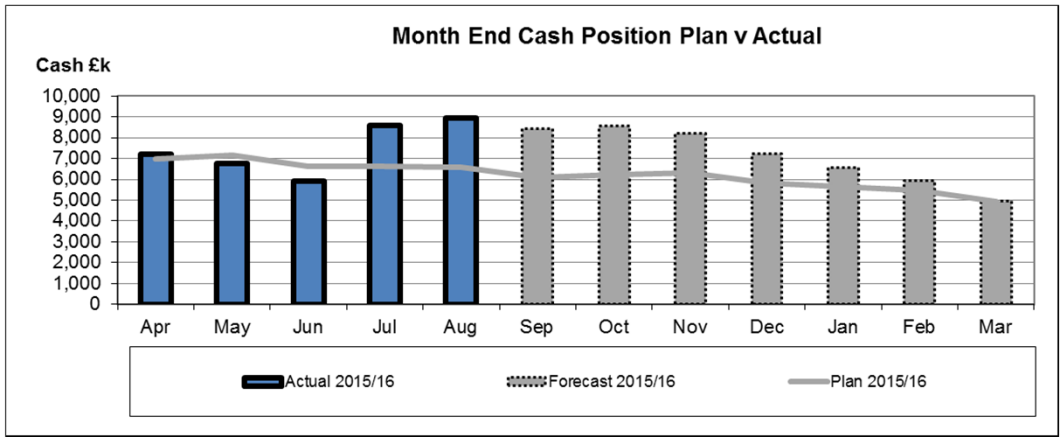
Actions

- 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 continues to liaise regularly with NHS debtors to enable prompt payment of in year debtors

Cash – M05 2015/16

Queen Victoria Hospital
NHS Foundation Trust





Summary

- The in month cash position is favourable on the basis of current liquidity and debt service ratios.
- The cash balance at month 5 is £8.9m , £378k higher than month 4.

Issues

- The capital programme is behind plan for the period therefore cash balances are higher than anticipated. Capital programme expenditure profile has changed with increased expenditure phased in the final quarters of the year.

Risks

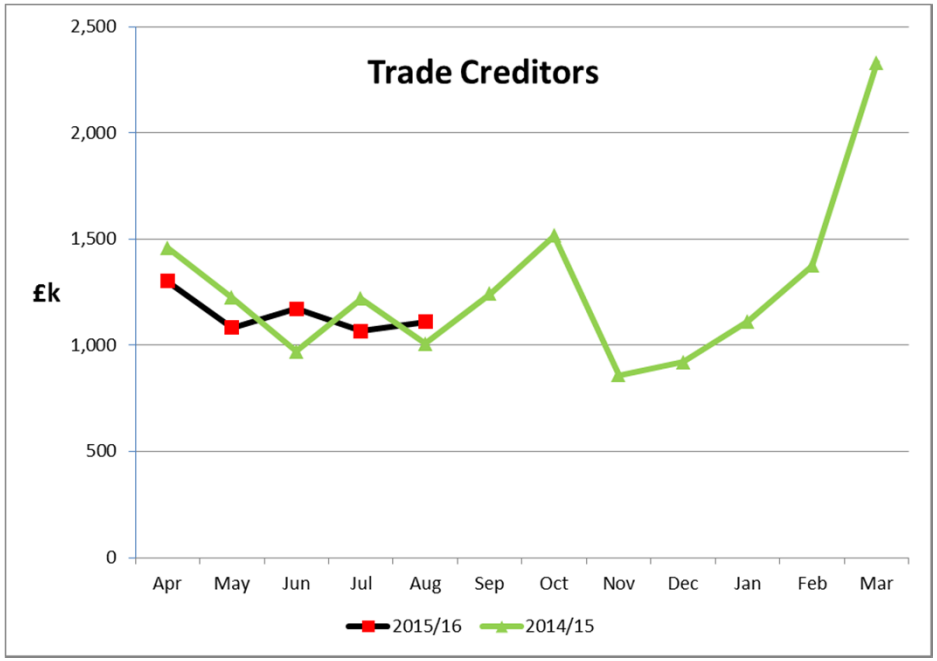
- The deterioration in I&E performance or delays in payment of debt will impact on liquidity and ability to maintain appropriate Monitor ratings.

Actions

- The Trust will continue to review short term cash flow on a daily basis to manage liquidity and inform decision making.
- The capital programme will be monitored to ensure that changes are accurately reflected in the cash flow forecast.

Creditors – M05 2015/16

Queen Victoria Hospital
NHS Foundation Trust



Better Payment Practice Code (15/16) August	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	1,441	1,255	7,338	8,342
Total **Non NHS** trade invoices paid within target	10,806	11,312	1,228	1,026	6,195	6,921
Percentage of Non-NHS trade invoices paid within target	**68%**	**68%**	**85%**	**82%**	**84%**	**83%**
Total **NHS** trade invoices paid	933	5,241	79	340	400	2,025
Total **NHS** trade invoices paid within target	505	3,037	63	225	298	1,527
Percentage of NHS trade invoices paid within target	**54%**	**58%**	**80%**	**66%**	**75%**	**75%**

Summary

- Trade creditors have averaged at £1.1m per month in year compared to £1.2m during 2015-16.
- Better Payment Practice code (BPPC) YTD performance has continued to show improvement against the 30 day target.
- Non NHS BPPC have improved in month based on volume and value whereas NHS has improved in volume but deteriorated against the value measure.

Issues

- The Trust is implementing a prompt payment programme where supplier savings have been secured based on favourable invoice payment terms.
- Pilot testing of online payment software have identified a number of issues with the process from feedback from users.

Risks

- Failure to achieve national BPPC target within the financial year.
- Supplier discounts will not be secured if payments not paid in accordance with prompt payment terms.

Actions

- Develop programme and processes to support the prompt payment programme.
- Engagement with software suppliers to resolve issues with implementation of online approval software.

Appendices

Appendix 1: Departmental Performance Summary – M05 2015/16

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
1 Operations															
1.1 Plastics															
1.11 Breast	9	(28)	(1)	(3)	(3)	(6)	(1)	(6)	3,850	317	312	5	1,564	1,607	(43)
1.12 Burns	(19)	(339)	(0)	(2)	0	(0)	(0)	1	7,527	593	612	(19)	2,801	3,142	(341)
1.13 Hands	(99)	(263)	(0)	(2)	3	9	(2)	(19)	12,890	948	1,047	(99)	5,105	5,380	(275)
1.14 Skin	38	543	(1)	(4)	0	2	(0)	(9)	4,427	397	360	38	2,380	1,848	532
1.15 Plastics	-	2	-	-	16	(56)	6	11	(3,355)	(258)	(280)	22	(1,441)	(1,398)	(43)
1.1 Plastics Total	**(70)**	**(85)**	**(2)**	**(10)**	**16**	**(51)**	**3**	**(22)**	**25,338**	**1,997**	**2,050**	**(53)**	**10,409**	**10,579**	**(169)**
1.2 Oral															
1.21 Head & Neck	153	191	2	9	(6)	(20)	(6)	(14)	5,605	590	448	142	2,508	2,342	166
1.23 Orthodontic	(33)	(132)	(0)	1	11	54	(9)	(3)	1,739	108	139	(31)	647	726	(79)
1.24 Prosthetics	15	43	(1)	(5)	(2)	25	(2)	1	(432)	(27)	(37)	10	(116)	(180)	64
1.2 Oral Total	**136**	**101**	**1**	**5**	**2**	**59**	**(17)**	**(16)**	**6,912**	**671**	**550**	**121**	**3,039**	**2,889**	**150**
1.3 Eyes															
1.31 Corneoplastic	(17)	(7)	0	0	4	39	3	(57)	2,553	194	204	(10)	1,041	1,067	(26)
1.32 Oculoplastic	1	26	-	-	0	1	(1)	(7)	137	11	11	(0)	77	57	20
1.33 Eye Bank	-	-	(1)	(17)	(1)	(5)	5	7	52	7	4	3	6	22	(16)
1.3 Eyes Total	**(15)**	**18**	**(1)**	**(17)**	**3**	**35**	**7**	**(57)**	**2,741**	**212**	**219**	**(7)**	**1,124**	**1,146**	**(22)**
1.4 Sleep															
1.41 Sleep	(50)	(177)	0	0	(0)	(1)	42	93	2,013	152	160	(8)	756	841	(86)
1.4 Sleep Total	**(50)**	**(177)**	**0**	**0**	**(0)**	**(1)**	**42**	**93**	**2,013**	**152**	**160**	**(8)**	**756**	**841**	**(86)**
1.5 Clinical Support															
1.51 Imaging	(36)	9	(2)	(14)	(7)	(23)	(0)	(7)	299	(23)	22	(45)	90	125	(35)
1.52 Pathology	4	21	1	4	2	(38)	11	21	(1,493)	(106)	(124)	18	(615)	(622)	7
1.53 Therapies	0	(18)	(2)	(6)	23	89	5	(2)	(711)	(36)	(62)	26	(233)	(295)	62
1.54 Pharmacy	(2)	26	(0)	3	2	11	2	(20)	(80)	(6)	(8)	1	(14)	(33)	19
1.55 Medical Photography	-	-	2	(2)	2	12	(2)	(2)	(183)	(13)	(15)	2	(68)	(76)	8
1.5 Clinical Support Total	**(34)**	**37**	**(3)**	**(17)**	**22**	**52**	**16**	**(10)**	**(2,168)**	**(185)**	**(187)**	**1**	**(840)**	**(901)**	**61**
1.6 Other Med & Admin															
1.61 Ops Admin	-	-	(4)	(22)	(2)	(5)	(2)	(2)	35	(7)	2	(9)	(14)	15	(29)
1.62 Elderly	4	15	-	-	(1)	(18)	5	27	5	8	0	8	27	2	25
1.63 Rheumatology	(5)	(9)	-	-	0	(1)	-	-	80	2	6	(5)	23	34	(10)
1.64 Cardiology	1	1	-	-	0	4	0	(0)	83	9	7	2	40	35	5
1.6 Ops Admin Total	**0**	**7**	**(4)**	**(22)**	**(2)**	**(20)**	**3**	**25**	**204**	**12**	**15**	**(3)**	**76**	**85**	**(10)**
1 Operations Total	**(34)**	**(99)**	**(10)**	**(61)**	**41**	**73**	**54**	**12**	**35,040**	**2,859**	**2,808**	**51**	**14,564**	**14,638**	**(74)**

Service line budgets include the full allocation of their specialty patient income as well as their direct costs. Therefore the net budget is positive and represents their gross contribution to the Trust. Other support services have negative budgets representing net costs of that service.

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	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	(0)	(1)	(0)	1	23	159	(19)	(141)	(6,949)	(575)	(579)	4	(2,877)	(2,895)	18
2.12 Elective Care Nursing	-	-	1	10	(5)	(7)	(0)	(18)	(4,916)	(413)	(410)	(4)	(2,064)	(2,048)	(15)
2.13 Emergency Care Nursing	(2)	4	(2)	(8)	(21)	(90)	(19)	(105)	(3,180)	(311)	(268)	(44)	(1,523)	(1,324)	(199)
2.14 Anaesthetics	-	-	(2)	(11)	(16)	(1)	(8)	(49)	(3,292)	(301)	(274)	(27)	(1,433)	(1,372)	(61)
2.15 Appointments & Records	-	0	-	0	(2)	(1)	(1)	1	(648)	(57)	(54)	(3)	(270)	(270)	0
2.1 Clinical Infrastructure Total	**(3)**	**3**	**(3)**	**(8)**	**(20)**	**60**	**(47)**	**(312)**	**(18,985)**	**(1,658)**	**(1,585)**	**(73)**	**(8,167)**	**(7,909)**	**(257)**
2.21 Risk	-	-	(2)	4	(6)	3	8	24	(704)	(58)	(59)	1	(262)	(293)	31
2.41 Practice Development	-	-	(1)	1	3	6	1	6	124	14	10	4	66	52	14
2.51 Director of Nursing	-	-	(0)	(2)	5	14	(4)	(1)	(826)	(122)	(123)	1	(368)	(379)	10
2.5 Director of Nursing Total	**-**	**-**	**(3)**	**3**	**3**	**24**	**6**	**29**	**(1,406)**	**(166)**	**(171)**	**5**	**(564)**	**(620)**	**56**
2 Nursing & Clinical Infrastructure Total	**(3)**	**3**	**(6)**	**(5)**	**(18)**	**84**	**(42)**	**(283)**	**(20,391)**	**(1,824)**	**(1,756)**	**(68)**	**(8,731)**	**(8,530)**	**(201)**

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

Appendix 1: Departmental Performance Summary – M05 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	Total Current Month			Total Year To Date		
Budget Performance	CMV	YTDV	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	-	-	(0)	(6)	3	7	(3)	(41)	(1,748)	(146)	(146)	(1)	(768)	(728)	(40)
3.12 Estates	-	-	0	1	2	12	(5)	69	(1,995)	(169)	(166)	(3)	(748)	(831)	83
3.13 IMT	-	-	(0)	(1)	3	8	7	28	(546)	(36)	(46)	9	(193)	(228)	35
3.1 Non Clinical Infrastructure Total	-	-	(0)	(6)	7	28	(1)	56	(4,289)	(351)	(357)	6	(1,709)	(1,787)	78
3.2 Commerce & Finance															
3.22 Commerce	-	35	-	-	(11)	(52)	0	(16)	(563)	(58)	(47)	(11)	(268)	(235)	(33)
3.31 Finance	-	-	0	1	(6)	(62)	2	(19)	(992)	(86)	(83)	(4)	(494)	(413)	(80)
3.2 Commerce & Finance Total	-	35	0	1	(17)	(114)	2	(35)	(1,556)	(144)	(130)	(15)	(762)	(648)	(114)
3.4 Finance Other															
3.41 Financing	-	-	-	-	-	-	19	22	(3,953)	(310)	(329)	19	(1,625)	(1,647)	22
3.42 Reserves	-	-	-	111	-	-	-	-	(721)	(28)	(28)	-	(239)	(350)	111
3.43 Exceptionals	-	-	-	1	(17)	38	(1)	41	(23)	(19)	(2)	(17)	71	(9)	80
3.44 Contract Penalties	-	-	-	-	-	-	-	-	(650)	(54)	(54)	-	(271)	(271)	-
3.45 Other Income	(13)	17	(1)	(58)	-	-	3	(9)	323	16	27	(11)	85	135	(50)
3.46 Activity Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.48 Closed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.49 Suspense	-	-	-	-	-	-	35	(3)	-	35	-	35	(3)	-	(3)
3.4 Finance Other Total	(13)	17	(1)	54	(17)	38	57	51	(5,023)	(361)	(387)	26	(1,982)	(2,143)	161
3 Finance and Non Clinical Infrastructure Total	**(13)**	**53**	**(1)**	**49**	**(27)**	**(48)**	**58**	**72**	**(10,868)**	**(857)**	**(874)**	**17**	**(4,453)**	**(4,578)**	**125**
4 Human Resources and Organisational Development															
4.11 Human Resources	-	-	1	15	2	6	(3)	4	(761)	(64)	(63)	(0)	(292)	(317)	25
4.21 Education	-	-	(6)	(21)	(1)	(2)	3	2	5	(2)	0	(3)	(19)	2	(21)
4 Human Resources and Organisational Development Total	**-**	**-**	**(5)**	**(6)**	**1**	**4**	**1**	**5**	**(755)**	**(66)**	**(63)**	**(3)**	**(311)**	**(315)**	**3**
5 Corporate															
5.11 Board	-	-	-	-	(2)	8	(6)	(39)	(654)	(63)	(54)	(8)	(303)	(272)	(31)
5.21 Operations Management	-	-	-	-	(16)	(46)	0	1	(859)	(91)	(75)	(16)	(406)	(360)	(45)
5.31 Corporate Affairs	-	-	0	-	5	7	(9)	(5)	(337)	(32)	(28)	(4)	(138)	(140)	2
5 Corporate Total	**-**	**-**	**0**	**-**	**(13)**	**(31)**	**(15)**	**(43)**	**(1,850)**	**(186)**	**(158)**	**(28)**	**(847)**	**(773)**	**(74)**
6 Medical Director															
6.11 Research	-	-	(1)	2	4	15	(0)	(0)	(99)	(6)	(8)	3	(24)	(41)	17
6.12 Research Projects	-	-	(4)	(20)	(1)	(5)	(0)	1	58	(0)	5	(5)	(0)	24	(24)
6.21 Clinical Audit	-	-	-	-	5	18	0	1	(119)	(4)	(10)	6	(30)	(50)	19
6 Medical Director Total	**-**	**-**	**(4)**	**(18)**	**8**	**28**	**(0)**	**2**	**(161)**	**(10)**	**(13)**	**4**	**(55)**	**(67)**	**12**
Non Clinical Total	**(13)**	**53**	**(11)**	**25**	**(30)**	**(47)**	**44**	**36**	**(13,633)**	**(1,118)**	**(1,108)**	**(10)**	**(5,666)**	**(5,732)**	**67**

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

Introduction of a financial sustainability risk rating

- Monitor is replacing the previously used 'continuity of service risk rating' with the 'financial sustainability risk rating'.
- This risk rating represents Monitor's view of the likelihood that a licence holder is, will be, or could be in breach of the continuity of service licence condition 3 and/or the provisions of the NHS foundation trust licence condition 4 (governance) which relates to finance.

The financial sustainability risk rating will be calculated using the following measures:

1. Liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
2. Capital servicing capacity: the degree to which the organisation's generated income covers its financial obligations
3. Income and expenditure (I&E) margin: the degree to which the organisation is operating a surplus/deficit. The I&E margin is defined as surplus/(deficit)/total operating and non-operating income. Surplus/(deficit) should be calculated before impairments, transfers by absorption, gains/losses on asset disposal and restructuring costs.
4. Variance from plan in relation to I&E margin: variance between a foundation trust's planning I&E margin in its annual forward plan and its actual I&E margin within the year.

	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	≤(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)–0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

*Scoring a 1 on any metric will cap the weighted rating to 2, potentially leading to investigation.

**Scores are rounded to the nearest number, ie if the trust scores 3.6 overall, this will be rounded to 4; if the trust scores 3.4, this will be rounded to 3.

***A 2* rating may be awarded to a trust where there is little likelihood of deterioration in its financial position.

Appendix 2: Financial sustainability risk rating – QVH Calculation M5

Financial sustainability risk rating	Description	Regulatory activity
4	No evident concerns	None
3	Emerging or minor concern potentially requiring scrutiny	Potential enhanced monitoring
2*	Level of risk is material but stable	Potential enhanced monitoring
2	Material risk	Potential investigation (see Chapter 5)
1	Significant risk	Likely investigation (see Chapter 5) Potential appointment of contingency planning team

*Weighted average, rounded to nearest number, across the components of the financial sustainability risk rating.

Monitor Risk Assesment Measures: financial sustainability risk ratings

Continuity of Services:

	Metrics	Measure	Rating	Weighting	Score
Balance Sheet sustainability: Capital Servicing Capacity	**£ks**				
Operating surplus	1,792	2.06	**3**	25%	**0.75**
Financial obligations (annual pro rata)	869				
Liquidity (days)					
Cash and equivalents held	8,207	51	**4**	25%	**1.00**
Operating Costs (per day)	162				

Financial efficiency:

I&E Performance - Margin (%)					
Surplus (deficit) year to date	167	0.6%	**3**	25%	**0.75**
Income year to date	26,073				
Variance from plan - I&E Margin					
Actual surplus margin	0.6%	-0.8%	**3**	25%	**0.75**
Plan surplu margin	1.4%				

FSRR (rounded) 3

Summary

- These calculations are based on current methodology pending updated Monitor guidance. On the previous measure as at the time of 15-16 planning the FRR would still be a 4.

Appendix 3: Financial Surplus Forecast - Baseline

Baseline Forecast 2015-16	1		2		3		4		5		6		7		8		9		10		11		12		Total Year	Total Year	Total Year
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	Actual	Budget	Variance
INCOME FROM ACTIVITIES	4,517	4,708	4,803	4,946	5,194	5,052	5,181	4,982	4,720	4,770	5,117	4,982	5,072	5,017	5,077	5,017	4,648	4,593	5,038	4,946	4,789	4,699	5,085	4,893	**59,241**	**58,605**	**636**
OTHER OPERATING INCOME	280	324	416	326	303	326	324	363	335	361	327	361	327	376	327	376	327	373	327	388	327	386	327	386	**3,948**	**4,346**	**(398)**
PAY EXPENDITURE	(3,302)	(3,396)	(3,338)	(3,396)	(3,415)	(3,397)	(3,452)	(3,436)	(3,443)	(3,436)	(3,410)	(3,437)	(3,427)	(3,416)	(3,432)	(3,416)	(3,440)	(3,417)	(3,473)	(3,416)	(3,440)	(3,416)	(3,457)	(3,415)	**(41,031)**	**(40,994)**	**(36)**
NON PAY EXPENDITURE	(1,695)	(1,739)	(1,756)	(1,739)	(1,886)	(1,740)	(1,923)	(1,751)	(1,694)	(1,751)	(1,780)	(1,752)	(1,785)	(1,745)	(1,775)	(1,745)	(1,795)	(1,745)	(1,801)	(1,745)	(1,782)	(1,744)	(1,777)	(1,743)	**(21,451)**	**(20,940)**	**(511)**
Total Monthly	**(201)**	**(103)**	**126**	**137**	**196**	**242**	**130**	**157**	**(83)**	**(56)**	**254**	**153**	**186**	**232**	**197**	**232**	**(259)**	**(196)**	**92**	**173**	**(107)**	**(75)**	**177**	**122**	**707**	**1,017**	**(310)**
Variance Monthly		**(97)**		**(11)**		**(46)**		**(28)**		**(27)**		**101**		**(46)**		**(35)**		**(63)**		**(81)**		**(32)**		**55**			
Total Year to date	(201)	(103)	(75)	33	121	275	250	433	167	376	421	530	607	762	804	994	545	797	637	970	530	895	707	1,017			
Variance YTD		(97)		(109)		(155)		(182)		(209)		(108)		(154)		(189)		(253)		(334)		(365)		(310)			

Summary

- The baseline forecast shows a deficit of £310k against planned surplus.
- This forecast is based upon a detailed bottom up review of expenditure and income, the removal of non recurrent items, the identification of cost pressures, review of current plans for recruitment to vacancies and the impact of activity developments .

Risks

- A further deterioration in activity performance .
- Other events that may affect operational or patient activity – e.g. Patient flow issues (identification, referral, scheduling), weather, infection outbreaks , recruitment and staff availability, estate and utilities availability.

Appendix 3: Financial Surplus Forecast with Interventions

Intervention Forecast	1		2		3		4		5		6		7		8		9		10		11		12		Total Year	Total Year	Total Year
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	Actual	Budget	Variance
Baseline Forecast	(201)	(103)	126	137	196	242	130	157	(83)	(56)	254	153	186	232	197	232	(259)	(196)	92	173	(107)	(75)	177	122	**707**	**1,017**	**(310)**
Tactical savings																											
NON PAY EXPENDITURE											14		6		6		6		6		6		6		**47**		**47**
Additional cost savings																											
NON PAY EXPENDITURE											2		2		8		10		11		11		11		**52**		**52**
Activity projects, risk adjusted																											
INCOME FROM ACTIVITIES													73		99		99		99		99		99		**565**		**565**
PAY													(33)		(37)		(37)		(37)		(37)		(37)		**(218)**		**(218)**
NON PAY													(9)		(12)		(12)		(12)		(12)		(12)		**(69)**		**(69)**
Sub total: Contribution													**31**		**49**		**49**		**49**		**49**		**49**		**278**		**278**
Total Interventions:	-		-		-		-		-		**16**		**38**		**63**		**65**		**66**		**66**		**66**		**378**	-	**378**
Revised Forecast	(201)	(103)	126	137	196	242	130	157	(83)	(56)	270	153	224	232	260	232	(195)	(196)	157	173	(41)	(75)	243	122	1,085	1,017	68

Appendix 3: Interventions

Intervention Plans														
Plans to achieve target surplus:	**Type**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**FY Position**
Tactical savings														
Bank overdraft facility - removal	NON PAY						2	2	2	2	2	2	2	12
Income - misc	NON PAY						0	0	0	0	0	0	0	2
Expenditure controls - not urgent ordering	NON PAY						-	0	0	0	0	0	0	2
Depreciation review	NON PAY						-	-	-	-	-	-	-	-
Supplier Discounts - phase 1	NON PAY						-	0	0	0	0	0	0	2
Review bed debts provision policy	NON PAY						-	3	3	3	3	3	3	18
Private payment income (Jersey)	NON PAY						12	-	-	-	-	-	-	12
Tactical Savings Total		-	-	-	-	-	**14**	**6**	**6**	**6**	**6**	**6**	**6**	**47**
Activity Interventions, risk rated contributions														
Sleep Business Case	INCOME FROM ACTIVITIES								26	26	26	26	26	128
Sleep Business Case	PAY								(3)	(3)	(3)	(3)	(3)	(17)
Sleep Business Case	NON PAY								(3)	(3)	(3)	(3)	(3)	(17)
100% Sleep Business Case	Contribution								19	19	19	19	19	93
Oral/MF : minor ops	INCOME FROM ACTIVITIES							6	6	6	6	6	6	36
Oral/MF : minor ops	NON PAY							(4)	(4)	(4)	(4)	(4)	(4)	(22)
80% Oral/MF : minor ops	Contribution							2	2	2	2	2	2	14
Corneo - daycase, cataracts	INCOME FROM ACTIVITIES							9	9	9	9	9	9	51
Corneo - daycase, cataracts	NON PAY							(3)	(3)	(3)	(3)	(3)	(3)	(17)
80% Corneo - daycase, cataracts	Contribution							6	6	6	6	6	6	34
Hands - daycase	INCOME FROM ACTIVITIES							11	11	11	11	11	11	64
Hands - daycase	NON PAY							(2)	(2)	(2)	(2)	(2)	(2)	(13)
80% Hands - daycase	Contribution							9	9	9	9	9	9	51
Trauma list	INCOME FROM ACTIVITIES							48	48	48	48	48	48	286
	PAY							(33)	(33)	(33)	(33)	(33)	(33)	(201)
50% Trauma list	Contribution							14	14	14	14	14	14	86
Total Activity Interventions, risk rated contributions		-	-	-	-	-	-	**31**	**49**	**49**	**49**	**49**	**49**	**278**
Additional Cost Savings														-
Theatre gowns	NON PAY						-	-	4	4	4	4	4	20
Sleep	NON PAY						0	0	0	0	0	0	0	1
Plates & screws -Synthes	NON PAY						2	2	2	2	2	2	2	11
Digital Dictation	NON PAY						-	-	0	0	0	0	0	1
Insurance	NON PAY						-	-	-	0	0	0	0	1
Dental-3M spend	NON PAY						-	-	1	0	0	0	0	2
switch to f/work or switch supplier	NON PAY						-	-	0	1	1	1	1	4
Mattresses	NON PAY						-	-	-	-	1	1	1	3
Clinical products spend through supply chain	NON PAY						-	-	1	1	1	1	1	4
Sterile Services	NON PAY						-	-	-	2	2	2	2	7
Total Additional Cost Savings		-	-	-	-	-	**2**	**2**	**8**	**10**	**11**	**11**	**11**	**52**
		-	-	-	-	-	**16**	**38**	**63**	**65**	**66**	**66**	**66**	**378**

Appendix 4: Action Log

Action Log N	Meeting Da	Meetin	Page N	Type	Requested Item	Assigned To	Update 11/9/15	Due Dat	Complete
1	20/07/2015	FPC	n/a	I & E	Patient activity delivery plan - developed and implemented by end of financial year	Ops Team	*Plan being presented to Sept F&P and is currently being implemented.*	31/03/2016	
2	20/07/2015	FPC	n/a	I & E	Purchasing practices and expenditure controls to be reviewed	Finance and Ops Team	*New protocols to be implemented Sept 15*	30/09/2015	Yes
3	30/07/2015	FPC	7	CIP	All CIP plans to be reviewed to assess delivery	Finance and Ops Team	*All CIP schemes have now been reviewed.*	11/08/2015	Yes
4	30/07/2015	FPC	7	CIP	Understand the causes of slippage and actions to be taken	Finance and Ops Team	*This is complete, but very few additional schemes have been proposed.*	11/08/2015	Yes
5	30/07/2015	FPC	7	CIP	New schemes to be developed to mitigate CIP underperformance. Worskhops to identify new schemes	Finance and Ops Team	*Business managers required to feedback on new schemes or suggestions to mitigate the slippage*	30/09/2015	Yes
6	20/07/2015	FPC	n/a	Capital	Capital Planning, Monitoring and Control Group (CPG) set up to ensure delivery and monitoring of capital programme	Finance	*ToR agreed. Membership Agreed*	15/10/2015	Yes
7	20/07/2015	FPC	n/a	Capital	Details of all approved capital schemes to be agreed at CPG	Finance	*To be discussed at meeting on 15th Oct 15*	15/10/2015	
8	20/07/2015	FPC	n/a	Capital	A draft medium and long term capital plan will be agreed	Finance	*Included in papers*	15/10/2015	
9	20/07/2015	FPC	n/a	Capital	Identify schemes from 2016/17 cpaital programme to be implemented quickly in the event of 2015/16 slippage	Finance	*To be agreed at next meeting*	15/10/2015	
10	20/07/2015	FPC	n/a	Capital	Capital planning to be embedded into business planning for 2016/17 to begin at end of Q2	Finance	*Agreed*	15/10/2015	

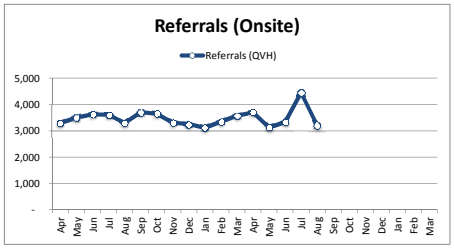
Queen Victoria Hospital NHS
NHS Foundation Trust

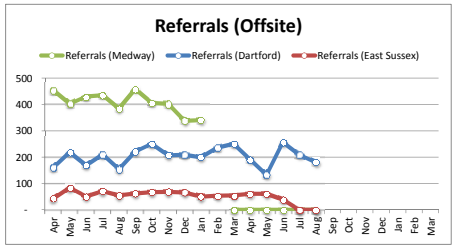
Author (charts): Rob Lock (Information Manager)
Author (narrative):

Trust Level Report (All Services)

Period : 2015-16 Month 5 (August)

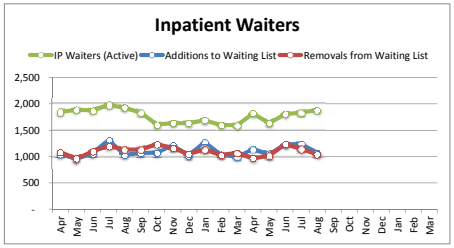
DEMAND

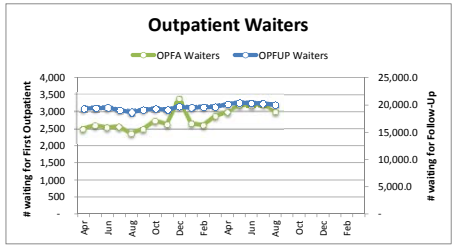




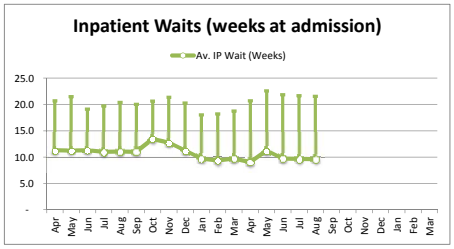
Medway referrals data not yet available since their PAS Upgrade - progressing with K&M HIS this month

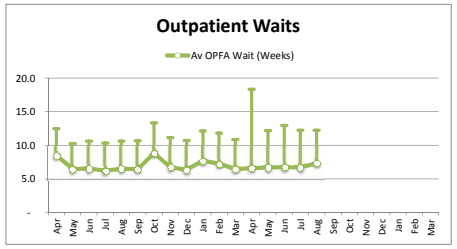
WAITING LIST





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
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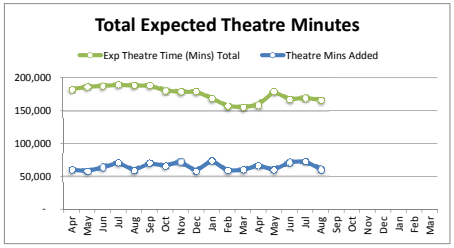
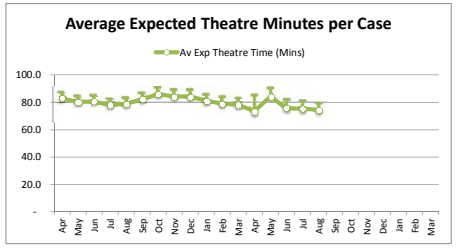
Trust Level Report (All Services)

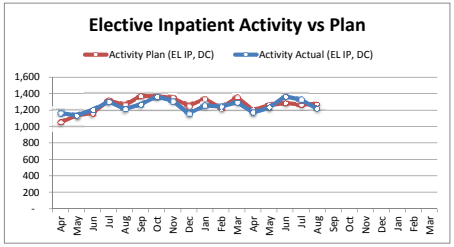
Period : 2015-16 Month 5 (August)

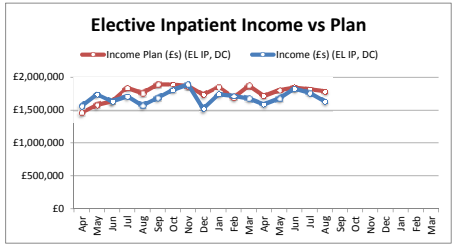
THEATRE MINS



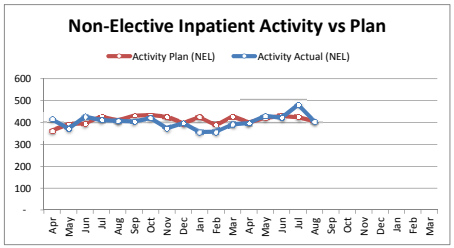


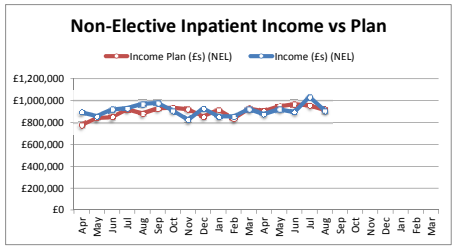
Elective Inpatients





Non-Elective Inpatients





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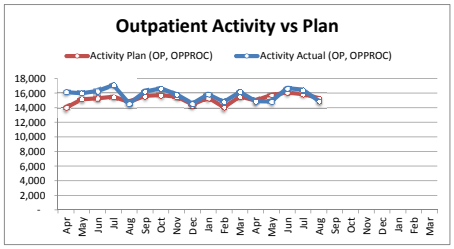
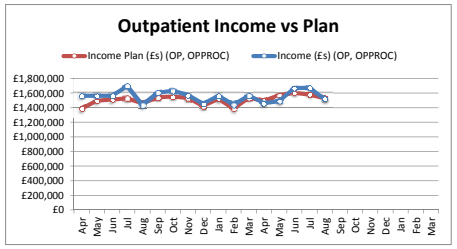
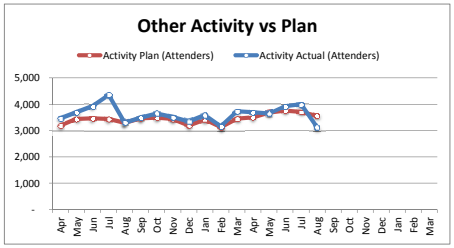
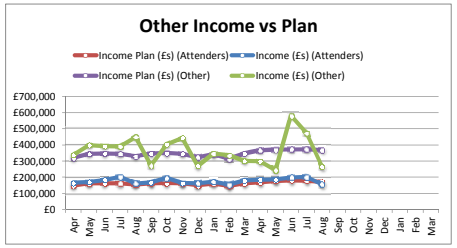
Outpatients





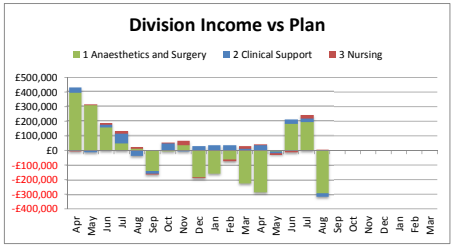
Other Activity/Income

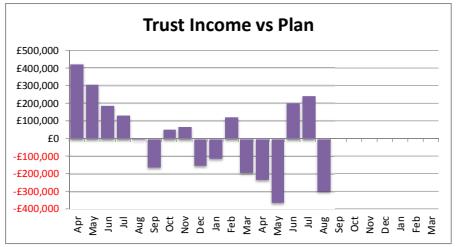




"Other" income is Excluded Drugs and Devices
"Attenders" is a combination of Radiology and MIU activity

Income vs Plan





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

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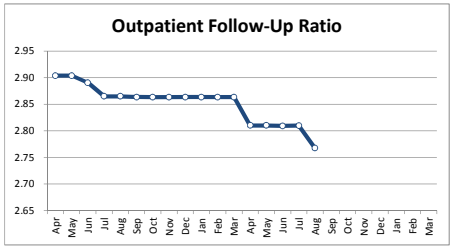
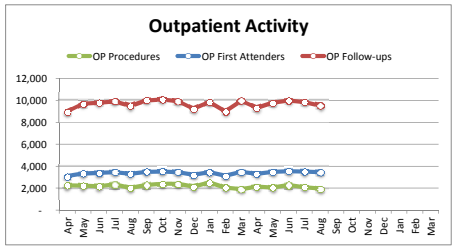
Follow-up Ratios





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	Jul-15	Aug-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%	93.31%	90.84%		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%	96.65%	95.70%		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%	95.86%	96.00%		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%	TBC		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%	99.04%		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%	93.1%	97.5%	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	#N/A	TBC	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%	98.7%	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%	95.9%	96.4%	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%	89.1%	91.4%	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%	60.0%	#N/A	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%	100.0%	66.7%	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 canc	85%
1				0			0			0		0	0	0	0		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	0	0	0	Zero tolerance MRSA	0
0	0	0	0	0	0	1	0	0	0	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	0	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%	99.3%	99.5%	TBC	TBC	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (APC	99%
99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%	99.7%	99.7%	99.7%	99.7%	99.4%	99.6%	TBC	TBC	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance (OP)	99%
99.4%	99.0%	98.7%	98.4%	98.4%	98.3%	98.3%	98.3%	98.4%	98.4%	98.4%	98.4%	98.5%	99.6%	97.9%	TBC	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	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%	94.1%	93.1%	94.4%	TBC	TBC	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE (now reported Qtrly 15/16)	95%
TRUE	TRUE	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	0	0	Never Events	0

	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	
	2014	2014	2014	2014	2014	2014	2014	2014	2014	2015	2015	2015	2015	2015	2015	2015	2015	2015	2015	2015	2015	2016	2016	2016	
	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	
Referrals (QVH)	3,296	3,502	3,625	3,607	3,294	3,711	3,646	3,306	3,254	3,118	3,342	3,581	3,693	3,128	3,329	4,455	3,216								QUVI
Referrals (Medway)	454	403	430	435	384	459	406	402	338	341	-	-	-	-	-	-	-								MM
Referrals (Dartford)	160	219	169	210	154	221	251	207	209	199	236	251	191	132	256	209	180								DART
Referrals (East Sussex)	42	84	51	70	55	62	67	68	65	49	53	54	60	61	38	-	-								ES
Referrals (Total)	3,952	4,208	4,275	4,322	3,887	4,453	4,370	3,983	3,866	3,707	3,631	3,886	3,944	3,321	3,623	4,664	3,396								
IP Waiters (Active)	1,845	1,890	1,876	1,979	1,928	1,834	1,608	1,634	1,637	1,688	1,600	1,596	1,818	1,637	1,805	1,834	1,882								
IP Waiters (Planned)	361	412	451	445	458	459	496	486	488	393	382	389	351	488	402	411	350								
Av. IP Wait (Weeks)	11.3	11.2	11.3	11.0	11.0	11.0	13.4	12.7	11.2	9.7	9.3	9.7	9.0	11.2	9.7	9.6	9.6								
Av. IP Wait (Weeks) StDev	11.7	11.3	12.1	12.1	11.9	12.4	87.7	90.7	13.3	12.2	12.5	12.5	11.9	13.3	12.8	12.9	12.9								
Minimum Wait (Weeks)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-								
Maximum Wait (Weeks)	166.3	131.0	138.0	139.0	145.0	149.0	3,654.3	3,854.9	162.1	167.0	172.0	175.1	181.0	162.1	188.0	191.0	197.0								
Exp Theatre Time (Mins) Total	182,651	186,304	187,588	189,163	188,284	188,309	180,698	178,573	179,035	168,513	156,879	155,113	158,834	179,035	167,164	169,408	166,190								
Av Exp Theatre Time (Mins)	82.8	80.3	80.6	78.0	78.9	82.1	85.9	84.2	84.3	81.0	79.2	78.1	73.2	84.3	75.7	75.5	74.5								
Exp Theatre Time (Mins) StDev	87.8	85.4	89.1	86.0	88.9	92.0	92.2	92.1	92.9	93.2	91.6	90.9	85.0	92.9	88.5	87.5	91.8								
OPFA Waiters	2,510	2,612	2,550	2,576	2,384	2,507	2,742	2,643	3,363	2,666	2,621	2,870	2,984	3,188	3,171	3,221	2,992								
Av OPFA Wait (Weeks)	8.4	6.4	6.5	6.2	6.5	6.4	8.8	6.7	6.3	7.7	7.2	6.4	6.6	6.7	6.7	6.7	7.4								
Av OPFA Wait (Weeks) StDev	11.7	5.5	6.2	5.6	4.9	6.1	8.0	9.7	4.3	6.6	7.0	7.1	7.9	8.3	7.4	12.2	8.1								
OPFUP Waiters	19,341.0	19,423.0	19,459.0	19,057.0	18,667.0	19,138.0	19,299.0	19,130.0	19,649.0	19,473.0	19,562.0	19,611.0	20,206.0	20,405.0	20,378.0	20,302.0	20,070.0								
Av OPFUP Wait (Weeks) since Referral	111.5	110.1	111.6	110.3	110.6	112.1	115.7	112.3	108.8	116.2	116.0	114.9	117.6	116.6	118.1	116.8	117.5								
Av OPFUP Wait (Weeks) StDev	141.3	142.7	143.7	142.5	141.8	143.8	144.3	141.5	135.4	143.8	142.3	142.0	145.1	144.7	145.1	145.5	146.3								
Income vs Plan (£s) monthly	£424,919	£307,398	£190,067	£133,845	-£6,354	-£161,389	£52,455	£69,222	-£149,734	-£112,211	£121,910	-£190,846	-£232,604	-£358,912	£203,755	£244,886	-£297,080								
Activity Plan (EL IP, DC)	1,050	1,134	1,164	1,317	1,260	1,372	1,366	1,347	1,251	1,337	1,222	1,352	1,198	1,259	1,286	1,268	1,273								Inpatient / Daycase
Activity Actual (EL IP, DC)	1,166	1,133	1,202	1,300	1,211	1,270	1,362	1,313	1,157	1,253	1,242	1,292	1,170	1,229	1,366	1,326	1,217								Inpatient / Daycase
Activity Plan (NEL)	364	393	396	427	409	430	433	427	397	424	388	429	400	420	429	423	406								NEL Inpatients
Activity Actual (NEL)	414	373	426	411	408	405	419	374	398	357	358	392	398	431	421	480	405								NEL Inpatients
Activity Plan (OP, OPPROC)	14,029	15,152	15,299	15,487	14,823	15,616	15,727	15,505	14,398	15,394	14,065	15,561	14,984	15,735	16,069	15,847	15,347								Outpatient
Activity Actual (OP, OPPROC)	16,103	15,995	16,279	17,096	14,599	16,205	16,662	15,823	14,569	15,843	14,807	16,174	14,892	14,840	16,699	16,475	14,900								Outpatient
OP Procedures	2,248	2,221	2,168	2,344	2,030	2,290	2,409	2,416	2,135	2,527	2,056	1,918	2,135	2,064	2,302	2,092	1,960								
Activity Plan (Attenders)	3,187	3,442	3,467	3,442	3,295	3,467	3,491	3,442	3,196	3,418	3,123	3,454	3,501	3,679	3,759	3,706	3,547								Attendance
Activity Actual (Attenders)	3,462	3,695	3,927	4,359	3,292	3,492	3,650	3,510	3,347	3,591	3,164	3,734	3,701	3,654	3,933	3,995	3,119								Attendance
Income Plan (£s) (EL IP, DC)	£1,459,998	£1,576,854	£1,630,663	£1,836,567	£1,757,857	£1,888,102	£1,892,054	£1,865,405	£1,732,162	£1,852,081	£1,692,189	£1,872,068	£1,716,299	£1,803,740	£1,842,603	£1,816,695	£1,786,909								Inpatient / Daycase
Income (£s) (EL IP, DC)	£1,561,591	£1,738,650	£1,630,808	£1,708,696	£1,566,880	£1,684,291	£1,805,302	£1,890,773	£1,518,762	£1,740,142	£1,714,651	£1,676,488	£1,589,951	£1,673,434	£1,827,232	£1,761,904	£1,631,410								Inpatient / Daycase
Income Plan (£s) (NEL)	£778,211	£840,498	£846,502	£921,497	£882,005	£928,079	£934,661	£921,497	£855,676	£914,915	£835,930	£924,788	£902,513	£947,931	£968,117	£954,660	£915,867								NEL Inpatients
Income (£s) (NEL)	£892,356	£858,079	£918,625	£931,402	£969,825	£978,637	£908,528	£824,095	£928,788	£856,254	£855,158	£923,924	£876,007	£919,547	£892,995	£1,033,957	£908,341								NEL Inpatients
Income Plan (£s) (OP, OPPROC)	£1,386,516	£1,497,491	£1,512,194	£1,529,241	£1,463,702	£1,541,768	£1,552,703	£1,530,834	£1,421,489	£1,519,899	£1,388,685	£1,536,301	£1,493,636	£1,568,843	£1,602,269	£1,579,985	£1,528,755								Outpatient
Income (£s) (OP, OPPROC)	£1,562,649	£1,563,153	£1,563,758	£1,695,097	£1,438,067	£1,601,976	£1,633,963	£1,571,935	£1,453,331	£1,561,674	£1,440,502	£1,569,079	£1,464,656	£1,488,301	£1,670,369	£1,674,850	£1,514,627								Outpatient
Income Plan (£s) (Attenders)	£149,142	£161,079	£162,230	£161,079	£154,176	£162,230	£163,380	£161,079	£149,574	£159,929	£146,122	£161,655	£167,864	£176,432	£180,240	£177,701	£170,086								Attendance
Income (£s) (Attenders)	£165,193	£169,688	£182,746	£202,383	£160,675	£167,797	£194,905	£164,246	£161,483	£172,726	£153,223	£179,327	£184,454	£185,126	£197,839	£201,027	£154,955								Attendance
Income Plan (£s) (Other)	£321,327	£345,051	£347,338	£345,336	£331,604	£347,625	£349,913	£345,336	£322,449	£343,047	£315,583	£346,480	£367,150	£371,441	£373,342	£372,073	£368,080								0
Income (£s) (Other)	£338,324	£398,801	£393,057	£389,988	£447,543	£273,715	£402,470	£442,325	£269,250	£346,863	£336,884	£301,629	£299,791	£243,069	£581,890	£474,263	£263,283								0
OPFUP Ratio	2.90	2.90	2.89	2.86	2.86	2.86	2.86	2.86	2.86	2.86	2.86	2.86	2.81	2.81	2.81	2.81	2.77								
OPFUP Ratio Target	#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	#N/A	#N/A								
OP First Attenders	3,099	3,347	3,392	3,465	3,317	3,496	3,521	3,471	3,223	3,447	3,149	3,484	3,316	3,484	3,558	3,509	3,444								OPFA
OP Follow-ups	8,997	9,717	9,804	9,928	9,502	10,011	10,082	9,940	9,230	9,869	9,017	9,976	9,326	9,790	9,996	9,859	9,530								OPFU
Additions to Waiting List	1045	959	1058	1312	1031	1069	1073	1210	1019	1268	1038	995	1139	1038	1232	1236	1072								
Removals from Waiting List	1082	961	1097	1201	1130	1133	1230	1168	1052	1134	1034	1066	964	1016	1234	1145	1043								
Theatre Mins Added	60,015	57,830	63,608	70,540	59,010	69,816	66,293	72,250	57,888	74,581	58,610	59,757	66,585	59,677	71,523	73,237	61,010								
Var from Activity Plan (EL IP, DC)	11%	0%	3%	-1%	-4%	-7%	0%	-3%	-7%	-6%	2%	-4%	-2%	-2%	6%	5%	-4%								
Var from Income Plan (EL IP, DC)	7%	10%	0%	-7%	-11%	-11%	-5%	1%	-12%	-6%	1%	-10%	-7%	-7%	-1%	-3%	-9%								
Var from Activity Plan (NEL)	14%	-5%	8%	-4%	0%	-6%	-3%	-12%	0%	-16%	-8%	-9%	0%	3%	-2%	13%	0%								
Var from Income Plan (NEL)	15%	2%	9%	1%	10%	5%	-3%	-11%	9%	-6%	2%	0%	-3%	-3%	-8%	8%	-1%								

Division																									
1 Anaesthetics and Surgery	£393,327	£310,687	£157,509	£47,148	£11,897	-£134,145	-£4,947	£39,910	-£180,384	-£154,779	-£56,668	-£222,223	-£278,955	-£5,056	£180,394	£196,761	-£286,441								1 Anaesthetics and Surgery
2 Clinical Support	£36,618	-£10,039	£17,333	£68,920	-£35,185	-£16,704	£52,574	-£65	£31,596	£35,805	£35,711	£11,846	£38,742	-£9,171	£32,368	£21,497	-£21,929								2 Clinical Support
3 Nursing	-£5,027	£6,750	£15,226	£17,778	£16,934	-£10,540	£4,828	£29,377	-£946	£5,220	-£14,165	£19,531	£7,609	-£10,051	-£9,007	£26,628	£11,290								3 Nursing

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	21 September 2015
Reference number:	204-15
Report from:	Sharon Jones, Director of Operations and Clare Stafford, Director of Finance and Performance

Delivery plan

1. Purpose

1.1. The purpose of the paper is to provide an overview of the trust delivery plan to achieve the planned surplus of £1m for 2015/16.

2. Background

2.1. The trust reported a surplus of £167k year-to-date at the end of August (month 5), which is £209k less than the plan for the year. The main reasons for the shortfall are due to an under achievement of the elective inpatient activity plan, under delivery of the cost improvement programme plans and increase in non-pay expenditure in some areas.

2.2. A diagnostic review was undertaken which identified that although the inpatient elective activity has been higher in quarter 1 than in the previous year; it is under performed against the 2015-16 plan. This has been mainly driven by a combination of the following factors:

a) Shift in case-mix - activity has increased the associated income is down due to a change in case-mix or an issue with coding/data-capture; and

b) Medical capacity - There has been considerable 'optimism bias' in the ophthalmology business case with a planned activity increase of 28.8% based largely on an additional consultant. However the consultant is not scheduled to start until the autumn suggesting delivery of this level of additional activity is unlikely.

3. Baseline forecast

3.1. A bottom up forecast has been produced based on latest financial position - Month 05, adjusted for non-recurrent items and incorporating future cost pressures. This forecasts a surplus of £707k at the end of the year which is £310k below plan. There has been deterioration in the forecast of £64k compared to that reported in Month 04 due to additional cost pressures including the cost of backfill associated with staff additional

Christmas leave and additional backlog equipment maintenance identified at the Medical Devices Committee. Appendix 1 shows details of bottom-up phased forecast and comparison to plan.

4. Delivery plan

A number of work streams have been developed to deliver the plan which is detailed in the following sections. Progress on each of the work streams will be monitored at the service performance review meetings.

4.1. Improvement against existing activity plan

a) Sleep services

Business planning for the Sleep Disorder Centre in 2015/16 was based on delivering 2014/15 actual activity levels. In addition, there has been a 14.5% increase in referrals since the start of this calendar year which has led to capacity pressures for overnight diagnostic testing and ventilator treatment.

A business case has been developed to employ additional staff and purchase equipment to:

- Address the shortfall in the day case activity plan and deliver the 2015/16 DC activity for M7-12;
- To deliver additional overnight diagnostics and follow-up technician treatments to meet current demand.

The investment delivers £127k additional income in the current financial year, at a cost of £35k delivering a net contribution of £93k.

b) Plastic surgery

There are two areas which can provide a viable contribution to the delivery plan. Therefore areas that can provide extra activity are as follows:

- Non-elective - the additional CEPOD trauma theatre will be open from 1 October 2015. It is anticipated that this will deliver a risk adjusted contribution of £90k in year.

- Hands – due to the additional trauma theatre, 54 elective hand cases can be undertaken over this period. It has been agreed to factor this into the trauma theatre capacity to prevent the need for third sessions and weekend sessions. A hand fellow will undertake this work and this will also help with

the waiting list pressures on this service; It is anticipated that this will deliver a risk adjusted contribution of £51k in year.

c) Maxillofacial services

On the basis of a review of current capacity and future demand the service will undertake an additional Saturday MOS list as a waiting list initiative – 40 per month. It is anticipated that this will deliver a risk adjusted contribution of £14k

d) Corneoplastic services

On the basis of a review of current capacity and future demand the service will Undertake an additional all day Saturday cataract list as a waiting list initiative – 12 cataracts per month. This will generate a risk adjusted surplus of £35k by the end of the year. Details of the interventions are shown at Appendix 2

4.2. Contribution from new streams of activity:

- The opportunity for new activity is as a result of waiting list initiatives being undertaken on behalf of other trusts. The following are in the process of being developed. These schemes are not at present included in the plan as they are still subject to agreement but do offer both an additional opportunity and contingency:-

Trust Name	Speciality	Q3	Q4
BSUH	Teeth	50 cases	Possible further 50 cases
Medway	ENT	50 cases	50 cases
MTW	To be confirmed but have approached with a list of ENT cases – on initial review these appear to be routine cases so feasible		

4.3. Expenditure controls.

Additional ordering and purchasing controls have been introduced within the trust in order to manage expenditure across all service lines. These include:

- Reduction in the number of staff who can order goods and services;
- All non-essential expenditure challenged and escalated authorisation;
- Produce lines reduced in order to reduce cost variation in ordering;
- All stock labelled to reduce wastage; and
- Additional review of expenditure lines across services with escalation meetings with high spending areas.

4.4. New cost improvement/productivity improvements

Additional procurement savings of circa £50k have been identified to be delivered by the end of the year.

4.5. Tactical savings

Tactical savings of circa £50k have been identified. These include savings from a review of banking charges, review on bad debt provision and discounts from suppliers from prompt payment.

5. Revised forecast

A revised forecast has been produced that details the impact of all the interventions detailed above. This is detailed at Appendix 3. The total impact of the interventions is an improvement of £378k which would ensure delivery of the plan in year. There are a number of risks to the delivery of the revised forecast.

6. Risks

- Further delays to the opening of the day treatment centre and associated additional trauma capacity.
- Theatre team recruitment - All additional surgical activity is reliant on the theatre teams being able to find capacity both in terms of theatre space and staff.
- Medical recruitment - Some schemes in the existing plan, such as the additional ophthalmology activity, are directly linked to successful recruitment.

7. Future planning approach

7.1. The trust has put in place changes that will ensure a more robust approach to planning and delivery is in place for the remainder for the financial year and going forward. These can be summarised as follows:

- A business planning steering group and a sustainability and productivity group will be in place to ensure there is adequate governance, oversight and coordination;
- Performance review meetings have been arranged with a set up/contextual meeting in August with monthly meetings from September. This gives protected time to ensure progress is monitored, with constructive challenge and senior support to unblock any barriers to delivery in a timely manner;
- All terms of reference of relevant groups have been reviewed and will incorporate CIP and productivity requirements where relevant- attached at Appendix 3;

- A focus on capacity modelling which will drive forward planning in a realistic manner;
- Dashboard and metric development allowing both transparent reporting and monitoring of progress;
- A structured business case template and approval process is being produced so that all costs are captured. All cases and associated projects will have the appropriate governance and implementation arrangements in place.

8. Recommendations

8.1. The board is asked to **NOTE**:

- The contents of the report and in particular the baseline forecast and details of the interventions that comprise the delivery plan.
- The risks to the delivery of the plan and independencies and in particular the recruitment of key staff.
- The future approach to planning that will be implemented in processes going forward and the terms of reference of the groups.

Appendices

Appendix 1 : Financial Forecast - Baseline

Baseline Forecast 2015-16	1		2		3		4		5		6		7		8		9		10		11		12		Total Year	Total Year	Total Year
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	Actual	Budget	Variance
INCOME FROM ACTIVITIES	4,517	4,708	4,803	4,946	5,194	5,052	5,181	4,982	4,720	4,770	5,117	4,982	5,072	5,017	5,077	5,017	4,648	4,593	5,038	4,946	4,789	4,699	5,085	4,893	**59,241**	**58,605**	**636**
OTHER OPERATING INCOME	280	324	416	326	303	326	324	363	335	361	327	361	327	376	327	376	327	373	327	388	327	386	327	386	**3,948**	**4,346**	**(398)**
PAY EXPENDITURE	(3,302)	(3,396)	(3,338)	(3,396)	(3,415)	(3,397)	(3,452)	(3,436)	(3,443)	(3,436)	(3,410)	(3,437)	(3,427)	(3,416)	(3,432)	(3,416)	(3,440)	(3,417)	(3,473)	(3,416)	(3,440)	(3,416)	(3,457)	(3,415)	**(41,031)**	**(40,994)**	**(36)**
NON PAY EXPENDITURE	(1,695)	(1,739)	(1,756)	(1,739)	(1,886)	(1,740)	(1,923)	(1,751)	(1,694)	(1,751)	(1,780)	(1,752)	(1,785)	(1,745)	(1,775)	(1,745)	(1,795)	(1,745)	(1,801)	(1,745)	(1,782)	(1,744)	(1,777)	(1,743)	**(21,451)**	**(20,940)**	**(511)**
Total Monthly	**(201)**	**(103)**	**126**	**137**	**196**	**242**	**130**	**157**	**(83)**	**(56)**	**254**	**153**	**186**	**232**	**197**	**232**	**(259)**	**(196)**	**92**	**173**	**(107)**	**(75)**	**177**	**122**	**707**	**1,017**	**(310)**
Variance Monthly		**(97)**		**(11)**		**(46)**		**(28)**		**(27)**		**101**		**(46)**		**(35)**		**(63)**		**(81)**		**(32)**		**55**			
Total Year to date	(201)	(103)	(75)	33	121	275	250	433	167	376	421	530	607	762	804	994	545	797	637	970	530	895	707	1,017			
Variance YTD		(97)		(109)		(155)		(182)		(209)		(108)		(154)		(189)		(253)		(334)		(365)		(310)			

Summary

- The baseline forecast shows a forecast surplus of £707k which is a deficit of £310k against plan.
- This forecast is based upon a detailed bottom up review of expenditure and income, the removal of non recurrent items, the identification of cost pressures, review of current plans for recruitment to vacancies and the impact of activity developments .

Risks

- A further deterioration in activity performance .
- Other events that may affect operational or patient activity – e.g. Patient flow issues (identification, referral, scheduling), weather, infection outbreaks , recruitment and staff availability, estate and utilities availability.

Appendix 2: Details of Interventions

Intervention Plans														
Plans to achieve target surplus:	**Type**	**M1**	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**FY Position**
Tactical savings														
Bank overdraft facility - removal	NON PAY						2	2	2	2	2	2	2	12
Income - misc	NON PAY						0	0	0	0	0	0	0	2
Expenditure controls - not urgent ordering	NON PAY						-	0	0	0	0	0	0	2
Depreciation review	NON PAY						-	-	-	-	-	-	-	-
Supplier Discounts - phase 1	NON PAY						-	0	0	0	0	0	0	2
Review bed debts provision policy	NON PAY						-	3	3	3	3	3	3	18
Private payment income (Jersey)	NON PAY						12	-	-	-	-	-	-	12
Tactical Savings Total		-	-	-	-	-	**14**	**6**	**6**	**6**	**6**	**6**	**6**	**47**
Activity Interventions, risk rated contributions														
Sleep Business Case	INCOME FROM ACTIVITIES								26	26	26	26	26	128
Sleep Business Case	PAY								(3)	(3)	(3)	(3)	(3)	(17)
Sleep Business Case	NON PAY								(3)	(3)	(3)	(3)	(3)	(17)
100% Sleep Business Case	Contribution								19	19	19	19	19	93
Oral/MF : minor ops	INCOME FROM ACTIVITIES							6	6	6	6	6	6	36
Oral/MF : minor ops	NON PAY							(4)	(4)	(4)	(4)	(4)	(4)	(22)
80% Oral/MF : minor ops	Contribution							2	2	2	2	2	2	14
Corneo - daycase, cataracts	INCOME FROM ACTIVITIES							9	9	9	9	9	9	51
Corneo - daycase, cataracts	NON PAY							(3)	(3)	(3)	(3)	(3)	(3)	(17)
80% Corneo - daycase, cataracts	Contribution							6	6	6	6	6	6	34
Hands - daycase	INCOME FROM ACTIVITIES							11	11	11	11	11	11	64
Hands - daycase	NON PAY							(2)	(2)	(2)	(2)	(2)	(2)	(13)
80% Hands - daycase	Contribution							9	9	9	9	9	9	51
Trauma list	INCOME FROM ACTIVITIES							48	48	48	48	48	48	286
	PAY							(33)	(33)	(33)	(33)	(33)	(33)	(201)
50% Trauma list	Contribution							14	14	14	14	14	14	86
Total Activity Interventions, risk rated contributions		-	-	-	-	-	-	**31**	**49**	**49**	**49**	**49**	**49**	**278**
Additional Cost Savings														-
Theatre gowns	NON PAY						-	-	4	4	4	4	4	20
Sleep	NON PAY						0	0	0	0	0	0	0	1
Plates & screws -Synthes	NON PAY						2	2	2	2	2	2	2	11
Digital Dictation	NON PAY						-	-	0	0	0	0	0	1
Insurance	NON PAY						-	-	-	0	0	0	0	1
Dental-3M spend	NON PAY						-	-	1	0	0	0	0	2
switch to f/work or switch supplier	NON PAY						-	-	0	1	1	1	1	4
Mattresses	NON PAY						-	-	-	-	1	1	1	3
Clinical products spend through supply chain	NON PAY						-	-	1	1	1	1	1	4
Sterile Services	NON PAY						-	-	-	2	2	2	2	7
Total Additional Cost Savings		-	-	-	-	-	**2**	**2**	**8**	**10**	**11**	**11**	**11**	**52**
		-	-	-	-	-	**16**	**38**	**63**	**65**	**66**	**66**	**66**	**378**

Risks – Activity interventions have been adjusted

Appendix 3 : Revised Financial Surplus Forecast with Interventions

Queen Victoria Hospital NHS
NHS Foundation Trust

Intervention Forecast	1		2		3		4		5		6		7		8		9		10		11		12		Total Year	Total Year	Total Year
	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	*Forecast*	Budget	Actual	Budget	Variance
Baseline Forecast	(201)	(103)	126	137	196	242	130	157	(83)	(56)	254	153	186	232	197	232	(259)	(196)	92	173	(107)	(75)	177	122	**707**	**1,017**	**(310)**
Tactical savings																											
NON PAY EXPENDITURE											14		6		6		6		6		6		6		**47**		**47**
Additional cost savings																											
NON PAY EXPENDITURE											2		2		8		10		11		11		11		**52**		**52**
Activity projects, risk adjusted																											
INCOME FROM ACTIVITIES													73		99		99		99		99		99		**565**		**565**
PAY													(33)		(37)		(37)		(37)		(37)		(37)		**(218)**		**(218)**
NON PAY													(9)		(12)		(12)		(12)		(12)		(12)		**(69)**		**(69)**
Sub total: Contribution													**31**		**49**		**49**		**49**		**49**		**49**		**278**		**278**
Total Interventions:	-		-		-		-		-		**16**		**38**		**63**		**65**		**66**		**66**		**66**		**378**	-	**378**
Revised Forecast	(201)	(103)	126	137	196	242	130	157	(83)	(56)	270	153	224	232	260	232	(195)	(196)	157	173	(41)	(75)	243	122	1,085	1,017	68

Business Planning Steering Group **Appendix 4**

Draft Terms of Reference

1. Purpose

The purpose of this group is to ensure the process redesign, risk assessment and operational delivery of the business planning cycle, to gain the planned outcomes and benefits and to drive the organisational change required to improve planning processes and outputs across the Trust.

2. Objectives

To develop an inclusive and integrated business planning framework, and processes, that meet the standards required to support the delivery of high quality care, clinical excellence and financial sustainability;

To develop, agree and communicate the assumptions that under-pin plan development and ensure that the impact of internal and external drivers and recognised and understood;

To understand the key performance metrics that require delivery (for e.g. RTT18, new to follow up ratios etc.) and provide assurance that delivery of these are built into the plan;

To consider and appraise the feasibility of individual business plans to ensure completeness, economic viability and strategic fit;

To ensure all plans have quality, equality and financial sustainability impact assessments completed; and

To set, and recommend for approval, Trust-wide annual (and longer term) integrated business plans.

Note – In-year delivery against 'the plan' will be monitored via the Performance Review Meetings.

3. Accountability and Reporting Arrangements

The Business Planning Steering Group will report formally to Business Development (W1) SMT.

Business Managers and Heads of Departments are responsible for ensuring the above principles and the detail underpinning the plan are agreed and understood with their respective teams – clinical and non-clinical.

4. Membership

The Business Planning Steering Group shall comprise the following:

- Director of Finance and Performance
- Director of Operations

- Deputy Director of Clinical Infrastructure
- Head/Deputy Head of Human Resources and Organisational Development
- Deputy Director of Finance
- Head of Commerce
- Head of Information
- Deputy Head of Human Resources
- All Business Managers
- Deputy Medical Director

5. Quorum

A quorum shall be four members, to include a minimum of one director, (Director of Finance and Performance and/or Director of Operations) or their nominated representatives, and two deputies.

6. Meeting Frequency and arrangement

- The Business Planning Steering Group will meet monthly, in the first instance, and members will be expected to attend 60% of all meetings;
- At the discretion of the Chair, additional meetings may be called;
- Responsibility for the operation of the meetings and organisation lies with the Chair;
- Draft actions will be forwarded to group members for review and comment soon after the meeting.
- An agenda shall be available prior to each meeting, and will allow for additional items under Any Other Business to be added to at the commencement of the meeting, subject to the approval of the Chair;
- The agenda, including papers, shall be circulated at least three days prior to the meeting.

7. Authority

The Business Planning Steering Group is a sub-group of the Business Development (Wk1) SMT.

To fulfil its requirements the Business Planning Steering Group will create and manage sub-groups as and when required to deliver specific outcomes.

8. Monitoring Effectiveness

The terms of reference and performance of the Business Planning Steering Group will be reviewed annually and ratified by the Business Development SMT to ensure continued effectiveness.

9. Key performance indicators

Achievement of planning milestones
Accuracy of planning
Monitoring of activity, income and expenditure
Ensure outcomes and benefits materialise as planned

10. Key Tasks

Propose timetable that will be set to ensure plans are consulted, completed and agreed at the Trust Board by end of March at the latest;

Formulate business planning and budget setting principles and communicate to the wider organisation to ensure ownership and transparency. These will be based on a combination of external and internal drivers.

Devise business planning and budget setting templates and guidance that support the efficient and effective development of plans;

Define acceptable risk profile and risk thresholds for business planning/budget setting and identify assurances and controls to mitigate risks;

Identify and follow relevant oversight arrangements for regularly evaluating and monitoring plans and planning processes;

Review commissioning intentions and support the development of a Trust response with actions as required;

Ensure that bottom-up capacity and demand modelling, adjusted for known factors, informs the setting of realistic income targets and contracting positions;

Ensure that the capacity and demand modelling is used to determine resources required with respect to staff, number clinics, theatre sessions and beds;

Ensure that the profiling of activity and income and expenditure plans across the financial year is consistent and that the underpinning principles are understood;

Ensure that the profiling of cost reduction, productivity and growth expectations are based on evidence and underpinned by robust implementation plans.

Review alignment of commissioner activity and income plans and ensure variances are assessed for risk and understood;

Resolve strategic and directional issues among plans which require the input and agreement of senior stakeholders to ensure delivery of outcomes;

Set up and manage sub-committees and Task and Finish groups as required.

Appendix 5

Performance Review Group

Terms of Reference

Draft - Version 1.0

Status:	Reports to Executive Management Team (scrutiny) Reports to Finance & Performance Committee & Quality & Risk Committee (assurance)
Chair:	Director of Finance & Performance
Frequency of Meetings:	Monthly/Quarterly

1. Purpose

Queen Victoria NHS Foundation Trust (QVH) intends to develop and implement an explicit corporate Performance Management Framework. It gives a clear line of accountability for all aspects of performance including patient safety, patient experience, operational standards, financial performance and staff engagement relating to each business unit or corporate department.

2. Objectives

The Performance Review Group will be exception focused and action orientated. It will take an integrated approach that aligns the delivery of clinical and non-clinical operational performance targets, quality indicators and financial measures.

The objectives of the Performance Review Meetings are as follows:-

a) To monitor compliance and ensure delivery of statutory duties, national and local standards/targets and other obligations;
b) To gain assurance of performance against activity and income plan;
c) The business units to provide a clear explanation of the causes of any underperformance;
d) To ensure the mitigating actions have explicit owners and timescales for delivery;
e) To give confidence in the successful delivery of the business units/corporate department's productivity, efficiency and cost improvement schemes;
f) To monitor business case implementation and review post implementation evaluation;
g) To make the case for the introduction of any significant 'one off' activity or service opportunities such as non-recurring activity from other Trusts;

3. Accountability and Reporting Arrangements

The Performance Review is established under the direction of the, and will be directly accountable to, Trust's Executive Management Team (EMT).

The Group shall refer to the Executive Management Team any issues of concern it has relating to the performance issues.

The actions of the Performance Review Meetings shall be formally recorded and available to the Executive Management Team.

From an assurance point of view, the Performance Review Group will report to the Finance & Performance and/or Quality & Risk Committee of the Board.

Challenge and/or support will be facilitated using an integrated performance dashboard that includes quality, performance, activity and finance targets aligned to the key strategic objectives.

5. Membership

Core Membership of the Performance Committee will comprise of the following: -

- Director of Finance & Performance (Chair);
- Director of Operations;
- Head of Commerce;
- Director of Human Resources
- Director of Nursing and Quality;
- The CEO and Medical Director have a standing open invitation

Core members should be represented by a deputy in their absence.

Attendance from business units, clinical infrastructure and corporate areas will be:

- Business Unit Manager (plastics, oral, sleep & eyes, clinical support services)
- Clinical Directors (plastics, oral, sleep & eyes)
- Head of Clinical Infrastructure/Deputy Director of Nursing
- Heads of Corporate Departments (HR, Corporate Affairs, Estates and Facilities, Finance, Commerce, Quality and Risk)
- HR Business Partner
- Finance Business Partner

The Director of Finance & Performance will chair meetings and in their absence the Director of Operations will chair.

The Chair may invite other members of staff to attend meetings as appropriate.

6. Quorum

A quorum shall be four members, to include a minimum of two directors, or their nominated representatives

Members are required to send a deputy with the appropriate skills and knowledge to represent them, and who can make decisions, if they are unable to attend a meeting.

7. Meeting Frequency and arrangements

a) Meetings will normally be held monthly for clinical business units and quarterly for non-clinical departments.;

b) Meetings may be held more frequently, as convened by the Chair;

c) The Chair has the authority to exercise an emergency or urgent decision where a particular issue requires a response that cannot be deferred to the next meeting.

d) The agenda for meetings will be prepared by the Director of Finance & Performance and the Director of Operations;

a) The agenda and reports for the meetings will be circulated by email one week prior to the meeting;

b) Action notes will be taken at each meeting by the Head of Commerce to keep a record of the business and issues to be carried forward;

c) The PA to the Director of Operations will be responsible for meeting arrangements and circulation of documents.

d) Monitoring Effectiveness

The performance of the Performance Review Group shall be monitored via the Executive Management Team

9. Ratification of Terms of Reference & Review Arrangements

Reviewed at the Performance Meetings September 2015;

To be reviewed annually: next review September 2016

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Reference number:	204-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	17th September 2015
Appendices:	Workforce report

Workforce report: September 2015

Key issues

1. The September report is a summarised version covering the headlines at trust level. The more detailed business unit analysis has been delayed this month following additional data requirements which have impacted on the HR/OD team producing the information for the board deadline. The highlights from the summary report are listed below.

2. Sickness in July 2015 (reported 1 month in arrears) has risen to 2.40% from 2.09% in June. Performance compared to last year has improved with only 1 business area above 3%. Supporting managers through the autumn and winter periods will be the focus for the HR/OD team to help maintain an improved performance compared to 2014.

3. The vacancy rate for July is 18.5% (information is based on 2015/2016 establishment figures). The budgeted establishment figure for July 2015 is 968.13 WTE, and the number of staff in post was 838.73 WTE. During the month of July the trust used approximately 81.82 WTE (excluding RMN) bank staff and agency workers. The reason for use of bank and Agency staff was due to establishment vacancies and sickness absence (the rate of absence in July was 2.40%).

4. Bank and agency usage remains low overall, there have been some increases in agency expenditure. The overtime pilot running across nursing continues to have a positive impact on covering shifts with our own bank staff and providing greater consistency of care to patients.

5. In September the executive management team approved a change in approach to statutory and mandatory training compliance and set a deadline of 30 September 2015 for 100% compliance. There has been a good response to date and it has been made clear that if there are organisational reasons why staff have elements of training outstanding after the deadline, then disciplinary action will not be taken. Overall there have been improvements with the top performing areas being across the nursing specialties.

6. The Director of HR/OD will provide further details.

Implications of results reported

7. The report provides the board with assurance against the workforce key performance indicators.

8. The information contained within the report will be available to our commissioners and the general public.

Action required

9. 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.

10. In addition to the above progress is also reported to the finance and performance committee on a monthly basis.

Link to key strategic objectives (KSOs)

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

Implications for board assurance framework (BAF) or corporate risk register (CRR)

11. The issues raised at paragraphs 1 – 5 above are not so serious as to merit inclusion on the CRR or BAF at this stage, although the potential for matters to escalate will be monitored and recommendations will be made if appropriate.

Regulatory impacts

12. 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 trust's delivery of high quality patient care. Consequently there is no adverse impact for regulatory compliance.

Recommendation

13. 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 July 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 July 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
968.13 WTE	838.73	↓	987	566	421

2. Sickness Absence Data

Business Unit / Department	Percentage of sickness absence in July 2015	Trends	Average number of sickness days per employee in Trust in July 2015	Number of absence days lost in July 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in Trust on a 12 month rolling period	Estimated costs related to sickness absence for July 2015
Nursing & Clinical Infrastructure	3.10%	↑	0.97	419.0	3.69%	13.47	£32,140
Corporate, Finance & Non Clinical Infrastructure	2.84%	↑	0.88	85.0	2.84%	10.37	£4,942
Clinical Support	2.04%	↓	0.63	56.0	3.16%	11.54	£5,370
Eyes and Sleep	1.50%	↓	0.46	33.0	1.17%	4.25	£1,176
Oral	2.30%	↑	0.71	76.0	1.83%	6.69	£5,647
Plastic Surgery	2.69%	↑	2.69	71.0	3.48%	12.72	£4,141
Trust	**2.40%**	↑	**0.74**	**740**	**3.16%**	**11.50**	**£53,416**

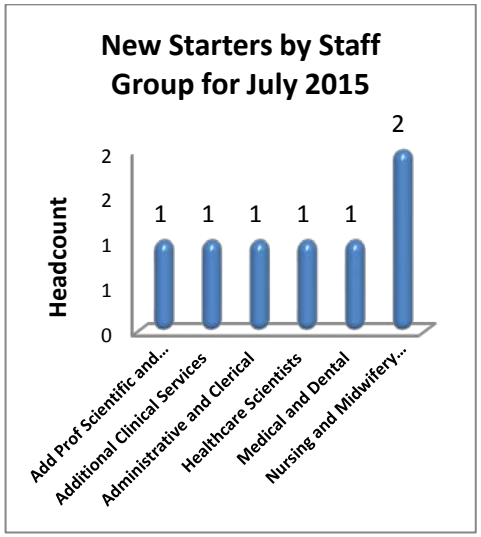
3. People Management (Employee Relations)

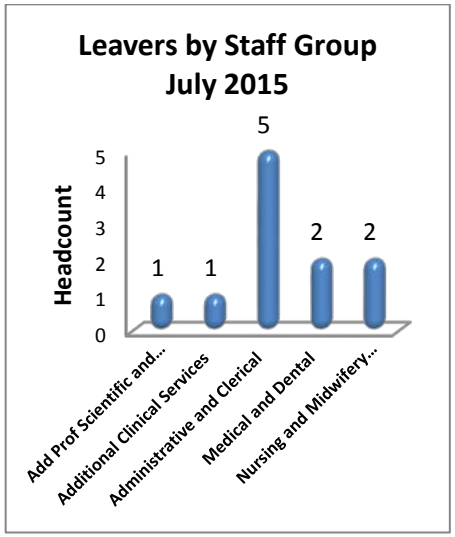
Type of Case (Formal)	Number of cases opened	Number closed
Sickness Absence	6	0
Disciplinary	2	0
Capability		0
Grievance	2 (on-going)	0
Whistleblowing / Raising Concerns	1 (on-going)	0
Total	**11**	**0**

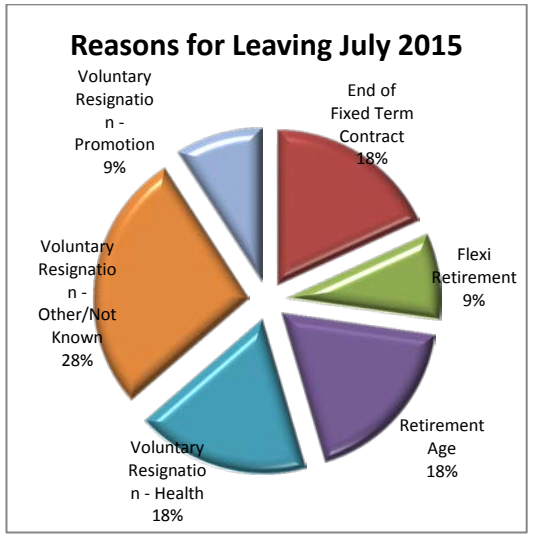
QVH Business Unit permanent staff compliance for 18 competencies as at 1st September 2015

Area	Permanent & Fixed Term Staff % Compliance		Trends	NON-Permanent Staff % Compliance		Trends	All staff % compliance		Trends
QVH Overall	81.38		↑	38.15			75.09		↑
Corporate	85.07		↑	42.22			63.03		↑
Plastic surgery	66.44		↑	70.00			66.67		↑
Oral	72.85		↑	26.96			67.81		↓
Sleep	82.46	} 82.75	↑	2.78	} 1.67		71.59	} 74.21	↑
Eyes	82.98			0.00			76.47		
Clinical Support	88.77		↑	0.00			87.78		↑
Nursing	82.72		↑	5.56			81.21		↑
QVH Overall compliance target - 80%							Green - 80% & higher		
							Amber - 70-79%		
							Red - 0-69.99%		

4. Starters and Leavers July 2015







Vacancy Information as at 31st July 2015

The vacancy rate for July is 18.5% (information is based on 2015/2016 establishment figures). The budget staff establishment figure for July 2015 is 968.13 WTE, and the number of staff in post was 838.73 WTE. During the month of July the Trust used approximately 81.82 WTE (excluding RMN) Bank staff and agency workers. The reason for use of Bank and Agency staff was due to establishment vacancies and sickness absence (the rate of absence in July was 2.40%).

5. Bank and Agency Usage

Staff type	% of monthly budget	Trend	Total number (WTE) during July	Total cost during July	Total number of hours during July
Bank (Target< 5%)	1.20%	→	117.12	£40,869	4392
Agency (Target < 5%)	1.16%	↑	49.76	£39,738	1866

6. Recruitment

See individual Business Unit breakdown. 25 posts advertised too many to list here.

QVH Workforce Summary

Workforce Profile – the QVH overall establishment is 968.13 (WTE) and the number of WTE staff in post is 838.73, an operational gap of 129.40 WTE posts. The operational gap was filled by bank and agency staff and the usage for the same period was 166.9. Whilst slightly above the gap of 129.40, agency and bank usage would have been used to also cover sickness absence which increased in August and in Nursing and Clinical Infrastructure increased from 2.53% in June to 3.10% in July.

Sickness Absence – the QVH overall percentage for July is 2.42%, an increase of 0.33% compared to the percentage in June 2015 of 2.09%. There are no apparent reasons for the increase given the warmer climate, and in addition there are a small number of long term sickness absence cases which are impacting on the overall figures.

People management – there were a number of new employee relations cases in July and in particular HR are seeing an increase in the number of grievances raised. Initially we expect to see the number of grievances increase as a result of more robust performance management and a change of culture.

Statutory & Mandatory Training – the compliance rates in all business units increased in July, except Oral, and we expect to report significant increases in August and September given the deadline set by EMT for all staff to be 100% compliant by 30 September 2015.

Bank & Agency Usage – see comments in Workforce Profile. The overall QVH usage increased in July compared to June by 25.72 (WTE), but is well below the target of 5%.

Recruitment – the summer months tend to be quiet, but July was busy with 25 advertisements being placed on NHS Jobs. Recruitment has been particularly active in the Clinical Support Directorate.

NB: Pages 3 to 14 provide only partial data and analysis and therefore are only provided for information.

Queen Victoria Hospital NHS
NHS Foundation Trust

Workforce Board Report

Nursing & Clinical Infrastructure

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

1. Workforce Profile

Agreed WTE Establishment (as at 1 July 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	394.27	470		

2. Sickness Absence Data

Percentage of sickness absence in July 2015	Trend	Average number of sickness days per employee in July 2015	Number of absence days lost in July 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 July 2015
3.10%	↑	0.97	419	3.69%	13.47	£32,140

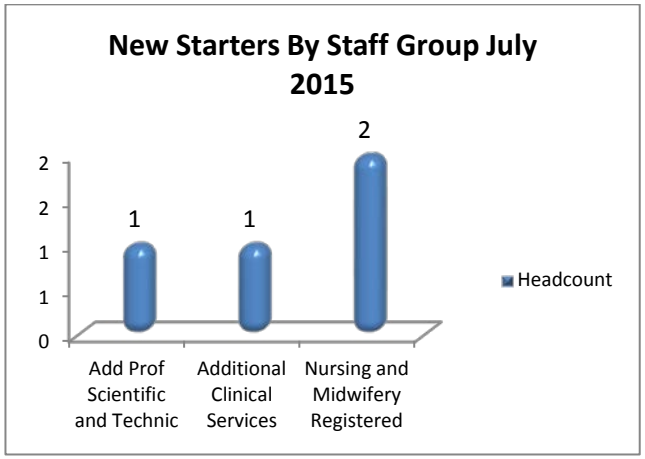
3. People Management (Employee Relations)

Type of Case (Formal)	Number of Cases opened	Number closed
Sickness Absence	1	0
Disciplinary	2	0
Capability	0	0
Grievance	0	0
Whistleblowing / Raising Concerns	0	0
Total	**3**	**0**

QVH Nursing & Clinical Infrastructure Business Unit permanent & fixed term staff compliance for 18 competencies as at 1st September 2015

Area	Headcount	Required	Achieved	Compliance %
276 200009 Healthcare Records	13	104	76	**73.08%**
276 210033 SLR ITU	17	187	138	**73.80%**
276 210029 Main Outpatients	19	225	175	**77.78%**
276 210002 Theatres	139	1,631	1,286	**78.85%**
276 210022 SLR MIU	18	207	165	**79.71%**
276 250002 Site Practitioners	14	169	136	**80.47%**
276 210001 Anaesthetics	31	364	293	**80.49%**
276 250007 Clinical Audit	2	16	13	**81.25%**
276 250001 Nurse Management	19	189	154	**81.48%**
276 210032 Burns Centre	33	377	310	**82.23%**
276 210005 Paediatrics	30	370	312	**84.32%**
276 210031 Canadian Wing	58	661	579	**87.59%**
276 210028 CorneoPlastic Nursing	23	277	243	**87.73%**
276 210027 Maxillofacial Nursing	28	317	290	**91.48%**
276 210030 Pre Assessment	9	102	95	**93.14%**
276 250008 Research	3	24	23	**95.83%**
276 200012 Admissions	15	120	116	**96.67%**
276 200021 MacMillan Centre	2	19	19	**100.00%**
276 250009 Risk Management	3	23	23	**100.00%**
276 260037 Matrons	3	35	35	**100.00%**
Business Unit Total				**82.72**

4. Starters and Leavers July 2015



5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during July	Total cost during July	Total number of hours during July
Bank (Target< 5%)	2.31%	↓	74.19	£27,596	2785.45
Agency (Target < 5%)	1.80%	↓	49.76	£39,738	1866

6. Recruitment

Job title of post advertised in August 2015	
Pain Management Nurse	6
Staff Nurse	5
Paediatric Safeguarding Nurse	7
Emergency Nurse Practitioner	7
Infection Control Nurse	5
Receptionist/Clerical Officer	2
Procurement & Sterile Equipment Assistant (p/t)	2
Procuremnt & Sterile Equipment Assistant (f/t)	2
Health Records Team Leader	5

Workforce Summary

Workforce Profile – there is an operational gap of 90.69 WTE posts
Sickness Absence – the percentage rate in Nursing increased by 0.57% to 3.10%
People management – there were two new disciplinary cases in July 2015
Statutory & Mandatory Training – the overall compliance rate for permanent and fixed term staff is 82.72% and all sections within Nursing and Clinical infrastructure are 70+% compliant.
Bank & Agency Usage – this is again showing a downward trend and as mentioned in the QVH overall summary the bank and agency usage in mainly due to the operational gap between establishment and number of staff in post
Recruitment – there were a total of nine posts advertised including a number of speciality nursing positions, and there is ongoing work to improve the recruitment of nurses to the trust.

Workforce Board Report

Corporate, Finance & Non Clinical Infrastructure

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

1. Workforce Profile

Agreed WTE Establishment (as at 1 July 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				

2. Sickness Absence Data

Percentage of sickness absence in July 2015	Trend	Average number of sickness days per employee in July 2015	Number of absence days lost in July 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 July 2015
2.84%	↑	0.88	85	2.84%	10.37	£4,942

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	0	0
Whistleblowing / Raising Concerns	1 (on-going)	0
Total	**2**	**0**

Corporate permanent & fixed term staff compliance for 18 competencies as at 1st September 2015

Area	Headcount	Required	Achieved	Compliance %
276 220004 Domestics & Portering	37	296	226	**76.35%**
276 230002 Operational Management	14	111	86	**77.48%**
276 260004 IMT Department	6	48	38	**79.17%**
276 220005 Hotel Services	5	40	32	**80.00%**
276 260003 Coding & Contracts	6	48	39	**81.25%**
276 230001 Trust Board	9	73	61	**83.56%**
276 220001 Catering	10	80	68	**85.00%**
276 220007 Building & Engineering	10	80	71	**88.75%**
276 240001 Human Resources	22	176	158	**89.77%**
276 240003 Library	3	24	22	**91.67%**
276 230003 Corporate Affairs	5	40	37	**92.50%**
276 260002 Commerce	5	40	37	**92.50%**
276 220006 Telephones	6	54	51	**94.44%**
276 260001 Finance Department	19	152	144	**94.74%**
276 240002 Medical Education	3	24	24	**100.00%**
Business Unit Total				**85.07**

4. Starters and Leavers July 2015

5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during July	Total cost during July	Total number of hours during July
Bank (Target< 5%)	1.16%	↓	12.24	£3775.40	459
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in August 2015	Band
Organisational Development Manager	7
HR Business Associate	6
Resourcing Manager	7
Apprentice – L & D	2
Head of Clinical Audit	8A
Clinical Audit & Outcomes Manager	6
IT Support Technician	3

Workforce Summary

Workforce Profile – there is an operational gap of xxx WTE posts
Sickness Absence – the percentage rate is 2.84% and has increased in July
People management – there was one new sickness absence case, which accounts for the slight increase in the sickness absence %.
Statutory & Mandatory Training – the overall compliance rate for permanent and fixed term staff is 85% and all sections are 70+% compliant.
Bank & Agency Usage – this is again showing a downward trend and as mentioned in the QVH overall summary the bank and agency usage in mainly due to the operational gap between establishment and number of staff in post. There was no agency usage
Recruitment – there were a total of seven posts advertised

Workforce Board Report

Business Unit: Clinical Support

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

1. Workforce Profile

Agreed WTE Establishment (as at 1 July 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				

2. Sickness Absence Data

Percentage of sickness absence in July 2015	Trend	Average number of sickness days per employee in July 2015	Number of absence days lost in July 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 July 2015
2.04%	↓	0.63	56	3.16%	11.54	£5,370

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**

Clinical Support permanent & fixed term staff compliance for 18 competencies as at 1st September 2015

Area	Headcount	Required	Achieved	Compliance %
276 200005 SLR Rheumatology	1	12	0	**0.00%**
276 210015 Speech & Language Therapy	2	24	16	**66.67%**
276 210013 Medical Photography	6	54	44	**81.48%**
276 210008 Histopathology	10	99	85	**85.86%**
276 210016 Psychotherapy	7	76	67	**88.16%**
276 210006 Diagnostic Imaging	20	230	206	**89.57%**
276 210009 Pharmacy	13	124	112	**90.32%**
276 210014 Therapies	40	425	395	**92.94%**
276 210010 Surgical Appliances	1	8	8	**100.00%**
276 210017 Dietetics	2	20	20	**100.00%**
276 260030 Elderly	1	8	8	**100.00%**
Business Unit Total				**88.77**

4. Starters and Leavers July 2015

5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during July	Total cost during July	Total number of hours during July
Bank (Target< 5%)	0.25%	↑	12.4	£2324.09	465.0
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in August 2015	Band
Specialist Hand Therapist	6
Rotational \Physiotherapist	5
Psychological Therapy Manager	8A
Occupational Therapy Technician	3
Advanced Practitioner – Ultrasound	7
Diagnostic Radiographer	6
Paediatric Therapist	7

Workforce Summary

Workforce Profile –
Sickness Absence – the percentage rate decreased compared to June 2015
People management – there were no new cases in this area
Statutory & Mandatory Training – the overall compliance rate for permanent and fixed term staff is 88.77%. However, there are two sections which are below 70% compliant. This should be addressed through the requirement that all staff are 100% compliant by 30 September 2015.
Bank & Agency Usage – Bank is showing an increase but at 0.25% well below the target of 5%
Recruitment – there are a number of vacant therapist position and these are mainly fixed term to cover maternity leave.

Workforce Board Report

Business Unit: Eyes and Sleep

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

1. Workforce Profile

Agreed WTE Establishment (as at 1 July 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				

2. Sickness Absence Data

Percentage of sickness absence in July 2015	Trend	Average number of sickness days per employee in July 2015	Number of absence days lost in July 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 July 2015
1.50%	↓	0.46	33	1.17%	4.25	£1,176

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	1 (ongoing)	0
Whistleblowing / Raising Concerns	0	0
Total	**1**	**0**

QVH Eyes & Sleep Business Unit permanent & fixed term staff compliance for 18 competencies as at 1st September 2015

Area	Headcount	Required	Achieved	Compliance %
276 200014 SLR Optical	2	20	11	**55.00%**
276 210018 SLR Clean Room	4	32	26	**81.25%**
276 200013 SLR Sleep Studies	22	228	188	**82.46%**
276 200015 SLR Corneo Plastics	23	230	197	**85.65%**
Business Unit Total				**82.75**

4. Starters and Leavers July 15

5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during July	Total cost during July	Total number of hours during July
Bank (Target< 5%)	0.59%	↓	6.66	£2209	250
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in August 2015	Band

Workforce Summary

Workforce Profile -
Sickness Absence – the percentage rate decreased compared to June 2015
People management – there was one new case in this area.
Statutory & Mandatory Training – the overall compliance rate for permanent and fixed term staff is 82.75%. However, there is one section which within this area which is only 55%. This should be addressed through the requirement that all staff are 100% compliant by 30 September 2015.
Bank & Agency Usage – Bank is showing a decrease compared to June 2015
Recruitment – there was no recruitment activity is this area during August 2015.

Workforce Board Report

Business Unit: Oral

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

1. Workforce Profile

Agreed WTE Establishment (as at 1 July 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

2. Sickness Absence Data

Percentage of sickness absence in July 2015	Trend	Average number of sickness days per employee in July 2015	Number of absence days lost in July 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 July 2015
2.30%	↑	0.71	76	1.83%	6.69	£5,647

3. People Management (Employee Relations)

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

QVH Oral Business Unit permanent & fixed term staff compliance for 18 competencies as at 1st September 2015

Area	Headcount	Required	Achieved	Compliance %
276 200019 SLR Maxillofacial	54	567	392	**69.14%**
276 200018 SLR Orthodontics	18	198	149	**75.25%**
276 210012 Prosthetics Laboratory	17	167	138	**82.63%**
Business Unit Total				**72.85**

4. Starters and Leavers July 15

5. Bank and Agency Usage

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

6. Recruitment

Job title of post advertised in August 2015	Band
Support Secretary	3

Workforce Summary

Workforce Profile -
Sickness Absence – the percentage rate increased compared to June 2015
People management – there were two new sickness absence cases in this area, which accounts for the increase in the sickness absence %.
Statutory & Mandatory Training – the overall compliance rate for permanent and fixed term staff is 72.85%. However, there is one section which is below 70% compliant. This should be addressed through the requirement that all staff are 100% complaint by 30 September 2015.
Bank & Agency Usage – there was no bank or agency usage in this area.
Recruitment – there was one vacant position advertised in August 2015.

Workforce Board Report

Business Unit: Plastic Surgery

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

1. Workforce Profile

Agreed WTE Establishment (as at 1 July 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				

2. Sickness Absence Data

Percentage of sickness absence in July 2015	Trend	Average number of sickness days per employee in July 2015	Number of absence days lost in July 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 July 2015
2.69%	↑	0.84	71	3.48%	12.72	£4,141

3. People Management (Employee Relations)

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

QVH Plastic Surgery Business Unit permanent & fixed term staff compliance for 18 competencies as at 1st September 2015

Area	Headcount	Required	Achieved	Compliance %
276 200020 RTT & Cancer Team	2	16	8	50.00%
276 200011 Plastic Surgery	37	425	255	60.00%
276 200001 SLR Skin	8	81	52	64.20%
276 200004 SLR Burns	9	88	58	65.91%
276 200003 SLR Hands	12	116	83	71.55%
276 200002 SLR Breast	15	144	122	84.72%
Business Unit Total				66.44

4. Starters and Leavers July 15

5. Bank and Agency Usage

Staff type	% of monthly budget	Trends	Total number (WTE) during July	Total cost during July	Total number of hours during July
Bank (Target< 5%)	0.26%	↑	11.30	£3853	424
Agency (Target < 5%)	0.0%	→	0	0	0

6. Recruitment

Job title of post advertised in July	Band
Medical Secretary	4

Workforce Summary

Workforce Profile -
Sickness Absence – the percentage rate increased compared to June 2015
People management – there were two new cases in this area, which accounts for the increase in the sickness absence %.
Statutory & Mandatory Training – the overall compliance rate for permanent and fixed term staff is low at 66.44%, and four of the six areas are below 70% compliant. This should be addressed through the requirement that all staff are 100% by 30 September 2015.
Bank & Agency Usage – Bank is showing an increase but at 0.25% well below the target of 5%
Recruitment – there are a number of vacant therapist position and these are mainly fixed term to cover maternity leave

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Agenda item reference no:	206-15
Author:	Kathleen Anderson, Company Secretary on behalf of the Governance Review Group
Date of report:	14 September 2015

Board governance review: final report

1. In 2014 the QVH board of directors charged the chair (then non-executive director and chair designate) with undertaking a review of existing board governance structures.

2. A small working group was established to lead the review on behalf of the board.

3. The following paper describes recent progress to complete the board governance review process and logs actions arising from the review.

4. The board is asked to consider the report and approve implementation of the recommendations previously agreed in principle.

Link to key strategic objectives (KSOs)

5. Ensuring that the trust's board governance arrangements are refined and robust supports the delivery of all KSOs, and in particular, KSO 5 – organisational excellence.

Implications for the Board Assurance Framework or Corporate Risk Register

6. None at present or anticipated.

Regulatory impact

7. The aim of the governance review is to strengthen the trust's board governance arrangements and to maintain the trust's regulatory ratings for governance.

8. Paragraphs 37 – 39 of the report describe specific issues and risks relating to the forthcoming inspection by the Care Quality Commission.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Agenda item reference no:	205-15
Author:	Kathleen Anderson, Company Secretary on behalf of the Governance Review Group
Date of report:	14 September 2015

Board governance review: final report

Purpose

1. The purpose of this paper is to:
   a. present recent progress to complete the board governance review process;
   b. log actions arising from the review; and,
   c. request final approval for implementation of the recommendations previously agreed in principle.

Background

2. In 2014 the QVH board of directors charged the chair (then non-executive director and chair designate) with undertaking a review of existing board governance structures.

3. Terms of reference for the review were established and agreed with the board of directors and a small working group was established to lead the review on behalf of the board of directors. The group comprises:
   a) The chair
   b) The chief executive
   c) The senior independent director
   d) The governor representative to the board of directors
   e) The company secretary.

4. In January 2015 the governance review group reported its progress to the board of directors and made initial recommendations which were agreed in principle. The board of directors asked the governance review group to develop further proposals regarding the board and committee meetings schedule to include information about the frequency, membership and timing of meetings and secretariat support. The governance review group's response to this request was provided along with a general progress update in April 2015.

5. In June 2015 a further paper described the latest progress and requested the board's approval of a series of recommendations so that logistical arrangements could be made in time for implementation from October 2015.

Progress since the last update

Board of directors

6. All logistical arrangements are now in place for the board to alternate its monthly meetings between a formal business agenda and an informal seminar session to allow more protected time for strategy development, interaction with staff and patients and

board development.

7. From October 2015 the board's annual schedule will comprise six business meetings and 5 seminar meetings, including away-day events.

8. All meetings have been scheduled to take place at the beginning rather than end of each calendar month with the exception of August when the board will not plan to meet.

9. In months when the board does not hold a business meeting, standard performance reports will not be submitted to the board. Instead, minutes of the meetings of relevant board sub-committees and a chief executive's report will be circulated for information. These documents will then be scheduled for discussion at the next business meeting.

10. The agendas for seminar sessions will include:
    - Presentations from staff colleagues and others focused on strategy and business performance and delivery
    - 'Board to ward' sessions to enable board members to spend time on wards and in departments meeting with staff and patients
    - Workshop sessions on a variety of topics similar to the current seminar sessions.

11. The governor representative will continue to be invited to attend all business meetings and seminar sessions in full.

Finance and operational performance (F&P) committee

12. The committee was established in shadow form in June 2015 to allow for a phased implementation of the most significant change to the board's sub-committee structure.

13. The committee has held three meetings (the fourth is scheduled to take place on 21 September) and has reviewed and refined its terms of reference. The chair of the committee has joined the governance review group to inform the final stages of the review.

14. The committee has trialled a report template as a means to assure the board of the in-year delivery of financial and performance targets and strategic initiatives. However, the committee has found that the report is not an effective method to enable assurance.

15. The governance review group and committee chair have considered the committee's experience. It is proposed instead for the committee, along with the quality and governance committee (see below), to adapt its meeting minutes to relay its assurances in closer context to the discussions it holds. The chair of the committee will work with the company secretarial team and the committee secretaries to develop this method.

16. Public governor Chris Orman assumed the role of interim governor representative to the F&P committee to September 2015. Governors are in the process of allocating governor representative roles from October 2015 and a verbal update of the outcome of this process will be provided to the board on 24 September.

17. On behalf of the committee and the board, the director of finance and performance is conducting a review of the committee's own sub-committee structure and processes. Terms of reference have been reviewed and refined and will contribute to a 'governance handbook' that will collate key charts, terms, templates and work programmes that support the trust's board and executive level governance structure.

Quality and risk (Q&R) committee

18. All logistical arrangements are now in place for the committee to meet monthly from October 2015 instead of quarterly. This will enable more regular assurance of quality and risk matters in parallel with the work of the F&P committee. Together, the two assurance sub-committees of the board enable it to make changes to the schedule of board meetings described above.

19. At its last meeting the committee agreed to adjust its name to the 'quality and governance' committee.

20. On behalf of the committee and the board, the director of nursing and quality will conduct a review of the committee's own sub-committee structure and processes. Terms of reference will be reviewed and refined and will contribute to the 'governance handbook' described above.

21. In parallel with the governance review, the medical director has initiated a review of clinical governance at QVH which is ongoing.

Audit committee

22. No fundamental changes are proposed to this statutory sub-committee of the board of directors. However, the committee is in the process of reviewing its terms of reference which will contribute to the 'governance handbook'.

23. Following consultation with the trust's external auditors the chairmanship of the committee has now passed to the senior independent director. This enables the various responsibilities of the non-executive directors (NEDs) be shared more evenly.

Nomination and remuneration committee

24. No fundamental changes are recommended for this statutory sub-committee of the board of directors.

25. However, the trust chair will take over as chair of the committee from October 2015 as one of the measures to share the responsibilities of the NEDs more evenly.

Charity committee

26. The name of the charitable funds advisory committee has changed but no other changes are recommended for this sub-committee of the board of directors in its capacity as corporate trustee of the QVH charity.

Executive management committee (EMC)

27. The chief executive has completed a review of the governance structure and processes that support and inform the board at an executive management level.

28. The EMC comprises the chief executives and his direct reports. The team meets monthly to oversee the effective delivery of the trust's strategic and operational objectives as agreed by the board.

29. A number of senior management groups are responsible to the EMC and it engages with the wider organisation through the trust's clinical cabinet and leadership forum.

30. Terms of reference for the EMC, sub-committees and advisory groups have been established or reviewed and will form part of the 'governance handbook'.

Human resources and organisational development (HR&OD)

31. Scrutiny and assurance of HR and OD matters will be provided across the board governance structure as follows:
    - Workforce metrics will be reported to the F&P committee
    - Safe staffing and workforce quality issues will be reported to the Q&G committee
    - Organisational development, staff survey and workforce strategy matters will be reported directly to the board.

32. In addition, the executive management committee has established an HR&OD sub-committee responsible for developing the trust's workforce strategy.

33. As a statutory committee of the board, the nomination and remuneration committee will continue to work to its standard work programme and responsibilities in relation to executive resources and development.

Next steps

34. Subject to approval of the recommendations described below, the governance review group considers its review to be complete.

35. However, a number of actions arising from the review are still in progress and could be overseen by the group. These include:
    - Reviews of the relevant terms of reference;
    - Creation of a suite of standard templates and 'hints and tips' for report authors and the secretariat teams;
    - Establishment of a new code of conduct for the board and its sub-committees based on relevant legislation, regulatory guidance and the trust's vision and values;
    - Completion of a suite of corresponding role profiles and 'rules of engagement' for governor representatives to the board and its sub-committees, and
    - Compilation and dissemination of a 'governance handbook'.

36. Beyond completion of the matters arising from the review, the board will seek to undertake its annual review of its effectiveness in September/October 2016. This review will consider the impact of the recommendations of the governance review and begin to scope the requirements of an independent governance review (against Monitor's well-led framework) which will be commissioned by the trust in 2017.

Issues and risks

37. Implementation of the key recommendations arising from the governance review will conclude shortly before the trust's planned inspection by the Care Quality Commission (CQC) in November 2015.

38. The CQC will assess the trust's services against five key questions which include "are they well-led?" By well-led the CQC means that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care,

supports learning and innovation and promotes and open and fair culture.

39. The changes arising from the governance review will contribute to the CQC's assessment of the trust within the well-led domain. Since the majority of changes will be relatively new at the time of the inspection, there are risks that the organisation will not be able to describe its board and executive level governance structure and processes consistently or evidence the effectiveness of the changes beyond a short time-frame.

Recommendations

40. The governance review group recommends that:

a) The trust proceeds with the implementation of its recommendations as previously agreed by the board and summarised in this paper;

b) By implementing its recommendations, the group will have fulfilled its primary purpose as defined by its terms of reference:
   i) To ensure an effective governance structure which will enable and support QVH to meet its strategic objectives and ensure compliance with regulatory requirements, including those of CQC and Monitor
   ii) To ensure the governance structures are fit for purpose and in line with best practice in the NHS and other sectors.

c) The board of directors should ask the review group to oversee the completion of the actions arising from the review and to report to the board again if necessary.

d) Brian Goode should continue as governor representative to the review group beyond the end of his term as governor representative to the board for continuity.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Agenda item reference no:	207-15
Author:	Richard Tyler, Chief Executive
Date of report:	16 September 2015

Board assurance framework (BAF)

1. Purpose

The purpose of this paper is to recommend a revised board assurance framework (BAF) following discussions at the trust board seminar in July 2015 and the finance and performance committee meeting in August 2015.

2. Background

The board assurance framework is the key mechanism through which the trust board assesses ongoing risks to the achievement of the trust's key strategic objectives. It should shape the trust board agenda, ensuring that sufficient time and focus is given to the key risks, associated controls and systems of assurance.

The trust board undertook an initial review of the BAF at its seminar meeting in May in the context of the wider governance review. The director of nursing and clinical infrastructure, head of risk and the chair of the finance and performance committee undertook further work and this was reported to a board seminar in July. It was agreed that the chief executive and the executive management team would review the emerging proposals and update the August meeting of the finance and performance committee prior to a final version being agreed by the board in September.

3. Proposed BAF structure

The proposed structure of the BAF is attached as annex A. Note this is a 'mock-up' and the risk scores are for illustration purposes only. The key points are as follows:

- There is a clear description of the risk associated with each of the key strategic objectives (KSO).
- There is an identified risk owner, committee owner and review date.
- There are actual and target/residual risk ratings for each risk.
- There is a graphical and quarterly trend analysis for each risk.
- There is a clear rationale for each risk score.
- Controls and gaps in controls are identified.
- There is a forward looking / horizon scanning section based on a modified PEST analysis to enable the board to look beyond the immediate in-year risks.
- The forward looking section uses four elements:
    - Policy – emerging policy issues that could impact on delivery;
    - Competition – emerging competitors who could impact on delivery;
    - Innovation – emerging innovations in practice that could impact on delivery
    - Resilience – as a small organisation is there an over reliance on individuals or small teams.

- There is a front-sheet which provides a graphical overview of the in-year risks and the current status of future threats.

4. Proposed BAF review process

The proposed review process is as follows:

- The executive management team will review the risk scores and horizon scanning at the monthly executive management committee;
- Trust committees will review the relevant section of the BAF at their monthly meetings;
- The board will review the entire BAF on a quarterly basis.

5. Recommendations

The Board is asked to:

- Endorse the revised BAF framework as set out in appendix A and described in section 3 above subject to any amendments arising from discussion;
- Endorse the revised review process as outlined in section 4 above subject to any amendments arising from discussion;
- Task the chief executive and the executive team with producing a revised ‘live’ BAF for the November meeting of the board.

Appendix A Delivering Excellence – QVH 2020

Key Strategic Objectives				
Director of Nursing	Medical Director	Director of Operations	Director of Finance	Director of HR & OD
KSO 1 Outstanding Patient Experience	**KSO 2 World Class Clinical Services**	**KSO 3 Operational Excellence**	**KSO 4 Financial Sustainability**	**KSO 5 Organisational Excellence**
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.	We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative R&D	We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.	We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services	We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership
Risks to delivery				
Patients lose confidence in the quality of our services and the environment in which we provide them due to increasing patient safety incidents, a decline in care standards and a failure to maintain a modern care environment	Clinicians & commissioners lose confidence in our services due to a decline in clinical outcomes, a reduction in research output and fall in teaching standards.	Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.	Regulators lose confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments.	Staff lose confidence in the Trust as place to work due to a failure to offer; adequate training, opportunities ; staff development; and a failure to act on the findings of the annual staff survey.

Delivering Excellence – QVH 2020

Where do we aspire to be by 2020?

KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
Our patient satisfaction rates are among the top x% in the country; our rate of serious incidents and never events is in the lowest x% in the country; and we have modernised our estate and facilities to ensure they meet the needs of patients and their families.	Our clinical and patient outcome measures indicate our clinical services are among the top x% in the country. We have a thriving R&D function (measure) and receive exemplary feedback from our trainees.	We continue to meet our access targets; and have streamlined our internal patient pathways achieving significant improvements in productivity through Investment in IM&T and internal process re-mapping.	We have increased our turnover by x% through growth in our five strategic areas; we have increased our productivity by y% ; and we have delivered an annual surplus of z% enabling us to make the investments necessary to support improvements in our infrastructure & productivity.	We demonstrate continuous improvements in our staff survey results, putting us in the top x% of NHS employers; our sickness and vacancy rates are within the lowest x% nationally; and our clinical leaders are recognised nationally for the quality of their leadership.

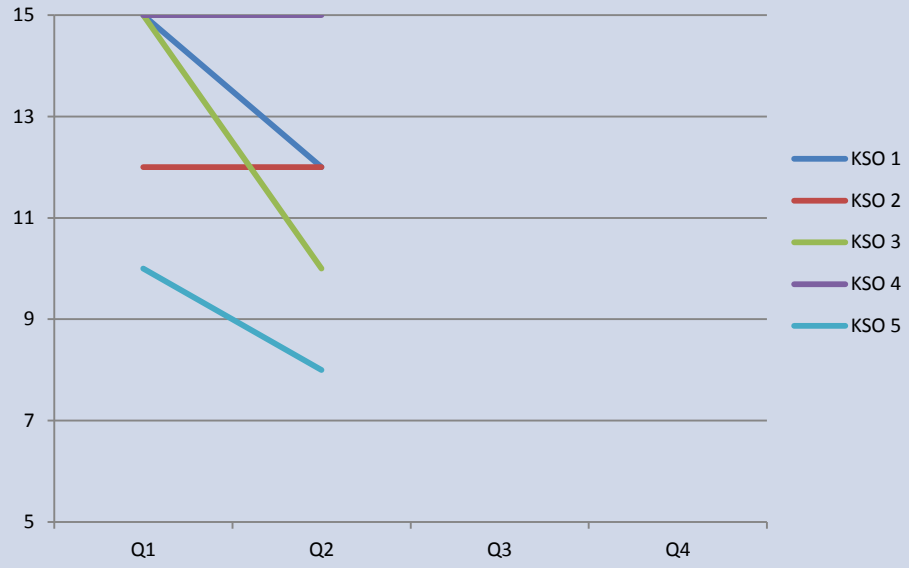
How do we measure excellence?

Friends & Family Test Patient Surveys NHS Choices Complaints SUIs Never Events Safe Staffing Pressure Ulcers Falls Infection Control PACE (?)	PROMS Clinical Outcomes Clinical Audit Research Output Grant applications Training surveys	RRT 18 Cancer waits Clinic waiting times MIU waits Cancelled operations Theatre start & finish times Returns to theatre Re-admission rates	Income Expenditure Productivity Annual surplus	Vacancy rates Sickness rates S&M Training Temporary Staffing Staff survey

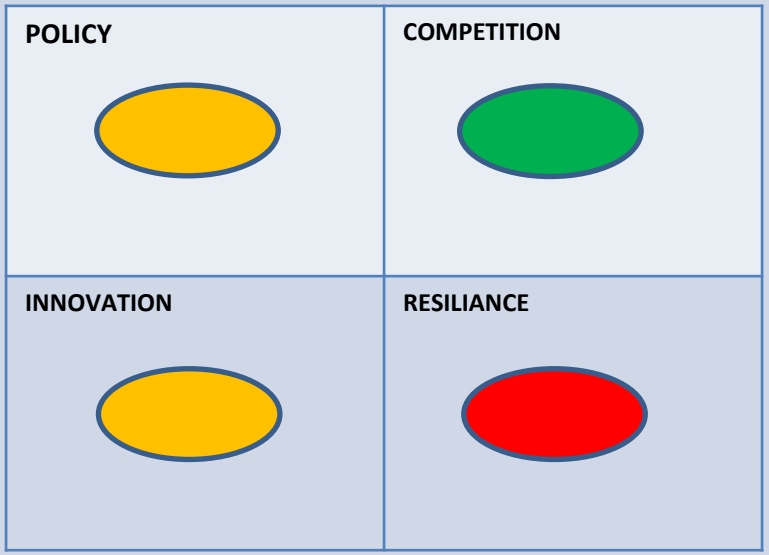
Board Assurance Framework – Risks to achievement of KSOs

KSO 1 Outstanding Patient Experience	KSO 2 World Class Clinical Services	KSO 3 Operational Excellence	KSO 4 Financial Sustainability	KSO 5 Organisational Excellence
Patients lose confidence in the quality of our services and the environment in which we provide them due to increasing patient safety incidents, a decline in care standards and a failure to maintain a modern care environment	Clinicians & commissioners lose confidence in our services due to a decline in clinical outcomes, a reduction in research output and fall in teaching standards.	Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.	Regulators lose confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments.	Staff lose confidence in the Trust as place to work due to a failure to offer; adequate training, opportunities ; staff development; and a failure to act on the findings of the annual staff survey.

Current Risk Levels



Future Threats



KSO1 – Outstanding Patient Experience

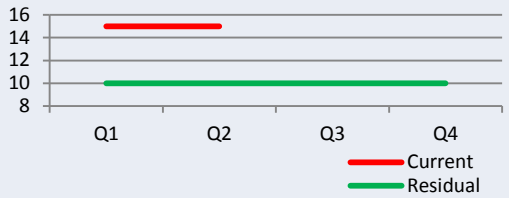
Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed:

Strategic Objective
We put the patient at the heart of safe, compassionate and competent care that is provided by well led teams in an environment that meets the needs of the patient and their families.

Risk
Patients lose confidence in the quality of our services and the environment in which we provide them due to increasing patient safety incidents, a decline in care standards and a failure to maintain a modern care environment

Current Risk Rating 3 x 5 = RED
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score
Missing national benchmarks
Non-compliance with regulators
FFT
Catering
Patient Safety
Never Events
Design a credible, affordable plan for modernisation of the estate
Triangulation of complaints , claims and incidents



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
Health and social Care Act 2014 has created new requirements particularly in safeguarding, MCA and DoLs
5YFV
Burns Network Requirements resulting in burns derogation work

COMPETITION
Failure to attract workforce with right skills
Patient choice if new services are available closer to home

INNOVATION

RESILIANCE
Many services single staff member which limits responsiveness.
CQC preparation work

Controls / Influences
Quality and Governance Committee
Patient Experience Group
FFT, Picker survey , patient and staff
Clinical Audit
Internal Audits relating to patient experience
Quality Account
CQUIN
Monthly CQC report

Gaps in controls / influences
Development of full estates strategy
Lack of data warehouse to support robust informatics system
Quality strategy
Quality assurance at spoke sites

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Quality & Governance
Date last reviewed:

Strategic Objective
We provide world class services that are evidenced by clinical and patient outcomes and underpinned by our reputation for high quality education and training and innovative R&D

Current Risk Rating **3 x 5 = RED**
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score
Hub & Spoke governance

Risk
Clinicians & commissioners lose confidence in our services due to a decline in clinical outcomes, a reduction in research output and fall in teaching standards.

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY

COMPETITION

INNOVATION

RESILIANCE

Controls / Influences

Gaps in controls / influences

KSO3 – Operational Excellence

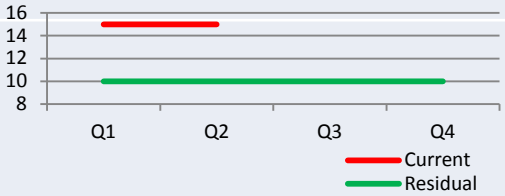
Risk Owner: Director of Operations
Committee: Finance & Performance
Date last reviewed:

Strategic Objective
We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.

Risk
Patients & Commissioners lose confidence in our ability to provide timely and effective treatment due to an increase in waiting times and a fall in productivity.

Current Risk Rating **3 x 5 = RED**
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score
- Theatre utilisation/productivity;
- Case mix
- Coding
- Design & deliver key IT projects
- Knowledge management/information/benchmarking



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
- National Policy changes to access targets e.g. Cancer & complexity of pathways, QVH is reliant on other trusts timely referrals onto the pathway;
- NHS Tariff changes & volatility;

COMPETITION
Negative
- Spoke sites begin to repatriate routine elective work & so loss of activity & associated income;

Positive
- Neighbouring trusts requiring additional elective capacity;

INNOVATION
- Spoke sites offer the opportunity to pursue further partnership approaches to providing services;

RESILIANCE
- Reputation as a centre of excellence – can capitalise on our brand & market position;

Controls / Influences
- Three times weekly access meeting reviews and forward plans activity/booking- includes Cancer;
- Patient Access Manager – new role commences on Sept 21st;
- Business unit performance meetings & regular review of performance/forecast of performance;
- Finance and Performance Committee in place;
- PTL accessible by all relevant managers;
- Performance Dashboard in development with first draft available from Sept 15;
- Business Planning meetings and cycle put in place from Sept 15 for 16/17;

Gaps in controls / influences
- Not all spoke sites on QVH PAS so access to timely information can be limited;
- Shared pathways for cancer cases with late referrals from other trusts;
- Demand and capacity modelling with benchmarking requires further development for each speciality;
- Productivity information and programme required for theatres;

KSO4 – Financial Sustainability

Risk Owner: Director of Finance
Committee: Finance & Performance
Date last reviewed

Strategic Objective
We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services

Risk
Loss of confidence in the long-term financial sustainability of the Trust due to a failure to create adequate surpluses to fund operational and strategic investments

Current Risk Rating 3 x 5 = RED
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score (at Month 4)
- Surplus -0.87%
- Non-Pay £284k o/s
- CIP slippage 27%

Rationale for forecast
- Deliver surplus target (£1m)
- Sustainability Risk Rating (4)

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
- Tariff changes
- Commissioning intentions
- Public Sector Borrowing Round
- Revised Monitor risk rating methodology
- 5YFV

COMPETITION
- Spoke-site activity repatriation
- New entrants into existing market
- Ability to capture new activity streams

INNOVATION

RESILIENCE
- Small teams that lack capacity, agility , technical and back-up support.
- Historic structures that do not support modern operating models.

Controls / Assurances
- Performance Management regime in place
- Standing Financial Instructions
- Activity Diagnostic Completed
- Contract monitoring process

- Monthly performance reports to the Trust Board
- Finance & Performance Committee in place Q2 FY16
- Audit Committee and reports - internal control 2015/16
- Internal Audit Plan including main financial systems and budgetary control.

Gaps in controls / assurances
- Two year rolling Cost Improvement & Productivity (CIP) Programme with contingencies in place
- Cost Improvement Strategy
- Quality Impact Assessment Process
- Monitoring of CIP Programme
- Budget Setting and Business Planning Processes (including capital programme) incorporating risk identification and mitigation.
- Monitoring and delivery of Capital Programme
- Capital investment in relation to backlog maintenance

KSO5 – Organisational Excellence

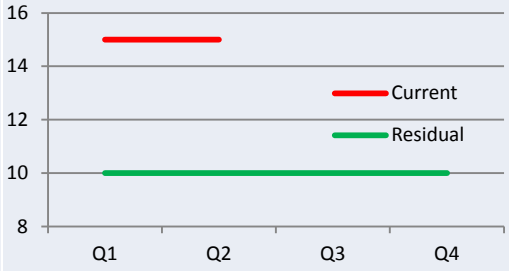
Risk Owner: Director of HR & OD
Committee: Trust Board
Date last reviewed

Strategic Objective
We seek to maintain and develop a strong professional and caring culture through clear standards, high expectations and exemplary leadership

Risk
Staff lose confidence in the Trust as place to work due to a failure to offer; a good working environment; fairness and equality; training and development opportunities ; and a failure to act on feedback to managers and the findings of the annual staff survey.

Current Risk Rating 3 x 5 = RED
Residual Risk Rating 2 x 5 = GREEN

Rationale for current score
Capacity planning & workforce modelling
Seven day services
Junior doctors
Revalidation



HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
Consultant contract negotiations
Junior doctor contract negotiations
CQC recommendations
Tariff changes impacting on overall staffing costs

COMPETITION
More private sector competition, lower cost for same quality
Competitors becoming more agile and responsive i.e. delivering services through new job roles and responsibilities

INNOVATION
National terms and conditions can prevent flexibility to address local issues e.g. retention of skilled nursing staff
Workforce systems need to become user friendly to benefit from self service

RESILIANCE
High turnover in some nursing specialties vs lack of turnover in corporate functions
Adapting to changes in service delivery i.e. new way s of working

Controls / Influences
Developing long term workforce planning (3 years) for FY16/17 in linking to business planning process
Leadership programme designed for Business Units management teams and corporate services
Workforce strategy to be implemented by Q4 FY15/16 and will include plans for improving recruitment and retention
Implemented a Board approved staff survey action plan
HR/OD metrics revised to support the Business Units

Gaps in controls / influences
Current level of management competency in workforce planning
Continuing resources to support the development of staff

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 24 September 2015
Reference number: 208-15
Report from: Jo Thomas, Director of Nursing
Author: Alison Vizulis, Head of Risk
Report date: 15 September 2015
Appendices: Corporate Risk Register

Corporate risk register (CRR)

Key issues

1. Two new risks were added to the CRR rated as a 12 or above during August 2015. One of these was immediately rescored to a 3x3=9, and has therefore been removed from this register for monitoring locally. The other risk is detailed below:

    - ID823 - Charging area for recovery, and potential fire hazard due to equipment being charge/recharged in appropriate environment. Also impact upon staff due to continuous alarming (4x3=12)

2. One risk scoring 12 or above was closed during August 2015.
    - ID 814 – Secure drugs treatment room in burns ward - No working air conditioning (4x3=12). This risk was closed as part of ongoing risk reviews.

3. No risks had a score decreased from a 12.

4. The CRR was reviewed at the monthly Clinical Governance Group and Clinical Cabinet in August.

5. There has been extensive review of the corporate risk register during August and September.

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 (KSOs)

- 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 board assurance framework (BAF) or corporate risk register (CRR)

6. Significant corporate risks have been cross referenced with the trust's BAF.

Regulatory impacts

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

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

Recommendation

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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Changes during month	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
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
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
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
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 General Manager for CSS together with MD. Onsite cover available on Monday, Wednesday and Thursdays from July 21st 2015, return of Tej Richardson for 1.5 days per week, Dr Simon returns to SASH and Tej picks up the rehab clinic, Mark Bayliss will be retained giving 3 day per week cover and working to get further physician input Agency locum finishing but available for short term cover Telephone cover provided as part of SLA with Brighton. Geriatrics Clinic covered by Locum Geriatrician from SASH, to be covered by Tej Richardson WEF 21st July Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Steve Fenlon	Dr Tim Vorster	↔	Patient Safety	12	6	Explore GPSI option and cover from London Trusts SASH work has not progressed as of July 15, to continue to work with BSUH but potential for tie in with community services as part of trust strategy SLA proposal from East Surrey Hospital Arrangements agreed in principal with ESH Meeting between QVH Medical Director and Head of Geriatrics at ESH	30/07/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Changes during month	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
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 Correlation of CQC results against assessment results Focus on completion of off site spoke H&S assessments during 2015 and Trust Board reporting Ongoing monitoring via KPIs Feedback to DoNs at sites	07/07/2015
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 Addition of Human Factors & Non Technical Skills aspects to RCA reports from Sept 2015 to assist with ongoing analysis	Jo Thomas	Alison Vizulis	↔	Compliance (Targets / Assessments / Standards)	12	8	Revisions scheduled for CQC regulations in 2015 Human Factors CQUIN agreed and training to be developed and implemented Governance reporting review underway	15/09/2015
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	Range of information awaited from Phillips (as per controls column) Discussed at CSS Mtg 05/05/2015: Current score of 12 to remain until PACS upgrade completed (due at end of May 2015)	10/09/2015
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	20/08/2015
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 Discussions at each MDC	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 Discussed at Sept MDC and possibility of Avensys undertaking areas of role to be explored	10/09/2015
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	13/07/2015

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Changes during month	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed
806	24/07/2015	Patient Monitoring in Intensive Care (End Tidal Monitoring)	• Obsolete monitors in use in Burns ICU. • Several components of these are 11 year old - monitors either do not work or regularly malfunction. • Replacement parts are no longer available. • End Tidal CO2 monitoring modules- only one of 4 modules function (unreliably)	• Unreliable monitoring can delay or prevent the identification of clinical deterioration in ITU patients. • Any delay in identification of deterioration can lead to delayed treatment and clinical incidents in a time critical environment. • Sudden failure of monitoring in unstable critical care patients could have serious adverse consequences. • Reliable ETCO2 monitoring is recommended in the NAP4 report and the ICS Critical Care standard. This is the gold standard for managing the risk of dislodged tracheostomy tubes.	• Currently there is one functioning module for the obsolete GE monitoring system in ITU. • There is a borrowed ETCO2 monitor from Recovery. • There is access to a Dash (transport) monitor with ETCO2 capability (this monitor has to be available for patient transfer), and our transport ventilator can monitor ETCO2 (also needed for patient transfer). • Between these 4 options, 2 different methods of ETCO2 are used, requiring different consumables and principles. • This contingency plan comprises of 4 different machines each with different settings/operations. • Three of these machines require extra space at the bedside. • One of these machines (GE) is extremely unreliable. • It is possible to provide ETCO2 monitoring reliably for 2 patients.	Steve Fenlon	Michael Turner	↔	Patient Safety	12	8	Range of actions identified in RCA and ongoing monitoring of completion	07/09/2015
823	07/08/2015	Charging Area for recovery	Fire hazard due to equipment being charge/recharged in makeshift stationery cupboard and shelving on various extension leads as not enough power points. Also impact upon staff due to continuous alarming.	Very high risk of fire from overloading of extension leads in a highly flammable cupboard.	no controls in place. Proposed action to minimise risk; 1 to install fire proof cupboard with charging points 2 to install fire proof shelving with more power points fitted instead of extension leads	Clare Stafford	Jo Davis	↔	Staff Safety	12	4		07/09/2015

Status	
↔	no change
↑	increase in risk score
↓	decrease in risk score

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Reference number:	209-15
Report from:	Jo Thomas, Director of Nursing
Author:	Michael Brown, Named Child Safeguarding Lead
Report date:	15 September 2015
Appendices:	Annual Report

Child protection and safeguarding annual report

Key issues

1. The Chief Executive is required to have in place arrangements which reflect the importance of safeguarding and which promote the welfare of children within organisations. This responsibility is delegated to the Director of Nursing as the executive lead for child protection and safeguarding. Statutory guidance is followed to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.

Implications of results reported

1. Training at level 1 and 2 requires further improvement to increase safeguarding potential of the whole workforce at QVH.
2. Good professional relationships with the Local Safeguarding Children Board (LSCB) have been sustained with regular attendance at LSCB.
3. Completion of the self-assessment against section 11 of the Children Act has not identified new concerns within the organisation or with the LSCB.
4. The attached annual report has been reviewed by the Quality and Governance Committee.
5. The trust is meeting its duty outlined in legislation (Children's Act 2004) to make arrangements to safeguard and promote the welfare of children and young people and is co-operating with other agencies to protect children and young people from harm

Actions required for 2015/16

6. Achieve level 1 training target of 100% and level 2 training target of 80%.
7. For 2015/16 safeguarding strategy to be developed and implemented.
8. Review of child safeguarding policy.
9. Review of resources allocated to safeguarding roles in the trust against the revised Intercollegiate Document (2014).
10. Clinical supervision for QVH child safeguarding nurses from West Sussex Designated Child Safeguarding Nurse to be agreed and implemented.
11. Review TOR for child safeguarding steering group.
12. Establish Strategic safeguarding group at QVH.
13. Establish quarterly child protection and safeguarding feedback to Quality and Governance Committee.

Link to key strategic objectives (KSOs)

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

14. The attached assessment can be seen to impact on four of the trust KSO's.

Implications for board assurance framework (BAF) corporate risk register (CRR)

15. Delivery of safe care is reflected within both the BAF and corporate risk register.

Regulatory impacts

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

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

Recommendation

18. The Board is recommended to **note** the contents of the annual report and the actions identified for 2015/16.

Queen Victoria Hospital
NHS Foundation Trust

Child Protection and Safeguarding
Annual Report
2014-2015

Child Protection and Safeguarding Team:

Jo Thomas: Board Lead for Child Protection

Dr. Mohammed Rahman: Named Doctor for Child Protection

Michael Brown: Named Nurse for Child Protection

Debra Yeoh: Paediatric Safeguarding Nurse

Katy Fowler: Paediatric Safeguarding Nurse

June 2015

INTRODUCTION

Child Protection and safeguarding work, continues to have an extremely high profile, on both local and national agendas, and this is reflected at Queen Victoria Hospital NHS Foundation Trust (QVH).QVH has a statutory responsibility to make arrangements to safeguard and promote the welfare of children (as set out under Section 11 of the Children Act 2004). This report provides an overview of how the Trust ensures that robust systems are in place to safeguard children and young people. Under Section 11 of the Children Act, the Trust is required to be compliant with CQC Outcome 7 and Standard 5 of the National Framework for Children, all of which relate to safeguarding and promoting the welfare of children.

A revised *Working Together to Safeguard Children (2015)* has been released. This replaces the previous 2013 document and statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 1989.

Although revisions have been made in the 2015 document, the overarching aim of *Working Together to Safeguard Children* is to clarify the core legal requirements of both individuals and organisations to keep children and young people safe. Essentially, it is underpinned by two key principles:

- A child – centred approach is to always be implemented
- Safeguarding is *everyone's* responsibility.

The *Working Together* guidance therefore continues to form the focus of the safeguarding strategy within QVH and it is regularly highlighted within training sessions. It is also the framework for the Local Safeguarding Children Board (LSCB) to monitor effectiveness of local services (including the safeguarding at QVH).

It is acknowledged that during 2015, children remain at great risk of abuse within the UK (HM Government 2015). The way in which children may be at risk has changed over time, with factors such as the internet and complex terrorist networks changing the threats towards children completely. Therefore, the staff at QVH need to be able to react and respond to a variety of less traditional threats facing children in the current day. This year the team have identified both the depth and breadth of safeguarding changes, this is most evident with the implementation of recent national inquires in child sexual exploitation and developments in our understanding about Female Genital Mutilation as a safeguarding concern. Changes in our communities, demands that QVH staff are supported, well trained and aware of safeguarding concerns in the above areas.

Many factors of safeguarding overlap between children and adults and it is important for staff to see safeguarding on a continuum, for example in Domestic Abuse. As such, this year, Domestic Abuse has been a strong focus of the Trust's Level 2 training programme as it allows staff to foster links between adult and paediatric care and acknowledges the impact of parental physical and mental health, on a child's wellbeing. This is particularly crucial at QVH, where many children are cared for by adult or general trained staff (e.g., in Outpatients and Maxillofacial departments etc.)

SAFEGUARDING/ CHILD PROTECTION TRAINING AND EDUCATION

As has been stated in previous Annual Reports, Queen Victoria Hospital has made a clear statement within its Safeguarding policies that all Trust employees (regardless of their position and including those who work primarily with adults) have a responsibility for safeguarding children and must make themselves aware of both Trust and Local Authority Policies. This is a responsibility that has been underlined within all job descriptions for staff throughout the Trust since 2012/13. The safeguarding team is responsible for developing, implementing and managing the delivery of Safeguarding children Level 1, Level 2 and Level 3 training.

The current QVH training strategy, has been greatly updated within the last 12 months, was developed in response to 2014 guidance from the Royal College of Paediatrics and Child Health: '*Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate Document'*. This document gave clarity for healthcare Trusts about the relevant training required by different staff groups and was a major update on the previous 2010 Intercollegiate Document. The guidance in the new document is far clearer in that the skills required are now applicable to all health providers and can be more easily identified and audited by the LSCB. It also emphasised the importance of being able to maximize flexible learning opportunities so that health care staff acquire knowledge and skills from research, case studies and serious case reviews (SCRs). This is an approach the safeguarding team have started to implement at QVH, with nursing staff in particular being asked to take part in more case discussions and document these for their own PDR, which in turn can be used to inform their Level 3 competency record held by the Learning and Development Team. This is an approach to Level 3 development that is advocated by the Intercollegiate Document (RCP 2014).

As a result of this review of training guidelines, QVH have been able to review their current requirements for staff training. This now means that our training strategy is completely in line with the relevant National guidance in terms of which staff receive which training. This has also resulted in our training strategy being totally aligned with the National Training Passport initiative, meaning new staff are able to commence work without having to repeat recently completed training (provided they can provide appropriate evidence).

Although a certain level of flexibility is required in regards to training and each staff member's needs are assessed individually, the following approach is largely adhered to within the Trust-

- Level 1- all non-clinical staff.
- Level 2- clinical staff who have regular patient contact

  (*Within Trust this includes all clinical staff – HCA and above, regardless of Practice setting*)
- Level 3-Clinical Staff with regular contact with Paediatric patients.

  (*At QVH this equates to Paediatric Nurses on Peanut Ward and Minor Injuries Unit (MIU), Emergency Nurse (and care) Practitioners in MIU, Specialist Physiotherapists (of which there are 3 in Trust) Burns Surgeons.)*

At present, both Level 1 and Level 2 Child Protection are delivered in-house at QVH by the Named Nurse and Specialist Nurse. It is also possible to access these via e-learning, for those who do not wish to attend a face-to-face session. Level 3 taught sessions have also started to be delivered jointly between the Named Nurse and Named Doctor and have been well received and evaluated by staff. Level 3 training is also provided by West Sussex LSCB, and can be booked via their website. This provides essential inter-agency training for all staff who require this level of knowledge and is free for all Trust staff. While this has many benefits, in that it promotes true multi-agency working, it also requires staff to attend 1-2 days training externally which are usually situated some distance from QVH (mostly Worthing and Chichester areas). With current staffing constraints, this can prove difficult to release staff for 2 whole days and therefore it is felt important that the in-house training model continues to be provided also.

Current training competence across the Organisation is as follows:

Level 1: 82.05% against target of 100%

Level 2: 78.5% against a target of 80%

Level 3: 89.18% against a target of 80%

(April 2015 data from SDC and safeguarding databases).

As can be seen above- there has been a great increase in the number of staff who have achieved competency in Level 2 over the last 12 months (last year this sat at around 59%). This is a result of a major drive to increase competency, with the number of sessions being run by the Named Nurse for Child Protection being quadrupled last winter to achieve this.

In February 2015, the Level 1 and Level 2 training sessions were audited by the Designated Nurse for Safeguarding Children for Coastal West Sussex CCGs and was reviewed extremely positively. It was deemed to meet all of the necessary standards required in the Intercollegiate Document and the use of scenarios and case discussions that form the basis of the higher level training were deemed to be 'of an excellent standard and very forward thinking'. This provides the Named Nurse with confidence that Trust staff are receiving suitable training to meet their needs.

CLINICAL AND SAFEGUARDING SUPERVISION.

Queen Victoria Hospital understands the necessity of both clinical and safeguarding supervision and the need for this to be embedded within all Child Protection work. This was identified by Munro (2012) as being an essential component towards ensuring services are able to appropriately meet the needs of children and ensure their safety. The Trust Lead for safeguarding has closely reviewed the current processes within QVH to ensure the supervision of staff is suitable. A Serious Case Review in West Sussex in 2013 (entitled 'Child G') identified an inadequate (or at least inconsistent) level of supervision for health staff working directly with safeguarding caseloads. Therefore, it was deemed crucial that all Trusts review their supervision process and prioritise the safe and effective supervision of their clinical safeguarding staff.

All staff are able to access supervision as and when required from the Named Nurses. The Paediatric Safeguarding Nurses receive monthly supervision from the Trust Lead for safeguarding- this provides them with the opportunity to discuss any issues affecting their role or individual cases of concern if required. A formal model of documented supervision has been implemented, with a new written safeguarding template added to the Trust Safeguarding Children Policy. The Trust Lead then receives regular safeguarding supervision externally- from the Designated Nurse for Safeguarding Children for Sussex. This process provides a clear structure of safeguarding supervision throughout the Trust.

POLICY AND PROCEDURES.

Queen Victoria Hospital's *Child Protection Policies and Procedures* are available on the intranet and in all areas where children are seen or treated. The policy is referenced during staff training, to ensure all staff are aware of the appropriate procedures to follow and that they also understand their responsibilities. The policy continues to be updated regularly to ensure it keeps in line with the Sussex Child Protection and Safeguarding Procedures. The Named Nurse and Specialist Nurses maintain close links with the

SAFEGUARDING CONCERNS AND ACTIVITY.

Total concerns 2014/15: 188.

Referrals made to Children's services by QVH: - 16

Referrals made by referring hospital to Children and Young People's Services: 51.

Total number of contacts for 2014/15: 36, 265 (2,992 inpatients, 29,764 outpatients, 3,509 MIU attenders)

Over the period of April 2014- March 2015, the Trust has continued to closely monitor the overall safeguarding activity and the type of concerns that have been raised. These are outlined below:

INJURIES with safeguarding / child protection issues by speciality:-

Age	Burn Injuries	Plastic surgery	Maxillofacial	Corneo	Others
0-2 years	84	11	2	0	3
3-10 years	26	9	4	0	2
11-18 years	19	19	8	0	1

The data above reveals that of the 188 concerns raised within QVH, 16 were referred to Social Care via our own staff and 51 were referred by other hospitals (although QVH were required to then assist with the safeguarding process once the child was referred to the Trust). However, these numbers only depict a small fraction of the work carried out by the safeguarding team and ward staff. Information sharing with other agencies also plays a huge part in the safeguarding workload. The team have also attended and provided written reports for Child Protection Case Conferences during the past year. It must be recognised that all of the 188 concerns were closely followed up by the Child Protection team, but not all required Social Services engagement and instead required intense liaison with other external agencies.

As is **our** requirement under Section 11 of the Children Act (1989), the Trust maintains a secure database to collate information regarding Paediatric cases that have raised a safeguarding concern. It allows us to ensure patients are effectively safeguarded and assists in the process of highlighting repeated admissions to the Trust etc., once Child Protection issues are identified.

MEETINGS AND EXTERNAL LIAISON

The Child Protection Steering Group meetings are held quarterly within the Trust. The group traditionally comprises:

- Named Doctor for Child Protection
- Named Nurse for Child Protection
- Lead Nurse for Safeguarding
- Link Nurses/ Practitioners from individual departments throughout the Trust.

This provides an opportunity to attempt to ensure that Child Protection services within the Hospital are co-ordinated and developed, adhering to relevant guidance and changes. In addition, it provides a useful forum for reflective practice, allowing any current concerns or issues in practice to be discussed, to promote shared learning from incidents and to consider feedback from the LSCB and any relevant recommendations from serious case reviews. Within the last 12 months, it has provided the opportunity to feedback concerns from staff and act upon these and has also resulted in several changes to the way in which children are safeguarded at QVH, including liaison methods with MIU etc. The minutes from the meetings are regularly shared (as requested) with the Designated Nurse for Coastal West Sussex CCG.

As a Trust, Queen Victoria Hospital also continues to actively engage with the Local Safeguarding Children's Board (LSCB) and its relevant partners. The Director of Nursing attends quarterly LSCB meetings where changes in practice are raised and discussed and these are then shared with the safeguarding team. Close liaison between the Director of Nursing (Board Lead for safeguarding Children) and the Lead Nurse for Safeguarding Children has proved extremely effective at ensuring required changes in practice are implemented early and also any potential issues are quickly raised back to Board level. Safeguarding Children data is shared with the Board on a Bi Monthly basis, this includes training figures, number of concerns raised and any relevant Action Plans. Once approved at Board level, this data is then shared with the CCG and forms part of the Designated Nurses' Bi Monthly reports to CCG partners. This ensures that QVH continues to fulfil its statutory requirements under Section 11 of the Children Act (2004), to act in an open and honest way. This transparency has been strongly embedded throughout all of our Safeguarding Children activities.

In April 2014, the Trust submitted its updated review of their Section 11 Action Plan to the LSCB. This was well received and QVH were commended for their proactive approach to safeguarding the vulnerable children in our care. There are now no current outstanding Actions on our Action Plan. The next full Section 11 Audit will be due by the end of 2016.

SUMMARY

As a Trust, the Queen Victoria Hospital continues to prioritise the safety of its patients and clearly recognises the importance of safeguarding children and its responsibility to do so. A great deal of work has been put in place over the last 12 months (which has been heightened further since the turn of the new financial year), to strengthen the line of accountability in terms of safeguarding children. A sound and formal supervision structure is in place, the training provision has been extremely well received and audited and there are plans to change the Lead Nurse role into a full-time position that will only continue to enhance the safety of our patients.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 24 September 2015
Reference number: 209-15
Report from: Sharon Jones, Director of Operations
Author: Sharon Jones, Director of Operations

Report date: 07 September 2015

Improving and Sustaining Cancer Performance

Context

Monitor, the National Trust Development Authority and NHS England wrote to all Trust and Foundation Trust chief executives on 14 July 2015 setting out the steps being taken nationally to improve 62-day performance. This included the creation of a national tripartite delivery group for cancer, identification of eight key priorities for improving performance and development of a national cancer delivery plan. Some of the specific pathways included in the priorities do not impact upon the Trust as we do not treat those patients.

All acute Trusts and Foundation Trusts, in collaboration with their local cancer network partners, were asked to:

- Conduct a self-assessment against these eight key priorities;
- Develop a local response to address any identified gaps;
- Submit an assurance statement to the Regional Tripartite that either confirmed compliance with the eight key priorities, or outlined the steps being taken to ensure compliance as soon as possible. As part of this process, all Trusts were also graded and those Trusts categorised as of concern were asked to submit improvement plans as well as the assurance statement. We did not fall into the category that needed an improvement plan.

A pro-forma assurance statement was provided and submission was required by 31 August 2015. The Regional Tripartite will review all assurance statements, and may ask for additional information. It is expected the initial review process will conclude by 11 September 2015 and we will be contacted again at that stage.

This paper set outs the strategic drivers and issues behind the eight key priorities and our submitted statement which is available at Appendix One.

Link to Key Strategic Objectives

- Outstanding patient experience
- Operational excellence
- Financial sustainability

Implications for BAF or Corporate Risk Register

1. There is no impact upon the BAF or Corporate Risk Register

Regulatory impacts

2. Currently the performance reported in this paper does not impact on our CQC authorisation or the current Monitor governance risk rating.

Recommendation

3. The Board is requested to note the contents of the report.

A New Standard for Cancer Waiting Times

1. Context

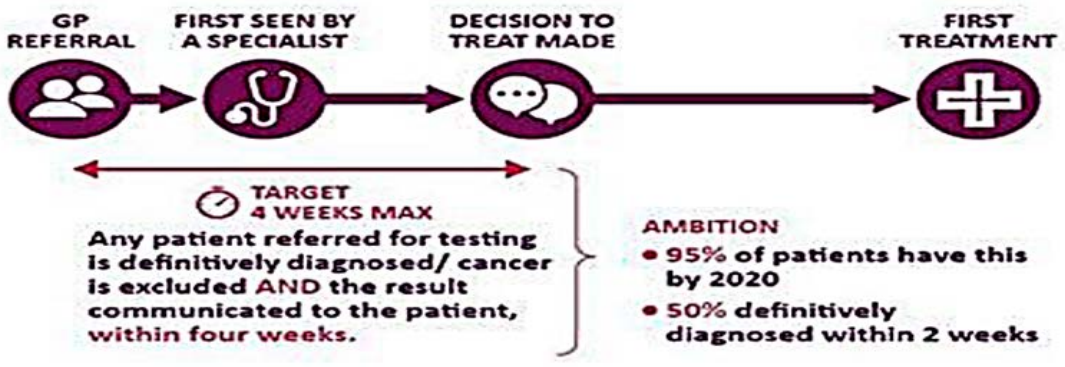
Cancer is one of 10 priority areas in the current NHS England (NHSE) Business plan. The improvements in outcomes require action on three fronts and these will be areas of focus for NHSE going forward:-

a) Better prevention
b) Swifter access to diagnosis
c) Better treatment and care for all those diagnosed with cancer

There are still issues and in particular in the following areas:-

- Relatively poor cancer outcomes in the UK compared to other developed countries and the evidence points to timely access to diagnosis and treatment as a factor;
- Increasing pressure on cancer services across all cancer tumour pathways. The underlying causes are multifactorial and include the impact of an ageing population, growth in demand, changes in GP referral processes and in cancer pathways. Demand at the start of the cancer pathway appears to be outstripping supply, with a particular pressure on diagnostics;
- The recent publication of new NICE guidelines on cancer referrals and the new National Strategy, with its focus on achieving earlier diagnosis to improve outcomes and bring the UK on par with international best practice, are both likely to drive increased referrals, and this will place further pressure on 2 week wait urgent referrals, diagnostics and on the 62 day standard as a whole.

The ultimate aim is that by 2020 95% of patients are diagnosed in 4 weeks.



2. Issues and Concerns

National Cancer performance is steadily deteriorating across a number of the standards. Current national performance and projections show the greatest risk of non-delivery in 2015/16 is with the 62 day standard. Nationally this standard has breached for the last 13 months. The national performance for this standard was 81.2% in May 2015 compared with 83.1% in April 2015, 84.1% in March 2015 and 83.4% in May 2014.

Nationally the median waits are considerably longer for shared pathway breaches. This has risen by almost 3 days over the last 2 year. It is thought that this is most likely due to delays in the "middle" stage where diagnostic tests are required and/or require inter provider referral processes. These patients often also have very complex diagnostic needs which add another layer of intricacy.

This has been reflected in Queen Victoria Hospital NHS Trust's performance (QVH) with the main area of pressure at present being the 62 day pathway and in particular those patients on shared pathways. For example in Quarter one 2015/16 all cancer targets were met with the exception of the 62-Day screening where all 3 breaches in the quarter involved patients on a shared pathway with other Trusts

At present the 2 week cancer target is being met within QVH but is showing increased pressure and we will always have a tendency to rely on extra clinics being organised at short notice.

It is important to note, in view of relationship with Medway, that the South region is the poorest performer for the 2 week wait. Medway NHS FT is the major contributor to the failure of this standard, which has in turn caused the standard for the whole of England to breach.

3. Challenges

NHSE has undertaken some work and this shows that the top 10 national challenges can be grouped under the following themes:-

i. MDT coordinator resourcing and tracking capacity;
ii. Leadership (especially clinical);
iii. Ownership of cancer performance outside the cancer team;
iv. Smaller treatment volumes where a small number of breaches result in non-compliance;

v. Lack of capacity and demand modelling;
vi. Inter Provider/Trust Referrals – late referrals, poor cross organisation communication, absence of agreed pathways/timelines;
vii. Patient choice breaches greater than tolerance;
viii. Non-patient choice breaches being recorded as patient choice such as appointments offered late in the pathway with little notice;
ix. Access policies and standard operating proceedures – lack of or inconsistent implementation;
x. Pathway issues especially prostate and lower GI;

Therefore from these issues and themes Monitor, the National Trust Development Authority and NHS England have decided to lead a national delivery group for improving 62 day performance. They have worked with the Cancer Waiting Times Taskforce (CWTT) 8 key priorities for local health systems to implement as a matter of urgency.

All acute Trusts were asked to complete a self-assessment of compliance with the 8 key priorities and return a plan to achieve full compliance, (or explanation of planned non-compliance), by the end of August 2015.

All Trusts are segmented as poor/high concern/low concern/good based upon current and recent performance data. All poor or high concern Trusts were expected to produce an improvement plan as well as the assurance statement by the end of August for review and sign off by the relevant Regional Tripartite. QVH has not been asked to submit an improvement plan.

All Trusts and Foundation Trusts are expected to produce weekly patient tracking lists for the 62 day standard and to be submitted via UNIFY2, so that information can be shared with commissioners. This commenced at the end of July and QVH complied with this deadline.

4. Other Issues

a) Capacity Planning

Each local health system will be required to prepare a cancer capacity plan setting out how it will deal with the projected increase in cancer demand. Further information will be sent regarding the detailed requirements and the required timeline for the Production of local system capacity plans. This will be commissioner led.

b) System Resilience Groups

The remit of System Resilience Groups (SRGs) will be explicitly expanded to cover the 62 day cancer standard given the need to drive better and sustained performance. At present many of these groups focus on non-elective care and the Emergency department 4 hours standard. For QVH, this will mean attendance at several SRGs.

5. Cancer Waiting Time Standards – Eight Key Priorities

Please see appendix one for QVH's submission with the Eight Key Priorities

Appendix One

The Queen Victoria Hospital		Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
1	Does the Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards?	Yes	The Director of Operations fulfils this role
2	Does the Board receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average?	Yes	The board reports state the number of 62 day breaches and whether this was a shared pathway or not. From the September board this will also include the pathway/tumour site for each breach.
3	Does the Trust have a cancer operational policy in place and approved by the Trust Board? This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.	Yes	This is included in the Trust's access policy. The trust has invested a new post of Patient Access Manager who will commence on September 21st 2015. This post will be the manager responsible for ensuring adherence to the cancer standards and other access standards. The Trust's Access policy was last reviewed in September 2014 and will be reviewed again during September to ensure that the Cancer requirements and updated Referral to treatment consultant led waiting times rules are reflected and understood by staff. The Trust employs 5 staff (mix and full and part time) as cancer data coordinators and MDT coordinators along with a cancer manager. The cancer manager is 1wte, the cancer data coordinators total 1.2wte and the MDT coordinators total 1.66wte. The part time element offers flexibility to ensure cover is provided during periods of leave.

Appendix One

The Queen Victoria Hospital		Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
4	Does the Trust maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast? These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.	No	QVH Is a specialist trust and the only relevant pathway in this section is the breast pathway. For this pathway the Trust undertakes 'immediates' where a mastectomy and reconstruction is undertaken at the same time. The trust provides the Plastic/reconstruction input, the referring trust the oncology/cancer surgeon. Therefore these patients are on a shared pathway and referrals tend to come in towards the latter part of the timescale (current average is day 44) therefore work is commencing during Sept and Oct to agree the timing of the pathway to prevent breeches. As there are several trusts involved in the pathway, it is anticipated that this work is completed by November 30th. The Trust will need to be aware of timescales (where relevant) in referring trusts improvement plans.
5	Does the Trust maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance? The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.	Yes	All patients are tracked, there are three times weekly access meetings that include all cancer patients and additional capacity is put in place when required.
6	Is a root cause breach analysis carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching)? These should be reviewed in the weekly PTL meetings.	Yes	Undertaken as part of the access meetings with further investigation as required

Appendix One

The Queen Victoria Hospital		Trust Response - Yes/No	Please provide appropriate supporting narrative for each question. Where you have given a "No" response could you please include in your narrative when you expect to be compliant.
7	Is capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) carried out? There should also be an assessment of sustainable list size at this point.	Yes	This is undertaken as part of the overall demand and capacity planning by the trust and is currently being reviewed as part of forward planning for 16/17 plans
8	Is an Improvement Plan prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard? This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.	Yes	This is part of the Trusts overall demand and capacity work. The risk areas relate to shared pathways and the action being taken is as described in section 4.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	24 September 2015
Reference number:	211-15
Report from:	Graeme Armitage, Director of HR & Operational Development
Author:	Graeme Armitage, Director of HR & Operational Development
Report date:	22 July 2015
Appendices:	1: Policy

Whistleblowing policy

Key issues

1. The recently agreed whistleblowing policy has been revised further to incorporate the recommendations contained in the 'freedom to speak up' review. The review was commissioned by the Secretary of State for Health in 2014 and was led by Sir Robert Francis following ongoing issues about the confidence staff have in raising their concerns within the NHS.

2. Whilst whistleblowing is only one aspect of creating the right culture for staff, it has been important to reflect the recommendations of the review so that where staff feel the need to use this policy they can do so with confidence. This means that the matter will be dealt with fairly and sensitively and that serious concerns are brought to and discussed at board level.

3. The policy has been revised in light of the review recommendations and will now go to the next quality and risk committee before final sign off by the board in September 2015. Therefore the policy is here for information.

Implications of results reported

4. The attached policy will be available to our commissioners and the general public.

Action required

5. The policy will be discussed at the next quality and risk committee and presented back to the board in September for approval.

Link to key strategic objectives (KSOs)

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

- Financial sustainability

Implications for board assurance framework (BAF) or corporate risk register (CRR)

6. There are no implications for the BAF.

Regulatory impacts

7. The revised policy has been revised to incorporate the recommendations of the ‘freedom to speak up’ review.

Recommendation

8. The Board is asked to note the revised whistleblowing policy.

Queen Victoria Hospital NHS
NHS Foundation Trust

DRAFT (REVISED) RAISING CONCERNS (WHISTLE BLOWING) POLICY

CLASSIFICATION	Corporate
TRUST POLICY NUMBER	CP.2027.1
APPROVING COMMITTEE	JCNC and LNC
RATIFYING COMMITTEE	Quality & Risk Committee
DATE RATIFIED	05 March 2015
DATE FOR REVIEW	05 March 2018
DISTRIBUTION	QVH Staff (via the QVH Intranet)
RELATED POLICIES	Counter Fraud Policy, Bullying and Harassment Policy, Disciplinary Procedure
DIRECTOR LEAD	Jo Thomas, Director of Nursing
AUTHOR	Carl Watson- Local QVH CF Specialist / Revised by Olive Jones, Deputy Head of HR
EQUALITY and HUMAN RIGHTS IMPACT ANALYSIS	42 2014
CONSULTATION	HR staff ; JCNC & LNC
THIS DOCUMENT REPLACES	HR4006.1
This document is available in alternative formats upon request, such as large print, electronically or community languages. In the first instance please contact Amanda Stevens, PA to the Head of HR/OD on 01342 414330 or email amanda.stevens@qvh.nhs.uk	

Contents

Executive Summary

Queen Victoria Hospital NHS Foundation Trust (QVH) encourages a climate of openness and dialogue where the constructive expression by staff of their concerns is welcomed by managers as contributing towards improving services in line with its core values of humanity, pride and continuous improvement of care

The underlying principles of this policy is to ensure that staff at QVH have the freedom to speak up without fear of repercussions of victimisation, when they raise genuine concerns where standards are not met or others may be at risk. The aim of this policy is to provide a clear and simple framework for members of staff to be able to raise genuine concerns reasonably and responsibly with the right people, and for them to be dealt with fairly and promptly.

The NHS Constitution emphasises the importance of honesty and openness and pledges that the NHS will "encourage and support staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised an acting consistently with the Public Interest Disclosure Act (PIDA) 1998." Further information about PIDA can be found in **Appendix 1.**

This Raising Concerns (Whistleblowing) policy is primarily for concerns where the interests of others or Queen Victoria Hospital NHS Foundation Trust are at risk. There may be times when we have concerns about what is happening at work. Usually, when raised, these concerns are easily resolved. However, when you are troubled about something that involves a danger (to patients, public or colleagues), professional misconduct or financial malpractice, it can be difficult to know what to do.

This policy enables people to blow the whistle safely so that issues are raised at an early stage and in the right way. The Trust will ensure that any individual who raises a genuine concern under this policy will not be at risk of losing their job or suffer any form of retribution as a result. We know from experience that to be successful we must all try to deal with issues on their merits. The Trust welcomes genuine concerns and is committed to dealing responsibly, openly and professionally with them. Without your help, we cannot deliver a safe service and protect the interests of patients, staff and the Trust. If you are worried, we would rather you raised it when it is just a concern, than to wait for proof.

The outcome and recommendations of the 'Freedom to Speak Up – review of whistleblowing in the NHS' undertaken by Sir Robert Francis and published in February 2015 are embedded within this policy.

1. Introduction

The policy covers concerns about:

- Criminal offences e.g. Financial Malpractice
- Failure to comply with legal obligations
- Miscarriages of justice
- Threats to health and safety of an individual
- Damage to the environment
- A deliberate attempt to cover up any of the above
- Clinical malpractice – including poor treatment, neglect/abuse of patients/service users.
- Failures in healthcare systems.

The policy does not cover personal grievances and these should be raised under the Trust's Grievance policy.

All concerns raised under this policy will be investigated.

2. Responsibilities

2.1 Trust Staff

This policy applies to all staff employed at Queen Victoria NHS Foundation Trust whether you are a permanent employee, agency, locum or bank workers, trainee, student non-executive directors, governors, or one of our contractors or volunteers.

All Trust staff have a duty to ensure that:

- patients / service users of the Trust are provided with high quality service and care.
- they report any matter they consider to be damaging to the interests of patients / service users without delay
- they report concerns about any other malpractice that may be damaging to the Trust or its patients and staff, including financial mismanagement, health and safety risks and crimes committed at work
- where registered with a professional body to adhere to their respective codes of conduct which place a duty on practitioners to raise concerns where they see instances of poor practice or wrongdoing.

Staff also have a duty of loyalty to the Trust and must, therefore, ensure that any issues about Trust services are raised in accordance with this procedure.

2.2 Managers / Directors / Non-Executive Directors

All Managers and Directors have a duty to:

- encourage staff to come forward with their concerns at the earliest opportunity
- foster a climate where staff feel confident to speak up and that they can raise issues without detriment
- effectively address concerns at an early stage
- hold regular discussions with staff about concerns at work and should focus on constructive discussion and dialogue, finding a solution, making improvements and dealing with risk.
- ensure that all concerns raised with them are taken seriously and are investigated promptly and thoroughly.
- be approachable and encourage staff to admit mistakes rather than concealing them so that they can be remedied, and identify any training or development needs for staff to support competency in their role.

2.3 The Chief Executive

The Chief Executive has overall responsibility for ensuring that this policy works effectively within the Trust and those procedures for raising concerns and speaking up are followed.

3. Key Principles

All staff have the right to speak up and contribute their views on all aspects of health service activities, especially the delivery of care and services to patients/service users. It is recognised that the free expression of staff views has an important role to play in maintaining good standards of care and improving the quality of the service.

The Trust will not tolerate the harassment or victimisation of anyone raising a genuine concern. Where it is proven that an employee has been harassed, bullied or victimised as a result of raising a genuine concern the perpetrator will be subject to the Disciplinary Policy.

Employees who express their views about health service issues in accordance with this policy will not be penalised in any way for doing so, providing that the matter is raised in good faith. This will apply even if the concern is subsequently considered to be unfounded (however, if allegations are proven to have been raised with malicious intent, then this will be treated very seriously and the Trust would consider whether it was appropriate to invoke the Disciplinary Policy or the Dignity and Respect at Work Policy). Staff who feel that they are in any way being victimised as a result of raising a concern should contact the Human Resources Department or their trade union representative. Equally, staff who feel that they are the victim of malicious allegations should also seek advice from the Human Resources Department or their trade union representative.

Staff should feel able to speak up and raise concerns without the need for secrecy. However, where a member of staff wishes to raise an issue in confidence, the manager will respect this and will not disclose their name more widely, without their prior consent. Where this inhibits the Trust's ability to resolve an issue, this will be discussed with the individual to establish how best to proceed.

When raising issues, staff have an obligation to safeguard all confidential information to which they have access, particularly information about individual patients / service users, which must not under any circumstances be inappropriately disclosed. However, if allegations of malpractice are made in confidence to a member of staff by a patient / service user, the staff member should make it clear that they will be obliged to share this information with their manager if it is in the best interests of the patient to do so.

The Trust is committed to tackling issues of malpractice quickly and effectively. Destroying or concealing evidence of poor practice or misconduct, or discouraging staff from coming forward with their concerns, will be treated as a serious offence.

4. Culture Change

QVH recognises that in order for staff to feel safe to speak up about concerns, it must create an open and transparent culture. In practice this means staff 'feel' that they can raise concerns or complaints knowing that they will be taken seriously and investigated.

To this end, culture change is the responsibility of all staff and managers and at QVH there are a number of activities and initiatives that are aimed at embedding this open and transparent culture. This in turn helps to ensure that all staff to feel valued and play an integral part in the success of the trust. Outlined below are the key initiatives and staff are encouraged to use these opportunities to feedback their views and concerns to managers in addition to the formal use of this policy:

Activity / Initiative	**Organisational Lead**
Senior managers – back to the floor	Director of HR/OD / SMT
Leadership Forum	Chief Executive
Leadership Framework – behavioural competencies	Director of HR/OD
Employee engagement – Staff Surveys	Director of HR/OD

Professional supervision (regular one to one meetings)	All managers responsible for managing others
Appraisals	All managers responsible for managing others
Corporate Induction (session on how to raise concerns)	Learning and Development Team
Access to professional development and training	Director of HR/OD & Director of Nursing and Clinical Infrastructure
Formal local (team) induction programme	All line managers
A wide range of developmental training programmes including Human Factors	Director of HR/OD
Staff Briefing sessions	SMT

5. Procedure for Raising Concerns

5.1 Sources of Support and Advice

If staff are unsure about whether they should raise a complaint or need advice in doing so, they should contact the Human Resources Department or their trade union representative in confidence where they can discuss the matter and decide on how to proceed with the issue. You can also contact the Whistleblowing Helpline which gives free advice for the NHS and Social Care on 08000 724 725.

Staff may also consult, or seek guidance and support from their professional organisation, or from statutory bodies such as the Nursing and Midwifery Council (NMC), the General Medical Council (GMC), The General Dental Council (GDC) the Health and Care Professions Council (HCPC) or other appropriate statutory body.

For support in coping with any personal anxiety or stress involved in raising an issue or becoming the subject of an issue raised, the individual may wish to contact the Occupational Health Department or Care first, the Trust's Employee Assistance Programme on 0800 174 319

A list of organisations and their contact details can be found in **Appendix 2.**

5.2 Stages of the Procedure

A flowchart of the process can be found in **Appendix 3** and the Top Tips for Reporting Concerns are in **Appendix 4**.

Stage 1:

- In the first instance, members of staff who have a concern should raise this informally with their line manager. If the concern is related to their line manager then they should inform the next level manager accordingly.

Stage 2:

- Where a member of staff has concerns they should, in the first instance, raise these with their immediate line manager, formally in writing by using the Raising Concerns Disclosure Form which can be found in **Appendix 5.**
- If the member of staff feels unable to raise the matter with their manager for any reason, or remains dissatisfied with their response, then they can raise the matter with the relevant Head of Department or Director.
- The manager, Head of Department or Director to whom the concerns are reported should follow the guidance set out in the Top Tips for Managers in **Appendix 6**.
- Alternatively, issues can be raised anonymously on the Trust's intranet using the 'Tell Jo' service.
- If the concerns relate to potential fraud or bribery, then the concern should be raised with the Director of Finance, the Local Counter Fraud Specialist, or NHS Protect national NHS Fraud and Corruption Reporting Line. Please refer to the Trust's Counter Fraud Policy for more information about what to do in these circumstances. Further information and guidance on issues of fraud and corruption are available on the Counter Fraud pages of the Trust's intranet).

Stage 3:

If the member of staff remains dissatisfied that their concerns have not been resolved, they can write to the Chief Executive. If the issue remains unresolved, the individual should write to the Trust Chairman, who may designate one or more Non-Executive Directors to investigate on their behalf.

Stage 4:

If the member of staff is still not satisfied that the issue has been dealt with appropriately AFTER following the procedures set out in Stages One and Two, they can, as a last resort, seek to raise the matter with appropriate external bodies, such as the Care Quality Commission, the Clinical Commissioning Group or NHS England Local Area Team. See section 5 below for details of a number of relevant bodies.

5.3 Investigation and Outcome

At all stages, the relevant manager should investigate the matter promptly and thoroughly. A meeting will normally be arranged with the individual within 7 days, so that they can explain their concerns fully. The member of staff may be accompanied at this meeting by a trade union representative or workplace colleague, if they so wish.

In cases of suspected fraud or corruption, the manager will notify the Local Counter Fraud Specialist immediately and seek their advice.

The staff member should be provided with feedback on the outcome of the investigation as promptly as possible, and certainly within 21 days of having raised the concern. If the investigation is prolonged beyond this, then regular contact should be maintained with the individual to explain the reasons for the delay. If the staff member is concerned that the investigation is taking too long at any level, then they can take the matter to the next stage. In particular, if the individual believes that a delay could result in serious harm to a patient / service user, then they should feel able to contact the appropriate senior manager at the earliest opportunity to make them aware of their concerns.

Where the investigation results in further action being taken, the individual will be provided with details of this action (with due regard to the confidentiality of other employees). The individual may also be asked to participate as a witness in such action, which may include writing a

statement and/or appearing at a disciplinary hearing or court case. If you chose to remain anonymous during the investigation, the anonymity may need to be lifted in the event of a disciplinary hearing or court case. This is because the person against whom proceedings are being initiated has the right to a fair process which includes being able to question or challenge the information presented to them. Support from the HR department and your trade union will be available in these situations. HR will be able to discuss you in further detail the options for continued anonymity.

Where further action is not considered appropriate for whatever reason, the member of staff should be given a prompt and thorough explanation in writing, if possible within 7 days, of the reasons for this. They should also be told what further stages are available to them under the procedure.

The trust will take all whistleblowing cases seriously and as such will require all cases to be reported through the Quality and Risk Sub-Committee of the Board. The Chair of that committee will be responsible for reporting cases at Board level for information and review where this is appropriate. Where cases are reported to the Board, they will be discussed in the private session in order to maintain the confidentiality of the individual raising the concern.

5.4 Mediation

Depending on the nature of the concern raised, it may be in the interests of the employee making the complaint, and subject of the complaint to refer the matter to mediation. Mediation is a voluntary process where two or more people in dispute attempt to reach agreement. Any agreement comes from those in dispute, not from the mediator. The mediator is not there to judge or to tell those involved in the mediation process what they should do. The mediator is in charge of the process of seeking to resolve the problem but not the outcome. Advice should be sought from Human Resources regarding the option of mediation.

Where the employee who has raised the concern and the other party / parties agree to mediation, HR will arrange the mediation and any continuing support. The Head of Service / Business Unit Manager will be responsible for monitoring the situation and should any further issues arise other options will be considered such as redeployment.

5.5 Redeployment

All requests from staff to be redeployed will be considered and if authorised the process for redeploying staff as outlined in the Trust's Redeployment Policy which is able on the intranet site – Qnet, will apply. The HR department will work actively with the individual to seek suitable alternative employment.

6. Reference to External Bodies

It is anticipated that by following this procedure, there will be no need to raise concerns outside of the Trust. (To unjustifiably do so could undermine public confidence in the Trust.)

However, if all stages of the procedure have been exhausted, and the member of staff is still dissatisfied, or if the member of staff feels that the Trust is not taking their concerns seriously enough or taking no action, then the member of staff could consider taking advice from one of the following:

The regulatory bodies relevant to the NHS are:

- Care Quality Commission www.cqc.org.uk
- HM Revenue and Customs www.hmrc.gov.uk
- Audit Commission (financial matters) www.audit-commission.gov.uk
- Health & Safety Executive www.hse.gov.uk
- Charity Commission www.charity-commission.gov.uk
- Occupational Pensions Regulatory Authority www.opra.gov.uk
- Monitor www.monitor-nhsft.gov.uk
- NHS Protect www.nhsbsa.nhs.uk/Protect

6.1 Fraud and corruption issues

The Trust has a nominated Local Counter Fraud Specialist. All matters concerning suspected fraud or corruption, including any issues relating to suspected bribery as defined in the Bribery Act 2010 can be reported directly to them or through the Trust's Director of Finance. Staff may also refer to the Trust's Counter Fraud Policy for guidance.

- Local Counter Fraud Specialist on 0118 952 4723
- The QVH Fraud and Corruption Hotline on 07763 199356
- NHS Fraud & Corruption Reporting Line on 0800 028 4060 (suspected fraudulent conduct)
- NHS Protect at www.nhsbsa.nhs.uk/Protect

6.2 Member of Parliament

Staff have a constitutional right to consult their local Member of Parliament in confidence for advice and guidance.

6.3 Mental Health: Care Quality Commission

Where an employee has a concern about the care of a patient/service user detained under the Mental Health Act 1993, they may be able to refer the matter to the Care Quality Commission. Further information on the Care Quality Commission's role in respect of the Mental Health Act can be found using the following link: http://www.cqc.org.uk/organisations-we-regulate/mental-health-services/mental-health-act.

6.4 The Health Service Commissioner (The Ombudsman)

The Ombudsman may look into complaints made by staff on behalf of a patient in the proven absence of anyone more appropriate to act on the patient's behalf.

6.5 Secretary of State

The Public Interest Disclosure Act provides for matters of concern which cannot be resolved in any other way to be referred to the appropriate Minister of the Crown.

6.6 Media

With the other options available, it is not anticipated that staff will find it necessary to go to the media as a means of addressing concerns. The media should only be contacted as a last resort

and when all other channels have been exhausted. If a member of staff is considering talking to the media, then they should notify the Trust of this to ensure that all alternative options for resolving the issue have been thoroughly explored. The Trust recognises the individual's right to freedom of speech but expects that exercising it through the media is a last resort.

7. Dissatisfaction with the Trust's Response

Through this policy, the Trust will try to respond to concerns in an open and transparent way. If the whistle-blower is dissatisfied with the response, they may wish to go to other levels within the Trust, the charity Public Concern at Work (www.pcaw.co.uk), the relevant trades union or professional body, or the external bodies detailed above.

8. Monitoring

Records will be kept of any concerns raised under this policy, and the outcome of investigations and any subsequent action taken will be monitored to ensure that its provisions are being implemented effectively.

9. Training and Awareness

All staff will receive training on raising concerns (whistleblowing) as part of the Corporate Induction into Trust.

This document is made available on the Trust intranet. Heads of departments will be kept informed of any changes to this policy and are responsible for cascading to their staff. The Trust's Local Counter Fraud Specialist provides training through the induction programme or other methods.

10. Equality

This policy and protocol will be equality impact analysed in accordance with the Trust Procedural Documents Policy, the results of which are published on our public website and monitored by the Equality and Diversity team

11. Review

This policy will be reviewed in three years' time. Earlier review may be required in response to relevant changes in legislation or guidance.

Appendix 1

WHAT THE LAW SAYS - DETAIL OF PIDA

What is the Public Interest Disclosure Act 1998 (PIDA)?

The Public Interest Disclosure Act 1998 protects whistle-blowers from detrimental or unfavourable treatment and victimisation from their employers and co-workers after they have made a qualifying disclosure of a concern in the public interest.

The way PIDA works is to allow people to apply to an Employment Tribunal for a remedy or compensation if they feel they have suffered bad treatment as a result of whistleblowing. The Employment Tribunal route is, however, not an easy one. It is important to take advice from a Trade Union, solicitor or an independent helpline at an early stage to support you through this process.

Who is covered?

The Act covers all workers including those on temporary contracts or supplied by an agency, and trainees. PIDA does not cover volunteers or Governors of NHS Foundation Trusts (who are not employees of the Trust), and does not usually cover students

NOTE: Students should take advice if they are thinking of raising concerns during their placements. They can talk to their university tutor or lecturer, their mentor, professional body, trade union or independent helpline.

Will you be automatically protected if you make a disclosure?

As from 25 June 2013, to qualify for protection under PIDA a disclosure should be in relation to a concern which is in the “public interest”. The public interest means the public good, not what is of interest to the public, and not the private interests of the person raising the concern. (For the difference between a grievance and a disclosure in the public interest, please see page 32). Whilst there is no longer a requirement for someone to have good faith when they raise a concern, an employment tribunal has the power to reduce any compensation award by up to 25% if it considers that the disclosure was made in bad faith (for example if the whistle-blower’s motives were to pursue a personal grudge against their manager).

What is a qualifying disclosure?

PIDA details six subject areas under which disclosures have to fit so as to be “qualifying disclosures”:

- criminal offences;
- failure to comply with legal obligations;
- miscarriages of justice;
- threats to health and safety of an individual;
- damage to the environment; or
- a deliberate attempt to cover up any of the above.

Are all disclosures protected under PIDA?

Certain conditions must be met for a whistle-blower to qualify for protection under the legislation, depending on to whom the disclosure is being made and whether it is being made internally or externally. To be protected, the disclosure must be in the public interest, the individual must have a reasonable belief that the information shows that one of the categories of wrongdoing listed in the legislation has occurred or is likely to occur (see What is a qualifying disclosure? above), and the concern must be raised in the correct way.

Internal disclosures:

Workers are encouraged to make internal disclosures (raise concerns with their employer) with the view that employers will then have an opportunity to address the issue. If a worker makes a qualifying disclosure internally to an employer (or other reasonable person) they will be protected.

External disclosures:

If a disclosure is made externally there are conditions which need to be satisfied before a disclosure will be protected. One of these conditions must be met if a worker is considering making an external disclosure.

If the disclosure is made to a "prescribed person" (a list of prescribed persons is made under PIDA, and you can find details of relevant prescribed persons for the NHS and social care in the Appendix at page 39), the worker must reasonably believe that the concern that they are raising is one which is relevant to that prescribed person (i.e. comes under their area of responsibility as a regulator) and that the disclosure is substantially true

A worker can also be protected if they reasonably believe that the disclosure is substantially true, the disclosure is not made for personal gain, it is reasonable to make the disclosure, and one of the following conditions apply:

- at the time he/she makes the disclosure, the worker reasonably believes that he/she will be subjected to a detriment by his/her employer if he/she makes a disclosure to his/her employer; or
- the worker reasonably believes that it is likely that evidence relating to the failure / wrongdoing will be concealed or destroyed if the disclosure is made to the employer; or
- the worker has previously made a disclosure to his/her employer.

Additional conditions apply to other, wider disclosures to the police or the media. These disclosures can be protected if the worker reasonably believes that the disclosure is substantially true, the disclosure is of an exceptionally serious nature, and it is reasonable to make the disclosure.

Please note that these conditions do not apply to disclosures made to legal advisors in the course of obtaining legal advice.

Appendix 2 - List of Prescribed Persons

Please see latest edition of this document at:

www.gov.uk/government search '*list of prescribed persons'* as it is updated annually

Care Quality Commission about the provision of health care on the NHS or independent health care services

CQC National Customer Service Centre

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

Tel: 03000 616161

www.cqc.org.uk

The Independent Regulator of NHS Foundation Trusts about the regulation and performance of NHS foundation trusts

Monitor

4 Matthew Parker Street

London

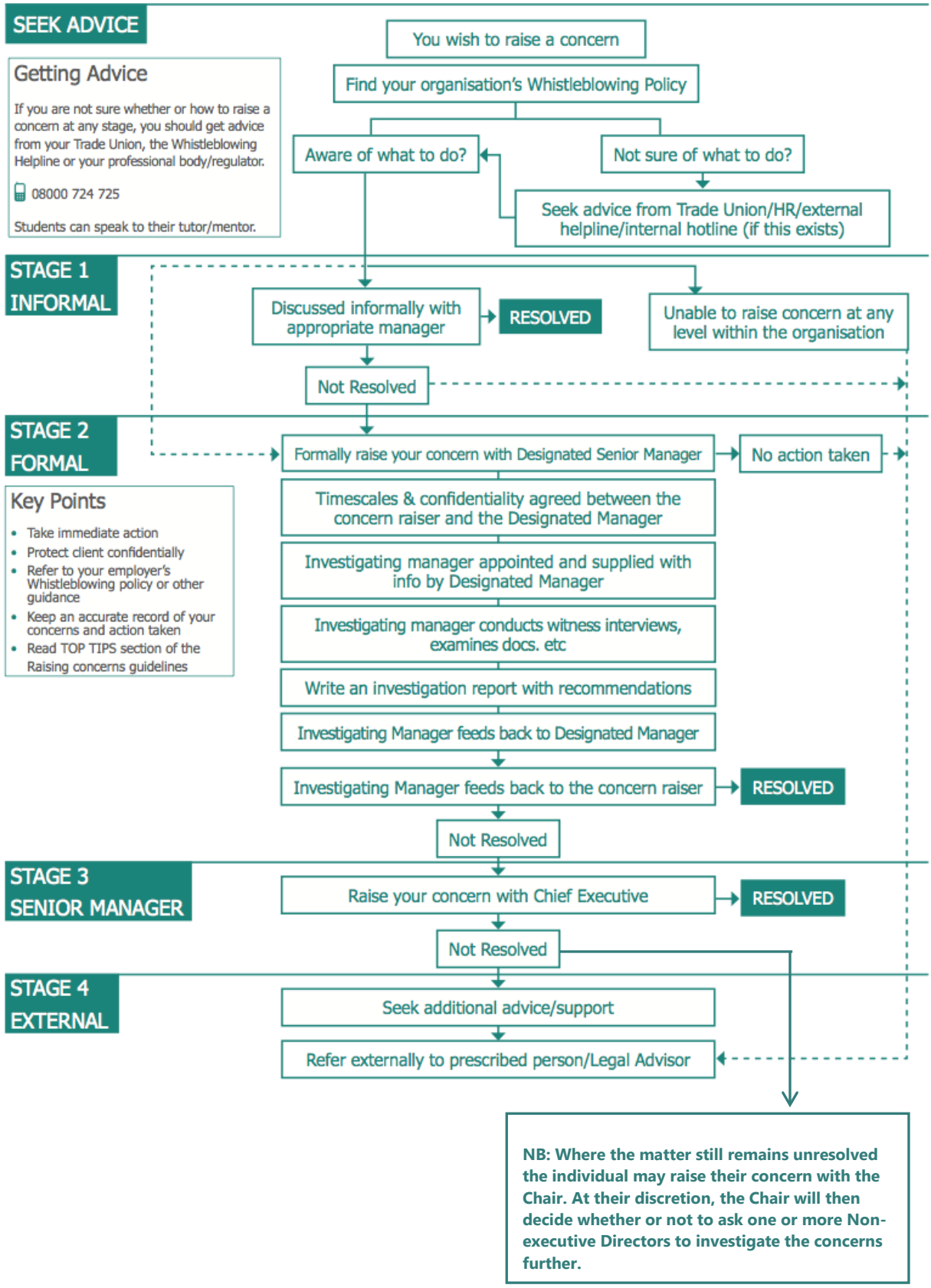
SW1H 9NP

Tel: 020 7340 2400

Email: enquiries@monitornhsft.gov.uk

www.monitor.hsft.gov.uk

Appendix 3


SEEK ADVICE
You wish to raise a concern
Find your organisation's Whistleblowing Policy
Aware of what to do?
Not sure of what to do?
Seek advice from Trade Union/HR/external helpline/internal hotline (if this exists)
Getting Advice
If you are not sure whether or how to raise a concern at any stage, you should get advice from your Trade Union, the Whistleblowing Helpline or your professional body/regulator.
08000 724 725
Students can speak to their tutor/mentor.
STAGE 1 INFORMAL
Discussed informally with appropriate manager
RESOLVED
Unable to raise concern at any level within the organisation
Not Resolved
STAGE 2 FORMAL
Formally raise your concern with Designated Senior Manager
No action taken
Timescales & confidentiality agreed between the concern raiser and the Designated Manager
Investigating manager appointed and supplied with info by Designated Manager
Investigating manager conducts witness interviews, examines docs. etc
Write an investigation report with recommendations
Investigating Manager feeds back to Designated Manager
Investigating Manager feeds back to the concern raiser
RESOLVED
Not Resolved
Key Points
Take immediate action
Protect client confidentially
Refer to your employer's Whistleblowing policy or other guidance
Keep an accurate record of your concerns and action taken
Read TOP TIPS section of the Raising concerns guidelines
STAGE 3 SENIOR MANAGER
Raise your concern with Chief Executive
RESOLVED
Not Resolved
STAGE 4 EXTERNAL
Seek additional advice/support
Refer externally to prescribed person/Legal Advisor
NB: Where the matter still remains unresolved the individual may raise their concern with the Chair. At their discretion, the Chair will then decide whether or not to ask one or more Non-executive Directors to investigate the concerns further.

Appendix 4

Top tips for employees considering raising concerns

Whistleblowing is when you speak out about something you are concerned about at work because you think it needs bringing out into the open for the public good. It can be a hard decision to do this. Here are some top tips to help you make your decision in an informed way and to help you access any support you may need:

1. Read the whistleblowing policy

(This is sometimes called the "Raising Concerns Policy"). It should tell you:

- what type of concerns are covered
- when and how a concern should be raised and who with.

You can normally find the policy on the staff intranet or ask the HR department; you need to follow the procedure to make sure you remain protected under the law – this is called the Public Interest Disclosure Act 1998 (PIDA).

If you feel you need to have independent advice you can get this by contacting your Trade Union representative, the Whistleblowing Helpline (for NHS and Social Care staff) on 08000 724725 or a Citizens Advice Bureau. In some circumstances, you may also wish to obtain independent legal advice.

2. Raise the concern immediately or at the earliest opportunity

If you believe that something is wrong, you do not need proof. Speaking out early could stop the issue from becoming more serious, dangerous or damaging.

3. Consider if your concern can be discussed/resolved informally

You may wish to use other occasions to raise your concerns informally such as supervision meetings, at your appraisal, team or departmental meetings or at staff forums.

4. Find out if other workers share your concerns

You may be able to raise your concern as a group - there can be strength in numbers.

5. Check the QVH policy to find out whom to report your concerns to

Your line manager is usually the first person to go to. If you believe that your manager may be involved or you feel unable to raise it with them, you may need to go to another manager or someone else following advice from the HR Department.

If you think the ways to report are not clear or you do not feel supported or safe then again you should contact HR or your Trade Union for advice in the first instance.

6. Try to see if you can sort things out inside your organisation first

But if you are not satisfied, then you might need to tell someone outside of where you work. This might mean telling your professional regulator or the CQC.

Reporting anything to the media should always be the LAST thing you turn to. Try all the other places talked about first – particularly if what you want to report involves private or confidential information.

7. When you report your concern, focus on factual information and evidence

This means being specific about;

- dates and times
- what happened and the order of events
- who was involved
- any witnesses.

Act honestly and professionally at all times in the interests of patients and service users.

8. Try to present the situation as clearly and with as much information as possible

Identify what you believe to be the key issues and risks. For example, is there a risk to the patient/service user or is it to do with a professional/clinical practice etc.? Writing it down will help you to get your thoughts in order particularly if you are upset, worried or feeling emotional about it. Your trade union and the Whistleblowing Helpline can offer support.

Provide as much supporting information as you can, for example files or emails. ALWAYS ask for further advice, for example from your Trade Union or professional body, if these contain private or confidential information.

9. Check out the process and what will happen next.

Talk about what might happen next with your manager or the person nominated in the whistleblowing policy.

You will need to give them a reasonable amount of time to check the facts and to find out more if they need to, before they feed back to you.

Respect the fact that your manager may need to keep some information private and confidential if it relates to other people.

Try to cooperate with any investigation into what you have reported and the attempts to resolve the issues and put things right.

You are entitled to get support from a work colleague or union representative at any meeting to discuss your concerns or during any investigation that takes place.

10. Keep track of what is happening.

Even if you raise your concern verbally, you should also keep a record in writing of any discussions relating to your concern – this means things like the dates things happened, who you talked to, what was said, what the response was.

One way of keeping track of things is to email the manager/nominated person after any discussion with a summary of the main points. Make it clear that you are raising a concern in line with your organisation's whistleblowing policy and the Public Interest Disclosure Act 1998 (PIDA). This is the law to do with whistleblowing.

11. Maintain confidentiality.

It is best if you can speak out openly about what you think, although you can ask for your identity to be kept confidential.

The person/manager with whom you talk about things should make every effort to protect your identity. However, there may be times when, because of the nature of the investigation or what you want to say, it will be necessary to say who you are publicly. If this IS going to happen then the person you raise your concerns with should make every effort to let you know first.

Remember, if you work in a small team then people you work with might guess or work out your identity. If this happens, tell your manager and let him/her know if you are being bullied or harassed or being treated badly as a result.

Concerns raised anonymously – this means when you do not reveal your name - can be more difficult to deal with and investigate in the best way. More action is likely and possible if your identity is known when you report something.

12. If you are not satisfied…

If you feel your concern has not been addressed or the issues have not been resolved to achieve a solution and positive outcome, you should use the sources of support and help available to pursue the matter. Not speaking up might mean that poor care will carry on and may even get worse.

If this is the case, you will need to refer to your organisation's policy in order to be clear about what action you can take and where you can go next.

If there is nothing more you can do inside your organisation, then you can raise a concern with a regulator. This means somewhere like the Care Quality Commission (CQC). They have a confidential number you can call on 03000 616161. If your concern is regarding an individual professional's practice, the professional regulator would be best placed to take action - a list of them is given at Appendix 2. If you do this, you need to have reason to believe that the information you give and any allegation you make is substantially true – if you only suspect something then that is not enough when you report concerns outside of where you work. You can raise your concern with a regulator such as the Care Quality Commission even if you have left your job. And, as from 6 April 2014, members of the House of Commons (MPs) have been added to the list of 'prescribed persons'.

Talking to the police or the media are also protected under the PIDA law, but only under certain circumstances. For example, if you genuinely believe you would be victimised or bullied if you raised the matter internally or with a regulator, you would probably be protected.

Going to the media should always be the last resort. Doing this could have an impact on your employment and it is a good idea to get advice before telling anyone outside of work.

Remember…

PIDA is there to protect you. So if you are being bullied or experience bad treatment as a result of raising a concern, tell your manager, Trade Union representative, or HR.

Appendix 5

Raising Concerns Disclosure Form

STRICTLY CONFIDENTIAL

This form is to be completed by individuals who want to raise a concern under the Public Interest Disclosure Act 1998.

SECTION 1 – DETAILS OF THE PERSON RAISING THE CONCERN

If you wish to remain anonymous, please go straight to section 2. However please note that whilst such concerns will be given due consideration, it will not be possible to progress matters in accordance with this policy (cross refer to the section of your policy which deals with anonymous reporting)

Name	
Home address	
Home contact number / mobile	
Work Address	
Work contact number / mobile	

Which address do you wish any correspondence to be sent to i.e. home address / work address (please delete as appropriate)

Date disclosure form submitted:.....

SECTION 2 – DETAILS OF THE DISCLOSURE

What is your concern about? (Please tick)

☐ **Patient/service user care**
☐ **Patient/service user safety**
☐ **Conduct (including malpractice, unethical conduct)**
☐ **Criminal offence/legal obligation**
☐ **Professional/clinical practice or competence**

Other (please state).....
Who is involved? Please list witnesses and anyone carrying out the act causing you concern, and the date(s), time and place(s) the act occurred:

.....

.....

Please describe what has happened/what you think will happen. Please provide as much detail as you can (use additional sheets of paper as needed):
.....

.....

SECTION 3 – PERSONAL INVOLVEMENT/PERSONAL INTEREST

Please declare any personal interest you may have in this matter (i.e. does the outcome of this matter have the potential to affect you personally in any way?)
.....
Have you personally been involved in this matter previously? YES / NO
If yes, please outline your involvement:
.....

SECTION 4 – EXPRESSED PREFERENCES

Do you wish your identity to be kept confidential (bearing in mind that, depending on the nature of the investigation or disclosure, it may become necessary to disclose your identity)?

YES/NO (delete as appropriate)

Appendix 6

TOP TIPS FOR MANAGERS

1. Listen carefully to any worker raising a concern

- Commit to taking the matter seriously.
- Thank the person for raising it (even if you think they may be mistaken).
- Acknowledge how they may be feeling, that it may be a difficult or stressful situation, and offer reassurance.
- Respect the worker's belief that they are raising a genuine concern in the public interest.
- Treat this as being reasonable.
- Avoid pre-judging whether this is correct or valid until an appropriate investigation has taken place.

2. Respond positively and clearly

- Reassure the person that the concern will be looked into promptly and (where appropriate) investigated thoroughly and fairly as soon as possible.
- Manage expectations of the individual – discuss next steps, reasonable timeframes and arrangements for feedback on the outcome.
- Respect a worker's request for confidentiality and any concerns about their job or career, but explain any circumstances where there may be limits on confidentiality.
- Offer advice about the type of support available to them (eg, relevant contacts they can speak to such as a designated whistleblowing lead within the organisation, HR, Trade Union, counselling, occupational health, or where they can seek independent advice – such as the Whistleblowing Helpline, or Citizen's Advice Bureau).
- Be clear on what the worker should do and where they should go if they experience any reprisals or unacceptable behaviour, eg, bullying, harassment or victimisation, from managers or colleagues.
- Give the individual a copy or refer them to your organisation's whistleblowing or "raising concerns" policy.

3. Ensure a fair process of investigation

- Ensure any investigation is carried out fairly and thoroughly.
- Keep an open mind – you may not want to believe all that you hear, but it's important to remain objective.
- Focus on the information that is being disclosed, not on the worker who is raising the concern.
- Don't let personal views influence your assessment of the issues.
- Recognise any strong emotions you may have and ask for help if you need it. (It is not unusual to have feelings such as anger, shock or distress.)

4. Assess how serious and urgent the risk is

- Decide whether the concern would be best dealt with under the whistleblowing policy or some other procedure (such as grievance).
- Don't dismiss the disclosure as an exaggeration or being trivial unless there is clear evidence to support this assessment.
- Decide whether the assistance of, or referral to, senior managers or a specialist function (eg, finance) is desirable or necessary.
- Where there are grounds for concern, take prompt action to investigate or, if the concern is potentially very serious or wide-reaching, make sure this is escalated to the most appropriate person within the organisation to undertake further investigations.

5. Maintain good communication with the worker who raised the concern

- Keep the worker advised and informed on progress.
- Update on any changes or delays in process.
- Give feedback on the outcome to the worker.
- Explain any action to be taken (or not), but maintain confidentiality where this involves other parties.
- Explain any mistaken perceptions or misunderstandings which may have occurred.
- Ideally feedback should be given face to face and followed up in writing.

6. Act fairly

- Understand that you are accountable for your actions.
- Be clear on any action taken or not taken and the reasons for this.
- Never attempt to ignore or cover up evidence of wrongdoing.
- Always remember that you may have to explain how you have handled the concern.
- Don't ever penalise someone for making a disclosure that proves unfounded if, despite making a mistake, s/he genuinely believes that the information was true.

7. Seek appropriate advice and/or support where required

- If you are uncertain about how to proceed with a concern, always seek advice from HR or other relevant person/department within your organisation that has lead responsibility for personnel functions.
- They will also be able to support and advise you throughout any investigations you need to undertaker into the issues raised, an in undertaking any actions required as a result of evidence being presented.

8. Keep clear, concise records of all discussions

- Date/s, what was said, response given by whom.
- Keep a record/log of all concerns raised (can be anonymised).
- Note the nature of the concern.
- Record how the investigation was conducted.
- Record outcome, decisions or action taken.
- Retain record for a minimum of 5 years.

9. Follow up action.

- Consider the potential actions:
  - Is this a serious disciplinary matter?
  - Are there alternative ways to achieve constructive, positive solutions for future improvement rather than simply apportioning blame?
  - Address any issues of competence of ability highlighted via training and development.
- Report on issues identified to the Board or owner (perhaps through your organisational monitoring system).
- Make recommendations across the organisation where appropriate, ie, feed into the "bigger picture" and taken remedial, proactive and preventative action where it is needed.
- Take steps to share any learning, establish long-term solutions and prevent recurrence of the issue elsewhere in the organisation.
- Raise any issues identified in other relevant forum e.g.
  - Health and safety
  - Risk assessment
  - Incident reporting
  - Quality reviews

- Service or performance reviews
- Business planning discussions
- Training and development reviews.

10. Ensure the process has a positive outcome.
    - Publicise and "celebrate" positive outcomes/actions/improvements resulting from someone raising a concern and speaking up (the person need not be named). This may encourage others to do the same.
    - Provide appropriate feedback on the outcome to the person raising the concern.
    - Build or rebuild working relationships and teams after a concern has been raised (the whistle has been blown) with appropriate support and advice from HR, Trade Unions, etc.
    - Check on the worker's wellbeing at regular intervals to ensure they have not suffered any disadvantage, bullying, harassment or victimisation as a consequence of raising a concern.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 24th September 2015
Reference number: 212-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: 30th July 2015

Report of the Chair of Nomination & Remuneration Committee

Key issues

1. Senior Management Pay Strategy
   It was confirmed that senior managers' pay should be reviewed within the context of the overall health economy, but focussed on the south east of England and on QVH's proximity to London. However, note should also be taken of the pay actions for QVH staff generally, and the impact changes in senior management pay may have on staff perceptions and morale. In the light of these factors, changes to the CEO, Director of Human Resources and Head of Corporate Affairs' salaries were discussed and agreed. All other members of the Executive team were either recent hires or are on nationally agreed terms and therefore no other reviews were required at this time. It was also agreed that an update on the subject of performance related pay for senior managers, with a recommendation whether it should be implemented or not, would be submitted to the March 2016 N & R Committee.

2. Board Member objective setting
   Annually, the Chair agrees objectives with each member of the Board and it was agreed that for FY 2015/16 onwards these objectives would comprise a core set of objectives common to all Board members (to be circulated by the Chair) plus a set of personal objectives related to an individual's functional responsibilities and their personal development needs.

3. Director and senior manager appraisals
   From April 2016 onwards in respect of the 2015/16 financial year, formal 360 feedback on achievement against objectives set will be undertaken for all Board members and for Executive Directors' direct reports.

4. Talent Management Process
   It was agreed that at the January 2016 N & R committee a talent management and succession planning review would be undertaken by the Committee of all staff at Management levels 1, 2 and 2a, plus the direct reports of staff at level 2a. The detailed process and timetable leading up to the review will be submitted to the Committee at its 15th October meeting.

5. Terms of Reference / Work Plan
   The Terms of Reference and annual Work Plan were reviewed and approved by the Committee.

Items to be referred to the Board of Directors

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

.

Additional information or assurance sought

7. None.

Implications for Board Assurance Framework or Corporate Risk Register

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

Recommendation

9. 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: 24th September 2015
Reference number: 213-15
Report from: Lester Porter, Non-Executive Director
Committee meeting date: 9th September 2015
Appendices: None

Report of the Chair of the Audit Committee

Key issues discussed

1. **Board Assurance Framework**. Although the BAF remains a key Board document, the AC's role is to ensure that it is regularly reviewed as being fit for purpose, and therefore the BAF quarterly updates will be tabled at the Audit Committee immediately preceding a board meeting.

2. **Terms of Reference**. It was agreed that the TORs needed further work and that a sub group of the three NED members of the AC would meet to review these for resubmission to the December meeting for approval.

3. **Audit Committee report to COG**. JT to draft the annual audit committee report for the Council of Governors meeting on 8th October.

4. **Outstanding internal audit recommendations**. CS presented a report on overdue historic recommendations from 2014/15. 39 existing overdue recommendations had now been reduced to 28 and her team will continue to focus on the remaining ones. From April 2015 onwards, responsibility for regularly tracking recommendations now reside with the new internal auditors, Mazars.

5. **Internal Audit 2015/16 Annual Plan**. The draft plan was discussed and agreed with Mazars with some modifications, focussing in the short term on a range of financial systems. It was agreed that a broader balance of issues should be introduced into the plan in future years.

Items to be referred to the Board of Directors

6. **Responsibilities in relation to the Board Assurance Framework**. Following the board governance review and in light of changes to board meeting frequency and sub-committee structure, it is recommended that the Board formally reviews and reaffirms responsibilities for the BAF in relation to content, process, timing and any actions required.

Implications for BAF or Corporate Risk Register

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

8. The Executive Team has assumed responsibility for completing and reporting back to the Board on the current updating of the BAF priorities.

Recommendation

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 05 November 2015
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

PROPOSED SCHEDULE		
BUSINESS MEETING OF THE BOARD OF DIRECTORS: SESSION HELD IN PRIVATE		
09.00 – 10.00	**IT infrastructure – Full Business Case (FBC)**	
	Estates Strategy Strategic Outline Case (SOC)	
BUSINESS MEETING OF THE BOARD OF DIRECTORS: SESSION HELD IN PUBLIC		
10:00 - 13.00		
	PATIENT STORY	
	Safety	Director of Nursing & quality
	RESULTS AND ACTIONS	
	Assurance: Minutes of Quality and governance meetings held on 03 September and 15 October	Committee Chair
	Patients: safe staffing and quality of care	Director of Nursing & quality
	National cancer survey results	Director of Nursing and quality
	Assurance: Minutes of Financial and operational performance committee meeting held on 19 October	Committee Chair
	Operational performance	Director of Operations
	Financial performance	Director of Finance & performance
	Workforce	Director of Human resources & OD
STRATEGY		
	Burns strategy update	Chief Executive
	Private Patient Strategy	Chief Executive
GOVERNANCE		
	Board Assurance Framework	Director of Nursing and quality
	Corporate risk register	Director of Nursing & quality
	Statutory duties of co-operation	Company secretary
	Annual seal register	Company Secretary
	Council of Governors' governance review	Company Secretary
	VIP/Celebrity visitors' policy	Company Secretary
	CQC preparation for inspection	Director of Nursing and quality
	R & D annual report	Medical Director
	R & D general discussion	Medical Director
	Audit plan	Director of Finance and performance
	Review of Clinical Governance	Medical Director
	Approval of Governance handbook	Company Secretary
	Fit & Proper Person Test	Company Secretary
SUB-COMMITTEE REPORTING		
	Nomination & remuneration	Committee Chair
	Charity Corporate Trustee	Company Secretary

*CiC = commercial in confidence