Queen Victoria Hospital NHS
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 7 January 2016

Session in public at 10.00

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: 7 January 2016

Members (voting):

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

In full attendance (non-voting):

Director of Human Resources & OD	-	Graeme Armitage
Director of Operations	-	Sharon Jones
Company Secretary	-	Kathleen Anderson
Deputy Company Secretary	-	Hilary Saunders
Governor Representative:	-	Chris Orman

Queen Victoria Hospital NHS
NHS Foundation Trust

Annual declarations by directors 2015/16

Declarations of interests

As established by section 40 of the trust's constitution, a director of the Queen Victoria Hospital NHS Foundation Trust has a duty:

- to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust.
- not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
- to declare the nature and extent of any relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the foundation trust to the other directors.

To facilitate this duty, directors are asked on appointment to the trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the trust and recorded in the following register of interests which is maintained by the company secretary.

Register of declarations of interests

	Relevant and material interests						
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	Director: Professional Governance Services Ltd (clients	Nil	Director: Professional Governance Services Ltd	Nil	Nil	Nil	Nil

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	include the Royal College of Surgeons)						
Lester Porter Senior Independent Director	Nil	Nil	Nil	Nil	Nil	My wife and I are longstanding clients of Mazars LLP, Sutton who are our personal tax advisors, and of Mazars Financial Planning Ltd who manage our self-invested personal pension funds.	Nil
Ginny Colwell Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Nil	My brother's partner is employed by Brighton and Sussex University Hospitals NHS Foundation Trust as deputy director of facilities and estates.
Ian Playford Non-Executive Director	1. Non-Executive Director: Ministry of Justice – Her Majesty's Courts and Tribunals Service 2. Board Advisor:	Nil	Nil	Nil	Nil	Nil	Nil

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	Kingsbridge Estates						
John Thornton Non-Executive Director	1. Non-Executive Director: Golden Charter Ltd 2. Non-Executive Director: Osmo Data Technology Ltd	Nil	Nil	Nil	Nil	Nil	Nil
Richard Tyler Chief Executive	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Steve Fenlon Medical Director	Nil	Nil	I am a member of a syndicate of anaesthetists called EGAS and practice in private hospitals in East Grinstead and Tunbridge Wells	Nil	EGAS does not have NHS contracts but members are asked to anaesthetise some NHS patients that surgeons have contracted to operate on.	EGAS occasionally supplies anaesthetists for out-of-hours lists paid at the agreed NHS rate.	Nil
Jo Thomas Director of Nursing	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Clare Stafford Director of Finance	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Other members of the board (non-voting)							
Kathleen Anderson Company Secretary	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Graeme Armitage	Nil	I own EQUUS HR	I own EQUUS HR	Nil	Nil	Nil	Nil

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Director of HR and OD		Consultancy which provides services to NHS and public sector organisations.	Consultancy which provides services to NHS and public sector organisations.				
Sharon Jones Director of Operations	Nil	Nil	Nil	Nil	Nil	Nil	My spouse joined Smith and Nephew as a strategic programme manager on 28/09/15.
Chris Orman Governor Representative	Pending	Pending	Pending	Pending	Pending	Pending	Pending
Hilary Saunders Deputy Company Secretary	-	-	-	-	-	-	-

Fit and proper person declarations

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director of the trust under given circumstances known as the "fit and proper person test".

By completing and signing an annual declaration form, QVH directors confirm their awareness of any facts or circumstances which prevent them from holding office as a director of QVH NHS Foundation Trust.

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board (voting)							
Beryl Hobson Chair	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Lester Porter Senior Independent Director	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Ginny Colwell Non-Executive Director	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Ian Playford Non-Executive Director	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
John Thornton	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

Register of fit and proper person declarations

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Non-Executive Director							
Richard Tyler Chief Executive	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Steve Fenlon Medical Director	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Jo Thomas Director of Nursing	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Clare Stafford Director of Finance	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Other members of the board (non-voting)							
Kathleen Anderson Company Secretary	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Graeme Armitage Director of HR and OD	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Sharon Jones Director of Operations	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Chris Orman Governor Representative	-	-	-	-	-	-	-
Hilary Saunders Deputy Company Secretary	-	-	-	-	-	-	-

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 7 January 2016 at 10:00
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

Agenda: session held in public		
Welcome		
04-16	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Standing items		
05-16	**Draft minutes of the meeting session held in public on 5 November (for approval)** *Beryl Hobson, Chair*	1
06-16	**Matters arising and actions pending** *Beryl Hobson, Chair*	11
07-16	**Chief executive's report** • **BAF overview** • **Corporate Risk Register** *Richard Tyler, Chief Executive*	13
Key strategic objective 1: outstanding patient experience		
08-16	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	24
09-16	**Patient story: experience** *Jo Thomas, Director of Nursing*	-
10-16	**Quality and Governance Committee: assurance report** *Lester Porter, Senior Independent Director on behalf of Ginny Colwell, Non-Executive Director and committee chairperson*	25
11-16	**Safe staffing and quality of care** *Jo Thomas, Director of Nursing*	27
Key strategic objective 2: world-class clinical services		
12-16	**Board Assurance Framework** *Steve Fenlon, Medical Director*	52
13-16	**Medical Director's report** *Steve Fenlon, Medical Director*	53
Key strategic objectives 3 and 4: operational excellence and financial sustainability		
14-16	**Board Assurance Framework** *Sharon Jones, Director of Operations and Clare Stafford, Director of Finance*	56

15-16	**Financial and Performance Committee: assurance report** *Ian Playford, Non-Executive Director on behalf of John Thornton, Non-Executive Director and committee chairperson*	58
16-16	**Operational performance** *Sharon Jones, Director of Operations*	61
17-16	**Financial performance** *Clare Stafford, Director of Finance*	71
18-16	**Bank mandates report** *Clare Stafford, Director of Finance*	96
Key strategic objective 5: organisational excellence		
19-16	**Board Assurance Framework** *Graeme Armitage, Director of Human Resources and Organisational Development*	101
20-16	**Workforce report** *Graeme Armitage, Director of Human Resources and Organisational Development*	102
Board governance		
21-16	**Engagement policy for celebrity, VIP and other high-profile visitors and supporters** *Kathleen Anderson, Company Secretary*	117
22-16	**Approval of terms of reference of board sub-committees:** • **Finance and performance committee** • **Quality and Governance Committee** • **Audit Committee** *Kathleen Anderson, Company Secretary*	125
23-16	**QVH Charity Committee report** *Lester Porter, Senior Independent Director and committee chairperson*	140
24-16	**Audit Committee report** *Lester Porter, Senior Independent Director and committee chairperson*	142
25-16	**Corporate trustee of the QVH charity report** *Beryl Hobson, Chair*	145
26-16	**Draft agenda for the March 2016 business meeting** *Kathleen Anderson, Company Secretary*	147
Any other business (by application to the Chair)		
27-16	*Beryl Hobson, Chair* • Approval of trust policies (KA) • Approval of amendments to the constitution (KA)	-
Observations and feedback		
28-16	**Feedback from key events and other engagement with staff and stakeholders** *All board members – please submit list in advance to the Deputy Company Secretary*	-

29-16	**Observations from members of the public** *Beryl Hobson, Chair*	-
30-16	**Observations and feedback on the meeting** *Graeme Armitage, Director of Human Resources and Organisational Development*	-

Date of the next meetings		
Board of Directors: **Seminar:** 04 Feb at 11:00 **Public**: 03 Mar at 10:00	**Sub-Committees** **Q&G:** 14 Jan 2016 at 09:00 **N&R:** 14 Jan 2016 at 11:00 **F&P:** 18 Jan 2016 at 14:00 **Audit**: 02 March 2016 at 14:00 **Corp. Trustee**: TBA **Charity:** 31 March 2016 at 09:00	**Council of Governors** **Public**: 14 Jan 2016 at 15.00

Queen Victoria Hospital NHS
NHS Foundation Trust

Document:	**Minutes (draft and unconfirmed)**	
Meeting:	**Board of Directors (session in public)** **Thursday 5th November 2015, 10.00 – 13.00, 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)	Senior Independent Director
	Clare Stafford (CS)	Director of Finance and Performance
	Jo Thomas (JMT)	Director of Nursing
	John Thornton (JT)	Non-Executive Director
	Richard Tyler (RT)	Chief Executive
In attendance:	Graeme Armitage (GA)	Director of Human Resources and Org. Development
	Kathleen Anderson (KA)	Company Secretary
	Sharon Jones (SJ)	Director of Operations
	Chris Orman (CO)	Governor Representative
	Hilary Saunders (HS)	Deputy Company Secretary (minutes)
Public Gallery:	Moira McMillan	Public governor
	Christine Halloway	Public governor

Welcome	
228-15	**Welcome, apologies and declarations of interest** BH opened the public session and welcomed two public governors to the meeting. There were no apologies. Under declarations of interest, SJ asked the board to note a potential conflict of interest and confirmed her Declaration of Interest form had been updated to reflect the change.
Standing items	
229-15	**Draft minutes of the meeting session held in public on 24 September 2015 for approval** The following changes were highlighted: • 199-15: Wording to be amended to *'…. GC emphasised that whilst the IT business case was approved through F & PC, any governance issues should be addressed through Q & GC'* • 200-15: Wording to be amended to: *'…..Whilst the FFT response rate for Inpatients had improved'* • 201-15: Remove the word 'to' in the penultimate sentence. • 207-15: The BAF to 'be reviewed every two months'. Taking into account these amendments, the minutes were **APPROVED** as a correct record.
230-15	**Matters Arising & Actions Pending** The board reviewed the current record of matters arising and actions pending. The update was received and **APPROVED**.
231-15	**Chief Executive's report** RT presented his regular update on progress and risks to key internal targets. He also provided

	an update on those external issues likely to impact on the trust's ability to achieve these targets. In presenting his report, RT highlighted in particular recent achievements in respect of statutory and mandatory training. He formally thanked GA and his team for their considerable efforts. Updates not contained within the written report included: • Apprising the board of a reply from Monitor acknowledging RT's response to David Bennett's letter from 3 August. This reiterated unprecedented financial challenges in 2015-16 and noted our comments about being unable to commit to an improved position. The letter requested the trust continue to seek opportunities to further improve its position, and as a minimum deliver to our original plan; • Details of a subsequent letter from Monitor asking trusts to put capital spend on hold. RT advised that some trusts were being asked to undertake capital to revenue transfers to reduce their operating deficits, meaning they must scale back capital spending plans. He would apprise the board of the trust's response in due course. There were no further questions and the board **NOTED** the contents of the Chief Executive's update.
232-15	**Board Assurance Framework (BAF)** RT reminded the board that in September, it had agreed the BAF would be revised in line with recommendations from the Executive Management Team (EMT). The EMT was then tasked with producing the first 'live' version of the BAF in time for today's meeting. RT explained the agreed BAF review process would be as follows: • The EMT to review risks scores and horizon scanning at its monthly meeting; • Trust sub-committees to review the relevant section of the BAF at their monthly meeting, and • The Board to review the entire BAF on a bi-monthly basis. RT reminded the board that scoring was determined by assessing likelihood against impact. The residual rating would be the result if management had done everything possible to reduce the likelihood of the event. He then went on to explain the rationale behind 'horizon scanning' of future threat levels. As this was the first review of the new BAF, the board was asked to consider current scores to determine whether it considered them to be appropriate in light of commentaries provided and also relevant matters arising from the November performance reports. RT explained that for future board agendas, each KSO update would start with its corresponding BAF progress report, highlighting risks to the delivery of that KSO. For today, however, the BAF would be considered in its entirety. Discussion points for each KSO included: KSO1: Outstanding patient experience: • Clarification that those items highlighted as impacting on the current score had not been listed in any particular order; • Acknowledgement that failure to comply with current regulations or achieve national benchmarks could impact negatively on patient experience; • Burns network requirements resulting in burns derogation work would impact adversely on our nursing workforce; • Whilst Friends and Family Test (FFT) response rates continued to improve, they were still volatile; • A reminder that an action plan was in place to address the issues with catering, and was now

showing measurable improvements;

- The risk to the current complaints service which was led by a single staff member. This could limit responsiveness, and affect patient experience at times;
- Whilst not a risk to patient safety, more work needed to be done around spoke site quality assurance in order to improve patient experience, and
- Assurance that recruitment issues had been captured within 'horizon scanning'

KSO2: World class clinical services

- SF explained that the rationale behind the current score of 15 included risks to hub and spoke governance and capacity, seven day services and paediatric in-patients, and
- The ability to prove clinical outcomes was becoming more challenging, but in this respect the trust was in a similar position to other hospitals.

KSO3: Operational excellence

- The board was advised that it was not possible to prioritise any particular issue as they were all interrelated;
- From 1st October, a new rules suite for 18-weeks referral to treatment had been introduced. SJ explained the impact of the removal of the provision to pause or suspend an RTT waiting time clock, and how this could also put pressure on the admitted target. As previously reported, shared pathways for cancer cases with late referrals from other trust could also have a detrimental effect;
- Late referrals for 18RTT from neighbouring trusts, (two of which were in special measures) would impact negatively on the trust, and
- Mitigations for next year to include targeted work within skin oncology to manage and review referrals received, and provide greater focus on cancer patients.

KSO4: Financial sustainability

- Assurance that the trust will still deliver surplus, but needs to start delivering underlying projects;
- Performance management regime now in place to improve understanding of the service lines;
- Explanation of the Quality Impact Assessment Process;
- Requirements for greater resilience around small teams, structures and systems;
- Work underway to improve business continuity arrangements, and
- Assurance that current risks ratings were appropriate, given the level of scrutiny applied by the F& PC.

KSO5: Organisational excellence

- Insufficient focus on recruitment and retention could lead to increase in bank and agency costs, impacting on quality of patient care over time. (Also, agreement that '*Development of long term workforce planning (3 years) for FY16/17*' to be moved across from '*controls/influence*' to '*Gaps in controls/influences*');
- Assurance of better controls in place now with regard to agency and bank staff;
- Assurance of improved engagement with staff (not just as a result of CQC inspection) which would continue in the future, and
- For consistency, agreement that 'Impact rating' should be changed from amber to red (ie. from 4 to 5).

BH suggested that more time could be dedicated to horizon scanning. It was agreed that this could be a topic for discussion at a future seminar. **[Action: RT]**

RT thanked the board for its input and agreed to reflect on today's comments. The executive team would recalibrate the risks in light of today's discussion and a revised BAF would be circulated in 2-weeks' time.**[Action: RT]**

	BH thanked RT and his team for the hard work in bring this to completion. The board **APPROVED** the revised BAF which was now live with effect from today's meeting.
233-15	**Corporate Risk Register (CRR)** JMT presented an update on the CRR following its review in September 2015. Significant changes included: • One new risk (Medical Devices ID832) rated as a 12 or above added during September 2015, whilst the score for one risk (Spoke Sites - ID 585) had increased to 12 from 9. JMT assured the board that she was working closely with the medical director to mitigate risks and much progress had been made. • Ten risks scoring 12 or above were closed during September 2015 and a further eight risks were closed following the data review. • The scores for two risks had decreased from a 12. The board sought and received assurance on the following: • Significant corporate risks had been cross referenced with the trust's Board Assurance Framework. • Paediatric services would be included in the Out of Hours register as a corporate risk. **[Action: JMT]** • As a live document, it was not possible to guarantee data was always the most current. But, the CRR would be published to Qnet (the trust's intranet) and updated on a monthly basis. • Future reporting would include a detailed summary as a preface to the register. This would identify which risks had been removed from the previous register. • Whilst the impact of all risks was high, their likelihood was managed and mitigated appropriately. There were no further questions and the board **NOTED** the contents of the report.
Key strategic objective1: outstanding patient experience	
234-15	**Patient story: safety** JMT apprised the board of a case of an elderly patient whose discharge had been expedited to take account of his need to get home quickly. Staff had perceived the patient's particular circumstances and demonstrated their commitment to meet the needs of patients and their families. IP suggested that the board might consider a more effective means of engaging in the patient story session. It was agreed that this could be a topic for discussion at a future seminar. **[Action: JMT]**
235-15	**Quality and Governance assurance report** An assurance report had been prepared and circulated to the board. Following a request for clarification from LP, the Chair agreed to review the rationale behind publishing sub-committee minutes in addition to an assurance report. **[Action: KA]** There were no further questions and the board **NOTED** the contents of the update.
236a-15	**Safe staffing and quality of care** JMT presented a report on the quality performance of the trust in respect of safety, effectiveness and patient experience. Whilst the summary sheet had been omitted from this month's report, JMT assured the board it would be included in future reports to support the board's focus on pertinent issues.

	JMT highlighted the response rate for out-patient FFT scores which had dropped slightly this month. But, she reminded the board these response rates were subject to fluctuation. IP raised a query in respect of the metrics relating to medication errors on Ross Tilley ward. JMT explained the anomaly and assured the board that this area was closely monitored with pharmacy teaching sessions continuing on a rolling programme. There were no further questions and the board **NOTED** the contents of the update.
236b-15	**6 monthly nursing workforce review** In response to recommendations by Francis and NICE, the board received its 6-monthly nursing workforce review, designed to provide assurance that current workforce levels were sufficient to provide safe, effective, compassionate and high quality services to our patients. (JMT asked the board to note that this report adhered to a prescribed format). JMT felt confident that there was transparency with planned versus actual staffing, with a clear vision and focus on workforce to ensure that the quality of our services were as safe as possible within the available resources. And, she went on to provide examples of where staff are moved around the trust when appropriate. The board was asked to note that whilst the Burns and ITU staffing levels met the criteria, the variance in activity meant that staff worked flexibly between the areas as required in order to safely manage acuity and patient need, (whilst minimising costs where appropriate). The board concluded that the report demonstrated the trust was meeting its requirements and **AGREED** to continue to support the staffing ratio principles recommended by NICE: JMT explained how variances in funded budgets compared to those with uplifts of 22% demonstrated a gap which accounted for overspend on pay budgets, but was not the sole reason for this. The board was warned that this would need to be considered with a full review of all nursing budgets. JMT went on to describe a proposal developed to address the issues in the short term, (and then as a planned solution for 2016/17). CS expressed concern at the proposal. She advised that she felt unable to support the recommendation, but did agree to support further work around the allocation of budgets. In conclusion, the board **NOTED** the current position and **AGREED** to refer the allocation of budgets back to the executive team, with a revised proposal to be returned to the board in 6 months' time. **[Action: JMT]**
Key strategic objective 2: world-class clinical services	
237-15	**Medical director's report** • SF apprised the board of the background into the imminent strike by junior doctors. He also warned against relying too heavily on current media reporting of the situation • The board was reminded of next week's Joint Hospital Governance meeting (formerly Joint Hospital Clinical Audit Meeting) which was taking place. Next week's agenda would include information on 'never events' and Human Factors. There were no further questions and the board **NOTED** the update.
238-15	**Clinical governance review** SF presented a report designed to provide assurance on the effectiveness of clinical governance at QVH, and which highlighted the processes in place to deliver safe, effective, and evidenced clinical care. Highlights included

	• A description of the governance summits held earlier in the year. SF conceded that whilst including a wide representation of clinical staff, nursing had not been incorporated at this stage and this report focused predominantly on medical staff. • Changes to joint monthly clinical governance meetings, appointment of governance leads and changes to directorate. As reported under item 237-15, the launch of the Joint Hospital Governance meeting would take place next week. In response, the board requested: • Assurance that metrics showing a green rating were still tested. GC explained that areas of low reporting were scrutinised by the Q & GC. She also reminded the board that the risk manager was currently undertaking an audit in areas with low levels of reporting to ensure compliance with incident reporting. • That the clinical audit function be included in the board seminar programme. **[Action: KA]** There were no further questions and the board **NOTED** the contents of the report.
239a-15	**Research and development: annual report 2014-15** SF presented the board with the annual report providing assurance in respect of research and development activity at the trust up to April 2015. (He explained that for a variety of reasons it had not been possible to present this report to the board any earlier this year). The board went on to discuss the matters arising from the report, including: • Queries in respect of funding streams. SF observed that funding of research did not appear to be fully understood at present. The Chair suggested it might be something the F & PC could review in the future. • Clarification of the trust's support of a PhD student in 2014-15, (registered at the University of Brighton). SF confirmed that funding came via a grant award won from the charity Sparks. • A question as to why the trust had engaged the services of NHS Innovations South East to assist with the commercialising and development of its intellectual property. SF explained that it was mandatory for any innovation to be managed via this route. There were no further questions and the board **NOTED** the contents of the annual report.
239b-15	**Research and development: strategy update** SF presented a report designed to support the board in its aims to agree a future strategy for the trust's research and development. This highlighted the aims of research including patient benefits, driving best practice, attracting high calibre staff, ensuring sustainability, attracting funding and enhancing the reputation of the trust. The board was reminded that research activity had not been strong at the trust over the last ten years, although more recently (thanks to funding from the QVH charity and the activities of a small number of research-orientated clinicians) there had been a renewed vigour. However, SF warned that any future strategy required greater focus and clear objectives. The board went on to discuss the matters arising from the report, including: • Clarification that this report was not intended as a strategy in itself. Instead it was designed to describe research options in order to help the board agree which areas it wanted to support; • Acknowledgement that funding of the R & D Director role (currently supported by the QVH Charity) was not self-sustaining. So, any long term investment required further consideration; • Appreciation of the R &D initiatives to date, whilst noting that the trust needed to decide where R & D sat against other priorities; After due consideration, the following was agreed: • That future funding of the role of the R & D Director would be considered within the 2016-17

	budget setting process to ensure a decision was not taken in isolation **[Action: SF];** • A broader discussion around longer term investment in Research and Development would be arranged as part of the board seminar programme.**[Action: SF]**
Key strategic objectives 3 and 4: operational excellence and financial sustainability	
240-15	**Finance and operational performance assurance report** As Chair of the F & P committee, JT presented the monthly report, providing assurance that delivery of financial and performance targets, and trust strategic initiatives were being carefully scrutinised. After due consideration: • CO sought clarification regarding bad debt provision highlighted within finance report. CS explained this included £27k costs from an increase in the provision for RTA bad debt following new guidance from the Department of Health, which had raised the recommended rate of provision. • The board reiterated requests for consistency around sub-committee board reporting, as raised under item 235-15. There were no further questions and the board **NOTED** the contents of the update.
241-15	**Operational performance** Having provided a comprehensive update under item 232-15, SJ had nothing further to add. There were no questions and the board **NOTED** the contents of the report.
242-15	**Financial performance** CS presented a report detailing the trust's financial performance for the six months to 30th September 2015. This highlighted the following: • The Trust had delivered an actual surplus of £188k for the month, £34k higher than planned but lower than forecast, (due to bad debt provision as explained under 240-15). The cumulative surplus was currently £355k (£175k behind plan); • The Trust has a Monitor financial sustainability risk rating (FSRR) of 4, which is an improvement from the previous month due to the achievement of a surplus of above 1%; • The new performance review meetings with the key business units were starting to reap benefits, with business managers and clinical directors working together as a team. It was anticipated that the delivery plan would still deliver the full year budget surplus; • As reported under item 231-15, and as a reflection of the wider NHS position, Monitor had written to request the trust defer its capital spend this year. The board noted that whilst currently behind plan, our capital expenditure was already fully committed in respect of medical devices, IT allocation and the EDM project; • Whilst the cost improvement programme was substantially behind plan, the board was assured that the delivery plan had been implemented to address the shortfall in performance. CS confirmed the goal remained to achieve a £1m surplus, and • Non-pay was overspent in the month as a result of clinical supplies and services in Theatres, Burns and Corneo. The Deputy Director of Finance was currently leading a review with the theatre leads to address the situation. There were no further questions and the board **NOTED** the contents of the report.
Key strategic objective 5: organisational excellence	
243-15	**Workforce report** GA provided a summary of the November workforce report. The board noted that new reporting

	deadlines had impacted on this month's data and so it had not been possible to align with finance and safe staffing reports. As a result, this report focused mainly on the position at the end of August. The board was assured that work was in progress to address any anomalies for the future. GA reminded the board that the vacancy gap represented the number of vacancies compared to budgeted Whole Time Equivalent establishment numbers, (per business unit). This currently stood at 11.75%, with (as anticipated) the highest percentage within Nursing. GC sought clarification in respect of Employee Relation trends. GA agreed to include this in future reporting. **[Action: GA]** There were no further questions. The board **NOTED** the contents of the report.
244-15	**Fit and proper person test: procedure** The Fit and proper persons requirement policy was circulated for approval. GA explained this policy placed a duty on the trust not to appoint a person, or allow a person to continue, as a board director of they did not meet (or continue to meet) the test. This policy would be applied to all board members plus the Company Secretary, Director of Operations and Director of Human Resources. The test would also be incorporated into the appraisal process and would be monitored annually. There were no further questions and the board **APPROVED** the policy.
245-15	**Equality and diversity: annual report** GA apprised the board of the requirement, under Equality Delivery System 2, to publish an annual equality and diversity report. He explained that this report was based on actions associated with an earlier version of EDS, which the Equality and Diversity Strategy Group had now revised. Although activity had been slow throughout 2014 (as a consequence of the significant re-structuring), GA was confident that the 2015 report would show much greater progress. Future reports would also be published to the website. There were no further questions and the board **NOTED** and **APPROVED** the report.
246-15	**Workforce race equality standard** GA advised that it was also now a requirement for the trust to publish the Workforce Race Equality Standard each year, as part of the trust's ongoing commitment to equality and diversity. As mentioned earlier, the trust was in the process of implementing the Equality Diversity System 2 (EDS2) to support the Trust to identify, implement, embed and deliver our equality objectives. The next report would be presented to the board in the new financial year. Future annual WRES reports would therefore reflect some of the outcomes associated with implementing EDS2. There were no further questions and the board **NOTED** and **APPROVED** the report.
Board governance	
247-15	**Board-level governance engagement with governors** Following discussion at last month's Council of Governors meeting, KA presented a report formalising principles of engagement between governor representatives and the trust's board-level structures and mechanisms. This was an updated version of the paper submitted to Council, highlighting some minor revisions.

	LP queried the rationale for the audit committee governor representative to be excluded from its formal business meetings. After due consideration, it was agreed this decision was at the discretion of the chair of the sub-committee. Accordingly item 7.3 would be removed. There were no further queries and the board duly **APPROVED** the principles of engagement for immediate adoption.
248-15	**Co-operation with third parties with roles in relation to NHS foundation trusts** To enable the board to fulfil its obligations under section E.2 of the NHS FT Code of Governance, KA had prepared an paper setting out the trust's existing relationships with other NHS bodies and relevant organisations. Whilst the Code no longer required the trust to maintain a public schedule of third party relationships, there was still an annual requirement for the board to take note of where and how it was interacting with relevant third party bodies. The board was reminded of the organisations with which it had spent a significant amount of time over the last year. It was noted that the Blond McIndoe Research Foundation should be added to the existing list. CO asked the board to clarify at which point co-operation might cross over into 'significant transaction'. He was reminded that a definition, (as approved by Council) was contained within the trust's constitution. BH assured him that the board remained cognisant of apprising governors of significant transactions. The board **NOTED** and accepted the assurance contained within the report regarding the continued effectiveness of the trust's co-operation with relevant third parties.
249-15	**Trust seal: annual report** In order to comply with section 8 of the trust's standing orders, KA had circulated the annual report setting out all sealings made since the last report in August 2014. There were no questions and the board **NOTED** the contents of the report.
250-15	**Draft agenda for the January 2016 business meeting** The draft agenda was **NOTED** by the board.
Any other business (by application to the Chair)	
251-15	There was no other business and the chair closed the formal session of the meeting.
Observations and feedback	
252-15	**Feedback from key events and other engagement with staff and stakeholders** Due to time constraints, BH did not address each individual member on their recent levels of engagement. However she thanked those who had already provided written feedback to the Deputy Company Secretary for the record.
253-15	**Observations from members of the public** MM and CH commended the meeting as an ideal forum in which to observe NEDs at work on a regular basis. MM would be encouraging governor colleagues to attend future board meetings, to better enable them appraise the performance of NEDs and hold them to account.

254-15	**Observations and feedback on the meeting** LP had been nominated to lead on feedback on this occasion. His observations included: • An acknowledgement of the progress made to date on the BAF, although noting that there was still more work to be done. RT reminded the board that in future months, each KSO update would begin with its corresponding BAF progress report, highlighting risks to the delivery of that KSO. • A need for greater assurance that the executive team was fully conversant with reports prior to publication; • The new scheduling of meetings may need to be reviewed in coming months (ie should the private session follow on from the public session, as previously?); • As a result of this year's board development 'away days' there now appeared to be a better quality of discussion with overall a more productive meeting. RT felt there was still too much focus on financial matters and suggested that the balance of discussions could be adjusted in future. He felt it would have been helpful to allow greater discussion around the R & D strategy. IP felt the meeting was unsettled, due in part to recent changes in scheduling, and had not flourished as it should have done. He also requested that future reports included a greater steer as to what the board's focus should be. CO acknowledged that reports had been interesting but suggested more focus in them should be considered in future.

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**
5 November 2015						
1.	**232-15**	Board seminar to be dedicated to BAF horizon scanning	**RT**	TBA		**Pending**
2.	**232-15**	EMT to recalibrate BAF risks following November board discussion. Revised version to be recirculated to the board for information.	**RT**	TBA		**Pending**
3.	**233-15**	Paediatric services to be added to Out of Hours register as a corporate risk.	**JMT**	ASAP		**Pending**
4.	**234-15**	Board to consider most effective method of engaging in patient story session. To be added to board work programme for future seminar.	**JMT**	~~TBA~~ March 2016	**03 12 15** Board agreed that a patient should be invited to formal board meetings to provide their story in person from March 2016.	**Pending**
5.	**235-15**	Chair and Co Secretary to review the rationale behind publishing sub-committee minutes plus addition to an assurance report.	**KA**	TBA		**Pending**
6.	**236b-15**	Executive team to review allocation of nursing staff budgets and report conclusions in 6 months' time.	**JMT**	May 16		**Pending**
7.	**238-15**	Discussion around clinical audit function to be included in the board seminar programme.	**SF**	TBA		**Pending**
8.	**239b-15**	Future funding of the role of the R & D Director to be considered within the 2016-17 budget setting process	**SF**	TBA		**Pending**
9.	**239b-15**	Discussion around longer term investment in Research and Development to be added to board work programme for future seminar.	**SF**	TBA		**Pending**
10.	**243-15**	Future workforce reporting to include enhanced information in respect of Employee Relation trends	**GA**	Jan 2016		**Pending**
24 September 2015						
11.	**198-15**	Formal plan on future of burns services in partnership with Brighton & Sussex University Hospitals (BSUH) being developed. An update to be presented to board in November.	**RT**	November	**05 11 15** Discussed at private session of board	**Complete**
12.	**198-15**	Formal plan on future of paediatric services being developed. An update to be presented to board in November.	**RT**	November	**05 11 15** Discussed at private session of board	**Complete**

Matters arising and actions pending from previous meetings of the Board of Directors (BoD)						
No.	**Reference**	**Action**	**Owner**	**Action due**	**Latest update**	**Status**
13.	**198-15**	Board to be apprised of results of recent QVH bid to national vanguard programme	**RT**	November	**05 11 15** Update contained within CEO report presented at public session of board	**Complete**
14.	**198-15**	Chair to assign a NED to join QVH/Horder Healthcare collaboration group	**BH**	ASAP	**05 11 15** BH confirmed that LP would join collaboration group.	**Complete**
15.	**211-15**	Whistleblowing policy to be amended to remove details of Director of Nursing as the accountable officer.	**GA**	ASAP	**05 11 15** GA confirmed this is now actioned	**Complete**
25 June 2015						
16.	**160-15**	Audit plan for 2015-16 to be circulated to board for information and assurance once agreed by the committee.	**CS**	Nov	**05 11 15** Subsequently agreed by Audit Chair and DoF that this should not come to the board as approval is the responsibility of the Audit Committee. To be removed from matters arising.	**Complete**
17.	**160-15**	Discussion on function of audit committee and assurance required by board.	**KA**	Jan	**05 11 15** • KA advised the **function** of the committee was being developed by the Audit Committee. Revised ToRs and work plan will be brought to the board in January 2016 for approval. • A seminar to discuss **assurance** required by the board would be arranged in due course.	**Pending**
30 April 2015						
18.	**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~~ Nov	**05 11 15** Discussed at public session of Nov board	**Complete**

Queen Victoria Hospital NHS
NHS Foundation Trust

Chief Executive's Report					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**07-16**	
Report title:	**Chief Executive's Report**				
Sponsor:	n/a				
Author:	Richard Tyler, Chief Executive				
Executive summary					
Purpose:	To update the board on progress and risks to key internal targets and to provide an update on external issues that may have an impact on the trust's ability to achieve its internal targets.				
Recommendation:	To note the report				
Purpose:	Information				
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	External issues will be considered as part of the BAF 'horizon scanning' section.				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Management Team – relevant sections only				
	Date:	21/12/15	Decision:	Endorsed	

CHIEF EXECUTIVE'S REPORT
JANUARY 2015

TRUST ISSUES

Finance & Activity – Month 8

The Trust declared a surplus in month 8 of £35k compared to £216k in month 7. This has increased the year to date surplus to £606k, £388k behind plan. The reasons for the drop off in performance were discussed at the December Finance & Performance Committee (F&P) and the detail is provided within the Board papers. However in headline terms the drop off relates to lower than forecast activity in both elective and non-elective services.

In relation to our year-end position we are now a further £225k behind forecast and it is clear that additional interventions are needed if we are to achieve our planned surplus. At the time of writing these interventions are being developed with a view to implementation in early January. As yet these have not been signed off as I am seeking assurances about the potential impact on other areas of the Trust's activity. I will, however, be in a position to update the Board when we meet.

Burns Services

The Trust and BSUH NHS Trust held a joint burns and major trauma (lower limb) engagement workshop on 9th December to set out and discuss the emerging proposals around the future shape of burns services which are currently in development.

The event was attended by 70 people comprising wide range of stakeholders. The event allowed senior clinicians to set out the clinical case for change needed for the existing services to adapt to meet the national burns specifications and service standards.

The Trust will now submit a strategic outline case to NHS England in March 2016 to look to secure support for the planned changes and setting out the transitional support required to enable the changes to take place.

Executive Management Team

EMT met in November and December. The Team discussed the following standard items; emerging estates strategy; trust objectives 2015/16; outstanding audit reports; Board Assurance Framework; CQC inspection; F&P papers, including the delivery plan; and the governance handbook.

Clinical Cabinet

Clinical Cabinet met in November and December. The cabinet discussed the following items; emerging estates strategy; M8 performance; the CQC inspection; and proposed changes to the delivery of out of hour's medical cover.

Trust Leadership Forum

The Trust Leadership Forum met in November and December. Items discussed included the CQC inspection and a general review of the year-to-date.

LOCAL HEALTH ECONOMY ISSUES

Primary Care Home – Vanguard Bid

I am pleased to report that the Trust has been successful, along with GP colleagues in East Grinstead, in becoming a vanguard for Primary Care Home, an initiative developed by the National Association of Primary Care (NAPC) and supported by the New Models of Care Team. The primary care home concept builds on previous work

to develop a locality-based approach to the commissioning and delivery of care that centers on primary care as focal point for an individual's care supported by acute and community providers, social care and the voluntary sector. It is consistent with the community-focused strategy we have been pursuing for the last 18 months and is fully in line with the latest NHS planning guidance (see below).

EXTERNAL ISSUES

Delivering the Forward View: NHS Planning Guidance 2016/17 to 2020/21

The planning guidance was published on 22nd December and both the guidance and the NHS providers briefing were circulated to Board members before the Christmas Break. A more detailed discussion will take place as part of the February Board seminar. However the key point to note is that NHS organisations will be required to produce two plans; all local health and care systems will be required to develop a five year sustainability and transformation plan (STP) covering the period October 2016 to March 2021 to be submitted in June 2016; and all NHS Trusts will be required to submit one year operational plans for 2016/17 in time to enable contract sign off by end of March 2016.

BOARD ASSURANCE FRAMEWORK

Board members will note that this is the first board agenda operating with the new structure with each section of the agenda prefaced by the relevant section of the board assurance framework (BAF). As agreed the front sheet is included with my report. The Board will note that in respect of current risk levels KSO1 has been reduced to a risk score of 10 while KSO5 has increased from 12 to 15. Detailed explanations will be provided within the relevant section of the Board report. In relation to future risks, members will note that the risks regarding competition have been increased from green to amber. This reflects ongoing changes to both case-mix and reduced levels of routine day-case activity, most notably in hand surgery, suggesting increased levels of repatriation from local services.

Richard Tyler
December 2015

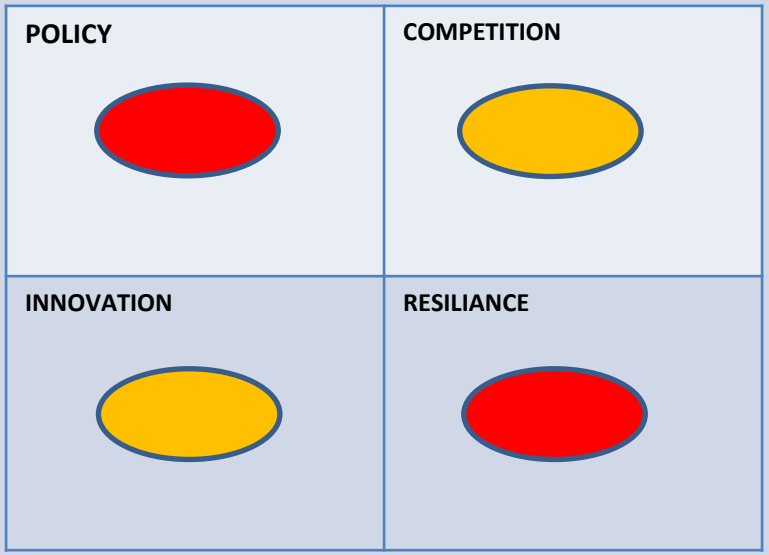
Board Assurance Framework – Risks to achievement of KSOs

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	Patients, 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

	Q1	Q 2	Q 3	Q 4
KSO 1	15	12	10	
KSO 2	15	15	15	
KSO 3	15	15	15	
KSO 4	15	15	15	
KSO 5	15	12	15	

Future Threats



Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**07-16**	
Report title:	**Corporate Risk Register (Reporting period 01/11/2015 to 30/11/2015)**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Alison Vizulis, Head of Risk				
Executive summary					
Purpose:	To provide high level assurance that quality and risk is being effectively managed within QVH.				
Recommendation:	To note.				
Purpose:		Information			
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	Internal links exist from this document to the corporate risk register and the board assurance framework.				
Corporate risk register:	As above				
Regulation:	Monitor and Care Quality Commission (CQC) requirement				
Legal:	As above				
Resources:	Not applicable				
Assurance route					
Previously considered by:	Not applicable				

1. One new risk was added to the Corporate Risk Register scored/rated as a 12 or above between 01/11/2015 – 30/11/2015.
This risk was scored as a 4x3=12 (ID 908) Lack of Pan endoscopy instrumentation - Lack of sufficient pan-endoscopy equipment to enable the Head and Neck Cancer Team to meet the level of demand and ensure patients are diagnosed and treated in a timely manner. Failure to obtain more equipment could severely compromise patient care. Loan/alternative equipment has been sourced on a temporary basis.

2. No risks scoring 12 or above were closed between 01/11/2015 – 30/11/2015.

3. One risk had a score/grading decreased from a 12:

ID895 – Medical staffing in Sleep Studies - Consultant posts for Sleep Centre consist of Clinical Director, (6 sessions per week) and Respiratory/Sleep Consultant, (contracted two session per week.)

Medical input/patient care significantly depends on the Clinical Director. If any unexpected, long-term unavailability were to arise this would be a risk to the service.

Score decreased to a 3x2=68 (CxL) (from a 4x5=20) due to discussions with Director of Operations and data cleansing.

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

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Approval status	Corporate/Department Risk
907	21/09/2015	Lack of equipment for cataract surgery to support additional activity and new consultant appointment	Equipment required to support 5th consultant appointment Additional activity in theatres and specifically in Day Treatment Centre . Lack of equipment to enable productivity and utilisation of all areas to support 18 weeks RTT and demand and capacity plans	Lack of equipment will reduce utilisation in theatres and enable the business unit to support this workload	Mitigation Operating at weekends using WLI to support productivity Additional lists during the week if not utilised by other areas	Sharon Jones	Colette Donnelly	Compliance (Targets / Assessments / Standards)	12	12		25/11/2015	In holding area, awaiting review	Corporate Risk (for main Trust Risk Register)
908	25/11/2015	Lack Pan endoscopy instrumentation	Lack of sufficient pan-endoscopy equipment to enable the Head and Neck cancer team to meet the level of demand and ensure patients are diagnosed and treated in a timely manner. Failure to obtain more equipment could severely compromise patient care	Patients could be harmed due to late diagnosis/treatment of head and neck cancer due to lack of appropriate equipment.	A loan pan endoscopy set was available for a period of time combined with the opening of a variety of sets to undertake the procedures. This latter control is not sustainable as it may compromise the traceability of the instrumentation.	Sharon Jones	Dumiso Ncube	Patient Safety	12	8		25/11/2015	In holding area, awaiting review	Corporate Risk (for main Trust Risk Register)
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	Jo Thomas	Nicola Reeves	Finance	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	13/10/2015	Approved	Corporate Risk (for main Trust Risk Register)
727	21/07/2014	Limited on site Physician cover, need to review medical concerns of the surgical patient	Limited on site Physician cover and non compliance with NCEPOD standards (2010) routine daily input for elderly patients having surgery; however patient population and nature of surgery differ.		Cover arrangements managed by General Manager for CSS together with MD. 24/7 phone cover and transfer available. Onsite cover available on Mon, Wed and Thurs from 21.07.15, 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 Tej Richardson from 21.07.15 Patient would be transferred to Brighton (Haywards Heath) if specialised care required	Steve Fenlon	Dr Tim Vorster	Patient Safety	12	6	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 Explore GPSI option and cover from London Trusts	12/11/2015	Approved	Corporate Risk (for main Trust Risk Register)

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Approval status	Corporate/Department Risk
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 . Lack of clinical indicators and audits, lack of evidence of best practice, allocation of incidents and complaints not clear, staff training and development not recorded.		Annual H&S assessments programme (monitored by quarterly H&SC). Annual infection control/decontamination reviews CQC/HSE notifications of queries relating to service provision Spokes action plan to incorporate clinical governance specified in SLAs including management and ownership of incidents, complaints, never events, policies and procedures, to ensure the quality of patient care, changes to engagement of non-consultant career grades and trainees in spokes. Plan to establish links with local risk and complaint teams and ensure lessons are embedded. Regular senior management and exec visits.	Steve Fenlon	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 Exec and SMT visits and oversight SLA specify the governance arrangements. Ongoing monitoring via KPIs Feedback to DoNs at sites	19/10/2015	Approved	Corporate Risk (for main Trust Risk Register)
743	09/09/2014	Harm to patients and reputational damage to the Trust as a result of the occurrence of Never Events	Harm to patients and 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 including 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	Patient Safety	12	8	Revisions scheduled for CQC regulations in 2015 Human Factors CQUIN agreed and training to be developed and implemented Governance reporting review underway	18/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
748	03/10/2014	Field safety notice FSN83000189 patient data may not be updated when exporting to 3rd party devices using 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 mismatch in patient data between PACS and VNA. -A description of a workflow to reduce/remove the risk of mismatched patient data between the PACS and VNA -Implement Kona across Surrey and Sussex to correct this error -Identify studies that have mismatched data -Produce and implement a fix for the identified mismatched data	Sharon Jones	Paul Gable	Information Governance	12	6	Discussed at CSS Mtg 05/05/2015: Current score of 12 to remain until PACS upgrade completed (due at end of May 2015) Range of information awaited from Phillips (as per controls column) Reconcile VNA data once PACS remiation work and upgrade complete. Anticipated to begin May 2016	12/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
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 IT and PG working to resolve as BSUH cannot do so	26/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
789	12/03/2015	Failure to meet Trusts Medical Education Strategy	Failure to meet Trusts Medical Education Strategy		1. Funding of the non deanery clinical lead 2. Temporary education centre in place	Steve Fenlon	Graeme Armitage	Compliance (Targets / Assessments / Standards)	12	6	Recruitment drive commenced Permanent Education Centre has had outline Board approval and funding TBA Reduced activity in some areas	19/10/2015	Approved	Corporate Risk (for main Trust Risk Register)
799	20/05/2015	Risks associated with non consultant medical staff providing services offsite	Risks associated with non consultant medical 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	13/10/2015	Approved	Corporate Risk (for main Trust Risk Register)

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Approval status	Corporate/Department Risk
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 years 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	19/10/2015	Approved	Corporate Risk (for main Trust Risk Register)
832	07/09/2015	Risk of harm to patients from inappropriately maintained medical devices	Impact upon patients if equipment used has expired its required maintenance dates	Unreadable maintenance labels Medical devices requiring maintenance not removed from clinical areas Staff not checking maintenance labels on equipment prior to use	Medical Devices Policy in place. Exec SM walk round of all high risk areas, expired equipment identified and serviced or removed. Equipment inventory not maintained - will be revised by Avensys. Revised maintenance and contract provider (EME) for medical devices in place (Avensys since 1.6.15). Action plan developed to address remedial work. Cost analysis requested from EME provider to ascertain work completion requirements and costs. Medical Device committee monitoring progress. Re-audit of equipment confirms significant progress - only 10% of equipment requires maintenance checks. On target to achieve all equipment to be in date by the end of Dec 15	Steve Fenlon	Alison Vizulis	Patient Safety	12	6	Re-audit scheduled for Nov 2015	19/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
844	13/10/2015	Medical cover out of hours	Ability of on site medical staff to function safely within the hospital at night team and ensure all patients have access to adequate medical expertise appropriate to both the needs of adults or children within a suitable timeframe; lack of understanding of the need for greater medical cover at all levels out of hours. Failure to comply with intensive care unit cover guidance; ability to assure support for junior medical and nursing staff out of hours, complying with the requirement of the 7 day services NHS standards.	Dependent on on-call medical cover at senior level. For reasons of practicality, safety and cost senior cover is focused when activity is highest, but risk out of hours not understood. Better definition of the clinical risks out of hours.	Achieve a better time based understanding of the risks to care out of hours in particular the unique situation of QVH which has only 3 surgical specialties, small ITU and an ability to control the level of activity and exposure to risk according to the day of the week.	Steve Fenlon	Dr Tim Vorster	Patient Safety	12	6	Out of hours operating to be managed according to absolute need on the background of the needs of other patients in the organisation. First assessment of the anaesthetic cover provided by consultant staff and how that links to handover ensuring patients can be clearly assessed and managed.	13/10/2015	Approved	Corporate Risk (for main Trust Risk Register)
845	13/10/2015	External guidelines - process not embedded	Process for identifying, screening, implementing and monitoring relevant external guidelines is not embedded following changes to exec and SMT. 1. Failure to comply with principles of clinical governance in not incorporating best clinical practice. 2. Failure to demonstrate best practice (lack of assurance). 3. Potential harm to patient.	Small exec and support team, lack of policy, lack of clarity over ownership.	1. Rewrite policy with clear allocation. 2. Agree roles and responsibilities in SMT and exec team. 3. Resource audit dept. to lead this policy. 4. Project management in audit dept. to maximise efficient use of resources. 5. Enable clinical governance leads to engage with process. Project manager in place in audit dept.	Steve Fenlon	Jacqueline Packer	Patient Safety	12	6	Flow chart and process to be agreed with governance leads Rewrite policy, approve through CGG and monitor through same.	19/10/2015	Approved	Corporate Risk (for main Trust Risk Register)

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Approval status	Corporate/Department Risk
846	15/10/2015	Orthodontic patients may be treated without their medical records	Patients may be treated inappropriately as Consultant/ Registrar may not know the patient medical history which can significantly impact upon their safety, surgical care pathway and treatment. This could potentially have a detrimental effect upon the reputation of the Trust.	Medical notes are stored away from the unit, these may be difficult to pull when patients arrive for an emergency orthodontic review. Inadequate process in place to access the medical records in a timely fashion.	Secretarial staff have DECT phone to allow communication between orthodontic secretarial team and individual pulling the medical notes.	Sharon Jones	Dumiso Ncube	Patient Safety	12	6		18/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
849	15/10/2015	Non QVH patients arriving for Phlebotomy service main Outpatients from GP practices	Trust is unaware of patient arriving from GP practices for phlebotomy services. At present unable to cope with demand within current nursing establishment. This level of service with the GP's has not been agreed with the Trust. Patient safety could be compromised.	Patients are seen without medical records, staff therefore unaware of previous/ current medical history or of future treatment plan. inadequate feedback mechanisms to the GP with patient test results. Lack of GP awareness of the service provided by GP	Staff ensure patients are informed of service provision and ensure accurate recording of GP details on phlebotomy request form. Awaiting mail shot to be sent to GP Practices reminding them of the service provided at QVH.	Sharon Jones	Paul Gable	Patient Safety	12	6	Awaiting mail shot to be sent to GP Practices reminding them of the service provided at QVH	12/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
853	15/10/2015	Insufficient space in MIU to treat patients	Building footprint too small for activities of both trauma clinic and MIU walk-in patients, totalling approx. 17,000 patients per annum lack of privacy and dignity for patients as MIU pts. seen in a curtained only area. Clinic patients are seen in appropriate examination rooms.	1.Poor patient experience due to lack of privacy and dignity 2.Accidental exposure of patients undergoing treatment due to area being curtained. 3.Unacceptable patient waiting times for treatment due to lack of space to see patients 4. lack of space to see patients with more critical conditions such as chest pain and acute exacerbation of asthma	Plans are in place to move the trauma clinic to an alternative location early in 2016 which will free up the required space for walk-in patients.	Jo Thomas	Nicola Reeves	Patient Safety	12	6		12/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
854	16/10/2015	Inefficiency in Plastics hand clinics within Outpatients causing delay in patient treatment	Patients are not seen in a timely manner, causing excessive wait times within the hand clinics. This is due to both overbooking of the outpatient appointment slots and inefficiencies within the clinic.	Patients refusing to wait for their appointment, leaving without treatment/ consultation. Lack of clinical staff available to cover the clinic appropriately. Trust loss of reputation by not providing efficient, safe and effective quality care to outpatients. Increase in staff anxiety levels within the nursing and therapy departments.	Matron and Nurse manager have met with Plastics Business Unit Manager. From 26/10/2015 trail with hand clinics to work in a different way. Consultant and Registrar will remain in one consulting room each, with nurse allocated to work solely with Consultant. Patients will be seen in one room, nursing staff can ensure efficient and effective patient flow occurs therefore reducing the clinic waiting times. Plastics Business Manager will address clinic template and patient pathway to ensure waiting times are reduced and to identify alternative patient follow up appointments to enhance patient flow.	Sharon Jones	Paula Smith	Compliance (Targets / Assessments / Standards)	12	6		13/11/2015	Approved	Corporate Risk (for main Trust Risk Register)

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Approval status	Corporate/Department Risk
878	21/10/2015	IT infrastructure resilience	1)There is a significant risk to operational performance due to reliability, as well as resilience, in the event of a major incident. 2) The infrastructure does not support the Trust's future ambitions to develop Clinical and Corporate systems as identified as part of QVH 2020, and the associated Information strategy. 3) There is a material risk with regard the sourcing of appropriate replacements for maintaining existing infrastructure.	1) The age, design and location of the QVH current infrastructure is not fit for purpose and poses a significant risk to current operations. 2)The underlying wired network is inadequate for current and future requirements as the majority of components are no longer supported by the manufacturers. 3) There is limited wireless technology deployed across the site which compromises the delivery of I.T related initiatives and/or interdependent projects. 4) The security of the Trusts infrastructure needs to be enhanced to remain secure and comply with current NHS Governance guidelines. 5)The environment of the current equipment room and datacentre is not fit for purpose and fibre network deployment is not resilient with cabinets connected by single fibres. Failure to provide IT services due to equipment failure	1) Disaster recovery server and local and offsite storage of Trust data 2) Business continuity procedures 3) Maintenance and support contractual arrangements for key hardware and software 4) Site wide backup generator and Server rooms have Uninterrupted Power Supply (UPS) protection in the event of power loss	Clare Stafford	Jason McIntyre	Information Governance	12	6	1) The Trust has approved the full business case for the Improvement of the IT infrastructure. The project is currently being implemented with an expected completion in Q1 2016-17 2) Review and update of disaster recovery procedures	11/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
882	21/10/2015	Potential loss of activity as a result of competition and / or new market entrants.	1. Loss of activity and corresponding income particularly where competitors or new market entrants gain market share for high volume / low complexity work. 2. Residual activity is complex and loss making."	1. Local Trusts expanding sub specialist interests. 2. Commissioners tendering whole services either as Any Qualified Provider (AQP) or via a lead provider arrangement. 3. New market entrants.	1. Market analysis software purchased. 2. Business Development and Productivity Steering Group reviews opportunities. 3. Performance Review Meetings.	Clare Stafford	Jason McIntyre	Finance	12	9	1. Publish outcome data to secure pipeline of referrals.	11/11/2015	Approved	Corporate Risk (for main Trust Risk Register)

ID	Opened	Title	Hazard(s)	Cause(s)	Controls in Place	Executive Lead	Risk Owner	Risk Type	Current Rating	Residual Rating	Actions	Date Reviewed	Approval status	Corporate/Department Risk
884	22/10/2015	Potential for Unauthorised Data Breaches	Lack of technical and physical security measures around handling of personal information.	1) External confidential patient information breaches 2) Risks to Information Assets 3) Failure to safely destroy computer hard disk resulting in a data protection breach and subsequent fine. 4)Breach of information security due to use of unsecure email accounts to transfer person identifiable data (patient and staff. 5)Potential loss of activity and income affecting financial liability of organisation. 6)Unencrypted Disks containing Patient Information being sent outside the Trust.	1) External confidential patient information breaches 1.1 Mail checked for visible personal details by porters. 1.2. Reminders of correct postal information required placed regularly in "Q-Net" 1.3. E mail instruction sent to administration staff. 2) Risks to Information Assets 2.1 Policy & Procedures 2.2 Awareness Training 2.3 Understanding of the Law 3) Failure to safely destroy computer hard disk resulting in a data protection breach and subsequent fine. 3.11. All disks currently destroyed on site only 4) Breach of information security due to use of unsecured e-mail accounts to transfer person identifiable data (patient and staff. 4.1 NHS e-mail accounts available for all staff upon request and encouraged through IG training 4.2 Information security acceptable use e-mail policy in place 5) Potential loss of activity and income affecting financial liability of organisation. 5.1 Quality of work and reputation of QVH provides a	Clare Stafford	Dominic Bailey	Information Governance	12	8	Regular reminders to all staff of correct procedures when handling personal information in the IG section on Q-Net Purchase encryption hardware for Radiology IT disposal Policy to be ratified and Contractor to be selected Implement Data Leakage Prevention Software on Trust e-mail exchange IG Group to monitor and review progress against actions	11/11/2015	Approved	Corporate Risk (for main Trust Risk Register)
885	27/10/2015	Slips trips and falls	Covered corridors which run from main kitchen block around to new theatres in poor condition with uneven and broken surfaces. Floor finish flaking in areas where painted.	Slips trips and falls. Trolleys and handling equipment overturning. Poor first impression to visitors.	Ado repairs. Surface of part of corridor re painted in 2013 Civil engineering consultants engaged to undertake feasibility study. Orders raised for civil engineering consultants to undertake detailed design, prepare tender documents and supervise construction work on site. Programme developed to start work on site from January 2016	Clare Stafford	John Trinick	Estates Infrastructure & Environment	12	6		11/11/2015	Approved	Corporate Risk (for main Trust Risk Register)

KSO1 – Outstanding Patient Experience

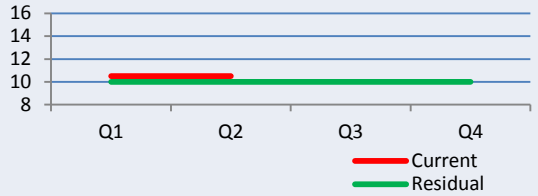
Risk Owner: Director of Nursing
Committee: Quality & Governance
Date last reviewed: 21 December 2015

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, decline in care standards or failure to provide a safe, modern care environment

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

Rationale for current score
Compliance with regulatory standards
Meeting national quality standards and bench marks
Very strong FFT recommendations
Patient Safety incidents triangulated with complaints and outcomes monthly no early warning triggers
No Never Events
Affordable plan for modernisation of the estate in development
Failure to attract workforce with right skills



HORIZON SCANNING – MODIFIED PEST ANALYSIS

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

COMPETITION
Patient choice if new services are available closer to home 5YFV

INNOVATION
Application of Human Factors to risk assessment and investigation.
Patient experiences shared at public board

RESILIANCE
Many services single staff member.
Pre and Post CQC preparation work

Controls / assurance
Programme of ongoing maintenance and remedial work
Estates work and issues monitored by the Health and Safety Committee
Clinical care monitored by the Quality and Governance Committee and the Joint Audit Committee
Regular and ongoing safer nursing care metrics and CQUIN data collection
External assurance and assessment undertaken by regulatory bodies and external partners
Regular monitoring of FFT and patient survey results
Patient participation and feedback at the Patient Experience Group
Quality Account
Compliance in Practice (CIP) audits assessing the clinical environment

Gaps in controls / assurance
Development of full estates strategy
Quality strategy to be developed
Robust clinical outcomes to be developed to ensure as effective baseline of clinical care
Service level patients experience surveys relating to the environment to be developed

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	10-16	
Report title:	**Quality and Governance (Q&G) Committee: assurance report**				
Sponsor:	Ginny Colwell, Non-Executive Director and Chairperson - Q&G Committee				
Author:	Ginny Colwell, Non-Executive Director and Chairperson - Q&G Committee				
Executive summary					
Purpose:	Assurance				
Recommendation:	To note				
Purpose:				Assurance	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:			
	Outstanding patient experience	World-class clinical services			
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Not applicable				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 10-16
Report from: Ginny Colwell, committee chair
Report date: 29 December 2015

Quality and Governance committee assurance report

Key issues discussed included the following:

1. The committee reviewed the previous action plans and noted in particular that:
   - the Clinical audit post remains open and therefore limited activity has taken place in this area;
   - Compliance in Practice dates are now set;
   - the annual programme for the committee is being developed and will ensure that the Terms of Reference are fully reflected. (see board agenda item 20-16)
2. Papers considered;
   - The risk exception report was discussed. The dashboard and reporting schedule continues to evolve. There were no serious incidents in November. The process to achieve the 30 day reporting target is being reviewed.
   - The CQC action plan was received and will be reviewed monthly at the Exec meeting;
   - The actions to date from the Kate Lampard review were received. GA was asked that further action be taken to assure the committee in regard to the actions concerning volunteers;
   - The monthly patient experience report was received. Further work will be taken to refine the reporting schedule to the Board and Q&G. Five complaints were opened in November and four closed. The highest number of negative comments within the Family and Friends Test report concerned waiting times. It was agreed that these comments will be further analysed and return to the February meeting with an action plan;
   - A report was received from the Research and Development Group and newly formed Research Strategy Group which will determine the joint strategy for its main collaborators; Blond McIndoe Research Centre and the University of Brighton.

3. Reports from the following groups were noted:
   - Clinical Governance Group;
   - Patient experience Group;
   - Nursing Advisory Group;
   - Patient Documentation Group;
   - Report on the excellent progress made in updating policies

Queen Victoria Hospital NHS
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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**11-16**	
Report title:	**Safe staffing and quality of care**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Jo Thomas, Director of Nursing				
Appendices:	2 appendices				
Executive summary					
Purpose:	To provide information and assurance on inpatient ward staffing levels. To provide updated quality information and assurance that quality of care at QVH is safe, effective, responsive, caring and well led.				
Recommendation:	The Board is recommended to note the contents of the report.				
Purpose:	Approval	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	No new implications for the BAF.				
Corporate risk register:	The CRR was reviewed prior to writing this report.				
Regulation:	Compliance with regulated activities in Health and Social Care Act 2014.				
Legal:	As above				
Resources:	No changes				
Assurance route					
Previously considered by:	Quality and Governance committee				
	Date:	10/12/15	Decision:	Endorsed	

Executive Summary Safe Staffing and Quality of Care November 2015

Domain	Highlights
Safe	No MRSA or MSSA Bacteraemia and no C difficile QVH acquired cases. No serious incidents requiring investigation under National Framework for Reporting and Learning. Harm free care at 97% against national average of 94.2%.
Effective	No QVH attributable mortalities. Interim CQC action plan compiled.
Caring	No backlog with complaints management, 5 complaints opened in month. 100% of our inpatients and 95% of our out patients would reccommed QVH to a friend or family member.
Responsive	MIU, 98% of patients were assessed and treated within 4 hours.
Nursing Workforce	Total of 44.79 nursing vacancies (19% of the establishment) the majority of vacancies in theatres and C wing. There were 7 starters and 3 leavers in month The nursing sickness rate is 3.77% which is higher than the trust rate of 3.24%. Nursing agency usage is 4.8% of the establishment.
CQUIN/ QA	Out of hours trauma surgery is above the threshold of 5 cases per month. In Q2 this was 7.3 cases which is the broadly the same as 2014/15 Q2 average of 7.6. Scheduling of surgery 3 weeks in advice is at 49% (target 70%)due to intentional list management.

Safe - Current Compliance

Domain	Current Compliance	Action Taken
Infection control	No MRSA healthcare associated infections (HCAI) bacteraemia No MSSA HCAI bacteraemia No C difficile HCAI	Rigorous screening and monitoring continues to be led by trust infection control team and all wards and departments.
Medication errors	There were 19 prescribing/drug administration errors All of theses were no low or no harm to patient	All incidents were investigated,1 graded as amber- full RCA. Departmental and organisational learning identified and action plan in place. All incidents reviewed at monthly pharmacy incident group.
Serious incidents	There are no serious incident reported or identified. No never events reported of identified. There are 19 internal amber investigations open.	The two SIs investigations reported in q1 are complete. The open amber investigations date from June 2015 work in progress to agree realistic timescale to close these and for new incidents to be closed in 30 days, the same as SIs.
Pressure ulcers	Two grade 2 QVH acquired pressure ulcers were reported. One on return from theatre to ITU following 12 hours operation and one in ITU.	Following investigationby the matron the incident relating to theatre and ITU was graded as a grade 1 pressure ulcer. Learning for staff member asessing initial injury identified.
Falls	There were 2 falls reported one on Margaret Duncombe and one in Corneo OPD	Both falls have been investigated and closed. No harm for inpatient fall minor bruising for out patient fall.
Nurse staffing	Increase in sickness in all ward areas apart from Peanut. 14 shifts where planned staffing levels did not meet actual staffing . Vacancies in theatres are 22.8 wte which is 15% of the	All incidents managed safely staff moved from other areas or matron providing extra support. Triangulation of patient safety incidents and complaints shows no links to days where staffing was below planned template.

levels	workforce, agency usage equated to 2.5%. Vacancies have increased in month on Cwing to 11wte which is 18% of the workforce, agency usage equated to 4.8%.	Theatre recritment day booked for end of Jan. 1.92 RN wte recrited in Dec. HCA and A&C staff commencing in Jan and interviews for RN and HCA booked for Jan.

data extracted from November workforce score card appendix 1

Safe - Performance Indicators

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															
MRSA Bacteraemia acquired at QVH post 48 hrs after admission	0	0	0	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	0	0					0
MRSA screening - elective	96%	>95%	99%	98%	98%	99%	98%	98%	98%	98%					98%
MRSA screening - trauma	97%	>95%	97%	96%	97%	96%	96%	96%	96%	99%					97%
Incidents															
Serious Incidents	10		0	1	1	0	0	0	0	0					2
Never Events	2		0	0	0	0	0	0	0	0					0
Medication errors															
Total number of incidents involving drug / prescribing errors	210		19	21	15	9	11	15	12	19					121
No & Low harm incidents involving drug / prescribing errors	209		19	21	15	9	11	15	12	19					121
Moderate, Severe or Fatal incidents involving drug / prescribing errors	1		0	0	0	0	0	0	0	0					0
Medication administration errors per 1000 spells	2.2		4.9	3.9	1.1	0.6	1.3	1.4	1.7	1.9					2.1
Harm free care rate (QVH)	97%	>95%	97%	95%	94%	95%	100%	95%	98%	97%					96%
Pressure Ulcers															
Hospital acquired - grade 2	11		2	2	1	0	2	1	0	2					10
Hospital acquired - grade 3															
Hospital acquired - grade 4															
VTE initial assessment	100%	>95%	100%	100%	100%	97%	97%	90%	98%	97%					97.4%
Patient Falls															
Patient Falls assessment completed within 24 hrs of admission	90%	>95%	100%	97%	88%	92%	67%	93%	98%	100%					91.6%
Patient Falls resulting in no or low harm	49	—	2	4	4	4	3	5	3	2					27
Patient Falls resulting in moderate or severe harm or death	1	—	0	0	0	0	0	0	0	0					0
Nursing workforce - safe staffing															
Ross Tilley															
Margaret Duncombe															
Burns															
Peanut															
Critical Care															

Effective - Current Compliance

Domain	Current Compliance	Action Taken
Mortality	No QVH mortalities in November.	Work continues to track acute transfers to other providers to ensure mortalitry data is accurate.
NICE Compliance	IPG 534 reviewed, Implantation of a corneal graft–keratoprosthesis for severe corneal opacity in wet blinking eyes. QS97 Drug allergy: diagnosis and management reviewed and closed.	Audit completed previously. QS97 No changes to policy required.
Clincal audit	New National Ophthalmology Database (NOD) available freeuntil 2017. Corneo will participate in National Cataract database and publication of the legacy data. DAHNO have published final Head & Neck Cancer Report.	Resource will be required to participate in NOD. Data collection issues identified for South East region(DAHNO). Local audit to review QVH standards required.
CQC	Planned CQC inspection 10-13 November. Initial report will be in January and quality summit in February. No immediate compliance issues or enforcement notices received.	DoN AND Medical Director leading on taking actions forwards prior to formal CQC report and action plan , areas of focus are risk management and critical care/out of hours cover.

Caring - Current Compliance

Domain	Current Compliance	Action Taken
Patient experience	2015 National Cancer Experience Survey was delayed in starting, results are not expected till late spring 2016. QVH current compliance with the survey is 56% against the national average response rate of 48%.	Second reminder for completion of survey will be sent out in January. QVH updating dataset to ensure no surveys sent to deceased patient or their families.
Complaints	31 complaints received YTD which is less than the 57 received at this point in 2014. The five new complaints related to medical staff with patients being unhappy with aesthetic outcome or attitude of the staff member.	Four of the complaints related to one specialty- in-depth review undertaken by clinical lead and manager, all relate to different staff members and sub specialties findings, no themes review shared at governance meeting.
Friends and Fmaily Test (FFT)	100% of inpatients completing the FFT survey would recommend QVH, 266 inpatients out of484 (55%).95% of outpatients would recommend our services, 2572 outpatients out of 13142 (20%).	Work led by outpatient matron and patient experience manger to identify and improve experience in progress will report to PEG in February 2016. Patients in MIU continue to be encouraged to do FFT.

data extracted from November patient experience report appendix 2

Caring - Performance Indicators

Metric	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	
Complaints															
Complaints per 1000 spells *	4.3		2.8	3.4	1.1	3.5	0.7	2.1	2.3	3.2					
Claims per 1000 spells *	1.1		0.7	0.0	0.6	0.6	0.0	2.1	1.7	1.9					
Friends and Family Test															
FFT score acute in-patients: likely and very likely to recommend QVH	99%	>90%	99%	100%	99%	98%	100%	99%	98%	100%					99%
FFT score acute in-patients: unlikely and very unlikely to recommend QVH	0%		1%	0%	1%	0%	0%	0%	0%	0%					
FFT score MIU: likely and very likely to recommend QVH	95%	>90%	93%	99%	96%	96%	96%	94%	91%	89%					94%
FFT score MIU: unlikely and very unlikely to recommend QVH	3%		2%	1%	0%	2%	4%	3%	5%	5%					
FFT score OPD: likely and very likely to recommend QVH	98%	>90%	96%	100%	95%	94%	94%	94%	94%	95%					95%
FFT score OPD: unlikely and very unlikely to recommend QVH	1%		1%	0%	2%	2%	2%	2%	2%	2%					
FFT score DSU: likely and very likely to recommend QVH	90%	>90%	99%	100%	94%	100%	100%	97%	96%	97%					98%
FFT score DSU: unlikely and very unlikely to recommend QVH	0%		0%	0%	3%	0%	0%	1%	1%	1%					
FFT score Sleep disorder centre: likely and very likely to recommend QVH	98%	>90%	97%	93%	97%	100%	93%	97%	99%	97%					97%
FFT score Sleep disorder centre: unlikely and very unlikely to recommend QVH	0%		0%	2%	0%	0%	3%	1%	0%	0%					
Privacy and dignity															
Mixed Sex accommodation breach	0	0	0	0	0	0	0	0	0	0					
Patient experience - Did you have enough privacy when discussing your condition or treatment (indicates a yes response)	97%	>90%	99%	N/A	N/A	N/A	99%	99%	99%	99%					

* 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)

Responsive

Domain	Current Compliance	Action Taken
Compliance in Practice	Compliance in practice tool re-launch date in January 2015	New tool developed to reduce repetition and incorporate learning from CQC preparedness work. Pilot of the new tool planned for December.
Incident Reporting	Shorter time to complete investigations and RCAs (identified as part of CQC preparedness work and via Q&GC and CGG) and improved evidence of leaning being shared and embedded. Incorporate human factors learning into local management of incidents.	Review of current time scales, new time scales identified. Relevant changes to risk management policy. Agreement and support from lead clinicians . Higher profile at departmental governance meetings and additional support and professional challenge by risk team.
Dementia	Distraction technique and conversation starter "Twiddle Muff" initiative in progress. Launch of Carers Experience questionnaire. Signed up to Dementia Friendly Hospital Charter.	Local knitting group replenishing twiddle muff stock Questionnaires analysed and feedback given at PEG Awaiting feedback form Alzheimer's association re peer support and shared learning.

Nursing Workforce

Domain	Current Compliance	Action Taken
Ross Tilley	No PU or falls , no significant changes in Datix and medication error reporting. Sickness increased in month which reflects a higher seasonal increase in sickness. Safe staffing achieved	Postive feedback to Ward Sister re improvement in falls and sustained performance re PU. Assurance sought and revieved that all sickness is being proactively managed as per trust policy.
Margaret Duncombe	No PU or falls , no significant changes in Datix increase inmedication error reporting. Sickness increased in month which reflects a higher seasonal increase in sickness. Safe staffing achieved	Positive feedback to Ward Sister re improvement in falls and sustained performance re PU. Increased medication awareness and learning has had impact on reporting of incidents. Sickness management as per RT action above.
Burns	No PU or falls, no significant changes in Datix and medication error reporting. Higher usage of agency reflects higher sickness and seasonal trends. Safe staffing achieved.	Sickness managed as per RT action above.
Peanut	Sustained performance re safer nursing metrics. Improved position in sickness at 2.1%. Safe staffing achieved.	Positive feedback to Ward Sister re improvement in sickness.
Critical Care (ITU)	2 reported grade 2 PU no falls. Sickness very high in month due to flu like illness. High usage of agency on a few shifts due to short notice sickness. Safe staffing achieved.	1 PU changed to grade 1 following RCA and review by NAG. Triangulation of patient safety incidents and PU, no links to shifts with higher agency usage. Sickness management plan requested.
Agency Caps	23 November Monitor introduced agency caps to drive down costs. QVH is choosing to comply with weekly reporting of this information. Some of QVH preferred provider agencies have some shift rates above the cap.	Weekly reporting system set up. Escalation system for approving agency above cap rate implemented. Meetings booked with agencies to negotiate rates to below cap.

Data extracted from November workforcescore card appendix 1

Nursing Workforce

Workforce Board Report – December

Nurses and HCA's

1. Workforce Profile

Staff type	Agreed WTE Establishment (as at 1 April 2015)	Number of WTE in post as at 30 November of report	Headcount as at 30 November 2015	Number of vacant posts (WTE) as at 30 November	Percentage of vacant posts (WTE)
Nurses	227.92	181.31	220	44.79	19.44
HCA's	87.52	81.35	97	11.67	14.16

2. Sickness Absence Data

Staff type	Trends	Percentage of sickness absence in October 2015	Average number of sickness days per employee in Unit A in October 2015	Number of absence days lost in October 2015	Percentage of sickness absence on a 12 month rolling basis	Average number of sickness absence days per employee in Unit A on a 12 month rolling period
Nurses		3.77	1.17	266	4.0	14.59
HCA's		4.35	1.35	134	4.06	14.81

3. Starters and leavers

Starters	**Nurses**	**HCA's**
7 in total	4	3
Leavers	**Nurses**	**HCA's**
3 in total	2	1

4. Nurse and HCA bank and agency usage

	Staff type	**% of establishment WTE**	**Total cost during November**	**Total number of hours during November**
Nurses	Bank	8.33 wte = 3.65%	£22 360.58	3756.72
Nurses	Agency	10.95 wte = 4.80%	£74 945.98	
HCA's	Bank & Agency	3.78 wte = 4.32%	£4471.96	

CQUIN

Domain	Current Compliance	Action Taken
Quality Account	Q3 quality account position will be presented at January Q&GC and a summary will be included in March Board papers. Out of hours trauma surgery is above the threshold of 5 cases per month. In Q2 this was 7.3 cases which is the broadly the same as 2014/15 Q2 average of 7.6. Scheduling of surgery 3 weeks in advice is at 49% (target 70%)due to intentional list management. Lack of corneo equipment in DTC and late allocation of lists at times means patients scheduled with < 3 weeks notice in order to achieve optimum productivity. In plastics additional DTC lists have been taken up to free up main theatre lists for eyes so these have been for LAs only so these have been cases who are seen and added to wait list as 2WW or urgent and then dated within next 2weeks – appropriate management of 2WW and cancer patients. Improvement in patients food noted in Q2 as per plan	Additional trauma list from October 2015 has not significantly improved out of hours operating on trauma. Introduction of business manager of the day from 11th January 2016 – attendance at trauma meetings, 0800 and 1530 and liaise with floor walker in theatres co-ordinating trauma to ensure lists are used efficiently and effectively to minimise out of hours operating and that no patients are turned away inappropriately. Additional corneo kit has been ordered. Trialled and plan to roll out secretary in OPD to date patients as they leave consulting room – improvement in service and efficiency but will need to monitor patients experience of this as it will not always offer 3weeks notice.
	The NHS England 2016/17 Quality Account(QA) list will be published on the Healthcare Quality Improvement Partnership (HQIP) in early January 2016. NHS England will agree the list in late December following a survey of all known national clinical audits and clinical outcome review programmes.	Preliminary requests for 2016/17 QA priorities have been sent to PEG , patient experience manager, stakeholders and Healthwatch. Request for auditable quality indicator made to COG in October awaiting response.

CQUIN

Source	Metrics	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%	92%	93%	100%					91.3%
	Dementia >75 having diagnostic assessment	95%	90%	100%	100%	100%	100%	100%	100%	100%	100%					100.0%
	Dementia >75 referred for further diagnostic advice	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%					100.0%
	Dementia training for staff	87%	65%	92%	94%	93%	86%	84%	85%	83%	83%					87.5%
	Dementia strategy	_	NA	Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	AK1 Acute Kidney Injury	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Sepsis	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Human factors training	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Improving patients with mental health experience of trauma pathways at QVH	NEW		Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Quality Account 2015/2016															
	Scheduling of elective surgery with 3 weeks notice			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Expand trauma capacity			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			
	Improve patient experience of food			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			Reported 1/4ly			

Appendix 1: Nursing Workforce

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	10.93	8.24	11					7.5%	18%				Advert continues for band 5 posts, shorlisted, awaiting further interviews in January,
Est = (hrs)	1680	1673	1550	1599	1599	1776	1339	1782										
Temp staffing Bank	680.8	662	613	651	495	571	472	551					10%					Agency useage decreased on last month . Bank continues due to current vacancies
exc RMN Agency	508	527	621	476	294	567	564	485										
Sickness %	6.1%	1.7%	2.5%	3.8%	2.6%	2.7%	2.6%	4.5%					2%					Increased sickness due to several long tgerm sickness episodes.
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	74.5%	93.5%	100%	100%	100%	100%	100%	100.0%					85%					Appraisal holding at 100%
Statutory & Mandatory%	77.6%	68.1%	86%	88%	83.2%	93%	95.0%	95.0%					85%					Figures taken from SDC central records
Drug Assessments %	100%	100%	100%	100%	100%	100%	100%	100%					95%					Drug assessments maintained at 100%
Staff FFT Score %	_	_	_	_	_	_	_	_					_					
Budget (YTD)	6866	2607	24950	38816	53234	62784	81327	71598					<0					Corneo spend for agency now moved
Margaret Duncombe																	Trend	Improvement Plan/Actions
Shift meets est % RN	99%	100%	101%	100.8%	98.4%	98.5%	100%	101%					95%					Staffing is aligned with patient acuity, entered onto the Safer Care module of the eroster
Day HCA	98%	102%	100%	100%	96.8%	100%	98.4%	98.4%					95%					
Shift meets est % RN	97%	99.1%	100%	99.1%	97.9%	99.1%	102%	99%					95%					This depends on day to day, shift by shift patient acuity and inpatient numbers
Night HCA	95%	100%	97%	100%	90.9%	93.3%	93.8%	100%					95%					
Ross Tilley																	Trend	Improvement Plan/Actions
Shift meets est % RN	99%	98.2%	98.2%	98.3%	97.0%	98.1%	100%	102%					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%	98.6%	100%	101%					95%					
Shift meets est % RN	99%	97.6%	100%	96.4%	96.2%	95.2%	96.7%	95.2%					95%					
Night HCA	100%	90.6%	100%	89.7%	96.7%	100%	96.7%	93.3%					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	1	3	1	0	0	0	0	0					0					
Falls	0	1	0	0	1	1	1	0					0					
Medication Errors	8	8	7	1	4	0	4	8					0					Monitoring impact of pharmacy sessions, action plan process now
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0					0 / 0					
Incidents Reported (Datix)	14	19	20	6	10	18	12	10										
VTE reassessment %	100%	100%	85.7%	91.7%	100%	67%	100%	100%					95%					100% compliance
Nutrition MUST assessment	100%	100%	100%	100%	100%	100%	100%	100%					95%					100% compliance
7 day review	100%	100%	100%	100%	100%	80%	100%	100%										
Patient numbers	146	143	160	163	138	156	159	150					N/A					
Patient FFT Score %	97%	99%	100%	99%	100%	100%	96%	100%					95%					Improvement in month
Ross Tilley																		
Pressure Ulcers	1	0	0	0	0	0	0	0					0					
Falls	1	1	1	3	1	2	1	0					0					
Medication Errors	8	8	4	2	2	3	2	3					0					Monitoring impact of pharmacy sessions, action plan process now in place for reoccurring issues
MRSA / C. diff	0/0	0/0	0/0	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	11	9	7										
VTE reassessment %	100%	100%	71.4%	90.9%	83.3%	30%	100%	100%					95%					100% compliance
Nutrition MUST assessment	100%	100%	100%	100%	100%	94%	100%	100%					95%					1 patient assessemnt not compliant
7 day review	100%	100%	100%	100%	66.7%	40%	100%	50%										
Patient numbers	170	175	210	195	188	197	192	178					N/A					
Patient FFT Score %	98%	100%	100%	97%	100%	99%	98%	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	0	0					0					No grade 2 PU since August 2014
Falls	0	2	0	0	0	0	0	0					0					
Medication Errors	1	0	0	2	2	3	1	1					0					ward manager reviewing incidents
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0					0 / 0					
Incidents Reported (Datix)	2	7	3	7	4	3	4	9										incidents discussed at burns management meeting for learning
VTE reassessment %	100%	66.7%	100%	100%	100%	100%	100%	75%					95%					1 patient not reassessed within correct time frame
Nutrition MUST assessment	100%	100%	100%	100%	100%	100%	100%	100%					95%					
7 day review	50%	100%	N/A	100%	50%	N/A	N/A	100%										1 patient did not have reassessemnt on time
Patient numbers	21	25	23	25	22	36	31	19					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	3.2	2.4	2.4					7.5%	6.8%				continued ongoing recruitment
Est = (hrs)	337.30	450	450	450	708.5	520	396.5	396.5										
Temp staffing Bank	464.15	95	168	138.5	137.5	81	80	137					10%	62.5%				
exc RMN Agency	84	208.5	60	264	200.25	143	108	253										
Sickness %	NA	1.7%	2.7%	5.9%	4%	3.1%	2.7%	3.5%					2%					x1long term sickness in phased return
Shift meets est % RN	98%	96.6%	98.8%	96.6%	98.8%	100%	101.3%	97.8%					95%					
Day HCA	94%	96.9%	90%	87.1%	96.3%	104%	100%	105%					95%					
Shift meets est % RN	98%	100%	100%	95.7%	101.6%	98.3%	96.6%	100%					95%					
Night HCA	100%	100%	100%	100%	100%	100%	100%	300%					95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	64.5%	100%	97%	100%	80.5%	100%	100%	100%					85%	-20%				
Statutory & Mandatory%	83.9%	84%	87%	78%	76.5%	93.1%	100%	100%					85%	-1%				
Drug Assessments %	100%	100%	100%	100%	94%	100%	100%	100%					95%					
Patient FFT Score %	100%	100%	100%	100%	100%	89%	100%	100%					95%					
Staff FFT Score %	–	–	–	–	–	–	–	–					–					
Budget (YTD)	72094	90508	84296	132972	172048	128991	110132	115109					>0					overspend split equally pay/non-pay. Actively recruiting to reduce agancy spend. Stockroom at basic levels only - investigating increase in costs

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	0	2					0					2 reported grade 2 PU , after RCA, 1 downgraded to grade 1
Falls	0	0	0	0	0	0	0	0					0					
Medication Errors	2	4	1	0	0	1	2	4					0					ward manager reviwing inidents
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0					0 / 0					
Incidents Reported (Datix)	8	5	7	8	7	14	6	17										RCA underway for medication error, x8 datix's relate to x2 patients and need linking
VTE reassessment %	100%	100%	100%	66.7%	100%	100%	100%	100%					95%					
Nutrition MUST assessment	100%	100%	100%	100%	100%	100%	100%	100%					95%					
7 day review	100%	100%	66.7%	N/A	33.3%	N/A	100%	100%										The % decrease relates to 1 patient
Patient numbers	15	20	19	14	11	17	16	16					N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	0	6.6	5.6	7	6.7	5.7	4.65	4.65					7.5%					
Est = (hrs)	0	984	910	1137.5	1095	926	755.5	755.5										
Temp staffing Bank	191	28.5	120	264	31.5	48	31	196.5					10%					Increase in usage reflects sick cover, 162.5 maternity cover in addition to vacancies - actively being recruited.
exc RMN Agency	504	709	592.5	131.7	264	124	71	336										
Sickness %	N/A	5.7%	6.3%	3.3%	1.8%	1.0%	3.5%	7.9%					2%					mostly short term sickness due to flu type symptoms
Shift meets est % RN	98%	100%	100%	96.1%	93.7%	95%	97.5%	96.4%					95%					Achieved on or above standard since November 2014
Day HCA	100%	100%	100%	100%	100%	100%	100%	100%					95%					
Shift meets est % RN	103%	100%	100%	88.3%	93.0%	85.5%	80.8%	85.7%					95%					safe staffing achieved by moving staff from other areas
Night HCA	100%	100%	100%	100%	100%	100%	100%	100%					95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	66.7%	95%	95%	92%	96%	96%	96%	97.5%					85%	-18%				x1 person showing as outstanding, booked
Statutory & Mandatory%	71.9%	84%	86%	78.3%	76.4%	92.1%	92%	98%					85%	-13%				target of 100% complaince by end of September
Drug Assessments %	87%	77%	88%	88%	94%	100%	100%	100%					95%					improvement in assessments this month
Patient FFT Score %	_	_	_	_	_	_	_	_					95%					
Staff FFT Score %	_	_	_	_	_	_	_	_					_					
Budget (YTD)	159	2378	6357	21828	24823	34115	28032	32883					>0					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	0	0					0					No PU during 2015
Falls	0	0	0	0	0	0	0	0					0					No falls during 2015
Medication Errors	0	0	1	2	0	0	0	0					0					
MRSA / C. diff	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0					0 / 0					No MRSA/CDI during 2015
Incidents Reported (Datix)	2	1	3	2	2	2	5	3										
Patient numbers	N/A	206	187	212	199	180	219	180					N/A					
Staff Utilisation	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Vacancies wte	1.75	3	2	1.32	2	2.2	0	1					7.5%	7.0%				
Est = (hrs)	285.16	450	325	214.5	325	357.5	0	162.5										
Temp staffing Bank	240.45	119.5	116.9	224.1	107.3	186	126	110					10%	*9%				
exc RMN Agency	71.3	54.75	63.75	90.7	50.75	54	91	19										
Sickness %	N/A	5.5%	1.7%	4.4%	4.5%	4.0%	4.8%	2.1%					2%	0%				improvement in month
Shift meets est % RN	98%	96.2%	100%	90.6%	100%	98.8%	101%	100%					95%					
Day HCA	92%	100%	97%	100%	97.1%	97.1%	94.7%	100%					95%					
Shift meets est % RN	97%	98.4%	98%	93.5%	98.3%	94.9%	95%	96.7%					95%					
Night HCA	100%	100%	100%	100%	200%	100%	100%	100%					95%					
Training / Appraisal	No / %												Target	Var.	RAG	Change	Trend	Improvement Plan/Actions
Appraisals %	80%	98%	98%	97%	84%	97%	100%	99%					85%	-5%				
Statutory & Mandatory%	82%	93.5%	92%	80.9%	76.4%	91.2%	94%	94.5%					85%	-3%				
Drug Assessments %	100%	90%	100%	100%	100%	100%	100%	100%					95%					
Patient FFT Score %	100%	100%	100%	100%	97%	100%	100%	100%					95%					
Staff FFT Score %	_	_	_	_	_	_	_	_					_					
Budget (K)	1663	9440	5937	1	2891	3480	9341	9524					>0					recoery plan requested

Appendix 2

Monthly Patient Experience Report

1 November 2015 – 30 November 2015

The patient experience report aims to present a rounded picture of patient experience and provide information on all aspects of experience. Where poor experience is identified, actions are taken to ensure improvements are made and the outcomes are documented within the report. The report presents a wide range of information from different sources, including the following: complaints, claims, friends and family test and live feedback (NHS Choices/Patient Opinion).

Monthly Patient Experience Report

1 November 2015 – 30 November 2015

Performance Indicators	July	August	September	October	November
Number of new formal complaints received in the month	7	1	3	4	5
Number of complaints referred to the Ombudsman for 2nd stage review	0	0	0	0	0
Number of complaints re-opened	0	0	0	0	0
Number of claims	1	0	3	3	3

Complaints

The Trust remains up to date with complaints management and reports that there is no backlog although there is still a constant flow of complaints received,

We aim at all times to provide local resolution and take all complaints seriously. We listen carefully, we are open, honest and transparent in our responses and welcome the opportunity to put things right.

Many complaints are resolved local by front line staff who are able to resolve the patient/relative concerns to their satisfaction in a timely manner. The Trust actively encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. This timely intervention can prevent an escalation of the complaint.

We actively monitor the key themes identified and triangulate this information with information generated through incidents, audit and patient feedback.

Open complaints: There were 5 complaints that were opened during this period. All complaints received are acknowledged, investigated and responded to. Any actions that are identified are monitored for completion by the monthly clinical governance group.

The number of complaints that have been received year to date are 31. This is a significant reduction on the same time last year where we had received 57 complaints.

Plastics

1. **Medical - Surgical treatment** – The patient has raised concerns about the overall and aesthetic outcome of their surgery. It is understood that the patient was informed that their surgery would be a 'small excision biopsy' for the removal of a mole (benign) but upon removal of dressing has found a 25mm incision that has six stitches along the length of the nose. Patient has indicated that if they had been made aware of this then they would not have consented to have the surgery. Patient wishes to know what the Trust will do to resolve this matter and remove the scar from their nose. I**nvestigating lead – Consultant and Clinical Director**

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

   Comment/Action – Still undergoing investigation.

2. **Medical – Surgical treatment –** The patient is unhappy with the outcome of their hand surgery (ring finger). I**nvestigating lead – Consultant and Clinical Director**

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

Comment/Action – Still undergoing investigation.

3. **Medical – Attitude/communication** – Complaint made by mother of patient who is upset by comments made by clinician, which were found to be insensitive and unprofessional. **Investigating lead – Consultant and Clinical Director**

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

   Comment/Action – Still undergoing investigation. Patients consent is required and being obtained as the patient is 54 and consent is required in order to discuss their concerns with the complainant.

4. **Medical – communication/clinical care** – Carer for patient with learning disabilities has raised concerns about the skin cancer treatment that has been provided. Patient/carers have been has been told that there was nothing further that could be done for them by consultant at QVH.

   Concerns have also been raised about the treatment provided by Conquest, Eastbourne DGH and Royal Sussex which QVH is coordinating and leading on.

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

   Comment/Action – Still undergoing investigation.

Anaesthetics

5. **Medical – communication** - Concerns have been raised by the parent in the way that the clinician communicated with their child who has Asperger's.

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

   Comment/Action – Still undergoing investigation.

Closed complaints: There were 4 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.

Burns

1. **Medical – Attitude** – The patient has concerns about the way that the clinician spoke to them in relation to their ongoing care and considered that accusations in relation to their alcohol intake were unfounded. Patient would also like to be reimbursed for the cost that they have incurred in travelling in taxi fares £400. **Investigating lead – Ward Manager and Clinical Lead.**

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

   Comment/Action – Due to a communication error by the staff in the department the patient attended unnecessarily. The patient should have been informed that a meeting was being held to discuss their future treatment plan. This was held the following week where it was decided that surgery was not appropriate for this patient. Apologies have been given if the clinician came across as being rude however this was not their intention and it was considered at the time that the consultation went well. An ex-gratia payment for £50 has been given to the patient to cover the cost of their travelling expenses for the unnecessary journey that they made.

Complaint Outcome: Upheld in part

Corneo plastics

2. **Medical - Overall care** – The patients has raised concerns about the experience during cataract surgery that was performed. Patient had similar surgery earlier in the year which was a very different experience. **Investigating lead – Consultant and Clinical Director**

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

   Comment/Action – Comment/Action – Sincere apologies conveyed as this patient should not have experienced any pain during the surgery. The clinician was being assessed and was nervous. The surgeon has taken this matter extremely seriously and since this incident has spoken with his colleagues who have advised him on how to improve his surgical technique and other patients who have commented on the lack of communication. The clinician will now work extremely hard to improve both these issues.

   Complaint Outcome: Upheld

3. **Medical/Nursing/Equipment – Infection control -** Following eye surgery, patient called unit complaining of a painful right eye which was sensitive to light and red. The patient had an infection (MRSA) and would like an explanation as to how this was acquired. Patient has asked for compensation.

   This case was initially reported as an incident: ID 12033.

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

   Comment/Action – It is considered that this was community acquired MRSA which tends to be more common in the eye area as opposed to hospital acquired MRSA. No offer of restitution made.

   Complaint Outcome: Unsupported

Plastic Surgery

4. **Nursing –** Overall care – The patient has concerns about the overall care and information given to the patient by the nursing staff that were involved with patients care following breast surgery. **Investigating lead – Ward Manager and Matron.**

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

   Comment/Action – Overall review of the patient care has been undertaken and it is felt that there are some issues that could be improved upon. i.e. the regularly change of TED stockings. Staff have been asked to inform patient the use of the heart shaped cushions that are given to breast patients. Also patients to be made fully aware that the length of stay will be between 3-8 days and not to be given a specific length. Reassurance given to the patient that the appropriate treatment was given.

   Complaint Outcome: Upheld in part

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

Claims

Open claims: There were 3 new claims opened during this period. Overall there are 57 claims. A quarterly report is disseminated through the Joint Hospital Governance meeting each quarter on cases settled and the lessons learnt.

Incident date	Claim date	Directorate	Service	Description	Initially Complaint	Reported as an incident
n/k	17/11/15	Corneo	n/k	Limited information. It would appear that following spinal surgery at another hospital the patient sustained damage to their eye resulting in a referral to QVH.	No	No
n/k	13/11/15	Theatres	Medical	Failure to move patient during surgery which resulted in pressure sore at back of head. This has resulted in permanent loss of hair.	No	No
n/k	19/11/15	Plastics	Medical	Concerns about care and treatment provided at William Harvey Hospital, Kent and Canterbury and QVH. Failure to diagnose severe compartment syndrome in patients legs, which has resulted in 'prolonged suffering'.	No	No

Closed claims: There were 1 claims closed during this period.

Patient Experience – NHS Choices/Patient Opinion

In the month of November 2015 the NHS Choices/Patient Opinion website received 5 feedback comments with regards to the, these related to care in maxillofacial, breast surgery and hand surgery.

Of these feedback reports five were given 5 star ratings by service users. The Patient Experience Manager has responded to all comments.

All reviews are seen by all staff via Qnet.

Friends and Family Test

The Trust wide FFT scores for in-patients in November was **100%** of our patients would recommend us. 266 inpatients out of a possible 484 inpatients completed the questionnaire. This is a **response rate of 55% last month was 52%.**

The FFT score for out-patients in November was **95%** of patients would recommend us. 2572 outpatients out of a possible 13142 completed the questionnaire either by paper, SMS or integrated voice message. The response rate has improved from last month which was 18% to **20%** this month.

The following are the top 8 themes used by our outpatients (and the number of times) in the past month 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**	
Implementation of care	1088	Waiting time	69
Staff attitude	831	Staff attitude	30
Waiting time	202	Communication	8
Communication	206	Environment	10
Environment	165	Implementation of care	20
Clinical treatment	110	Admission	12
Patient mood/feeling	100	Patient mood/feeling	8
Admission	81	Clinical treatment	9
Staffing levels	26		

Examples of real-time comments (the number 5 represent 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.

Date of attendance	**Clinic**	Score	**Comment**
09/11/15	OP/OPTHALMOLOGY	**5**	Everyone is so nice but the waiting times aren't.
17/11/2015	OP/MAXILLO FACIAL/MOS	**5**	5, as I was treated by some students which were not well trained, so will not recommend to anyone else.
11/11/2015	OP/MAXILLO FACIAL/DMC	**5**	Because,I had been waiting nearly 3 months for the recent appointment I made to cut off little mucocele(lump) which is on my lip, as my GP suggested me it supposed to be done same day, but it wasn't . It was for only little check-up which took 10 mins, and re-referred which will be another 3 months.. what a disappointed it is.. NHS is #Dont #care #services for the patients ... They give option to patients Wait or die..

The following are the specific area/wards FFT score, % score for extremely likely/likely and return rate.

Area	Total Responses	Total Eligible	Response rate	Percentage recommended	Percentage Not recommended
MD ward	107	133	80%	100%	0%
RT ward	121	155	78%	100%	0%
Peanut ward	32	169	19%	100%	0%
Burns ward	6	27	23%	100%	0%
Sleep centre	63	195	32%	97%	0%
MIU	267	934	29%	89%	5%
OPD	2572	13142	20%	95%	2%
DSU	418	606	69%	97%	1%

All wards and departments continue to display their monthly Friends and Family results as part of the ward communication boards, which provide an opportunity for wards to state to patients and their carers, action they

are taking in response to feedback. The information shown gives the matron and ward managers an opportunity to discuss with staff, patients and their carers.

'You said – we did' actions implemented based upon patient feedback and ward discussion to improve the patient experience include:

Corneo Plastics – Communication - 'I feel when one first phones as an SOS, it should be clearly explained that you will be seen but it may not be in the clinic but in the evening on the ward.'

Our reply - Shared this information with the rest of the team to ensure patients are given clear instructions.

MD ward – Patient care – 'Staff are fantastic, however, they sometimes forget to readjust the bed to move the bed table back after performing duties.'

Our reply - We will remind staff at our next team meeting that it is important to do this, especially for patients with limited mobility.

Main OPD – Waiting times - 'We waited for 1hr and 42mins beyond our appointment time. Not good with a bored 7 year old! An hour wait for a 2 minute appointment!'

Our reply - We are looking at new ways of working within outpatients to address the long waiting times.

KSO2 – World Class Clinical Services

Risk Owner: Medical Director
Committee: Quality & Governance
Date last reviewed: 21 December 2015

Strategic Objective
We provide world class services evidenced by clinical and patient outcomes. Our clinical services are underpinned by our high standards of governance, education innovation.

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

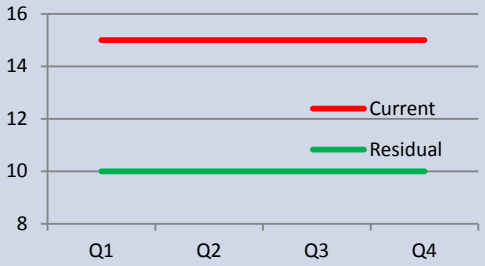
Rationale for current score
QVH governance: Out of hours care; Paediatrics; ITU; Spokes.
Dental middle grades
Loss of Deanery posts and support
Internal governance resource
Lack of NIHR engagement/research investment

HORIZON SCANNING – MODIFIED PEST ANALYSIS

POLICY
National Standards:
ITU Burns Paediatrics NICE etc
Deanery training posts
NIHR
Seven day services
Medical contract negotiations
CQC inspection

COMPETITION
Positive:
Horder. BMRF collaboration
Vanguards, networked care, community provision, private patients
Negative:
Spoke repatriation
Consultants retiring/forming LLPs

Risk
Patients, clinicians & commissioners lose confidence in our services due to a decline in or inability to publish clinical outcomes, a reduction in research output and fall in teaching standards. Quality of care may suffer by failure to deliver clinical governance standards.



INNOVATION
Greater efficiency in job planning
Greater efficiency in theatre/OPD use
Deliver optimum OOH care
Education and simulation training
Innovation, our own and network R&D, link to BMRF and universities
Outcomes publication
Human factors training

RESILIANCE
Loyalty and engagement of workforce
Shared burns care
Appointment of CDs and governance leads
Spoke demand strong
CEA incentives
Management support for operational initiatives
Single points of failure with specialist staff
Response to clinical demand

Controls and assurances:
Clinical governance group and leads
Monitoring clinical indicators; some outcomes
Spoke visits and project
Consultation and scope for OOH solution
Cross site governance for spoke services
Networks for QVH cover-e.g. burns
Training and supervision of all trainees with deanery model
Investment in research/research outcomes defined

Gaps in controls and assurances:
Limited extent of reporting /evidence on internal and external standards
Limited data from spokes/lack of service specifications
Scope and addressing seven day services
Recruitment (dental especially)
Expected outcomes for research investment
Balance service delivery with training and research commitments
Intention of NHS for specialist small providers
Job planning

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page						
References						
Meeting title:	**Board of Directors**					
Meeting date:	**07/01/16**		**Agenda reference:**	**13-16**		
Report title:	**Medical Director's report**					
Sponsor:	Steve Fenlon, Medical Director					
Author:	Steve Fenlon, Medical Director					
Executive summary						
Purpose:	Routine update from the perspective of the medical director.					
Recommendation:	For the board to note the contents of the report.					
Purpose:		**Information**	**Discussion**			
Link to key strategic objectives (KSOs):		**KSO2:**				
		World-class clinical services				
Implications						
Board assurance framework:	Yes					
Corporate risk register:	No					
Regulation:	No					
Legal:	No					
Resources:	Yes					
Assurance route						
Previously considered by:	Not applicable.					

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 13-16
Report from: Steve Fenlon, Medical Director
Report date: 29 December 2015

1. Clinical Governance:

The Clinical Governance Group has responsibility for the safety and quality of clinical care at QVH. It reviews and advises on external and internal quality measures, incidents, risks, complaints, concerns, learning and action plans and approves new clinical policy. The group considers the input and output of governance meetings run at service level and provides over sight of trust wide matters affecting all or more than one directorate to ensure learning and best practice are understood and embedded with all clinical staff. The group has changed over time, now meets monthly and has excellent attendance from all staff groups with nominated medical governance leads for all directorates. There has been a refresh of matters of clinical concern to the organisation and changes to the risk register and clinical action plans as a result. Key agenda items are out of hours cover, spoke site governance, understanding and preventing dental never events, and staff culture within the operating department. The group reports monthly to the Quality and Governance Committee. The group helps to set the agenda of the trust wide Joint Hospital Governance Meeting, a forum for all clinical staff, and presents here a wide range of clinical information, including all mortality in hospital and within 30 days of discharge.

The recent CQC visit was an opportunity to review governance processes and the functions of the clinical audit department; aligning its work more closely with the expectations of our regulator. The lead post, vacant since June, will be re-advertised as Lead for Quality and Compliance, hopefully for interview in the New Year. The change in name and role reflect greater responsibility whilst taking account of the needs highlighted by the CQC data requests and expectations of clinical information to measure quality of care against other organisations. Feedback from consultant staff is that the CQC inspectors were knowledgeable in their field, and many had detailed conversations with a broad range of medical staff including trainees who were encouraged to attend the stakeholder session. Many of the consultants helped provide information in advance to inform the inspection.

Production of consultant level outcome measures remains a long term objective for the trust, the last year has seen competing priorities take precedent, but a reviewed option to provide externally verified outcome measures will be considered by the executive team for 2016-17.

QVH will be visited by NHS England in January for the first of a five yearly Independent Verification Inspection to examine the quality of the mechanisms for revalidating medical staff. The visit will scrutinise how we recruit, induct, supervise, train, appraise and develop all medical staff together with how we have identified and managed areas of concern around medical conduct and capability.

2. Clinical Strategy

The details of the clinical strategy are covered elsewhere. There continues to be excellent engagement from clinical staff in driving forwards the plans to grow and diversify services offered to patients on the QVH site and further afield.

3. Education

The medical education department has worked hard to achieve high levels of compliance with mandatory training. Most of the effort was to cleanse data and to explain and make available training sessions for all medical staff. Dr Rachael Liebmann has updated contact details and registers and where necessary provided the impetus to individuals to update their training. Dr Ed Pickles, Director of Medical Education, is responsible for the training and supervision of all junior medical staff, including those recruited directly to the organisation but training predominantly outside the UK. QVH aims to provide an equivalent level of training and support to all doctors who do not enjoy the benefit of Local Educational Training Board (LETB) employment. Ed is supported by Helen Moore, Medical Education Manager and Dr Alison Chalmers, a consultant anaesthetist with an interest in simulation training, (an increasingly important part of education in healthcare with its complex interplay of multidisciplinary staff, equipment and processes). The temporary education centre is fully utilised and has benefitted from charitable funds to upgrade the audio-visual equipment.

4. Research

The research strategy comprises two main elements:

- Development of alliances with other organisations, but in particular the Blonde McIndoe Research Fund (BMRF);
- Connecting all research with targets to improve the quality of tissue healing, which translates into improved patient outcomes.

Research strategy group meetings began in late 2015 and synergy between BMRF (with its laboratory based expertise) and QVH (with its clinical expertise) lends itself to a much closer working relationship. The alliance formed is in a strong position to build external networks with academic institutions such as the University of Brighton and wider afield. Currently both QVH and BMRF support staff from our nearest university from charitable donations. QVH is reviewing this successful arrangement and will continue to provide funding from trust resources, at a level gauged by the outcomes achieved to date. An ambitious plan for investment in research to expand the administrative and recruitment support, and in particular provide consultant time to create research projects has been prepared. The intention is to create an environment where research is the norm for staff and patients and supported by an infrastructure ensuring innovation is captured, driven and measured by recruitment, reputation and enhancement of care. The plan will be reviewed by the executive team this year.

KSO3 – Operational Excellence

Risk Owner – Director of Operations
Committee – Finance & Performance Committee
Date last reviewed - December 21st 2015

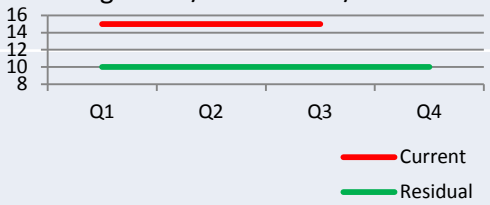
Strategic Objective
We provide streamlined services that ensure our patients are offered choice and are treated in a timely manner.

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

- Impact of new rules and no longer can use pauses on the admitted pathway will impact upon our performance particularly due to our small denominator;
- 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 / Assurance

- Regular access meeting reviews and forward plans activity/booking-includes Cancer;
- Patient Access Manager – new role and joined the Trust on Sept 21st;
- Monthly business unit performance review meetings in place with a focus on exceptions, actions and forward planning;
- Finance and Performance Committee in place;
- PTL accessible by all relevant managers;
- Performance Dashboard in place;
- Business Planning meetings and cycle put in place from Sept 15 for 16/17

Gaps in controls / Assurance

- 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;
- Late referrals for 18RTT from neighbouring trusts, two of which are in special measures and others with severe pressures;
- Productivity information and programme required for theatres;

KSO 4 – Financial Sustainability

Risk Owner: Director of Finance & Performance
Committee: Finance & Performance
Date last reviewed: 19th October 2015

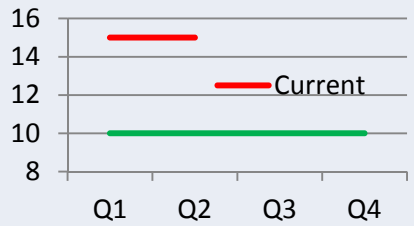
Strategic Objective
We maximize existing resources to offer cost-effective and efficient care whilst looking for opportunities to grow and develop our services

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 8)
- Surplus - (0.9%)
- CIP slippage - (34%)
- Capital Plan slippage – (67%)
- Sustainability Risk Rating - 4

Rationale for forecast
- Forecast delivery of surplus (£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
- New workforce models and strategic partnerships designed to address resilience issues internally and support the wider health economy
- Using IT as platform to support innovative solutions and new ways of working

RESILIENCE
- Small teams that lack capacity, agility , technical and back-up support.
- Systems and processes that cannot support real-time decision making.
- Aging, deteriorating estate
- Limited resources to invest

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

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**7 January 2016**		**Agenda reference:**	**15-16**	
Report title:	**Finance and Performance (F&P) Committee: assurance report**				
Sponsor:	John Thornton, Non-Executive Director and Chairperson of the F&P Committee				
Author:	John Thornton, Non-Executive Director and Chairperson of the F&P Committee				
Executive summary					
Purpose:	Assurance				
Recommendation:	The board is asked to note the contents of this report				
Purpose:		Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):			KSO3:	KSO4:	KSO5:
			Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	The trust has continued to achieve a Monitor financial sustainability risk rating (FSRR) of 4.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Not applicable.				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 15-16
Report from: John Thornton, committee chair
Report date: 28 December 2015

Finance and performance assurance report

The minutes of the meeting will show that given the unexpectedly weak performance against budget in November the Chairman changed the order of items on the agenda to start with a round table discussion of financial performance including the underlying operational case activity.

1. Financial performance

An unexpected shortfall in clinical income in November led to a significant underperformance against the planned budget.

A long discussion took place on the causes of this shortfall in income. The committee took some assurance that the executive had reviewed this thoroughly and could identify a number of specific reasons. These included a shift in case mix caused by the half term holiday, a lack of non-elective cases, other trusts 'repatriating' some work, and absence of key staff due to illness.

The committee agreed it was not appropriate to over react to one month's numbers. But the committee was concerned that the planned activity for the month had not given an indication of the likely shortfall and that the MI available didn't provide a clear picture of the areas of shortfall. Assurance was provided that improvements would be made to the presentation of key management information but that this would not take place until the start of the new financial year.

Committee noted that the final three months of the financial year requires very strong performance in January and March to achieve the budget surplus. Given the unexpected shortfall in November and the difficulty in forecasting the committee cannot provide assurance that these numbers will be achieved.

The delivery plan put in place following the half year review to fill the shortfall at that time is performing well and is likely to achieve its targets for the year.

Following the further shortfall in November the executive team has reacted quickly to identify further initiatives to support delivery of the annual budget. These were in three key areas and totalled c.£400k. But the CEO added that all of these may not be achievable as they needed to be balanced against other priorities.

The committee can provide assurance that every effort is being made to ensure budget is achieved. But at this point the CEO considered that he could only

provide assurance that the surplus would be somewhere between £0.6m and £1.0m.

2. **Operational performance**
   Although the case mix has not delivered the required income the overall levels of activity are still high. RTT targets are being met and our standard of performance is strong relative to other hospitals. Recent changes to booking procedures have been well received so far. The committee noted that we remain vulnerable because of our relationship with spoke sites but is satisfied that this is being monitored and managed.

3. **HR performance**
   Sickness levels had risen and anxiety/stress continues to be the major reason given. Committee was given assurance that this is being addressed. The mindfulness course run for selected staff had been well received and would be rerun for a wider group.

   While our overall staff stability is good assurance was given that we are seeking ways to address higher turnover and vacancy levels in key areas such as wards.

4. **IT Infrastructure Improvement Programme**
   The committee can provide assurance that the project is on track overall with no major issues identified. Due to the committed expenditure on this project and the EDM project we are likely to meet our capital expenditure plans for the year.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**16-16**	
Report title:	**Operational Performance**				
Sponsor:	Sharon Jones, Director of Operations				
Author:	Business Managers				
Appendices:	1.				
Executive summary					
Purpose:	To give assurance on operational performance against key performance indicators and national standards.				
Recommendation:	To note the report.				
Purpose:				Assurance	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	To give assurance and confidence the controls are adequate.				
Corporate risk register:	To give assurance and confidence that risks are mitigated.				
Regulation:	Not applicable.				
Legal:	Not applicable.				
Resources:	Not applicable.				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	21/12/15	Decision:	Noted	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Meeting date:	7th January 2016
Reference number:	16-16
Report from:	Sharon Jones, Director of Operations
Author:	Business Managers
Appendices:	1. Trust Level Report – all services
Report date:	30th December 2015

Operational Performance: Targets, Delivery and Key Performance Indicators

Key Messages

Waiting Lists

1. **Diagnostic Waits**

The Trust continues to deliver against the diagnostic target of 99%. This target requires that 99% of patients have had their diagnostics completed within 6 weeks of referral.

2. **Monitor 18 RTT Open Pathway Target**

The Trust achieved 92.31% against the 92% target for November. December data is currently being validated for the submission date in mid-January. At the time of writing the unvalidated position is 91.48% and is likely to improve.

All business managers are attending the regional demand and capacity training events being held during January 2016

3. **Admitted and Non-Admitted Targets**

It is unlikely that the Trust will reach the admitted and non-admitted targets due to:-

- The impact of the doctors strike that resulted in 95 patients requiring to be rescheduled;
- Lower levels of patients accepting appointments during the Christmas and New Year period (for both outpatients appointments and surgery) which is affecting the target. There is no seasonal profiling for the target;
- Capacity issues in the Oral/Max Fax specialities which are described in more detail in the paper.

However these two are no longer national targets

4. **Monitor Cancer Standards**

Cancer targets were met for October with the exception of the 62-Day where one breach was solely attributable to QVH. The issue was that cancer was not originally suspected and so the additional diagnostics to ascertain the correct diagnosis lengthened the pathway. All of the remaining breaches in the month involved patients on a shared pathway with other Trusts in skin and breast. This will continue to be a risk for the Trust. Please note that the national cancer reporting timeline is always retrospective by two months.

5. **Activity Plan**

Please see detailed notes below

6. **Delivery Plan**

The additional delivery plan has achieved to date.

Key Performance Indicators

18 weeks

7 **Open pathways**

In line with the new guidance only the open pathway position is now reported. The Trust achieved the target in November at 92.31%

Actions for December 2015

- A new weekly report is now produced that focuses on long waiting patients. This is a particular issue as we get very late referrals from other Trusts. This will ensure that we are alerted to these in a timely manner, can take remedial action in a timely manner, put any learning in place and prevent 52 week breaches;
- We are re-focusing of trackers work to working more closely with Business Managers on specific areas to ensure backlogs are managed proactively;

8 **Cancer**

Summary of Performance for October 2015

Targets	Achievement	National Average	Operating Standards	Total pts	Breaches
2WW	97.2%	93.2%	93%	143	4
31-Day	96.0%	97.6%	96%	66	3
31-day Subsequent Tx	96.2%	97.9%	94%	53	2
62-DayGP to 1st Tx	82.0%	82.5%	85%	25	4.5
62-Day Consultant upgrade to 1st Tx	100%	94.0%	85%	2	0

Cancer targets were met with the exception of the 62-Day where one breach was solely attributable to QVH. The issue was that cancer was not originally suspected and so the additional diagnostics to ascertain the correct diagnosis lengthened the pathway. All of the remaining breaches in the month involved patients on a shared pathway with other Trusts in skin and breast.

The Trust's cancer waiting time performance is particularly sensitive to any changes in activity due to low levels of patients treated at QVH, complex multi-organisational pathways and late secondary referrals. Late referrals from off sites are a recurrent issue.

Actions

- Liaison with management teams off site to improve processes for joint pathways;
- Contacting individual trusts when an immediate breach has occurred due to unavailability of visiting consultant or any other reason, raising our concern and asking them to review systems;
- Liaise with health records manager regarding the cancer administration team having full access to all oncology referrals.
- Implement a 2week wait proforma – this has previously been highlighted with the commissioners
- New skin 2WW path ways for management of referrals being developed and will commence in January 2016 after communication with GPs and CCGs.

Business Unit Specific Operational and Performance Issues
Maxillofacial

9 **RTT – Oral Maxillofacial Surgery**

Oral Maxillofacial surgery has focused on reducing the backlog patient numbers. In November this has resulted from a significant reduction in the number of backlog patients being treated by 66 patients. This trend is set to continue and as of the time of waiting there are 70 long waiters (greater than 18 weeks) being treated in December. This will help deliver and sustain the open pathway target.

As part of the business planning process work is being undertaken with colleagues in the information to populate the IMAS Modelling Tool to enable demand/capacity management and to produce a demand and capacity plan for a sustainable waiting list. This is likely to highlight a demand and capacity gap

10 **Activity**

Max Fax moved by -1 in month from 61 (M7) to 60 (M8) against the month plan of 64. This is against a monthly average (M1 -7) of 74. However this average includes 2 months where double the activity was undertaken due to a theatre productivity pilot and a focus on backlog reduction. Otherwise the activity in month is broadly inline.

Other points to note are:-

- October included the half term holiday. Leave was high however the operating lists were maintained with Registrars doing the lists and so this meant more high volume cases. For Max Fax meant predominantly teeth extractions. Hence day case activity was 261 against a plan of 236. In November the plan was exceeded but only by 4 cases and this suggests that there was a less rich casemix going through;
- With respect to inpatient activity there were 60 cases treated against a plan of 64. Again this is being investigated to see whether this was a casemix issue;
- It was noted that in the information provided to the team that the Critical Care bed days activity was down. However it was found that this was due to a timing of the information data set as data from ICU shows that the bed days for OMF were as expected.

Plastics

11 **Breast**

Overall day case and elective activity in month 8 was 136 cases above plan but income was below plan by £16K due to case mix. This is a recurring trend throughout the year due to more day case surgery being undertaken. This has been incorporated into the business planning for 16/17.

12 **Burns**

Overall day case and elective active is 463 cases above plan in month 8 but £29K below income plan. This is a recurring trend throughout the year due to more day case surgery being undertaken.

Non-elective activity was 10 cases below plan – however this activity cannot be predicted or planned for.

13 **Hands**

Hands continue to underperform on elective cases by 20 in month 8 and 142 year to date. This downward trend matches previous years.

Non-elective cases were 72 below plan in month but non-elective activity within plastics needs to be recorded as one line for breast; hands and skin due to the activity being recorded per Consultant not procedure. This is currently being looked at so that the decreases in activity can be better understood. To date non-elective activity in plastics (excluding burns) is 116 cases above plan.

14 **Skin**

Overall day case and elective activity in month 8 was 12 cases above plan but income was below plan by £10K due to case mix. This is a recurring trend throughout the year due to more day case surgery being undertaken

15 **Trauma Theatre**

Activity within trauma since opening of second trauma theatre in September continues to be monitored monthly. In October 3 cases were induced after 10pm and in November 7 cases were induced after 10pm. In November 329 trauma cases were undertaken compared to 307 in November 2014. This is a decrease from the 378 cases in October but would be an expected seasonal decrease due to the nature of trauma undertaken

16 **Eyes**

Overall activity is behind plan in terms of OPD and follow up appointments. The eye unit are above plan on elective surgery. The mitigation plan that was submitted to the board in September to close this gap identified that the eye department could deliver an additional 12 cataracts a month. The department have consistently delivered 40 to 60 more cataracts a month compared to the 80 on average being delivered between March 2015 and August's 1015.

16.1 We are forecast to better last years activities by 3,543 rather than the 783 highlighted in M3 and the highest ever amount of activity by the service. We have already achieved last years total activity. This is a straight line extrapolation from M8 so does not take into account seasonality.

16.2 This also demonstrates the additional 12 monthly cataracts as required by the delivery plan has been achieved.

16.3 The department are delivering on average 130 cataracts a month instead of 80 by carrying out activity in main theatres and additional Saturday lists. The longer term plan is to utilise the DTC to support further throughput and maximise the theatre capacity in both main theatres and DTC. In order for this area to be utilised additional equipment is required and has gained approval to be ordered. This will allow up to an additional 15 lists to be undertaken per month.

16.4 The recruitment process for the 5th consultant has taken place and the Consultant who is a specialist in glaucoma will start on the 4th January 2016.

16.5 The Centre for Sight flood that took place in October continues to have significant impact on our services with all work relocated to Surrey. Unfortunately it is unlikely that we will move back to the CFC until March 2016. CFC are reviewing their offer of lists and we are working closely with them to support additional activity in Surrey.

16.6 The Eye department will resubmit the Business case for the purchase of laser equipment at QVH through the business planning process.

17 **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 significant increase in referrals since the start of this calendar year which has led to capacity pressures for overnight diagnostic testing and ventilator treatment.

17.1 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.

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

17.3 Sleep has appointed band 4 trainees into the sleep technician role .They will be able to increase activity with additional clinics and day cases from the 2nd of November following appropriate training and competency sign off.

17.4 A Band 3 post has also been appointed to which enable will sleep services to treat an additional patient every night (6 in total 6 nights a week) by the end of November. We are appointing into the administrative post now as the band 3 post was an internal applicant.

17.5 Sleep business unit are confident that they can deliver the additional activity to support the activity plan

18 **Clinical Support Services**

Following AQP accreditation, the new Community Urology Service went live in October. Referrals have been slow to start, but have allowed the service to be mobilised in a manageable way without incurring significant staffing costs. The trust has now successfully undertaken it first outpatient procedures and flexible-cystoscopies. There will now be further communications to promote this service and the first satellite clinic is planned for January/February

The radiology department has now taken over the management of diagnostic imaging services in High Weald Lewes and Havens on behalf of Sussex Community Trust. QVH has played an active role in getting the services back on track with reduced waiting and reporting times which has been appreciated by SCT.

19 **Cancelled Operations**

There were 9 trauma operations cancelled on the day of admission in November all of which were re-booked appropriately.

There were 7 elective operations cancelled on the day of admission in November – 6 of which were rebooked within 28 days and 1 of which was booked at 30days.

A more robust escalation process to manage elective cancellations is being set up by the Business Managers

20 **MIU**

The Trust MIU performance in November was 98.2%.

21 **Link to Key Strategic Objectives**

- Outstanding patient experience
- Operational excellence
- Financial sustainability

22 **Implications for BAF or Corporate Risk Register**

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

23 **Regulatory impacts**

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

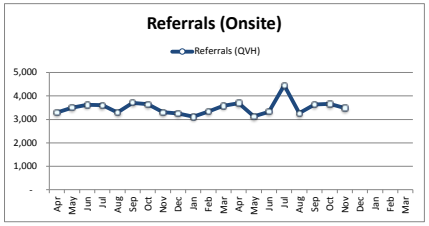
The Committee is recommended to note the contents of the report.

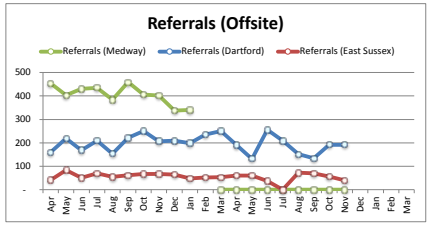
Queen Victoria Hospital NHS
NHS Foundation Trust

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

Trust Level Report (All Services)
Period : 2015-16 Month 8 (November)

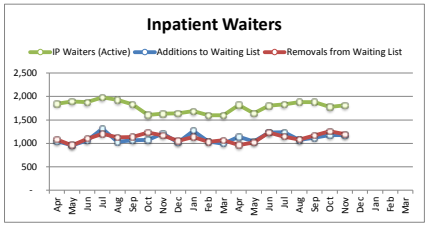
DEMAND

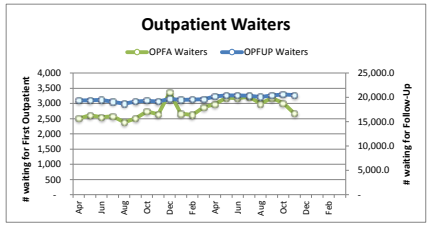




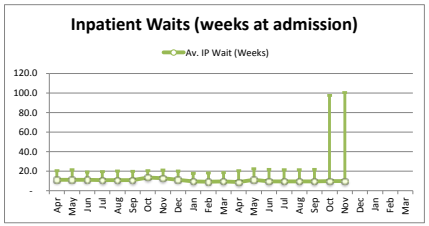
incomplete referrals data available at the time of publication:
- progressing with K&M HIS this month
Alternative provison being actively investigated.

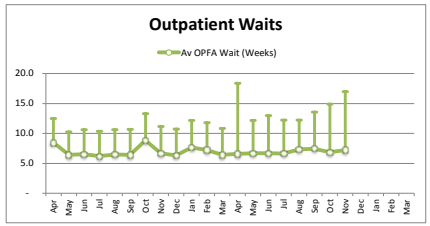
WAITING LIST





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.

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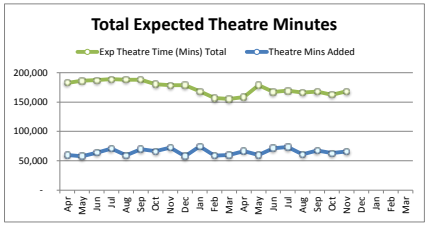
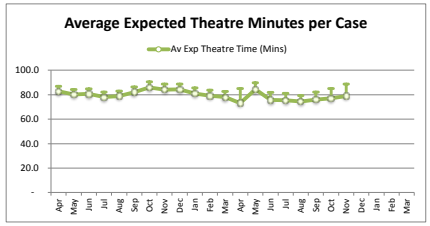
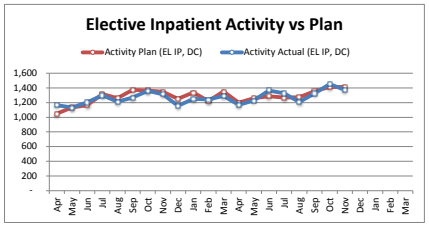
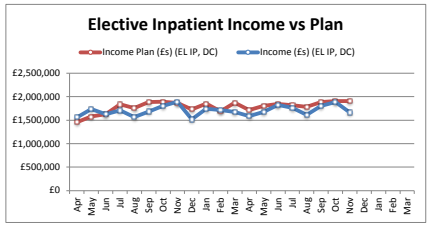
THEATRE MINS



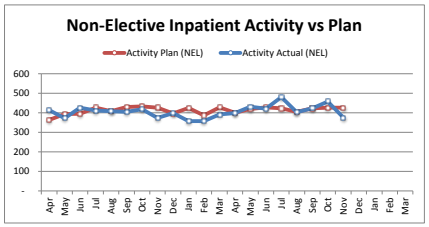


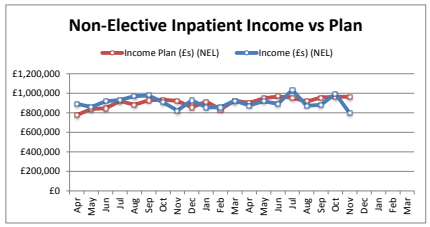
Elective Inpatients





Non-Elective Inpatients





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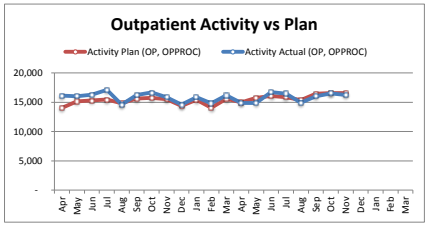
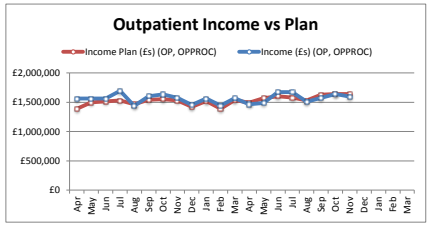
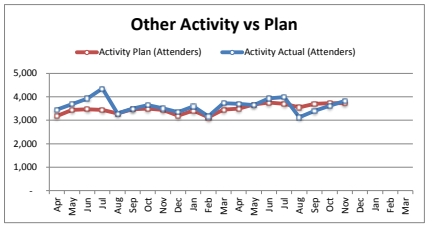
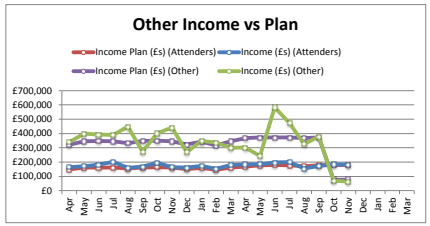
Outpatients





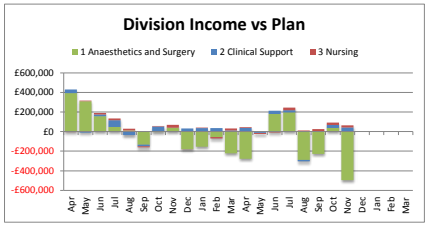
Other Activity/Income

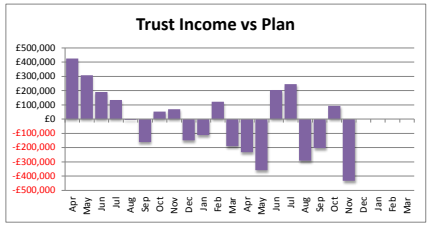




"Other" income is Excluded Drugs and Devices
"Attenders" is a combination of Radiology and MIU activity

Income vs Plan





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

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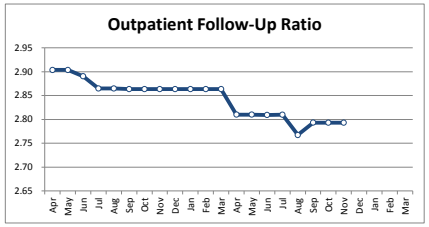
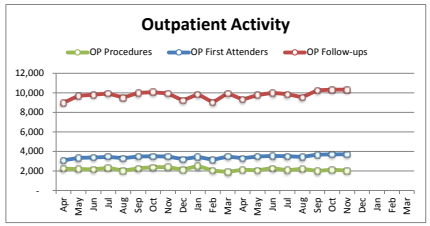
Follow-up Ratios





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	Sep-15	Oct-15	Nov-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%	90.71%	90.03%	86.19%		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%	93.3%	95.01%	93.77%		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%	95.79%	95.46%	93.6%	TBC	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%	99.6%	100.0%	99.00%	99.65%	99.53%	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%	98.97%	98.89%	98.92%	98.47%	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%	94.3%	91.0%	97.20%	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	#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%	98.1%	98.3%	94.5%	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%	98.1%	100.0%	97.95%	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%	81.1%	72.7%	82.0%	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	100.0%	0.0%	#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%	#N/A	60.0%	100.0%	TBC	% of Service Users waiting no more than 62 days for 1st definitive treatment following a consultant's decision to upgrade the priority of the Service User (all cance	85%
	1			0			0			0		0	0	0	0	0	0	0	1	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	0	0	0	Zero tolerance MRSA	0
0	0	0	0	0	0	1	0	0	0	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	TBC	TBC	TBC	Zero tolerance RTT waits over 52 weeks for incomplete pathways	0
99.2%	99.3%	99.5%	99.4%	99.4%	99.4%	99.4%	99.4%	99.5%	99.5%	99.5%	99.5%	99.5%	99.3%	99.5%	99.6%	TBC	TBC	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%	99.6%	TBC	TBC	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%	97.4%	TBC	TBC	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	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%	97.4%	97.2%	97.8%	92.4%	93.2%	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	TRUE	TRUE	TRUE	Publication of Formulary	TRUE
0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Never Events	0

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**17-16**	
Report title:	**Financial performance**				
Sponsor:	Clare Stafford, Director of Finance				
Author:	Jason McIntyre, Deputy Director of Finance				
Executive summary					
Purpose:	The report details the trust's financial performance for the eight months to 30 November 2015. The trust delivered an actual surplus of £35k for the month, £197k lower than planned and £225k below forecast. The cumulative surplus is £606k which is £388k behind plan.				
Recommendation:	The committee is asked to note the contents of this report.				
Purpose:		Information		Assurance	
Link to key strategic objectives (KSOs):			KSO3:	KSO4:	
			Operational excellence	Financial sustainability	
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	The trust has continued to achieve a Monitor financial sustainability risk rating (FSRR) of 4.				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	21/12/15	Decision:	Noted	

Queen Victoria Hospital
NHS Foundation Trust

Finance Report
November 2015

Executive Director: Clare Stafford

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Queen Victoria Hospital NHS
NHS Foundation Trust

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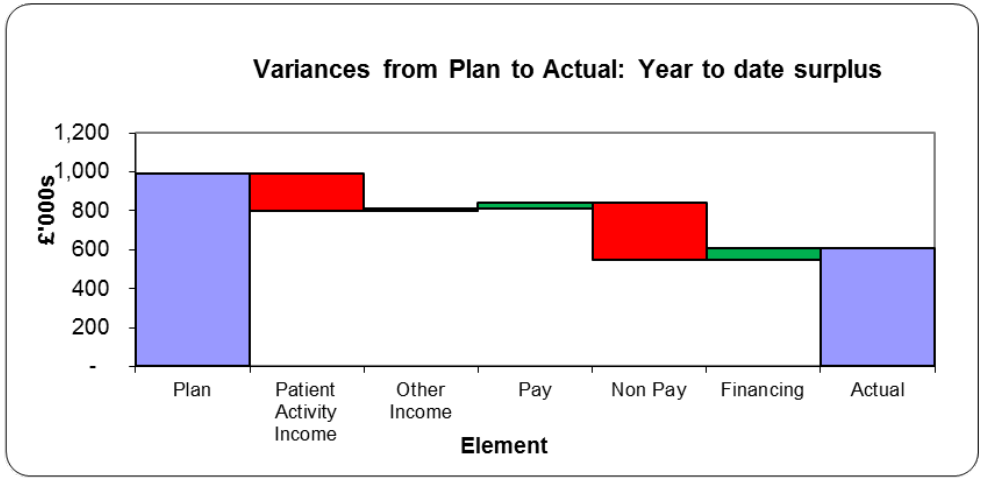
Summary Actual Position – YTD M08 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Financial Performance	2015-16	November 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	4,744	5,050	(306)	39,077	39,269	(192)
Other Income	4,346	364	343	21	3,027	3,017	10
Pay	(40,994)	(3,502)	(3,416)	(86)	(27,301)	(27,331)	29
Non Pay	(16,987)	(1,269)	(1,416)	147	(11,621)	(11,327)	(294)
Operational EBITDA	**4,970**	**338**	**561**	**(223)**	**3,182**	**3,629**	**(447)**
as a %	*7.9%*	*6.6%*	*10.4%*	*-3.8%*	*7.6%*	*8.6%*	*-1.0%*
Financing	(3,953)	(303)	(329)	26	(2,576)	(2,635)	59
Current Year Surplus / (Deficit)	**1,017**	**35**	**232**	**(197)**	**606**	**994**	**(388)**
Surplus (Deficit) %	1.6%	0.7%	4.3%	-3.6%	1.4%	2.3%	**-0.9%**

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



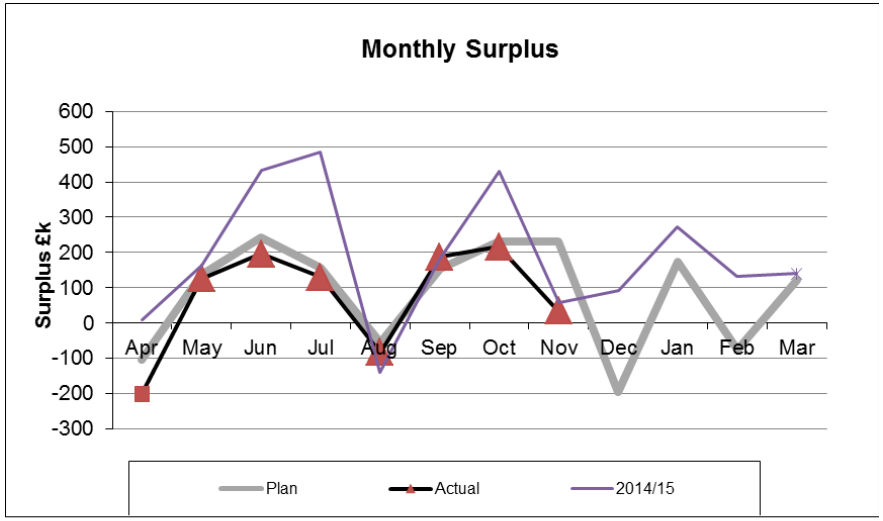
Summary

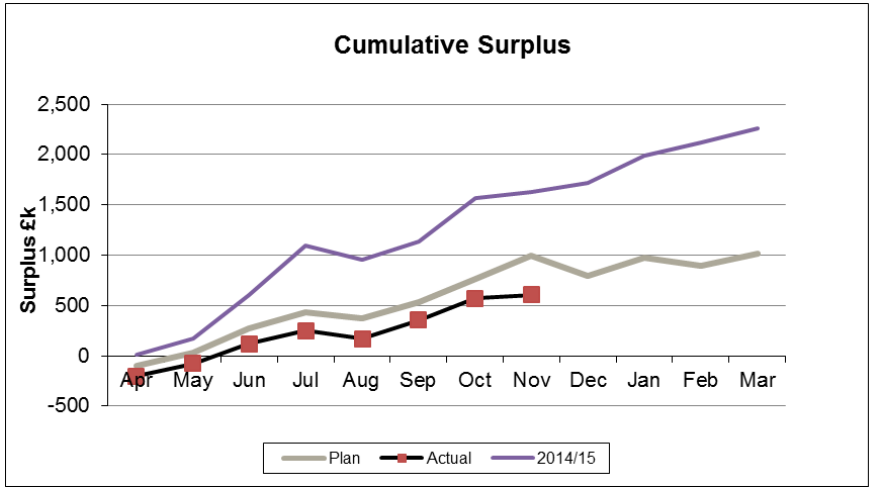
- The Trust delivered a surplus of £35k in month compared to £216k last month, increasing the YTD surplus to £606k, £388k below plan.
- There has been a material deterioration in performance; an adverse variance to plan (£197k) and the forecast (£225k). The movement is largely due to an unanticipated reduction in clinical income, principally within non- elective and elective points of delivery.
- Clinical Income under recovered by £306k in November(£394k less than forecast) The key drivers are (see appendix 6):
  - Non-Elective activity, which has underperformed against plan and trend within hands and burns service lines, which have had 81 fewer spells in month compared to YTD average trend, an indicative loss of income of £176k.
  - Elective activity, which has underperformed against plan and year to date trend. This is largely within burns, skins, breast and maxillofacial service lines, in which there have been 55 fewer spells in month compared to the YTD average trend, an indicative loss of income of £168k.
- Pay has overspent by £86k in month (£33k more than forecast) due to additional agency expenditure within theatres and corporate areas. In addition there has been unanticipated Medical ENT expenditure in month.
- Non Pay is underspent by £173k (£394k less than forecast) - £147k non pay and £26k financing) in month due to a benefit from a validation review of open purchase orders. In addition depreciation charge is less than anticipated although there remains underlying pressures due to CIP slippage and cost pressures on clinical supplies and SLAs.
- The key variance to the YTD plan is a shortfall of inpatient income partially offset by critical care income. There are also significant pressures within expenditure.
- The delivery plan marginally over delivered in month and Cip delivery was in line with forecast.
- The financial sustainability risk rating remains at 4;due to the YTD position

Actions

- The Trust needs to develop and implement additional interventions to recover current underperformance to ensure delivery of plan by the end of the year.

Surplus Trend Position – M08 2015/16





Summary

- The in month surplus is £35k against the plan of £232k, increasing the year to date surplus to £606k.
- M8 Performance is below plan and forecast which challenges the Trust to over deliver against delivery plan in the remainder of the year to meet the year end forecast.
- The Trust is expecting significant surpluses in January and March to offset the limited income expected in December and February due to reduced working days and the impact of holidays.
- The Trust now needs to generate an average monthly surplus of £103k in the remaining months of the year to deliver the planned surplus.

Activity Performance by POD : M08 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

November 2015	Previous	Previous	Previous	Previous	Previous	Previous	Previous	Average YTD	Variance to Average	Current Month Activity			Year To Date Activity		
Activity by Point of Delivery	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**Actual**	**Actual**	**Actual**	**Plan**	**Variance**	**Actual**	**Plan**	**Variance**
Elective	372	369	374	374	324	390	360	***366***	*-15.1%*	**311**	421	-110	2,874	3,313	-439
Non Elective	411	447	451	530	420	445	478	***455***	*-13.8%*	**392**	438	-46	3,574	3,448	126
Day Case	853	881	1,028	1,031	902	993	1,092	***969***	*9.6%*	**1,062**	990	72	7,842	7,425	417
Critical Care Days	28	107	119	69	40	45	51	***66***	*-51.2%*	**32**	49	-17	491	382	109
Minor Injuries	1,028	1,065	1,103	1,156	974	999	1,024	***1,050***	*-12.5%*	**919**	1,033	-114	8,268	8,129	139
Exclusions	12	29	24	30	25	37	31	***27***	*-59.0%*	**11**	0	11	199	0	199
Outpatient Procedure	2,708	2,449	2,633	2,670	2,485	2,315	2,452	***2,530***	*-1.4%*	**2,495**	2,770	-275	20,207	21,797	-1,590
Outpatient First Attendance	3,270	3,501	3,776	3,907	3,187	3,496	3,678	***3,545***	*0.3%*	**3,556**	3,702	-146	28,371	28,393	-22
Outpatient Follow Up	10,000	9,494	10,673	10,754	9,293	10,544	10,691	***10,207***	*4.1%*	**10,626**	10,341	285	82,075	79,455	2,620
Radiology	2,328	2,283	2,363	2,271	1,867	2,101	2,296	***2,216***	*11.0%*	**2,460**	2,425	35	17,969	19,075	-1,106

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

Summary

The table shows patient activity levels (as per SLAM) against plan by the point of delivery (POD), monthly for the year to date, April to November 2015, and compares the current month activity with the average of the previous period year to date.

This table highlights the material reduction in activity in month and the continued under performance in elective inpatients and outpatient procedures . Although there is a known timing issue with the coding of outpatient procedures a central adjustment has been made to completed to address.

The key drivers in month 8 are:

- Non-Elective activity, which has underperformed against plan and trend within hands and burns service lines. Non elective activity by its nature is more difficult to predict.
- Minor injury activity has been the lowest in month performance since the beginning of the financial year . Although income loss is modest this does impact on non elective performance.
- Elective activity, which has underperformed against plan and year to date trend. This is largely within burns, skins, breast, and maxillofacial service lines.

Risks

The failure to address the activity and income under recovery will impact on the ability of the Trust to meet surplus target for the year.

Action

Additional recovery interventions have been developed to address the shortfall. Interventions of circa £0.4m have been identified which are currently being finalised.

Divisional Performance Position – YTD M08 2015/16

Queen Victoria Hospital NHS
NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for November 15-16			Total Year To Date		
November performance against financial plan	CMV	YTDV	CMV	YTDV	CMV	YTDV	CMV	YTDV	Annual Budget	Actual	Budget	Variance	Actual	Budget	Variance
Operations															
1.1 Plastics	(221)	61	(2)	(17)	(14)	(95)	4	(45)	24,078	1,840	2,074	(234)	16,159	16,255	(96)
1.2 Oral	(69)	(36)	1	14	(11)	41	(3)	(46)	7,032	531	613	(82)	4,754	4,781	(27)
1.3 Eyes	(92)	(412)	(16)	(28)	1	53	2	(96)	3,880	274	379	(105)	1,958	2,441	(483)
1.4 Sleep	6	(200)	0	0	(3)	14	(2)	110	2,013	176	174	2	1,285	1,361	(75)
1.5 Clinical Support	61	113	(12)	(23)	3	65	9	(15)	(2,025)	(101)	(162)	61	(1,190)	(1,330)	140
1.6 Other Med & Admin	-	-	23	24	(2)	(11)	(5)	21	35	19	3	16	58	23	34
Operations Total	**(315)**	**(475)**	**(6)**	**(29)**	**(26)**	**68**	**5**	**(71)**	**35,014**	**2,738**	**3,081**	**(343)**	**23,024**	**23,531**	**(507)**
Nursing & Clinical Infrastructure															
2.1 Clinical Infrastructure	21	73	(4)	17	(12)	58	(55)	(455)	(18,984)	(1,629)	(1,579)	(50)	(12,953)	(12,646)	(307)
2.5 Director Of Nursing	-	-	33	25	(14)	(13)	2	34	(1,406)	(91)	(112)	21	(912)	(957)	45
Nursing & Clinical Infrastructure	**21**	**73**	**29**	**41**	**(26)**	**44**	**(53)**	**(421)**	**(20,390)**	**(1,720)**	**(1,691)**	**(29)**	**(13,865)**	**(13,603)**	**(262)**
Corporate Departments															
3.1 Non Clinical Infrastructure	-	-	0	3	10	57	13	37	(4,289)	(333)	(357)	24	(2,762)	(2,859)	97
3.2 Commerce & Finance	1	38	0	1	(25)	(181)	6	(33)	(1,556)	(148)	(130)	(18)	(1,212)	(1,037)	(175)
3.4 Finance Other	(13)	171	(0)	(7)	11	134	232	396	(4,992)	(211)	(441)	229	(2,496)	(3,191)	694
4.1 Human Resources	-	-	(1)	(15)	(9)	(22)	(5)	(8)	(755)	(77)	(63)	(14)	(547)	(503)	(44)
5.4 Corporate	-	-	-	-	(29)	(127)	(22)	(87)	(1,850)	(205)	(154)	(51)	(1,448)	(1,234)	(214)
6.1 Research	-	-	(1)	15	3	18	(4)	(46)	(41)	(5)	(3)	(2)	(40)	(28)	(13)
6.2 Clinical Audit	-	-	-	-	6	38	0	(3)	(124)	(4)	(10)	6	(48)	(83)	35
Corporate Total	**(12)**	**210**	**(2)**	**(2)**	**(33)**	**(83)**	**221**	**257**	**(13,607)**	**(984)**	**(1,158)**	**174**	**(8,554)**	**(8,935)**	**382**
QVH Total	**(306)**	**(192)**	**21**	**10**	**(86)**	**29**	**173**	**(235)**	**1,017**	**35**	**232**	**(197)**	**606**	**994**	**(388)**

Key:
Figures are all in £thousands.
Variance of Performance is shown as Actual reported income and expenditure minus the Plan (Budget). Therefore a negative or bracketed figure is an adverse variance of underachieving income or overspending on expenditure against plan.
Performance is shown for the reporting month just completed and for the cumulative performance for the financial year to date
CMV: Current month variance **YTDV**: Year to date variance
Total budgets for an area are positive where the area has a net income target, i.e. the key clinical specialities which generate patient activity income.

Summary

Material Variances in month:

- Income: Patient activity income position is £(306)k, significantly behind plan for the month, giving a year to date under-performance of £(192)k. (see appendix 1 for detail by service line/speciality and appendix 7 for an activity variance extract). This is largely with Plastics, Eyes and Oral service lines.
- Pay: £(86)k overspent in the month due to additional agency expenditure within theatres and corporate areas. In addition there has been additional Medical ENT expenditure.
- Non-pay: has underspent by £173k in month due to a benefit from a validation review of open purchase orders. In addition depreciation charge is less than anticipated due to the re-phasing of the capital programme. There remains underlying pressure clinical supplies partially due to CIP slippage and SLAs cost pressures.
- There has been a material deviation from the forecast position largely within operations due to shortfall in clinical income in month, principally within plastics, oral and eyes service lines partially offset by underspends within corporate areas.

Year-to-date:

- Operations performance is £(507k) behind plan for the year-to-date and £(343k) behind on the month with the Eyes Service line contributing the majority of the underperformance. Clinical infrastructure overspend is mainly within theatre and burns centre clinical supplies. Key drivers continue to be CIP slippage, clinical supplies and SLA cost pressures.

CIP & Delivery Plan – YTD M08 2015/16

Queen Victoria Hospital NHS Foundation Trust

Cost Improvement Programmes	Annual Plan £000's	YTD Plan - Month 8 £000's	Achieved £000's	Achieved %	Shortfall £000's
Other Income	74	49	12	24%	(37)
Pay	662	383	281	73%	(102)
Non Pay	927	600	388	65%	(212)
Total Cost Improvement Programmes	**1,663**	**1,032**	**682**	**66%**	**(351)**

CIP Programme

- At M8 the Trust has achieved savings of £682k YTD which represents 66% of the CIP planned for the year to date. There is slippage of £351k.
- The in month delivery is in line with expectations.
- The Trust is forecasting saving of £1,092k for the year – expected delivery of 66% of plan. This excludes the impact of delivery plan actions.

Intervention Plans	M8 £k	M8 Actual £k	M8 Var £k	YTD M8 £k	YTD Actual £k	YTD Var £k	Annual Plan £k
Tactical Savings	6	27	22	25	59	34	47
Activity Interventions, risk rated contributions	49	37	(13)	80	51	(29)	278
Additional Cost Savings	8	7	(1)	11	10	(1)	52
Total	**63**	**71**	**8**	**116**	**121**	**4**	**378**

Delivery plan

- The interventions schemes identified as part of the delivery plan overperformed in month by £8k and against YTD plan by £4k .
- In month £71k savings were realised against a plan of £63k. Tactical savings exceeded plan by £22k which fully offsets the shortfall on activity interventions - trauma. The YTD position is £121k delivered against the plan of £116k.
- For further scheme details see appendix 6.
- The Trust has delivered combined savings of £803k YTD which represents 78% of original CIP plan.

Balance Sheet – YTD M08 2015/16

Queen Victoria Hospital NHS Foundation Trust

Balance Sheet at: Month 8 2015/16	2014/15 Outturn £000s	Current Month £000s	Previous Month £000s
Non-Current Assets			
Fixed Assets	37,705	36,969	36,973
Other Receivables	-	-	-
Sub Total Non-Current Assets	37,705	36,969	36,973
Current Assets			
Inventories	440	457	441
Trade and Other Receivables	8,351	6,033	6,871
Cash and Cash Equivalents	6,548	10,618	9,700
Current Liabilities	(7,880)	(8,667)	(8,610)
Sub Total Net Current Assets	7,459	8,441	8,403
Total Assets less Current Liabilities	45,164	45,410	45,376
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**	**37,027**	**36,993**
Tax Payers Equity			
Public Dividend Capital	12,237	12,237	12,237
Retained Earnings	18,382	18,990	18,955
Revaluation Reserve	5,801	5,801	5,801
Total Tax Payers Equity	**36,420**	**37,027**	**36,993**

NB Analysis is subject to rounding differences

Summary

- Net current assets increased marginally in month.
- Trade and other receivables have reduced due to the receipt in month of central funding for the EDM scheme and cash balances increased accordingly.
- Theatre loan repayments of £0.4m in June and December will reduce non-current liabilities will reduce in year. 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 £0.2m PA.

Issues

- Sufficient cash balances need to be generated by the Trust to provide liquidity, service the capital plan and meet the requirements of Monitor's Financial Sustainability measures.

Actions

- Further details of actions taken to ensure robust cash management processes are outlined on the debtor and cash slides.

Capital – M08 2015/16

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	2	7	180	(32)
Jubilee refurbishment	377	92	11	116	(261)
Consultants' offices	130	119	-	125	(5)
Other projects	96	153	4	188	92
Estates Total	**880**	**405**	**22**	**648**	(232)
YTD Plan		790			
YTD Estates variance		(385)			
Medical Equipment	**690**	**308**	**30**	**690**	-
YTD Plan		433			
YTD Medical Equipment variance		(125)			
IT Equipment & Software					
Infrastructure improvement	2,000	136	2,136	2,272	272
Electronic Document Management (EDM)	590	-	844	844	254
Other projects	360	15	6	66	(294)
IT Total	**2,950**	**151**	**2,986**	**3,182**	232
YTD Plan		1,392		2,950	
YTD IT variance		(1,241)			
Total capital spend	**4,520**	**864**	**3,038**	**4,520**	**-**
YTD Plan		**2,616**			
YTD Total Variance		**(1,752)**			

Summary

- Capital YTD expenditure is £864k which is £1,752k (67%) below nominal plan.
- The medical devices allocation will be fully spent as there are bids approved in principle, but awaiting final business case approval.
- The IT allocation is dependent on the delivery of the IT Infrastructure Improvement Programme (IIP) and Electronic Document Management (EDM). The accounting treatment of the costs and revenues associated with the EDM project have been finalised. The equipment element of the project is now expected to be ahead of plan by nearly £254k at year-end. This will be offset by reductions in later years. As previously noted, expenditure on the IIP project is also expected to be £272k ahead of the annual plan, but this will be offset in 2015/16 by slippage in other projects and by reduced spend in 2016/17.

Issues

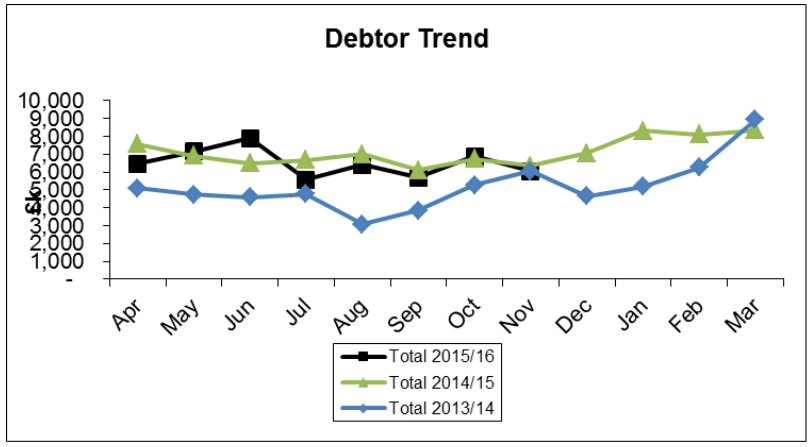
- The capital programme is behind the nominally phased plan but this is expected to be recovered in the remainder of the year as the IT programmes progress in last quarter of the financial year.

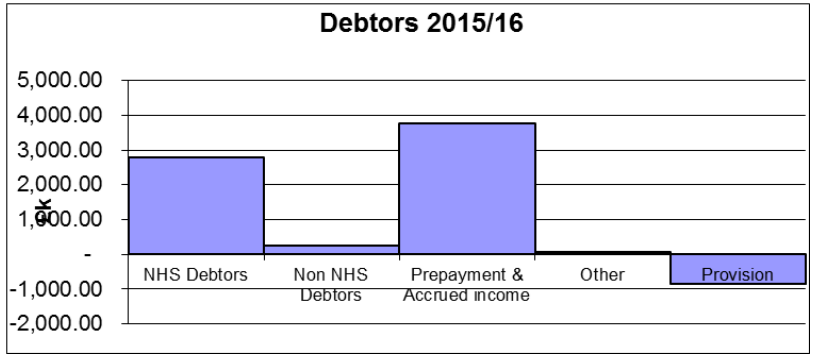
Actions

- The Capital planning group will meet on 22 December to review risks re the delivery of the 2015-16 programme.
- The DSU option for the Trauma Centre is being evaluated.

Debtors – M08 2015/16

Queen Victoria Hospital NHS Foundation Trust





Summary

- The debtor balance decreased by £838k from month 7 largely due to payments received from NHS England , funding the EDM project.
- The month 8 debtor balance of £6.03m continues to be below the average monthly balance in 2014-15 of £7.1m. This is largely due to faster resolution of monthly performance invoices with local NHS bodies.

Issues

- There is £1.0m of accrued income for activity over-performance and NCAs which has reduced by £0.4m compared to the previous month.

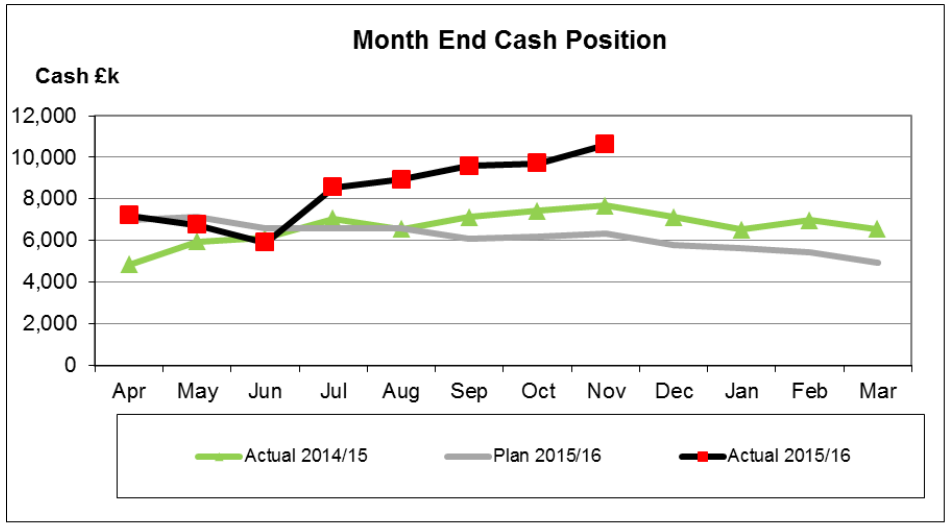
Risks

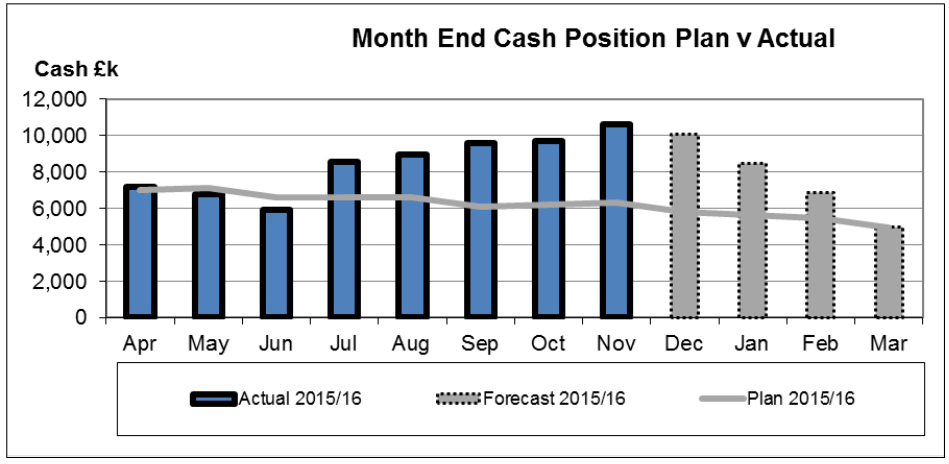
- Delays to billing of performance reduce the probability of collection of debts in full.
- Delayed payments of over-performance negatively affects cash balances.

Actions

- Financial services team is currently targeting aged debt with other NHS bodies in advance of the agreement of balances exercise.
- The billing process for commissioners has been reviewed with changes in processes being implemented to improve standard operating procedures .

Cash – M08 2015/16





Summary

- The in month cash position is favourable on the basis of current liquidity and debt service ratios.
- The cash balance at month 08 is £10.6m, an increase of £0.7m from M7.

Issues

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

Risks

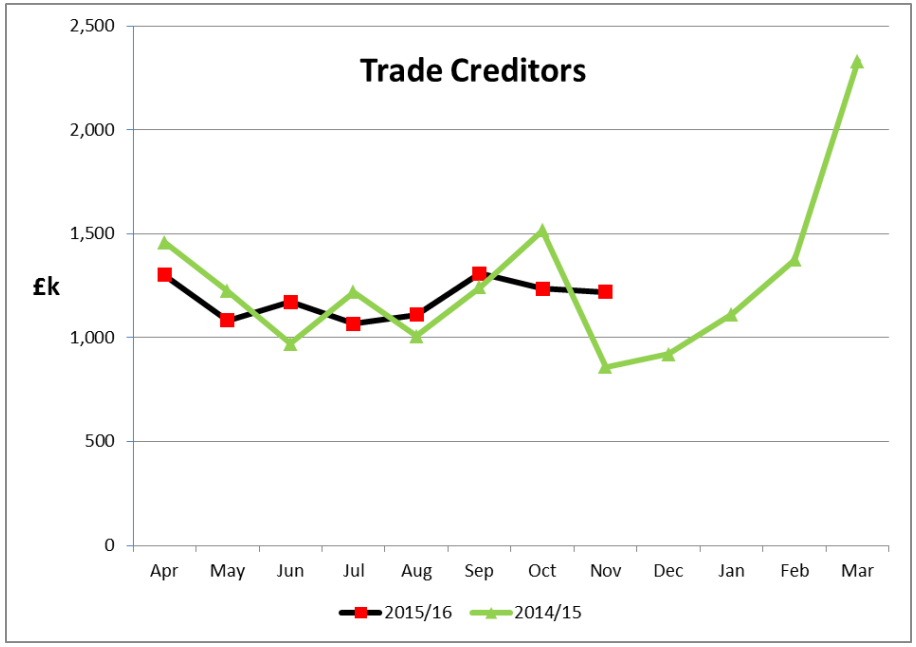
- Deterioration of I&E performance or delays in payment of debt will impact on liquidity and ability to maintain appropriate Monitor ratings.
- The full delivery of the capital programme in line with revised phasing.

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 – M08 2015/16

Queen Victoria Hospital NHS Foundation Trust



Better Payment Practice Code (15/16) November	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	1,605	1,582	11,685	13,095
Total **Non NHS** trade invoices paid within target	10,806	11,312	1,270	1,157	9,729	10,518
Percentage of Non-NHS trade invoices paid within target	**68%**	**68%**	**79%**	**73%**	**83%**	**80%**
Total **NHS** trade invoices paid	933	5,241	87	305	613	2,948
Total **NHS** trade invoices paid within target	505	3,037	48	130	424	1,973
Percentage of NHS trade invoices paid within target	**54%**	**58%**	**55%**	**43%**	**69%**	**67%**

Summary

- Trade creditors at month 8 is now an average of £1.19m in year compared to £1.27m during 2014-15.
- Better Payment Practice code (BPPC) YTD performance for both NHS and Non-NHS suppliers dropped in month due to the payment of a number of overdue items that had been in dispute or were received late by the Finance department
- The total volume paid has increased in month by 10% (150 invoices), but decreased in value by £384k (17%).
- Savings from prompt payment discounts taken in month amounted to £2k in line with plan

Issues

- The Trust is implementing a prompt payment programme where supplier savings have been secured based on favourable invoice payment terms.
- Currently the trust's BPPC calculation does not adjust for certain delays to payments, such as invoices being held in dispute. This has an adverse effect on the reported value of BPPC.

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

- The phased full roll out of online authorisation is on-going in line with plan.

Appendices

Appendix 1: Departmental Performance Summary – M08 2015/16

Queen Victoria Hospital NHS Foundation Trust

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for November 15-16			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	(2)	(45)	(1)	(5)	(6)	(23)	1	(17)	3,850	323	331	(8)	2,508	2,597	(89)
1.12 Burns	16	272	(0)	(4)	7	15	1	8	6,184	552	529	23	4,456	4,164	291
1.13 Hands	(247)	(909)	(0)	(3)	3	18	(1)	(41)	12,943	865	1,111	(246)	7,792	8,726	(934)
1.14 Skin	13	741	(1)	(6)	0	3	(1)	(11)	4,457	394	382	12	3,732	3,004	728
1.15 Plastics	-	2	-	-	(18)	(109)	4	16	(3,355)	(294)	(280)	(14)	(2,328)	(2,237)	(91)
1.1 Plastics Total	**(221)**	**61**	**(2)**	**(17)**	**(14)**	**(95)**	**4**	**(45)**	**24,078**	**1,840**	**2,074**	**(234)**	**16,159**	**16,255**	**(96)**
1.2 Oral															
1.21 Head & Neck	(66)	149	2	22	(17)	(60)	1	(29)	5,725	416	497	(81)	3,971	3,889	82
1.23 Orthodontic	(24)	(252)	(0)	(0)	12	88	(1)	(8)	1,739	139	152	(13)	1,007	1,180	(173)
1.24 Prosthetics	21	67	(1)	(8)	(5)	13	(3)	(9)	(432)	(24)	(36)	12	(224)	(287)	63
1.2 Oral Total	**(69)**	**(36)**	**1**	**14**	**(11)**	**41**	**(3)**	**(46)**	**7,032**	**531**	**613**	**(82)**	**4,754**	**4,781**	**(27)**
1.3 Eyes															
1.31 Corneoplastic	3	(82)	0	0	2	60	(4)	(113)	2,931	264	264	1	1,812	1,947	(135)
1.32 Oculoplastic	(95)	(330)	-	-	0	1	(1)	(7)	897	16	111	(95)	123	459	(336)
1.33 Eye Bank	-	-	(16)	(28)	(1)	(8)	6	24	52	(6)	4	(10)	23	35	(12)
1.3 Eyes Total	**(92)**	**(412)**	**(16)**	**(28)**	**1**	**53**	**2**	**(96)**	**3,880**	**274**	**379**	**(105)**	**1,958**	**2,441**	**(483)**
1.4 Sleep															
1.41 Sleep	6	(200)	0	0	(3)	14	(2)	110	2,013	176	174	2	1,285	1,361	(75)
1.4 Sleep Total	**6**	**(200)**	**0**	**0**	**(3)**	**14**	**(2)**	**110**	**2,013**	**176**	**174**	**2**	**1,285**	**1,361**	**(75)**
1.5 Clinical Support															
1.51 Imaging	36	19	(8)	(13)	(13)	(34)	(6)	(7)	273	34	26	9	157	191	(35)
1.52 Pathology	5	35	1	6	(15)	(81)	(9)	22	(1,493)	(142)	(124)	(18)	(1,013)	(995)	(18)
1.53 Therapies	4	(12)	(7)	(19)	18	143	4	3	(711)	(37)	(56)	19	(350)	(465)	116
1.54 Pharmacy	7	47	2	4	2	18	19	(49)	(80)	23	(7)	30	(34)	(54)	20
1.55 Medical Photography	-	-	1	(2)	2	18	(0)	(4)	(183)	(13)	(15)	2	(110)	(122)	12
1.56 General Specialities	9	23	-	-	9	1	1	21	169	34	15	19	159	115	44
1.5 Clinical Support Total	**61**	**113**	**(12)**	**(23)**	**3**	**65**	**9**	**(15)**	**(2,025)**	**(101)**	**(162)**	**61**	**(1,190)**	**(1,330)**	**140**
1.6 Other Med & Admin															
1.61 Ops Admin	-	-	23	24	(2)	(11)	(5)	21	35	19	3	16	58	23	34
1.6 Ops Admin Total	**-**	**-**	**23**	**24**	**(2)**	**(11)**	**(5)**	**21**	**35**	**19**	**3**	**16**	**58**	**23**	**34**
1 Operations Total	**(315)**	**(475)**	**(6)**	**(29)**	**(26)**	**68**	**5**	**(71)**	**35,014**	**2,738**	**3,081**	**(343)**	**23,024**	**23,531**	**(507)**

Clinical speciality Business Unit 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.

Appendix 1: Departmental Performance Summary – M08 2015/16

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for November 15-16			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)	(2)	0	1	(11)	149	(24)	(258)	(6,949)	(614)	(579)	(35)	(4,743)	(4,633)	(110)
2.12 Elective Care Nursing	-	-	(1)	8	1	(25)	(31)	(21)	(4,916)	(440)	(410)	(30)	(3,315)	(3,277)	(37)
2.13 Emergency Care Nursing	22	75	(2)	26	(9)	(64)	6	(116)	(3,179)	(245)	(262)	17	(2,188)	(2,109)	(79)
2.14 Anaesthetics	-	-	(2)	(18)	6	(6)	(3)	(62)	(3,292)	(273)	(274)	1	(2,281)	(2,195)	(87)
2.15 Appointments & Records	0	0	-	0	1	3	(4)	2	(648)	(57)	(54)	(3)	(427)	(432)	5
2.1 Clinical Infrastructure Total	**21**	**73**	**(4)**	**17**	**(12)**	**58**	**(55)**	**(455)**	**(18,984)**	**(1,629)**	**(1,579)**	**(50)**	**(12,953)**	**(12,646)**	**(307)**
2.21 Risk	-	-	1	(4)	1	8	14	55	(704)	(43)	(59)	16	(410)	(469)	59
2.41 Practice Development	-	-	(1)	(1)	3	17	1	8	124	14	10	4	107	83	24
2.51 Director of Nursing	-	-	32	30	(18)	(39)	(13)	(29)	(826)	(62)	(64)	2	(609)	(571)	(38)
2.5 Director of Nursing Total	**-**	**-**	**33**	**25**	**(14)**	**(13)**	**2**	**34**	**(1,406)**	**(91)**	**(112)**	**21**	**(912)**	**(957)**	**45**
2 Nursing & Clinical Infrastructure Total	**21**	**73**	**29**	**41**	**(26)**	**44**	**(53)**	**(421)**	**(20,390)**	**(1,720)**	**(1,691)**	**(29)**	**(13,865)**	**(13,603)**	**(262)**

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

Variance by type: in £ks	Activity Income		Other Income		Pay		Non Pay		Position	for November 15-16			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	-	-	1	3	5	21	(6)	(62)	(1,748)	(146)	(146)	0	(1,203)	(1,165)	(38)
3.12 Estates	-	-	0	2	0	16	10	67	(1,995)	(156)	(166)	11	(1,244)	(1,330)	85
3.13 IMT	-	-	(0)	(2)	5	20	9	32	(546)	(32)	(46)	13	(315)	(364)	50
3.1 Non Clinical Infrastructure Total	-	-	0	3	10	57	13	37	(4,289)	(333)	(357)	24	(2,762)	(2,859)	97
3.2 Commerce & Finance															
3.22 Commerce	-	37	-	-	(13)	(94)	(1)	(19)	(563)	(61)	(47)	(14)	(451)	(376)	(76)
3.31 Finance	1	1	0	1	(12)	(87)	7	(14)	(992)	(86)	(83)	(4)	(760)	(661)	(99)
3.2 Commerce & Finance Total	1	38	0	1	(25)	(181)	6	(33)	(1,556)	(148)	(130)	(18)	(1,212)	(1,037)	(175)
3.4 Finance Other															
3.41 Financing	-	-	-	50	-	-	26	59	(3,953)	(303)	(329)	26	(2,527)	(2,635)	109
3.42 Reserves	-	-	-	-	11	87	11	90	(690)	(60)	(82)	22	(145)	(322)	177
3.43 Exceptionals	1	1	-	1	-	47	199	253	(23)	198	(2)	200	286	(15)	301
3.44 Contract Penalties	-	-	-	-	-	-	-	57	(650)	(54)	(54)	-	(376)	(433)	57
3.45 Other Income	(14)	12	(0)	(58)	-	-	1	(37)	323	13	27	(14)	132	215	(83)
3.46 Activity Income	-	158	-	-	-	-	-	-	-	-	-	-	158	-	158
3.48 Closed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3.49 Suspense	-	-	-	-	-	-	(5)	(25)	-	(5)	-	(5)	(25)	-	(25)
3.4 Finance Other Total	(13)	171	(0)	(7)	11	134	232	396	(4,992)	(211)	(441)	229	(2,496)	(3,191)	694
3 Finance and Non Clinical Infrastructure Total	**(12)**	**210**	**0**	**(3)**	**(4)**	**10**	**251**	**400**	**(10,837)**	**(692)**	**(928)**	**235**	**(6,470)**	**(7,087)**	**617**
4 Human Resources and Organisational Development															
4.11 Human Resources	-	-	2	14	(8)	(18)	(4)	(10)	(761)	(74)	(63)	(10)	(521)	(507)	(14)
4.21 Education	-	-	(2)	(28)	(1)	(4)	(1)	2	5	(3)	0	(4)	(27)	4	(30)
4 Human Resources and Organisational Development Total	-	-	**(1)**	**(15)**	**(9)**	**(22)**	**(5)**	**(8)**	**(755)**	**(77)**	**(63)**	**(14)**	**(547)**	**(503)**	**(44)**
5 Corporate															
5.11 Board	-	-	-	-	(1)	(2)	(13)	(70)	(654)	(68)	(54)	(14)	(508)	(436)	(72)
5.21 Operations Management	-	-	-	-	(30)	(141)	(1)	(6)	(859)	(102)	(71)	(31)	(721)	(574)	(147)
5.31 Corporate Affairs	-	-	-	-	1	16	(8)	(11)	(337)	(34)	(28)	(6)	(219)	(225)	5
5 Corporate Total	-	-	-	-	**(29)**	**(127)**	**(22)**	**(87)**	**(1,850)**	**(205)**	**(154)**	**(51)**	**(1,448)**	**(1,234)**	**(214)**
6 Medical Director															
6.11 Research	-	-	(0)	3	3	26	0	(2)	(99)	(5)	(8)	3	(40)	(66)	26
6.12 Research Projects	-	-	(1)	13	-	(7)	(4)	(44)	58	(0)	5	(5)	(0)	39	(39)
6.21 Clinical Audit	-	-	-	-	6	38	0	(3)	(124)	(4)	(10)	6	(48)	(83)	35
6 Medical Director Total	-	-	**(1)**	**15**	**9**	**56**	**(4)**	**(49)**	**(166)**	**(10)**	**(14)**	**4**	**(88)**	**(110)**	**22**
Non Clinical Total	**(12)**	**210**	**(2)**	**(2)**	**(33)**	**(83)**	**221**	**257**	**(13,607)**	**(984)**	**(1,158)**	**174**	**(8,554)**	**(8,935)**	**382**

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 M08

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.

Month 8 2015/16 :Monitor's financial sustainability risk ratings

Continuity of Services:

	Metrics	Measure	Rating	Weighting	Score
Balance Sheet sustainability: Capital Servicing Capacity	**£ks**				
Operating surplus	3,182	2.29	**3**	25%	**0.75**
Financial obligations (annual pro rata)	1,390				
Liquidity (days)					
Cash and equivalents held	7,984	49	**4**	25%	**1.00**
Operating Costs (per day)	162				

Financial efficiency:

I&E Performance - Margin (%)					
Surplus (deficit) year to date	606	1.44%	**4**	25%	**1.00**
Income year to date	42,104				
Variance from plan - I&E Margin					
Actual surplus margin	1.44%	-0.91%	**3**	25%	**0.75**
Plan surplus margin	2.35%				
FSRR (rounded)					**4**

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 financial risk rating would also be a 4.

Appendix 3: Financial Surplus Forecast M08

Table 1															
Forecast updated with outturns	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Total Year**	**Total Year**	**Total Year**
	Actual	Actual	Actual	Actual	Actual	**Actual**	**Actual**	**Actual**	*Forecast*	*Forecast*	*Forecast*	*Forecast*	**Forecast Actual**	**Budget**	**Variance**
INCOME	4,797	5,219	5,497	5,505	5,055	**5,389**	**5,534**	5,109	5,099	5,491	5,239	5,531	**63,464**	**62,951**	**514**
PAY	(3,302)	(3,338)	(3,415)	(3,452)	(3,443)	**(3,392)**	**(3,456)**	(3,502)	(3,477)	(3,500)	(3,458)	(3,474)	**(41,210)**	**(40,994)**	**(216)**
NON PAY	(1,695)	(1,756)	(1,886)	(1,923)	(1,694)	**(1,810)**	**(1,861)**	(1,572)	(1,767)	(1,772)	(1,754)	(1,749)	**(21,238)**	**(20,940)**	**(299)**
Total Monthly	**(201)**	**126**	**196**	**130**	**(83)**	**188**	**216**	**35**	**(145)**	**219**	**28**	**308**	**1,016**	**1,017**	**(1)**

Table 2	Month 8 November		
Outturn	**Forecast**	**Actual**	**Variance to Forecast**
INCOME	5,502	5,109	(394)
PAY	(3,469)	(3,502)	(33)
NON PAY	(1,774)	(1,572)	202
Total	**260**	**35**	**(225)**

Summary

- Table 1 shows the revised forecast outturn following the month 8 performance. The Trust is forecasting to achieve plan by the end of the year.
- Table 2 shows the comparison of actuals reported against the forecast..
- The in month position was £225k less than forecast as detailed in table 2.
  - Income was £394k less due to underperformance within elective and non-elective activity. The activity forecast assumed continuation of existing trend.
  - Pay expenditure was higher than anticipated due to higher agency usage and additional medical costs
  - Non pay is lower due to reduced activity in the period and the benefit of a validation of open purchase orders and depreciation savings.

Risks

- A further deterioration in clinical 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.

Actions

- Additional interventions have been identified and reflected in the forecast.

Intervention Plans												
Plans to achieve target surplus:	**Type**	**M8**	**M8 Actua**	**M8 Var**	**M9**	**M10**	**M11**	**M12**	**FY Position**	**YTD M8**	**YTD Actual**	**YTD Var**
		£k	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
										-	-	-
Bank overdraft facility - removal	NON PAY	2	2	-	2	2	2	2	12	5	5	-
Income - misc	INCOME	0		(0)	0	0	0	0	2	1	15	14
Expenditure controls - not urgent ordering	NON PAY	0		(0)	0	0	0	0	2	1	-	(1)
Depreciation review	NON PAY	-	20	20	-	-	-	-	-	-	20	20
Supplier Discounts - phase 1	NON PAY	0	2	1	0	0	0	0	2	1	2	2
Review bed debts provision policy	NON PAY	3	-	(3)	3	3	3	3	18	6	-	(6)
Private payment income	INCOME	-	4	4	-	-	-	-	12	12	17	5
Tactical Savings Total		**6**	**27**	**22**	**6**	**6**	**6**	**6**	**47**	**25**	**59**	**34**
Activity Interventions, risk rated contributions				-						-	-	-
Sleep Business Case	INCOME FROM ACTIVITIES	26	28	3	26	26	26	26	128	26	28	3
Sleep Business Case	PAY	(3)	(4)	(0)	(3)	(3)	(3)	(3)	(17)	(3)	(4)	(0)
Sleep Business Case	NON PAY	(3)	(4)	(0)	(3)	(3)	(3)	(3)	(17)	(3)	(4)	(0)
100% Sleep Business Case	Contribution	19	21	2	19	19	19	19	93	19	21	2
Oral/MF : minor ops	INCOME FROM ACTIVITIES	6	5	(2)	6	6	6	6	36	12	9	(3)
Oral/MF : minor ops	NON PAY	(4)	(3)	1	(4)	(4)	(4)	(4)	(22)	(7)	(6)	2
80% Oral/MF : minor ops	Contribution	2	2	(1)	2	2	2	2	14	5	3	(1)
Corneo - daycase, cataracts	INCOME FROM ACTIVITIES	9	9	-	9	9	9	9	51	17	17	-
Corneo - daycase, cataracts	NON PAY	(3)	(3)	-	(3)	(3)	(3)	(3)	(17)	(6)	(6)	-
80% Corneo - daycase, cataracts	Contribution	6	6	-	6	6	6	6	34	11	11	-
Hands - daycase	INCOME FROM ACTIVITIES	11	11	-	11	11	11	11	64	21	11	(11)
Hands - daycase	NON PAY	(2)	(2)	-	(2)	(2)	(2)	(2)	(13)	(4)	(2)	2
80% Hands - daycase	Contribution	9	9	-	9	9	9	9	51	17	9	(9)
Trauma list	INCOME FROM ACTIVITIES	48		(48)	48	48	48	48	286	95	24	(72)
	PAY	(33)		33	(33)	(33)	(33)	(33)	(201)	(67)	(17)	50
50% Trauma list	Contribution	14	-	(14)	14	14	14	14	86	29	7	(21)
Total Activity Interventions, risk rated contributions		**49**	**37**	**(13)**	**49**	**49**	**49**	**49**	**278**	**80**	**51**	**(29)**
Additional Cost Savings				-					-	-	-	-
Theatre gow ns	NON PAY	4	3	(1)	4	4	4	4	20	4	3	(1)
Warm up jackets	NON PAY		0	0								
Sleep	NON PAY	0		(0)	0	0	0	0	1	0	-	(0)
Plates & screw s -Synthes	NON PAY	2	2	0	2	2	2	2	11	5	5	0
Digital Dictation	NON PAY	0		(0)	0	0	0	0	1	0	-	(0)
Insurance	NON PAY	-		-	0	0	0	0	1	-	-	-
Dental-3M spend	NON PAY	1	1	0	0	0	0	0	2	1	1	0
sw itch to f/w ork or sw itch supplier	NON PAY	0		(0)	1	1	1	1	4	0	-	(0)
Mattresses	NON PAY	-		-	-	1	1	1	3	-	-	-
Clinical products spend through supply chain	NON PAY	1	1	0	1	1	1	1	4	1	1	0
Sterile Services	NON PAY	-		-	2	2	2	2	7	-	-	-
Total Additional Cost Savings		**8**	**7**	**(1)**	**10**	**11**	**11**	**11**	**52**	**11**	**10**	**(1)**
Total		**63**	**71**	**8**	**65**	**66**	**66**	**66**	**378**	**116**	**121**	**4**

Appendix 5: Cost Improvement Programme (CIP) Schedule part 1.

Directorate	Division	Specialty	Proposal	Start month	All 2015/16 CIP Target	Started 2015/16 CIP Target	YTD Total				Forecast Outturn	FYE	RAG Status	Comments
							Plan	Actual	Variance	% Achieved	£	£		
1 Operations	1.1 Plastics	1.15 Plastics	Reduce banding of registrars as per JM	Apr-15	**50,000**	**50,000**	33,333	33,333	0	100%	50,000	50,000	Green	Email from BM: The re-banding of middle grades is unlikely to deliver as this it appears was never agreed with the CD and he is not supportive. I wouldn't remove it just yet until I confirm . Currently taking the underspends only.
1 Operations	1.1 Plastics	1.14 Skin	Savings from K Cullen retirement - NI & Pension	Apr-15	**34,765**	**34,765**	23,177	23,177	0	100%	34,765	34,765	Green	Dr Cullen Retired 28/08/2014 and returned to work on 01/09/2015
1 Operations	1.2 Oral	1.21 Head & Neck	5 PA reduction from existing consultants to part offset new consultant cost	Sep-15	**50,000**	**50,000**	21,429	21,429	0	100%	50,000	50,000	Green	Provisionally taking just underspend for the consultant line.
1 Operations	1.3 Eye	1.33 Eye Bank	Clean Room: Cornea charge incr to £1,200 per cornea as per P Gable 13.2 Subj: 454500 / 454800	Apr-15	**53,200**	**53,200**	35,467	0	-35,466	0%	0	53,200	Red	Further work needs to be done with BH/BM to come up with an alternative schemes to replace current scheme
1 Operations	1.4 Sleep	1.41 Sleep	Employers pension saving from Venn retirement	Sep-15	**20,733**	**20,733**	8,886	8,886	0	100%	20,733	20,733	Green	Due to start in Sept
1 Operations	1.5 Clinical Support	1.51 Imaging	Radiography: Xray eqpt mtc: PACS contract with Philips as per K Humphry	Apr-15	**17,000**	**17,000**	11,333	11,333	0	100%	17,000	17,000	Green	
1 Operations	1.5 Clinical Support	1.51 Imaging	Radiography: X ray film: External storage of xray films no longer needed as films being disposed of as per J Morris	Apr-15	**2,000**	**2,000**	1,333	1,333	0	100%	2,000	2,000	Green	CIP already taken, no budget for the year
1 Operations	1.5 Clinical Support	1.51 Imaging	Radiography: Based on 14/15 activity - BSUH chest xrays @ £400pw as per K Humphry	Apr-15	**20,800**	**20,800**	13,867	11,925	-1,942	86%	17,887	20,800	Amber	Due to late start but hope to pick up in the following quarter.
1 Operations	1.5 Clinical Support	1.51 Imaging	Radiogrphy: Agency PAMS: Out of Hours svc changes as per K Humphry 13.2	Apr-15	**10,000**	**10,000**	6,667	6,667	0	100%	10,000	10,000	Green	
1 Operations	1.5 Clinical Support	1.52 Pathology	Pathology: Reduce pathology drugs as per P Gable. Line not used.	Apr-15	**1,476**	**1,476**	984	984	0	100%	1,476	1,476	Green	CIP already taken, no budget for the year

Appendix 5: Cost Improvement Programme (CIP) Schedule part 2.

Directorate	Division	Specialty	Proposal	Start month	All 2015/16 CIP Target	Started 2015/16 CIP Target	YTD Total				Forecast Outturn	FYE	RAG Status	Comments
							Plan	Actual	Variance	% Achieved	£	£		
1 Operations	1.5 Clinical Support	1.52 Pathology	Histo: Reduction in agency fees in line with reduced usage as per F Lawson	Apr-15	25,550	25,550	17,033	17,033	0	100%	25,550	25,550	Green	Changed - Previously being reported as under delivering but this was becaused other staff cost were coded to the that line.
1 Operations	1.5 Clinical Support	1.52 Pathology	Histo: Prof Fees: reduction in costs as accreditation now achieved	Apr-15	50,000	50,000	33,333	33,333	0	100%	50,000	50,000	Green	
1 Operations	1.5 Clinical Support	1.52 Pathology	Histo: Other Clinical Costs: Svc provided by 'Backlogs' repatriated in house as per F Lawson 13.2	Apr-15	10,000	10,000	6,667	6,667	0	100%	10,000	10,000	Green	
1 Operations	1.5 Clinical Support	1.52 Pathology	Histo: Pathology - BSUH: Remove unused budget	Apr-15	1,596	1,596	1,064	1,064	0	100%	1,596	1,596	Green	CIP already taken, no budget for the year
1 Operations	1.5 Clinical Support	1.53 Therapies	Therapies: B5: Reduce pressure garment technician hours as per J Morris	Apr-15	1,800	1,800	1,200	1,200	0	100%	1,800	1,800	Green	
1 Operations	1.5 Clinical Support	1.53 Therapies	Therapies: Sterile Products: CSSD saving ref. disposable scissors	Apr-15	2,000	2,000	1,333	1,333	0	100%	2,000	2,000	Green	
1 Operations	1.5 Clinical Support	1.53 Therapies	Therapies: Eqpt and materials: reduce splinting materials budget in line with usage	Apr-15	1,000	1,000	667	667	0	100%	1,000	1,000	Green	
1 Operations	1.5 Clinical Support	1.53 Therapies	Psychotherapy: Other Clinical Costs: Renegotiation of psychotherapy contract from £12k to £9k as per J Morris	Apr-15	3,000	3,000	2,000	1,935	-65	97%	2,903	3,000	Amber	
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.11 Perioperative Care - Theatres	Theatres staff retirements	Apr-15	6,000	6,000	4,000	4,000	0	100%	6,000	6,000	Green	
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.11 Perioperative Care - Theatres	Theatres staff retirements	Apr-15	25,000	25,000	16,667	16,667	0	100%	25,000	25,000	Green	
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.11 Perioperative Care - Theatres	Theatres staff retirements	Apr-15	8,000	8,000	5,333	0	-5,333	0%	0	8,000	Red	No Savings on retirement
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.11 Perioperative Care - Theatres	Theatres pay protection ended	Apr-15	31,596	31,596	21,064	0	-21,064	0%	0	31,596	Red	Pay Protection is for 7year not 2yrs
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.11 Perioperative Care - Theatres	Propofol saving - savings to reduce by 50k , as per Keith Manfield's email	Sep-15	108,000	108,000	54,000	0	-54,000	0%	0	108,000	Red	Due to start in Sept
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.12 Elective Care Nursing	0.80 B7 CIP (C-Wing)	Apr-15	35,500	35,500	23,667	23,667	1	100%	35,501	35,500	Green	
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.13 Emergency Care Nursing	Remove 1 x B5 ITU post as per Jo Thomas	Apr-15	27,000	27,000	18,000	18,000	0	100%	27,000	27,000	Green	
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.13 Emergency Care Nursing	Reduced Sunday working (Paeds) as per Jo Thomas	Apr-15	5,000	5,000	3,333	0	-3,333	0%	0	5,000	Red	
2 Nursing & Clinical Infrastructure	2.1 Clinical Infrastructure	2.14 Anaesthetics	Steve Squires retirement	Apr-15	30,000	30,000	20,000	20,000	0	100%	30,000	30,000	Green	Need confirmation confirm retirement date

Appendix 5: Cost Improvement Programme (CIP) Schedule part 3.

Directorate	Division	Specialty	Proposal	Start month	All 2015/16 CIP Target	Started 2015/16 CIP Target	YTD Total				Forecast Outturn	FYE	RAG Status	Comments
							Plan	Actual	Variance	% Achieved	£	£		
2 Nursing & Clinical Infrastructure	2.2 Quality & Compliance	2.21 Risk	CNST: £4.9k CIP as per 15-16 contract costs.	Apr-15	**4,900**	**4,900**	3,267	3,267	0	100%	4,900	4,900	Green	
2 Nursing & Clinical Infrastructure	2.2 Quality & Compliance	2.21 Risk	CNST: £470 CIP as per 15-16 contract costs.	Apr-15	**470**	**470**	313	313	0	100%	470	470	Green	
2 Nursing & Clinical Infrastructure	2.2 Quality & Compliance	2.21 Risk	CNST: £49k CIP as per 15-16 contract cost.	Apr-15	**49,000**	**49,000**	32,667	32,667	0	100%	49,000	49,000	Green	
2 Nursing & Clinical Infrastructure	2.5 Director of Nursing	2.51 Director of Nursing	Banding change B7 to B6 for compliance post	Apr-15	**14,000**	**14,000**	9,333	9,333	0	100%	14,000	14,000	Green	
2 Nursing & Clinical Infrastructure	2.5 Director of Nursing	2.51 Director of Nursing	Reduce Deputy Director of Nursing budget to mid point	Apr-15	**3,939**	**3,939**	2,626	2,626	0	100%	3,939	3,939	Green	
3 Finance and Non Clinical Infrastructure	3.1 Non Clinical Infrastructure	3.12 Estates	Band 6 Programme Office post	Apr-15	**21,467**	**21,467**	14,311	14,311	0	100%	21,467	21,467	Green	CIP already taken, no budget for the year
3 Finance and Non Clinical Infrastructure	3.1 Non Clinical Infrastructure	3.12 Estates	Sewerage - reduce with usage	Apr-15	**1,000**	**1,000**	667	667	0	100%	1,000	1,000	Green	No evidence provided
3 Finance and Non Clinical Infrastructure	3.1 Non Clinical Infrastructure	3.12 Estates	Full year effect of OT 6 lease termination based on Outturn	Apr-15	**202,000**	**202,000**	134,667	134,667	0	100%	202,000	202,000	Green	Underspend YTD but will need confirmation from BH that this has been implemeneted
3 Finance and Non Clinical Infrastructure	3.1 Non Clinical Infrastructure	3.13 IMT	IT Licence fees - reduction in line with actual	Apr-15	**25,000**	**25,000**	16,667	16,667	0	100%	25,000	25,000	Green	
3 Finance and Non Clinical Infrastructure	3.2 Commercial Development	3.22 Commerce	Reduction in CHKS contract	Apr-15	**6,000**	**6,000**	4,000	4,000	0	100%	6,000	6,000	Green	
3 Finance and Non Clinical Infrastructure	3.3 Finance Department	3.31 Finance	Reduce Deputy Director of Finance budget to mid point	Apr-15	**12,000**	**12,000**	8,000	8,000	0	100%	12,000	12,000	Green	
3 Finance and Non Clinical Infrastructure			**Procurement CIP to be reallocated**	Apr-15	**400,000**	**400,000**	266,667	110,363	-156,304	41%	165,545	400,000	Red	Trust-wide non-pay CIP
3 Finance and Non Clinical Infrastructure	3.3 Finance Department	3.31 Finance	Stationery - reduction in line with actual	Apr-15	**1,800**	**1,800**	1,200	0	-1,200	0%	0	1,800	Red	Overspent YTD
3 Finance and Non Clinical Infrastructure	3.3 Finance Department	3.31 Finance	External Consultancy Fees - reduction in line with actual	Apr-15	**4,351**	**4,351**	2,901	2,901	0	100%	4,351	4,351	Green	CIP already taken, no budget for the year
4 Human Resources and Organisational Development	4.2 Education	4.22 Education	Intrepid Database licence 14/15 £750	Apr-15	**250**	**250**	167	167	0	100%	250	250	Green	
5 Corporate	5.1 Board	5.11 Board	Temp staff target reduction as per K Mansfield	Sep-15	**250,000**	**250,000**	125,000	53,142	-71,858	43%	123,999	250,000	Red	Need to check if this proposal is trust wide or not just for trust board - take variance on that line
5 Corporate	5.3 Corporate Affairs	5.31 Corporate Affairs	ASHN fee	Apr-15	**36,000**	**36,000**	24,000	24,000	0	100%	36,000	36,000	Green	No invoice has been sent this year and supplier has been informed we will no longer be carrying on with ASHN sub

Activity Extract		Activity Actuals												
Specialty	POD	M1	M2	M3	M4	M5	M6	M7	M8	Average price	Average Activity M1-7	Activity Change M8: Variance to average	M8: Variance to average	Impact of the M8 variance at indicative average price
Burns	Elective	20	47	30	19	46	36	25	**18**	£ 3,945	**32**	**-14**	-43%	**-£54,660**
Skin	Elective	27	26	28	29	18	81	33	**18**	£ 2,410	**35**	**-17**	-48%	**-£39,931**
Breast	Elective	39	49	35	38	36	36	51	**32**	£ 3,910	**41**	**-9**	-21%	**-£33,513**
Maxillofacial	Elective	108	51	74	115	55	54	61	**60**	£ 2,363	**74**	**-14**	-19%	**-£33,083**
Hands	Elective	29	21	23	12	15	21	13	**17**	£ 3,063	**19**	**-2**	-11%	**-£6,563**
												-55		**-£167,750**
Hands	Non Elective	268	265	293	326	254	250	283	**211**	£ 2,116	**277**	**-66**	-24%	**-£139,684**
Burns	Non Elective	59	69	51	73	69	69	53	**48**	£ 2,361	**63**	**-15**	-24%	**-£36,095**
												-81		**-£175,779**

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**18-16**	
Report title:	**Bank mandates report**				
Sponsor:	Clare Stafford, Director of Finance				
Author:	Evan Haselwood, Finance Manager				
Appendices:	Appendix A –Signatory groups Appendix B - Signatory authorisation limits				
Executive summary					
Purpose:	The purpose of this paper is to provide the board with background to the revision of the bank mandate and to approve the changes to the bank mandate.				
Recommendation:	To note the contents of this report and APPROVE the proposed changes to the Bank Mandate.				
Purpose:	Approval	Information			Review
Link to key strategic objectives (KSOs):				KSO4:	KSO5:
				Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	Not applicable.				
Corporate risk register:	Not applicable.				
Regulation:	Not applicable.				
Legal:	It is a legal requirement to hold a bank mandate for each bank account or group of bank accounts.				
Resources:	Not applicable.				
Assurance route					
Previously considered by:	Not applicable.				

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 18-16
Report from: Clare Stafford, Director of Finance and performance
Author: Evan Haselwood, Finance Manager
Report date: 30 December 2015

Bank Mandates Report

1. Purpose

1.1. The purpose of this paper is to provide the Board with background to the revision of the bank mandate and to approve the changes to the bank mandate.

2. Background

2.1 Bank mandates are provided to the Trust's banks stating authorisation limits and are required to be updated to reflect changes in personnel within the Trust.

2.2 It is a requirement of the Trust commercial bank, Lloyds Bank Plc, that new mandates are approved at a meeting of the Board of Directors of the Trust.

3. Current Status

3.1 The Trust has three Bank accounts, one is held with the Government Banking Service (GBS), where most payments are received and the vast majority of cash is held.

3.2 The contract for all GBS accounts was recently re-tendered by the Department of Health and will be moving to the National Westminster Bank in the early 2016, a mandate has been completed in line with the current SFIs and sent to the GBS.

3.3 Two corporate accounts are held with Lloyds Bank Plc, the balances in these accounts are kept to a minimum and they are primarily used to make payments to the Trust's staff and suppliers.

3.4 The mandate covering the Lloyds accounts was last reviewed in full in 2011; additional signatories have been added in the meantime and the operational viability of the accounts remains intact.

3.5 Due to the changes in senior management a new mandate is required to be authorised before any major changes could be made to the account, such as opening or closing accounts; this is a risk to the Trust and has therefore triggered a review.

3.6 To ensure day to day activities can be appropriately authorised whilst maintaining the need for higher authority for exceptional decision making, it is proposed that signatories are split into two panels, A and B.

3.7 Appendices A and B set out proposed panel members and authorisation limits respectively. Panels have been designed to separate senior management who are able to authorise exceptional items e.g. authorising a bank loan, from managers in the finance department ensuring working capital transactions are appropriately authorised.

4. Recommendations

4.1 To note the contents of this report and APPROVE the proposed changes to the Bank Mandate.

Appendix A – Proposed Signatory Groups

Signatory Groups
Group A
Chief Executive
Chair
Director of Finance & Performance
Deputy Director of Finance
Group B
Finance Manager
Reporting & Planning Manager
Capital Accountant

Appendix B – Signatory Authorisation Limits

Purpose	Valid Signatory Combinations	£value limits for Lloyds Bank Plc
Opening new & closing existing bank accounts and entering the trust into forward buying agreements (including foreign currencies).	2 x As or 1A + 1B	
Approving banking services (including loans & overdrafts)	2 x As or 1A + 1B	
Notify additions/deletions of authorised signatories and provide specimen signatures to the bank	2 x As or 1A + 1B or 2 x Bs	
Authorise the bank to make payments from the Trust's account (cheques)	1A or 1B 2 x As or 1A + 1B or 2 x Bs	Up to £10k Over £10k

KSO5 – Organisational Excellence

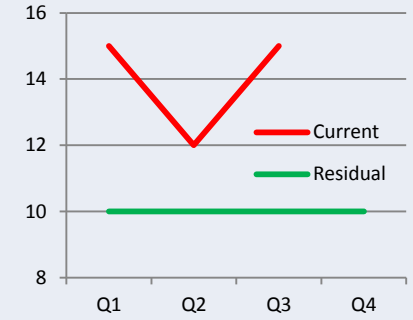
Risk Owner: Director of HR & OD
Committee: Trust Board
Date 21st December 2015

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

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

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. Insufficient focus on recruitment and retention across the Trust leading to an increase in bank and agency costs and having longer term issues for the quality of patient care



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 ways of working

Controls and Assurances
Developing long term workforce planning (3 years) for FY16/17 and 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
Implementing a Board approved staff survey action plan
HR/OD metrics revised to support the Business Units
Theatres recruitment day in January 2015
Performance review meetings to identify and address identified staffing shortfalls

Gaps in controls and Assurances
Current level of management competency in workforce planning
Continuing resources to support the development of staff
Continuing retention problems in theatres and ward areas and medical staff in Max Facs

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**20-16**	
Report title:	**Workforce Report**				
Sponsor:	Graeme Armitage, Director of HR/OD				
Author:	Graeme Armitage, Director of HR/OD				
Executive summary					
Purpose:	The December workforce report provides the board of directors with a breakdown of the key workforce metrics and the associated trust performance.				
Recommendation:	The board of directors is asked to note the report.				
Purpose:		Information	Discussion	Assurance	
Link to key strategic objectives (KSOs):	KSO1				KSO5:
	Outstanding patient experience				Organisational excellence
Implications					
Board assurance framework:	Trust reputation as a good employer and ensuring there are sufficient and well trained staff to deliver high quality care.				
Corporate risk register:	Recruitment and retention being addressed along with sickness absence and bank and agency usage.				
Regulation:	None.				
Legal:	None.				
Resources:	Managed with HR/OD.				
Assurance route					
Previously considered by:	Finance and Performance Committee				
	Date:	21/12/15	Decision:	Noted	

Human Resources & Organisational Development

Workforce Report

December 2015

1. Introduction and Summary

This report contains the Trust position for establishments, staff in post, bank and agency usage, sickness absence, recruitment activity and statutory mandatory training compliance. Additional information is provided which aims to update the Board of Directors of the Trust on progress against the key HR targets. It is important to note that all the information contained within the report relates to November 2015, except for Sickness Absence, which is for the month of October 2015.

2. Agency Caps

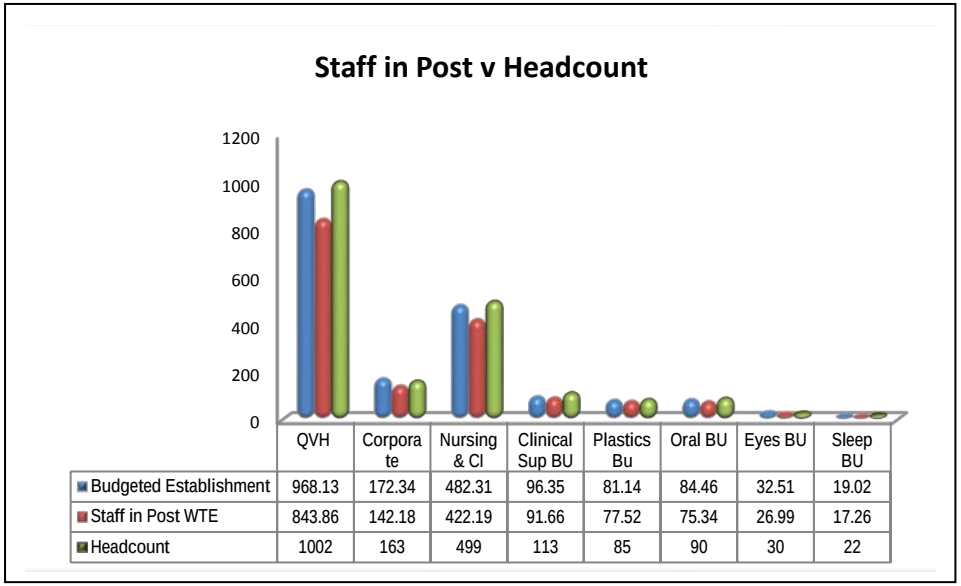
On the 23 November 2015 Monitor imposed agency worker caps for Medical / Dental, Clinical and Non-Clinical workers for Trusts in either special measures or in receipt of financial assistance. QVH has decided to follow the guidelines associated with the cap on a voluntary basis as this will help to drive down our temporary staffing costs. Therefore we will now only be engaging agency workers where rates are in accordance with the recommendations wherever possible. We are currently aware of agency use where some rates are above the cap and negotiations are taking place with those agencies to address this. The area causing the most concern, in terms of the guidance, is critical care nurses as there are very few agencies who have confirmed that they can provide these types of nurses within the capped rates. Meetings have been arranged with some of the agencies and a further update will be provided in the next board report.

As outlined in the report mostly agency usage at the Trust is for nursing and administrative staff. The use of agency medical locums is rare and there in addition there is occasional use of HCA's. HR will be undertaking a recruitment exercise to attract more bank nurses, HCA's and will be extending this to administrative staff.

Headlines:

- The number of vacant positions in November 2015 increased by 10.45 wte since September 2015, and this is reflected in the turnover rate which was 18.72% in September and is now at 19.67% in November 2015 (NB: the rate includes the twice yearly intake of doctors).
- The overall vacancy gap (number of established post and actual staff in post) is 124.27 wte.
- The wte agency and bank usage for November was 31.24, a slight increase compared to September 2015. The level of usage is much lower than the vacancy gap of 127.84, this narrows when the 50 (net 30 wte) are added but only represents around 50% of the vacancy gap. This is being addressed with the Business Units as part of the performance review meetings.
- Recruitment activity for November was less than in September and August, which is an unusual trend for this time of year. However we expect that activity in January and February will increase as a result of the planned recruitment open day for nurses.
- The highest reason reported for sickness in November was Anxiety / Stress / Depression. The launch of the second mindfulness programme took place in October. This is an 8 week course aimed at coaching employees on how to manage their stress. The HR Team are also planning a Health and Wellbeing day in January / February 2016.
- The current Statutory and Mandatory Training compliance rate across the Trust is 91.85% with overall performance being maintained. Changes to the way statutory and mandatory training is delivered is being implemented in January 2016 to provide a more sustainable position through FY16/17

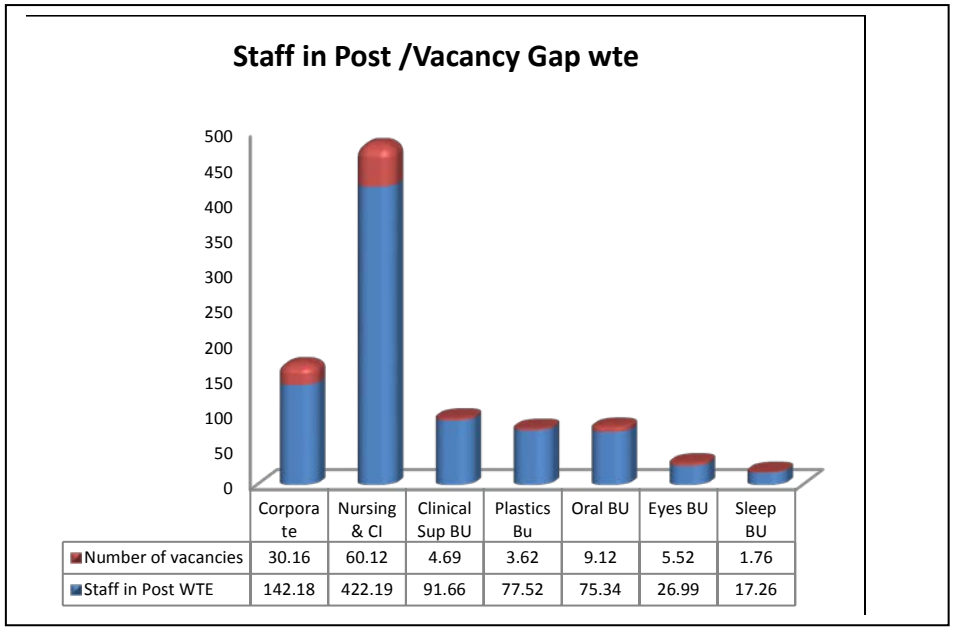
2. Establishment, Staff in Post and Vacancies



Vacancy Rate – number of vacancies compared to budgeted wte establishment per Business Unit			
Business Unit	**% of vacancies**	**Number of vacancies**	**Trend**
Corporate	17.51%	30.16	↓
Nursing & Clinical Infrastructure (overall)	12.47%	60.12	↓
o **Nursing staff**	(19.44%)	(44.79)	↑
o **HCA's**	(14.16%)	(11.67)	↓
Clinical Support BU	4.87%	4.69	↓
Plastics BU	4.47%	3.62	↑
Oral BU	10.80%	9.12	↑
Eyes BU	16.98%	5.52	↑
Sleep BU	9.26%	1.76	↓
Total (QVH overall)	12.84%	124.27	↑

Summary

2.1 **Establishment:** this is the figure agreed at the start of the financial year for QVH overall. The Finance team are reviewing these at the present time therefore this may change.
2.2 **Staff in post:** the headcount is 1002 (same as in September and the staff in post wte is 843.86, there is a vacancy gap of 124.27 (12.84%) which is the difference between the budgeted establishment and the staff in post wte (see vacancy gap on the right)
2.3 **Vacancies:** The current vacancy gap is 124.27 wte. The highest percentage of vacancies is in Nursing (19.44%). There will be a Nursing Recruitment Open day in January 2016
2.4 **Posts vacant for three months or more:** These include Band 5 staff nurses in the Canadian Wing, Corneo, Theatres and a fixed term contract post for a rotational Physiotherapist.



3. Recruitment

Recruitment Activity for November 2015

Total number of Posts Advertised	18.5 (15.75 wte)
Total number of Job Offers	26
Number of Candidates in the Recruitment Process (as at 30 November 2015) – job offer candidate made not started	50

Business Unit	**Number of (New) Posts Advertised during reporting period**	**Number of Candidates in the Recruitment Process (as at 30 November 2015)** – job offer made candidate not started
Corporate	4	23
Nursing and Clinical Infrastructure	(6.5)	(16)
o **Nursing Staff**	3	10
o **HCA's**	2.5	2
Clinical Support	4	2
Plastics Business Unit	1	6
Eyes Business Unit	1	1
Sleep Business Unit	2	1
Oral Business Unit	0	1
Total (QVH Overall)	18.5 (15.75 wte)	50

Recruitment Summary

During November we have advertised for 18.5 new roles. Our biggest areas of advertising have been within Nursing & Clinical Infrastructure, and Corporate and Clinical Support. During November there were 3 positions advertised for Nursing staff and 2.5 for HCA's. There were 4 new positions advertised within the Corporate and the Clinical Support business areas. The number of applicants going through recruitment clearance was 50 for November, with the highest being within the Corporate business unit at 23. This was due to 10 new applicants being offered a position within our bank staffing which has increased our number of applicants moving through clearance in Corporate.

This month was have cleared 16 applicants in total, 4 in Plastics, 6 in Corporate, 3 in Nursing, 1 in Eyes, Sleep and Oral, therefore our total number of applicants moving through clearance at the end of November is 32.

There are a number of roles across QVH which have been open for 3 months or more. These include Band 5 staff nurses in the Canadian Wing, Corneo, Theatres and a fixed term contract post for a rotational Physiotherapist. HR will be working closely with the Matrons,
And Business Unit Managers to deliver strategies to enable us to fill these positions with our next open day being planned for Theatre Nursing Recruitment for January 2016.

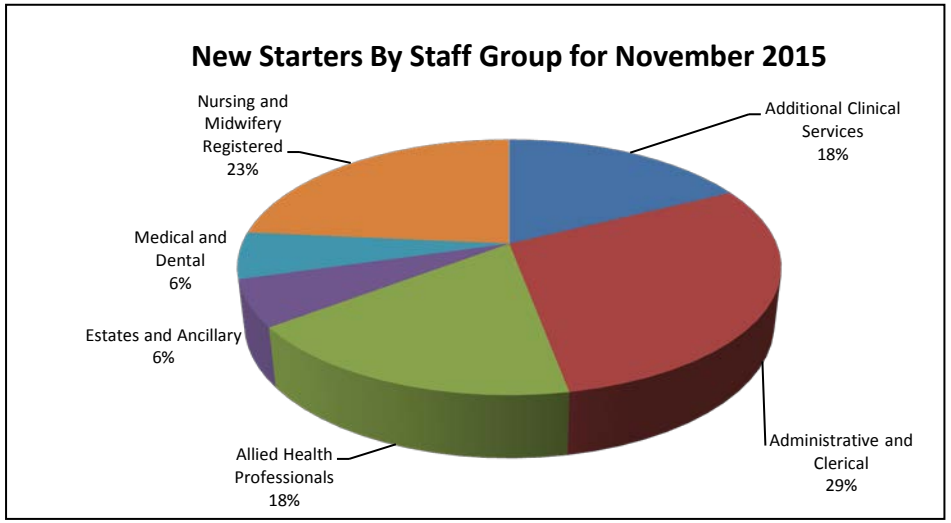
Medical and Dental Recruitment

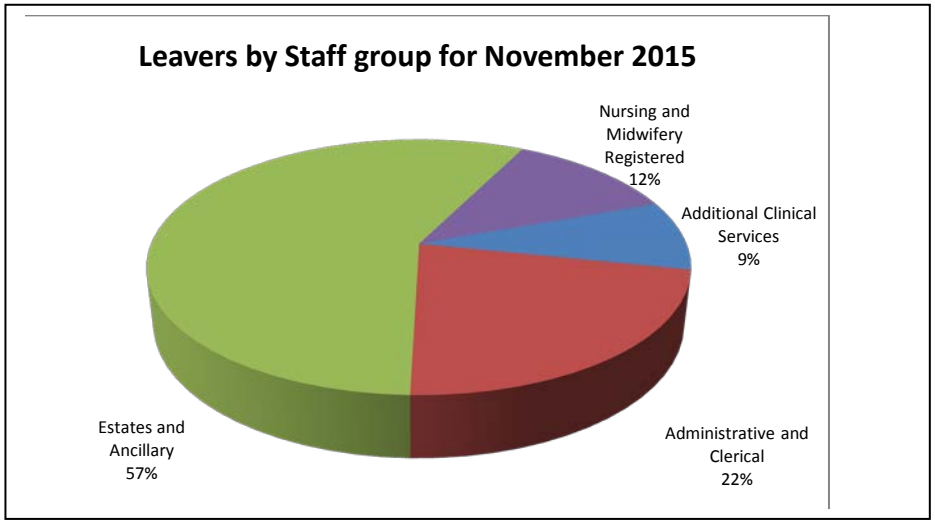
Have successfully recruited to 0.6 wte Specialty Practitioner in Orthodontics with expected start date in early December.
Have successfully recruited to 2.0 wte Trauma & Reconstructive Fellows (fixed term posts) to start in January & February 2016 which will enable the Trust to carry out trauma lists on a Saturday.
Have successfully recruited to 1.0 wte Consultant in Ophthalmology to start in new financial year.
Plan to advertise Consultant Plastic Surgeon in Skin in next month.

Medical Locums

No agency locums used during November
3.0 wte NHS Locums using to cover Consultant Plastic Surgeon with an interest in Skin, Specialty Doctor in Oral Surgery based at Medway & a consultant Orthodontist.

4. Turnover – Starters and Leavers





Business Unit	Starters	Leavers
Corporate	3	4
Nursing and Clinical Infrastructure	2	2
o **Nursing Staff**	4	2
o **HCA's**	3	1
Clinical Support	3	0
Plastics Business Unit	1	2
Eyes Business Unit	0	0
Sleep Business Unit	1	0
Oral Business Unit	0	0
Total (QVH Overall)	17	11

Turnover Summary
Turnover rate – for the month of November is 1.93% for Permanent/fixed term staff. Turnover rate for 12 months (01.12.14 to 30.11.15) for Permanent/fixed term staff is 19.67%. **Stability Index** (number of staff in post today that were in post 12 months ago) 01.12.14 to 30.11.15, 999 fixed term/permanent employees were in post at the start of the period with 842 remaining at the end, meaning 84.14% of employees were retained (this figure includes trainee doctors). The stability Index for Kent, Surrey and Sussex, excluding bank, locums and trainee doctors between July 2014 and July 2015 was **89.8%.** Source: Health and Social Care Information Centre. This is currently the most up to date information available. NB: NHS England (London) has undertaken streamlining work regarding recruitment and has reported that stability in the NHS generally is reducing. This also reflects the change in career aspirations of newer entrants in to the NHS.

5. Bank and Agency Usage

Business Unit	Total bank & agency usage in hours & wte	Total bank costs in Nov	% of monthly budget (bank)	Total agency costs in Nov	% of monthly budget (agency)	Trend from Sep
Corporate	545.33 (3.35 wte)	£5343.49	1.14%	0	0	↓
Nursing and Clinical Infrastructure	975.25 (5.98 wte)	£8536.14	0.56%	0	0	↑
o **Nursing Staff**	191.33 (11.78 wte)	£20583.00	1.34%	£22 387.61	1.46%	↑Bank ↓Agency
o **HCA's**	290.75 (1.78 wte)	£2782.81	0.18%	0	0	↓
Clinical Support	411 (2.52 wte)	£7377.88	2.49%	0	0	↑
Plastics Business Unit	202.25 (1.24 wte)	£1840.46	0.42%	0	0	↑
Eyes Business Unit	512 (3.14 wte)	£4511.85	3.41%	0	0	↑
Sleep Business Unit	121 (0.74 wte)	£1272.19	1.98%	0	0	↑
Oral Business Unit	116.5 (0.71 wte)	£1060.15	0.25%	0	0	↑
Total (QVH overall)	5093.41 (31.24 wte)	£53 307.97	1.56%	£22 387.61	0.65%	↑Bank ↓Agency

Bank and Agency Usage Summary

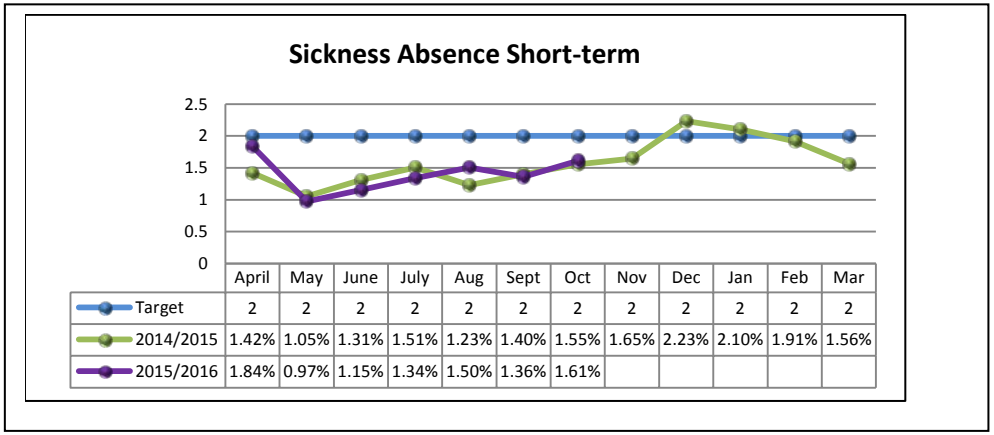
The total wte of agency and bank staff used at QVH overall during November was 31.24 wte. Bank and agency staff are in the main used to cover vacant posts. 59% of the requests are made for this reason.

The increases for bank use in the following areas were mainly for the reasons listed below:

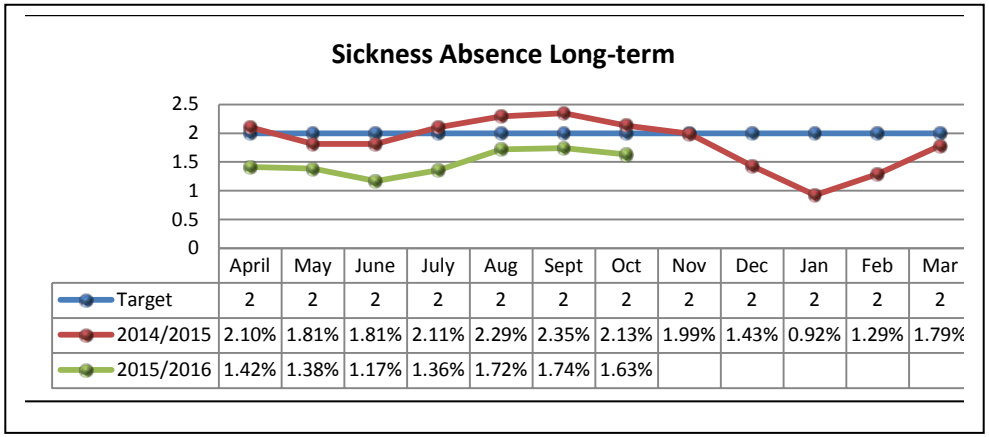
- Clinical Support: Additional Workload
- Plastics: Vacant posts
- Eyes: Vacant posts
- Sleep: Additional Workload
- Oral: Vacant posts

The total agency usage remains well below the trust target of 5% and the Monitor ceiling of 10%.

6. Sickness Absence



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target	2	2	2	2	2	2	2	2	2	2	2	2
2014/2015	1.42%	1.05%	1.31%	1.51%	1.23%	1.40%	1.55%	1.65%	2.23%	2.10%	1.91%	1.56%
2015/2016	1.84%	0.97%	1.15%	1.34%	1.50%	1.36%	1.61%					



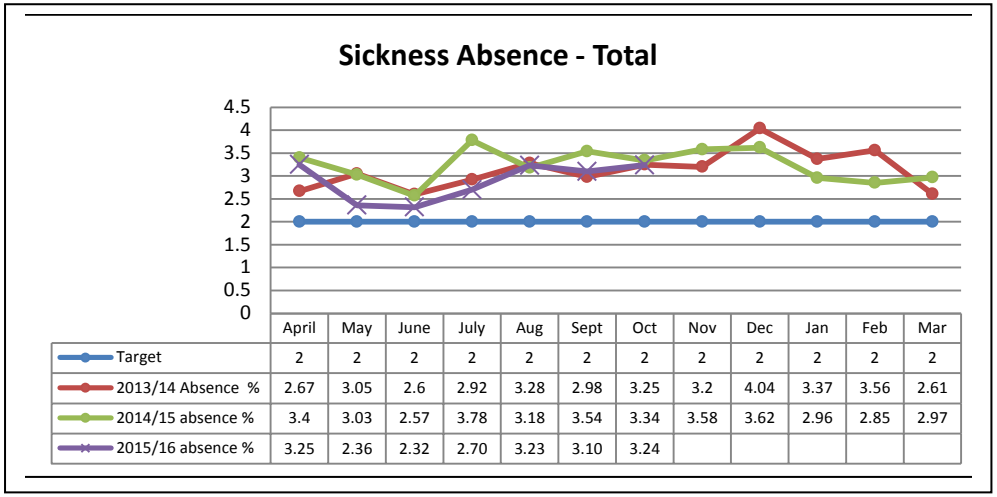
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target	2	2	2	2	2	2	2	2	2	2	2	2
2014/2015	2.10%	1.81%	1.81%	2.11%	2.29%	2.35%	2.13%	1.99%	1.43%	0.92%	1.29%	1.79%
2015/2016	1.42%	1.38%	1.17%	1.36%	1.72%	1.74%	1.63%					

Short term Sickness Absence

Short-term sickness for October was 1.61% which is an increase of 0.25% from last month. Sickness absence is following a similar trend to the 2014/15.

Long term Sickness Absence

The Long-term sickness absence rate for October was 1.63% which is a decrease of 0.11% from last month; this is due to a number of employees having returned to work or submitting their resignation. Long-term sickness is slowly decreasing which is following the trend for 2014/15.

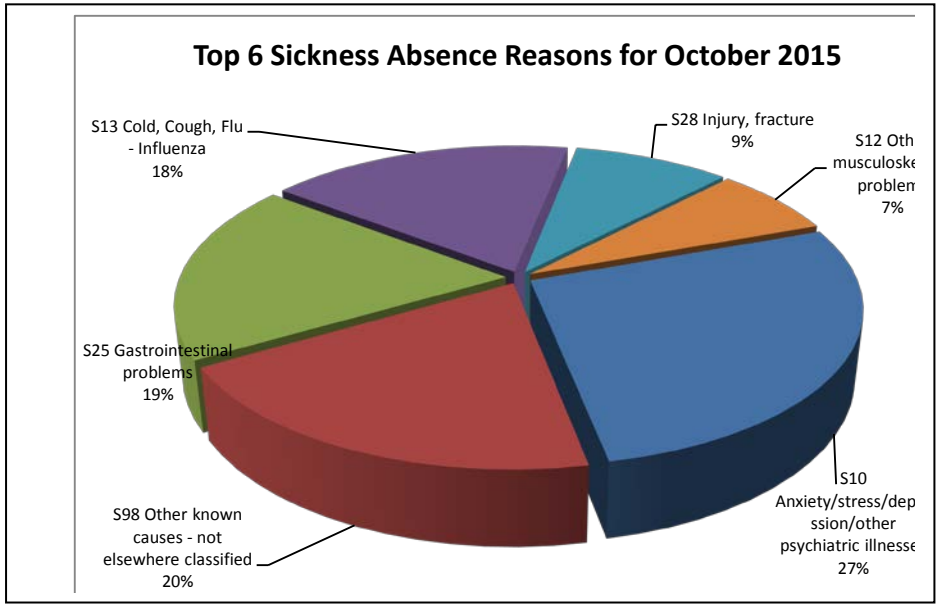


	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target	2	2	2	2	2	2	2	2	2	2	2	2
2013/14 Absence %	2.67	3.05	2.6	2.92	3.28	2.98	3.25	3.2	4.04	3.37	3.56	2.61
2014/15 absence %	3.4	3.03	2.57	3.78	3.18	3.54	3.34	3.58	3.62	2.96	2.85	2.97
2015/16 absence %	3.25	2.36	2.32	2.70	3.23	3.10	3.24					

Sickness Absence % and costs by Business Units

Business Unit	Trend	Percentage	Costs
Corporate	↑	3.34	£7,432
Nursing and Clinical Infrastructure	↓	3.50	£38,595
Clinical Support	↑	4.60	£10,010
Plastics Business Unit	↓	2.71	£4,521
Eyes Business Unit	↑	1.40	£553.91
Sleep Business Unit	↑	2.04	£657.25
Oral Business Unit	↑	4.91	£12,274.51
Total (QVH Overall)	↑	3.24	£74,043.37

Sickness performance is at the same level as for the last 3 years and is 1.24% above target. The areas with highest levels of sickness are to provide progress reports to monthly performance meetings



Health & Wellbeing

Occupational health summary

- 19 management referrals were assessed in November 2015 by Team Prevent.
- Of these:
  - 31% were for musculoskeletal disorders including injury and fractures (MSD)
  - 25% were for mental health problems
- 42 work health assessments were carried out.
- There were 35 immunisations and blood test events
- There were 9 needle stick injuries
- 5 people were referred for physiotherapy
- 17.8% did not attend their appointment

7.2 Sickness Absence Benchmarking Data – Sickness as percentage absence rates for June 2015 (*Source: Health & Social Care Information Centre)*

Dartford and Gravesham NHS Trust	3.10
Medway NHS Foundation Trust	3.82
Ashford and St. Peter's Hospitals NHS Foundation Trust	3.83
Surrey and Sussex Healthcare NHS Trust	3.23
East Kent Hospitals University NHS Foundation Trust	3.87
Maidstone and Tunbridge Wells NHS Trust	3.55
East Sussex Healthcare NHS Trust	3.84
Brighton and Sussex University Hospitals NHS Trust	4.35
Western Sussex Hospitals NHS Foundation Trust	3.73

Sickness Absence Summary

The overall sickness absence rate at QVH in October was 3.24%, showing an increase of 0.14% compared to last month. The sickness absence total for October is following the sickness trend for 2014/15, and is one of the lowest in the Sussex, Surrey and Kent area

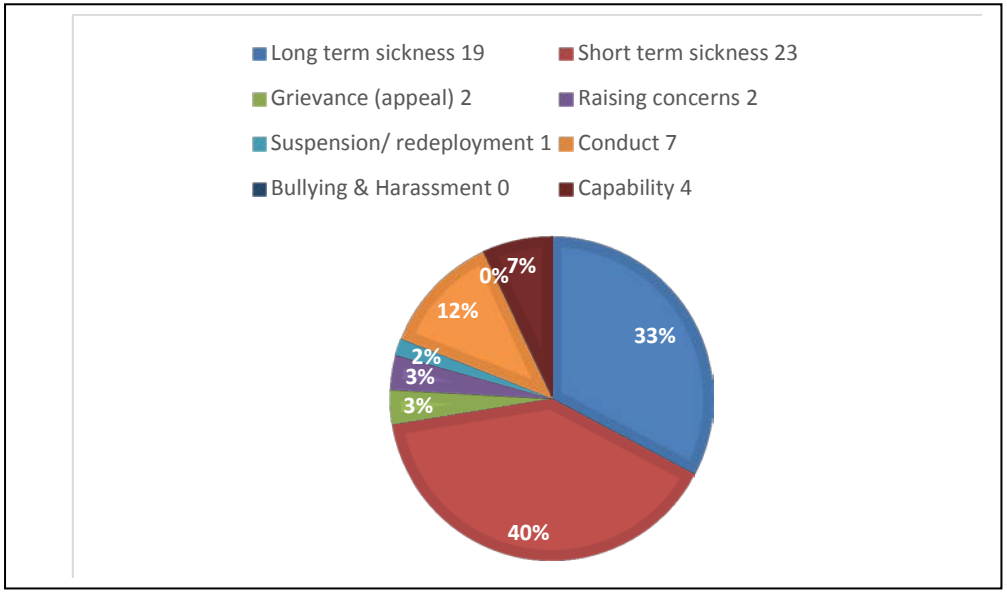
Highest reason for absence recorded - Anxiety/Stress/Depression

Highest first day absence - Monday (it was an Tuesday in September)

Number of one day sickness absence episodes - 71

Number of long term sickness absence cases (20 working days or more) - 16

8. Employee Relations



Employee Relations Summary

The pie chart shows that there were 59 employee relations cases opened and on-going at the end of November 2015. The cases include informal and formal management actions.

Suspension/ redeployment

There was one suspension on-going in November and continued under formal investigation during November.

Sickness absence

The pie chart also shows the number of long-term and short-term sickness cases in October which are being managed in line with the Trust's Managing Sickness Absence Policy either informally or formally. The focus for the next couple of months will be reducing the number of long term sickness absence cases in the Trust.

Conduct

We have seen an increase in the number of conduct cases

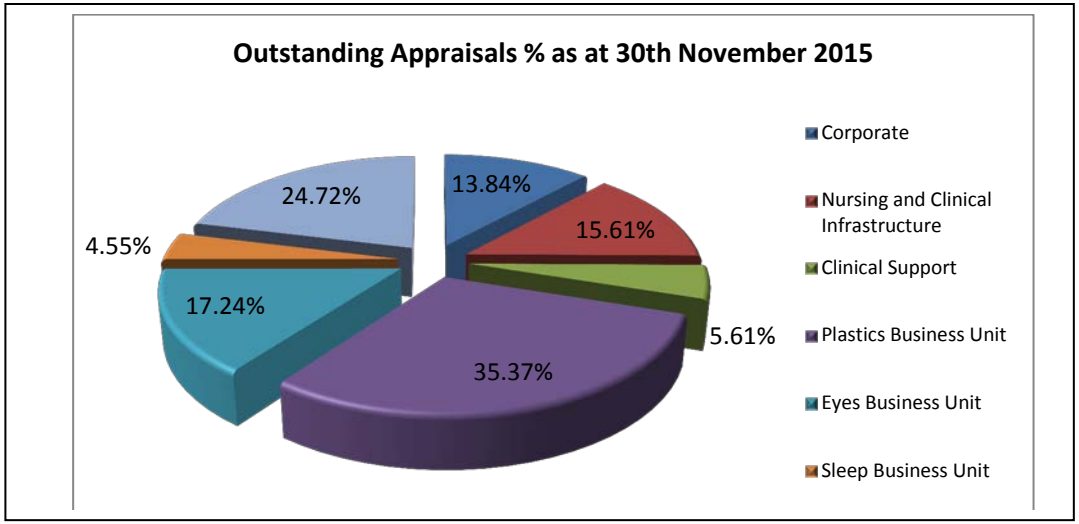
Medical and Dental

Specialist Practitioner in Orthodontics who has returned to work on 11th October 2015 on phased return following substantial period of absence. Anaesthetic Specialty Registrar returned to work in month.

Business Unit	% sickness absence rate	% of bank & agency usage	Number of incidents	Number of near misses	Summary
Corporate	3.34	1.14%	1	4	There does not appear to be a link between absenteeism / agency usage and the number of incidents. For example, in Clinical Support the sickness absence rate is 4.60% in October, the second highest in the Trust yet the number of incidents and near misses is 0.
Nursing and Clinical Infrastructure	3.50		4	0	
Clinical Support	4.60	2.49%	0	0	
Plastics Business Unit	2.71	0.42%	3	1	
Eyes Business Unit	1.40	3.41%	0	0	
Sleep Business Unit	2.04	1.98%	0	0	
Oral Business Unit	4.91	0.25%	3	1	
Total (QVH Overall)	3.24		11	6	

9. Training, Education and Development

Appraisal Compliance Rates as at 30.11.15 (target 100%)	
Corporate	86.16%
Nursing and Clinical Infrastructure	84.39%
Clinical Support	94.39%
Plastics Business Unit	64.63%
Eyes Business Unit	82.76%
Sleep Business Unit	95.45%
Oral Business Unit	75.28%
Total	83.49%



QVH staff compliance for 18 competencies as at 30th November 2015 exc PDR

Area	Permanent & Fixed Term Staff % Compliance	Trends	NON-Permanent Staff % Compliance	Trends	All staff % compliance	Trends
QVH Overall	95.10	↑	64.54	↑	91.85	↑
Corporate	97.34	↑	65.00	↑	81.98	↑
Plastic surgery	92.45	↑	66.67	→	91.12	↑
Oral	93.92	↑	59.09	↑	90.93	↑
Sleep	95.30	↓	55.56	↑	90.00	↓
Eyes	96.93	↑			96.93	↑
Clinical Support	96.68	↑	33.33	→	96.04	↑
Nursing	94.44	↑	75.00	→	94.27	↑

QVH Overall compliance target - 80%

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

Statutory & Mandatory Training summary – Compliance Target 80%

Green 80% & higher / Amber 70-79.99% / Red 0-69.99%

The following competencies are included in the compliance rates:
LOCAL: Emergency Planning (Clinical & non-clinical).
CSTF: Equality, Diversity & Human Rights, Health, Safety & Welfare, Infection Control, Information Governance, Moving & Handling, Conflict Resolution, Resuscitation Level 2 (Adults & Paediatric), Safeguarding Adults, Safeguarding Children Level 1-3.
The majority of business units have continued to raise their compliance rates since last month. Sleep has dropped its overall compliance rate but remains high at 90%. There remains a consistent push for booking staff onto training. The appraisal compliance rates have continued to rise the previous report.

Medical & Dental Statutory & Mandatory Compliance

Medical Education continue to work closely with all medical and dental staff to maintain the levels of compliance achieved recently. Bank staff are a challenge.
Induction for junior doctors will be reviewed in 2016 in line with new requirements and changes to Trust induction.
Where there are problems with access to e-learning via the OLM system, we continue to offer e-Learning for Healthcare as an alternative.

9.1 Learning and Development

Medical Education Summary
In October two new Higher Plastics trainees started, as did a Plastics Trust registrar, a Cataract Fellow, and a Microsurgical Fellow; all attended Doctors' Induction. Many of the current Higher Plastics trainees requested to extend their placements at QVH and therefore will remain with us until Apr 16. Theatre Critical Incident training was implemented successfully and will be run on a monthly basis by the Trust Simulation Lead, who was also involved in another Tracheostomy Study Day. A training day for specialty doctors from the KSS region was run on 19 Nov and was very well received. The topic was Effective Communication Skills with Patients. Work continues on the Integrated Education project funded by HEKSS.

Courses delivered within the period (excluding statutory & mandatory training)		
Course	**Number of attendees**	**% of attendees rating objectives met as good / excellent**
2015 11 02 Tracheostomy Study Day	20	100%
2015 11 17 Planning for your retirement-Awing 9.30-13.00- Tuesday	37	95%
2015-11-19 Effective Communication Skills with Patients for SAS Doctors	12	Helen Moore

10. Staff Engagement, Career progression Apprentices and Work Experience Placements

Staff Survey Action Plan / Family & Friends Test Update

The 2015 Staff Survey results will be available in January / February 2016.

Career progression – number of internal staff promoted to higher band during November 2015

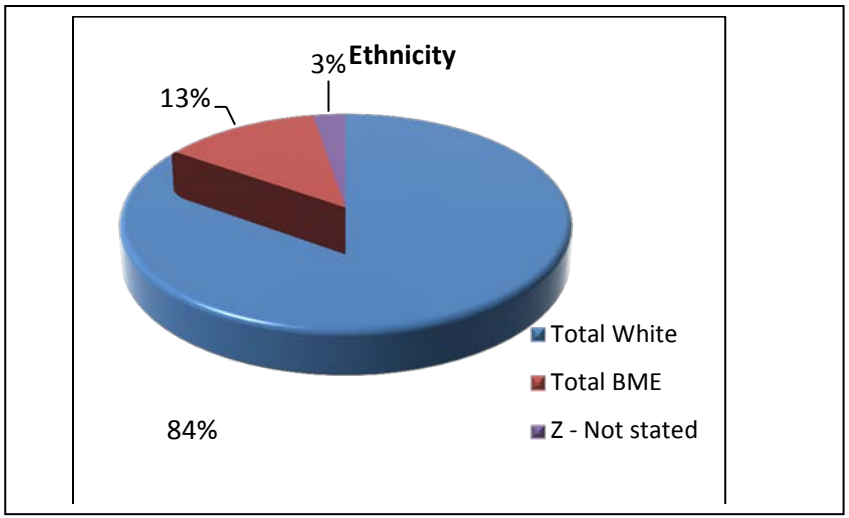
- Occupational Therapist band 5 to Occupational Therapist band 6 in Therapies
- HCA band 2 to Theatre Practitioner band 5 in Theatres

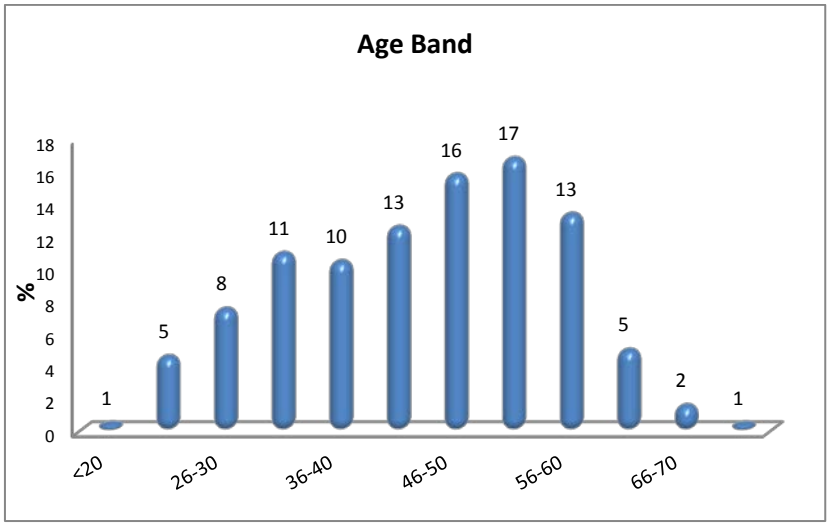
Apprenticeship Scheme and Work Experience Update

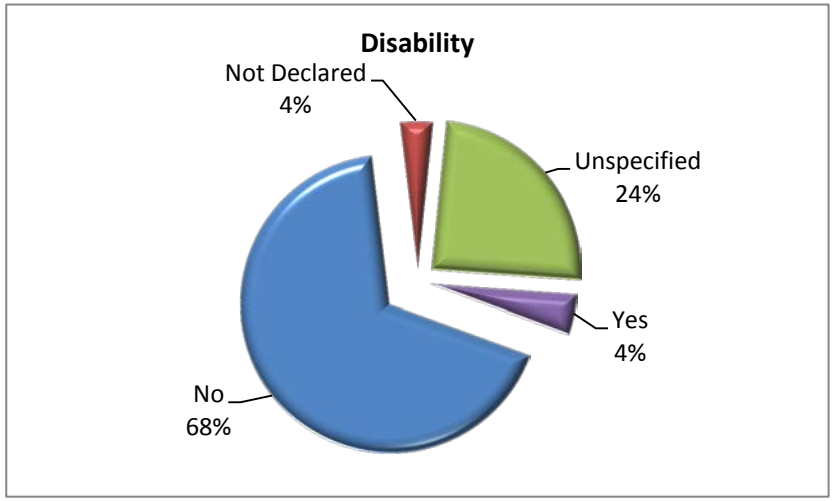
- 9 apprentices on programme
- 3 are existing staff and 6 are new starts
- 4 are business admin (3 at level 2 , 1 at level 3) and 5 are clinical (4 at level 3, 1 at level 4)

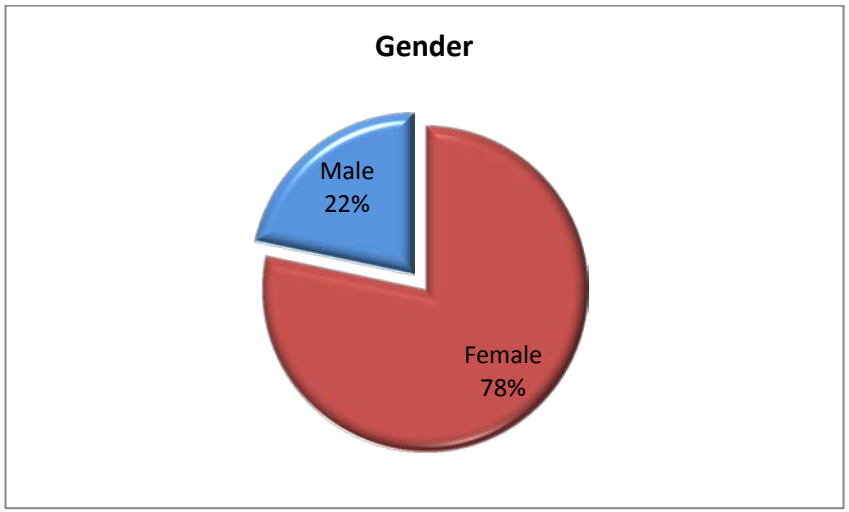
No work experience update this month

11. Workforce Diversity Profile









12. HR&OD Performance

This section outlines the performance of the HR&OD team against the key performance indicators outlined below:

Key Performance Indicator (KPI)	Target	Previous month	Current Month	RAG status
• Reduction in the number of sickness absence days across the trust	2%	3.10%	3.24%	
• All employee relations cases to be managed in accordance with the appropriate policy procedure	100%	100%	100%	
• All pre-employment checks to be completed within 4 weeks of job offer	100%	2 breaches	3 breaches	
• Successful job applicants (who complete evaluation) to rate the recruitment and process as good or excellent	95%	90%	No surveys completed	
• Job applicants are advised within two working days of pre-employment checks completion of their start date.	100%	100%	100%	
• Internal training attendees rate training delivery as excellent / good, and	80%	91%	88%	
• Internal training attendees to say that the objectives of the training have been met	80%	83%	88%	
• Training bookings (by email) to be actioned within 4 working days	100%	0%	100%	
• 90% of internal course attendees to complete the course evaluation form	90%	74%	*42%	
• 12 Apprentices in post by 31 December 2015	12	8 in post	9 in post	
• All payroll entries to be key accurately	100%	95%	95%	
• All contracts of employment to be issued with accurate details	100%	95%	95%	

*The fall in the number of staff completing a course evaluation is due to the change in process. Course attendees are now required a survey online, and it is clear that some staff forget to do this when they return to work or just do not find the time. HR&OD will need to monitor this over the next few months and work with attendees to ensure that they are engaged and provide feedback by completing the survey.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**	**Agenda reference:**	**21-16**		
Report title:	**Engagement policy for corporate guests and visitors**				
Sponsor:	Jo Thomas, Director of Nursing				
Author:	Kathleen Anderson, Company Secretary				
Executive summary					
Purpose:	To establish principles and guidance for hosting and engaging with corporate guests and visitors on the hospital site. To help all staff to recognise a "corporate" guest or visitor, engage with them professionally and appropriately and direct them to the most appropriate colleague(s).				
Recommendation:	Review and consider for approval.				
Purpose:	**Approval**	Information	Discussion	Assurance	**Review**
Link to key strategic objectives (KSOs):	**KSO1:**				**KSO5:**
	Outstanding patient experience				**Organisational excellence**
Implications					
Board assurance framework:	None.				
Corporate risk register:	None.				
Regulation:	Recommendations for the NHS and government following the investigations into the activities of Jimmy Savile relating to the NHS (the 'Lampard' report) were published in February 2015. Themes and lessons learnt from the investigations stressed the need for NHS charities and trusts to agree a specific policy for managing visits by celebrities, VIPs and other official visitors and that these policies should apply to all such visits without exception.				
Legal:	None.				
Resources:	None.				
Assurance route					
Previously considered by:	Not applicable. This policy replaces the 'QVH protocol for ceremonial occasions and VIP visits' last considered by the board of directors in November 2013.				

Queen Victoria Hospital NHS Foundation Trust

Engagement policy for corporate guests and visitors

Draft, December 2015

1. Purpose

1.1. This policy sets out principles and guidance for hosting and engaging with corporate guests and visitors on the hospital site.

1.2. This policy aims to help all staff to recognise a “corporate” guest or visitor, to engage with them professionally and appropriately and, if necessary, to direct them to the most appropriate colleagues.

2. Scope

2.1. This document replaces the ‘QVH protocol for ceremonial occasions and VIP visits’ of November 2013.

2.2. This policy does not relate to:

- guests and visitors of patients
- volunteers
- governors
- contractors working from the trust’s site
- apprentices, medical students and work-experience candidates undertaking professional training placements
- members of staff of organisations that share the trust’s site, including:
    - QVH League of Friends
    - QVH Macmillan Cancer Information and Support Centre
    - Blonde McIndoe Research Foundation
    - McIndoe Centre (Horder Healthcare)

2.3. Any type of guest or visitor described in this policy may also experience the trust’s services as a patient. In which case, this policy would not apply and all other relevant policies relating to the care and treatment of patients would apply fully.

3. Basic principles

3.1. QVH is proud to provide a warm welcome to its corporate guests and visitors.

3.2. QVH takes very seriously its responsibilities to maintain the safety, privacy and dignity of its patients, staff and other visitors. For this reason, the trust is committed to a policy for engaging with corporate guests and visitors which is robust but also pragmatic and proportionate.

3.3. All members of staff who engage with corporate guests and visitors are expected to act professionally in accordance with the trust's values, standards of business conduct policy and other relevant policies.

3.4. Many members of staff will be used to inviting guests to attend meetings and receiving visitors for other business purposes. Nonetheless it is important for all staff to be mindful that:

3.4.1. The principles of this policy apply to all corporate guests and visitors

3.4.2. Staff are responsible for their corporate guests and visitors and must ensure that they:

- Remain within designated and appropriate areas of the site at all times
- Are accompanied at all times in non-public / restricted areas of the site
- Behave appropriately towards members of staff, patients and their friends and families and the general public.

4. Business visitors

4.1. A business visitor is someone employed by another organisation or business whose professional position or role relates to or contributes to the trust's services and objectives.

4.2. Most business visitors will attend a scheduled business meeting at the hospital for a period of time not usually longer than one working day. For this reason most business visitors would not be expected to be provided with an identity pass or access to restricted areas.

4.3. All business visitors must be hosted by a designated member of staff. The host would usually be the organiser and/or chairperson of the meeting the visitor is invited to.

4.4. As part of their meeting or business activities at the trust, some business visitors may be invited to observe clinical care or interact with staff, patients and visitors.

4.5. Business visitors who are invited to undertake business activities in non-public areas of the hospital site should be accompanied at all times by their host or a suitable member of staff who will be responsible for the visitor's movements and actions.

5. Special guests

5.1. From time to time the trust will invite special guests to attend a high-profile meeting, event or visit on the hospital site.

5.2. Special guests will always have been scheduled in advance to attend. Their visit will have been planned by and will be managed by the corporate affairs team on behalf of the executive management team and/or board of directors or by the team that supports the relevant and responsible executive director.

5.3. Types of special guests include:

5.3.1. VIPs such as:

- Members of Parliament and senior representatives of local government
- Very senior NHS officials

5.3.2. Celebrities

Individuals in the public eye whose activities and presence on the hospital site is likely to attract the attention of the press and general public.

5.3.3. Ceremonial guests such as:

- Members of the Royal family
- Religious leaders and very senior representatives of faith groups
- Very senior officials of the British Armed Forces
- (Lord) Mayors (for the purposes of this policy directly elected mayors would be a local government VIP.

5.4. The trust refers to the Jonathan Street PR *Ceremonial occasions: a guide* as a professional reference point for planning and delivering ceremonial occasions and other special guest visits events. Royal visits are guided by advice and protocol provided by relevant Palace officials.

5.5. Most special guests will be accompanied by other people such as assistants and aides, personal security personnel and representatives of specialist press and media. The principles and guidance set out in this section of the policy apply equally to a special guest's entourage as to the special guest(s).

5.6. Special guests and their entourage must be accompanied by a member of trust staff (usually a member of the corporate affairs team or executive management team) at all times while visiting the hospital site.

5.7. These members of staff will be identified and briefed in advance and will be responsible for:

5.7.1. greeting special guests and their entourage as they arrive on site

5.7.2. escorting special guests and their entourage from their point of arrival to their point of departure

5.7.3. using their identity badge and security access to escort special guests and their entourage into any patient or other restricted areas as defined by the event plan

5.7.4. leading special guests to and from areas and facilities reserved for special guests and their entourage to take comfort breaks. These will always be provided in non-patient areas.

5.8. The trust will ensure that any member of staff with responsibility for accompanying special guests and their entourage have appropriate Disclosure and Barring Service (DBS) clearance to access the areas defined in the event plan, according to the trust's policies. They must also have up-to-date training regarding privacy and dignity, safe-guarding training and infection prevention and control, according to the trust's mandatory and statutory training policies.

5.9. The trust would not expect to provide special guests with an identity pass. However, for certain ceremonial guests it will be expected that designated member of the guest's entourage are provided with an identity pass and access to non-public areas. In this case:

5.9.1. Any passes provided for the purpose of the visit must be signed in and out

5.9.2. Where possible, passes will be programmed to allow access only to those areas defined in the event plan

5.9.3. Passes and/or lanyards will be clearly marked "visitor" to ensure that any special guest who may be required to wear specific protective or disposable clothing are always identifiable to patients and visitors and cannot be confused for members of staff.

5.10. Planning for a special guest visit will always include advanced notification of the visit and itinerary to the trust's executive management team, security officers, estates team and all relevant managers and clinical staff, in addition to the relevant authorities and advisors such as the Police and Palace.

5.11. Visits that incorporate opportunities for special guests to meet patients will only do so with the advanced and explicit agreement of the patient, as follows:

5.11.1. Appropriate clinical staff will be consulted first to provide assurance of a patient's mental capacity to agree to meet a special guest

5.11.2. Agreement for a special guest to visit a paediatric patient can only be made by the child's parent or legal guardian who must also accompany the child at all times during the visit

5.11.3. A relevant member of clinical staff will always be present during any meeting between a special guest and a patient, in addition to the nominated escort and

any parent/guardian or carer necessary according to the patient's circumstances.

6. Media representatives

6.1. Most guests and visitors that represent the media will have arranged or have been invited to attend the hospital site in advance.

6.2. Some representatives of the media may visit the hospital site without prior notice. If so, they should be directed immediately to the corporate affairs team who will help them.

6.3. Media representatives must be accompanied by a member of the corporate affairs team at all times while present on the hospital site.

6.4. Most media representatives will be present on the hospital site for a scheduled period of time not usually longer than one working day. For this reason most media representatives would not be expected to be provided with an identity pass or access to restricted areas.

6.5. Occasionally the corporate affairs team will arrange for media representatives to be provided with an identity pass or access to restricted areas and access to patients who have given their consent in advance. These arrangements will always be discussed in advance with relevant members of staff to avoid disruption to services and maintain the privacy and dignity of patients and visitors. The corporate affairs team may also require media representatives to sign a confidentiality agreement and/or evidence of appropriate DBS checks before allowing them to work from the hospital site.

6.6. Types of media representatives include:

- Journalists: usually people who research and write articles for publication in print and online. They may be employed directly by the popular or specialist press or be freelance individuals who sell their completed work to publishers
- Reporters: usually people who research and present audio or visual programmes for broadcast. Sometimes these individuals may work alone and operate their own recording equipment
- Producers and directors: usually people who commission and lead projects to research and develop ideas for publications and programmes
- Camera men and women: people who specialise in recording moving images and sound for broadcasting
- Photographers: people who specialist in recording still images for publication.

6.7. All media recordings and photography will be subject to the following guiding principles:

- Patients, their families and friends and other visitors to the site must be asked for their permission to be filmed or photographed in advance. They must also be asked to sign an associated consent form to indicate how they would like their image to be used. For these reasons, particular care must be taken with general images of the hospital site and public areas.

- All patients, visitors and staff have the right to ask not to be photographed or filmed and for any unconsented images to be deleted.

7. Regulators

7.1. The services and practices of Queen Victoria NHS Foundation Trust are subject to regulation by relevant authorities that include Monitor and the Care Quality Commission.

7.2. Official representatives of the trust's regulators may visit and inspect the hospital site at any time and may do so without prior notice.

7.3. When they arrive on the hospital site, representatives of the trust's regulators are expected to report to the main entrance or to a relevant member of the executive management team and to provide identification.

7.4. For scheduled inspections expected to take place over a period of time longer than one working day, representatives of the trust's regulators may be provided with an identity badge.

7.5. For scheduled inspections, clear information about access for regulators to restricted areas will be provided to all relevant staff by the responsible executive director or their team.

8. Participants in events

8.1. Occasionally the trust organises events on the hospital site which are open to members of the public. Common types of events include:

- Education and training events

- Open day / information events such as recruitment events

- Celebration events such as special guest visits

8.2. Open events should be organised to take place in non-patient areas of the hospital site and cause minimal disruption to services and routine activities.

8.3. Some events may take place in non-patient areas of the hospital site but which are not usually open to the general public such as areas adjacent to staff offices. Event

organisers should be mindful of the location of their event and manage their participants accordingly.

8.4. Where possible, event organisers should provide attendees with individual name badges.

9. Prospective employees and contractors

9.1. The trust regularly invites individuals to attend interviews, stakeholder panel meetings and other events in order to consider offering employment or other service contracts.

9.2. For the purposes of this policy, prospective employees and contractors should be considered to be business visitors.

10. Supporters

10.1. Supporters of the trust's charity and other charities associated with the trust may visit the hospital site to take part in fundraising activities, to meet with the charity team, to thank hospital staff and/or present them with funds raised in their honour.

10.2. Supporters will usually be accompanied by a member of the corporate affairs team and a representative of the relevant charity.

10.3. The trust's charity and other charities associated with the trust will occasionally invite special guests to attend charitable events. In which case, the principles of engagement set out in section 5 above will apply.

10.4. The trust will work closely with other charities associated with it, especially those which share the trust's site, to apply this policy equally and fairly according to the basic principles set out in section 3 above.

Kathleen Anderson

Company Secretary

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**	**Agenda reference:**	**22-16**		
Report title:	**Approval of terms of reference of board sub-committees**				
Sponsor:	Beryl Hobson, Chair				
Author:	Kathleen Anderson, Company Secretary				
Executive summary					
Purpose:	For the board to approve terms of reference of its audit, finance and performance and quality and governance sub-committee, as developed and agreed by the sub-committees following an integrated review by the company secretary. Draft revised terms of reference for the board's nomination and remuneration committee will be considered by the sub-committee at its meeting on 14 January 2016.				
Recommendation:	Approval				
Purpose:	Approval				
Link to key strategic objectives (KSOs):					KSO5:
					Organisational excellence
Implications					
Board assurance framework:	None.				
Corporate risk register:	None.				
Regulation:	• Consist with the expectations of the Monitor *Code of Governance* and good governance practice • Strengthens the board governance arrangements following review • Contributes to maintaining regulatory ratings for governance.				
Legal:	None.				
Resources:	None.				
Assurance route					
Previously considered by:	**Audit Committee**				
	Date:	02/12/15	Decision:	Approved.	
Previously considered by:	**Quality and Governance Committee**				
	Date:	10/12/15	Decision:	Approved subject to minor corrections now incorporated.	
Previously considered by:	**Finance and Performance Committee**				
	Date:	21/12/15	Decision:	Approved subject to one correction now incorporated.	

Terms of reference

Name of governance body

Finance and performance (F&P) committee

Constitution

The finance and performance committee ("the committee") is a standing and permanent sub-committee of the board of directors, established in accordance with the trust's standing orders, standing financial instructions and constitution.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The board of directors has delegated authority to the committee to take the following actions on its behalf:

- Approve specific policies and procedures relevant to the committee's remit
- Approve submission of quarterly monitoring reports to the trust's regulator
- Approve other exception or ad-hoc reports required by the regulator
- Approve submission of the trust's annual plan to the trust's regulator
- Seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Purpose

The purpose of the committee is to assure the board of directors of:

- In-year delivery of financial and performance targets; and
- In-year delivery of the trust's strategic initiatives.

To provide this assurance the committee will maintain a detailed overview of:

- the trust's assets and resources in relation to the achievement of its financial plans and key strategic objective four: financial sustainability;
- the trust's operational performance in relation to the achievement of its activity plans and key strategic objective three: operational excellence; and
- the trust's workforce profile in relation to the achievement of key performance indicators and key strategic objective five: organisational excellence.

To fulfil its purpose, the committee will also:

- identify the key issues and risks requiring discussion or decision by the board of directors;
- advise on appropriate mitigating actions; and
- make recommendations to the board to amend or modify the trust's strategic initiatives in the light of changing circumstances or issues arising from implementation.

Responsibilities and duties

Responsibilities

On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of the trust's:

- monthly financial and operational performance

- estates and facilities strategy and maintenance programme
- information management and technology (IM&T) strategy, performance and development.

The committee will make recommendations to the board in relation to:
- capital and other investment programmes
- cost improvement plans
- business development opportunities and business cases.

Duties

Financial and operational performance
- Review, interpret and challenge in-year financial and operational performance
- Review, interpret and challenge workforce profile metrics including sickness absence, people management, bank and agency usage, statutory and mandatory training compliance and recruitment
- Oversee the development and delivery of any corrective actions plans and advise the board of directors accordingly
- Review and support the development of appropriate performance measures, such as key performance indicators (KPIs), and associated reporting and escalation frameworks to inform the organisation and assure the board of directors
- Refer issues of quality or specific aspects of the quality and governance committee's remit, to the quality and governance committee and maintain communication between the two committees to provide joint assurance to the board of directors.

Estates and facilities strategy and maintenance programmes
- Review the delivery of the trust's estates and facilities strategy and planned maintenance programmes as agreed by the board of directors
- Consider initiatives and review proposals for land and property development and transactions prior to submission to the board of directors for approval.

Information management and technology (IM&T) strategy, performance and development
- Review the delivery of the trust's IM&T strategy and planned development programmes as agreed by the board of directors.

Capital and other investment programmes and decisions
- Oversee the development, management and delivery of the trust's annual capital programme and other agreed investment programmes.
- Evaluate, scrutinise and recommend the financial validity of individual significant investment decisions, including outline and full business cases. Business cases that require approval by the board of directors will be referred to the committee following initial review by the executive management team and/or capital planning group.

Cost improvement plans
- To oversee the delivery of the trust's cost improvement plans and the development of associated efficiency and productivity programmes.

Business development opportunities and business cases
- Evaluate emerging opportunities on behalf of the board of directors
- Consider the merit of developed business cases for new service developments and service disinvestments prior to submission to the board of directors for approval.

Meetings

Meetings of the committee shall be formal, minuted and compliant with these terms of reference and the trust's relevant codes of conduct.

The committee will meet once in each calendar month.

The chairperson of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.

Chairmanship

The committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

If the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by one of the other non-executive director members of the committee.

Secretariat

The executive assistant to the director of finance shall be the secretary to the committee and shall provide administrative support and advice to the chairperson and members. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the committee's work programme.

Membership

Members with voting rights

The following posts are entitled to permanent membership of the committee with full voting rights:

- x3 non-executive directors
- Chief Executive
- Executive Director of Finance
- Executive Director of Nursing
- Director of Operations
- Director of HR and Organisational Development

Designated deputies (as described below) are entitled to temporary membership of the committee with full voting rights.

Ex-officio members

The following bodies shall be invited to nominate an ex-officio member of the committee to represent their interests:

With voting rights

- Council of Governors of Queen Victoria Hospital NHS Foundation Trust

The chairperson, members of the committee and the governor representative shall commit to work together according to the principles established by the trust's policy for engagement between the board of directors and council of governors.

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the committee in full or in part but shall neither be a member nor have voting rights:

- The secretary to the committee (for the purposes described above)
- Any other member of the board of directors, senior member of trust staff or advisor considered appropriate by the chair of the committee.

Quorum

For any meeting of the committee to proceed, two non-executive director members of the committee and either the chief executive or director of finance must be present.

Attendance

Members are expected to attend all meetings or to send apologies to the chairperson and committee secretary at least one clear day* prior to each meeting.

Applicable members may, by exception and with the consent of the chairperson, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on the behalf of the committee member.

Papers

Meeting papers shall be distributed to committee members and individuals invited to attend committee meetings at least two clear days* prior to each meeting.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

Minutes of committee meetings and an assurance report from the committee chairperson shall be submitted to the board of directors at its next formal business meeting.

Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.

The committee chairperson and governor representative to the committee shall report verbally at quarterly meetings of the council of governors.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to approve all changes.

The next scheduled review of these terms of reference will take place in October 2016, in parallel with the next annual review of the effectiveness of the board of directors.

**** Definitions***

- In accordance with the trust's constitution, **'clear day'** means a day of the week not including a Saturday, Sunday or public holiday.

Terms of reference

Name of governance body

Quality and Governance (Q&G) Committee

Constitution

The quality and governance committee ("the committee") is a standing and permanent sub-committee of the board of directors, established in accordance with the trust's standing orders, standing financial instructions and constitution.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The board of directors has delegated authority to the committee to take the following actions on its behalf:

- Approve specific policies and procedures relevant to the committee's purpose, responsibilities and duties
- Engage with the trust's auditors in cooperation with the audit committee
- Seek any information it requires from within the trust and to commission independent reviews and studies if it considers these necessary.

Purpose

The purpose of the committee is to assure the board of directors of:

- The quality and safety of clinical care delivered by the trust at either its hub site in East Grinstead or any other 'spoke' sites
- The management and mitigation of clinical risk
- The governance of the trust's clinical systems and processes.

To provide this assurance the committee will maintain a detailed overview of:

- Health and safety
- Clinical and information governance
- Management of medicines and clinical devices
- Safeguarding
- Patient experience
- Infection control
- Research and development governance
- All associated policies and procedures.

To fulfil its purpose, the committee will also:

- Identify the key issues and risks requiring discussion or decision by the board of directors and advise on appropriate mitigating actions
- Make recommendations to the board about the amendment or modification of the trust's strategic initiatives in the light of changing circumstances or issues arising from implementation
- Work closely with the audit and finance and performance committees as necessary.

Responsibilities and duties

Responsibilities

On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of:

- the trust's performance against the three domains of quality; safety, effectiveness and patient experience

- compliance with essential professional standards, established good practice and mandatory guidance including but not restricted to:
    - Care Quality Commission national standards of quality and safety
    - National Institute for Care Excellence (NICE) guidance
    - National Audit Office (NAO) recommendations
    - Relevant professional bodies (e.g. Royal colleges) guidance
- delivery of national, regional, local and specialist care quality (CQuIN) targets.

Duties

- Support the compilation of the trust's annual quality accounts recommend to the board of directors its submission to the Care Quality Commission
- Recommend quality priorities to the board of directors for adoption by the trust
- Ensure that the audit programme adequately addresses issues of relevance and any significant gaps in assurance
- To receive a quarterly report on healthcare acquired infections and resultant actions
- To receive and review quarterly integrated reports encompassing complaints, litigation, incidents and other patient experience activity
- To ensure that workforce issues, where they impact or have a direct relationship with quality of care are discussed and monitored
- Review quarterly quality components of the corporate risk register and assurance framework and make recommendations on areas requiring audit attention, to assist in ensuring that the trust's audit plans are properly focused on relevant aspects of the risk profile and on any significant gaps in the assurance
- Ensure that management processes are in place which provides assurance that the trust has taken appropriate action in response to relevant independent reports, government guidance, statutory instruments and ad hoc reports from enquiries and independent reviews
- Ensure there are clear lines of accountability for the overall quality and safety of clinical care and risk management
- Hold business units and directorates (clinical infrastructure/non clinical infrastructure) to account on all matters relating to quality, risk and governance.

Meetings

Meetings of the committee shall be formal, minuted and compliant with these terms of reference and the trust's relevant codes of conduct.

The committee will meet once in each calendar month for at least 10 months per year.

The chairperson of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.

Chairmanship

The committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

If the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by one of the other non-executive director members of the committee.

Secretariat

The personal assistant to the director of nursing shall be the secretary to the committee and shall provide administrative support and advice to the chairperson and members. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson

- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the committee's work programme.

Membership

Members with voting rights

The following posts are entitled to permanent membership of the committee with full voting rights:

- x2 non-executive directors
- Chief Executive
- Medical Director
- Director of Nursing
- Deputy Director of Nursing/Head of Clinical Infrastructure
- Director of Finance
- Director of Operations
- Director of HR and Organisational Development.

Designated deputies (as described below) are entitled to temporary membership of the committee with full voting rights.

Ex-officio members

The following bodies shall be invited to nominate an ex-officio member of the committee to represent their interests:

With voting rights

- Council of Governors of Queen Victoria Hospital NHS Foundation Trust
  The chairperson, members of the committee and the governor representative shall commit to work together according to the principles established by the trust's policy for engagement between the board of directors and council of governors.

Without voting rights

- The trust's internal auditor
- Clinical Commissioning Group (CCG) – principle commissioner of the trust's services

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the committee in full or in part but shall neither be a member nor have voting rights:

- The secretary to the committee (for the purposes described above)
- Business managers
- Allied health professional lead
- Infection control lead
- Head of risk
- Pharmacy lead
- Company secretary
- Audit and outcomes lead

Quorum

For any meeting of the committee to proceed, the following combination of members must be present:

- one non-executive director
- either the director of nursing or deputy director of nursing must be present

- one other director with voting rights

four members without voting rights.

Attendance

Members are expected to attend all meetings or to send apologies to the chairperson and committee secretary at least one clear day* prior to each meeting.

Applicable members may, by exception and with the consent of the chairperson, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on the behalf of the committee member.

Papers

Meeting papers shall be distributed to committee members and individuals invited to attend committee meetings at least five clear days* prior to the meeting.

In the event of a significant adverse variance in any of the key indicators of clinical performance or patient safety, the responsible executive director will make an immediate report to the committee chairperson copied to the trust chair and chief executive, for urgent discussion at the next meeting of the committee and escalation to the trust board.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

Minutes of committee meetings and an assurance report from the committee chairperson shall be submitted to the board of directors at its next formal business meeting.

Issues of concern and/or urgency will be reported to the board of directors in between formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.

Final and approved minutes of committee meetings shall be shared with the clinical cabinet and a quarterly update from the committee chairperson shall be provided to the audit committee.

The committee chairperson and governor representative to the committee shall report verbally at quarterly meetings of the council of governors.

Review

These terms of reference shall be reviewed annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to approve all changes.

The next scheduled review of these terms of reference will take place in October 2016, in parallel with the next annual review of the effectiveness of the board of directors.

*** Definitions**

- In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Terms of reference

Name of governance body

Audit Committee

Constitution

The Audit Committee ("the committee") is a statutory, non-executive committee of the board of directors.

Accountability

The committee is accountable to the board of directors for its performance and effectiveness in accordance with these terms of reference.

Authority

The committee is authorised by the board of directors to:

- investigate any activity within its terms of reference.
- commission appropriate independent reviews and studies.
- seek relevant information from within the trust and from any employee (all departments and employees are required to co-operate with requests from the committee).
- obtain relevant legal or other independent advice and to invite professionals with relevant experience and expertise to attend meetings of the committee.

Purpose

The purpose of the committee is the scrutiny of the organisation and maintenance of an effective system of governance, risk management and internal control. This should include financial, clinical, operational and compliance controls and risk management systems. The committee is also responsible for maintaining an appropriate relationship with the trust's internal and external auditors.

Duties and responsibilities

On behalf of the board of directors, the committee will be responsible for the oversight and scrutiny of the trust's:

1. **Integrated governance, risk management and internal control**
   The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

   In particular, the committee will review the adequacy and effectiveness of:
   - All risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board of directors.
   - The underlying assurance processes, including the board assurance framework, that indicate the degree of achievement of the trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
   - The draft quality accounts, including the rigour of the process for producing the quality accounts, in particular whether the information included in the report is

accurate and whether the report is representative of both the services provided by the trust, and of the issues of concern to its stakeholders.
- The board of director' sub-committees, including terms of reference, workplans and span of reporting on an annual basis.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work, the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key governance bodies of the trust (for example, the quality and governance committee) so that it understands processes and linkages.

2. Financial reporting

The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board of directors including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submissions to the board of directors, focusing particularly on:
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statement in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanations for significant variances

The committee should review the trust's standing financial instructions, standing orders and the scheme of delegation on an annual basis and make recommendations for change to the board of directors.

Internal audit

The committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the committee, chief executive (as accountable officer) and board of directors. This will be achieved by:
- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the annual internal audit plan and more detailed

programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit
The committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:
- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment allow (and making recommendations to the council of governors when appropriate).
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual audit plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation.
- Reviewing all external audit reports, including the trust's annual quality report (before its submission to the board of directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Whistle blowing
The committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns raised were investigated proportionately and independently.

Counter fraud
The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Management
The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

Other assurance functions
The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality

Commission and the NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

In addition, the committee will review the work of other committees within the organisation whose work can provide relevant assurance to the committee's own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

In reviewing the work of a clinical governance committee, and issues around clinical risk management, the committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Meetings

Meetings of the committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the trust's codes of conduct.

The committee will meet quarterly.

At least once a year, the committee should meet privately with representatives of the external and internal auditors.

The chair of the committee may cancel, postpone or convene additional meetings as necessary for the committee to fulfil its purpose and discharge its duties.

The board of directors, chief executive (as accountable officer), representative of the external auditor and head of internal audit may request additional meetings if they consider it necessary.

Chairmanship

The committee shall be chaired by a non-executive director, appointed by the trust chair following discussion with the board of directors.

If the chairperson is absent or has a conflict of interest which precludes his or her attendance for all or part of a meeting, the committee shall be chaired by one of the other non-executive director members of the committee.

The representative of the external auditor, head of internal audit, and counter fraud specialist have the right of direct access to the chairperson of the committee to discuss any matter relevant to the purpose, duties and responsibilities of the committee or to raise concerns.

Secretariat

The deputy company secretary shall be the secretary to the audit committee and shall provide administrative support and advice to the chairperson and membership. The duties of the secretary shall include but not be limited to:

- Preparation of the draft agenda for agreement with the chairperson
- Organisation of meeting arrangements, facilities and attendance
- Collation and distribution of meeting papers
- Taking the minutes of meetings and keeping a record of matters arising and issues to be carried forward
- Maintaining the committee's work programme.

Membership

Members with voting rights

The committee will comprise at least three non-executive directors who shall each have full voting rights. The chairperson of the trust shall neither chair nor be a member of the committee but can attend meetings by invitation of the committee chairperson.

Ex-officio attendees without voting rights

- Chief Executive (as Accountable Officer) who shall discuss with the committee at least annually the process for assurance that supports the annual governance statement. The chief executive should also be in attendance when the committee considers the draft annual governance statement along with the annual report and accounts.
- Representatives of the trust's internal auditors.
- Representatives of the trust's external auditors.
- The trust's counter fraud specialist who shall attend at least two meetings of the committee in each financial year.
- Representative of the QVH Council of Governors

The chairperson, members of the committee and the governor representative shall commit to work together according to the principles established by the trust's policy for engagement between the board of directors and council of governors.

In attendance without voting rights

The following posts shall be invited to attend routinely meetings of the committee in full or in part but shall neither be a member nor have voting rights:

- Executive Director of Finance.
- Executive Director of Nursing.
- The secretary to the committee (for the purposed described above).
- Designated deputies (as described below).
- Any other member of the board of directors, senior member of trust staff or advisor considered appropriate by the chair of the committee, particularly when the committee will consider areas of risk or operation that are their responsibility.

Quorum

For any meeting of the committee to proceed, two non-executive director members of the committee must be present.

Attendance

Members and attendees are expected to attend all meetings or to send apologies to the chairperson and committee secretary at least one clear day* prior to each meeting.

Attendees may, be exception and with the consent of the chairperson, send a suitable deputy if they are unable to attend a meeting. Deputies must be appropriately senior and empowered to act and vote on behalf of the committee member.

Papers

Meeting papers to be distributed to members and individuals invited to attend at least five clear days prior to the meeting.

Reporting

Minutes of the committee's meetings shall be recorded formally and ratified by the committee at its next meeting.

The committee chairperson shall prepare a report of each committee meeting for submission to the board of directors at its next formal business meeting. The report shall draw attention to any issues which require disclosure to the board of directors including where executive action is continually failing to address significant weaknesses.

Issues of concern and/or urgency will be reported to the board of directors in between its formal business meetings by other means and/or as part of other meeting agendas as necessary and agreed with the trust chair. Instances of this nature will be reported to the board of directors at its next formal business meeting.

The committee will also report to the board of directors at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts

The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

In addition, the committee shall make an annual report to the council of governors in relation to the performance of the external auditor to enable the council of governors to consider whether or not to re-appoint them.

Review

These terms of reference shall be reviewed by the committee annually or more frequently if necessary. The review process should include the company secretarial team. The board of directors shall be required to ratify all changes.

The next scheduled review of these terms of reference will take place in October 2016, in parallel with the next annual review of the effectiveness of the board of directors.

* Definitions

- In accordance with the trust's constitution, 'clear day' means a day of the week not including a Saturday, Sunday or public holiday.

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	07/01/2016		**Agenda reference**	23-16	
Report title:	QVH Charity committee report				
Sponsor:	N/A				
Author:	Lester Porter				
Appendices:	None				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the Charity Committee				
Recommendation:	To note the contents of this report.				
Purpose:				**Assurance**	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	QVH Charity Committee				
	Date:	17/12/15	Decision:	Endorsed	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 23-16
Report from: Lester Porter, committee chair
Report date: 30 December 2015

QVH Charity Committee report
Meeting held on 17th December 2015

1. **Terms of Reference**
   Revised TORs were approved by the committee for submission to the board of directors acting in its capacity as Corporate Trustee.

2. **Charity Policy**
   A draft of the proposed new Charity Policy was discussed and approved by the committee for submission to the Corporate Trustee in the first quarter of 2016. It was agreed that an additional section, relating to fund raising, should be added during 2016 but that this should not hold up final approval, and introduction of the policy with effect from 1st April 2016.

3. **Outstanding Audit Action Plan items**
   With the Corporate Trustee's recent agreement to a restructure of the Charitable funds, and subject to its approval of the new Charity Policy, all outstanding actions can be completed.

4. **Applications for funding**
   There was a high level of applications submitted for £88586 in total. Following discussion of each application, a total of £44,330 was approved providing full or partial funding for seven items.

5. **Etherington report on the Regulation of Fundraising**
   The committee was provided with the report and assurance that the QVH Charity is currently compliant with its recommendations. The committee noted in particular the Report's guidance on aggressive approaches to vulnerable people for fundraising purposes, and was assured that the Charity does not undertake such practices.

There are no other matters requiring further action by the board other than those highlighted above.

LWM Porter
30/12/2015

Queen Victoria Hospital NHS
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Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference:**	**24-16**	
Report title:	**Audit Committee report**				
Sponsor:	Lester Porter, Senior Independent Director and Committee Chairperson				
Author:	Lester Porter, Senior Independent Director and Committee Chairperson				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters dealt with at the audit committee's quarterly meeting.				
Recommendation:	The board of directors is asked to note this report.				
Purpose:				**Assurance**	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	The audit committee undertakes wide ranging reviews of board assurance framework and corporate risk register issues to provide assurance on governance, internal control, and the identification and management of risk.				
Corporate risk register:	As above				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Audit Committee				
	Date:	02/12/15	Decision:	Endorsed	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 24-16
Report from: Lester Porter, committee chair
Report date: 29 December 2015

Audit Committee report
Meeting held on 2nd December 2015

1. **Board Assurance Framework**
   The chair submitted a proposal for providing assurance to the board of directors in relation to the Key Strategic Objectives including:
   - that the audit committee should review the BAF and Corporate Risk Register at each meeting to ensure they remain up to date, relevant and 'fit for purpose';
   - that the nominated executive lead for each of the Trust's KSO's attends audit meetings on a rolling basis, in order to provide more detailed assurance on the risks;
   - that the chairs of the Finance & Performance and Quality & Governance subcommittees also provide a regular assurance report to the audit committee.

   It was agreed to commence this rolling programme of review from June 2016 onwards.

2. **Terms of Reference and Audit Work Plan**
   Revised versions were approved by the committee, and are attached to the board papers for approval/ information as appropriate.

3. **Prior year Internal Audit Recommendations**
   The 29 outstanding recommendations have now been reduced to 18 and all bar one are expected to be completed by March 2016.

4. **Internal Audit Progress Report**
   Progress to date has been slower than anticipated, although Mazars assured the committee that all planned work would be completed by year end. Subsequent to the committee meeting, the chair had a discussion with Mazars to emphasize that it was essential that all projects were completed before year end, and that Mazars should alert the chair at the earliest opportunity if there was any further risk of slippage.

5. **2015/16 External Audit Plans**
   KMPG outlined their proposed plans for this year's audit, and confirmed that the audit fee would remain the same as last year.

6. **Revised Standing Financial Instructions**
   The Director of Finance presented proposals for amended SFI's targeted for introduction in April 2016, and the intention to develop an integrated suite of

governing documents, which would be presented to the committee next March.

7. **2015/16 Accounts Timetable**
   The timetable for this year's accounts and plans was circulated for information.

There were no issues requiring specific action by the board of directors

LWM Porter
29/12/2015

Queen Victoria Hospital NHS
NHS Foundation Trust

Report cover-page					
References					
Meeting title:	**Board of Directors**				
Meeting date:	**07/01/16**		**Agenda reference**	**25-16**	
Report title:	**Corporate trustee of the QVH charity report**				
Sponsor:	Beryl Hobson, Trust Chair and Committee Chairperson				
Author:	Beryl Hobson, Trust Chair and Committee Chairperson				
Executive summary					
Purpose:	To provide assurance to the board in relation to matters discussed at the meeting of the corporate trustee of the QVH charity.				
Recommendation:	To note the contents of this report.				
Purpose:				**Assurance**	
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	Outstanding patient experience	World-class clinical services	Operational excellence	Financial sustainability	Organisational excellence
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	Charities Commission				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Corporate Trustee of the QVH Charity				
	Date:	03/12/15	Decision:	Endorsed	

Queen Victoria Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Meeting date: 7 January 2016
Reference no: 25-16
Report from: Beryl Hobson, committee chairperson
Report date: 29 December 2015

Report from the Corporate Trustee of the QVH Charity

1. The Corporate Trustee met following the board seminar on 3 December 2015.

2. The annual report and accounts for the charity were accepted and approved, and authority was delegated to the chief executive to sign the management representation letter to the auditors on behalf of the corporate trustee. The report and accounts have been submitted to the Charity Commission which will publish the document on its website in due course.

3. The Corporate Trustee agreed to continue using the Trust's auditors and recognised that this appointment was subject for review in the course of 2016.

4. The charitable fund action plan, which was developed following an internal audit in 2014, was discussed. In addition to the recommendations by the auditors, the Charity Committee had reviewed the overall charitable funds structure and a proposal to reduce the number of designated funds had been agreed by the Corporate Trustee in September 2015. The Corporate Trustee was pleased to see the progress on the action plan, and noted that outstanding actions all related to the development of a charity policy which will include donations, fundraising and applications for funds. The work on this is well advanced and will be presented to the Corporate Trustee early in 2016.

Beryl Hobson, Trust Chair

Queen Victoria Hospital NHS
NHS Foundation Trust

Business meeting of the Board of Directors
Thursday 3 March 2016 at 10:00
The Cranston Suite, East Court, College Lane, East Grinstead RH19 3LT

Agenda: session held in public		
Welcome		
-16	**Welcome, apologies and declarations of interest** *Beryl Hobson, Chair*	-
Standing items		
-16	**Draft minutes of the meeting session held in public on 7 January (for approval)** *Beryl Hobson, Chair*	
-16	**Matters arising and actions pending** *Beryl Hobson, Chair*	
-16	**Chief executive's report** *Richard Tyler, Chief Executive*	
-16	**Corporate Risk Register (CRR)** *Richard Tyler, Chief Executive*	
Key strategic objective 1: outstanding patient experience		
-16	**Board Assurance Framework** *Jo Thomas, Director of Nursing*	
-16	**Patient story: experience** *Jo Thomas, Director of Nursing*	-
-16	**Quality and Governance Committee: assurance report** *Ginny Colwell, Non-Executive Director and committee chairperson*	
-16	**Safe staffing and quality of care** • national cancer survey results • national inpatient survey • national paediatric survey *Jo Thomas, Director of Nursing*	
Key strategic objective 2: world-class clinical services		
-16	**Board Assurance Framework** *Steve Fenlon, Medical Director*	
-16	**Medical Director's report** *Steve Fenlon, Medical Director*	

Key strategic objectives 3 and 4: operational excellence and financial sustainability		
-16	**Board Assurance Framework** *Sharon Jones, Director of Operations and Clare Stafford, Director of Finance and Performance*	
-16	**Financial and Performance Committee: assurance report** *John Thornton, Non-Executive Director and committee chairperson*	
-16	**Operational performance** *Sharon Jones, Director of Operations*	
-16	**Financial performance** *Clare Stafford, Director of Finance and Performance*	
Key strategic objective 5: organisational excellence		
-16	**Board Assurance Framework** *Graeme Armitage, Director of Human Resources and Organisational Development*	
-16	**Workforce report** *Graeme Armitage, Director of Human Resources and Organisational Development*	
-16	**Staff Survey report** *Graeme Armitage, Director of Human Resources and Organisational Development*	
-16	**Education and wellbeing centre** *Richard Tyler, Chief Executive and Ian Francis, Clinical Director for Strategy*	
Board governance		
-16	**Council of Governors** *Kathleen Anderson, Company Secretary*	
-16	**Nomination & Remuneration committee** *Beryl Hobson, Trust Chair*	
-16	**Draft agenda for the May 2016 business meeting** *Kathleen Anderson, Company Secretary*	
Any other business (by application to the Chair)		
-16	*Beryl Hobson, Chair*	-
Observations and feedback		
-16	**Feedback from key events and other engagement with staff and stakeholders** *All board members – please submit list in advance to the Deputy Company Secretary*	-
-16	**Observations from members of the public** *Beryl Hobson, Chair*	-
-16	**Observations and feedback on the meeting** *Ginny Colwell, non-executive director*	-
Date of the next meetings		

Board of Directors:	Sub-Committees	Council of Governors
Seminar: 07 April at 11:00	**Q&G:** 10 March 2016 at 09:00	**Public**: 21 April 2016 at 15.00
Public: 05 May at 10:00	**F&P:** 21 March 2016 at 14:00	
	Charity: 31 March 2016 at 09:00	
	N&R: 14 April 2016 at 11:00	
	Audit: 19 May 2016 at 14:00	
	Corp. Trustee: TBA	