



Forward Plan Strategy Document for

Queen Victoria Hospital NHS Foundation Trust
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Plan for y/e 31 March 2012 (and 2013, 2014)

Section 1 – Strategy

1.1 Trust's current position and vision

Current Position at QVH

A year ago the Trust faced an uncertain future and needed to address significant issues such as

- Deteriorating underlying financial performance
- An urgent need to invest significantly in the estate
- Its ability to continue as a stand alone organisation

In response the Trust's management team developed a financial plan that sought to address the cost base of the organisation and ensure all service lines contributed their target surplus, improving the overall financial performance. The plan was shared and agreed with Monitor.

The Board also undertook a strategic review of the options on standing alone or merging with a partner organisation in order to support the necessary investment in replacement of unsatisfactory estate.

Strategic Review

A Strategic Review was carried out looking at options for the organisation's longer term future. The short listed options were

- Stand Alone
- Merge with a partner organisation maintaining services at East Grinstead

After rigorous analysis of the options and their respective ability to achieve the agreed objectives, including consultation with various stakeholder groups, the Board concluded that none of the merger options were likely to meet the criteria around securing the long term future of services on the QVH site. At the same time the financial performance was sufficiently improved to enable the Trust to maintain its independence and to make the necessary investment in replacing 6 of our 10 theatres. The Board reinforced the commitment of QVH to continue to work with partner hospitals in developing and delivering our core reconstructive surgery services.

Strategic Direction

The overall direction of QVH remains as set out in our Mission statements:

Purpose:

We provide specialist reconstructive surgery and expert rehabilitation services for the South of England, together with first class community medical services for our local population.

Mission:

We aim to be a national and international reference centre for reconstructive surgery, therapy, and rehabilitation services, and to be recognised locally for the high quality of our community medical services.

Vision:

Through a fully resourced and expert team of leading clinical specialists, we will be a centre of excellence for our specialist reconstructive and rehabilitation services, which we will offer through a network of facilities across the South of England, centred on East Grinstead. We will continue to provide and extend direct access to the medical and diagnostic services we offer to our local population.

1.2 The Trust's Strategy over the Next Three Years

Key Strategic Objectives for QVH

The key strategic objectives (KSOs) for the organisation are:

1. To deliver the highest standards of patient care and safety
2. To streamline our care pathways for the benefit of patients
3. To achieve and maintain a sustainable financial position
4. To provide a safe, reliable and comfortable physical environment for staff and patients
5. To be an exemplary employer treating our employees with fairness and respect
6. To maintain a strong culture of professionalism and a culture of caring

The key priorities identified for the coming period to achieve our strategic objectives are

1. Ensuring that QVH remains the hospital of choice in its core services for patients across Kent, Surrey, and Sussex (KSO 1,3).
2. Continue to improve the efficiency of our services through our streamlining projects, ensuring the minimum of inconvenience and disruption to patient pathways. (KSO 2,3)
3. Commence the replacement of our aged theatres at QVH. Continue to develop operating sessions in partner organisations. (KSO 1, 4)
4. Further improve our performance management and organisational efficiency (KSO 4).
5. Focus on and develop the core business of QVH, addressing issues of non-sustainable services. (KSO 3)
6. Implement our values-based organisational development programme. The staff survey will be used as a barometer to measure the success of this initiative (KSO 5,6)

1.3 Table of key priorities

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2011-12)	Key milestones (2012-13)	Key milestones (2013-14)
Achieve improved level of services to patients from Surrey (hand surgery, skin cancer) and in Sussex (partnership with BSUH)	Maintain referrals of patients	<p>Hand surgery service to East Surrey GPs established</p> <p>Active membership of skin cancer MDT in Surrey</p> <p>Clear patient pathways for Sussex skin cancer agree with BSUH and cancer network</p> <p>New hand surgery service established following conclusion of SOTC tender.</p>	Maintained and improved patient referrals	Maintained and improved patient referrals
<p>Our stated priorities for improving quality of care for 2011/12 are</p> <p>1. We aim to guarantee that once an outpatient appointment is made to attend QVH it will not be changed, except at the patient's request.</p> <p>2. We aim to provide all patients with written communication about their surgery and discharge Management</p> <p>3. We aim to take patient consent for</p>	Continued improvement in quality of care and service. Improvement in patient safety and good practice.	<p>Maximum of 10% cancellations, aspiration 0%</p> <p>100% compliance established</p>	<p>Maximum of 10% cancellations, aspiration 0%</p> <p>100% maintained</p>	<p>Maximum of 10% cancellations, aspiration 0%</p> <p>100% maintained</p>

elective surgery prior to the day of surgery at QVH. 4. We aim to roll out of electronic discharge notification to General Practitioner's for all patients by March 2012		Minimum achieved 60% 100% compliance	Minimum achieved 80% 100% maintained	Minimum achieved 80% 100% maintained
In 2011/12 our priorities for service improvement will be: Further development of Trauma pathway Elective pathway including pre-assessment Cancer pathway Prosthetics Laboratory	Continued streamlining and improved efficiency for patients. Improved use of resources	Consolidate arrangements to ensure over 90% trauma patients treated within 24 hours. Ensure >80% elective patients preassessed on day of outpatients. Minimised cancellations Revised skin cancer patient pathway to further reduce waiting times and improve efficiency. Specific focus in patients referred to off site clinics Further improve Prosthetic lab patient pathway. Reduced waiting times for assessment and first treatment.	Maintain >90% Increase to 90%	Maintain >90% Increase to >95%
Launch the construction of 6 new theatres to replace the A wing and day surgery theatres	Addresses key strategic vulnerability of aged and unreliable estate	FBC adopted. Procurement complete. Building work commenced Q3	Progress to project plan	Progress to project plan
Introduce further service line	Improved performance	New reporting framework		

reporting and accountability (sub speciality level) Introduce consultant-based reports on quality and delivery	management and accountability across the hospitals' services	finalised and adopted. Incorporated into service line governance and review structure and process		
In 2011/12 the Trust will review and develop its Private Patient strategy.	Subject to removal of PP Cap. Maintains critical mass of services and contributes to support for NHS services. Attracts and retains lead clinicians	Strategy finalised	Subject to removal of cap, strategy implemented in partnership with on-site private hospital	
Divest Jubilee Ward community medical beds.	Significantly loss making service, and not core to reconstruction. ? include due to variable patient numbers it is difficult to retain staff and ensuring quality of care is essential to a group of vulnerable patients	Notice given. Support to PCT and GP commissioners in finalising alternative proposals.	Jubilee ward divested month one.	
Design and deliver phase 2 of the work to produce a set of QVH values, including further promulgation of the NHS Constitution; Continue planning leadership development opportunities and events; develop an e-learning plan to roll out e-packages for mandatory and statutory training;	Continued development of workforce. Reinforced culture and values key to future success.	Values and supporting documentation (e.g. behaviours) finalised and adopted. Leadership framework finalised and adopted. . Elearning strategy adopted. First phase of elearning packages in place.	Incorporated into recruitment and appraisal processes Incorporated into promotion, recruitment, appraisal, and PDP processes.	

Review externally provided training courses and develop a framework of development for leadership positions;				
Maintain a skilled workforce to deliver clinical care	Maintains quality of care patients receive	Annual skill mix reviews of clinical areas using national benchmarking and trust quality metrics to support proposed staffing /skill levels	Annual skill mix reviews of clinical areas using national benchmarking and trust quality metrics to support proposed staffing /skill levels	Annual skill mix reviews of clinical areas using national benchmarking and trust quality metrics to support proposed staffing /skill levels
Develop second hub in Kent	Ensures continued service to whole of South East. Improves access and waiting list management	Complete evaluation of options	Launch hub by April 2012	

Section 2 External Environment

Summary of External Environment

Key External Impact	Risk to / impact on strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Development of new commissioning structures	Increased number of commissioners to deal with	Develop relationships through establishment of QVH Programme Board	Improved contact networks with GP Consortia and PCT Clusters	Appropriate attendance and effective working of Programme Board
Wider economic position	Tariff reductions and commissioner savings targets affect sustainability of services eg Hand Surgery, Cataracts	Continual review of service costs and efficiency	Financial pressures will inevitably increase	Financial performance / FRR

Changes to commissioning intentions / thresholds – diversion of patients to less expert general services	Income and service sustainability adversely affected	Ensure agreement of appropriate clinical pathways and thresholds Ensure evidence of compliance in notes Ensure appropriate approval reference on all accepted referrals	QVH currently compliant	Activity and Referral levels Service line analysis
Development of alternative services by commissioners	Income and service sustainability adversely	Ensure patient choice is maintained	Referral to CCP if necessary	Activity and Referral levels

Section 3 Trust Plans

3.1 Financial Plans - Income

The Trust has based its activity and financial planning on its strategy of focussing on core surgical specialities and in light of commissioner plans for service and referral changes. Total income is expected to fall slightly over each of the next three years from £55.5m in 2011/12 to £53.5m in 2013/14.

Overall activity levels planned for 2011/12 are broadly in line with 2010/11 outturn. There are reductions planned where commissioners are identifying changes to pathways and new referral management processes. The areas affected include cataract surgery, low priority procedures, referral management of dental and orthodontic work. The alternative providers are not in place in all cases and there remain challenges to some schemes in the light of their potential impact of reducing patient choice. QVH has established a Programme Board, a bi-monthly meeting of senior Trust representatives and commissioning leads from PCTs and GP Consortia. At its meeting in May 2011 this group confirmed the Trust's planning and income assumptions were reasonable and supported the planned investment in Operating Theatres to replace existing ageing estate capacity.

Trust income is also adversely affected by tariff changes in core services, where some of the higher tariffs previously attracted by this work have been reduced. This will reduce income by £975k.

There is a small mitigation from an increase in Market Forces Factor which increases income by £258k.

The Trust expects to see increased activity in some specialities where work is repatriated to QVH from outside the area or is focussed on the Trust as the specialist provider ensuring optimum clinical outcomes. Examples are described in the Service Developments section of the Plan.

Key income risks are set out in the table below

Key Income Risk	Amounts and timings	Mitigating actions and delivery risk
Low Priority Procedures – if commissioners reduce spend on current procedures then activity and income could fall e.g. hand procedures (Dupuytren's, Ganglions); Skin lesions (non malignant, BCC); non-oncological breast reconstruction; dentoalveolar treatments	QVH believes there is compliance with current clinical criteria and therefore financial impact will be minimal. Commissioners hope to identify more significant savings in 2011/12	<ul style="list-style-type: none"> • Ensure agreement of appropriate clinical pathways and thresholds • Ensure evidence of compliance in notes • Ensure appropriate approval reference on all accepted referrals
LPP – Hand surgery	To be confirmed as clinical modelling for activity develops	<ul style="list-style-type: none"> • to become the regional hub for Sussex/South Surrey working in collaboration with neighbouring hospitals, amending the current referral management system, establishing out reach clinics •
Competitor services established in glaucoma, cataract, dermatology	To be confirmed once final scope of competitor services is defined by commissioners	<ul style="list-style-type: none"> • Evaluate potential for bidding / retaining work • Improve awareness of clinical outcomes at QVH through marketing and communications • Potential challenge if infringes patient choice • If service lost would need to reduce capacity and costs at QVH
Loss of Cataracts activity	Up to £425k (500 cases) in 2011/12 but alternative provider not yet identified	<ul style="list-style-type: none"> • Deferral of clinical staff recruitment • Seek to ensure continued access for secondary cataract service with focus on complex cases
GP Referral Management schemes diverting activity away from QVH	Commissioners seeking £1.6m reduction on 2010/11 activity.	<ul style="list-style-type: none"> • Potential challenge if infringes Patient Choice and Any Willing Provider • Improve awareness of clinical outcomes at QVH through marketing and communications
Reductions in Cancer	To be confirmed as clinical	<ul style="list-style-type: none"> • QVH will continue to

referrals	modelling for activity develops	<p>work with cancer networks and Diagnosis Orientated Groups in Surrey, Kent, and Sussex to establish and maintain QVH cancer treatment options on all relevant treatment pathways.</p> <ul style="list-style-type: none"> • In particular, establish agreed clinical pathways for skin cancer referrals for surgery in north Sussex, east Surrey, and Kent. • Further establish microvascular breast reconstruction as a prime treatment option following or in association with mastectomy in Kent, Surrey, and Sussex. • Continued development of collaboration on head and neck cancer with Surrey and Sussex Hospital, BSUH, and with Western Sussex Hospitals.
Reductions in referrals to Orthodontic / dentoalveolar services	Included in £1.6m identified above	<ul style="list-style-type: none"> • Establish referral pathways and criteria for dentoalveolar/orthodontic services complementing orthognathic services
Unacceptable behaviour by Commissioners eg non payment of invoices		<ul style="list-style-type: none"> • Ensure explicit agreement with all major commissioners for monthly block payments • Establish a clear and timely escalation process for disputes including arbitration • Be more proactive in holding to account on compliance with Code of Conduct and Payment by Results guidance • Reconciliation of SLAM and SUS

		systems patient data to reduce risk of challenges
Burns Network review		<ul style="list-style-type: none"> Cooperate with the review and provide evidence of good clinical outcomes
Ageing estate increases risk to service disruption		<ul style="list-style-type: none"> Planned major investment in new Theatres to replace existing A wing Ongoing capital programme
Tariff reductions in hand and breast surgery adversely affecting service line profitability	Already included in plans	<ul style="list-style-type: none"> Review clinical practice to ensure procedures match tariff assumptions Seek local prices where clinically justified
Impact of Local Authorities reducing social care packages, leading to delayed discharge and / or unplanned readmissions	To be confirmed	<ul style="list-style-type: none"> Monitor closely Continue engagement with Local Authorities through the local Chief Executives' group and escalate as appropriate

3.2 Financial Plans – Service Developments

Service development priorities	Contribution to the strategy	Key actions and delivery risk	Key resource requirements	Measures of progress 2011/12 2012/13 2013/14
Organic / innovation:				
Maintain existing levels of referrals to specialist services. Improve links to St Richards and Chichester catchment population Develop	Key overall threat to the future of the hospital is reduction of referrals to our specialist services.	Maintain and develop strategic relationship with neighbouring DGH hospitals, ensuring development of complementary services. Delivery risk is	Presence at key cancer network meetings and MDTs across three cancer networks – heavy time demand from managers and lead clinicians. Liaison and	11/12 Improved business analysis and reporting – specifically focussing on referral lines from each catchment area. Target referral numbers

<p>services for East and South Surrey in partnership with East Surrey GP Consortium. Specifically hand and skin cancer.</p> <p>Further development clinical links with Brighton & Sussex University Hospitals in development of trauma services. Improve presence of plastics surgery in Brighton.</p> <p>Maintain full membership and links to three cancer networks (Surrey, Sussex, Kent)</p>		<p>competition and inappropriate development of single handed practitioner special interests.</p> <p>Establish appropriate referral pathways across relevant cancer networks (skin, head and neck, breast). Key delivery risk is protectionism from other services and inappropriate implementation of referral management services</p> <p>Liaison and engagement with new GP consortia across three counties. Risk is protection of local budgets and short term rather than strategic view.</p>	<p>development and senior corporate level with neighbouring hospitals (Medical Director, CEO, operations lead)</p> <p>Liaison with large number of GP Consortia. Complexity of different positions across the consortia. Requires clear single lead commissioner. Heavy demand on management and clinical time.</p>	<p>established.</p> <p>12/13 Strategic relationships reinforced. Commissioning principles agreed with all commissioners. Service line targets achieved.</p> <p>13/14. Continued performance against established targets.</p>
Acquisition, etc.:				
<i>None planned</i>				
Transferred / discontinued activity:				
Jubilee community medical beds divested or discontinued.	Loss making service, not financially supported by PCT.	Formal notice submitted to PCT. Staff, Governors, and HOSC fully advised. Discussions held with neighbouring hospitals regarding transfer of service to them. Continue to	Continued management time.	11/12 Proposals for future finalised with PCT and neighbouring hospitals. Necessary consultations led by PCT supported by QVH. Staff advised and managed appropriately.

		explore divestment options as alternative to closure.		12/13. Month one, service discontinued or divested.
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3.3 Financial Plans Activity and Costs

Table A - Cost Improvement Plans

Key Operating Efficiency programmes	Amounts and timing	Contribution to overall strategy	Key actions and delivery risk	Key resource requirements	Milestones
Reduce Corporate and support staff	£1.3m saving in 2011/12	Supports KSO 2,3	Consultation process April 2011 Implementation summer 2011	Management capacity for process	Consultation process April 2011
Reduce medical staff costs	£0.5m in 2011/12	Supports KSO 2,3	Review of medical staffing and on call rotas	Management capacity	Changes introduced by July 2011
Non pay savings	£0.4m in 2011/12	KSO 3	List of potential savings opportunities agreed	Capacity in procurement team to deliver	Programme timelines agreed by quarter

3.4 Financial Plans - Workforce

Key workforce priorities	Contribution to the overall strategy	Key actions and delivery risk	Key resource requirements	Milestones 2011/12 2012/13 2013/14
Organisational Development	Implement our values-based organisational development programme. The staff survey will be used as a barometer to measure the success of this initiative	Complete Culture and Values work to develop specific QVH values, owned by staff. To include further promulgation of NHS Constitution. Leadership development – embed	Management and Staff time. Some design and printing costs for 'Licence to Lead';	Values to be delivered by Q4 11/12; embedded in recruitment, person specs etc during 12/13. Licence to Lead to be implemented by Q4, 11/12; clinical leadership activities every

		<p>Leadership development programme; develop 'licence to lead'; continue clinical leadership activities.</p> <p>Review externally provided training courses to ensure that the Trust is getting value for money.</p> <p>Roll out E-Learning programme so that key mandatory training modules are available.</p>		<p>year at least annually; Key E-Learning modules to be available by end 11/12; full range by end 12/13.</p>
Staff Engagement	<p>Implement our values-based organisational development programme. The staff survey will be used as a barometer to measure the success of this initiative</p>	<p>Communications Manager to produce staff engagement toolkit; use output from staff survey and culture and values meetings to address issues and engage staff in solutions.</p>	<p>Management time; cost of Communications Manager (contracted out function);</p>	<p>Tool kit by end 11/12; staff survey and culture and values output to be pulled together and communicated by Q2, 11/12.</p>
Improve productivity and quality	<p>Continue to improve the efficiency of our services through our streamlining projects, ensuring the minimum of inconvenience and disruption to patient pathways.</p>	<p>Review ways of working (Service leads); streamline processes; support implementation of Time, Attendance and Rostering (TAR); review Recruitment and Retention Premia.</p>	<p>Management time; cost of e-rostering system (estimated at £35k annual cost plus £25k start up cost); continued cost of Recruitment and Retention Premia if retained.</p>	<p>Continuation of streamlining and re-processing work (don't know milestones as not leading on this); TAR project implementation to begin 11/12 but based on other Trusts, will take some years to full roll out. RRP's to be reviewed by Q3 11/12.</p>

Workforce planning and information	Further improve our performance management and organisational efficiency	Continue to work with both Service Leads and Finance Leads to develop workforce planning intentions; further develop monthly reporting to Board to provide assurance on safety; review profile of Trust in the light of the removal of the default retirement age.	Management time.	On going through out 11/12
Health and Wellbeing	Further improve our performance management and organisational efficiency	Monitor success of Employee Assistance Programme (introduced in December 10); work with Director of Nursing and Quality and Operational Managers to find ways of reducing sickness absence amongst Nursing staff.	Management time.	Monitoring quarterly every year. Sickness absence target reduction – current rate is 3.5%; will be expecting a reduction on this by end of 11/12, with an eventual target of 3%, timescale to be determined.
Maintain a skilled workforce to deliver clinical care	Maintains quality of care patients receive	Annual skill mix reviews of clinical areas using national benchmarking and trust quality metrics to support proposed staffing /skill levels	Annual skill mix reviews of clinical areas using national benchmarking and trust quality metrics to support proposed staffing /skill levels	Annual skill mix reviews of clinical areas using national benchmarking and trust quality metrics to support proposed staffing /skill levels

3.5 Financial Plans – Capital programmes (including estates strategy)

Key capital expenditure priorities	Amounts and timing (including financing schedules)	Contribution to the strategy (incl. service delivery)	Key actions and delivery risk (inc. finance risks)
Development:			
MaxFac POD	£1.14m in 2011/12 £0.07m in 2012/13 £0.07m in 2013/14	Enable modification in order to accommodate physical connection to new OPD Pod	Board sign off in June 2011
Paediatrics & Telemedicine	Paediatrics: £1.90m in 2011/12 Telemedicine: £0.43m in 2011/12 £0.20m in 2012/13	Externally funded services transformation for burns network	Project already underway and complete August 2011
Energy Centre/Medical Gases/equipment/enabling	£0.30m in 2011/12 £1.20m in 2012/13 Design work will commence in the 3 rd quarter of 2011 with the major capital spends being in the calendar year of 2012. Final valuations and retentions will be paid in 2013/14.	Backlog projects brought forward to accommodate new development	Board sign off in May 2011
Health Records	£0.21m in 2011/12 Spend will be in Q2 2011/12	Existing Health Records building needs to be demolished to create some of the space required for the new Theatre development.	Off site location has been identified. Lease financial details have been agreed in principle. Work has commenced on the legal agreement. Transfer needs to be completed by December 2011 so as not to impact on the Theatres project.
Estates Department	£0.11m in 2011/12 Q2	The Estates Department is located on the site identified for the relocated Out-Patients Department 2.	The existing department will transfer to the refurbished Toy Box crèche building. Plans and tender documents are being prepared at present. This move has to be complete by the end of August 2011 as it is an enabling contract that allows the major move of OPD2.

Out-Patients Department 2	£0.49m in 2011/12 Spend profiles are predicated on the main building unit being leased on a 5 year period from a modular build company.	Out-Patients Department 2 is the second major demolition required to create the space on site for the Theatres development.	Once the Estates Department has moved, the existing offices will be demolished and the new OPD2 completed on that site. Plans and tender documents are being prepared at present. OPD2 needs to be operational by December 2011 so as not to delay the Theatres project. Some smaller moves will follow on from this but these are moves within the existing site buildings.
New Theatres	£0.90m in 2011/12 £8.90m in 2012/13 Design work will commence in the 3 rd quarter of 2011 with the major capital spends being in the calendar year of 2012.	The new Theatre suite is the Strategic Strategy of this project. It will provide 6 modern theatres, with the possibility of a further 4 being added in the future. The Theatres will bring the stock up to current health care building design standards and provide an infrastructure that complements the high quality of care provided by the hospital.	Procurement of the design and construction of the new Theatres will be via the P21+ Framework. A selection of the PSCP is programmed for the end of June. A very good level of planning detail has already been signed off by the user group, so design development will commence as soon as a PSCP is appointed. The Enabling projects need to maintain their programme dates so as not to delay the start of work on site in the 1 st quarter of 2012.
Maintenance:			
Theatre Equipment	£0.3m in 2012/13	Health & Safety	Compliance
Capital Contingency & other expenditure	£1.20m in 2011/12 £1.26m in 2012/13 £1.26m in 2013/14	Health & Safety	Compliance
Sleep Studies and old theatre maintenance	£1.04m in 2013/14	Health & Safety	Compliance
Total Backlog Maintenance	£1.20m in 2011/12, £1.56m in 2012/13 and £2.30m in 2013/14	Health & Safety Business Continuity	Compliance

Other Capital Expenditure			
Ongoing investment in medical equipment	£0.50m per annum	Ensure patient safety and maintain clinical efficiency	Priority areas identified and procurement underway for 2011/12
Ongoing investment in IT supporting the Trust's overall IT Strategy	£0.25m per annum	Improving operational efficiency of the Trust	Priority areas identified and procurement underway for 2011/12

3.6 Clinical Plans

Quality issues and measures	Contribution to the strategy	Key actions and delivery risk	Performance in 2010/11	3 year targets / measures for 2011/12 2012/13 2013/14
We aim to guarantee that once an outpatient appointment is made to attend QVH it will not be changed, except at the patient's request.	Continued improvement in quality of care and service. Improvement in patient safety and good practice	Introduction of nurse led clinics Increased arrangements to cover cancelled clinics Appoint an orthoptist Only book appointments once histology results are available	Maximum of 10% cancellations, aspiration 0%	Maximum of 10% cancellations, aspiration 0%
We aim to provide all patients with written communication about their surgery and discharge management:	Continued improvement in quality of care and service. Improvement in patient safety and good practice	Full review of what information is provided along their pathway of care. Monitoring of electronic discharge information, information provided at consent and GP copy letters. This will enable us to target information gaps.	>80% satisfaction in the Picker inpatient survey for were you given written information about what you should do after leaving hospital >60% Did you receive copies of letters sent	>85% satisfaction in the Picker inpatient survey for were you given written information about what you should do after leaving hospital >70% Did you receive copies of letters sent from hospital doctors to your

			from hospital doctors to your GP	GP
We aim to take patient consent for elective surgery prior to the day of surgery at QVH.	Continued improvement in quality of care and service. Improvement in patient safety and good practice	Specific activity to remind clinicians of the benefits of active consent	>60% completed the day prior to surgery	>80% completed the day prior to surgery
We aim to roll out of electronic discharge notification (EDN) to General Practitioner's for all patients by March 2012	Continued improvement in quality of care and service. Improvement in patient safety and good practice	Further roll out of current EDN system to all specialities	Maintain 100%	Maintain 100%
Maintain infection control rates below national maximum level identified	Continued improvement in quality of care and service. Improvement in patient safety and good practice	Maintain current standards and remain proactive – risk is the low numbers of the maximum target MRSA = 1 C Difficile = 5	MRSA 2 against a max limit of 1 C Diff 6 against a maximum limit of 4	MRSA = 1 C Difficile = 5
Maintain a reduction in falls and pressure ulcers demonstrating excellence in care	Continued improvement in quality of care and service. Improvement in patient safety and good practice	Maintain current standards and remain proactive – risk is the low numbers of the maximum target	Pressure ulcers = 9 2010/11 Falls with harm = 31 2010/11	SHA target on whole year Pressure ulcers Pressure ulcers 2010 - 10 2011 - 9 2012 - 7 Falls 2010 – 29 2011 – 28 2012 - 26

Each month the Board of Directors are provided with an Infection Control report and a Quality and Risk report. The infection control report details the number of cases of MRSA, MSSA and C Difficile that have occurred within the previous month as well as any notable outbreaks. Any specific infection control risks are documented and a report on hand hygiene compliance across the trust is provided.

The monthly Quality and Risk reports provide information on incidents that have been rated red or amber. All Serious Untoward Incidents would be rated red and the final action plan is provided to the Board with updates incorporated into the monthly report. The board is also provided with the information on the number of open and closed red and amber risks, this enables challenge if they are able to note that red risks have not been closed as all actions

have not been completed by the responsible operational group. All risks rated above 12 are included along with the mitigating actions required, where appropriate these are linked to the Board assurance framework. A Quality Metrics dashboard is in place that provides monthly/quarterly information on aspects of safety involving patients and staff, which includes measures on delivery against mixed sex accommodation requirements, patient experience upon discharge and staff incidents causing harm. The report also provides an update on the number of complaints and claims during the preceding month and provides information where complaints have not been satisfied with the outcome of their complaint. In addition the board is provided with reports on events as they occur ie National inpatient survey results, CQC visits, staff survey results etc.

A workforce report also provides information on staffing across the organisation including sickness and absence rates, attendance at training and appraisal provision. In addition the report provides department specific information on vacancies, bank or agency usage and the occurrence of pressure ulcer development at grade 2 or above and the number of patient falls involving harm. This allows us to consider harm along side department staffing levels and their vacancy rates.

Clinical quality improvements are in addition identified within our quality account and improvement against these measures and CQUINs are included within the monthly quality and risk Board report.

All these reports provide the board with an overall picture of safety and quality across the trust and allow for triangulation of data allowing the Board to identify any areas of concern.

Section 4 Regulatory Requirements

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Governance rating	Governance rating "amber/red" at Q4 2010/11	Ongoing scrutiny of HCAI Review and streamlining of patient pathways to ensure delivery of national targets	Green rating
Financial Risk Rating	NHS facing significant financial challenges which may affect Trust performance	Delivery of Trust strategy including maintenance of activity and achievement of CIPs	Maintain at least FRR 4

Jubilee ward	Cessation of Mandatory Service	Engagement with stakeholders and local community to ensure acceptable long term solution	Acceptable long term solution found by April 2012
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Section 5 Leadership and Governance

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2011/12 2012/13 2013/14
Ensure Board remains appropriately skilled and resourced to undertake role	Risk that Board unable to function effectively	Trust Board to undertake NHS Institute Board development tool	Tool completed by March 2012 and action plan implemented
Ensure necessary leadership skills are in place across senior postholders	Ineffective leadership leading to deteriorating performance	Leadership programme for clinicians and senior managers being rolled out	All key staff trained by March 2012
Non Executive / Senior Independent Director retires in Sept 2011	Loss of skills and corporate memory to Board	Replacement appointed	Replacement in post by September 2011

As part of the Planning process the Trust Board works closely with the Board of Governors in establishing the priorities for the organisation. The Governors' Steering Group coordinates comments and proposals from members and these are reviewed by the Executive team. Feedback on which items will formally be included in the Annual Plan (and which if any are excluded) as well as how they will be monitored is given in public at a Board of Governors meeting during the planning stage. The draft plan is shared with Governor Representatives at Board meetings and the final Plan is presented to a public Board of Governors meeting on completion.

Appendix

Detailed Financial Summary £m		2010-11	2011-12	2012-13	2013-14
		Actuals	Plan	Plan	Plan
Total operating income		56.8	55.5	54.5	53.6
Employee Expenses		(36.2)	(35.2)	(33.8)	(32.3)
Drugs expense		(1.0)	(0.9)	(1.0)	(1.0)
Supplies (clinical & non-clinical)		(11.6)	(11.8)	(12.2)	(12.5)
PFI expenses		0.0	0.0	0.0	0.0
Other Costs		(2.3)	(2.1)	(2.2)	(2.2)
Total operating expenses		(51.1)	(50.0)	(49.1)	(48.0)
EBITDA		5.7	5.5	5.4	5.5
Net Surplus / (Deficit)		(1.4)	2.3	0.3	1.6
EBITDA % Income	%	10.1%	9.9%	10.0%	10.3%
CIP% of Op.Exp. less PFI Exp.	%	2.7%	4.1%	4.3%	4.3%
Capital expenditure		(1.2)	(7.4)	(12.6)	(3.1)
Net cash inflow/outflow		2.2	(2.9)	(0.3)	0.9
Cash and cash equivalents		7.0	4.0	3.8	4.7
Liquidity days		65.2	45.5	43.9	51.1
Net current assets/(liabilities)		5.5	2.5	2.2	3.1
Planned borrowings		0.0	0.5	9.0	9.5

Cost Improvement Plans (CIPs) Totals		Actual for Year ending 31-Mar-11	Plan for Year ending 31-Mar-2012	Plan for Year ending 31-Mar-2013	Plan for Year ending 31-Mar-2014
Totals			Value £m	Value £m	Value £m
Analysis of Revenue Generation and Expense CIPS					
Recurring CIPs + revenue generation schemes		1.398	2.139		
Non-recurring CIPs + revenue generation schemes		0.000	0.000	2.206	2.180
Total (agrees to above)		1.398	2.139	2.206	2.180
1 Short Name or Description					
Reduce Corporate and support staff					
Total revenue generation scheme effect			1.217	1.392	1.376
2 Short Name or Description					
Reduce medical staff costs					
Total revenue generation scheme effect			0.545	0.500	0.494
3 Short Name or Description					
Non Pay Saving			0.378	0.314	0.310

List of Directors, Governors and elections for Queen Victoria Hospital NHS FT

Directors (at 31 May 2011 or date of submission, whichever is earlier)						
Role	Job Title	Name of Director	Tenure	Date appointed		
example Finance Director	Director of Finance and Information	Ms Jane Doe	Acting	01/05/2010		
Chair	Chairman	Peter Griffiths	Permanent	01/04/2005		
Chief Executive	Chief Executive	Dr Adrian Bull	Permanent	15/12/2008		
Medical Director	Medical Director	Mr Ken Lavery	Permanent	01/11/2007		
Finance Director	Director of Finance and Commerce	Richard Hathaway	Permanent	01/04/2010		
Nursing Director	Director of Nursing & Quality	Amanda Parker	Permanent	01/08/2009		
NED	Deputy Chairman and Non Executive Director	Hugh Ure	Permanent	01/04/2007		
NED	Non Executive Director	Jeremy Beech	Permanent	01/10/2005		
NED	Non Executive Director	Renny Leach	Permanent	01/01/2007		
NED	Non Executive Director	Shena Winning	Permanent	01/04/2009		
Governors (at 31 May 2011 or date of submission, whichever is earlier)						
Constituency Type	Full Name of Constituency	Name of Governor	Origin	Date appointed/elected		
example Public	North west outtown	Mr John Jones	Elected	01/05/2010		
Public	Public	Mr Bernard Atkinson	Elected (Contested)	01/07/2009		
Public	Public	Mr Len Barlow	Elected (Contested)	01/07/2009		
Public	Public	Mr Stuart Barnett	Elected (Contested)	01/07/2009		
Public	Public	Miss Gill Baxter	Elected (Contested)	01/07/2008		
Public	Public	Mr Edward Belsey	Elected (Contested)	01/07/2009		
Public	Public	Mr John Bowers	Elected (Contested)	01/07/2008		
Public	Public	Mrs Patricia Bridgen	Elected (Uncontested)	01/07/2010		
Public	Public	Mr Adrian Fuchs	Elected (Contested)	01/07/2008		
Public	Public	Mr Brian Goode	Elected (Uncontested)	01/07/2010		
Public	Public	Mr Peter Harper	Elected (Contested)	01/07/2008		
Public	Public	Mr Bill Hatton	Elected (Contested)	01/07/2008		
Public	Public	Miss Caroline Hitchcock	Elected (Contested)	01/07/2009		
Public	Public	Mrs Sue Hull	Elected (Contested)	01/07/2008		
Public	Public	Mrs Valerie King	Elected (Contested)	01/07/2008		
Public	Public	Mrs Shirley Mitchell	Elected (Contested)	01/07/2008		
Public	Public	Mrs Moira McMillan	Elected (Uncontested)	01/07/2010		
Public	Public	Mrs Manya Sheldon	Elected (Contested)	01/07/2009		
Public	Public	Mr Ian Stewart	Elected (Contested)	01/07/2008		
Public	Public	Mr Alan Thomas	Elected (Contested)	01/07/2009		
Staff	Staff	Mrs Mabel Cunningham	Elected (Uncontested)	01/07/2010		
Staff	Staff	Mrs Carol Lehan	Elected (Uncontested)	01/06/2010		
Staff	Staff	Mr Christian Petersen	Elected (Uncontested)	01/07/2010		
		Dr Andrew Robertson	Appointed	01/07/2010		
		Mr Peter Evans	Appointed	01/07/2009		
		Mr Paul Treveithick	Appointed	01/05/2010		
Elections Held (between 1 April 2010 and 31 March 2011)						
Constituency Type	Full Name of Constituency	No. of candidates	No. of Votes cast	Turnout	No. of Eligible voters	Date of election
example Public	North west outtown	4	1,345	16.3%	8,230	01/05/2010
Public	Public	5	Uncontested	n/a	n/a	
Staff	Staff	1	Uncontested	n/a	n/a	

Membership return for Queen Victoria Hospital NHS FT

Membership size and movements					
Public constituency			2010/11		2011/12 (estimated)
	At year start (April 1)	+ve	10,650		10,346
	New members	+ve	77		
	Members leaving	+ve	381		
	At year end (31 March)		10,346		10,346
Staff constituency			2010/11		2011/12 (estimated)
	At year start (April 1)	+ve	839		814
	New members	+ve	42		
	Members leaving	+ve	67		
	At year end (31 March)		814		814
Patient constituency			2010/11		2011/12 (estimated)
	At year start (April 1)	+ve			0
	New members	+ve			
	Members leaving	+ve			
	At year end (31 March)		0		0

Analysis of membership at 31 March 2011			
Public constituency		31 Mar 2011 Actual members	31 Mar 2011 Eligible membership
Age (years):			
	0-16	26	1,742,088
	17-21	4019	732,813
	22+	6301	3,647,011
	Unknown	0	
			6,121,912
Ethnicity			
	White	10081	5,886,903
	Mixed	40	61309
	Asian or Asian British	121	102,589
	Black or Black British	56	26782
	Other	48	44329
	Unknown	0	0
Socio-economic groupings*:			
	ABC1	6,590	3,793,183
	C2	1,732	1,048,089
	D	1583	1,018,825
	E	441	261,815
	Unknown	0	0
Gender:			
	Male	4,748	2,972,093
	Female	5,598	3,149,819
	Unknown	0	0
Patient Constituency		31 Mar 2011 members	Eligible membership
	Age (years):		
	0-16		
	17-21		
	22+	0	
Staff Constituency		31 Mar 2011 members	Eligible membership
	Members	814	822